Children and Young People's Mental Health Green Paper:
Consultation Questions
Transforming children and young people's mental health provision: A Green Paper

Response from the Royal College of Speech and Language Therapists
28 February 2018

Introduction

What is your name?
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What is your organisation?
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Would you like us to keep your responses confidential?
No

Response from the Royal College of Speech and Language Therapists

Question 1:

The core proposals in the green paper are:

- All schools and colleges will be incentivised and supported to identify and train a Designated Senior Lead for Mental Health who will oversee the approach to mental health and wellbeing
- Mental Health Support Teams will be set up to locally address the needs of children and young people with mild to moderate mental health issues, they will work with schools and colleges link with more specialist NHS services
- Piloting reduced waiting times for NHS services for those children and young people who need specialist help

Do you think these core proposals have the right balance of emphasis across a) schools and colleges and b) NHS specialist children and young people's mental health services? Please give your answer below (max 250 words)

It is difficult to say if this is the right balance as the specialist mental health services and Mental Health Support Teams composition is unclear. Speech and language therapists (SLTs), with the appropriate level of specialism and service provision, should be included.

Comprehension, expression and social communication skills are central to effective communication.

Speech, language and communication needs (SLCN) are a mental health risk factor.

- 81% of children with emotional and behavioural disorders have significant unidentified language deficits.[1]
- Children with vocabulary difficulties at age five are three times as likely to have mental health problems in adulthood.[2]
- Children with language difficulties have a worse quality of life in terms of moods and emotions and are more at risk in terms of social acceptance and bullying.[3]
- People with a primary communication difficulty are at greater risk of a secondary mental health disorder, commonly anxiety or depression.[4]
- Language difficulties are common in children presenting to mental health services.[5]

SLCN, often unidentified, often co-occur with other risk factors:

- ADHD;[6]
- conduct disorder;[7]
- attachment difficulties;[8]
- abuse and neglect;[9]
- trauma;[10]
- selective mutism.[11]

Benefits of SLCN identification and support:

- reduced risk of:
    - mental health problems developing or existing problems escalating;
    - referrals and assessments being inaccessible or inaccurate;
- meaningful engagement with therapy.

SLTs can support:

- identification of and appropriate response to SLCN;
- the Designated Senior Lead for Mental Health and Mental Health Support Teams

to fulfil their responsibilities;

- children who need therapy;
- parents and carers;
- psychological formulation;[12]
- removal of barriers to engagement and better outcomes.

Question 1 references

1 Hollo A, Wehby JH, Oliver RM. Unidentified Language Deficits in Children with Emotional and Behavioral Disorders: A Meta-Analysis. Exceptional Children 2014; 80(2): 169-186. http://journals.sagepub.com/doi/abs/10.1177/001440291408000203
2 Law J et al (2009), Modelling developmental language difficulties from school entry into adulthood: literacy, mental health, and employment outcomes, Journal of Speech, Language and Hearing Research, 52(6): 1401-16.
3 Lindsay G, Dockrell J (2012), The relationship between speech, language and communication needs (SLCN) and behavioural, emotional and social difficulties (BESD), Department for Education research report DFE-RR247-BCRP6. http://tinyurl.com/p8yhpsa.
4 Botting N, Durkin K, Toseeb U, Pickles A, Conti-Ramsden G (2016). Emotional health, support, and selfefficacy in young adults with a history of language impairment. British Journal of Developmental Psychology; 34, 538–554.
5 Cohen, N.J. et al. (1993). Unsuspected Language Impairment in Psychiatrically Disturbed Children: Prevalence and Language and Behavioral Characteristics. J. Am. Acad. Child Adolesc. Psychiatry, 32, 3:595–603. Cohen, N.J. (1996). Unsuspected language impairments in psychiatrically disturbed children: Developmental issues and associated conditions. In J.H.Beitchman, N.J. Cohen, M. Konstantareas, &R. Tannock (Eds.), Language, Learning and Behavior Disorders (pp. 105–121). Cambridge: Cambridge University Press
6 Green, B. C., Johnson, K. A. and Bretherton, L. (2014), Pragmatic language difficulties in children with hyperactivity and attention problems: an integrated review. International Journal of Language & Communication Disorders, 49: 15–29 and Walsh IP, Scullion M, Burns S, MacEvilly D & Brosnan G (2014) Identifying demographic and language profiles of children with a primary diagnosis of attention deficit hyperactivity disorder Emotional and Behavioural Difficulties Special Issue: Language and Communication in the Child with Emotional and Behavioural Difficulties 19 1
7 Bonamy RO, Edward DB, Mandy WPL Skuse D, Maughan B (2011), Social Cognition and Conduct Problems: A Developmental Approach Journal of the American Academy of Child & Adolescent Psychiatry, 50 4 385–394
8 Sadiq F A, Slator L David Skuse, D, Law J, Gilberg C, Minnis H 2012 Social use of language in children with reactive attachment disorder and autism spectrum disorders European Child & Adolescent Psychiatry ; 21(5):267-76.
9 Sylvestre A, et al. Language Problems Among Abused and Neglected Children: A Meta-Analytic Review. Child Maltreat 2015; November 30: 1-12 and Law J and Conway J. The effect of abuse and neglect on the development of children's speech and language. Development Medicine and Child Neurology 1992; 34 (11): 943–948.
10 Refuge (2005). Refuge assessment and intervention for pre-school children exposed to domestic violence.
11 Ford MA, Sladeczek IE, Carlson J & Kratochwill TR (1998) 'Selective mutism: phenomenological characteristics', School Psychology Quarterly, 13(3), pp192-227.
12 Speech and language therapists can support psychological formulation through identifying and describing the speech, language and communication needs (SLCN) of a child or young person. They can also contribute to understanding of how SLCN might contribute to the development and maintenance of other difficulties, for example, how a child or young

person interacts with others, their behaviour, and their motivation at school. This can benefit not only the child or young person, but also family members and other professionals by increasing understanding of the difficulties flowing from SLCN and how they might impact across all aspects of development including mental health.

Response from the Royal College of Speech and Language Therapists

Mental Health Support Teams

Question 4:

Trailblazer phase: A trailblazer phase is when we try out different approaches
Do you know of any examples of areas we can learn from, where they already work in a similar way to the proposal for Mental Health Support Teams?

Please give your answer below (max 250 words)

In one region, Primary Mental Health workers funded by CAMHS already work in schools. A parallel education funded multiagency team, including speech and language therapists (SLTs), went into schools to support teachers to teach pupils with speech, language and communication needs (SLCN). A partnership model integrating these services would provide a framework for Mental Health Support Teams.

In North Yorkshire, the new Back on Track team is extending the 'No Wrong Door' methodology to those with social, emotional and mental health needs (SEMH).[1] The support provided focuses on vulnerable young people, known or at risk of being known to social care, in Year 6 and mainstream secondary schools, alternative provision and special schools. Practitioners (including SLTs) are responsible for delivering outreach in relation to those referred for support. The objectives are to demonstrate the positive impact of a multi-disciplinary and therapeutic approach to the needs of children and families adopting the Thrive framework and to enable this to be used within the school as a whole. It aims to:

- work with young people and their school to help them re-engage with learning and enjoy school;
- prevent further exclusions;
- support young people to access school local to where they live, wherever possible.

Clayfields House Secure Children's Home is an example of good practice in the secure estate, based on the Secure Stairs model, which could be generalised to the community.[2]

Some universities have a network of Mental Health Advisors, for example Loughborough.

Question 4 reference

1 For an evaluation of the No Wrong Door model see: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/625366/Evaluation_of_the_No_Wrong_Door_Innovation_Programme.pdf

2 For more on Secure Stairs, see https://www.england.nhs.uk/commissioning/health-just/children-and-young-people/

Response from the Royal College of Speech and Language Therapists

Question 5:
Different organisations could take the lead and receive funding to set up the Mental Health Support Teams. We would like to test different approaches.

Which organisations do you think we should test as leads on this? Please rank the following organisations in order of preference:

- Clinical Commissioning Groups (CCGs) 5
- Groups of schools 2
- Local authorities 4
- Charity or non-government organisation 3 a provider such as Place2B or Young Minds would have expertise and advocacy skills to lead, prioritising the needs of service-users over stakeholders more so than school groups
- Other: 1 a collaborative organisation between schools and relevant health services, including speech and language therapy services. The lead body for of the collaborative would be health. Harnessing the unique clinical expertise of the whole health workforce, working in collaboration with schools, is crucial to delivering a whole-system approach.

  Given the many significant links between mental health and speech, language and communication needs (SLCN), speech and language therapists (SLTs), with their unique clinical expertise in speech, language and communication, have a crucial role to play as part of a multi-disciplinary team. They can help with identifying SLCN, training the Designated Senior Lead, Mental Health Support Teams and other professionals in awareness of SLCN, their interaction with mental health, and how to respond to them appropriately. This would help ensure the accessibility and accuracy of support, referrals, assessments, and interventions. SLTs can also provide therapy to those who need it, contribute to their psychological formulation[1] and also support parents and carers to understand SLCN and respond appropriately. This can lead to higher levels of engagement and better outcomes as once SLCN is recognised and strategies implemented a barrier is removed.

Question five reference

1 Speech and language therapists can support psychological formulation through identifying and describing the speech, language and communication needs (SLCN) of a child or young person. They can also contribute to understanding of how SLCN might contribute to the development and maintenance of other difficulties, for example, how a child or young person interacts with others, their behaviour, and their motivation at school. This can benefit not only the child or young person, but also family members and other professionals by increasing understanding of the difficulties flowing from SLCN and how they might impact across all aspects of development including mental health.

Response from the Royal College of Speech and Language Therapists

Question 6:

Mental Health Support Teams will work and link with a range of other professionals and we would like to test different approaches. From the list below, please identify the three most important 'links' to test in the way they would work with Mental Health Support Teams:

- Educational psychologists 2
- Local authority troubled families teams
- Local authority children and young people's services 3
- Local authority special educational and disability (SEND) teams
- School nurses
- School-based counsellors
- Charity or non-government organisation
- Youth offending teams
- Other: 1 speech and language therapists with the appropriate level of specialism. 81% of children with emotional and behavioural disorders have significant unidentified language deficits.[1] Left unidentified and unsupported, these deficits risk support, referrals, assessments, and interventions being inaccessible, inaccurate or ineffective. Harnessing the unique clinical expertise of the whole health workforce is crucial to delivering a whole-system approach.

  Given the many significant links between mental health and speech, language and communication needs (SLCN), speech and language therapists, with their unique clinical expertise in speech, language and communication, have a crucial role to play as part of a multi-disciplinary team. They can help with identifying SLCN, training the Designated Senior Lead, Mental Health Support Teams and other professionals in awareness of SLCN, their interaction with mental health, and how to respond to them appropriately. This would help ensure the accessibility and accuracy of support, referrals, assessments, and interventions. SLTs can also provide therapy to those who need it, contribute to their psychological formulation[2] and also support parents and carers to understand SLCN and respond appropriately. This can lead to higher levels of engagement and better outcomes as once SLCN is recognised and strategies implemented a barrier is removed.

Question 6 references

1 Hollo A, Wehby JH, Oliver RM. Unidentified Language Deficits in Children with Emotional and Behavioral Disorders: A Meta-Analysis. Exceptional Children 2014; 80(2): 169-186. http://journals.sagepub.com/doi/abs/10.1177/001440291408000203

2 Speech and language therapists can support psychological formulation through identifying and describing the speech, language and communication needs (SLCN) of a child or young person. They can also contribute to understanding of how SLCN might contribute to the development and maintenance of other difficulties, for example, how a child or young person interacts with others, their behaviour, and their motivation at school. This can benefit not only the child or young person, but also family members and other professionals by increasing understanding of the difficulties flowing from SLCN and how they might impact across all aspects of development including mental health.

Response from the Royal College of Speech and Language Therapists

Question 7:

Mental Health Support Teams and Designated Senior Leads for Mental Health in schools and colleges will work closely together, and we will test this working through the trailblazer phase.

Out of the following options how do you think we should measure the success of the trailblazer phase? Please pick your top three:

- Impact on children and young people's mental health 1
- Impact on quality of referrals to NHS Children and Young People Mental Health Services
- Impact on number of referrals to NHS Children and Young People Mental Health Services
- Quality of mental health support delivered in schools and colleges
- Amount of mental health support delivered in schools and colleges
- Effectiveness of interventions delivered by Mental Health Support Teams
- Children and young people's educational outcomes 2
- Mental health knowledge and understanding among staff in school and colleges
- Young people's knowledge and understanding of mental health issues, support and self-care 3
- Numbers of children and young people getting the support they need
- Other

To ensure the success of the trailblazer phase can be measured fully, meaningfully, and accurately, it is essential that:

- the totality of children and young people's needs, and how they impact on mental health, are identified and appropriately responded to. Without this, there is a risk that children and young people's mental health will not improve and may even worsen. One such need are speech, language and communication needs (SLCN). These are often unidentified. 81% of children with emotional and behavioural disorders have significant unidentified language deficits.[1] Unidentified SLCN will reduce a child's ability to make their needs known and will reduce the validity of verbally mediated assessment.
- the totality of needs that can impact on children and young people's ability to engage with education are identified and supported. If they are not there is a risk that educational outcomes will not improve and may even worsen. SLCN are one such need.
- children and young people's SLCN (be they comprehension, expression and/or social communication) are identified and responded to appropriately, including through the differentiation of questions and materials. For instance, Cognitive Behavioural Therapy and talking therapies will need to be differentiated for those children and young people with SLCN. If not, children and young people will not be able to demonstrate knowledge and understanding of their mental health issues, support and self-care. There is a risk their mental health will worsen and they will be unable to access support and will not be able to care for themselves.
- the tools used to measure success are accessible to those with SLCN. If they are not, there is a risk that undifferentiated measurement tools will return inaccurate results. Similarly, those undertaking any measurements need to be trained in awareness of SLCN and how to respond appropriately.

Question 7 references

1 Hollo A, Wehby JH, Oliver RM. Unidentified Language Deficits in Children with Emotional

and Behavioral Disorders: A Meta-Analysis. Exceptional Children 2014; 80(2): 169-186. http://journals.sagepub.com/doi/abs/10.1177/001440291408000203

Response from the Royal College of Speech and Language Therapists

Question 8:

Trailblazer phase: A trailblazer phase is when we try out different approaches
When we select areas to be trailblazers for the Mental Health Support Teams, we want to make sure we cover a range of different local factors. What factors should we take into account when choosing trailblazer areas?
Please rank the following in order of importance:

- Deprived areas 2
- Levels of health inequality 3
- Urban areas 4
- Rural areas 5
- Areas where children and young people in the same school/college come under different Clinical Commissioning Groups (CCGs) 6

Other: 1 Prevalence of SEND, including particularly speech, language and communication needs (SLCN) given the many significant links between mental health and SLCN. 81% of children with emotional and behavioural disorders have significant unidentified language deficits.[1]

SLCN are often unidentified in children and young people with mental health problems or at risk of developing them. In addition, those with identified SLCN may be at risk of having unidentified mental health problems. Indicators for SLCN include behaviour, educational attainment and difficulties forming and maintaining friendships. SLCN are often undetected, often co-occur with mental health problems and with mental health risk factors. It is essential they are identified and responded to appropriately to ensure children and young people are able to access and benefit from support, referrals, assessments, and interventions.[2,3] Once SLCN are recognised and strategies implemented a barrier is removed and higher levels of engagement and better outcomes can be achieved. In addition, any services that provide support to young people who meet the following conditions need to ensure that they are also acting in accordance with the NHS England Accessible Information Standard: are over 18 years of age, have an active Education, Health and Care Plan that provides support up until the age of 25 years of age, are accessing CAMHS services.[4]

Question 8 references

1 Hollo A, Wehby JH, Oliver RM. Unidentified Language Deficits in Children with Emotional and Behavioral Disorders: A Meta-Analysis. Exceptional Children 2014; 80(2): 169-186. http://journals.sagepub.com/doi/abs/10.1177/001440291408000203
2 As a result of the Government review into the abuse of adults with learning disabilities at Winterbourne View, RCSLT developed the Five Good Communication Standards through the RCSLT National Forum for Adults with Learning Disabilities. These good practice standards provide advice to commissioners and providers on making reasonable adjustments to communication that individuals with learning disability and/or autism should expect in specialist hospital and residential settings. These also have wider relevance for ensuring people with communication needs have their needs responded to appropriately and are also applicable in this context. https://www.rcslt.org/news/good_comm_standards
3 For the links between language and complex verbally mediated therapies and the need to ensure they are accessible see, for example, Devapriam, J. & Alexander, R.T. (2012), "Tiered model of learning disability forensic service provision", Journal of Learning Disabilities and Offending Behaviour, Vol. 3 No. 4, pp. 175-85 and Snow, P. C., & Powell, M. B. (2011). "Oral language competence in incarcerated young offenders: Links with offending severity." International Journal of Speech Language Pathology, 13(6), 480–489.

4 https://www.england.nhs.uk/ourwork/accessibleinfo/

Response from the Royal College of Speech and Language Therapists

Question 9:
How can we include the views of children and young people in the development of Mental Health Support Teams?
Please provide your answer below (max 250 words)

To include the views of children and young people in the development of the teams, it is essential that any speech, language and communication needs (SLCN) are identified and supported. These are often unidentified in children with mental health problems or at risk of developing them.[1, 2]

Development of the teams should include children giving their views on how their SLCN were identified and supported, including giving feedback on how adults communicated with them.

Verbal and written material will need to be accessible. If it is not, those with SLCN may not understand what is being asked of them, may not be able to express their views, or may express their views in an inaccurate or misleading ways.[3, 4]

Those gathering the views of children and young people must have the necessary skills and knowledge to communicate effectively with those who have both mental health problems and SLCN. Questionnaires are unlikely to be an effective method of gathering their views. A semi-structured interview by suitably trained and experienced workers, who can support the young people to understand the questions and express their answers, may be necessary. This might include the use of differentiated materials, questions, communication styles such as pictures, symbols, scaling, and Augmentative and Alternative Communication (AAC) where necessary.[5]

With their unique clinical expertise in speech, language and communication, speech and language therapists would have a central role both in training and supporting these workers as appropriate and supporting those children whose SLCN require direct therapy to give their views meaningfully.[6]

Question 9 references

1 Hollo A, Wehby JH, Oliver RM. Unidentified Language Deficits in Children with Emotional and Behavioral Disorders: A Meta-Analysis. Exceptional Children 2014; 80(2): 169-186. http://journals.sagepub.com/doi/abs/10.1177/001440291408000203
2 Beitchman, J. H., Wilson, B., Johnson, C. J., Atkinson, L., Young, A., Adlaf, E., & Douglas, L. (2001). Fourteen-year follow-up of speech/language-impaired and control children: Psychiatric outcome. Journal of the American Academy of Child & Adolescent Psychiatry, 40(1), 75-82.
3 Snow, P. C., & Woodward, M. N. (2016). Intervening to address communication difficulties in incarcerated youth: A Phase 1 clinical trial. International Journal of Speech-Language Pathology, 1-15. 2012. Snow, P. & Powell, M. 'Youth (in)justice: Oral language competence in early life and risk for engagement in antisocial behaviour in adolescence', Australian Institute of Criminology, Trends and issues in crime and criminal justice, No. 435, April 2012. Bryan, K., Garvani, G., Gregory, J. & Kilner, K. (2015). Language difficulties and criminal justice: the need for earlier intervention. International Journal of Language and Communication Disorders, 50 (6), 763- 775. Bryan, K. & Gregory, J. (2013). Perceptions of staff on embedding speech and language therapy within a youth offending team. Child Language and Teaching Therapy, 29 (3), 359- 371.
4 As a result of the Government review into the abuse of adults with learning disabilities at

Winterbourne View, RCSLT developed the Five Good Communication Standards through the RCSLT National Forum for Adults with Learning Disabilities. These good practice standards provide advice to commissioners and providers on making reasonable adjustments to communication that individuals with learning disability and/or autism should expect in specialist hospital and residential settings. These also have wider relevance for ensuring people with communication needs have their needs responded to appropriately and are also applicable in this context. https://www.rcslt.org/news/good_comm_standards See also the Accessible information Standard which could also provide a model for ensuring accessibility. https://www.england.nhs.uk/ourwork/accessibleinfo/ Any services that provide support to young people who meet the following conditions need to ensure that they are also acting in accordance with the NHS England Accessible Information Standard: are over 18 years of age, have an active Education, Health and Care Plan that provides support up until the age of 25 years of age, are accessing CAMHS services.

5 Hughes, N, Chitabesan, P., Bryan, K., Borshmann, R., Swain, N., Lennox, P. and Shaw, J. (2017) Language impairment and comorbid vulnerabilities among young people in custody. Journal of Child Psychology and Psychiatry, 58, 1106-1113. 2013. Conti-Ramsden, G., Mok, P. L., Pickles, A., & Durkin, K. Adolescents with a history of specific language impairment (SLI): Strengths and difficulties in social, emotional and behavioral functioning. Research in developmental disabilities, 34(11), 4161-4169.

6 An example of this is provided by work NHS England has recently undertaken with the CAMHS service at Clayfields House Secure Children's Home. This included working with the speech and language therapist to create adapted semi-structured questions to explore young people's views of services. These reasonable adjustments allowed the young people to meaningfully engage in the process.

Response from the Royal College of Speech and Language Therapists

Piloting a waiting time standard

Question 10:

Waiting time standards are currently in place for early intervention for psychosis and for eating disorder services.

Outside of this, are you aware of any examples of local areas that are reducing the amount of time to receive specialist NHS help for children and young people's mental health services? Can we learn from these to inform the waiting times pilots?

Please give your example(s) below (max 250 words)

The case of Child B offers an example of reducing waiting times by providing immediate intervention meaning she was not subject to community SLT and CAMHS waiting times.

B was a girl of 15 in the care system, known to the Youth Offending Team (YOT) and with a long history of violence and drug use. She presented to CAMHS services as highly distressed and 'hearing voices'. She was diagnosed with psychosis with a view to prescribing anti-psychotic medication. The YOT speech and language therapist (SLT) worked with B, her mother, the YOT mental health worker, YOT Officer and drug worker to provide a differential diagnosis of a pre-existing Developmental Language Disorder compounded by her drug use and Developmental Trauma. B worked hard to understand her language disorder and that the voices she heard were in fact her own internal fragmented expressive language trying to make sense of her traumatic childhood experiences. B's distress, violence and drug use immediately decreased. She no longer reported hearing voices. Her care placement stabilised. B was empowered to participate in meetings by first explaining that she had a language disorder and how she could be helped to participate. Before this meetings such as Care Order meetings had ended in B becoming abusive and walking out. B's diagnosis of psychosis was revised to Developmental Language Disorder with no anti-psychotic medication being prescribed, saving the NHS a significant sum through non-prescription of medication. B completed her Court Order. No repeat offending has been recorded.

Response from the Royal College of Speech and Language Therapists

Schools and colleges

Question 11:

Schools publish policies on behaviour, safeguarding and special educational needs and disability.

To what extent do you think this gives parents enough information on the mental health support that schools offer to children and young people?

- All of the information they need
- Most of the information they need
- Some of the information they need X
- None of the information they need
- Don't know

Please tell us more about why you think this (max 250 words)

Speech and language therapists (SLTs) report inconsistency in the policies published by schools.

It is essential that a child presenting with behavioural or mental health problems has a detailed language and communication assessment delivered by an SLT.

Those presenting to mental health services with unsuspected language impairments are less likely to have their educational needs identified.[1] Policies should detail the links between mental health and speech, language and communication needs (SLCN) and set out how SLCN will be identified and responded to, including how children's views on how their needs have been identified and accommodated are to be collected and recorded. Those presenting for assessment and treatment for mental health problems are often described as purposefully noncompliant to directions, oppositional, lazy and lacking interest in school.[2] These behaviours are interpreted as wilful rather than being linked to inadequate communication and comprehension skills and working memory problems.[3] Policies should provide details of how they are differentiated to meet the mental health needs and SLCN of pupils presenting with emotional-behavioural problems, including how SLCN, and other SEND, will be identified and supported as a first response to those problems.[4]

Selective mutism should also be explained in policies, to enable early identification and intervention and avoid later problems requiring more complex, aggressive and expensive management.[5]

Policies should be provided in differentiated format so they are accessible to any parents and families who may themselves have SLCN or face language and literacy barriers.[6]

Question 11 references

1 Cohen, N.J. et al. (1998). Language, Achievement, and Cognitive Processing in Psychiatrically Disturbed Children with Previously Identified and Unsuspected Language Impairments. Journal of Child Psychology and Psychiatry and Allied Disciplines. Vol. 39, No 6, pp865-877.

2 Cohen, N.J. et al. (1998). Language, social cognitive processing and behavioural characteristics of psychiatrically disturbed children with previously identified and unsuspected language impairments, Journal of Child Psychology and Psychiatry and Allied Disciplines. 39 pp853-864 Cohen, N.J. et al. (1998). Language, Achievement, and Cognitive Processing in Psychiatrically Disturbed Children with Previously Identified and Unsuspected Language Impairments. Journal of Child Psychology and Psychiatry. Vol. 39, No 6, pp865-

877.
3 Cohen, N.J. et al. (2013). Higher order language competence and adolescent mental health. Journal of Child Psychology and Psychiatry. Vol. 54, No 7, pp733-744.
4 Mental health and behaviour in schools, Department for Education, 2016.
5 Johnson M & Wintgens A (2016) The Selective Mutism Resource Manual, Routledge Publishers, Abingdon.
6 As a result of the Government review into the abuse of adults with learning disabilities at Winterbourne View, RCSLT developed the Five Good Communication Standards through the RCSLT National Forum for Adults with Learning Disabilities. These good practice standards provide advice to commissioners and providers on making reasonable adjustments to communication that individuals with learning disability and/or autism should expect in specialist hospital and residential settings. These also have wider relevance for ensuring people with communication needs have their needs responded to appropriately and are also applicable in this context. https://www.rcslt.org/news/good_comm_standards See also the Accessible information Standard which could also provide a model for ensuring accessibility. https://www.england.nhs.uk/ourwork/accessibleinfo/. Any services that provide support to young people who meet the following conditions need to ensure that they are also acting in accordance with the NHS England Accessible Information Standard: are over 18 years of age, have an active Education, Health and Care Plan that provides support up until the age of 25 years of age, are accessing CAMHS services.

Response from the Royal College of Speech and Language Therapists

Question 12:
How can schools and colleges measure the impact of what they do to support children and young people's mental wellbeing?
Please give your answer below (max 250 words)

Schools and colleges can measure the impact of what they do to support children and young people's mental wellbeing in a number of ways.

First, by measuring the totality of needs impacting on mental health, including the prevalence of speech, language and communication needs (SLCN), and how they are supported. This is particularly important given the known behavioural difficulties exhibited by children and young people presenting with mental health needs and (often unidentified) SLCN. 81% of children with emotional and behavioural disorders have significant unidentified language deficits.[1]

Second, they can measure what impact the children and young people think the support has had by asking them how well they understood information that was given to them (by asking them to explain it), how well adults communicated with them and enabled them to express themselves, and how well they understand themselves and can use strategies to help themselves.

Third, adopting a range of other measures, including:

- number of incidents of truancy;
- number of temporary and permanent school exclusions;
- outcomes measures, in relation to improved learning outcomes, and quality of life;
- number of risk behaviours;
- number of incidents;
- number of pupils requiring onward referral to specialist CAMHS services as needs are sufficiently met by the school/college Mental Health Support Teams (something to measure the effectiveness of early and appropriate intervention, including identification of SLCN, at school/college level).

Question 12 references

1 Hollo A, Wehby JH, Oliver RM. Unidentified Language Deficits in Children with Emotional and Behavioral Disorders: A Meta-Analysis. Exceptional Children 2014; 80(2): 169-186. http://journals.sagepub.com/doi/abs/10.1177/001440291408000203

Response from the Royal College of Speech and Language Therapists

Vulnerable groups

Question 13:

In the development of the Mental Health Support Teams, we will be considering how teams could work with children and young people who experience different vulnerabilities.
How could the Support Teams provide better support to vulnerable groups of children and young people?

Please give your answer below (max 250 words)

To better support vulnerable groups, Support Teams should include all relevant health professionals so the totality of needs affecting mental health are identified and responded to appropriately.

The prevalence of speech, language and communication needs (SLCN) is so high in some vulnerable groups that it should be assumed that they have SLCN until the expected level of language skill is positively demonstrated.[1]

Vulnerabilities that often have undetected communication and interaction difficulties include:

- social, emotional and mental health needs;[2]
- conduct disorder;[3]
- selective mutism;[4]
- excluded from school;[5]
- young people in the youth justice system;[6]
- residential care;[7]
- ADHD;[8]
- social disadvantage;[9]
- attachment difficulties;[10]
- the consequences of perinatal mental health;[11]
- having a physical health condition;
- young people who are carers.

Developmental Language Disorder is a mental health vulnerability.[12]

Given their unique clinical expertise in speech, language and communication, speech and language therapists (SLTs) have a crucial role to play in preventing mental health problems developing and existing mental health problems escalating. As part of multi-disciplinary Support and Specialist teams, appropriately specialised SLTs can:

- identify SLCN;
- train and support others, including the Designated Senior Lead and the Mental Health Support Team, in SLCN awareness and how to respond, including through differentiation;
- provide therapy to those who need it and contribute to their psychological formulation;[13]
- support parents and carers;
- ensure support, referrals, assessments, and interventions, which make significant demands on language processes, are accessible and accurate;
- enhance young people's, their carers' and families' quality of life and wellbeing;
- promote physical and mental health parity of esteem.

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13 Speech and language therapists can support psychological formulation through identifying and describing the speech, language and communication needs (SLCN) of a child or young person. They can also contribute to understanding of how SLCN might contribute to the development and maintenance of other difficulties, for example, how a child or young person interacts with others, their behaviour, and their motivation at school. This can benefit not only the child or young person, but also family members and other professionals by increasing understanding of the difficulties flowing from SLCN and how they might impact across all aspects of development including mental health.

Response from the Royal College of Speech and Language Therapists

Support for children looked after or previously looked after

Question 14:
As we are rolling out the proposals, how can we test whether looked after children and previously looked after children can easily access the right support?
Please give your answer below (max 250 words)

So looked after children can access support, it is essential their totality of needs are identified and supported, the unique clinical expertise of all relevant health professionals is harnessed, and services are flexible and accessible. Given the prevalence of speech, language and communication needs (SLCN) in this population is so high, they should be assessed for SLCN.

- Severe and pervasive communication impairment, much of it previously unidentified, has been found in children and young people in residential care.[1]
- An ONS report on the mental health of looked after children found that, despite evidence of serious underreporting, SLCN were the second most frequently reported difficulty.[2]
- 58% of those seen by 'No Wrong Door', North Yorkshire County Council's model around 'rethinking care for adolescents', were identified as having SLCN.[3]

With unique clinical expertise in speech, language and communication, appropriately specialised speech and language therapists (SLTs) have a crucial role to play as part of multi-disciplinary Support and Specialist teams. They can:

- identify SLCN;
- train and support others, including the Designated Senior Lead and the Mental Health Support Team, in SLCN awareness and how to respond, including through differentiation;
- provide therapy to those who need it and contribute to their psychological formulation;[4]
- support families and carers;
- ensure support, referrals, assessments, and interventions, which make significant demands on language processes, are accessible and accurate;
- enhance young people's, their carers' and families' quality of life and wellbeing;
- support chidren to express their views, wishes and feelings;
- promote parity of esteem between physical and mental health.

Question 14

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3 Evaluation of the No Wrong Door Innovation Programme Research Report, Department for Education, 2017. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/625366/Evaluation_of_the_No_Wrong_Door_Innovation_Programme.pdf

4 Speech and language therapists can support psychological formulation through identifying and describing the speech, language and communication needs (SLCN) of a child or young person. They can also contribute to understanding of how SLCN might contribute to the

development and maintenance of other difficulties, for example, how a child or young person interacts with others, their behaviour, and their motivation at school. This can benefit not only the child or young person, but also family members and other professionals by increasing understanding of the difficulties flowing from SLCN and how they might impact across all aspects of development including mental health.

Response from the Royal College of Speech and Language Therapists

Support for children in need

Question 15:

As we are rolling the proposals out, how can we test whether children in need who are not in the care system can access support?

Please give your answer below (max 250 words)

To ensure children in need can access the right support it is essential that their totality of needs are identified and supported, the unique clinical expertise of all relevant health professionals is harnessed, and services are flexible and accessible.

Children in need who are not in the care system who are at higher risk of mental health problems, are also at a higher risk of having unidentified speech, language and communication needs (SLCN). This includes children and young people who have:

- Experienced abuse and neglect;[1]
- Witnessed domestic violence;[2]

Given their unique clinical expertise in speech, language and communication, speech and language therapists (SLTs) have a crucial role to play in preventing the development of mental health problems and existing mental health problems escalating. As part of multi-disciplinary Support and Specialist teams, appropriately specialised SLTs can:

- identify SLCN;
- train and support others, including the Designated Senior Lead and the Mental Health Support Team, in SLCN awareness and how to respond, including through differentiation;
- provide therapy to those whose SLCN requires it and contribute to their psychological formulation;[3]
- support families and carers;
- ensure support, referrals, assessments, and interventions, all of which make significant demands on language processes, are accessible and accurate;
- enhance young people's, their carers' and families' quality of life and wellbeing;
- support children in need to express their views, wishes and feelings thereby allowing them to engage with support, referrals, assessments, and therapy;
- removal of barriers to engagement and better outcomes.
- promote parity of esteem between physical and mental health.

Question 15

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3 Speech and language therapists can support psychological formulation through identifying and describing the speech, language and communication needs (SLCN) of a child or young person. They can also contribute to understanding of how SLCN might contribute to the development and maintenance of other difficulties, for example, how a child or young person interacts with others, their behaviour, and their motivation at school. This can benefit not only the child or young person, but also family members and other professionals by increasing understanding of the difficulties flowing from SLCN and how they might impact across all aspects of development including mental health.

Response from the Royal College of Speech and Language Therapists

Support for children and young people with special educational needs or disability

Question 16:

As we are rolling the proposals out, how can we test whether children and young people with special educational needs or disability are able to access support?

Please give your answer below (max 250 words)

To ensure children with special educational needs and disabilities (SEND) can access the right support it is essential that their totality of needs are identified and supported, the unique clinical expertise of all relevant health professionals is harnessed, and services are flexible and accessible.

There is a high prevalence of speech, language and communication needs (SLCN) among those with SEND.

- 20.5% of children with SEN in England have SLCN as their primary need.[1]
- Other primary types of SEN will also have SLCN: moderate learning difficulty, Autism Spectrum Disorder, and hearing impairment.
- These other types of SEN are also mental health risk factors:
    - 71% of children with ASD;[2]
    - 40% of deaf children;[3]
    - 36% of those with a learning disability.[4]

Given their unique clinical expertise in speech, language and communication, speech and language therapists (SLTs) have a crucial role to play. As part of multi-disciplinary Support and Specialist teams, appropriately specialised SLTs can:

- identify SLCN;
- train and support others, including the Designated Senior Lead and the Mental Health Support Team, in SLCN awareness and how to respond, including through differentiation;
- provide therapy to those whose SLCN requires it and contribute to their psychological formulation;[5]
- support families and carers;
- ensure support, referrals, assessments, and interventions, all of which make significant demands on language processes, are accessible and accurate;
- enhance young people's, their carers' and families' quality of life and wellbeing;
- support children with SEND to express their views, wishes and feelings;
- promote parity of esteem between physical and mental health.

Question 16 references

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5 Speech and language therapists can support psychological formulation through identifying and describing the speech, language and communication needs (SLCN) of a child or young person. They can also contribute to understanding of how SLCN might contribute to the development and maintenance of other difficulties, for example, how a child or young person

interacts with others, their behaviour, and their motivation at school. This can benefit not only the child or young person, but also family members and other professionals by increasing understanding of the difficulties flowing from SLCN and how they might impact across all aspects of development including mental health.

Response from the Royal College of Speech and Language Therapists

Providing evidence for an Impact Assessment
A consultation stage Impact Assessment was published alongside the green paper. The following questions seek to gather further evidence to inform future versions of the Impact Assessment. We welcome references to any evidence, published or in development, or expert opinion on the topics set out above to help refine our final Impact Assessment.
If you have not read the Impact Assessment or do not wish to respond to these questions then please skip to the next section.

Question 17
Please provide any evidence you have on the proportion of children with diagnosable mental health disorders, who would benefit from support from the Mental Health Support Teams
Please give your answer below

Selective Mutism (SM): estimates of the prevalence of SM have increased over the years and most recent studies suggest that about 1 in 140 children under 8 years of age are affected. When older children are included, prevalence is lower; about 1 in 550 children.[1] Studies[2, 3, 4, 5] report a range from 0.71 to 1.9% in young school-aged populations with an excess in inner city bilingual immigrant children.[6]

Given the many significant links between mental health and often unidentified speech, language and communication needs (SLCN), the Mental Health Support Teams should include developmental and adolescent language disorder expertise.

There is a very high co-occurrence of mental health difficulties with SLCN.[7] Children with unresolved speech and language difficulties are at risk of psychiatric morbidity.[8] In addition, there is a strong association of mental health difficulty associated with self-harm[9] and substance misuse.[10] Work with young offender populations has also shown a strong association of SLCN with various forms of neurodisability including, intellectual disability, traumatic brain injury, autistic spectrum disorder and mental health difficulties.[11]

Given the potential complexities and co-morbidity summarised above, it is essential that a speech and language therapy assessment identifies any SLCN so that the child or young person can have a modified and supported assessment that will enable a true picture of their strengths and difficulties to be identified.

Similarly, where SLCN are present, the wider Mental Health Support Team will need ongoing support from a speech and language therapist to ensure that verbally mediated interventions are accessible to the young person.[12]

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Response from the Royal College of Speech and Language Therapists

Pre diagnosable: Children and young people who have mild or low-level needs which do not constitute a diagnosable mental health condition but are at risk of developing one and would benefit from a form of support

Question 18:
Please provide any evidence you have on the proportion of children with pre-diagnosable mild to low-level mental health problems who would benefit from support from the Mental Health Support Teams

Without effective help a third of children with speech, language and communication difficulties need treatment for mental health problems in adult life.[1]

Higher order language development such as inferential thinking, understanding abstract concepts and the understanding and use of figurative language has both direct and indirect effects on psychosocial development.[2] Young people who experience difficulties developing higher order language skills are vulnerable to both social and academic failure and isolation.[3] 45% of children and young people (CYP) (12 – 18yrs) referred for assessment and treatment to Community Mental Health Centres were found to have higher order language impairments. However 15% of the comparison group (i.e. matched CYP not referred to Community Mental Health Centres) were also found to have higher order language impairments. These findings suggest that there is a percentage of non-referred youth who have significant social-emotional problems that are currently being overlooked but could benefit from support.[4]

Amongst children with speech-language delays at 5.5 years, those with more severe and persistent language difficulties and low nonverbal IQ are at higher risk of psychiatric morbidity in adolescence.[5]

Question 18 references

1 Clegg J., Ginsborg J., eds, (2006), Language and social disadvantage: theory into practice, John Wiley & Sons.
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Response from the Royal College of Speech and Language Therapists

Question 19:
Please provide any evidence you have of the impact of interventions for children with mild to moderate mental health needs, as could be delivered by the Mental Health Support Teams. We are interested both in evidence of impact on mental health and also on wider outcomes such as education, employment, physical health etc.
Please give your answer below

A random control trial of a communication intervention delivered by a community mental health team was effective in facilitating increased communication in children and young people with selective mutism.[1] The follow-up study one year later demonstrated that the children who overcame their SM were those whose teachers implemented a programme of graded exposure.[2]

Vocabulary/language intervention is effective in school age children excluded from school due to social, emotional and mental health difficulties.[3]

Studies have shown:

- intervention to support specific language impairment resulted in improved educational outcomes for adolescents;[4]
- the benefits of whole school language based intervention.[5]
- adding speech and language therapy input to a community based youth offending team enabled young people to improve their language skills with functional improvements as well as significant improvements on standardised language assessments.[6]
- an evidence based framework for improving communication outcomes for young offenders.[7]

Clinical examples include.

Child R

- R was a 17 year old Looked After Child, physically abused by his father who was well known to the adult prison system.
- R had a history of persistent serious multiple offences. R was a chaotic poly drug user.
- R had a poor education history and had been excluded from mainstream provision. No formal educational qualifications achieved. R was not in education or training and had no experience of employment.
- R was perceived by Youth Offending Team (YOT) officers as difficult to manage and engage due to his chaotic and volatile presentation compounded by drug use. His engagement with the YOT was extremely erratic. He was considered at high risk of receiving a custodial sentence due to his inability to comply with community court orders.
- R presented with mental health difficulties including self-harming and was diagnosed with a Conduct Disorder. However he was unable to engage in therapeutic support due to his frequent and intense emotional dysregulation.
- R was assessed by the YOT speech and language therapist (SLT) and diagnosed with a Developmental Language Disorder.
- R met with the YOT SLT in order to understand the implications of this diagnosis and the impact of the language disorder on his life. R then agreed to work with the YOT Mental Health Social Worker.
- The YOT SLT supported the effectiveness of these therapy sessions by helping overcome any difficulties relating to R's communication problems.

- The YOT SLT devised a visual cue – the YOT Mental Health practitioner would hold up a card saying *Speech and Language*. This visual sign was sufficient to remind R of his language difficulties which allowed him to manage his emotions long enough for the communication error to be explored and explained in a way he could understand.
- R's ability to stay in the room and engage with the therapy significantly increased and he was able to move forward successfully.
- R ceased to offend and substantially reduced his drug use. Very unusually he returned to Court where his 12 month Youth Rehabilitation Order was ended early due to his outstanding progress.
- R achieved and sustained full time employment and was additionally drug free 12 months post the end of his last order. R said he was happy.

Case study Q

- The Youth Offending Team (YOT) SLT worked with a Family Practitioner to support Q.
- Q was a 10 year old boy with a diagnosed Conduct Disorder who also had a severe Developmental Language Disorder (previously undiagnosed).
- He was referred to by the Educational Psychologist as 'uneducable'.
- Systemic work with Q and his mother only become possible when we used a 'Comic Strip Conversation' approach to visually narrate the sessions as they unfolded which enabled Q to regulate his emotions and externalised behaviours and participate in the therapy.
- Following this intervention, Q was successfully re-integrated into mainstream primary school and the application for him to be taken into care was halted.

Question 19 references

1 Oerbeck, B., Stein, M.B., Wentzel-Larsen, T., Langsrud, O., & Kristensen, H. (2014). A randomized controlled trial of a home and school-based intervention for selective mutism-defocused communication and behavioural techniques. Child & Adolescent Mental Health, 19, 3, 192-198.

2 Oerbeck, B., Stein, M.B., Pripp, A.H. & Kristensen, H. (2015) Selective mutism follow-up study 1 year after end of treatment, European Child and Adolescent Psychiatry, 24 (7), pp757-66.

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Response from the Royal College of Speech and Language Therapists

Question 20:
Please provide any evidence you have on the impact of Children and Young People Mental Health Services therapeutic treatments
Please give your answer below

Speech and language therapy has been shown to be effective with children with:

- social communication disorders[1]
- social, emotional mental health needs[2]

A random control trial of a communication intervention delivered by a community mental health team was effective in facilitating increased communication in children and young people with selective mutism.[3] The follow-up study one year later demonstrated that the children who overcame their SM were those whose teachers implemented a programme of graded exposure.[4]

Vocabulary/language intervention is effective in school age children excluded from school due to social, emotional and mental health difficulties.[5]

Including language assessment into the psychiatric assessment process can enhance the outcomes of therapeutic programmes. Providing feedback to parents, teachers and children and young people (CYP) concerning the presence of language problems and how they may affect perceptions of CYP and attributions for their behaviour is itself therapeutic. Findings of a telephone follow-up of 286 families of CYP known to mental health services 6-12 months after language assessment had been carried out revealed that:

- 56% of parents of CYP with language impairment found the assessment useful in understanding their children's problems;
- 40% of parents of CYP with language impairment said the assessment had a positive impact on their relationship with their children;
- 45% of parents of CYP with language impairment said that the specific recommendations given at the time of the feedback led to changes at school that were based on the recommendations.[6]

Speech and language therapists (SLTs), with the appropriate level of specialism, can also make an important contribution to the success of therapeutic interventions for those with speech, language and communication needs.[7] Speech and language therapy can lead to higher levels of engagement and better outcomes as once SLCN is recognised and strategies implemented a barrier is removed.

SLTs can provide assessment of mental state verbs, complex syntax, verbal narrative skills and figurative language which are fundamental to the development of many essential social-emotional competencies integral to mental well-being and therapeutic programmes including:

- self-monitoring;
- the capacity to reflect;
- emotional regulation;
- achieving social goals;
- mentalisation (the ability to understand and interpret the intentions of others);
- empathy;
- perspective taking (viewing situations from other's point of view);
- decision making;
- understanding cause-effect relationships;
- understanding consequences,

- social problem solving
- understanding and resolving ambivalent emotions.

Communicative functions such as the use of verbal language for negotiation, persuasion, compromise are part of SLT assessment skills and recommendations. These communicative functions are not only an important component of adolescent social competency but can also support the therapeutic relationship and efficacy of intervention.[8]

Figurative language is an important predictor of social cognition in adolescents referred for mental health services and even mild difficulties in this skill may put an adolescent at risk for interpersonal conflicts with others. Advice from SLTs to mental health practitioners regarding modifying their verbal input, monitoring usage of figurative language, or being mindful that the young person may not be 'getting it' would optimise the success of any treatment, intervention, or therapy.[9]

SLTs can also provide a host of relatively simple but critically important recommendations made for CYP with language impairments generally that can also be applied to interviewing, testing and treating CYP with dual language and socioemotional problems. These include using verbal and visual cues simultaneously, limiting auditory input, gaining children's attention before speaking, pausing between phrases to enhance comprehension, and using repetition of information and concepts liberally.[10]

Question 20 references

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Response from the Royal College of Speech and Language Therapists

Question 21:
Is there any other evidence that we should consider for future versions of the Impact Assessment?
Please give your answer below

Future versions of the Impact Assessment should include:

- evidence of the prevalence of mental health risk factors, including speech, language and communication needs (SLCN), expressive, receptive, and social communication;[1]
- evidence of the co-occurrence of physical and developmental problems with mental health, including SLCN;
- evidence of how those risk factors, including SLCN, impact on a child or young person's ability to access, give accurate responses to, and benefit from mental health referrals, assessments and interventions;
- evidence of how children and young people with SLCN are at risk of unrecognised mental health needs;
- evidence of how mental health problems can present and are communicated by children and young people with SLCN;
- further exploration of the link between SLCN, poor mental health and offending risk as this is significant and will have an impact on the way in which services liaise i.e. CAMHS services linking with Forensic CAMHS services to share skills and knowledge.[2]

This would help:

- increase awareness and understanding of the extent of issues that can impact on a child or young person's mental health, including SLCN;
- demonstrate how to reduce some of the mental health risk factors, including how SLCN are identified and accommodated;
- demonstrate how children and young people's individual needs, including any SLCN, could be addressed to ensure mental health referrals, assessments and interventions are accessible;
- ensure open channels of communication between services, aid smooth transitions and avoid duplication and absence of specialist interventions such speech and language therapy.

Mental health and communication
There are important links between mental health and communication.

- As evidenced below, speech, language and communication needs (SLCN) are a mental health risk factor.
- Difficulty with communication when a person is stressed and anxious will have a particular impact on children and young people with SLCN. It is important that this is recognised to ensure that children and young people receive appropriate support. If not, they may be at risk of a range of negative outcomes in relation to support, referrals, assessments, and interventions.

SLCN are a mental health risk factor

- Public Health England has highlighted that good communication skills are a mental health risk factor for children and young people.[3]
- The Department for Education has highlighted the same and also that communication difficulties are a risk factor for child and adolescent mental health.[4]
- The Department for Education has stated that 'consistent disruptive or withdrawn behaviour can be an indication of an underlying problem, and where there are

concerns about behaviour there should be an assessment to determine whether there are any causal factors such as undiagnosed learning difficulties, difficulties with speech and language or mental health issues.'[5]

- Early language development is a child wellbeing indicator.[6]
- Children with vocabulary difficulties at age five are three times as likely to have mental health problems when they reach adulthood.[7]
- Children with language difficulties have an impoverished quality of life in terms of moods and emotions and are more at risk in terms of social acceptance and bullying.[8]
- Anxiety is higher in individuals with DLD than age matched peers and remains so from adolescence to adulthood; individuals with DLD have higher levels of depression symptoms than do peers in adolescence. Levels of depression in those with DLD decreased post-compulsory schooling but rose again by 24 years of age.[9]
- People with a primary communication impairment are at greater risk of a secondary mental health disorder, commonly anxiety or depression.[10]
- Studies consistently observe a higher rate of past early language problems among adults with anxiety or social phobia disorders.[11]
- Language difficulties are also strongly associated with behavioural problems, with studies observing consistently higher levels of disruptive and antisocial behaviour amongst children also identified with speech and language needs.[12]
- Longitudinal studies of children with identified language and communication impairments demonstrate an elevated risk for these children and young people of social, emotional and behavioural difficulties in adolescence and adulthood.[13]
- Children presenting to mental health services with unsuspected language impairments have the most serious externalising behavioural problems.[14]
- Young people (12-18yrs) referred to mental health services are three times more likely than their non-referred peers to meet the criterion for higher order language disorders affecting inferential thinking, understanding abstract concepts and the understanding and use of figurative language.[15] Higher order language impairments are associated with parent ratings of severity of externalising psychopathologies in the clinic setting.[16]
- Young offenders with delayed higher order language skills were found to be at high risk for mental health problems.[17]
- Adolescents referred for mental health services have difficulties with structural and figurative language and less developmentally mature social cognitive skills. In particular, clinic-referred adolescents have difficulty using language to identify and know how to overcome potential obstacles to problem resolution and knowing when an interpersonal conflict is really resolved.[18]
- Figurative language is an important predictor of social cognition in adolescents referred for mental health services and difficulties in this skill put an adolescent at risk for interpersonal conflicts with others.[19]
- Language skills are essential for autobiographical memory.[20] These include conversation skills (discourse), complex expressive language, receptive and expressive narrative skills, understanding and use of time language. Adults experiencing major depressive disorder (MDD) have been consistently found to have impaired autobiographical memories.[21] Studies focusing on both adolescents and adults have found autobiographical memory deficits in those identified as high risk for developing MDD.[22] Autobiographical deficits at age 11 years predicted depressive symptoms at 12 years in girls.[23] While more research is needed focusing on CYP with language impairments these studies suggest that those who may have difficulties associated with the forming of autobiographical memories, such as CYP with language difficulties, may be at elevated risk for MDD.
- Deficits in pragmatic language (social communication) precede early and late adolescent psychotic experiences and early adolescent depression. Interventions

aimed at helping children improve pragmatic language skills may reduce the incidence of adolescent psychopathology and associated psychological disorder and dysfunction later in life.[24]

- A large general population cohort showed that early language development at 2 and 4 years makes a significant contribution to emotional and behavioural functioning at 5 years. This means that language development in the pre-school period is involved in developing the social, emotional and mental health of children as they grow older. More developed language ability means better adjusted social, emotional and mental health.[25]
- At 9 years of age children's pragmatic communication abilities are involved in later teenage emotional and behavioural functioning. This means that pragmatic communication ability at the end of middle childhood plays an important role in teenage social, emotional and mental health. More developed pragmatic communication means less risk of social, emotional and mental health difficulties.[26]
- Developmental language disorder in childhood as a risk factor for later mental health difficulties in late adolescence and adult life.[27]
- There is an association between pragmatic language impairment and social, emotional and mental health difficulties.[28]
- Language ability predicts the development of behaviour problems in children.[29]
- A receptive developmental language disorder involves significant deficits in theory of mind, verbal short-term memory and phonological processing, together with substantial social adaptation difficulties and increased risk of psychiatric disorder in adult life.[30]
- Receptive language disorders are as high-risk indicators, often undiagnosed. Language disorders and delays are psychiatric risk factors and have implications for evaluation, therapy, and research. However, they are often undiagnosed in child mental health and community settings. [31]
- Without effective help a third of children with speech, language and communication difficulties need treatment for mental health problems in adult life.[32]

For more on the links between psychiatric disorders and SLCN see:
Bryan K. (2014) Psychiatric disorders and Communication. Louise Cummings (ed) Handbook of Communication Disorders. (pp. 300-318) Cambridge: Cambridge University Press.

There is a high prevalence of SLCN

- Over 10% of children have some form of speech, language or communication need that persists and impairs social or educational functioning:
    - 2.34% of those children have language difficulties associated with another biomedical condition, including brain injury, acquired epileptic aphasia in childhood, certain neurodegenerative conditions, genetic conditions such as Down syndrome, cerebral palsy, sensori-neural hearing loss, autism spectrum disorder (ASD), and learning disability.[33]
    - For 7.58% of children their language difficulties are not associated with another condition. This is known as Developmental Language Disorder.[34]
    - Speech, language and communication needs also include conditions such as speech difficulties, stammering and many others.
- In addition, in areas of high social deprivation in the United Kingdom between 40% and 56% of children start school with delayed language.[35]
- SLCN can also co-occur with:
    - attention deficit hyperactivity disorder; [36]
    - conduct disorder;[37]
    - complex needs;

- There is a high prevalence of previously unidentified SLCN in adolescents growing up in significant socio-economic deprivation and this impacts on poor educational attainment/GCSEs at 16 years and increases the risk of SEMH/mental health difficulties.[38]
- There is high prevalence of SLCN in young offenders on custodial sentences and lower language ability increases the risk of offending behaviour.[39]

SLCN are a barrier to accessing mental health referrals, assessments and interventions and risk inaccurate results

SLCN may impact on the child or young person's ability to access support. Children with recognised SLCN are at risk of unrecognised mental health needs due to:

- diagnostic overshadowing (where signs of a mental health condition may be attributed to an existing SLCN), and/or
- difficulties with communicating their mental health needs in a way that enables them to access the mental health service.

Access to effective mental health support for children and young people with SLCN depends on a high level of awareness of how mental health difficulties can present and are communicated by those with SLCN.

Mental health referrals, assessments and interventions put a significant demand on language processes both expressive and receptive and on social communication. Unless SLCN are identified and accommodated, assessments and treatment programmes risk being inaccessible or delivering inaccurate results.

- The success of cognitive behavioural therapy (CBT) is reliant on participants' language and verbal reasoning capabilities.[40]
- As most therapies are verbally based it is notable that language competence is rarely evaluated systematically before such therapies are undertaken.[41]
- Language impairments are common in children presenting to mental health services (more than 50%) and frequently undiagnosed.[42] E.g. 63.6% of 7-14 year olds referred to psychiatric services had a language impairment. 40% previously unidentified.[43]
- Many psychological interventions rely heavily on the individual's ability to use language to identify treatment goals, articulate the difficulties they are experiencing and exceptions to problems, reflect on their behavioural strengths and resources and regulate their own behaviour and interactions. There is therefore a need to consider language ability in order to plan and deliver effective mental health interventions and predict response to treatment.[44]
- Figurative language competency is important for social communication and even mild difficulties in this skill may put an adolescent at risk for interpersonal conflicts with others. This type of language difficulty is rarely taken into consideration during assessment or treatment in mental health settings, a critical oversight given the language-based nature of most psychotherapeutic interventions.[45]
- Deficits in autobiographical memory are a known risk factor for major depressive disorder in adolescents.[46] However, assessment of the language skills that underpin autobiographical memory are not currently part of mental health assessments or interventions.
- Youth with higher order language impairments may be seen as uncooperative, resistant or argumentative when, in fact, they are not catching the nuances in conversation.[47] Given that language facilitates change in treating intra- and interpersonal conflicts, clinical assessment of adolescents referred for mental health treatment should include routine evaluation of a range of language skills.[48] When a higher order language impairment is diagnosed, therapists must be apprised that there are areas rife with opportunities for miscommunications with some adolescents and where inaccurate inferences may be made about their behaviour.[49] Moreover,

since there are therapeutic techniques for helping children and youth with higher order language impairments,[50] failing to use such techniques is a serious gap in treatment that could be remedied.[51]

- Recent research has highlighted the many barriers people with learning disabilities face in accessing psychological therapies, including individual, therapist, and service factors.[52] Evidence suggests that the risk of anxiety & depression being co-occurring diagnoses in this population is significant [53] and research highlights that such needs, where possible should be addressed within the context of appropriate and robust community services.[54]

Removing barriers

Speech and language therapy can lead to higher levels of engagement and better outcomes as once SLCN is recognised and strategies implemented a barrier is removed.

- The Five Good Communication Standards provide one model of reasonable adjustments that can be made to communication styles for those with communication needs.[55] These Standards can be adapted for a range of settings.
- NHS England's Accessible Information Standard is also relevant in this context. Any services that provide support to young people who meet the following conditions need to ensure that they are also acting in accordance with the Accessible Information Standard: are over 18 years of age, have an active Education, Health and Care Plan that provides support up until the age of 25 years of age, are accessing CAMHS services.[56]

SLCN, mental health and youth justice

For the links between SLCN, mental health and youth justice see:

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SLCN is a mental health risk factor

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Removing barriers

55 As a result of the Government review into the abuse of adults with learning disabilities at Winterbourne View, RCSLT developed the Five Good Communication Standards through the RCSLT National Forum for Adults with Learning Disabilities. These good practice standards provide advice to commissioners and providers on making reasonable adjustments to communication that individuals with learning disability and/or autism should expect in specialist hospital and residential settings. These also have wider relevance for ensuring people with communication needs have their needs responded to appropriately and

are also applicable in this context. https://www.rcslt.org/news/good_comm_standards.
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