**CLINICAL BOTTOM LINE:**
Communication partners are beneficial to people with aphasia in terms of increased social participation in the absence of any clinical change in the degree of aphasia.

**IS CHANGE REQUIRED TO CURRENT CLINICAL PRACTICE?**
- Yes
- No
- Undecided, more evidence needed

**Clinical Question**
Is it feasible to implement a volunteer communication partner scheme in Newcastle and what results could we expect?


**Method: Design and Procedure**

- **Design:** Pre-post test design. Randomisation of 9/10 subjects to treatment n=7 and deferred groups n=3. Communication partners (CP) were randomly assigned to subject to create a dyad. Method of randomisation not discussed.

- **Treatment schedule/intensity:** Two phases of treatment. Phase 1: 16 weeks of 2x weekly sessions (1.5hr) to establish effective and optimal communication between subject and CP. Phase 2: 14 weeks of 2x weekly sessions. Session 1 conducted with CP and SP to determine goals. Session 2 in the home or community depending upon the goals set by the subject.

- **Data collection:** Standardised outcome measures used pre and post included BDAE, CADL & ABS. Assessors were not blinded to treatment vs. deferred groups. Assessment was video-recorded. Non standardised outcome measures included two questionnaires developed specifically for the study: Communication Readiness and Use Index (CRUI) and the Psychosocial Well-being Index (PWI). No discussion re: construction, peer review, sample testing and refining of questionnaires. All subjects assessed prior to commencing Phase 1. The deferred group were re-tested 2 months post enrolment and commenced Phase 1 if no significant change detected. Informal measures included documentation of activities commenced during the study, continued after the conclusion of the study and new activities commenced post-study. Two independent SPs familiar with the subjects rated outcomes on a 1-3 scale with 1: less than expected, 2: expected outcome and 3 better than expected outcome. All post-test assessment completed 6 months post.

- **Reliability:** 20% of Standardised OMs were randomly selected and rescored by a non-blinded SP. Inter-rate reliability exceeded 90%. 25% of CRUI and PWI were readministered within 3 days both pre and post. Mean differences averaged 8% with subjects demonstrating more variability. Inter-rater reliability on the informal scale reached 75% agreement.

**Method: Participants**

- **Participants** (where relevant note number of participants, inclusion/exclusionary criteria, characteristics of participants in experimental group and control group/s):
  - 10 treatment dyads in total. 10 people with aphasia greater than 1 year post stroke. Inclusion criteria: no existing cognitive deficits, ambulant short distances, independent with ADLs, not receiving SP input and no hearing/visual impairments and able to reliably communicate simple content by any means. Mean age 68.
  - CPs: Inclusion criteria: normal cognition, vision, hearing and psychiatric history. Mean age 45 SD 17, 9 were female. Recruitment method not discussed.
Results:
Standardised OMs analysed with ANOVA. No significant difference between treatment and deferred groups.

Informal measures: Wilcoxon signed ranks test completed (cannot assume normal distribution). Significant difference in mean ranks for both CRUI and PWI. Unclear whether improvement on CRU and PWI due to treatment or from other causes (subjective measures). The deferred group demonstrated mild-moderate gains while waiting.

9/10 subjects sustained activities commenced during the study.
8/9 subjects added new activities post treatment.

Pearson Product moment correlation completed between all standardised and informal measures. A positive correlation \( r=+0.89 \) was observed between clinician judged outcomes and sustained activity level only.

Level of Evidence (NH&MRC, 2009)  
Circle one  I  II  III-1  III-2  III-3  IV

Quality of Evidence:  
☐ √Rated  ☐ Not Rated  
(i) rating system (e.g., PEDro, RoBIN-T Scale from SpeechBITE)  RoBIN Scale for SpeechBITE  
(ii) score 2/10

Nature of Evidence:  ☐ feasibility  ☐ efficacy study  ☐ √effectiveness study

Relevance to practice (e.g., were the participants and/or treatment context similar/different to everyday clinical practice?  
Is replication possible in clinical practice? What barriers might prevent the results from be applied to everyday clinical practice?  
What could be done to address barriers? If barriers can’t be modified, how could the procedure be modified to accommodation limitations in clinical practice?)

Replication may be possible in a completely different format within community stroke.
Exclusion criteria are quite restrictive and therefore sample not considered to be representative. Exclusion criteria would need to be relaxed (i.e. non-ambulant and dependant) to allow subjects at increased risk of social isolation to be included in the program.
Time intensive for training of volunteers. Significant barrier for both the volunteer and the SP.
Unclear how/where volunteers were recruited therefore unable to comment on potential barriers to recruitment
Large amount of funding would be required to implement this volunteering program in its original format.
Discussed difficulty quantifying improvements to participation and the elements involved in this.
Lack of blinding of the assessors (used SPs familiar with the groups and PWA).
Small number of participants.

Additional comments
Complex methodology with the addition of a deferred treatment group. Randomisation and recruitment not discussed which raises potential for selection bias. Makes accurate replication of the study impossible. The method of constructing the questionnaires is not discussed in any detail and therefore difficult to comment on reliability.
Assessors were not blinded to treatment or deferred group. Study unlikely to have internal or external validity.

Appraised By: Kerrie Strong & Jo Steele  
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