

**Health Education and Improvement Wales and Social Care Wales consultation on the Strategic Mental Health Workforce Plan for health and social care.**

The Royal College of Speech and Language Therapists (RCSLT) Wales welcomes the opportunity to respond to the consultation on the Strategic Mental Health Workforce Plan for Health and Social Care.

RCSLT Wales views the plan as a real opportunity to remodel current provision and create sustainable services which ensure that all people in Wales can access appropriate mental health support. We believe that multidisciplinary working – with a well-trained, supported workforce that is equipped to meet the demands – should be central to the future provision of mental health services. This approach would enable each group of professionals to use their own unique skills, knowledge, and abilities to better meet the needs of individuals. In our view, development and improvement of the mental health workforce must include the full range of allied health professionals and bring in new professions and skillsets including speech and language therapy.

We provided significant evidence on the the case for the inclusion of speech and language therapists (SLTs) within the mental health workforce in Wales, the current speech and language therapy workforce within mental health and our proposal for a potential future model of delivery as part of the evidence gathering section of the consultation. This paper may be found [here and at Annex A.](https://heiw.nhs.wales/programmes/consultation-workshops-mental-health-workforce-plan/engagement-technical-summary-document/) In this response, we focus on the key actions of relevance, namely actions 2, 3, 5, 7, 18, 26 and 27. We have also produced a joint response to the plan alongside the Royal College of Occupational Therapists, the Chartered Society of Physiotherapy, the Royal College of Podiatry and the British Dietetic Association

We would be very keen to be involved in further discussions about the next iteration of the plan. Please contact Caroline Walters, External Affairs Manager (Wales) on caroline.walters@rcslt.org

Comments on relevant actions

**Action 2: Undertake scenario planning to inform the shape of the specialist mental health workforce including nursing, pharmacy, psychiatry, social work, psychological therapies and AHPs for the next 10 years.**

We welcome this action point and would be keen to be involved in further discussions about scenario planning for the AHP mental health workforce both as an individual professional body and as a member of the Health and Social Care policy officers – a grouping which comprises of policy officers from 6 AHP professional bodies. We work closely with our colleagues in England and Northern Ireland who are also engaged in developing national mental health workforce plans and believe we could bring helpful learning from these experiences to further discussions.

In our earlier paper (referenced above), we highlighted a number of key points with relation to the development of the future speech and language therapy workforce.

* New and developing service provision requires innovative clinicians with suitable and broad clinical experience and leadership experience. They also need post graduate training, including in the areas of dysphagia (swallowing difficulties) and advanced clinical practice around communication and mental health.
* Newly commissioned services therefore require leadership by clinical lead speech and language therapists (8a). This clinical leadership can then allow for requirement to band 7 and 6 speech and language therapists.
* The recruitment of band 5 speech and language therapists and newly qualified practitioner (NQP) SLTs is also essential to this field. Where few SLTs exist in services then typically a higher banding is required for this level of autonomy, yet it can skew the workforce to look very specialist and look like a high banding is required. This is not the case should the right workforce structure be in place. NQP and band 5 therapists are interested in and would be highly effective in mental health services and we need to create the right workforce structures to facilitate this with clinical and professional supervision and also career progression.
* An SLT specialist workforce is required within MH services specifically, in order to provide the right service with the right skills. Some mental health literacy is also required across all areas of speech and language therapy.
* It will also be crucial to understand the role of the independent sector (where some secure settings employ SLTs independently +/- seeking support from the NHS, for example.) Knowledge of cross-sector working will be essential to the future workforce, as will the development of the workforce out with health/social care services.

There is much to be learnt from the experience of speech and Language therapy within dementia services.  Following a specific recommendation from the previous Senedd Health, Social Care and Sport Committee in their report on the use of anti-psychotic medication in care homes (Senedd Health, Social Care and Sport Committee, 2018) and references to communication and swallowing support within the Welsh Government Dementia Action Plan for Wales (Welsh Government, 2018), we have seen significant increases in the number of SLTs available to support people affected by dementia and the development of key roles to scope service need.  A peer group has also been developed to support SLTs working in this area to share training, resources and expertise.

We would wish to see scenario planning specifically consider the need to expand speech and language therapy roles within mental health.

Scenario planning also needs to consider the impact of coordinating Continuing Health Care (CHC) funding and care and how this funding influences the workforce in many ways including, retention, job satisfaction, role clarity, taking up a lot of what should be specialist clinical time. There is also an impact with regard to the commissioning of packages in private sectors e.g. to what extent do they commission speech and language therapy, occupational therapy, psychology as part of the package of care.

Action 3: Ensure that data quality improvement projects under the workforce strategy address the needs of the mental health workforce.

Paucity of data collection is a key issue in relation to health inequalities which requires further attention and we are pleased to see this proposed action point. Information from the NHS electronic staff record (ESR) and vacancy rates will only provide us with intelligence about what workforce we currently have and which may not indicate clinical work carried out depending on service structures and responsibilities.  As we highlighted in our earlier report, we have significant concerns about the data captured from ESR to inform the draft plan. We are of the view this data may present a misleading view of current speech and language therapy provision within mental health services in NHS Wales. This data appears to include posts in learning disability teams where speech and language therapy has historically but not currently been represented. We believe the data may also include dementia services, neurodevelopmental services and youth offending teams. It may also include SLTs providing limited in-reach to patients accessing mental health services who are not specifically employed to provide consistent and adequate services.

We feel there is significant potential to look at data from local health boards on need – met, under-met and unmet to inform the development of the future workforce.

Action 5: Develop and implement plans to ensure that there is an appropriate supply of trained professionals to undertake new and existing legal roles.

We believe given the forthcoming proposed changes to mental health legislation, it is pressing that scenario planning takes place for the speech and language therapy workforce.

RCSLT responded to the Reforming the Mental Health Act White Paper making a number of calls including that SLTs should be added to the list of professionals for the approved clinician/responsible clinician role. The recently published consultation on the liberty protections safeguards adds SLTs to the designated approved mental capacity professionals under changes to the law. The Department of Health in England has invited RCSLT to support discussions round potential future workforce supply in terms of placements, training and appetite amongst existing workforce to undertake these new roles. We believe a similar approach is required for Wales. These considerations will also need to feed into discussions around commissioning numbers given likely workforce capacity challenges.

**Action 7: Develop and implement a specialist mental health Allied Health Professional (AHP) model as a pathfinder for rollout across Wales.**

We would be very interested in being involved in further discussions about the pathfinder model both as an individual profession and as a member of the collective AHP policy officers grouping. Given the limited number of current speech and language therapy posts in mental health services in Wales we would be keen to share learning from services across the border and within the other devolved nations. At appendix B, we have included a number of case-studies for consideration include case studies from Belfast and Cumbria.

Action 13: Develop a targeted attraction campaign programme for the mental health workforce, supported by [Train Work Live](https://www.wales.com/train-work-live) and [We Care Wales](https://wecare.wales/).

RCSLT believe that it is essential that that the longer term (Phase 2) campaign plan includes AHPs. We have been very interested to learn more about the Health Education England AHPs in Mental Health programme under which a number of films have been produced showcasing AHPs’ unique contribution with mental health. The programme has also produced a guide and films highlighting the benefits of practice-based learning through placements in mental health and learning disability settings for Allied Health Professions (AHP) students. The speech and language therapy case study highlight how placements have enabled the service to evidence need and develop a pipeline of future band 5s. We would be keen to see consideration of a potential similar programme in Wales.

**Action 18: Building on the work developed by** [Health Education England](https://www.hee.nhs.uk/sites/default/files/documents/New%20Roles%20in%20Mental%20Health%20Project%20Resources.pdf) **(HEE) design an All Wales resource for implementation of new, expanded and extended roles into mental health multi-disciplinary teams.**

We would be very keen to learn more about the progress of the three trailblazer projects funded under this work stream to demonstrate how optimising the input of AHPs working to their upper capacity can improve outcomes for patients with mental health issues and believe this could influence the proposed AHP pathfinder.

We are supportive of the development of an All Wales resource for the implementation of new, expanded and extended roles. SLTs have a unique role to play as members of multi-disciplinary mental health teams in identifying communication difficulties and swallowing disorders, in their support and in the management and reduction of associated harm and risk. It is essential that the profession is included within the compendium.

Action 26: Commission professional bodies to assess interprofessional education and training opportunities for the specialist mental health workforce.

As we highlighted in our previous report, there is compelling evidence on the relationship between mental health and swallowing and communication difficulties.

We have developed a [**free e-learning tool**](https://www.rcsltcpd.org.uk/courses/mind-your-words-children-and-young-peoples-mental-health/)- Mind Your Words (children and young people’s mental health) for professionals working with children and young people.

The tool aims to improve understanding of children and young people who have both mental health needs (or social, emotional and mental health needs – SEMH) and speech, language and communication needs (SLCN). The online training highlights the links between mental health and communication and outlines how professionals can work together to remove communication barriers and help these children and young people achieve their potential.

The course consists of 15 modules, of which the first five apply to all settings. Each module takes between 10 and 20 minutes to complete. The five core modules explain what speech, language and communication needs are, what social, emotional and mental health needs are, and how to recognise them, as well as how they are interrelated and some general strategies that can be put in place. The remaining modules look in more detail at ways professionals can support children and young people, including getting support from speech and language therapy, working collaboratively, modifying risk assessment and de-escalation techniques, becoming a communication accessible service and much more.

We believe this course offers significant potential for multi-professional learning.

We would also wish to to ensure that the inter-professional development of the mental health workforce commences at under-graduate level. We believe HEIW have a clear role to play in this agenda, in close collaboration with higher education institutions.

 **Annex A: The potential Speech and Language Therapy (SLT) Workforce within mental health services in Wales**

The Royal College of Speech and Language Therapists (RCSLT) in Wales are grateful for the opportunity to contribute to the development of the new Social Care Wales/Health Education Improvement Wales mental health workforce plan. We view the plan as a real chance to remodel current provision and create sustainable services which ensure that all people in Wales are able to access appropriate mental health support.

We believe that multidisciplinary working – with a well-trained, supported workforce that is equipped to meet the demands – should be central to the future provision of mental health services. This approach would enable each group of professionals to use their own unique skills, knowledge, and abilities to better meet the needs of individuals. In our view, development and improvement of the mental health workforce must include the full range of allied health professionals and bring in new professions and skillsets.

This paper is organised into four main sections.

In the first section, we present the case for the inclusion of speech and language therapists within the mental health workforce in Wales, we describe;

* the growing evidence base on the links between mental health and communication and swallowing
* the role of speech and language therapists in both adult and children and young people’s mental health services taking into account the policy and legal context and clinical guidance– **pages 2-6.**

In the second section of the report, we provide a commentary of the current speech and language therapy (SLT) workforce within mental health and the current delivery model – **pages 7-8.**

In the third section of the report, we present our proposal for a potential future model of delivery and consider the potential future workforce– **pages 9-11**.

In the fourth section of the report, we provide case studies from across the UK – **pages 12-14**.

References are provided on **page 15**.

We would be delighted to provide further information if this would be helpful. Please contact wales@rcslt.org

**SECTION 1: The case for inclusion of Speech and Language Therapy within the mental health workforce in Wales**

Speech and language therapists are experts in supporting people with communication and swallowing needs. There is a growing research body showing the important links between mental health and communication and swallowing and the importance of the role of speech and language therapists within core mental health teams. This is summarized in the box below.

|  |
| --- |
| ***Communication - adults**** 80% of adults with mental health disorders have impairment in language (Walsh et al, 2007).
* Over 60% have impairment in communication and discourse (Walsh et al, 2007).

***Communication – children and young people**** Children with a mental health disorder are five times more likely to have problems with speech and language (NHS Digital, 2018).3
* 81% of children with social, emotional and mental health needs have significant unidentified language deficits (Hollo et al, 2014).4
* Adolescents and young adults with developmental language disorder (DLD) are more likely to experience anxiety and depression than their peers (Conti-Ramsden at al, 2008; Botting et al, 2016).

***Swallowing – adults**** Over 30% of adults with mental health disorders have some impairment in swallowing (Walsh et al, 2007).
* There is a greater prevalence of dysphagia (swallowing difficulties) in acute and community mental health settings compared to the general population - 35% in an inpatient unit and 27% in those attending day hospital, which compares to 6% in the general population (Regan et al, 2006).
 |

**The impact of communication and swallowing needs**

As the statistics above highlight, speech, language and communication difficulties are common in mental health problems.People with a primary communication difficulty are at a greater risk of experiencing mental health problems than their peers (Beitchman et al, 2001; Botting et al, 2016; Clegg et al, 2005). Communication impairment and swallowing needs may also be intrinsic to some mental health difficulties such as schizophrenia or psychosis (Colle et al, 2013; Boudewyn et al, 2017). Furthermore, speech, language and communication needs and swallowing problems can occur due to the side effects of medication used to treat mental illness (Gabbert et al, 2002).

**The impact of unmet communication needs**

Left unidentified and unsupported, communication difficulties can result in:

* referrals and assessments, including risk assessments for capacity and consent, which are inaccessible and/or return inaccurate results or diagnoses; and
* interventions that are verbally delivered being unsuccessful, due to omission of effective reasonable adjustments and communication support strategies with the potential for public resources to be wasted on failed interventions and legal ramifications. It is a legal requirement within the [Mental Health Measure 2010](https://www.legislation.gov.uk/mwa/2010/7/contents) to provide individuals with accessible information for aspects of care.

**The impact of unmet swallowing needs**

Unmet swallowing needs can pose a significant risk to patient safety, including through choking and aspiration pneumonia.

* the risk of death due to choking in people with schizophrenia has been reported as 30 times more likely than in the general population (Ruschena et al, 2003).

**The role of speech and language therapists within mental health**

Speech and language therapists have a ***unique*** role to play as members of multi-disciplinary mental health teams in identifying communication difficulties and swallowing disorders, in their support and in the management and reduction of associated harm and risk. As such, speech and language therapists should be considered as key in ensuring delivery on the priorities within the [Together for Mental Health delivery plan (2019-2022)](https://gov.wales/sites/default/files/publications/2020-01/together-for-mental-health-delivery-plan-2019-to-2022.pdf) as communication is essential for delivering high quality and effective health care.

**The legal context**

Persons with mental ill health and associated ill health are at risk as defined by the Mental Capacity Act (2005). It is also a legal requirement within the [Mental Health Measure 2010](https://www.legislation.gov.uk/mwa/2010/7/contents) to provide individuals with accessible information for all aspects of care. As part of the introduction of the Liberty Protection Safeguards, introduced in the [Mental Health Capacity (Amendment) Act (2019](https://www.legislation.gov.uk/ukpga/2019/18/enacted)), RCSLT has been calling for Approved Mental Capacity Professionals to be trained in awareness of communication needs and for speech and language therapists to be able to be trained as Approved Mental Capacity Professionals.

**Clinical guidance**

Given the increasing evidence base on the linkage between mental health difficulties and swallowing and communication needs, the role of SLT within mental health is starting to be recognised within clinical guidance as is the need to consider speech, language and communication needs.

* [‘Rehabilitation for patients with complex psychosis’](https://www.nice.org.uk/guidance/ng181/resources/rehabilitation-for-adults-with-complex-psychosis-pdf-66142016643013) (NICE, 2020) includes the wording “Speech and language therapist input would be needed to deal with the additional communication needs that can be experienced by this group” (NICE, 2020).
* [NICE Guidelines: Depression in children and young people: identification and management](https://www.nice.org.uk/guidance/ng134) (2019) notes that “Certain therapies may not be suitable or may need to be adapted for use with children generally or those with comorbidities, neurodevelopmental disorders, learning disabilities or different communication needs.”
* [NICE Quality Standard - Early years: promoting health and wellbeing in under 5s](https://www.nice.org.uk/guidance/ng181/resources/rehabilitation-for-adults-with-complex-psychosis-pdf-66142016643013) (2016) notes that “Children and young people with communication difficulties are at increased risk of social, emotional and behavioural difficulties and mental health problems. So, identifying their speech and language needs early is crucial for their health and wellbeing.”

SLT is a therapeutic protective intervention. It can help reduce inequalities and can enable successful relationships and relational security. Supporting health literacy is currently an area that is poorly serviced within mental health provision. Speech and language therapists are able to support this through assessment, individual intervention, provision of accessible information and ensuring the communication environment around the individual is enabling. Good communication supports resilience, for example it enables individuals to communicate effectively about emotions and promotes problem solving. Successful communication can facilitate access to verbally mediated psychological therapies and can also provide access support to the criminal justice system (CJS). For those individuals that need communication adjustments and supports, SLT should therefore be an integral part of the multi-disciplinary team (MDT) and mental health service.

**SLT role within adult mental health services**

[RCSLT guidance](https://www.rcslt.org/members/clinical-guidance/mental-health-adults/mental-health-adults-guidance/#section-5) recommends that the role of speech and language therapists within adult mental health services is to;

* establish the language skills level of individual patients to make informed decisions about suitability for verbally mediated interventions, eg. anger management, and to indicate whether the patient has the necessary skills to cope with group-based interventions. Difficulty in managing emotions such as anger can be underpinned by specific difficulties in social cognition or social perception. Speech and language therapists are vital to ensure individuals have sufficient health literacy and language skills in order to access psychological interventions (verbally mediated or via written mode) given that 43% of adults (aged 18-65) struggle with text-based health information (Rowlands et al, 2015)
* establish capacity for informed consent
* improve the accuracy of risk assessments by making information accessible and supporting patients to communicate their needs and issues. This is vital in order to comply with the Mental Health Measure 2010
* gain additional information about patients’ worries, dislikes, preoccupations, goals, etc.

Supporting the MDT to have a full profile of the patient and to support staff to achieve effective communication and goal attainment. This is particularly important as part of the Mental Health Integrated Care Pathway Approach (CPA)

* Increasing access to other interventions - may include targeted language development, group interaction skills, etc.
* Specific individual therapy programme, eg. fluency or swallowing interventions
* Language and communication programmes delivered in partnership with other staff, eg. key workers, education staff, nursing and OT assistants
* Joint working, eg. with psychiatrists, to calibrate drug dosage in manic depression to manage willingness to speak vs dysfluency

Joint working to enable patients to benefit from other interventions such as education, art therapy, vocational workshops (largely adapting interventions, supporting communication and scaffolding understanding). Psychological Talking Therapies are verbally mediated and may therefore be inaccessible to those with speech, language and communication needs. Appropriately trained speech and language therapists are therefore well placed to deliver Talking Therapies as outlined in [Matrics Cymru](file:///C%3A%5CUsers%5Ccaroline.walters%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5COX95Q074%5CMatrics%20Cymru) (especially level 1 interventions).

**SLT role within children and young people mental health services**

Additionally, speech and language therapists have an important role to play at every level of children and young people’s mental health services. RCSLT has produced the following information and tiered model to support understanding of the speech and language therapist role ([RCSLT, 2020](https://www.rcslt.org/wp-content/uploads/media/docs/RCSLTCYPMHSA4Digital.pdf));

**Tier 1 - Universal**

Speech and language therapists work in early years settings, schools and with families to support emotional wellbeing through promoting the development of language and communication skills, which are strongly associated with social, emotional and behavioural development. They also identify children who may be in need of additional support and make referrals to targeted or specialist services.

**Tier 2 – Targeted**

Speech and language therapists work in targeted services such as early help and youth offending teams. They should also be part of mental health support teams. By assessing and supporting communication needs, they help to reduce the likelihood of at-risk children and young people developing mental health problems. Speech and language therapists also train other staff and parents to identify and respond to communication needs, including by adapting their own communication style, supporting effective access to appropriate services and interventions.

**Tier 3 – Specialist**

Speech and language therapists work in community CAMHS as part of a multidisciplinary team. Their unique skills in assessing speech, language and communication mean they can diagnose speech, language and communication needs and contribute to differential diagnosis, including in relation to neurodevelopmental conditions such as autism.

For young people with identified communication needs, speech and language therapists can provide direct interventions to maximise their communication potential, as well as providing advice and support to other professionals and settings on how to develop communication supportive environments and adapt psychological therapies.

**Tier 4 – Highly specialist**

Speech and language therapists are a crucial part of the multidisciplinary team in Tier 4 services. In addition to the input described in Tier 3, they work jointly with other professionals to make important contributions to the quality of care provided to young people in inpatient settings, including supporting young people to understand and be involved in decisions about their care, and creating a supportive communication environment which can help to reduce the need for physical interventions and restrictive practices. They also support successful and timely transition out of inpatient settings through contributing to risk assessments, creating communication passports and providing advice and training to settings that will support the young person in the community upon discharge.

Speech and language therapists should also work in other specialist children and young people’s mental health services, including regional forensic CAMHS and secure children’s homes.

**SECTION 2: The Specialist SLT Mental Health Workforce**

Electronic staff record (ESR) data collected as part of data gathering for the mental health workforce plan has recorded the following information.

**Speech and Language Therapist**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **<=20 Years** | **21-25** | **26-30** | **31-35** | **36-40** | **41-45** | **46-50** | **51-55** | **56-60** | **61-65** | **>65** | **Total** |
| **Speech and Language Therapist** |   | 1 | 4 | 6 | 6 | 3 | 7 | 10 | 2 |   |   | **39** |
| **Allied Health Professionals** |   | 22 | 43 | 62 | 78 | 70 | 64 | 61 | 41 | 7 | 1 | **449** |

**Speech and Language Therapist Specialist**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **<=20 Years** | **21-25** | **26-30** | **31-35** | **36-40** | **41-45** | **46-50** | **51-55** | **56-60** | **61-65** | **>65** | **Total** |
| **Speech and Language Therapist Specialist** |   |   | 1 | 2 | 1 | 2 | 1 |   |   |   |   | **7** |
| **Allied Health Professionals** |   | 22 | 43 | 62 | 78 | 70 | 64 | 61 | 41 | 7 | 1 | **449** |

**Speech and Language Therapist Manager**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **<=20 Years** | **21-25** | **26-30** | **31-35** | **36-40** | **41-45** | **46-50** | **51-55** | **56-60** | **61-65** | **>65** | **Total** |
| **Speech and Language Therapist Manager** |   |   |   |   | 2 |   | 1 | 1 |   | 1 |   | **5** |
| **Allied Health Professionals** |   | 22 | 43 | 62 | 78 | 70 | 64 | 61 | 41 | 7 | 1 | **449** |

We are concerned this data may present a misleading view of current SLT provision within mental health services in NHS Wales. We believe that this data includes posts in learning disability teams where speech and language therapy has historically but not currently been represented. We believe the data may also include dementia services, neurodevelopmental services and youth offending teams. It may also include speech and language therapists providing limited in-reach to patients accessing mental health services who are not specifically employed to provide consistent and adequate services.

We have completed a recent survey with SLT managers across NHS Wales on specific mental health workforce provision. This has revealed thatthere is little dedicated SLT workforce into;

* primary care
* specialist secondary care
* inpatient or community for mainstream working age adult mental health inpatient.

There are no SLT services in adult mental health and forensic services and speech and language therapists are under-represented within Specialist Tertiary Services. The All Wales Neuropsychiatry service is the only such service in Wales and is a specialist tertiary service providing neuropsychiatric rehabilitation for those presenting with ABI and resulting cognitive/communication, emotional, behavioural and psychiatric conditions. Despite some provision, there is considerable SLT unmet need within the service which needs to be addressed. Additionally, whilst there is some provision for children, eg. within youth offending services, this is not included in all services and even where it is present, it is not relative to the need. This does not transfer into adult services.

***Current model***

The current provision that typically exists in Wales is a referral-based system into adult learning disabilities services or adult acquired/neuro SLT services. These services are not commissioned or designed to meet the needs of people with mental health needs. The areas of SLT specialism from these services do not lie clinically within mental health. They do not form part of many patient mental health pathways and are not embedded into the clinical structures or workforce plans. The current model is typically one of episodic care, where individuals get referred to an ‘external’ speech and language therapist. This model leads to many individuals not getting the right service they need, at the right time and not in the right place. It can mean that an individual does not get seen at all and is declined by a core NHS SLT service, or, if they do get seen, a model of assessment and advice may not be sufficient to meet need. This is evidenced in many mental health patient clinical notes and MDT meetings. Communication needs that are addressed in a siloed way may not always be appropriate or effective. The lack of SLT mental health provision can result in many risks to the individual and to the service itself. Lack of SLT maintains some inequalities for many people with mental health difficulties, which is not acceptable.

The communication and eating drinking needs of people with mental health difficulties are often long term and may well have predated the onset of the metal illness, often since childhood. The support required is for dedicated mental health SLT to sit as *part of an MDT* and provide interventions as part of a coherent and comprehensive pathway. Communication support throughout the system in order to access to mental health services may be necessary for many individuals and long term support to develop and manage communication difficulties is often indicated in order for real change to happen. SLT support should be seen as integral to care and treatment and recovery plans for many individuals. Speech and language therapists have a role in supporting the individual, their family, carers and other members of the MDT. Speech and language therapists also have a wider role in providing support and education to the wider workforce to recognise where difficulties may occur regarding eating, drinking and communication needs of people with mental health difficulties and strategies to implement to reduce the impact of such difficulties.

**SECTION 3: Proposed SLT workforce model**

*Speech and language therapists*

New and developing service provision requires innovative clinicians with suitable and broad clinical experience and leadership experience. They also need post graduate training, including in the areas of dysphagia (swallowing difficulties) and advanced clinical practice around communication and mental health. Newly commissioned services therefore require leadership by clinical lead speech and language therapists (8a). This clinical leadership can then allow for requirement to band 7 and 6 speech and language therapists. The recruitment of band 5 speech and language therapist and newly qualified therapists (NQP) is also essential to this field. Where few speech and language therapists exist in services then typically a higher banding is required for this level of autonomy, yet it can skew the workforce to look very specialist and look like a high banding is required. This is not the case should the right workforce structure be in place. NQP and band 5 therapists are interested in and would be highly effective in mental health services and we need to create the right workforce structures to facilitate this with clinical and professional supervision and also career progression.

Speech and language therapists as part of an Allied Health Professions (AHP) workforce are an untapped resource in the provision of talking therapies such as Cognitive Behavioural Therapy (CBT), Acceptance and Commitment Therapy (ACT), Motivational interviewing (MI), ([Matrics Cymru](http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Matrics%20Cymru%20%28CM%20design%20-%20DRAFT%2015%29.pdf)). SLTs are not routinely able to access this training to gain appropriate skills.

Beyond being an integral part of the MDT, the SLT workforce should also be part of the day to day functioning of a service, where the SLT scope of practice includes roles such as care and treatment plans and clinical care coordination, direct facilitation of recovery interventions, involvement of wider patient care including behaviour supports and physical intervention. This embedded MDT model is being introduced into some learning disability inpatient services and would be equally as desirable within remodelled mental health services.

*Speech and Language therapy assistant posts / Communication development officer band 4*

These posts would be an essential part of the workforce. They can provide day to day and in situ support and resources for the individual recommended by the speech and language therapist. Implementation of communication techniques needs skilled in situ support to build confidence and competency across the whole MDT team supporting the individual. Training staff teams, such as nursing teams on inpatient wards, about communication techniques and approaches and in eating and drinking supports provides some transferable to practice competencies. Additional to this knowledge, such training may provide an understanding attitudes and values. Training alone however, may not be sufficient to ensure effective skill development within staff teams and the SLT assistant can help bridge this gap effectively and efficiently.

The SLT mental health workforce would need to be commissioned for and located within each area of service delivery, influenced by local priorities, plans and data;

* inpatient secondary care (adult working age PICU, assessment and rehab)
* within community mental health services (adult working age)
* Older Peoples Mental Health – in patient and community teams
* Forensic services and CJS teams
* YJS
* CAMHs
* Substance misuse services
* Eating disorders
* Perinatal services
* Specialist Tertiary Services such as Neuropsychiatry
* Primary care

SLT support within primary care to address communication needs across the lifespan is also required. The risk of communication difficulties contributing to the development of social, work and education difficulties and the development of some poor mental wellbeing outcomes also needs attention and workforce development. It could also provide GPs with further alternatives to medicalised prescribing and could help access to social prescribing opportunities. There is positive work being initiated through the Recovery College (hosted within C&V UHB) who offer self-management courses and opportunities. However, individuals with speech, language and communication needs may find formats inaccessible. Speech and language therapists should be core to developments such as this.

This workforce needs to be in addition to and not from within existing SLT services, e.g. from Learning Disabilities, neurodevelopmental services, neurological, ear nose and throat services, etc. Due to lack of current service provision, it may be the case that insufficient data is currently available to inform local workforce planning and that newly commissioned and developed posts would need to have an initial role in scoping and demand data collation, pathway development, as well as initial outcomes data from clinical inputs.

**The future workforce**

We currently have one undergraduate speech and language therapy course in Wales at Cardiff Metropolitan University with another course due to commence in Wrexham Glyndwr University in September 2022. Mental health is covered across the programme in Cardiff Metropolitan University for both children and adults as per the RCSLT curriculum which asks for:

*Mental health conditions (adults)*

Identify aetiological factors, co-morbidities and communication characteristics of common mental health conditions. Recognise and explain interactions between mental health conditions, communication and social interaction, and eating, drinking and swallowing, and their implications for speech and language therapy assessment and intervention.  Evaluate and apply current approaches to assessment, differential diagnosis, intervention and management with adult individuals with mental health conditions that affect communication and swallowing.

Currently the emphasis is on adults and predominantly at level 6 (final year) with 6 dedicated hours of specialist teaching delivered by Cardiff and Vale Health Board SLT Mental Health and assessment in a final year exam paper.

Content includes:

* Causes, incidence, associated problems
* Consequences and impact
* Interdisciplinary approach including medical intervention
* Specialist and support roles of SLT and contribution to the team, ethical issues
* SLT assessment and management

*Mental health conditions (children)*

Identify aetiological and prognostic factors and presenting features in the following conditions, including, but not exclusive to, the accepted and preferred terms in current usage:

1) Social, emotional and mental health in children (SEMH)

2) Selective mutism

For children, Cardiff Metropolitan University provide 3 hours on selective mutism at level 6 and then cover the other areas of social and emotional development within lifespan psychology teaching and professional development modules.

Key graduate capabilities:

* Recognise and explain interactions between mental health conditions, communication and social interaction, and eating, drinking and swallowing, and their implications for speech and language therapy assessment and intervention
* Evaluate and apply current approaches to assessment, differential diagnosis, intervention and management in children and young people with mental health conditions that affect communication and swallowing

Course providers at Glyndwr University are working closely with Cardiff Metropolitan University to develop the new course content and we will be kept updated on planned teaching in this area.

There is opportunity for close working between HEIW and the higher education institutions around this area to ensure students are graduating with the required skills for the Welsh workforce. Students who have undertaken placements in this area report interest in working within mental health services.

**SECTION 4: Case studies**

Due to the limited number of specialist mental health roles, we have included case studies from across the United Kingdom.

**Case study – South Wales**

A lady residing in a step down NHS home had been referred to SLT 4 times over 2 years. Existing adult SLT services did not feel she met their service criteria and did not feel they could offer the service she needed.

A lead SLT from LD and MH delivery unit agreed to see this lady and offer a brief assessment and advice service, as her unmet communication needs meant she was not able to fully participate in her recovery programme and this was delaying her progress and resulting in her remaining within the service longer than anticipated and hoped for. Upon discussion with the MDT it was evident that the team struggled with the clinical understanding of communication difficulties. Following SLT communication assessment and in discussion with her MDT, key communication targets were identified and advice on how to support the lady was given by the speech and language therapist. The advice was passed on to the OT technician as the most suitable person to support her to achieve them at the time.

Following this the psychiatrist expressed a wish to refer another 4 of the people living at the accommodation to the speech and language therapist for advice as he believed there were many misunderstood and unaddressed communication needs and this was impacting on patient outcomes and patient flow. It was acknowledged that this would be desirable and that this would be fed back to senior management as part of the reports to commission SLT for MH services.

**Case study – Northern Ireland**

Speech and Language Therapy – Children with disabilities

The speech and language therapy community paediatric service in the Southern Health and Social Care Trust, works with children with special educational needs in Child Development Clinics and Special Schools. The children supported by the service also experience a range of mental health needs and difficulties. Speech and language therapists work alongside OT, physiotherapy and education staff in special schools to help understand any behaviours of concern, adopting a trauma informed approach. Speech and language therapists have started working with intellectual disability CAMHS and are supporting the completion of assessments. Speech and language therapists have also joined with MDT therapeutic planning meetings, provide recommendations for the plans and set goals.

Challenging behaviour is often communicating an unmet need or a distress particularly if a child is feeling unsafe, insecure and disconnected. Speech and language therapists, as part of the MDT, can provide important information on speech, language and communication needs, training and advice on alternative communication tools and strategies, as well as contributing to the development of a more comprehensive plan and effective practice across all aspects of care. This can help the child’s feeling of safety and security and therefore lead to better outcomes.

**Case study – Cumbria,** Northumberland, Tyne and Wear NHS Foundation trust- Implementation of a SLT service for adult mental health wards

The service was established due to;

* Challenging behaviour relating to communication need
* Lack of staff knowledge and skills in relation to dysphagia
* Lack of staff knowledge and skills in relation to communication needs in people with mental health conditions
* Risks associated with unmet communication needs (disengagement from services, inability to access talking therapies, health literacy, increased length of stay, ineffective discharges, readmission)
* High use of medication and restrictive practices to manage challenging behaviour arising from communication need
* Lack of awareness of dysphagia risks in mental health population
* Risks of not meeting dysphagia needs for this population (physical health, risk to the organisation, quality of life)
* Lack of knowledge and skills of staff in relation to mental capacity assessment for individuals with communication needs impacting on their care and self advocacy.
* Bed reductions in Learning Disability and Autism, leading to an increased number of patients with these conditions on mainstream adult MH wards creating challenges for staff in terms of their care needs, their day to day behavioural management and their discharge.

A pilot SLT service was delivered into Older People’s dementia inpatient wards in line with aims set out in the RCSLT dementia position paper. The remit of posts was to provide dysphagia care but also to work with the MDT to understand and manage challenging behaviours that lead to patients requiring hospital admission.

This led to increased understanding of the speech and language therapist’s role within inpatient care and requests for SLT input in adult mental health wards. Increased communication and dysphagia need was recognised and with continued investment the team grew to 4 SLT posts covering 36 inpatient mental health wards.

4 years on the team has had various compositions and operational managers. The team has been able to respond to communication need and has increased awareness of it within the inpatient wards.

The following outcomes have been realised:

* Individual examples of mental health diagnoses being revoked based on communication evidence
* reduction of seclusion use for individuals
* transition support
* increased reasonable adjustments made for patients in relation to capacity assessments, talking therapies, meaningful activity.

Mandatory dysphagia awareness training has been introduced for all inpatient clinical staff on a yearly basis.

There has been increased SLT involvement in wider trust initiatives in relation to MH, eg. talk first, positive and safe agenda, PMVA training, health literacy, coproduction.

**Referral data from 2013- 2017**

|  |  |  |
| --- | --- | --- |
|  | Communication referrals  | Dysphagia referrals  |
| January 2013 – June 2013 | 13 | 24 |
| June 2013 – January 2014  | 25 | 23 |
| January 2014 – June 2014 | 18 | 14 |
| June 2014 – January 2015  | 33 | 60 |
| January 2015 – June 2015 | 31 | 59 |
| June 2015 – January 2016 | 54  | 86 |
| January 2016 – June 2016  | 47 | 21 |
| June 2016 – January 2017  | 84 | 77 \* period with most SLTs in team  |
| January 2017 – June 2017  | 52 | 102 |

*Awaiting up to date referral data as service ahs significantly increased in size.*

**References**

Beitchman, J., Wilson, B., Johnson, C., Young, A., Atkinson, L., Escobar, M. & Taback, N. (2001). Fourteen year follow-up of speech/language-impaired and control children: Psychiatric outcome. Journal of the American Academy of Child and Adolescent Psychiatry, 40(1), 75-82. doi: <https://doi.org/10.1097/00004583-200101000-00019>

Botting N., Durkin K., Toseeb U., Pickles A., & Conti-Ramsden G. (2016). Emotional health, support, and self-efficacy in young adults with a history of language impairment. British Journal of Developmental Psychology, 34, 538–554. doi: 10.1111/bjdp.12148

Boudewyn, M., Carter, C., Long, D., Traxler, M., Lesh, T., Mangun, G., & Swaab, T. (2017). Language context processing deficits in schizophrenia: The role of attentional engagement. Neuropsychologia, 96, 262-273. doi: 10.1016/j.neuropsychologia.2017.01.024

Bryan, K. (2013). Psychiatric disorders and Communication in Cummings. L. (ed), Handbook of Communication Disorders. Cambridge: Cambridge University Press.

Colle, L., Angeleri, R., Vallana, M., Sacco, K., Bara, G., & Bosco, F. (2013). Understanding the communicative impairments in schizophrenia: a preliminary study. Journal of Communication Disorders, 46(3), 294-308. doi: 10.1016/j.jcomdis.2013.01.003

Gabbert, G., Schwade, N., & Tobey, E. A. (2002). A tutorial on speech production sequelae associated with psychotropic and antiepileptic treatment of mental illness. (Tutorial). Journal of Medical Speech-Language Pathology, 10(2), 87-100. Retrieved from: http://go.galegroup.com/ps/anonymous?id=GALE%7CA94207650&sid=googleScholar&v=2.1

Hollo, A. et al. (2014). Unidentified Language Deficits in Children with Emotional and Behavioral Disorders: A Meta-Analysis. Exceptional Children 80(2): 169-186.

NHS Digital. (2018). Mental Health of Children and Young People in England, 2017. https://files.digital.nhs.uk/42/9E0302/MHCYP%202017%20 Multiple%20Conditions.pdf

Regan, J. et al. (2006). Prevalence of Dysphagia in Acute and Community Mental Health Settings. Dysphagia 95–101.

Rowlands, G. , Protheroe, J., Richardson, M.,Seed, PT., and Rudd, R. (2015). A mismatch between population health literacy and the complexity of health information: an observational study. *The British Journal of General Practice: The Journal of the Royal College of General Practitioners, 65 (635), 379-386*

Ruschena, D. et al. (2003). Choking deaths: the role of antipsychotic medication. British Journal of Psychiatry, 183, 446-450.

Walsh, I. et al. (2007). A needs analysis for the provision of a speech and language therapy service to adults with mental health disorders. *Ir J Psych Med* 24(3): 89-93.

**Annex B: Case studies**

Speech & Language Therapy Pilot: Acute Mental Health Inpatient Service BHSCT – right support at the right time Since January 2019 an SLT has been employed part-time within the Acute Mental Health Inpatient Centre (AMHIC) in Belfast Health and Social Care Trust to support the high incidence of patients receiving acute mental health treatment who also have swallowing difficulties and/or communication difficulties. SLT supports patients with acute mental health disorders alongside other co-morbidities including; stroke, learning difficulties, autism, progressive neurological conditions and dementia. People with these conditions may present with swallowing difficulties as a result of their anti-psychotic medications or unsafe eating behaviours at mealtimes. People with a diagnosis of Schizophrenia are 30 times more likely to choke. Furthermore, those presenting with an acute mental illness commonly experience difficulties with both understanding language and speaking clearly. As part of the multi-disciplinary team, the SLT’s role is to provide direct assessment and management of both communication and swallowing difficulties, working alongside Psychiatry, psychology, mental health nursing, social work, physiotherapy and occupational therapy. In addition to direct assessment and management, a key aspect of the SLT role in the team is to support understanding and facilitate participation in complex discussions regarding discharge, guardianship, capacity and medication management. To support patient advocacy, the SLT has embedded Alternative and Augmentative Communication systems – such as Talking Mats and Communication passports to enable patient engagement in a full range of treatments and therapies. The SLT works with the wider team to; deliver training/education on swallowing issues, enhance MDT working, increase patient safety and patient choice and develop new models of working to address reducing the number of choking and near miss choking incidents across the unit. The OT, Physio and Speech therapist have all helped me get back to normality, the major impact was SLT. The other things wouldn’t have changed if I couldn’t have eaten full meals” (In patient, quote used with permission).

**Case study – Cumbria,** Northumberland, Tyne and Wear NHS Foundation trust- Implementation of a SLT service for adult mental health wards

The service was established due to;

* Challenging behaviour relating to communication need
* Lack of staff knowledge and skills in relation to dysphagia
* Lack of staff knowledge and skills in relation to communication needs in people with mental health conditions
* Risks associated with unmet communication needs (disengagement from services, inability to access talking therapies, health literacy, increased length of stay, ineffective discharges, readmission)
* High use of medication and restrictive practices to manage challenging behaviour arising from communication need
* Lack of awareness of dysphagia risks in mental health population
* Risks of not meeting dysphagia needs for this population (physical health, risk to the organisation, quality of life)
* Lack of knowledge and skills of staff in relation to mental capacity assessment for individuals with communication needs impacting on their care and self advocacy.
* Bed reductions in Learning Disability and Autism, leading to an increased number of patients with these conditions on mainstream adult MH wards creating challenges for staff in terms of their care needs, their day to day behavioural management and their discharge.

A pilot SLT service was delivered into Older People’s dementia inpatient wards in line with aims set out in the RCSLT dementia position paper. The remit of posts was to provide dysphagia care but also to work with the MDT to understand and manage challenging behaviours that lead to patients requiring hospital admission.

This led to increased understanding of the speech and language therapist’s role within inpatient care and requests for SLT input in adult mental health wards. Increased communication and dysphagia need was recognised and with continued investment the team grew to 4 SLT posts covering 36 inpatient mental health wards.

4 years on the team has had various compositions and operational managers. The team has been able to respond to communication need and has increased awareness of it within the inpatient wards.

The following outcomes have been realised:

* Individual examples of mental health diagnoses being revoked based on communication evidence
* reduction of seclusion use for individuals
* transition support
* increased reasonable adjustments made for patients in relation to capacity assessments, talking therapies, meaningful activity.

Mandatory dysphagia awareness training has been introduced for all inpatient clinical staff on a yearly basis.

There has been increased SLT involvement in wider trust initiatives in relation to MH, eg. talk first, positive and safe agenda, PMVA training, health literacy, coproduction.