

Service provision for post-stroke aphasia in acute and sub-acute settings: Solutions for addressing the evidence-practice gaps

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Therapy intensity

People with aphasia less than one month post onset should have access to intensive aphasia rehabilitation if they can tolerate it (CCRE Aphasia, 2014)

Gap: Higher intensity therapy results in significantly better recovery in acute and sub-acute aphasia (Brady et al, 2012; Cherney, 2012). Two hours of aphasia treatment per week is a *minimum* effective dose (Robey, 1998), yet patients receive, on average, less than 14mins/week in acute (Godecke et al., 2012, 2014).
Causes: Speech pathologists frequently prioritise dysphagia over communication therapy and feel that communication is less valued within the medical model (Foster et al, 2014). Intense therapy is felt to be out of reach with current resources, and its less valued within the medical model setting (Foster et al., 2015).

Ways forward: Traditional one-on-one therapy should be supplemented with group therapy and conversation groups, computer-based treatments, telerehabilitation and trained volunteers (CCRE Aphasia, 2014). Speech pathology in hospitals needs culture change to prioritising communication. This can be enabled through leadership and mentoring strategies (Foster et al., 2015).

Goal setting

People with aphasia and their family should be involved with setting therapy goals that are motivating and realistic (CCRE Aphasia, 2014)

Gap: Despite recommendations from guidelines, stroke patients and their families remain minimally involved in goal-setting, particularly in the acute phase (Rosewilliam et al., 2011; NSF, 2013). People with communication or cognitive impairments have even less involvement with goal setting (Hersh et al., 2012).
Causes: Articulating goals and needs is difficult for people with aphasia due to their language impairment and also challenging for health professionals. Patients often lack sufficient education on goal setting and feel that their goals do not align with those of health professionals (Hersh et al., 2012).

Ways forward: *Formal* goal setting processes should be established that involve both people with aphasia and their families (Wade, 2009; Rosewilliam et al., 2011). These might include purpose-built communication strategies and aids as well as patient education (Foster et al., 2013). Utilisation of the SMARTER goal framework also encourages collaborative, patient-centred goal setting (Hersh et al., 2012).

Education

People with aphasia should be offered personalised information about stroke & aphasia using relevant language & communication formats (CCRE Aphasia, 2014)

Gap: While there are known benefits of providing people with health information, people with aphasia are poorly informed about stroke & aphasia (Rose et al., 2009). NSF Acute Audit data found only 10% of hospitals had all their written information available in aphasia-friendly formats (NSF, 2013).
Causes: As the average length of hospital stays becomes shorter, patterns for providing health information are erratic, infrequent, & unplanned. Patient, health professional & environmental factors influence information provision (Knight et al., 2006).

Ways forward: Routine provision of appropriately formatted health information and improved access to the health professionals and services that provide information are two strategies for more successful stroke and aphasia education. A systematic and individualised approach to health information provision is necessary (Rose et al., 2009).

Accessible environments

Communicatively accessible environments should be provided for people with aphasia (CCRE Aphasia, 2014)

Gap: People need to be able to communicate effectively with their healthcare providers and access information about their health in a range of different ways to participate in their own healthcare. People with aphasia are at risk of not being able to communicate with their healthcare providers or to access the information they need, placing them at greater risk of poorer health outcomes (O'Halloran, 2010).
Causes: The creation of communicatively accessible healthcare environments requires a high level of commitment, support from executive administration, and effort over a long period of time (O'Halloran, 2010).

Ways forward: Addressing the many different environmental factors that influence the ability of people with aphasia to communicate effectively within healthcare environments, including:

- products and technology
- support and relationships, and
- services, systems, and policies (O'Halloran et al., 2008).