

**Royal College of Speech and Language Therapists**

**Response to**

**Consultation on extending the age of referral to the Principal Reporter**

**October 2020**

**1. Do you agree that the maximum age of referral to the Reporter should be increased to 18?**

**a) Yes – All cases**

b) Yes - Care and protection cases only

c) Yes - Offence cases only

d) No change – The existing age criteria should remain

The Royal College of Speech and Language Therapists (RCSLT) fully endorses the proposal for 16/17-year olds to be referred to the Children’s Hearing System on welfare and offence grounds.

Speech, Language and Communication Needs (SLCN) is the umbrella term used to describe the difficulties some children and young people have with listening, understanding and communicating with others. Children with SLCN may have difficulty with only one speech, language or communication skill, or with several (Afasic 2018). For some children, their difficulties may be ‘mild and limited to particular situations’ (Children’s and Young People’s Centre for Justice (CYCJ) 2017, p. 9), but, for many children with SLCN, their difficulties are ‘persistent, pervasive and complex’ (CYCJ 2017 p. 9). Children with SLCN are likely to need support to develop the complex and numerous skills involved in communication. Each child also has unique strengths (Afasic 2018).

A well-established research evidence base suggests that SLCN are over-represented in looked after children and young people (LACYP) (McCool and Stevens 2011) and young offending populations (Snow 2019). Looked-after children with communication needs can have difficulty understanding what is being said to and asked of them. They can also have difficulty making themselves understood. Common difficulties include learning and using complex vocabulary, social communication skills, naming and managing emotions (including self-control), self-awareness, vocabulary, concepts related to time, working memory and the ability to retain, process, recall and sequence information. Communication needs are often hidden and older children in particular may have developed masking techniques for these needs. Some looked-after children communicate through behaviour that may result in offending (Royal College of Speech and Language Therapists 2017).

In the US, Amster, Greis, and Silver (1997) found language delay in over 50% of over 200 children under 31 months in foster care. Hagaman et al (2010) administered a language skills screen to 80 young people entering residential care, 54% of participants were at risk for language impairment. In the only study of SLCN in looked-after children in Scotland to date, McCool and Stevens (2011) investigated communication impairment in 30 young people in residential care, using a carer-administered questionnaire. Communication impairment was indicated in 19 of the 30, with eight profiles suggestive of Autistic Spectrum Disorder. In nine out of ten available case histories of those demonstrating impairment, no concerns had been raised regarding their communication; in the one remaining case, no referral to SLT had been made, despite recorded concerns.

South of the Border, a recently adopted, well-received, model in Yorkshire (No Wrong Door) which delivers an integrated health and social care service to looked-after children and young people, found that 58.4% of their charges had SLCN, with the majority being previously unidentified (Lushey et al. 2017). This indicates a sizeable over-representation of SLCN in this population compared to a rate of 10% in the overall child population (Norbury et al. 2016).

These difficulties do not resolve by the age of 16. Indeed, the higher risk of poorer short term and long-term outcomes for children who have spent time in care is well documented. They are at significantly higher risk of poorer mental health outcomes (Stanley et al. 2005; Ford et al. 2007; Tarren-Sweeney 2008), lower levels of academic attainment (Berridge 2007; Scottish Government 2017), and at greater risk of social, emotional and behavioural disorder (Millward et al. 2006; Ford et al. 2007; Sempik et al. 2008) than the general population. The associations between looked-after status and these outcomes are clearly complex, and placement instability, trauma, abuse, neglect and attachment issues are influencing factors in such outcomes. The wide-ranging negative effects of abuse and neglect on child development are beyond doubt.

These long-term negative outcomes may significantly impact on a young person’s ability to engage with and participate in welfare and justice services. It would be beneficial for young people to have access to the CHS up to the age of 18, at least, in order that they can benefit from the Kilbrandon principles and a welfare-based approach considerate of their needs.

Children with neurodevelopmental disabilities are over-represented in child protection and young offending populations – and these children typically traverse both systems (Baidawi and Piquero 2020). The UN Committee on the Rights of the Child (CRC) stipulate (2019) that children with neurodevelopmental disabilities should not be in a juvenile justice system at all and when present their needs should be individually assessed with appropriate safeguards put in place to protect their rights without discrimination. Raising the age of referral to the CHS to include 16 and 17 year olds would allow such children to be cared for in an environment suited to their needs, as opposed to deeds.

Brain development continues until at least the age of twenty-five and varies on an individual basis (O’Rourke et al. 2020) meaning that young people have less impulse control, ability to plan their actions and make rational decisions. Risk factors including ACEs, TBI and alcohol/substance misuse affect how the brain develops. As such, Scottish Sentencing Council draft guidance (2020) concludes “rehabilitation is a primary consideration when sentencing a young person” and the Children’s Hearing System, arguably, lends itself to greater individualised early and effective intervention (EEI) programs.

It is important to bear in mind that there is a high likelihood that parents and siblings of those in contact with CHS may have SLCN of their own and that furthermore these needs may be unidentified and therefore unmet. They are therefore likely to require support in their daily lives and in specific situations, for example, when a parent attends a Hearing. The 16-17 year olds in the CHS may also be parents themselves which again highlights the need to support these young people to interrupt the negative Intergenerational Cycle of Speech, Language and Communication, Outcomes and Risk (Royal College of Speech and Language Therapists 2016).

**2. If the age of referral is increased to 18, are the existing grounds of referral to a Children's Hearing sufficient (see pages 11-12 for existing grounds)?**

a) Yes

**b) No**

These would need to be extended to include children at risk of pressure to engage in sexual or criminal activity. Having an SLCN makes a child more likely to be a victim of sexual abuse. Children with disabilities, including SLCN, are more than three times more likely to experience sexual assault than children without disabilities (Sullivan and Knutson 2000). A further study followed five year olds with SLCN to adulthood and found them to be nearly three times more likely to report childhood sexual abuse than their peers (Brownlie et al. 2017).

**3. What are your views on the potential implications, including resource, of increasing the age of referral to the Reporter for local authorities, Police and other service providers/organisations?**

As Scotland moves towards being a rights respecting nation, the implementation of this change would be in line with Article 1 of the United Nations Convention on the Rights of the Child (1989) which states that anyone under the age of 18 should be considered a child. Similarly, ‘Getting it Right for Every Child’ (GIRFEC) recognises all under 18s as children, and as such NHS paediatric speech and language therapy (SLT) services operate on an open-referral system for all under 18s.

Freedom of Information enquiries to all Scottish local authorities found there were very few referrals from the Hearings System particularly, and social work services more generally, to NHS SLT services (Clark & Fitzsimons 2016). There is a need for health and social care partnerships to have a greater role within youth justice and care settings and routine inclusion of Speech and Language Therapy screening for SLCN in order that appropriate supports are in place and rehabilitative solutions are accessible. Similarly, police officers have consistently reported having experience of encountering young people with SLCN and identified a need for further training in identifying and meeting SLCN of young people they work with (MacRae and Clark [in press]).

The profession specific expertise of SLTs will be needed to identify and support SLCN. There is no expectation that other professionals will take on this role, but that this is an opportunity to increase training on developmental norms, SLCN and neurodiversity of vulnerable young people for those who work with children and young people in Children’s Hearing System. Targeted and specific training would help support those working directly with the children and young people in preparing for hearings and in identifying communication support strategies which are helpful for them (Clark and Fitzsimons 2018).

Therefore, increased resources will be needed for NHS Speech and Language Therapists to identify and support SLCN of the 16-17 year old in the CHS and provide SLCN training for health, social care including criminal justice social workers, and police colleagues. An alternative model is an Edge of Care multi-disciplinary team (REACH in Perth and Kinross) that provides intensive support, including Speech and Language Therapy, to families with multiple complex needs, where there is a significant likelihood of the young person (aged between 12 and 18 years i.e. 16-17 year olds) becoming accommodated away from home. This includes young people whose current offending behaviour puts them at risk of being placed in secure care or their relationship with their parents/carers breaking down (Garland et al 2019).

**4. What are your views on the potential implications, including resource, of increasing the age of referral to the Reporter for SCRA (the public body which operates the Reporter service)?**

The implications of implementing this change would likely amount to increased resourcing requirements for SCRA. Arguably, this would not amount to a greater issue than those outlined above.

**5. What are your views on the potential implications, including resource, of increasing the age of referral to the Reporter for Children's Hearings Scotland (the body which operates the national children's panel)?**

Implications here are similar to those listed in Question 3: Increased support and training for panel members who will be dealing with, potentially, more complex cases; and the opportunity to require health-led screening assessment to be presented to panel members, ensuring a holistic view of the individual need is ascertained. This will require increased involvement of NHS Speech and Language Therapists to undertake screening.

The United Nations Convention on the Rights of the Child (1989) Article 12 firmly attests that children and young people have the right to freedom of expression and that they have the right to express views on all matters which relate to them, with those opinions being given requisite weight in decision-making. Article 13 allows that such expression can be made “either orally, in writing or in print, in the form of art, or through any other media of the child’s choice”. If a young person does not have the opportunity to express their views because their needs are not being recognised and supported, then the system fundamentally is failing to meet their basic human right to freedom of expression. There should now be a drive to increase systemic awareness that potential legal challenges may ensue, should there be a failure to uphold these international rights (MacRae and Clark [in press]).

Increased supports should be made available to ensure children and families have optional access to targeted, developmentally appropriate legal advice and representation. Furthermore, increased formal support should be made available for children with SLCN to ensure fair and effective participation within the CHS. This will require increased involvement of NHS Speech and Language Therapists to undertake screening assessments and provide integrated SLCN support. This is fully in line with UNCRC Article 3, 12, 13 and 40.

**6. If the age of referral to the Reporter was increased, are amendments required to ensure sufficient access to information and support for victims harmed by children?**

**a) Yes**

b) No

Consideration should be given to provision of additional information being available to victims, this is especially important as where the victims are children themselves. RCSLT recommend such information is communication inclusive given the higher risk of harm experienced by people living with a communication disadvantage.

Support should be made available to victims with SLCN during restorative justice processes. Routine inclusion of SLT services is essential in supporting victims (and offenders) with SLCN to fully and fairly engage in the Restorative Justice process, in line with UNCRC Articles 12 and 13 as discussed above.

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