IASLT

IASLT response to:

Appraisal of evidence for the effectiveness of Talking Therapies: Position Paper on Collaborative Layered Care Delivery Model for Talking Therapies.

Operational Guidelines for Talking Therapies delivered by General Adult CMHTs.

IRISH ASSOCIATION OF SPEECH & LANGUAGE THERAPISTS
July 2020

The Irish Association of Speech and Language Therapists (IASLT) is the recognised professional body for Speech and Language Therapists in the Republic of Ireland. One of the key functions of the IASLT is to represent the views of its members to inform public policy in relation to the provision of speech and language therapy services in the best interest of service users.

Background and Introduction:

This document is written in response to the development of a model of care for the delivery of Talking Therapies in General Adult Community Mental Health services. It is written from the perspective of Speech and Language Therapy (SLT) in adult mental services in order to support access to Talking Therapies for people with additional support needs, in particular people who have speech, language and communication needs (SLCN) associated with or intrinsic to their mental health difficulties.

Key Recommendations:

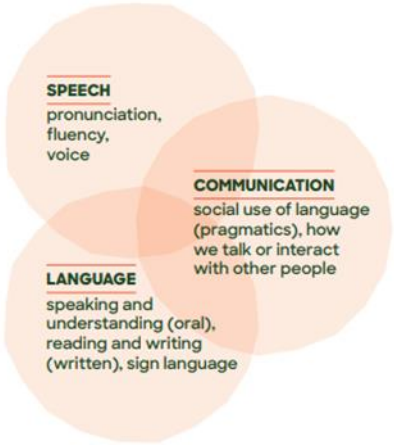
The information which follows aims to support the following key recommendations:

1. Consideration of the impact of, and barriers arising from speech, language and communication needs (SLCNs) for mental health service users in accessing Talking Therapies should be included in the Model of Care.
2. Speech and Language Therapists (SLTs) can input at all levels of the Collaborative/Stepped Care Model.
3. The Speech and Language Therapist should be included as a key member of the multidisciplinary team, who can work alongside practitioners at different stages of the service user journey (Consultation Document, 2019, p. 17 – 18) to enable people with communication support needs to access evidence based interventions.
4. SLT should be included in the staffing complement of the Talking Therapies 'Mini-Hubs'.

Recommendation One: Consideration of the impact of, and barriers arising from speech, language and communication needs (SLCNs) for mental health service users in accessing Talking Therapies, should be included in the Model of Care.

The terms 'speech', 'language' and 'communication' are often used interchangeably, but refer to different skills, all of which are required for a person to have successful interactions with other people in various aspects of everyday life. The following diagram defines what is meant by speech, language and communication, and represents the overlapping nature of these three domains.

Figure 1



Source taken from Speech Pathology Australia (2019) *Orygen: Clinical Practice in Youth Mental Health: Speech Language and Communication Needs in Youth Mental Health.*

Speech, Language and Communication Needs of Mental Health Service Users

The term "speech, language and communication needs" (SLCNs) describes difficulties across one or more of the aspects of communication outlined above.

There is a substantial body of evidence demonstrating the association between speech, language and communication needs and mental illness. Individuals with SLCNs are at a significantly greater risk of developing mental health problems than the general population (Beitchman et al, 2001; Botting et al, 2016; Clegg et al, 2005).

Furthermore, communication impairment is a core feature of some mental health difficulties, e.g. schizophrenia or psychosis (Colle et al, 2013 ; Boudewyn et al, 2017). In addition, SLCNs can arise due to the side effects of medication used to treat mental illness. (Gabbert, Scwhade, & Tobey, 2002).

There are also multiple factors that place someone at an increased risk of developing both communication difficulties and mental illness e.g. adverse childhood experiences, neurodevelopmental disability, intellectual disability. In some cases, there may be no known cause of the SLCN. However, social class, family history of language/literacy disorders, and environmental and biological/genetic factors all influence language and communication development (AlHammadi, 2017).

Prevalence of speech, language and communication needs in mental health services

In adults accessing mental health services, the prevalence of communication difficulties is over 60% (Emerson & Enderby, 1996; Walsh, Regan, Sowman, Parsons, & McKay, 2007). Despite this high prevalence, there is often under-recognition of the SLCNs experienced by individuals with mental illness.

Below are some of the main reasons why SLCNs may be overlooked:

- Undetected SLCNs often masquerade as poor motivation or attitude through behaviours, such as monosyllabic responses, poor eye contact and closed body language (Snow, 2011).
- People may have become expert at keeping their SLCNs hidden and superficially 'talking the talk'.
- High-risk behaviours, high levels of conflict or crises can distract the clinician.
- History of early SLCNs and/or relevant family history, may not be available.

The following table includes some guidance around the signs that can indicate a person has SLCNs.

Table 1: Signs a person maybe have SLCNs

Speech	• Unclear speech. • Difficulty pronouncing polysyllabic words. • Inappropriate volume, pitch, speech rate or unusual intonation. • Persistently nasal-sounding, husky or strained voice, or frequent loss of voice.
Language	• Poor ability to explain or relate a story, including: ▪ Insufficient background information ▪ Poor sequencing of thoughts ▪ Poor time references ▪ Poor logical thinking ▪ Excessive pauses and reformulations ▪ Word order mixed up • Few complex sentences (e.g. sentences containing "because", "if", "when", "so"). • Limited vocabulary (may use vague words, such as "stuff" or "thing", or overuse swear words) or have a narrow range of words to describe emotional states. • Difficulty understanding questions, instructions and conversations. • May take longer to process information than expected, or may not be able to remember information they've been told. • Difficulty understanding abstract language, metaphor, sarcasm and jokes, or may miss the point or take things literally. • Responses don't mesh with what was said or asked. • Reading or writing difficulties (this may be masked by avoidance of written activities).
Communication	• Difficulties initiating or ending conversations, turn-taking or staying on topic. • Socially awkward or inappropriate (overly direct or blunt; inappropriately forma or informal).

	• Scripted or stereotyped conversation patterns. • Difficulty understanding or using non-verbal communication (e.g. eye contact, gestures, facial expressions and body language). • Irrelevant or inappropriate detail. • Difficulty clarifying, asking questions or seeking help.
Behaviour	• Visible frustration when trying to communicate. • Only speaking in certain contexts or with specific people. • Difficulty concentrating for extended periods of time. • Superficially chatty but not much substance in what they say. • May seem overly complaint, or uncooperative. • May express emotions through behaviour rather than words, including difficulty resolving conflict verbally. • "Attitude" (masking behaviour), e.g. use poor eye contact, shrug their shoulders and respond in monosyllables (e.g. "yep", "nope"). • Acting out, acting the clown or withdrawing in social situations.

Source taken from Speech Pathology Australia (2019) *Orygen: Clinical Practice in Youth Mental Health: Speech Language and Communication Needs in Youth Mental Health.*

Timely consideration of SLCNs and provision of appropriate supports for those with SLCNs (including practical advice to other mental health practitioners on how interventions/interactions can best be modified or scaffolded to improve communication accessibilty) will reduce barriers to engagement and participation in Talking Therapies for those service users who have SLCNs. Consideration of, identification of and supports for SLCNs would best be provided through the unique skillset of a Speech and Language Therapist as an embedded member of the multidisciplinary mental health team.

Recommendation 2: SLTs can input at all levels of the Collaborative, Layered Care Model.

Given the high prevalence rates of SLCNs and the under-recognition of SLCNs within mental health service users, SLTs are key MDT members in supporting access to evidence based Talking Therapies for mental health service users who may require additional supports. This will add to the Model of Care proposed to ensure equity of access and opportunity for psychological support.

As described in the Consultation Document, a collaborative, layered care approach involves a multidisciplinary team which works together with the service user to jointly make decisions about the treatment of their disorder. Adopting a stepped care, collaborative model is expected to make the treatment more appropriate for patients with more complex or severe disorders.

This way of working is familiar to Speech and Language Therapists working in mental health services. SLTs also recognise the value of delivering care within a Layered Care Model (from community to highly specialist interventions) and offer individualised, tailored supports using this framework for example:

Table 2

Level of Supports	Focus	Example in practice
Person/Specific	Working directly with the service user and their immediate communication environmer to develop their speech, language and communication skills.	▪ Assessment and identification of speech, language and communication needs. ▪ 1:1 and group-based interventio ▪ Work with communication partners.

Environment/Targeted	Interventions to enable related services (e.g. nursing staff, training co-ordinators) to address the communication needs of people with MH difficulties	▪ Education about communication support needs. ▪ Creating supportive communication environments, e.g. in home, education, vocational contexts, or in HSE-supported residences.
Wider Community /Universal	Interventions aimed at a general population level, to increase communicative wellbeing and social inclusion of people with MH difficulties.	Developing advocacy, education and awareness of the communication suppo needs of people with mental health difficulties.

Table adapted from Irish Association of Speech & Language Therapists (2015). *Speech and Language Therapy in Mental Health Services: A Guidance Document*. Dublin: IASLT.

Table 3 Key Features of Collaborative Layered Care Model in relation to supporting service users with SLCNs

Accessible	• Mental Health Services should be aware of the often "hidden" nature of communication difficulties. A service user with SCLNs will require adjustments mad to increase their capacity to participate in talking therapies, which often rely on adequate verbal and cognitive skills. • A combination of speech, language and communication abilities are

	needed for a person to participate in structured, evidence-based psychotherapies, such as cognitive behavioural therapy (CBT) or interpersonal psychotherapy (IPT). Group interventions can place additional demands on communication abilities. The larger the group, the greater t language and cognitive load as the person manages multiple contributions, interjections and topic changes. Evidence-based psychotherapies require metacognitive skills and high level language abilities, e.g. thinking (and talking) about one's thinking so that unhelpful beliefs can be identified and modified through using language to reason and problem-solve, and using complex vocabulary to describe nuanced emotional states. Participation in these interventions depends on a combination of verbal, written and social communication skills. • The role of the mental health SLT involves supporting team members in ensuring that inputs offered are designed to reduce many of the barriers to involvement experienced by people with SLCNs, e.g. ensuring information is given in an accessible format, asking questions which are easily understood by the person, being flexible with timing and length of sessions/meetin **Suggestions which can facilitate access for people with SLCNs are outlined in Appendix 1 below**
Evidence Based	Access to evidence-based interventions may in some cases be limited to service users who have the verbal ability to engage. Indeed, most research is carried out on people who do not experience SLCNs. Also, service users with more complex, enduring mental health needs are often not prioritised for evidence-based psychological supports, given the degree of disability associated with cognitive communication difficulties. **There is a need to address this gap to ensure that all service users have an opportunity to avail of evidence-based treatment and care.**
Pathways to the right care	The Consultation Document (2019, p.10) states that "The choice of appropriate talking therapy should involve a thorough assessment of individual needs and appropriate matchin to a therapy or appropriate alternative supports. This

	should take into account a range of factors, including addiction and substance misuse." **It is recommended that Speech, Language and Communication Needs are also added to th range of factors to be considered.**
Recovery Oriented	As stated in the Consultation Document (2019, p.11), "Services should actively ensure the involvement and empowerment of service users, family members and carers in both accessing support and shaping the nature of service delivery." • There is strong agreement that it is difficult for people with SLCNs to become involved in their own care and in services in general (Beyond the Usual Suspects, 2013). • For people with both mental health difficulties and SLCNs, there may be extra challenges. These difficulties can be viewed from two perspectives: 1. Barriers due to SLCNs which are intrinsic to or related to the person and their mental health difficulty, e.g. cognitive difficulties, mental health symptoms, such as psychosis and anxiety, lack of social connection and support. 2. Barriers due to a mental health service which fails to take communication support needs into account, e.g. tokenism, culture of exclusion, unable to respond to peopl with SLCNs. These are not mutually exclusive, but merge and interplay with each other, thus increasing the cumulative effect. The values which underpin Recovery are also those which form the basis of the work of Speech and Language Therapy. SLTs are key players in the promotion of inclusio of people with mental health difficulties and can make a substantial contribution to this process in mental health services. **If the provision of talking therapies is part of an individualised recovery oriented care plan, which is developed in collaboration with the service user, then it is important to be aware of any barriers to this and seek advice and support from SLT, if required.**

	Co-production is emphasised at three levels within the Model of Care (p 10, Operational Guidelines). SLT supports co-production for people with SLCN by identifying communication support needs and any barriers to participation which may occur at the different levels.

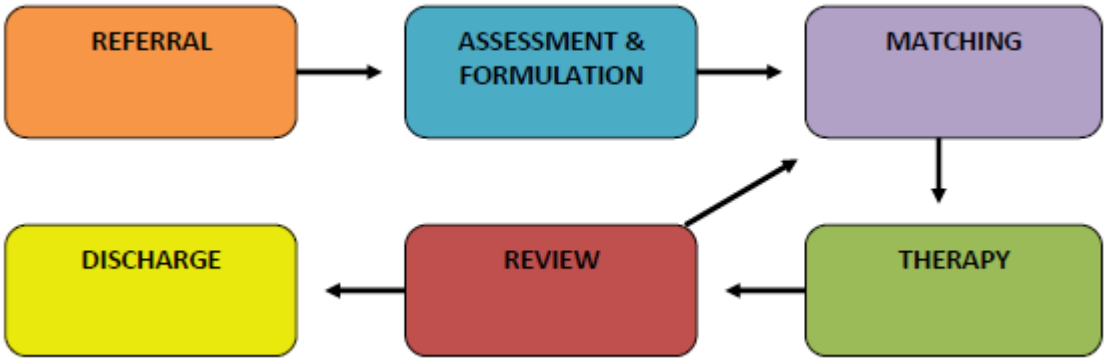
Recommendation 3: The Speech and Language Therapist is an essential member of the multidisciplinary team who can work alongside practitioners at different stages of the service user journey (Consultation Document, p17 – 18) to enable people with communication support needs to access evidence based interventions.

Service User Journey

Building on the key features for the proposed delivery model, level of interventions and tiers of service, and the recommended process for assessment, matching and reviewing interventions, the Sub-Group has outlined a possible service user journey in Figure 4 below. This figure seeks to illustrate the high-level stages in a service user journey when accessing talking therapies within the broader health system, i.e. across primary, secondary and tertiary mental health services, and via funded partner organisations.

Figure 1

Service user journey within collaborative layered care delivery model



Source taken from HSE Community Operations- Mental Health (2019) *Interim Report Consultation Document Position Paper: Collaborative Layered Care Delivery Model for Talking Therapies*.

1. Referral:

   SLT can support referrers to include those people with SLCNs when referring for Talking Therapies.

2. Assessment and Formulation:

   SLT can add to the "thorough assessment of individual needs…[to ensure that] the service user is matched to the right level and type of talking therapy" (Consultation Document, 2019, p. 3).

   Understanding the signs of SLCN can help you plan and adapt treatment, as well as indicate if a speech pathology referral is appropriate. A standard mental state examination (MSE)—i.e. assessment of appearance, behaviour, speech, mood, affect, thoughts, perception, cognition, insight and judgment—can be adapted to include a brief checklist focused on speech, language and communication skills. (Speech Pathology Australia, 2019)

   SLT can support the development of appropriate screening and assessment tools (Consultation Document, 2019, p. 14).

   Screening may include assessment of the following by an SLT:

   • Understanding spoken and written instructions and explanations.

   • Sharing information clearly and coherently.

   • Engaging in social interaction that is different from relating to peers, family and teachers.

   • Discussing, clarifying, disagreeing, compromising and negotiating.

   • Understanding and using non-verbal communication.

   • Participating collaboratively in verbally mediated interventions delivered one-to-one or in groups.

   • Participating in interventions or programs which may be provided in other settings.

(Speech Pathology Australia, 2019)

3. Matching

   SLT recommends consideration of referral to Creative Arts Therapies where Talking Therapies are not deemed to be appropriate due to the person's level of SLCNs.

4. Therapy

   SLT can offer a wide selection of recommendations and supports for involving people with SLCNs in Talking Therapies. Suggestions to facilitate access for people with SLCNs are outlined in Appendix 1below.

5. Review

   SLT can support the person with SLCNs to reflect back on their experience of therapy through specifically tailored visual and verbal prompts.

6. Discharge

   SLT can work with the team to identify further supports, commensurate with the person's identified level of SLCNs.

Recommendation 4: Mini-hubs/demonstration sites: It is recommended that SLT be included in the staffing complement of the Talking Therapies 'Mini-Hubs'.

For the reasons described above, it is recommended that SLT be included as a member of the team in delivering Talking Therapies throughout the demonstration phase. Given the underfunding of SLT posts within adult mental health services nationally, a demonstration site with an allocated SLT resource should be chosen initially. CHO 7 and CHO 9 currently have a dedicated SLT resource in adult mental health services. IASLT and the SLT MH Special Interest Group would be willing to work with the Talking Therapies Demonstration Site team to further develop this proposal.

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Appendix 1: Facilitating access to talking therapies for people with Speech, Language and Communication Needs.

- Consider writing a plain English (or 'Easy English') description of your service and its staff, including concepts such as consent and privacy, rights and responsibilities, and ideally including images to illustrate key messages and a simplified font, layout and design.
- Use visual aids (draw while you talk, diagrams, pictures, photos) to support your explanations. Number things to indicate order.
- Think about the task the person has to do. Does it require perspective taking, cause–effect thinking, understanding emotion words, thinking about past, present and future, generating solutions and predicting outcomes? Explore these with the person.
- Ask the person to repeat instructions or explain in their own words what they understand about a topic or what they understand they need to do next.
- Shift your expectations: expect to cover less content and take longer for the person to integrate it.
- Make sessions shorter.
- Learning is negatively impacted in the context of stress and emotional distress. Consider using neutral examples, fun and humour when introducing and practicing new concepts.
- Simplify language to aid comprehension.
- Consider whether a whiteboard or scrapbook for recording key information is helpful or distracting. Some people find it helpful to take a photo of a whiteboard summary and share this with their support network. Previous discussions can also be reviewed if photos are stored on a tablet.
- Remember that stress exacerbates speech, language and communication difficulties. Not understanding something can cause further stress and impact engagement in discussion and treatment.

- Consider pre-teaching concepts and vocabulary and priming the person in their individual sessions ahead of group sessions.
- Build groups based on common language and cognitive levels. Spend some time on group communication skills.
- Ensure exercises match communication competencies of group members so a person does not have their SLCN highlighted within a group.