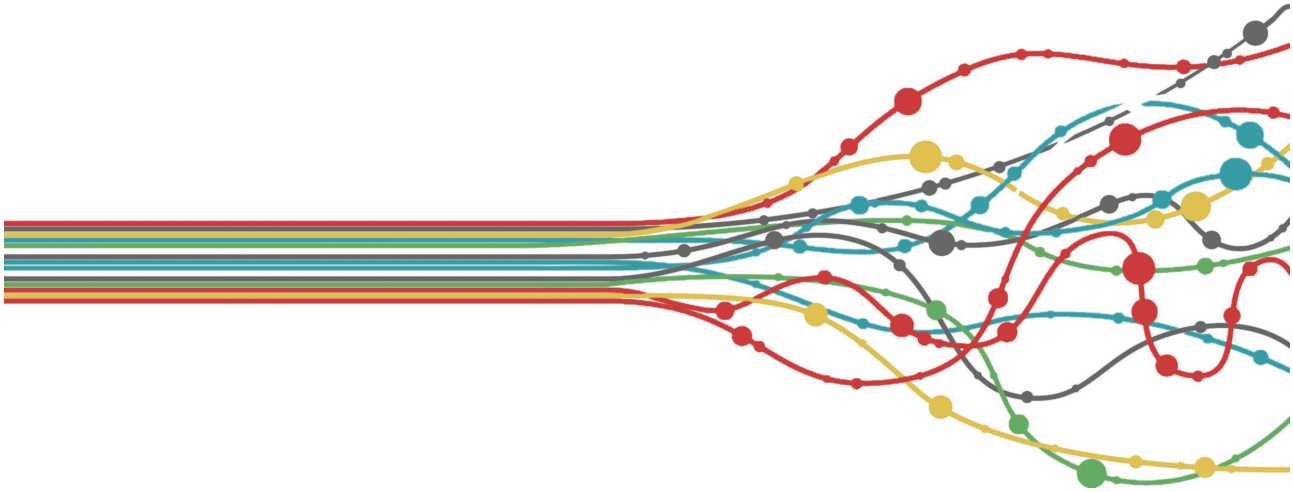
Aphasia Rehabilitation Best Practice Statements:

Concise supplement



Centre of Research Excellence in Aphasia Recovery and Rehabilitation

www.aphasiapathway.com.au

BEST PRACTICE STATEMENTS

The Australian Aphasia Rehabilitation Pathway Concise Supplement is a list of best practice statements for aphasia rehabilitation originally developed in 2014 by the National Health and Medical Research Council (NHMRC) funded Centre for Clinical Research Excellence in Aphasia Rehabilitation and updated by the NHMRC Centre for Research Excellence in Aphasia Recovery and Rehabilitation. The updated 2024 concise supplement contains a list of 86 best practice statements presented in a table format within a Microsoft Word document. This format is intended as a practical implementation tool for clinicians and managers and may support audit or implementation of the best practice statements.

The concise supplement should be used in conjunction with either the online or comprehensive forms of the statements outlined below.

The Australian Aphasia Rehabilitation Pathway website www.aphasiapathway.com.au**.** The website contains a detailed introduction to the best practice statements, 86 statements with rationales, references and level of evidence for each statement. It also provides a variety of additional literature, links and practical resources for clinicians.

The Australian Aphasia Rehabilitation Pathway Comprehensive Supplement. The comprehensive supplement is a PDF document that can be downloaded from the aphasia pathway website. It contains a detailed introduction to the best practice statements, 86 statements with rationales, the references, and level of evidence for each statement. It also contains a reference list of studies cited in the supplement.

Disclaimer

The best practice statements are provided as a guide to appropriate practice, subject to the clinician's judgement and the client's preference in each individual case. The statements are designed to provide information to assist decision-making and are based on the best evidence available at the time of their development.

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Aphasia Rehabilitation Best Practice Statements 2024

1	RECEIVING THE RIGHT REFERRALS
Community awareness of aphasia	
1.1	Community awareness of aphasia should be raised.
1.2	In awareness campaigns, it should be highlighted that aphasia can be an early and persisting symptom of stroke.
1.3	Appropriate aphasia-friendly stroke information should be given to people with aphasia and their family, friends and carers.
Communication training of health professionals	
1.4	Speech pathologists should provide education about the characteristics of aphasia and training on supported communication techniques to all people involved in the care of people with aphasia.
Referral Process	
1.5	People with acute onset of aphasia should be suspected of having a stroke and transferred directly to a hospital with dedicated acute stroke services.
1.6	All stroke patients should be screened using a valid and reliable tool that is sensitive to the presence of aphasia.
1.7	Any person with suspected aphasia should be referred to a speech pathologist
1.8	Speech pathology services for people with aphasia, including those in the community, should be promoted to all potential referral agencies to ensure appropriate access to services.

2	OPTIMISING INITIAL CONTACT
Initial Assessment	
2.1	People with suspected aphasia should receive assessment by a speech pathologist to determine the presence and severity of aphasia.
2.2	Stroke patients with suspected aphasia should receive assessment by a speech pathologist to determine the patient's ability to communicate their healthcare needs.
Initial Prognosis	
2.3	Individual language recovery cannot be accurately predicted immediately post stroke, therefore all individuals with post-stroke aphasia should be offered aphasia rehabilitation services.

Initial Management	
2.4	Speech pathologists should talk with the person with aphasia and their family, friends and carers about the roles the client has in their family and community.
2.5	People with aphasia and their family, friends and carers should be offered information about stroke and aphasia tailored to meet their changing needs using relevant language and communication formats.
2.6	Speech pathologists can offer education and training to support families, friends and carers of people with aphasia to become skilled conversational partners.
2.7	Speech pathologists should provide hospital staff with individualised communication strategies that are tailored to enhance both care-related and social and emotional communication with each patient with aphasia.
Additional considerations when working with Aboriginal and Torres Strait Islander clients	
7.5	Speech pathologists should routinely check Aboriginal and Torres Strait Islander status in clients' health records and with the clients themselves.
7.6	Speech pathologists should offer the involvement of an Aboriginal Liaison Officer (ALO) and/or Aboriginal Health Worker (AHW)* where possible to advise on cultural issues and liaise with the person with aphasia and family.
7.8	Speech pathologists should incorporate clinical yarning as a means to build rapport and trust with the Aboriginal and Torres Strait Islander person and their family and to discuss speech pathology terms in a relevant and culturally appropriate way.
Additional considerations when working with clients with a CALD background	
7.15	Where a patient reports having used more than one language premorbidly, comprehensive information about the patient's language history should be obtained.

3	SETTING GOALS AND MEASURING OUTCOMES
Goal setting	
3.1	Goal setting should be a dynamic process that is reviewed across the continuum of care in order to reflect the client and family context, wishes and language recovery.
3.2	Therapists should explain the goal setting process to the person with aphasia and their family and carers in an accessible way.
3.3	Collaborative goal setting between the speech pathologist, person with aphasia, their family and other team members should primarily focus on the goals identified by the person with aphasia and their family with consideration of assessment findings.
3.4	Systems should be established to ensure involvement of people with aphasia and their family as part of the rehabilitation team.
3.5	The 'SMARTER' framework can be used to help ensure that goal setting is truly collaborative and client-centred.
3.6	Maintaining or improving mental health and psychological wellbeing should be an explicit target of intervention for people with aphasia, therefore requiring attention during goal setting.
Measuring outcomes	
3.7	Outcome measures for people with aphasia should be relevant, meaningful, and important to stakeholders.
3.8	Outcome measures for people with aphasia should be suitable to the construct being measured and psychometrically robust (reliable, valid and sensitive).
3.9	Outcome data for people with aphasia should be reported in a full and unbiased manner to people with aphasia and their families.
Additional considerations when working with Aboriginal and Torres Strait Islander clients	
7.6	Speech pathologists should offer the involvement of an Aboriginal Liaison Officer (ALO) and/or Aboriginal Health Worker (AHW)* where possible to advise on cultural issues and liaise with the person with aphasia and family.
7.8	Speech pathologists should incorporate clinical yarning as a means to build rapport and trust with the Aboriginal and Torres Strait Islander person and their family and to discuss speech pathology terms in a relevant and culturally appropriate way.
7.9	Goal setting and aphasia management should be person-centred and strength-based and should be considerate of Aboriginal and Torres Strait Islander models of health and wellbeing.

4	ASSESSING
4.1	The assessment process should be iterative and dynamic.
4.2	Assessment should be therapeutic.
4.3	All domains of functioning and disability should be considered for assessment.
4.4	The person with aphasia and key conversation partners should be invited to contribute to the assessment.
4.5	All assessment results should be documented and reported in an accessible format to people with aphasia and their families.
4.6	Tele-assessment is an evidence-based alternative to in-person assessment.
4.7	People with aphasia should be screened by health professionals, including speech pathologists, for mood problems (depression and/or anxiety).
4.8	People with suspected clinical depression or anxiety following mood screening should receive further mood assessment using a clinical interview by a medical practitioner and/or psychologist who is competent in communicating with people with aphasia.
Additional considerations when working with Aboriginal and Torres Strait Islander clients	
7.6	Speech pathologists should offer the involvement of an Aboriginal Liaison Officer (ALO) and/or Aboriginal Health Worker (AHW)* where possible to advise on cultural issues and liaise with the person with aphasia and family.
7.8	Speech pathologists should incorporate clinical yarning as a means to build rapport and trust with the Aboriginal and Torres Strait Islander person and their family and to discuss speech pathology terms in a relevant and culturally appropriate way.
7.10	When considering assessment of aphasia in Aboriginal and Torres Strait Islander clients, Speech Pathologists should be mindful of the significant limitations of and potential harms in using formal assessment tools.
Additional considerations when working with clients with a CALD background	
7.16	Where possible, assessments should be used that are appropriate to the languages/dialects and cultural backgrounds of each client.
7.18	Language behaviours unique to the bi/multilingual person with aphasia such as translation, language mixing and code-switching should be considered in both assessment and intervention planning.

5	PROVIDING INTERVENTION
5.1	Speech and language therapy should be provided to people with aphasia – this can target functional communication, reading comprehension, auditory comprehension, general expressive language and/or written language.
Therapy timing	
5.2	People with aphasia should be offered therapy commencing within the first month post stroke onset to gain benefits in receptive and expressive language and communication in everyday environments.
5.3	People with aphasia more than three months post onset of stroke should be offered intensive/high dose speech and language therapy if they can tolerate it.
5.4	People with chronic aphasia should be offered speech and language therapy to gain benefits in receptive and expressive language, and communication in everyday environments.
Therapy principles	
5.5	Aphasia rehabilitation should address the consequences of aphasia on functional everyday activities, participation, social connectedness, and quality of life. Speech pathologists should consider targeting interventions on the impact of aphasia on relationships, vocation, and leisure in all phases of care.
5.6	Aphasia rehabilitation should address the needs of family, friends and carers.
5.7	Aphasia rehabilitation should include the provision of information tailored to meet the needs of people with aphasia and their family, friends and carers, using relevant language and communication formats.
5.8	Aphasia rehabilitation can focus on strategies to promote long-term maintenance of gains, including promoting independent communication practice and use, and maximising communication opportunities.
Treating different language modalities	
5.9	Aphasia rehabilitation: ● should target spoken production at the word level ● can target spoken production at the sentence level (e.g., syntactic, thematic roles).
5.10	Aphasia rehabilitation can target auditory comprehension at the: ● word level (e.g., auditory discrimination, lexical access, semantic access) ● sentence level ● above-sentence level.
5.11	Aphasia rehabilitation can target writing at the: ● word level ● sentence level ● above-sentence level.
5.12	Aphasia rehabilitation can target reading at the: • word level • sentence level • above-sentence level.
5.13	Aphasia rehabilitation can target discourse at the: ● monologue level ● interactional discourse (conversation) level.

5.14	Aphasia rehabilitation can target augmentative and alternative communication, including: • No-technology/low-technology AAC • High-technology AAC.
Alternative/additional modes of therapy	
5.15	In addition to individual therapy delivered by speech pathologists, aphasia rehabilitation can include the use of aphasia therapy software.
5.16	In addition to individual therapy delivered by speech pathologists, aphasia rehabilitation can include group therapy.
5.17	Aphasia rehabilitation can include telerehabilitation.
5.18	In addition to individual therapy delivered by speech pathologists aphasia rehabilitation can include trained and supported/supervised volunteers.
Treatment beyond language modalities	
5.19	For people with aphasia experiencing difficulties with coping and adjustment, suitable psychological therapies delivered with communication supports can be facilitated by a range of trained clinicians, including speech pathologists, to prevent the development of ongoing mood problems.
5.20	People with aphasia and mood concerns with a clinical diagnosis of depression and/or anxiety should be offered psychological therapy with communication supports by a psychologist or other appropriately qualified mental health practitioner.
5.21	Aphasia rehabilitation can include focus on enhancing social identity.
5.22	In addition to individual therapy delivered by speech pathologists, aphasia rehabilitation can include community aphasia groups.
5.23	Aphasia rehabilitation should include communication partner training.
Additional considerations when working with Aboriginal and Torres Strait Islander clients	
7.6	Speech pathologists should offer the involvement of an Aboriginal Liaison Officer (ALO) and/or Aboriginal Health Worker (AHW)* where possible to advise on cultural issues and liaise with the person with aphasia and family.
7.8	Speech pathologists should incorporate clinical yarning as a means to build rapport and trust with the Aboriginal and Torres Strait Islander person and their family and to discuss speech pathology terms in a relevant and culturally appropriate way.
Additional considerations when working with clients with a CALD background	
7.17	Where possible, treatment should be offered in all relevant languages and relevant modalities.
7.18	Language behaviours unique to the bi/multilingual person with aphasia such as translation, language mixing and code-switching should be considered in both assessment and intervention planning.

6	ENHANCING THE COMMUNICATIVE ENVIRONMENT
6.1	Communication partner training should be provided to improve the communicative environment provided by frequent communication partners for the person with aphasia.
6.2	People with aphasia should have aphasia-friendly material available to enable them to participate in communication.
6.3	Communicatively accessible environments should be provided for people with aphasia.
Additional considerations when working with Aboriginal and Torres Strait Islander clients	
7.6	Speech pathologists should offer the involvement of an Aboriginal Liaison Officer (ALO) and/or Aboriginal Health Worker (AHW)* where possible to advise on cultural issues and liaise with the person with aphasia and family.
7.8	Speech pathologists should incorporate clinical yarning as a means to build rapport and trust with the Aboriginal and Torres Strait Islander person and their family and to discuss speech pathology terms in a relevant and culturally appropriate way.

7	ENHANCING PERSONAL FACTORS
7.1	People with aphasia, their families and carers, and speech pathologists should work together to develop appropriate self-management strategies.
7.2	Connections with appropriate social supports should be facilitated for people with aphasia and their families.
Additional considerations when working with Aboriginal and Torres Strait Islander clients	
7.3	Speech pathologists should engage in training and other activities to develop interpersonal skills and reflective practices for examining cultural safety and anti-racism with particular reference to Aboriginal and Torres Strait Islander cultures.
7.4	Speech pathologists should implement local protocols that guide working with Aboriginal and Torres Strait Islander communities.
7.5	Speech pathologists should routinely check Aboriginal and Torres Strait Islander status in clients' health records and with the clients themselves.
7.6	Speech pathologists should offer the involvement of an Aboriginal Liaison Officer (ALO) and/or Aboriginal Health Worker (AHW)* where possible to advise on cultural issues and liaise with the person with aphasia and their family.
7.7	Where the speech pathologist is not proficient in a language of the person with aphasia, a trained and qualified interpreter, knowledgeable in the specific requirements for speech pathology, should be used.
7.8	Speech pathologists should incorporate clinical yarning as a means to build rapport and trust with the Aboriginal and Torres Strait Islander person and their family and to discuss speech pathology terms in a relevant and culturally appropriate way.
7.9	Goal setting and aphasia management should be person-centred and strength-based and should be considerate of Aboriginal and Torres Strait Islander models of health and wellbeing.
7.10	When considering assessment of aphasia in Aboriginal and Torres Strait Islander clients, speech pathologists should be mindful of the significant limitations of and potential harms in using formal assessment tools.
7.11	Speech pathologists should develop an awareness of local Aboriginal health services and Aboriginal specific social services.
7.12	Speech pathologists should develop reflective practice skills so that they learn from each experience with an Aboriginal or Torres Strait Islander client and improve the service they provide with each new client, with the guidance of a mentor.
Additional considerations when working with clients with a CALD background	
7.13	Healthcare providers should consider the cultural and linguistic background of the person with aphasia, their family, and their community.
7.14	Where the speech pathologist is not proficient in a language of the person with aphasia, a trained and qualified interpreter, knowledgeable with the specific requirements for speech pathology, should be used.
7.15	Where a patient reports having used more than one language premorbidly, comprehensive information about the patient's language history should be obtained.

7.16	Where possible, assessments should be used that are appropriate to the languages/dialects and cultural backgrounds of each client.
7.17	Where possible, treatment should be offered in all relevant languages and relevant modalities.
7.18	Language behaviours unique to the bi/multilingual person with aphasia such as translation, language mixing and code-switching should be considered in both assessment and intervention planning.
7.19	Speech pathologists should explain terminology in a way that is relevant and culturally appropriate.

8	PLANNING FOR TRANSITIONS
8.1	Planning for the next phase should be initiated as early as possible.
8.2	Speech pathologists should be part of the discharge planning team and adopt an advocacy role to promote optimal care.
8.3	During transitions, timely, up-to-date, accurate and appropriate patient-related information should be shared with the receiving healthcare providers.
8.4	At the time of any discharge or transition, information that includes current diagnosis, action plans, follow-up care, and goals should be provided to the person with aphasia, and their family, friends and carers using relevant language and communication formats.
8.5	The speech pathologist, as part of an interdisciplinary team approach, should contribute information about the communication skills of the person with aphasia that may influence appropriateness of discharge.
8.6	Services that provide early supported discharge should ensure that the person with aphasia and their family are linked in with ongoing (social) supports and appropriately prepared for the transition.
8.7	The speech pathologist should connect the person with aphasia and their family, friends and carers with other people with aphasia, community aphasia groups, and support organisations.
8.8	As part of the multidisciplinary team, the speech pathologist should, for legal issues, document all observations regarding the person's ability to understand written and verbal information and express their wishes.
8.9	People with aphasia and their family, friends and carers should have access to a contact person (e.g., a stroke coordinator or speech pathologist) for any queries post-discharge, and should know how to self-refer to appropriate speech pathology services after discharge if they feel further rehabilitation is required.
Additional considerations when working with Aboriginal and Torres Strait Islander clients	
7.6	Speech pathologists should offer the involvement of an Aboriginal Liaison Officer (ALO) and/or Aboriginal Health Worker (AHW)* where possible to advise on cultural issues and liaise with the person with aphasia and family.
7.8	Speech pathologists should incorporate clinical yarning as a means to build rapport and trust with the Aboriginal and Torres Strait Islander person and their family and to discuss speech pathology terms in a relevant and culturally appropriate way.
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