10-year plan to improve mental health
Department of Health and Social Care - call for evidence

About the Royal College of Speech and Language Therapists
The Royal College of Speech and Language Therapists (RCSLT) is the professional body for speech and language therapists (SLT) across the United Kingdom. The RCSLT currently has over 20,000 SLT members, including student members. We promote excellence in practice and influence health, education, employment, social care and justice policies.

Executive Summary
RCSLT are calling for recognition within the new mental health ten-year plan of the links between mental health and communication and swallowing needs. We also want to see the expert skills of speech and language therapists in supporting people living with complex communication difficulties recognised.

We would like to thank the Department of Health for their engagement with RCSLT on this issue in recent months.

Within our submission we have focussed on the evidence base that demonstrates the links between speech, language, communication and swallowing needs and mental health difficulties and the impact that this has on someone's life.

We have also focussed on specific proposals which we believe would help to reflect better the links between communication and mental health and facilitate greater support to communication which would improve the mental health of our population.

Chapter one - how can we all promote positive mental wellbeing?
Q1: Do you have any suggestions for how we can improve the population's wellbeing?

Recommendation one: A greater focus on speech, language and communication difficulties, how these skills promote good mental wellbeing and how communication difficulties are a risk factor for poorer mental health across the life course.
The Royal College of Speech and Language Therapists recommends that the importance of communication in supporting people's wellbeing is highlighted in the ten-year plan. Acknowledging and supporting communication difficulties, across all public services, is important to support the wellbeing of the population.

Good communication is a protective factor for good mental health (DfE, 2018). Good communication underpins, and is essential to, maintaining good mental wellbeing. The presence of speech and language difficulties affects wellbeing, resilience and self-esteem (Rees H, Forrest C, Rees G, 2018). Communication difficulties are a risk factor (when unsupported) for poorer mental health across the lifespan from birth to end of life (Money et al, 2016).

The Department for Education recognised that communication difficulties are a risk factor, and good communication skills as a protective factor in their Mental Health and Behaviour in Schools guidance (DfE, 2018). The Royal College of Speech and Language Therapists would like to see this understanding and consideration in the ten-year mental health plan for England.

In the prevention Green Paper, the Government recognised that speech, language and communication skills are an important indicator of children's wellbeing (DHSC, 2019). The RCSLT would like to see this understanding reflected in the ten-year mental health plan for England.

Recommendation two: Acknowledge the significant barriers that people with communication difficulties face when accessing services.
Communication disability in the UK affects millions of people. Up to 20% of the UK's population experience communication difficulty at some point in their lives, and more than 10% of all children have a long-term communication need. Communication difficulties leave millions without a voice and denies them access to services.

Communication needs are prevalent amongst children and adults with mental health difficulties. They are also prevalent among people with learning disabilities and autistic people who access mental health services.

When a person's needs are unsupported, these are a barrier to talking about how you feel and explaining your health concerns. Communication needs are also a barrier to accessing supportive interventions such as talking therapies which rely on the person being able to understand and be understood.

People with communication needs are at higher risk of mental ill health. It is important that the ten-year plan highlights these barriers. Action must be taken to breakdown these barriers, to increase access to the right care at the right time, and to tackle health inequalities.

Recommendation three: Roll out training in communication to professionals working with people with mental health conditions in all sectors.
To support prevention and early identification, professionals working in education settings, community and inpatient mental health services (children and adults), wider community services and justice, should be trained to understand the links between speech, language, communication and mental health.

Businesses and voluntary organisations should also be trained to better understand the impact of communication difficulties on mental health and wellbeing and how it can affect employment.

Mental health needs to be everyone's business. The Royal College of Speech and Language Therapists recommend that training in communication, via, for example, Communication Access UK, is made available, to remove the barriers to communication, and improve the lives of people living with communication and mental health difficulties in the community. Communication Access UK includes training to promote and support inclusive communication for all. This is aimed at any business or organisation which interface with the public (www.rcslt.org).

A better understanding of communication is important, so professionals, clinicians, managers and staff can:

- Recognise and understand the presence of communication needs
- Understand the importance of reasonable adjustments
- Provide communication friendly environments or workplaces
- Use communication support techniques

The Royal College of Speech and Language Therapists has also developed training programmes aimed at professionals in certain settings (https://www.rcsltcpd.org.uk):

1. Mind Your Words: training for people working with children and young people with mental health conditions.
2. The Box: training for people working in the justice sector.

Q2. How can we support different bodies/sectors to work together, and with their local community, to improve population wellbeing? Identify the barriers.

Speech and language therapists have proposed the following actions to breakdown the most common barriers:

- Training for all public sector bodies: to increase awareness/understanding of speech and language difficulties and the impact they can have on mental health.
- Better signposting and referral to services: between schools/community services and mental health services, and between mental health services and speech and language therapy.
- Improved sharing of information between inpatient/community/primary care sectors
- Improved support and focus from primary care to reach hard-to-reach populations, who frequently have communication needs.

The Royal College of Speech and Language Therapists recommend adding a case study in the discussion around this action that demonstrates the multidisciplinary, cross sectoral approach needed to implement this action. We would be happy to share one with you.

Chapter two - how can we all prevent the onset of mental ill-health?
Q3. What is the more important thing that the Government needs to address to reduce the numbers of people who experience mental ill-health?

Recommendation one: recognise the important links between mental health and speech, language, communication and swallowing needs; and provide speech and language therapy to meet these needs.

Communication difficulties are amongst one of the social, economic, biological and genetic factors that is associated with increased risk of mental ill-health. Evidence suggests that there are particular groups of children, young people and adults who are both more likely to have increased risk of poor mental health and speech, language and communication needs, as below:

- Research shows that there is a strong correlation between poverty and delayed language. It is estimated that over 50% of children in socially deprived areas may start school with impoverished speech, language and communication skills (Locke et al, 2002).
- Research conducted by domestic violence charity Refuge, has found that pre-school children exposed to domestic violence are likely to be at significant risk of developing significant speech and language problems. 50% of children involved in their study met the criteria for post-traumatic stress disorder (PTSD). The most frequently reported PTSD symptoms for pre-schoolers in the study included language regression and separation anxiety. The Home Office's statutory guidance for the Domestic Abuse Act highlights the link between speech, language and communication needs and people at risk of abuse.

- No Wrong Door, the service for young people in care and on the edge of care in North Yorkshire, found 58% of the young people accessing its service had communication needs (Lushey et al, 2017).
- Research found that 17% of rough sleepers had communication needs (Andrews & Botting, 2020)

- Over 60% of young people who offend have low language skills (Bryan et al, 2007) (McNamara N, 2012).
- 88% of long-term unemployed men were found to have language and communication needs (Elliott N, 2011).

Children who stammer can experience bullying and negative experiences pre-school and in school which impact on their perceptions of self and general happiness (Langevin et al, 2009, Crichton-Smith 2002, Davis et al, 2002, Hayhow 1999, Hugh-Jones & Smith 1999). Adults with a stammer tend to have developed higher levels of social anxiety, fear of negative reactions and may become anxious in communicative situations, especially where they have no control (Iverach & Rapee, 2014). Individuals who stammer are at risk of anxiety, depression, self-harm, substance abuse and suicide.

Children with selective mutism, are also at risk.

Children and adults in contact with mental health services have a higher incidence of communication difficulties than the general public:

Young people aged 12 - 18 referred to mental health services were three times more likely than their non-referred peers to meet the criterion for higher order language disorders (Cohen et al, 2013).

- 80% of adults in an acute inpatient psychiatric unit had impairment in language and 60% had impairment in communication and discourse (Walsh, 2007).
- 30% of adults with mental health disorders have some impairment in swallowing (Walsh, 2007).

Links between mental illness and communication needs are complex and bidirectional (Rees & Forest, 2019):

- Children and adults with (primary) communication difficulties are at greater risk of experiencing mental health problems than their peers (Goh et al, 2021) (Beitchman et al, 2001) (Botting et al, 2016) Clegg et al, 2005).
- People with mental health conditions are more likely to present with communication needs (Jagoe & Walsh, 2007)
- Furthermore, many groups of people who are at high risk for developing mental health conditions also have communication needs.

Many children and adults with mental health conditions have unsupported speech, language and communication difficulties and swallowing needs. Communication difficulties affect how we process information, ask questions and be understood. If a person at risk of poor mental health, or in contact with mental health services, cannot understand and be understood, there is a risk of deepening the inequalities that already exist (RCSLT, 2022).

Speech and language therapy supports people to express their wishes and preferences, to participate in decisions about their care and treatment and to engage in psychological interventions. This supports and maintains better health and wellbeing and will decrease the risk of someone's mental health problems escalating due to unmet communication needs.

Earlier this year, the Royal College of Speech and Language Therapists published two reports on the sustained impact of the pandemic on speech and language therapy services (RCSLT, 2022). The important data highlighted:

- Over 80% of speech and language therapy services reported that individuals' speech and language therapy needs impacted on their mental wellbeing and ability to carry out everyday activities (including engaging with work or education).

- Speech and language therapists themselves reported a worrying trend of their own mental wellbeing being negatively impacted (RCSLT, 2022).

This corroborates the findings of our report published the year previous - Speech and language therapy during and beyond COVID-19: building back better with people who have communication and swallowing needs - (RCSLT, 2021), where people in receipt of speech and language therapy shared their experiences of the pandemic. They told us that:

- Less or no speech and language therapy resulted in a decline in their mental health
- They were concerned about the future and highlighted the impact this would have on their mental health.

Q4. What does the Government need to address to prevent suicide? This might include actions for education, the NHS and justice services.

Recommendation: Investing in speech and language therapy to support people to access mental health support.
Left unidentified and/or unmet, communication needs can have a range of negative consequences on a person's social, emotional and mental health and wellbeing.

Being able to communicate is essential in explaining concerns around mental health.

- Unsupported communication needs can be a barrier to a person expressing health needs during assessment, treatment and care planning (Emerson E. et al (2010).
- People with communication difficulties are likely to have problems accessing and understanding information about their health leading to their needs being unidentified (UCL, 2015)
- People with communication difficulties and mental health needs often have less understanding of, and insight into, managing and maintaining their own mental health, resulting in barriers to rehabilitation and recovery (Rees H et al (2018).

A person deemed at risk of suicide, is at far greater risk if their communication difficulties are missed, so their ability to seek help via verbal means is reduced. Furthermore, their ability to participate in verbally mediated interventions, to prevent suicide, is compromised by communication difficulties.

Investing in speech and language therapy in mental health services will allow people at risk of unmet communication needs to be identified and supported.

Chapter three - intervene earlier when people need support with their mental health
Q5. How to ensure that people with wider health problems get appropriate mental health support at an early stage? You might want to consider barriers faced by individuals, as well as how health and social care services engage with those people

Recommendation one: investment in a trained, skilled and competent clinical workforce who understand mental health.
The skills and knowledge of the workforce is critical to support better understanding of mental health and wellbeing. Many mental health services are experiencing an increase in the complexity of cases. They are frequently supporting individuals with suspected or diagnosed learning disability and or autism. Mental health teams are feeling the impact of this. The Royal College of Speech and Language Therapists recommend that mental health training is embedded into undergraduate and postgraduate training for all clinical professions including allied health professionals (AHPs), nursing staff, medical staff and GPs. This training should include identification of the early signs of mental ill-health and ways to communicate about it and that changes in language/behaviour can be a sign of crisis in children and adults.

Recommendation two: referral to allied health professionals from GP surgery and primary care is strengthened.
As mental health support in GP practices is increased (NHS England 1 June) it is critical that allied health professionals are fully utilised to support people with mental health problems. Many people accessing mental health services have a complex range of physical comorbidities and needs. Clear signposting and referral to speech and language therapists is essential. Early intervention for communication needs will support accessible and accurate mental health referrals. Early intervention for dysphagia (swallowing needs) prevents aspiration, choking and pneumonia.

Recommendation three: **Embed speech and language therapists as a core part of the multi-disciplinary team in all relevant child, adolescent and adult mental health services for early intervention.**
Children and adults in contact with mental health services have a higher incidence of communication difficulties than the general public:

- Young people aged 12 - 18 referred to mental health services were three times more likely than their non-referred peers to meet the criterion for higher order language disorders (Cohen et al, 2013).
- 80% of adults in an acute inpatient psychiatrist unit had impairment in language and 60% had impairment in communication and discourse (Walsh, 2007).
- 30% of adults with mental health disorders have some impairment in swallowing (Walsh, 2007).

Supporting communication and swallowing needs is critical. However, too few mental health services have speech and language therapists embedded in their multi-disciplinary teams. Referral to community services has long waiting lists. This can risk escalating swallowing needs which can lead to pneumonia, or unmet communication needs resulting in an increased risk of mental health needs escalating and people being left out of decision making.

Speech and language therapists should be embedded as a core part of the multi-disciplinary team in all relevant child, adolescent and adult mental health services. They have a vital role in protecting and promoting the wellbeing and resilience of people with communication and swallowing needs (Rees H, Forrest C, Rees G, 2018). Utilising the expertise of speech and language therapists can also reduce restrictive practice and reduce seclusion and segregation while delivering choice and autonomy for individual patients as required by the new mental health reforms.

Chapter four - how can we improve the quality and effectiveness of treatment for mental health conditions?

Q6. What needs to happen to ensure the best care and treatment is more widely available within the NHS

Recommendation one: Invest in and expand the community mental health workforce**
To support people before they reach crisis point requires investment in early intervention and community services. Workforce shortages and demand for service, compounded by an increase in the backlog and new demand as a result of the COVID-19 pandemic, has affected the ability of services to respond.

Providing high-quality community mental health services is the best way to improve the care and outcomes for those with mental health needs. As detentions are reduced, community-based provision needs to be improved and expanded to make these services accessible to everyone. Expanding these services must include speech and language therapists, as part of the mental health workforce.

Recommendation two: **Increase in speech and language therapists in mental health teams**
Speech and language therapists should be embedded as a core part of the multi-disciplinary team in all relevant child, adolescent and adult mental health services.

Mental health teams are seeing more people with a range of complex needs, including learning disability, autism, acquired brain injury, or neurological conditions. It is critical that staff have the breadth of skills to work with these people. Speech and language therapists are uniquely placed to bring an extensive set of skills and knowledge to the role. Speech and language therapists frequently have a background in learning disabilities, autism, or challenging behaviour as well as mental health knowledge. This makes them well placed to meet the needs of what is increasingly becoming a very complex set of people.

Speech and language therapists support differential diagnosis, understand the impact of underlying communication needs (often unseen, or misdiagnosed as personality difficulties) on engagement with appointments, treatment, advice or guidance. Speech and language therapists are key in capacity assessment and creating therapeutic experiences on ward environments by creating communication friendly situations and environments that reduce the need for restrictive interventions.

The role of speech and language therapists is increasingly becoming recognised in supporting people with mental health conditions. In its submission to the Migration Advisory Committee's Full Review of the Shortage Occupation List, the Department of Health and Social Care argued that speech and language therapists should be added to the Shortage Occupation List because the profession is facing a range of pressures including increasing demand, in mental health in particular (Migration Advisory Committee, May 2019, https://bit.ly/36cX5KB).

Unmet communication needs carry a number of risks for the person, their friends and families, for the professionals working with them, and for the wider health and social care, education and justice system. Unsupported speech, language and communication needs can be a barrier to:

- Accurate care and treatment planning: The person may not be able to express their health needs
- Rehabilitation and psychological programmes: The verbal delivery of these is inaccessible
- Risk assessments for capacity and consent: The person may not be able to accurately weigh up the information and communicate their wishes

With changes to mental capacity legislation and changes to the Mental Health Act roles, it will be important that expanding the workforce includes non-medical posts such as dedicated posts for speech and language therapists in mental health services.

Recommendation three: **The wider workforce should receive training on the links between communication needs and mental health.**
There is a lack of awareness about the link between mental health and speech, language and communication and swallowing needs. Communication needs are hidden so their importance is frequently overlooked. Mental health staff often fail to recognise the importance of understanding a person's language and communication needs and how to adapt their communication style.

Being able to communicate is essential in explaining concerns around mental health.

- Unsupported communication needs can be a barrier to a person expressing health needs during assessment, treatment and care planning (Emerson E. et al (2010).
- People with communication difficulties are likely to have problems accessing and understanding information about their health leading to their needs being unidentified (UCL, 2015)

- People with communication difficulties and mental health needs often have less understanding of, and insight into, managing and maintaining their own mental health, resulting in barriers to rehabilitation and recovery (Rees H et al (2018).

One challenge in mental health wards is the frequency of restrictive interventions such as seclusion. The CQC Who Cares report (CQC, 2020) found that staff were often not trained in different communication methods. This can lead to a person being unable to communicate, becoming more distressed, and staff resorting to using restraint, seclusion or segregation. The annual cost of conflict and containment per ward is £357,000 (Flood, 2008).

Training on the links between speech, language and communication needs and mental health enables staff to modify their language, adapt their verbal de-escalation skills and recognise how unmet communication needs can lead to distress.

Our members highlighted that the target audiences is wide reaching and should include the wider mental health, education, health, social care, and justice workforce.

Recommendation four: All talking therapies and verbally mediated interventions must be made communication accessible. The barriers they present to people with communication needs must be acknowledged.
Aside from those conditions treated with medication, almost all mental health services and therapies are verbally mediated, that is conducted through language and interactions, for example, 'talking therapies'. The evidence shows that verbally mediated interventions and programmes are inaccessible to people with communication needs (Bryan, 2004) (Bryan et al., 2007).

NICE has also recognised that certain interventions and therapies may be unsuitable for children or adults with communication needs and these barriers needs to be addressed (NICE: Depression in adults, 2022; NICE: depression in children 2019).

Talking therapies put a significant demand on language processes, both expressive and receptive, and can be difficult for individuals with communication needs to access and benefit from. Offering talking therapies, without consideration of the adjustments required to support engagement, results in offering inappropriate interventions where the person has insufficient language skills to engage and increases their change of failure. Unmet needs impact on recovery and length of stay in mental health settings. This represents a waste of resources and public money.

It is crucial that verbally mediated interventions are tailored to make them accessible as a matter for priority. It is possible for assessments and interventions to be modified and adapted for use with people who have limited communication (Bryan K and Gregory J, 2013) (Gregory J and Bryan K 2011). This requires language assessment and skilled intervention by a speech and language therapist to underpin the work of other members of the multi-disciplinary team.

Recommendation five: **Services support individuals with communication needs to be involved with decisions about their care; and support people to express their needs in relation to their health and wellbeing.**
Communication skills are fundamental and foundational. They enable us to understand and to be understood. Communication is central to all of the key guiding principles of the reform to the Mental Health Act. People must be able to express their views and wishes if they want to have a say over their care and treatment. However, individuals with speech, language and communication needs are often either excluded from patient decision making processes or included in a tokenistic way. There is a risk that their needs and opinions are assumed, misinterpreted or ignored. People with communication

difficulties face avoidable health inequalities. Limited communication and health literacy reduces capacity to convey health needs effectively to others (RCSLT, 2021).

It is essential to consider communication needs to support individuals with their health. Information must be presented in a way that is easier for the person to understand. Staff must plan reasonable adjustments before all appointments and discussions around health and wellbeing (Five good communication standards).

Recommendation six: The link between anti-psychotic medication and dysphagia is recognised.
Some anti-psychotic medication has side effects, including dysphagia (eating, drinking and swallowing difficulties). They can result in choking, pneumonia, chest infections, dehydration, malnutrition and weight loss. They can also make taking medication more difficult.

There is a greater prevalence of dysphagia in acute and community mental health settings compared to the general population. People with a diagnosis of schizophrenia, are 30 times more likely to die from choking than the general population (Rushena et al, 2003). The prevalence of people with swallowing problems taking antipsychotic medication ranges from 21.9% to 69.5% (Font M. and Salsench R., 2017).

Question 7: What is the NHS currently doing well and should continue to support people with their mental health?
Recommendation: Speech and language therapists are embedded as a core part of the multi-disciplinary team in all relevant child, adolescent and adult mental health services.

Please see the case studies below:

Case study one: Implementation of a speech and language therapy (SLT) service for adult mental health wards, Cumbria, Northumberland, Tyne and Wear NHS Foundation trust

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 speech and language therapy service was provided to older people's inpatient wards. 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 speech and language therapy input in adult mental health wards. Increased communication and dysphagia need was recognised and with continued investment the team grew to 4 speech and language therapist posts covering 36 inpatient mental health 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 speech and language therapy involvement in wider trust initiatives in relation to mental health, such as talk first, positive and safe agenda, PMVA training, health literacy, coproduction.
- Increased referral to speech and language therapy for communication and dysphagia referrals.
- There are now 12.4 speech and language therapists employed across the mental health wards.

Case study two: Speech, Language and Communication Pathway and a Dysphagia Pathway in Adult Mental Health Inpatients, Nottinghamshire Healthcare NHS Foundation Trust

Access to speech and language therapy services is variable within adult mental health services across England. In Nottinghamshire, a speech and language therapist provides input into adult mental health acute inpatient wards across 3 hospital sites, consisting of 7 wards.

This included direct clinical contact, workforce development and consultation, resulting in:

- The development of a speech, language and communication pathway
- Development of a dysphagia (swallowing difficulties) pathway
- Developing other staff to understand and recognise communication needs that are often described as 'invisible' or 'hidden'

72 people with a range of mental health diagnoses were referred to speech and language therapy between Sept 2017-August 2018:

- 71% (51/72) of referrals were for input in relation to communication needs
- 18% (13/72) were for dysphagia
- 11% (8/72) were for combined communication and dysphagia needs

Impact

- Input from speech and language therapy increased individuals' ability to engage in verbally mediated therapies, through the provision of communication guidelines and joint working with other professionals, in line with the Accessible Information Standard. Of the individuals seen for communication input, 81% (48/59) presented with social communication needs and 51% (30/59) presented with difficulties in relation to understanding and processing verbal information, highlighting a significant barrier to therapeutic interventions such as talking therapies.
- 100% of staff who completed communication and dysphagia training demonstrated

increased knowledge, confidence and skills in supporting individuals, therefore enabling earlier identification and management to minimise the associated risks. This has been evidenced whereby one ward recognised that 88% (22/25) of people presented with communication needs.
- Service has been expanded to include another speech and language therapist.

Case study three: Speech and language therapy role in reducing distress and the use of restrictive interventions: Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Patients on inpatient mental health wards experience restrictive interventions such as seclusion. The speech and language therapy team wanted to establish if identifying any unmet communication needs would reduce distress, and in turn reduce the use of restrictive interventions which often follow.

Solution

- A comprehensive speech and language therapy assessment was completed with the patient. Staff were provided training to increase their understanding of the persons language and communication needs. The training also supported staff to adapt their verbal de-escalation skills to meet the needs of the person.
- The speech and language therapist worked jointly with the psychology team to consider the incidents of violence and aggression in the context of communication needs and supported the ward to identify how to identify triggers which would reduce incidents.

What were the challenges

- The main challenge was having the ward staff recognise the importance of understanding a persons language and communication needs and to adapt their communication style.
- This barrier was overcome through modelling and demonstrating the difference in interactions when the conversation was accessible to the person.
- Modelling was also utilised when the person was distressed to demonstrate how verbal de-escalation could be adapted to be successful.

What were the results?

- Speech and language therapy input had reduced the incidents of violence and aggression, and in turn has reduced the use of restrictive interventions.
- For the patient this has reduced the risk of trauma associated with seclusion.
- For the staff this has reduced staffing requirements associated with seclusion (and the additional cost)
- It has also increased the therapeutic relationship between the patient and the staff team and the admission was made accessible and meaning, and the person was able to contribute to their care.

What were the learning points?

- Speech and language therapist are uniquely skilled to reduce the use of restrictive interventions. Speech and language therapy can support organisations to meet national guidance such as NICE Guidance 10, Mental health units (use of force) act 2018, Towards safer services national minimum standard (draft, 2019) and the NHS Long Term Plan.

Next steps

- The next steps are to increase the funding for speech and language therapy within mainstream mental health wards and to grow the service. Considerations will be given to

current budget and future workforce planning.

- Speech and language therapy are now asked to present their role to teams across the organisation to increase awareness of language and communication needs.
- The speech and language therapy team are now meeting with organisations across the country who do not have any speech and language therapy provision in inpatient wards to demonstrate the impact it has made at this Trust.

Case study four: speech and language Therapists improving access to therapeutic mental health interventions in CAMHS, Nottinghamshire Healthcare NHS Foundation Trust - Children and Adolescents Mental Health Services (CAMHS)

Young people are referred to CAMHS to address a myriad of complex issues, and it is unlikely that these issues will be devoid of emotion. Emotions map onto our life experiences and influence our decisions; they help us to build and maintain relationships and recall/share our history. Individuals require the vocabulary relating to emotions, an understanding of how emotional states are observed and how they feel in order to discuss them. Knowledge and insight of these elements is termed 'emotional literacy.'

An intervention was designed to develop young peoples' emotional vocabulary in a way that would support them to develop their emotional literacy skills. This included language building activities (eg. venn diagrams), language expansion tasks (eg. mood diaries) which encourages practical application of vocabulary to scenarios, story writing and individuals' daily interactions, the use of colour coding emotions and blob trees.

This provided a foundation to explore real incidences of elevated emotion, such as self-harm, managing challenging behaviours, managing excitement about a visit or apprehension about attending court. This led to the discussion of regulation of emotions, mental health and social problem solving.

Impact
The evidence-based intervention resulted in young people developing their emotional literacy skills. 100% of young people developed a basic understanding of the difference between thoughts, feelings (emotions), bodily sensations and 100% gained an understanding of positive and negative emotions. 72% were able to describe five or more complex emotions and 100% were proficient in utilising the Blob Tree and the colour coding system.

This allows for identification as to whether a young person is utilising the skills learnt beyond their speech and language therapy intervention, and whether this is enabling them to better engage with other therapeutic interventions on their treatment programme.

Q8. What should be the Government's priorities for future research and data improvements over the coming decade?

DATA IMPROVEMENT

For too long workforce planning has not been fit for purpose. There has been no national assessment of the demand for speech and language therapy. There has been no assessment of the extent of unmet need.

Workforce planning does not take account of speech and language therapists who are employed by

non-health employers. This includes those working in independent practice. It also includes those employed by schools. It also does not take into account speech and language therapists employed by the NHS but working in non-health settings. This includes those working in schools and criminal justice settings. This has resulted in speech and language therapy becoming a shortage profession.

The UK government recognises that speech and language therapy is a shortage profession. The NHS Long Term Plan states that speech and language therapy is a profession in short supply. Speech and language therapists are also on the Government Shortage Occupation List. The Department of Health and Social Care called for this. It argued that the profession is facing a range of pressures, including from increasing demand in mental health.

The benefit of data must not be underestimated; until data about who is working where is available and robust, it will be challenging to understand, evaluate, and improve existing issues. Workforce planning and data must be improved.

RESEARCH

The RCSLT would like the government's research to focus on the following two priorities:
1. the effect of communication difficulties on (access to) psychological intervention; and
2. the impact of speech and language therapy input/interventions on the mental health of children, young people and adults with mental health problems.

We are also interested in research on:
1. Impact of accessible community-based services in reducing hospital admissions for acute episodes of mental health conditions
2. Diagnostic over-shadowing (especially with personality disorder)
3. Inequalities for people with communication needs accessing mental health services

Q9. What should inpatient mental healthcare look like in 10 years' time and What needs to change in order to realise that vision?

In ten years, all mental health services will consistently offer the following:

1. Mental health wards are led by allied health professionals (AHPs) not just nurses
2. Speech and language therapists are embedded in all inpatient and community mental health services, in all relevant child, adolescent and adult mental health services.
3. Everyone with a communication or swallowing need can access speech and language therapy
4. All mental health staff are trained in the links between speech, language and communication and mental health
5. All talking therapies are modified by speech and language therapists to be communication accessible
6. All inpatient setting environments are communication friendly
7. All wards implement the 5 Good Communication Standards (https://www.rcslt.org/wp-content/uploads/media/Project/RCSLT/good-comm-standards.pdf) and NHSE Accessible Information Standards
8. Implementation of reasonable adjustments as standard

For people with mental health problems, in line with the five Good Communication Standards, mental health services will be responsive to their needs:

- Staff understand me
- Staff understand how I communicate
- Staff listen to me

- I am included in decisions about my own care and treatment
- I receive the right diagnosis
- I am not restrained, staff don't use hands-on management with me

All mental health services will follow NICE advice around speech and language therapy and mental health:

- Rehabilitation for patients with complex psychosis, 2020 "Speech and language therapist input would be needed to deal with the additional communication needs that can be experienced by this group" and "The multidisciplinary team should have access to … speech and language therapists".
- Depression in adults, 2022 "address any barriers to the delivery of treatments because of any disabilities, language or communication difficulties" and "if needed, adjust the method of delivery or length of the intervention to take account of the person's ability to communicate, disability or impairment".
- Depression in children and young people: identification and management, 2019 "Certain therapies may not be suitable or may need to be adapted for use with children generally or those with… different communication needs" and "a full assessment of needs, including… communication needs".
- Early years: promoting health and wellbeing in under 5s, 2016 "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."

What needs to change in order to realise that vision?
The RCSLT is calling for:

- Recognition within the new ten-year mental health plan of the links between mental health and communication and swallowing needs
- Acknowledgment of the barrier that communication needs present and how they prevent people from accessing interventions and treatment in mental health services
- A commitment to providing accessible, patient-centred mental health services through early identification and support for communication and swallowing needs
- Speech and language therapists to be recognised as core team members in mental health services and embedded in all relevant mental health services
- Increased awareness, and training, among all mental health professionals about the links between swallowing and communication needs and mental health.

Chapter: **Implementation of the new plan**
Q10. What do you think are the most important issues that a new, 10-year national mental health plan must address?

Recommendation one: recognition within the new ten-year mental health plan of the links between mental health and communication and swallowing needs
Children and adults with mental health needs have a higher incidence of communication difficulties than the general public:

- 81% of children with emotional and behavioural disorders have significant unidentified language deficits.
- 80% of adults in an acute psychiatrist inpatient unit had impairment in language and 60% had impairment in communication and discourse (Walsh, 2007).
- 30% of adults with mental health disorders have some impairment in swallowing (Walsh, 2007).

Communication difficulties are a risk factor for poorer mental health across the lifespan from birth to end of life. Good communication is a protective factor against developing mental health problems (Money et al, 2016), (DfE, 2018).

Many adults with mental health conditions have unidentified speech, language and communication difficulties and swallowing needs. Recognition must be given in the ten-year mental health plan of the links between mental health and communication and swallowing needs.

Recommendation two: **providing and embedded speech and language therapists as a core part of the multi-disciplinary team in all relevant child, adolescent and adult mental health services for earlier intervention.**
With over 80% of children and adults with mental health conditions having, often unmet communication needs, and 30% having swallowing difficulties, supporting these needs should be recognised as an integral.

It is critical that a person can access the right support at the right time. Too few mental health services have speech and language therapists employed. Speech and language therapists should be embedded as a core part of the multi-disciplinary team in all relevant child, adolescent and adult mental health services. They have a vital role in protecting and promoting the wellbeing and resilience of people with communication and swallowing needs (Rees H, Forrest C, Rees G, 2018). Recognising speech and language therapists as core to the mental health workforce would also increase access to therapy. Delays in accessing speech and language therapy can lead to poorer mental health outcomes, as well as hospitalisation for chest infections or pneumonia.

Recommendation three: Extending the role of Approved Clinician (AC) and Responsible Clinician (RC) to speech and language therapists.
Some of the proposed changes to legislation, such as addressing the availability of AC and RC and approved mental health professionals, have clear implications for staffing. Where the staffing numbers are not available, the government must look to expanding the list of professionals able to train and undertake these roles. The professionals able to train and act as an Approved Clinician (AC) and Responsible Clinician (RC) should be extended to speech and language therapists.

The mental health workforce has developed, and the multidisciplinary team grown, since the legislation extended the AC and RC role to a small number of professional groups. To optimise the AC and RC role, and build the workforce for the future, will require non-medical expansion of these role. To enable sustainable change across mental health teams there is a need to develop the AC and RC roles to substantially increase communication difficulty expertise to meet patient need as well as to deliver the new Mental Health reforms.

Increasing non-medical take up of the AC and RC roles has a number of benefits. It provides a broader range of professionals to meet the needs of patients. It increases patient choice. It recognises the expertise of other professionals and importantly utilises clinical skills, knowledge and competence. Development of a diverse AC and RC workforce will also help to mitigate workforce pressures.

Recommendation four: Training of the mental health workforce on the links between mental health and speech, language, communication and swallowing needs and how to respond to them
There is a lack of awareness about the link between mental health and speech, language and communication and swallowing needs.

To prevent mental health problems escalating due to unmet communication needs, training needs to be provided on the links between speech, language, communication and mental health. Training could also

include the signs of mental health difficulty, communication difficulties as a risk factor, and strategies in how to respond. Our members highlighted that the target audiences is wide reaching and includes the wider mental health, education, health, social care, and justice workforce.

Q14. What 'values' or 'principles' should underpin the new mental health plan as a whole? Please explain.

The Royal College of Speech and Language Therapists recommends the following:

- Good communication skills are a protective factor against mental health problems
- Poor communication is a mental health risk factor
- The importance of identifying communication and swallowing difficulties of people in contact with mental health services
- Breaking-down the barriers faced by people with communication difficulties when accessing mental health services and interventions
- The importance of training the wider education, health and social care, and justice workforce in understanding the links between speech, language, communication and mental health

Q15. How can we support local systems to develop and implement mental health plans for their local populations?

Recommendation one: Ensure that every Integrated Care Board (ICB) includes allied health professional advice and leadership.
The RCSLT has called for the inclusion of allied health professionals on Integrated Care Boards in the interests of better patient care. The focus of allied health professionals' work is less "medical model" and much more about prevention, maximising potential, reducing dependency, return to work and recovery from elective surgery.

The inclusion of an allied health professional on an Integrated Care Board would contribute to delivering improved patient care pathways by helping to ensure that the totality of an individual's diagnostic and intervention needs were identified and appropriately supported. They would bring understanding of the short and longer term needs of a range of people, and how services need to be designed to meet these needs.

Allied health professionals (AHPs) are the third largest section of the health workforce, supporting people of all ages with a range of diagnostic and therapeutic interventions both within and beyond health and social care settings. Their contribution can often be overlooked in a narrative that frequently focuses on the role of doctors and nurses.

We are pleased that the government have put on the record that they: 'recognise the importance of communications needs, and the important part that they play in children's development. "

We are also pleased that the government's on the record comment that "Under the existing bill provisions, every ICB will be required to provide and improve rehabilitation services as part of its duty to provide a comprehensive health service. As an added layer of scrutiny, ICBs must publish an annual review detailing how they have discharged this function."

This recognition is welcome, but it not sufficient. ICBs need more than to be 'strongly encouraged'. They need to given clear guidance that the transformative skills, knowledge and experience of allied health professionals are essential to have – and must be - included on an ICB. This will enable strategic decisions can be taken and informed in light of the experience and expertise of that part of the health workforce.

In the NHSEI's Interim guidance on the functions and governance of the integrated care board, published in August 2021, it states specifically that the ICB should include, amongst others, a medical director and a director of nursing. This failure to specifically reference an allied health professional means that the third largest part of the health workforce is potentially excluded from membership of the ICB while the two largest parts are guaranteed a seat.

There is a danger that without a guaranteed seat at the ICB table, strategic decisions will not be informed by the whole range of diagnostic and therapeutic experience and expertise.

It is also unfortunate because allied health professionals are professionals who possess skills, knowledge and experience relevant to people whose conditions the Government recognise and accept will need to have a professional lead appointed to the ICB to support. These include autism and learning disability and mental health.

The RCSLT calls on the government to ensure that the diagnostic and therapeutic expertise of allied health professionals is harnessed and maximised in ICBs.

Recommendation two: Increase the number of Approved Clinician (AC) and Responsible Clinician (RC)
Some of the proposed changes to legislation, such as addressing the availability of AC and RC and approved mental health professionals, have clear implications for staffing. Numbers of AC and RCs are lacking; the government must look to expanding the list of professionals able to train and undertake these roles.

The mental health workforce has developed, and the multidisciplinary team grown, since the legislation extended the AC and RC role to a small number of professional groups. To optimise the AC and RC role, and build the workforce for the future, will require non-medical expansion of these role.

Increasing non-medical take up of the AC and RC roles has a number of benefits. It provides a broader range of professionals to meet the needs of patients. It increases patient choice. It recognises the expertise of other professionals and importantly utilises clinical skills, knowledge and competence. Development of a diverse AC and RC workforce will also help to mitigate workforce pressures.

The professionals able to train and act as an Approved Clinician (AC) and Responsible Clinician (RC) should be extended to speech and language therapists.

Recommendation three: Fill the gaps in community mental health services for child, adolescent and adults with speech and language therapists
To support people before they reach crisis point requires investment in early intervention and community services. Providing high-quality community mental health services is the best way to improve the care and outcomes for those with mental health needs. As detentions are reduced, community-based provision needs to be improved and expanded to make these services accessible to everyone. Expanding these services must include speech and language therapists, as part of the mental health workforce.

Mental health services are experiencing an increase in the complexity of cases. They are frequently supporting individuals with suspected or diagnosed learning disability and or autism. Mental health teams are feeling the impact of this. They don't have the skills or confidence to work with these people (RCN).

Speech and language therapists are uniquely placed to bring an extensive set of skills and knowledge. They frequently have a background in learning disabilities, autism, or challenging behaviour as well as mental health knowledge. This makes them well placed to meet the needs of what is increasingly becoming a very complex set of patients.

Speech and language therapists should be embedded as a core part of the multi-disciplinary team in all relevant child, adolescent and adult mental health services. They would support service planning and decisions, not just from a medical view, but focussing on prevention, maximising potential, reducing dependency, return to education/work and accurate diagnosis.

Chapter: Cross-cutting data priorities

Question 16: How can we improve data collection and sharing to help plan, implement and monitor improvements to mental health and wellbeing

Recommendation: Improve workforce data collection

For too long workforce planning and data collection has not been fit for purpose. The benefit of data must not be underestimated; until data about who is working where is available and robust, it will be challenging to understand, evaluate, and improve existing issues. Workforce planning and data must be improved.

Numerous data sets do not capture the mental health contribution of speech and language therapy:

1. The NHS benchmarking mental health dataset
2. The National Workforce - Mental Health Services Data Set https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set

However, NHS Digital mental health workforce data highlights speech and language therapists as part of its mental health workforce, although the ways in which certain staff groups, in certain settings are defined is nuanced; and it is unclear how speech and language therapists are accurately identified. https://committees.parliament.uk/writtenevidence/39834/pdf/

For mental health services to really become data-driven, there need to be some basic foundations in place. The RCSLT recommends the following:

1. Systems need to be configured to collect data that is needed to support patient care and service/quality improvement. The RCSLT outcomes event (June 2022) highlighted that it can be challenging for SLTs to get systems set up to collect what they need. The main barrier/blocker is capacity/resource of IT departments in NHS Trusts to make this happen – i.e. speech and language therapy services are having to wait a very long time until their requests are prioritised, meaning that they are left using paper-based system to collect the data that they need, or work-arounds such as spreadsheets. Naturally if these systems are difficult to use, compliance is low and the quality and quantity of data is poor.

2. Digital and data leadership roles

There is a need to improve digital and data literacy and competence across the workforce to drive these improvements. Data needs to be "everyone's business". We also need leaders that can drive improvements at a local level. Without the right skills in the clinical workforce, it will be challenging to move forward with developing good systems and quality data that are fit-for-purpose, meeting the needs of clinicians in supporting the provision of patient care and also for secondary purposes.

3. Workforce

We need a workforce that is skilled to know what to do with the data that is collected. Again, the RCSLT outcomes event (June 2022) showed that a large proportion of SLTs are relatively confident with

collecting data (when they have the tools/systems in place to support them to do this), but using this data to drive service improvements is a big step for most.

4. Information sharing
In terms of the point about information sharing, it is quite a technical one, but systems need to be 'interoperable', meaning that information can flow between systems. There is currently a lot of work happening to try to make it possible for data to flow to national datasets, and for key parts of the health and care record to be shareable with other professionals but there is still some way to go.

5. Standards
'Information standards', like those developed by the PRSB, aim to make the data collected within the NHS more standardised and consistent and therefore better able to be aggregated and used for these 'secondary purposes' (such as planning services) but implementation of these standards is quite low.