Development of a

National Mental Health Workforce

Strategy and Plan

Mental
Health
Workforce
Advisory
Committee

Template for written submissions

Thank you for requesting the template to make a written submission. As the covering email suggests, please save this document on your system with a title that includes your own name. This document is set up as a Word document with boxes that will expand to fit your content. When you have completed your submission, please attach it to an email addressed to alexandra.lewis@sigginsmiller.com.au. Alternatively, you can print it and post it, attention Alexandra Lewis, PO Box 1143, Kenmore Queensland, 4069.

The due date for written submissions is18th December 2009

The objectives of the project:

- Review Australian and international literature on mental health workforce that identifies key strengths and challenges, and notes current workforce innovations and reforms.
- Scope possible changes in treatment and technology that could affect the capacity and capability of the workforce.
- Identify major workforce capacity building requirements to ensure a sustainable, high quality response to the treatment and prevention of mental illness.
- Develop a nationally agreed strategy and related set of priority actions for the short, medium and longer term.
- Support a cross-jurisdictional approach to workforce development for those providing health & community mental health services to people with a mental illness.

The scope of this project:

The focus is health and community mental health service professionals whose primary role involves treatment, care or support for people with a mental illness in a mental health service or other health service environment. The scope includes mental health nurses, general registered nurses, medical practitioners, occupational therapists, social workers, psychologists, mental health workers, Aboriginal mental health workers, Aboriginal health workers, consumer workers and carer workers working in hospitals, healthcare and community mental health agencies across metropolitan, regional and remote areas of Australia.

It includes health and community mental health service professionals working across the range of service types—for example, mental health services for adults, children and adolescents, and aged persons. It also includes staff working in non-government community mental health services; nurses working in the Mental Health Nurse Incentive Program, and psychologists, occupational therapists and social workers providing services under the MBS Better Access to Mental Health Care program. The forensic mental health workforce is within the scope of the project. People working in the housing and employment sectors are outside the scope of the project.

We need to ensure that in the development phase of the plan we work backwards from outcomes for consumers and carers and their needs to what sort of workforce can meet those needs. On this basis, we seek your views and advice on the following key issues that arise from an analysis of the workforce development literature and experience in Australia and other countries.

We also welcome your comments on any other issues and any other suggestions you wish to register.

Please note that we do not expect that everyone will want to make a comment on all aspects of workforce development; so please feel free to comment only on those issues that are of interest to you or for which you have particular observations or suggestions.

To help us understand the views expressed through this survey, we need to gather some basic information about you (or your organisation, if you are responding as a representative). This will allow summary information to be presented to the Project Steering Committee about who has responded to the survey.

If you are responding as an individual, none of the information requested will allow you to be identified. If you are responding on behalf of an organisation, we do invite you to provide us with details of your organisation so that summary information can be prepared on the range of stakeholder organizations involved in mental health that have responded to this survey. This is same process that will be followed in the face-to-face consultations for the development of the strategy.

On what basis are you responding to this survey? (please tick or cross)

As an individual	
On behalf of your organisation	✖
Other (please specify)	

Name of stakeholder / organisation making this submission:

Speech Pathology Australia

Contact person (name and title)

(telephone and email):

Marie Atherton, Senior Advisor Professional Issues

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My comments or interests particularly concern (please tick or cross those that apply):

Aboriginal health workers		**Nurses**	
Adult mental health services	✖	**Occupational therapists**	
Aged persons mental health services	✖	**Other medical practitioners**	
Carer advocates		**Primary care**	✖
Child and adolescent mental health services	✖	**Private mental health services**	
Consumer advocates		**Psychiatrists**	
Forensic mental health services	✖	**Psychologists**	
General Practitioners		**Public mental health services**	✖
Non government community mental health services		**Social Workers**	
Other (please specify) Speech Pathologists	✖		

Please insert your responses in the answer boxes. You can choose to answer some questions only.

1. Implementing the recovery model

The Fourth National Mental Health Plan (2009 to 2014) has a strong emphasis on the implementation of the recovery model in individual practice and in changing organisational cultures and the way service systems work. Recovery models are more than just a change in language or jargon. Mental Health Services will be required to incorporate recovery principles into every day practice. In your view, what are the major challenges facing us in the way we all think about and/or behave in relation to recovery from mental illness? What strategies do you suggest might help consumers and carers, individual practitioners, organisations and services to align better with the recovery model?

Comments and suggestions; examples of good practice; case studies where things have not worked and lessons learned

The successful, long term management of mental health issues requires a coordinated, streamlined and multidisciplinary approach to service delivery. An effective approach to management requires a collaborative team approach in which key professionals provide comprehensive, holistic assessment and treatment services that meet the specific needs of individuals and are available along a continuum of care from childhood to senescence.

It is imperative that speech pathologists be recognised as key members of the multidisciplinary mental health team. Speech pathologists are university trained health professionals who specialise in the assessment and management of communication and swallowing problems that present across the lifespan. Speech pathology assessment and intervention in mental health considers the psycho-social, behavioural, emotional, academic and vocational functioning of an individual and the impact of these upon an individual's communication and social interaction. Indeed, speech pathologists play a key role in mental health at each stage of the life cycle:

Infant mental health and early intervention:

The time of birth is now recognised as a significant period in which early intervention can positively impact developmental processes (Mustard & McCain, 1999). Infant mental health practice is concerned with the impact of the care-giver relationship on the development of the infant and in providing interventions that mitigate any physical, emotional, and social risks experienced by infants and their families. Speech pathologists using an Infant Mental Health framework of practice understand the symbiotic relationship that exists between attachment and communication development and understand the importance of the role of language in facilitating a positive integrated sense of self. Speech pathologists understand the crucial importance of communication strategies within infant mental health interventions and thus are able to meaningfully contribute to caregiver-infant interaction, early detection, and assessment, management, communication and interpersonal skill development and parental support.

With regard to specific roles for the speech pathologist in infant health and early intervention, these include:

- early screening and detection of infants 'at risk' of developmental delay and mental health problems due to suboptimal infant-child interactions;

- provision of therapeutic support for mothers and families with regard to communication and facilitation of language development in their children;

- early identification of and intervention for children at risk of communication impairment where a parent suffers a mental illness, or where a child has suffered trauma, abuse or neglect;

-provision of information and education to health professionals working with infants and their families, including community health nurses and GPs.

Please insert your responses in the answer boxes. You can choose to answer some questions only.

Young children and adolescents:

Young mental health issues place a huge economic burden on the Australian community, with 7% of people aged 0-17 years reporting some form of mental health issue or behavioural problem (AIHW, 2006). Speech pathologists have an important role to play with young adults through knowledge of the impact of developmental communication disorders upon the transition to adulthood. Further, speech pathologists possess an intricate understanding of the relationship between pragmatic and social disorders and depression, interpersonal relationships and juvenile crime. Speech pathologists contribute important knowledge about the role of communication in the mental health well-being of young people and about a young person's participation in mental health programs. They have an understanding of adolescent norms and take a holistic view of adolescence, working within mental health teams that focus upon the medical, psycho-social, occupational and educational demands of adolescence.

With regard to specific roles for the speech pathologist in relation to adolescent mental health, these may include:

- assessment and identification of communication impairment and learning disabilities;

- specialist assessment of communication skills as part of differential diagnosis, i.e. assessment/review of pragmatic/social and high-order language areas in a client with suspected Asperger's Syndrome; assessment review of narrative/connected speech sample of a client with suspected schizophrenia due to the overlap of severe language disorder and thought disorder; assessment of the language profile of clients with eating disorders, a group which often has un-identified receptive language impairment, due to long-term mal-nourishment leading to cognitive impairments;

- provision of advice and consultation to mental health teams regarding the interplay between communication disorder, reduced employment options, social, emotional and behavioural problems across the life span, mental health problems, and criminal behaviour leading to juvenile offending and imprisonment;

- Provision of advice and consultation to multi-disciplinary team members on the modification of treatment programs and protocols to minimise barriers to participation caused by language and learning impairments;

- Treatment and rehabilitation of communication deficits in the areas of spoken language skills, auditory memory, semantics, sentence construction, narrative discourse;

- Treatment and rehabilitation with the domain of social problem-solving and higher order language-based skills, such as social information-processing and assertiveness training;

- Provision of group therapy targeting, for example, social skills and life skills training and psycho-education;

- Support for the young person, family and school staff during school re-integration and/or entry in pre-vocational and tertiary programs (TAFE, University), particularly for adolescents with long-term mental health issues.

Adults:

Research demonstrates a high prevalence of speech, language and swallowing disorders in adults with mental illness as a consequence of the nature of the illness and its treatment. Further, language and communication problems appear to be directly implicated with the onset of mental illness in adults. Swallowing difficulties (also known as dysphagia) are reported to be present in 35% of adults in mental health inpatient facilities, and in 27% of those attending day hospital services (Regan et al, 2006). Possible causes of dysphagia include neuroleptic exposure, institutional conditions, concurrent neurological disorders and manifestations of the illness itself. Complications of dysphagia include malnutrition, chest infection, choking and death.

With regard to specific roles for the speech pathologist in relation to adult mental health, these may include:

- Provision of assessment and diagnosis of specific communication disorders that affect verbal and non verbal communication skills;

- Provision of assessment and diagnosis of specific swallowing impairments and their impact;

- Provision of intervention to maximise the communication potential within an individual's and his/her environment, including facilitation of carers to communicate more effectively and easily with a person with mental health issues;

- Provision of intervention to maximise the safety of swallowing and maintain optimal nutritional status;

- Education of clients and health professionals regarding the impact mental illness may have on swallowing and communication;

- Conduct of individual and group programs targeting communication and social interaction.

For a detailed review of the literature regarding the inter-relation between mental health issues and compromised communication and swallowing, and the role of the speech pathologist, the reader is referred to Appendix 1.

Speech pathologists have an important role to play in facilitating and maximising outcome for individuals undertaking treatment for mental health issues. Verbally based assessments and psychological interventions (e.g. psychotherapy and Cognitive Behavioural Therapy - CBT) that are used in the treatment of mental illness assume a client's functional understanding and competent use of speech, language and pragmatic skills. Whilst Speech Pathology Australia supports the underlying approach within the Recovery Model to the management of individuals with mental health issues, there are a number of key points that must be made in this regard. Firstly, given the high incidence of language and communication disorders in this population, models that use a language/cognitive based approach to intervention may not always be the most appropriate model of service delivery. For example, emphasis upon language and cognitive reasoning will not meet the specific needs of children who are still developing skills in these areas. Further, such an approach may not be appropriate for adult clients with restricted communication and cognitive skills - it has been documented that individuals with diagnoses of anxiety, depression, eating disorders, psychosis and pervasive developmental disorders have limited social skills and a variety of communication problems such as poor listening skills, impaired reading and problem solving abilities (Clarke, 2006) that may prevent them from participating fully in language-based cognitive therapy programmes.

Secondly, in the extended care setting, as well as in the community, many adults suffer from *chronic* mental illness. Many have attempted unsuccessfully to live in the community, and despite a range of supports and services remain unable to; this is seen by many as 'non-recovery'. As such, adults with chronic mental illness and their families/carers may struggle with the concept of *recovery,* despite education to the contrary. They are also impacted long term by the stigma that surrounds mental illness. As such, an emphasis on *principles* of intervention rather than focus upon a label such as 'recovery' may assist not only with a reduced sense of failure to meet a state of 'recovery' but may also reduce the stigma associated with living with a chronic mental illness.

Speech Pathology Australia contends that recognition must be afforded to the communication and other key needs of children and adults with mental health issues, and appropriate strategies must be put in place so that individuals and carers are able to participate fully in intervention programs. To this end, speech pathologists are ideally placed to provide education and guidance to the mental health team regarding appropriate and relevant strategies to facilitate the meaningful participation of individuals in treatment. It is imperative that principles and models underpinning intervention in mental health address all areas of functioning (psychosocial, behavioural, emotional, academic and vocational) through a well developed understanding of individual strengths and limitations, thereby creating an environment that can optimise outcomes and reduce the potential for re-referral to acute-based mental health services.

Secondary prevention must be incorporated into any model of recovery from mental illness. Currently, acute symptom relief is the priority of models used in mental health service provision, with limited attention paid to the importance of programmes and services that promote early identification and prevention of mental illness. Early intervention and identification are clearly a role for the speech

pathologist and mental health clinicians, and individuals with communication/learning disorders and co-existing problems will have particular therapeutic needs. As communication and mental health disorders have long-term economic, social and emotional consequences across the life span, it is imperative that models of recovery incorporate early identification measures and interventions that give due recognition to these important issues.

2. Securing and developing the current workforce

The current workforce in mental health services provides the foundation on which new models of care and improved service systems rest. We are interested in your views about the key issues facing the current workforce and its managers in securing and developing the current workforce. *You may wish to comment on the organisational, system and individual factors that promote recruitment, retention and development of the current mental health workforce in your setting and make suggestions for improvements.*

Perceptions of and persisting stigma associated with mental illness and under-recognition of the role of speech pathologists in mental illness continue to see speech pathologists significantly under utilised with regard to their skill base and expertise. Speech pathologists have a specialist role in working with infants, children, adolescents, adults and families with mental health issues, and may be based in community health settings, hospital inpatient and outpatient settings, aged care, early intervention and educational settings, private practice or attached to an agency providing consultation in trauma programs, refugee agencies, and secure facilities for young offenders. Given the high co-occurrence of communication, social, academic and emotional/behavioural problems associated with mental health issues, speech pathologists are undoubtedly a “core disciple” within mental health. As noted previously, speech pathology assessment and intervention in mental health considers the psycho-social functioning of the individual and its impact on communication and socialisation.

It is the position of Speech Pathology Australia that:

Speech pathologists should be listed as eligible services providers under the ‘Better Access to Mental Health Care’ initiative to provide access to rebates for relevant clients.

As a means to developing the current speech pathology workforce, Speech Pathology Australia recommends the following:

1. The profile of speech pathologists within mental health services must be raised. Particularly within the community health setting, this could be addressed by:

- Speech pathologists being represented in all community mental health settings in Australia, i.e. metropolitan, regional, rural and remote (currently speech pathologists are represented some of these settings in NSW, QLD, SA, VIC & WA);

- Speech pathologists being represented in infant mental health, preschool and primary school ages, school age, adolescence, adult, forensic units and at the policy making level;

- Provision of rebates for speech pathology services be made, as outlined above through Medicare;

- Provision of access to mentoring, supervision and professional development – this is particularly relevant given most speech pathology positions within mental health are solo positions.

2. Speech pathologists already play a key role in infant mental heath. This role could be further developed by:

- Introducing speech pathologists into mother-child units where diagnosed parent/child issues such as poor attachment, difficulties feeding and/or poor interactional skills have been identified by hospital staff;

- Providing speech pathology assessment and follow-up to mothers with post-natal depression and premature infants;

- Ensuring identified "at risk' mothers/families receive screening assessments by speech pathologists and follow-up post-birth;

- Providing speech pathology screening assessments at child and maternal health centres with provision of information/education/inservices that provide "at risk" families with access to language, feeding, attachment information;

- Facilitating collaborative relationships with generic and specialist early childhood services to enable speech pathologists to play an integral role in developing understanding within the mental health team of the interplay between social, emotional and behavioural problems and communication issues;

- Supporting speech pathologists in research roles to improve the research base of speech pathology in this area – this applies to all life stages;

- Providing speech pathologists with education opportunities to develop knowledge in mental health principles that underpin current approaches to the assessment and management of mental health issues;

- Providing education regarding the role of speech pathologists in mental health to key undergraduate and post graduate professions, e.g.; maternity health nurses, etc.

3. Speech pathologists already play a key role with pre-school and primary aged children with mental health issues. This role could be further developed by:

- Provision of speech pathology assessment and screening of communication development and skills with "at risk" children/families screening, assessment, intervention and education to parent(s)/carer(s);

- Speech pathologists contributing to 'transition to school programs' for children with identified mental health/communication problems; speech pathologists working alongside parents, teachers and other childhood personnel;

- Education to staff within various childcare, pre-school and early primary education systems;

- Working alongside education-based speech pathologists for identification of "at risk" children – for example, developing networks such as exist in QLD with the 'Communication and Behaviour Action Group' (CABAG) – this group meets quarterly to discuss/network/develop/lobby around issues common to speech pathologists working with young people with communication and behavioral issues in health, education and disability services.

- Inservicing of parents regarding parenting skills, communication workshops, preventative based programs.

4. Speech pathologists already play a key role in young people with mental health issues. This role could be further developed by:

- Inclusion of speech pathologists in 'transition to high school' programs;

- Provision of consultancy services at the tertiary level to students on campus;

- Assessment and treatment of young people in juvenile detention centres, under judicial orders based in the community and forensic units, secure welfare, drug and alcohol services and trauma related youth programs. Such assessments reduce further costs placed on society that may occur in the future for the young person or over their lifespan. For example, future unemployment can be addressed by communication intervention such as developing literacy/written skills, social skills, interpersonal relationships.

5. Speech pathologists already play a key role in the assessment and management of adults with mental health issues:

For example, Queensland and South Australia currently have established stand-alone speech pathology positions which provide speech pathology services to adults with mental illness, both in extended care, and to a lesser degree in acute mental health services and the community. This is increasingly becoming the case also in NSW and Victoria, although in many mental health facilities, there still remain no

established positions and clinicians are often “borrowed” from mainstream health services. Further to this, whilst community care units (CCU) are increasingly being promoted as an important part of the future of community mental health services, there are still no speech pathology positions in CCU staffing profiles.

The role of speech pathologists within adult mental health services could be further developed by:

- Inclusion of speech pathologists in adult-related programs such as employment programs, alcohol and drug dependency services and support groups;

- Provision of consultancy services to both inpatient and day care facilities;

- Funded speech pathology positions within community care units;

- Provision of speech pathology assessment and treatment to adults in inpatient units, detention centres, under judicial orders based in the community and forensic units, secure welfare and trauma-related programs;

- Provision of speech pathology support to parents with mental illness in the context of fostering positive communication skills and interactional patterns within the parent/child relationship;

- Development of organisational policies that support speech pathologists in mental health and promote education and professional development.

6. At the policy making level in welfare, education and health speech pathologists have a wealth of knowledge and expertise with respect to communication and mental health disorders. To have the input of speech pathologists with respect to infant, child, young people, young adults and adults would provide a greater pool of expertise to contribute to issues such as:

- The development of policies and protocols aimed at networking and establishing links at government and service provision levels;

- Prevention of mental illness; health promotion activities supporting resilience, cognitive flexibility and developing coping/help-seeking behaviours amongst young people;

- Effecting what is included in training programs at educational, community and national levels;

- Early identification and screening of “at risk” children;

- Reducing mental health costs and costs associated with unemployment, crime, homelessness, self-harm/suicide, and relationship/family breakdowns.

7. The education and training of undergraduate and postgraduate speech pathologist students in all areas of mental health is already being targeted by speech pathologists working in the area. Examples exist of programs running with the aim of providing undergraduate and postgraduate training to target education in the area of communication and mental health problems. However, further development could be undertaken to specifically target the area of communication, swallowing and mental health problems. The following are suggested:

- Undergraduate and post graduate speech pathology training programs with specific courses on mental health disorders and speech pathology interventions, with lectures developed and delivered by a mix of university staff and invited, specialist clinicians working within the mental health sector;

- Undergraduate and post graduate tertiary courses where the interdependence of communication, educational engagement, criminal justice, psychology, youth counseling and social work/policy areas are presented;

- The development of dual positions between university speech pathology departments and health departments;

- Specialist placements for speech pathology students in the mental health sector;

- Formal professional supervision/mentoring for all new graduate speech pathologists in mental health;

Please insert your responses in the answer boxes. You can choose to answer some questions only.

- Provision education as teacher training programs regarding the role of speech pathologists in mental health at early childhood, primary and tertiary training levels, and to maternal and child health nurses;

- Provision of education regarding the role of speech pathologists in mental health to child and adolescent psychiatry training programs, and to general practice training programs.

3. Workforce development – mental health specialists and non-specialists

The consumers of mental health services and their carers come into contact with both specialist mental health services, such as acute inpatient units and those in the broader health system, such as GPs. Building capacity for the delivery of services to people with mental illness and their carers requires that we pay attention to workforce development in both the specialist and mainstream parts of the health system.

3a. Your suggestions about the best way to develop capacity in the **broader health workforce** to support consumers and carers would be appreciated.

Comments and suggestions, examples of good practice, case studies where things have not worked and lessons learned

A number of key programmes currently exist within Queensland that aim to grow the speech pathology workforce in mental health:

The Queensland government, the University of Queensland and the James Cook University have worked collaboratively to establish a number of university-based clinics that provide opportunities for speech pathology students to gain experience working with individuals who have mental health issues. Funding for clinical educators within these clinics is provided by the Queensland government through the Child and Adolescent Mental Health Service (CAMHS), thus enabling student speech pathologists to be exposed to and obtain training in mental health at an early stage in their careers. These clinical placements are highly sought after and feedback from students indicates a reduced level of fear associated with working with clients with mental health problems, as well as increased knowledge of mental health issues in general. More specifically, students report an increased interest in working within the mental health field; anecdotal accounts suggest this increased interest is being reflected in the increased number of applications received for vacancies in speech pathology positions within mental health in Queensland. Enablers and barriers to the implementation of these and other models of education and training require consideration so that they may be expanded to other states and territories.

Within some states of Australia (e.g.; Victoria and Queensland) speech pathologists and those with backgrounds in speech pathology e.g.; lecturers, psychologists previously trained in speech pathology, provide regular training to medical students, psychiatry registrars and students, and psychologists regarding the relationship between communication disorders and mental health issues, the impact of communication impairment on the development of mental health issues and their effective management, and the role of the speech pathologist in mental health. Feedback has indicated that students, registrars, trainees and lecturers alike view this as an extremely valuable means of informing the management of mental health issues.

As an outcome of the Western Australia State Government's 2004 enquiry into Attention Deficit Hyperactivity Disorder (ADHD), two multidisciplinary teams have recently been established as part of the WA '**Complex Attention and Hyperactivity Disorders Service (CAHDS)**'. These teams, which include speech pathologists as key members, provide multidisciplinary diagnostic and assessment services in the public service to children presenting with symptoms of ADHD and other related disorders, as well as promote the safe use of medication to manage ADHD. The CAHDS is a unique service in that it provides a multidisciplinary approach to the management of children with ADHD. It promotes a shared care model of service provision with referring agencies which is consultative and collaborative, and actively encourages professional collaboration of team members through the provision of and access to services

such as videoconferencing, professional development opportunities and other forums for team building and education.

http://www.nmahsmh.health.wa.gov.au/services/icaymhs_ext_cahds_his.cfm

As a means to further developing the capacity of the speech pathology workforce in mental health, it is recommended that government funded programs be developed that would enable less-experienced clinicians to access support from more experienced clinicians such as those working in CAMHS units or other areas of the mental health service, so that succession planning may be facilitated. Further to this, funding should be made available that supports the growing body of evidence of the role of speech pathologists in mental health, particularly in relation to research support, support for novel practice and innovation. An example of this already exists in south east QLD through the 'Allied Health Professional Enhancement Program' where funding is made available for health professionals to visit other organisations, undertake professional development and attend other leaning opportunities.

3b. Your suggestions about the best way to develop capacity in the **specialist workforce** to support consumers and carers would be appreciated.

The provision of education and training at undergraduate and postgraduate levels in speech pathology is essential to the understanding of how mental health plays a critical role in relation to the development of communication and swallowing disorders. An action plan could be developed identifying appropriate undergraduate and postgraduate training programs to target for education in the area of communication, swallowing and mental health problems. The following are suggested:

- Increased number of undergraduate and post graduate speech pathology training programs;

- Undergraduate and post graduate tertiary courses in communication, swallowing, linguistics, criminal justice, psychology, youth counseling, social work, chronic disease;

- Support for clinical placements in mental health, e.g.; extended care, dementia units, early intervention, etc.

- Provision of speech pathology education at teacher training programs at early childhood, primary and tertiary training levels;

- Provision of speech pathology education as part of child and adolescent psychiatry training programs and general practice training programs.

3c. Your suggestions about the best way to develop capacity in **the non-government community mental health workforce** to support consumers and carers would be appreciated

Speech pathologists currently work within non government agencies that provide services for adults and children with mental health issues (e.g. Autism Victoria and Autism QLD).

The capacity of speech pathologists within the non-government community mental health workforce could be developed through the implementation of a shared care model of service delivery that promoted collaborative working relationships between different health professionals across different sectors of the health service, including the non-government community. This would not only facilitate the opportunity for inter-professional education and training, but would also increase the capacity of the different sectors of the workforce to meet individual and specific needs of clients as they arise, as part of a holistic approach to the management of mental health issues in the community.

Please insert your responses in the answer boxes. You can choose to answer some questions only.

4. Education and Training; CPD; Supervision ; Mentoring and Coaching

The education and training and continuing professional development of the current and potential future workforce is a key component of all workforce development strategies. In recent times there has been considerable debate about the need for inter-disciplinary training, and for developing articulated programs and courses from the VET sector to the tertiary sector. Your comments and suggestions about the education, training, CPD and supervision, mentoring and coaching of the workforce are invited:

Speech pathologists working in mental health must be provided with opportunities for ongoing specialist training within the workplace. Speech pathologists require opportunities to develop a working knowledge of the range of disorders prevalent in child, adolescent and adult psychiatry. This would allow the integration of different fields of expertise, which is essential for differential diagnosis and a clinician's ability to participate in and contribute to appropriate service delivery models.

In addition to undergraduate competencies, speech pathologists working in the area of mental health are strongly encouraged to further their skills in this specialist area through continuing professional development and post graduate training as required.

Training and post graduate education options will vary between states and territories but may include:

- counselling skills;
- psychotherapy;
- family therapy;
- developmental psychiatry;
- infant mental health;
- adolescent/young people focused skills, e.g.; substance abuse; youth work related areas;
- adult mental health and chronic illness;
- trauma counselling;
- cultural/ethnic education.

Speech Pathology Australia, recommends minimum standards of professional supervision and ongoing mentoring by suitably qualified and experienced speech pathologists and other relevant practitioners.

5. Scope of practice

Broadening the scope of practice of some health professionals is being considered in the health workforce overall and in mental health. For example, allowing people other than medical practitioners prescribing rights once properly trained.

Comments and suggestions, examples of good practice, case studies where things have not worked and lessons learned

As identified above, there are numerous roles for speech pathologists in mental health, many of which are under-utilised due to staffing and resourcing issues.

The profession of speech pathology has actively promoted its role within mental health as a means to not only educate regarding the expertise that can be afforded by speech pathologists in mental health teams but also as a means to broadening the scope of practice of speech pathologists within this field. Examples of areas where a broadening of the scope of practice of speech pathology could be undertaken include:

- Facilitation of functional skills, e.g. vocational, life skills-based interventions such as accessing public transport, social problem solving skills;

- Supportive therapy and psycho-education, in particular the development of therapeutic stories;

- Consultation/support and mentoring in early intervention and parent management groups such as '**Hanen' and 'Take Two'** – it would be possible with appropriate funding for speech pathologists working in mental health to provide support to community-based speech pathologists who currently run 'Hanen' and 'Take Two' programs to facilitate the incorporation of mental health principles into these programmes. The Hanen Program works at the level of observable behaviours, and requires an understanding of mental health issues and principles to facilitate work with parents and children in relation to their interaction;

- Provision of specialist advice and training to mental health colleagues, including the provision of support to case managers and workers so as to enable information to be presented in such a manner that meets the knowledge and communication needs of an individual with mental health issues;

- Research;

- Consultancy and advocacy;

- The "spread" of mental health goals into mainstream areas such as education/schools;

- Psychologists who have previously trained as speech pathologists provide supervision and education to psychology students regarding the role of the speech pathologist in mental health, including the speech pathologist's role in assessment, intervention and social skills training.

6. Composition of mental health teams

Broadening the composition of mental health teams, including involvement of consumers and carers through the recovery model of service delivery has been broadly canvassed in Australia and internationally. This implies the need to develop or expand new roles, e.g. peer support workers, consumer advocates, consumer representatives, consumer mentors, carer advocates, carer representatives, carer support workers.

Comments and suggestions, examples of good practice, case studies where things have not worked and lessons learned

Speech pathologists must be included in all mental health teams at all levels/ areas. Speech pathologists are able to provide support to other health workers regarding the types of communication, swallowing and social skills disorders that may present in individuals with mental health issues, as well as contribute to the assessment of communication, swallowing and social competency in a holistic manner.

Advocacy for children at transitionary stages, such as from primary to middle school who present with learning difficulties and/or who require a team based approach in relation to management of their social skills can be undertaken by speech pathologists, in association with carers and relevant others.

Speech pathologists also have a key role in advocating for appropriate services for adults with mental illness, in the community, extended care and secure lodgings.

7. Future developments

It is possible that changes to models of care, changes in treatment methods, drug therapies and treatment philosophies and policies could impact on the capacity and capability of the workforce. What are some likely ways things might change and what would be the impact on the way services are delivered and configured?

Please insert your responses in the answer boxes. You can choose to answer some questions only.

A move away from the treatment of individuals as inpatients to management as day patients, and the move to deinstitutionalise adult mental health patients to community settings, will require the support from speech pathologists. For example, the move to treat individuals with anorexia nervosa in specialised units requires consideration of the special needs of this group of individuals. Specifically, it will be important to ensure that treatment acknowledges the documented difficulties this and other specific groups have with communication (i.e. receptive skills and social/emotional language), and ensure that speech pathologists are involved;

Young people and adults with depressive disorders and/or anxiety disorders require psycho-education social skills training and support for entry into education and workplace settings – speech pathologists with skills in mental health are suitably qualified to provide this training;

Speech pathologists are able to provide Juvenile offenders who require intervention for communication impairments, limited social skills and learning difficulties, with interventions that may include anger management, social problem skills and assertiveness training.

Involvement of speech pathologists in early parenting programs and development of information within the community and specialist agencies will address mental health issues at the earliest stage, with the potential to reduce mental health issues across the lifespan.

Given the greater focus on community-based services in models of care, support must be made available for the inclusion of speech pathologists within community care units.

What would be the flow on effects of the changes above for workforce development?

Inclusion of speech pathologists within the mental health team would see speech pathology services made available with increased areas of mental health and provide a holistic approach to the management of mental health issues in the community.

How might the skill mix or professional mix of teams change in the future, and still work to provide safe and quality care?

The trend towards community services being staffed by both professional and non-professionals, including volunteers, raises a number of important issues with regard to role descriptions, competency training and supervision. To ensure safety and quality of care, clear governance frameworks and structures would need to be developed, and accountability processes introduced that underpinned work practices.

With increasing inclusion of speech pathologists in the mental health workforce, all aspects of communication and swallowing would be considered and managed in clients with mental health issues, thereby not only facilitating effective, holistic management of mental illness but also potentially contributing to a reduced incidence of long term mental health issues within the community.

8. Access to services

The accessibility and appropriateness of services is an issue for all consumers of mental health services and their carers. There are however, particular groups for whom access is particularly difficult eg Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds and people in rural and remote and other underserved settings. What workforce developments could improve access for such groups?

Comments and suggestions, examples of good practice, case studies where things have not worked and lessons learned

There is difficulty with young children **accessing early intervention mental health services**. As it currently stands, many "at risk" children are not being identified, and when they are, they are seen for

treatment of their mental health issues but do not see a speech pathologist for issues that may relate to their communication and socialisation.

As is the case for with many services within **rural and remote** areas, access to mental health services is at best limited, with individuals often having to travel long distances to access appropriate services in regional towns and cities. Speech pathologists are well placed to be part of mobile teams providing mental health services to more isolated communities and regions.

Access to mental health services for **individuals with hearing impairment** is also limited; there is a high level of mental health issues in this population. Research at Monash Medical Centre, Victoria is currently being conducted in this area and it is anticipated that outcomes from this research will inform future needs for services that target the specific needs of this population.

Trauma in **refugee** immigrants seeking mental health services is a new population being managed by speech pathologists. Deeply complex communication and psychological issues may be present. For example, trauma associated with horrific experiences in an individual's country of origin, detention, the immigration process, assimilation and adaption to the new country are all compounded by English as a second language and the question of developmental communication and social issues. Assessment is complex and multilayered. The risk and protective factors for mental health in refugee children suggests that child and adolescent refugees have a high incidence of depression, anxiety and post traumatic stress disorder (Crowley, 2009). Further research into communication in this population is a matter of urgency.

Individuals from culturally and linguistically diverse backgrounds (CALD) experience specific barriers when accessing mental health services. Culturally safe educational training, service delivery models and literature is required to meets the needs of individuals from CALD backgrounds. There is also an urgent need for training to be made available for mental health workers from indigenous communities and for people who are respected as part of different cultures.

A good example of a program that aims to address the gaps in mental health services for people from CALD backgrounds exists in the New Zealand Ministry of Education, the governing body of all Education services within the New Zealand public sector. As a means to addressing the mental health needs of the Maori people, all mental health workers, including speech pathologists, are trained in very year level of undergraduate training (i.e. Years 1, 2, 3 & 4) & in post graduate studies in Maori culture and language. The New Zealand Ministry of Education has paid specific attention to the provision of education material in the Maori language, and the establishment of services that are provided in a culturally appropriate manner.

http://www.minedu.govt.nz/NZEducation/EducationPolicies/MaoriEducation.aspx

Further, all speech pathologists in New Zealand are trained at an undergraduate level to enter Te-Reo Kohangas (Maori early language learning centres) to screen children for early communication, hearing and other problems, thereby to reduce the likelihood of the development of mental health presentations in these children further down the track. http://www.kohanga.ac.nz/kohanga.html

Such a model is applicable to all CALD communities within Australia, but has particular relevance to the aboriginal community which remains profoundly disadvantaged in all areas of health, education and society in Australia.

9. Perceptions and status of work

How the community views mental health and those that work in the sector has been identified as a barrier to the recruitment and retention of workforce. Your reflections on the extent and nature of this in Australia and your suggestions for strategies to improve the status and standing of work in the mental health sector would be appreciated.

Please insert your responses in the answer boxes. You can choose to answer some questions only.

Comments and suggestions, examples of good practice, case studies where things have not worked and lessons learned

Perceptions of mental illness, persisting stigma associated with working in mental health and a fear of working in the field all contribute to difficulties attracting and retaining a workforce. States such as QLD, Victoria and South Australia have established positions in early intervention, youth and adolescent work, adult, extended care and some acute mental health services that have the potential to raise the profile of speech pathology in mental health and alleviate some of the misconceptions amongst speech pathology students and practitioners. Universities need to provide education and training specifically in the role of health practitioners in mental health - as noted in 3.1, undergraduate training opportunities have performed an educative role with regard to working in mental health, and have increased the interest of speech pathologists to enter the mental health field.

Ongoing issues that affect recruitment and retention of speech pathologists in the workforce in general impact retention of speech pathologists in mental health – these include a high percentage of sole and/or part time positions, a predominantly female profession (and family demands); lack of adequate supervision and professional support/supervision; increasing workloads. These issues are relevant not only in relation to recruitment and retention within the mental health area but in relation to the health workforce overall.

10. Managing the places where consumers and carers fall through the gaps between providers

In many parts of the health system, capacity is being built and access and quality improved by efforts to build networks between the government and non government sector, between primary care and hospital based services, between GPs and specialist mental health workers, between community and home based providers of nursing and personal support services and others. Your comments and suggestions for how we could enhance access by better knitting existing resources together would be useful

Comments and suggestions; examples of good practice; case studies where things have not worked and lessons learned:

Access to Medicare services provided by speech pathologists working in private practice (under the Federal Government's 'Better Access to Mental Health' initiative) would improve inter-referrals across professions. Examples include referrals from GPs to speech pathologists for mental health clients who require social skills work, or referral of hospital outpatients, particularly young people and adults with mental health issues to speech pathologists.

Some of the challenges to building speech pathology cross-sectoral partnerships is related to limited or lack of strategic direction within organisations with regard to this, limited time and resources to attend to this, reduced awareness and understanding of professional language, expertise and contribution to mental health, and lack of resources on the ground to develop new initiatives.

A 'shadowing model' has been used in Victoria to develop understandings between the Mental Health Sector and Drug and Alcohol Sector, with workers spending up to 3 months in each other's work settings. Pilots of this model could be undertaken in relation to speech pathologists working in CAMHS and community health and education therapists who work in settings such as 'Take Two', 'Centre for Sexual Assault', etc. Specific orientation programs would need to be developed to ensure key outcomes were agreed to, identified and evaluated.

A number of CAMHS and Schools Early Action Projects – (CASEAs) have been established in Victoria to provide a targeted early intervention response to families, teachers and children where a child presents with oppositional deviant behaviors. Not all teams have speech pathologists on staff due to difficulties in recruitment, the limited value placed on speech pathology input into mental health teams, or a lack of understanding of speech pathology services. To this end, consideration needs to be given to the

development of senior speech pathology positions so that the role and value of speech pathology input can be promoted.

11. Culture and management and leadership of services and the service system

Many researchers, commentators and advocates in the sector note that efforts to attract more people into the mental health workforce and retain them can be hampered by traditional professional cultures, rivalries and boundaries. Do the culture of the professions and services need to change, and how could positive change be supported?

Comments and suggestions; examples of good practice; case studies where things have not worked and lessons learned:

A number of key initiatives would assist to attract and retain speech pathologists in the mental health workforce. These include:

- Funding for an increased number of speech pathology positions in mental health, so that what speech pathology positions there currently are, are not sole positions;

- An increased number of undergraduate speech pathologists trained in mental health – so that when positions in mental health became available, there are sufficient numbers of suitable applicants;

- Access to regular, high quality profession-specific supervision in all areas of mental health;

- Access to mentoring that provides guidance and support to speech pathologists within mental health teams;

- Development of senior state-based senior speech pathology positions that would who essentially has a 'big picture' view of mental health speech pathology and function to perform a number of key roles: high-level advocacy, liaison with universities, management of state mental health speech pathology vacancies, supervision of speech pathologists, establishment of standards and the agenda for professional development within each state, coordination of the development of submissions, etc;

- Increased opportunity for education between professionals as to the various roles of individual professions.

There needs to be a valuing of communication competency as a key contributor to mental health well-being, and a risk factor for the development of mental health issues across the lifespan. Speech pathologists are able to contribute to this valuing through expansion of their service delivery within mental health beyond currently restricted roles.

Mental health services can be stressful places to work. Do you have any ideas, solutions or examples of actions that better support workers and managers in services?

Research into factors that impact job satisfaction for speech pathologists has indicated key determinants of job satisfaction to be:

Access to supervision; specifically:

- 1:1 profession-specific supervision – face to face and via telecommunications;

- Peer supervision and networks;

- Mentoring;

- Debriefing for critical incidents.

All of the above points require access to experts available to provide supervision and support.

Consideration must be given to models of supervision that provide regular access to supervision for health professionals – a good example of this process exists within the Australian Psychological Society – specialist registered psychologists are required to undertake regular supervision as part of their

ongoing registration and training. This model has validity for all mental health workers, including speech pathologists. Such a model has the potential to reduce professional isolation, avoid burn out, maintain professional standards and provide collegial support.

All of these suggestions require mental health workers who can offer this set-up regularly and on a needs-basis. This would allow managers and policy makers to be aware of the issues and stressors surrounding mental health workers, and increase the appropriateness and effectiveness of service planning and staffing.

Career paths and a range of roles for speech pathologists in mental health - as discipline-specific workers, team leaders, academics, policy writers, program/project directors, etc;

Team leaders should be recruited who have the skills in staff management, not solely in mental health. Workload issues should be proactively addressed within organisations and sufficient resources be made available to meet caseload demands and ensure ongoing employee satisfaction.

Support for speech pathologists to pursue research and specialist interests;

Earlier and more intensive training for undergraduate students, so that ***all*** students have at least some contact with the mental health services.

In some countries it has been found that asking service managers to become career mentors for clinicians helps to build bridges of understanding and support both ways. How can we build better mutually supportive working relationships between those who deliver clinical services, those who manage them and those who work at the policy and funding levels in the system?

Comments and suggestions; examples of good practice; case studies where things have not worked and lessons learned:

As speech pathologists working in the filed of mental health are generally small in number, consideration should to be given to the employment of speech pathologists in managerial positions who will be responsible for addressing policy issues such as service development, education needs and the extension of scope of practice.

12. Technology

The use of distance communication technologies for clinical consultations, providing support for other people in the workforce or volunteers (secondary consultation) and clinical supervision is increasingly possible as technology, broadband access and computer literacy and access to computers improves. Your views on the use of technologies such as this to support and build workforce capacity would be welcomed.

Comments and suggestions, examples of good practice, case studies where things have not worked and lessons learned

Clinical consultations:

Speaking in general terms, computer link-up between members of the mental health team may be appropriate for follow-up management of clients. However, use of similar technology during the diagnosis stage may be an issue; for example, it may be difficult for speech pathologists to diagnose and comment on communication problems presented via computer-based link-ups. It is important to note that for communicatively-impaired clients, this form of interaction requires high levels of comprehension/understanding and verbal/oral language which some individuals (children and adults) with mental health issues will lack. Likewise, computer links will be inappropriate for some specific populations, e.g. the visually impaired. As such, the use of technology may be better seen as an adjunct

to treatment rather than as a primary mode of delivery. It will also be important to ensure that those clients undertaking intervention via technology are not solely engaging with the mental health worker but are also engaging with and assimilating in the community.

As the mental health speech pathology workforce expands into rural and remote areas, with the associated likelihood that many positions may be sole, consideration will need to be given to how technology may be used to provide discipline specific and other forms of clinical consultation, professional development and mentoring.

As with all use of technology, cost effective ways of using the technology that are secure and do not involve a third party provider will need to be explored, with options disseminated and openly discussed with practitioners and organisations.

Clinical supervision:

The use of technology for the provision and recording of supervision is appropriate and has the potential to provide essential peer support for mental health practitioners in rural and remote areas. As noted in the above response how, how access to discipline specific clinical supervision is facilitated for sole practitioners will require careful consideration. It will be important that if even on an infrequent basis, face to face supervision and support also be made be available for mental health workers, particularly following critical incidents and/or when debriefing is requested.

Secondary consultations:

The current use of technology for educative purposed should be extended to include not only the mental health team, but support personal, carers, and other professionals with an interest in working in mental health, etc.

13. Data collection

Successful and cost effective workforce development rests on a foundation of good data and information about the current workforce, and the monitoring and evaluation of workforce strategies once in place. How best can current data collections be improved?

Do you have any examples of successful strategies already in place or being trialled?

Comments and suggestions; examples of good practice; case studies where things have not worked and lessons learned:

There are currently no national labour force surveys nor widespread standardised data collection regarding the practice of speech pathology within Australia, including practice within mental health and associated fields. Whilst Speech Pathology Australia has been able to collect a limited amount of data in the past, the Association does not have the capacity to conduct large scale, regular surveys of its membership nor obtain data that reflects speech pathology practice in Australia. Even where membership data has been collected, this is not necessarily reflective of the profession as a whole, given that membership of Speech Pathology Australia is voluntary. The subsequent lack of data regarding speech pathologists and speech pathology service provision makes it extremely difficult to evaluate the adequacy of current service provision and/or to set projections regarding the future supply of and demand for speech pathologists in mental health and all fields of speech pathology practice.

Whilst, as noted above, there is a general lack of data regarding speech pathology practice in Australia, there is specific data available from a small number of specialised mental health services throughout Australia. As an example, speech pathologists within the Child and Youth Mental Health Service

(CYMHS) in QLD are recognised as being one of the few professional groups to routinely collect data as part of a standard administration of assessments – this is now being increasingly used to drive research into areas such as the masking of communication impairment and difficulties with identifying young people with communication difficulties, and the profile of language functioning in young people who self-harm. Speech pathologists are also involved in the evaluation of therapy and intervention programs within CYMHS; for example, into the effectiveness of social skills training, and involved in research into specialist paediatric mental health groups such as traditionally difficult to engage young people with juvenile diabetes For further information regarding theses initiatives, please contact Narelle Anger, speech pathologist, Child and Family Therapy Unit, Royal Children's Hospital, Brisbane.

It is imperative that accurate data regarding the speech pathology profession in Australia be obtained to inform policy development, service planning and implementation, and general research into the needs of those with communication and swallowing disorders throughout Australia, not only in the mental health filed but in other fields in which speech pathologists work.

How can and planning, monitoring and evaluation methods for workforce strategies be improved?

Allocated time for data collection and informing mental health workers of what is being done with the data will increase meaningful data collection processes.

14. Evaluation of workforce development

Evaluation of mental health workforce initiatives internationally is at an early stage. A preliminary scan of the literature suggests a number of research and evaluation questions in relation to workforce development, for example, what are the most cost effective strategies to develop and deepen the capacity of the workforce? What impact will role redesign and redefinition have on outcomes for consumers?

Any other key evaluation questions relevant to workforce development?

Regardless of changes in role definitions, consumers require education about the role of mental health professionals and services available. This must be addressed in a manner that meets the needs of all individuals, with emphasis given to the particular education needs of individuals from culturally and linguistically diverse (CALD) backgrounds or those who have special needs. As an overarching principle, it should be acknowledged that communicatively impaired individuals may not have the ability to access written information so education regarding professional roles, services available, etc will need to be presented in different formats.

15. Cross-sectoral links

Building better links among the government, non government and private sectors is noted by some as a key way to improve capacity and access and return on investment in the current and future workforce.

Comments and suggestions; examples of good practice; case studies where things have not worked and lessons learned:

Forging strong and ongoing links between speech pathologists working in mental health and those working in the Education field has significant potential to build the capacity of speech pathologists at the coal face where the links between communication, emotional, social and behavioural development can be translated into practice. There is the potential for speech pathologists working in mental health units

such as CAMHS to provide mentoring, supervision and/or rotational clinical experiences. However, the educational workforce is currently under resourced, resulting in the scope of speech pathologist's practice limited to the more "traditional model" of speech pathology within mental health, i.e. language based leaning issues.

Working alongside education-based speech pathologists for identification of "at risk" children – for example, developing networks such as exist in QLD with the 'Communication and Behaviour Action Group' (CABAG) – has the potential to strengthen cross sectoral links. The CABAG group meets quarterly to discuss/network/develop/lobby around issues common to speech pathologists working with young people with communication and behavioral issues in health, education and disability services.

An increased number of senior speech pathology positions are required to facilitate links between government and the different sectors of the mental health workforce.

16. Any other issues/comments/ suggestions for the national workforce strategy you would like to make?

Please insert your responses in the answer boxes. You can choose to answer some questions only.

Appendix 1

This paper is a supplement to the written submission from Speech Pathology Australia to the *Mental Health Workforce Advisory Plan.* This paper aims to:

- **Identify the role of speech pathologists in mental health.**
- **Provide a brief review of the research that demonstrates the relationship between mental health and communication and swallowing disorders.**
- **Provide an outline of the roles in which speech pathologists can undertake in mental health settings.**

A. The Role of Speech Pathologists in Mental Health

- Due to the high correlation of between mental health and communication and swallowing disorders (dysphagia) speech pathologists are well positioned to work with individuals and families with mental health issues.
- Speech pathologists have unique skills due to their expertise in communication and swallowing to make a meaningful contribution to mental health.
- Speech pathologists are critical in understanding the communication skills of an individual and are able to contribute to the bio-psycho-social understanding of an individual with mental health issues.
- Speech pathologists are able to provide screening, assessment, treatment, management, and education to individuals and families with mental health issues. Consultation and education to other services providers and agencies is part of the role of speech pathologists.

B. A review of the research: The relationship between mental health and communication and swallowing disorders.

Several decades of literature and current evidence-based research demonstrate a strong relationship between communication disorders and mental health disorders across the lifespan. The service provision implications resulting from individuals experiencing life-long communication disorders add significantly to mental health service delivery costs (Bercow, 2008). A recent US report concludes that more than half of all mental, emotional and behavioural disorders occur during childhood (National Research Council, 2009). Socially disadvantaged groups in society are at greater risk for both communication and mental health problems along with the potential for intergenerational transfer of such

problems (Snow, 2009). The understanding of how communication and psychiatric disorders co-exist is essential.

The correlation between communication disorders and psychiatric disorders

Longitudinal studies clearly indicate an increase in the development of a psychiatric disorder over time when children initially present with significant speech/language impairments (Beitchman et al., 1996; Beitchman et al., 1986; Beitchman et al., 2001; Cantwell & Baker, 1987; Clegg et al., 2005). It is clear that children who present with significant communication disorders at an early age do not typically outgrow their disorders (Giddan & Milling, 1999). Research demonstrates a continuing risk from childhood into early adulthood of behavioural, social and emotional problems (Beitchman et al., 2001; Conti-Ramsden & Bottings, 2004; Clegg, et al., 2005). This is supported through studies that assess both psychiatrically disordered populations for communication problems, and communicatively impaired populations for psychiatric illness. Research demonstrates a remarkably high prevalence of communication impairments in children who present for psychiatric treatment (Caplan, 1996; Cohen et al., 1998). The same can be asserted for adolescents with a psychiatric diagnosis (Clarke, 2006; Perrott, 1998, 2009; Segrin, 2000; Segrin & Flora, 2000).

There is evidence that children with communication impairments are vulnerable to social-emotional difficulties and children with psychiatric diagnoses are found to have a higher than normal prevalence of language disorders (Paul, 1999). Literature that considers communication impairment in psychiatric populations has found that the reported range of co-occurrence is between 50-71.7% of children with a psychiatric diagnosis present with some form of speech or language impairment (Cohen et al., 1993; Cohen & Lipsett, 1991; Gualtieri et al., 1983; Kotsopoulos & Boodoosingh, 1987). There is also evidence to support the relationship between adolescent suicide attempts and social deficits (Spirito et al., 1990).

Dysfluency has been found to be associated with an increased risk for mental health disorders in adulthood (Iverach, 2009). Treatment outcomes demonstrate that the maintaining of fluency is difficult therefore addressing mental health problems in combination with speech treatments was recommended.

Language impairment and mental health

A prime example of potentially life-long disability is language impairment. The prevalence of language-learning disability (LLD) in children and adolescents is estimated to be between 10 and 15% (Conti-Ramsden et al., 2006). As Starling (2003) notes, school-aged children and adolescents with LLD are at risk for significant academic, social, emotional and behavioral problems. They are also likely to exit school early, often with minimal marketable work skills and little prospect of successful engagement in further education.

Please insert your responses in the answer boxes. You can choose to answer some questions only.

Language competence is a variable which can be modified when addressed at the infant, early intervention and preventative levels including high-risk families and groups in society. This becomes less modifiable and harder to effect as the developmental windows close across childhood and adolescence. It is essential that consideration be given to the strong link between communication and mental health problems that impact across the lifespan. Poor language ability and social, emotional and behavioral problems are correlated with psychopathology and psychosocial problems (Baltaxe & Simmons, 1990; Beitchman et al., 1996; Cantwell & Baker, 1987).Language impaired children demonstrate early experiences of peer group rejection (Voci et al.,2006; Lindsay et al., 2007). Specific populations such as juvenile young offenders have been found to present with oral language problems (Snow & Powell, 2004a, 2004b, 2005, 2008) and pragmatic disorders (Sanger et al., 1999).

A further variable to consider in psychiatric and communication disorders is literacy ability. Early receptive and expressive language difficulties have been shown to be associated with problems of later literacy acquisition (Beitchman et al., 1996; Catts et al., 2002). Similarly, a large-scale US study (Tomblin et al., 2000) demonstrates a direct correlation between early childhood language impairment and the later development of reading disorders, with associated behavioural disorders.

Psycho-social, emotional and behavioural issues

Speech pathology assessment in mental health considers the psycho-social functioning of the child and its impact on language development. Longitudinal studies indicate that poor psycho-social functioning in childhood is likely to persist into adolescence (Burt et al., 2008). It may be that, during the period of adolescence, being socially withdrawn increases risk of psychopathology as problems with loneliness and low-perceived social competence become more evident in adolescence (Rubin et al., 1995). Such problems may be antecedents to disorders such as depression and self-medication via psycho-active substances. Consequently, social skills assessment in children may be an indicator of depressive disorder (Kent at al., 1995). Burgess and Younger (2006) found that socially withdrawn children and adolescents tend to experience poor self-concept. Children with language impairment during the primary school years were identified as being lonely and rejected by their peers (Asher & Gazelle, 1999; Fujiki et al., 1999).

Psychological difficulties experienced by children with speech and language problems include relationship issues (Fujuki et al., 2001) and reduced self-esteem (Jerome et al., 2002). Van Daal et al., (2007) suggest that different types of communication disorder and specific behavioural problems correlate at a young age. For example, phonological problems show a relationship to externalising (aggression) problem behaviour; similarly, semantic language problems can be related to internalising (depression and anxiety) behavioural problems. Social problems were also found to be correlated to

language problems. Comprehension problems in children are associated with emotional and social problems (Beitchman et al., 1996; Rutter & Mawhood, 1991; Lindsay & Dockrell, 2000). A recent review of literature (Whitehouse, 2009) highlights the impact that communication disorders have on language and psych-social outcomes with mental ill-health highly represented in communicatively impaired adults.

The speech pathologist is aware that any impairment in psycho-social, emotional and/or behavioural function with associated language problems in children affects family functioning and contributes to family stress. Long et al., (2008) considered the impact of language delays and behaviour problems in young children on family function. It was found that over 50% of parents who reported language concerns also reported behaviour concerns. Lundrevold et al., (2008) demonstrated a correlation between language problems and behavioural-emotional problems as rated by primary school teachers.

Behavioural disorders may indicate undiagnosed communication, learning, literacy and/or attention/concentration problems. A high percentage of children, including toddlers and preschoolers, referred to welfare services have developmental and behavioural needs (Stahmer et al., 2005). Disruptive behaviour in children has been shown to become more severe over time (Neary & Eyberg, 2002). The issue of concern is that children with severe behavioural problems, including aggression, are very likely to continue demonstrating these problems into the school years (Gresham et al., 2000) compromising both academic achievement and the formation of pro-social bonds with other children. Attention deficits may also limit a child's ability to "tune in" sufficiently to learn the rules of communicative discourse.

Studies demonstrate that language difficulties are evident in samples of children with behavioural, emotional and social difficulties (Cohen et al., 2000; Fujiki et al., 2002; Ripley & Yuill, 2005). More specifically, conduct disorder and language problems can be correlated (Cohen et al., 2000; Lim, 2006).

If behavioural problems and language disorders remain untreated throughout childhood society is left to manage the associated issues further into the lifespan. Often adolescence is the period when both detected and undetected communication problems begin to mask themselves in antisocial or deviant behaviours, substance abuse, depression, anxiety and other mental illnesses. Longitudinal studies indicate that language impairment in childhood in boys is a significant risk factor for antisocial behaviour in adolescence (Beitchman et al., 1996; 2001; Bor et al., 2004).Additionally, Snow (2009) emphasises the substantial cross-over from child protection services to youth justice services, in populations with underlying language impairments.

Please insert your responses in the answer boxes. You can choose to answer some questions only.

The effect of trauma on communication

Significant disruption in the environment including neglect, abuse and trauma can affect communication and language acquisition and development. The impact of psychological trauma on language development in children is now recognised with disorders of multiple delays, communication and social relatedness identified in children who have been traumatised (Klapper et al., cited in Osofsky (ed.), 2007). In particular, emotional neglect has been found to be correlated with poor auditory comprehension and expressive language ability (Culp et al., 1991). The impact on academic performance includes reduced cognitive ability, sleep disturbance causing poor concentration and delayed receptive and expressive language development. The impact on social relationships includes a need for control, attachment difficulties, poor peer relationships and unstable living situations reducing learning and engagement at school (Downey, 2007). Maltreatment and compromised language and mental health outcomes have been recently identified by Snow (2009). Ball and Kahn (2009) assert the need for speech pathology input in complex trauma cases based on requests for intervention by other mental health clinicians. A pertinent role indeed exists for the speech pathologist from the early stages of a child presenting through to education of other team members.

A pertinent role exists for the speech pathologist from the early stages of a child who has experienced trauma presenting to mental health services including, collaborative consultation with, and education of other team members. Trauma in refugee immigrants seeking mental health services is a new population being managed by speech pathologists. A complexity of communication and psychological issues may present, for example, the need of the child to learn English as a second language, trauma associated with horrific experiences in the refugee's country of origin, detention, the immigration process, assimilation and adaptation to the new country. The risk and protective factors for mental health in refugee children suggests that child and adolescent refugees have a high incidence of depression, anxiety and post-traumatic stress disorder (Crowley, 2009). Communication assessment is complex and multilayered. Further communication research in this population is a matter of urgent priority.

Adult speech, language and swallowing disorders and mental health

Research demonstrates a high prevalence of speech, language and swallowing disorders in adults with mental health issues, and indeed, as is the case with child and adolescent mental health, there is a large body of evidence that links adult mental health illnesses with communication disorders. In looking closer at the evidence, there is a strong correlation between speech, language and communication difficulties and mental health:

- Disorders of mental health are often associated with speech, language and communication difficulties (France & Muir 1997; Thomas 1997, Frith 1997; Kramer 2001);
- Communication difficulties may compound the negative experience of mental illness, as the affected individual may have marked difficulty in expressing needs, wishes and desires coherently and effectively, and may thus fail to benefit fully from treatment programs (Walsh et al in press, 2007);
- The incidence of speech and language problems in adults receiving mental health care is substantially higher than general population (Bryan & Roach 2001);
- Recent research reports indicate moderate to severe difficulties in at least one aspect of speech and language in approximately 70% of individuals screened, especially in areas of comprehension, naming and spontaneous speech (Emerson & Enderby 1996; Walsh et al in press 2007);
- Psychiatrists and neurologists have difficulty differentiating schizophrenic from dysphasic speech but speech pathology assessment is known to be more reliable (Muir, Tanner & France 1991);
- Individuals with suspected dementia should have access to speech pathology assessment and management as part of a multidisciplinary team with specialist mental health skills (Heritage & Farrow, 1994);
- Language problems appear to be directly implicated with onset of psychological disorders and may well be risk factors (Baker, Cantwell & Mattison, 1979);
- Language assessment contributes to differential diagnosis between different types of dementia (Snowden & Griffiths, 2000) and make a vital contribution to early diagnosis (Garrard & Hodges, 1999);
- Faber, Abrams and Taylor (1983) and Fraser et al (1997) report on the value of speech pathologist descriptions of language in schizophrenia.

Swallowing Disorders and mental illness

There are a number of studies that confirm high fatality rates associated with swallowing disorders (also known as dysphagia), pneumonia and choking incidents in mental health services. Recent research reports that link speech, language and swallowing intervention with mental health include:

- Individuals with mental illness present with a higher rate of aspiration (food entering the lungs), and are more likely to develop pneumonia and die secondary to aspiration when compared to general population (Bazemore et al 1991);

- Individuals with mental illness are at a higher risk of choking than the general population (Craig et al 1982; Mittleman et al 1982; Fioretti et al 1997; Regan et al 2006);
- Overall dysphagia prevalence figures of 35% of individuals in a psychiatric inpatient unit to 27% prevalence of those attending day hospital services (Regan et al 2006);
- While 6% of the general population has swallow problems (Groher et al 1986), an increased incidence of dysphagia has been reported within the population of mental health disorders (Regan et al 2006). Possible causes for this higher prevalence include exposure to specific drugs used in the treatment of mental illness, institutional conditions, disorders such as dementia that affect brain function, and features of the illness itself (Bazemore et al 1992);
- Choking while drinking or eating has long been recognised within individuals who have mental health disorders (Regan et al 2006). Both choking episodes and long term aspiration suggest that psychiatric medications, movement disorders, seizures, neurologic impairments, poor dentition, and poor eating habits are all possible risk factors leading to dysphagia in this population;
- It is recommended that individuals attending mental health services be screened for dysphagia using a reliable assessment tool by a suitably trained clinician (Regan et al 2006).

Differential diagnosis of the nature of the swallowing problem, eg, whether the side effect of drug therapy versus psychological, is essential for effective management (Bach DB, Pouget S, Belle et al, 1989). As professionals qualified to assess swallowing function, speech pathologists can provide valuable input into the diagnosis and effective management of clients with mental health problems. Establishing safe and effective eating, drinking and swallowing ensures adequate nutrition, reduces risk of infection and illness and contributes to the general physical and mental well being of individuals.

Summary

This document has outlined the extensive literature and continually developing evidence base of the impact of mental illness on communication and swallowing function. The documented high prevalence of co-morbidity in relation to mental health, disorders of communication, socialisation and swallowing as described in this document impacts across the lifespan. As a consequence, as outlined within this submission from Speech Pathology Australia, there is a very real need for extended service provision by speech pathologists in mental health settings, including acting as key professionals at all stages of assessment, early intervention, adult services, prevention and policy-making.

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Please insert your responses in the answer boxes. You can choose to answer some questions only.

Thank you for your time, thought and effort in preparing your written submission to this project. Please email your submission by 18th December 2009 to:

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