



# Amit Kulkarni & Hannah Luff

**RCSLT Research and Development Manager Amit Kulkarni introduces SLT Hannah Luff, who describes her approach to the complex but familiar problem of maintaining an evidence-based approach in clinical areas with limited research**

## Evidence-informed practice in areas with limited research

**W**ithin the R&D forum, we have often discussed the RCSLT's support for an evidence-based approach to practice (Sackett, 2000). In some clinical areas, there are national guidelines based upon comprehensive research evidence to support this. However, in many other areas, guidelines may not be available because the evidence is not sufficiently comprehensive to meet guideline development criteria (see NICE criteria for details: [tinyurl.com/NICE-GuidelineDevelopment](http://tinyurl.com/NICE-GuidelineDevelopment)). So, while there is great research going on in speech and language therapy, it is a developing field, and we do not have the weight of evidence to answer all of our clinical questions. Consequently, it is important to be resourceful in the way we identify the theoretical underpinnings of our interventions.

In this month's R&D forum, Hannah Luff, one of our members working in the field of mental health, provides a great example of how she has set about this task, with a case study to illustrate her approach.

We would be interested to hear your thoughts about Hannah's strategy and whether you have any other tips or suggestions for managing a situation I'm sure all of us have found ourselves in at some point. If so, please let us know so we can share and reflect upon these ideas to help us provide the best, evidence-informed approach to our practice. ■

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### Working in mental health

**Hannah says:** As a clinician working in acute inpatient mental health wards and

specialist care units for older adults, my client group is varied: while many have dementia, there are also those with severe and enduring mental health issues, such as depression, anxiety, bipolar disorder, schizoaffective disorder and personality disorders. Additionally, there are those who have a pre-existing mental health condition and then develop dementia later in life.

People with severe and enduring mental health conditions are more likely to have poor health outcomes than those without (Walker et al, 2015), and many come onto acute mental health wards with high cardiovascular risk, frailty and other significant physical health needs (Osborn et al, 2008). They can subsequently be some of the most complex people to work with.

### An innovative approach

Very little high-level evidence exists to guide practice in this field, and there are few national, clinical guidelines that specify the role of speech and language therapy. To establish rationale behind intervention, I therefore need to look more widely for sources of evidence and think about which theoretical frameworks I can legitimately apply.

The approach I have taken involves using the evidence from studies lower down the evidence hierarchy, or from studies of closely related clinical areas, particularly traumatic brain injury (TBI). I also use approaches from other professional areas, for example neuropsychology, which have more history with this client group, and then adapt them in a person-centred way. Having a broader awareness of different theories across the biopsychosocial spectrum also supports my practice. In this



ILLUSTRATION BY Ben Leon

way, although there is not a 'handbook', I feel that I am striving to add rigour to my approach and see it as an opportunity to be pioneering, rather than as a stumbling block.

### Approach into practice

The support I offered to a patient with a diagnosis of schizophrenia, described below, illustrates this approach.

In the past, the focus has been on the management of the often distressing symptoms of psychosis, with first-line treatment being medication. However, more recently, there has been growing research into cognitive impairment, as it has been estimated that 90% of people with schizophrenia have a meaningful impairment in at least one neurocognitive domain and 75% in at least two (Gold, 2004). These impairments persist even when behavioural

*“I see it as an opportunity to be pioneering, rather than as a stumbling block”*

symptoms have been successfully managed, but are often not assessed or treated (Green et al, 2000).

One of the domains often affected is social cognition (Savla et al, 2013). A Cochrane review of social skills programmes used for clients with schizophrenia (Almerie et

al, 2015) concludes that it is possible that social skills training may improve the social communication skills of people in this client group; however, at present, the evidence is very limited. Nonetheless, drawing on work by Bornhofen et al (2008) and others working within TBI, I designed a

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personalised therapy programme.

### Patient intervention

Mrs X had been successfully treated using medication and psychological therapies following a psychotic episode. Although friendly, even when the content of her speech was devoid of paranoid thoughts, she was a little unsettling to talk to. For example, when I observed her interacting with others, I noticed that she stood very close to people and followed them even when they were clearly trying to leave or do something else. She did not respond to social cues, such as people looking at their watch, turning away, shuffling, frowning or standing by the door. In 10 minutes she received 17 of these cues but did not respond and continued to stand less than 50cm away from the person. When she was in a group, she reported that she felt people thought she was 'weird' and tried to avoid her.

As part of a small 'readiness to return home' group, through role play we focused on her awareness of how close she was standing to people and the cues that others were not interested. These sessions took place for around 30 minutes, twice weekly over three weeks.

When observed on the ward after these sessions, in a period of 10 minutes she initially stood about 50cm from the other person, but, when they stepped away, she remained where she was. She missed two cues that the person was ready to leave, but did not follow them when they walked away. I was therefore able to use personalised outcome measures to see change and to focus on specific behaviours. She reported feeling much happier and that people seemed to respond more positively to her.

When she returned home, a support worker continued to work with her in open spaces such as bus stops.

### Evidence of impact

Although I don't get many opportunities to work directly with communication difficulties, going forward I will be reviewing how we spend our time and focus our resources. Providing case-study-level information to providers about the impact we have, backed up by available research and theory, is imperative to maintaining speech and language therapy input with this client group. ■

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