1. **CLINICAL BOTTOM LINE:**
There is some evidence that social communication groups can improve language outcomes

- particularly for people with chronic aphasia
- for people with a range of aphasia severity & variety, usually without cognitive changes
- for a minimum 1.4 hours per week
- Speech Pathologist and/or Speech Pathology Student led
- using a variety of formats

There are also known improvements in Quality of Life outcomes, improved social networks and improved community access.

The literature indicated very clearly that there is a strong need for more well-designed studies.

2. **Clinical [PICO] Question**
Do social aphasia groups result in improved communication outcomes?

Sub-questions: 1. Is there a difference in outcomes between speech pathologist and non-speech pathologist (including peers, allied health assistants, volunteers) led groups?
2. Is there a difference in outcomes depending on timing of the group (acute, sub-acute, community)?

3. **SearchTerms/Systems:** social, aphasia, aphasia group, group therapy.

   Group members individually searched for relevant published articles using online search methods via accessible databases. Databases used for searches included: MEDLINE, PsychInfo, USYD Library, SpeechBITE, Google scholar, PubMed, Aphasiology Online, Cinahl, Ovid.

   A general literature search of aphasia groups was conducted prior to final definition of the clinical questions. These were subsequently discussed with themes extracted to formulate the clinical question. Following a decision on the clinical question, a second literature search was conducted with more specific inclusion/exclusion criteria for articles. The generated list of articles was also cross-checked with the reference list in 2 identified systematic reviews and a reference list for aphasia groups from an Aphasia workshop run by Miranda Rose in November 2014.

4. **Quantity of the evidence based:**
Number of papers identified: 22  Number of suitable papers actually capped: 9

   We found many articles related to groups, however there were a relatively small number of articles directly addressing the clinical question. Furthermore, the relevant articles ranged from 1981-2015.

5. **Overall level of the evidence base:** (number of studies according to each NHMRC level)

   I nil  II 2 studies (Elman & Wertz)  III-1 nil  III-2 1 article (Vickers)  III-3 nil  IV 6 articles

6. **Nature the evidence base:**
   Feasibility 0  Efficacy 9  Effectiveness 0

7. **Overall findings from the evidence-base are:**
   ○ compelling  ✓ suggestive  ○ equivocal

   **Comments:** See clinical bottom line.

8. **Results:**
1 of the 9 articles CAPped was identified as not answering the clinical question.

   Treatment effects:
6 of the 8 articles reviewed reported statistically significant improvements on some language outcome measures (impairment based or functional). 1 article did not find a statistically significant difference. Another article reported improvements, but did not report on statistical analysis.

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**NSW Speech Pathology EBP Network**

**Critically Appraised Topic (CAT)**


**PLEASE NOTE THE DATE WHEN THIS CAT WAS COMPLETED,**

**BECAUSE THE CLINICAL BOTTOMLINE MAY HAVE CHANGED IN LIGHT OF MORE RECENT RESEARCH.**
It should also be noted that the level of evidence for 6/9 studies was rated at III-IV.

Maintenance:
2 out of 8 articles (Hoover et al, 2015; Aten et al, 1982) demonstrated a maintenance effect. 2 articles did not find a maintenance effect. 5 articles did not report on maintenance effect at follow-up (or did not demonstrate statistical analysis).

Sub-question 1. The aphasia groups reported in the articles that demonstrated significant outcomes in communication were all led by Speech Pathologists or supervised Speech Pathology students.

Sub-question 2. We were unable to answer this question from the literature. It was noted, however, that in 7/8 studies the participants had chronic aphasia, so we can presume that the limited evidence reported above supports outcomes for people living with aphasia in the community.

The following limitations and factors must be taken into consideration in conjunction with the above results:

- Each article reported on groups that were conducted in very different ways with a range of activities and goals for each group.
- A range of outcome measures were used to measure change. These included standardised, non-standardised, impairment, functional, self-reported & QoL.
- There was a wide range of length of blocks and length of group time for all the groups reported.

The following systematic reviews were reviewed and considered in light of our clinical questions:


The systematic reviews supported previous findings of improved communication outcomes with groups, however the evidence favoured more structured therapy protocols and included predominately quality of life outcomes. In fact, Simmons-Mackie et al stated that “While researchers are increasingly measuring the effects of impairment-focused therapy on conversational behaviours, it is important to study the reverse also: the effects of conversation therapy on linguistic performance (e.g. Lexical retrieval, syntax) as well as natural conversation.” This is in line with the question we posed.

9. Recommendations:
Is evidence from current clinical practice the same as clinical bottomline?

☐ Yes  ☐ No  ✓ Undecided

Undecided because: ✓ more research evidence needed.

Current practice: SPs continue to provide groups for people with Aphasia despite limited research due to: the small amount of positive evidence; anecdotal evidence of improved social interactions & Quality of Life; patient & family enjoyment and positive feedback. There is no perceived harm in running groups and they are more time and resource efficient. SPs run groups for people with improving aphasia (not just chronic). Volunteers are used in some groups. The majority of groups are 1.5 hours or less due to time constraints.

✓ Change is needed to current clinical practice

10. Application to practice (when change has been indicated):

✓ Change is needed, and it is possible –

A variety of outcome measures (both impairment based as well as quality of life) need to be used in clinical practice to continue to develop and support the evidence for the effect of groups.