CLINICAL BOTTOM LINE:
Training volunteers can improve their knowledge of aphasia and communication strategies resulting in increased participation in conversation for the person with aphasia.

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

Clinical Question [patient/problem, intervention, (comparison), outcome]:
Is it feasible to implement a volunteer communication partner scheme in Newcastle and what results could we expect?

Citation: Rayner H & Marshall J.(2003) Training Volunteers as conversation partners for people with aphasia. 

Method: Design and Procedure (e.g., note type of research design, comment on randomization, summarize treatment intensity as appropriate, such as dose (trials) per session, session length, frequency, total treatment duration, summarize general procedure, resources / materials required)

Design: Case series Pre-post test design. Volunteers were randomly assigned to subjects but method of randomisation not discussed.

Treatment intensity: Training provided to volunteers 3hrs x 3 sessions using video footage, group discussion, handouts and role play.

Data collection: Each dyad was recorded conversing for 15 minutes on 4 separate occasions. Twice prior to training, 1 immediately post training and the last 9-10 weeks post training. Each clip was rated by a blinded SP external to the study. The order of the four clips was randomised for each of the dyads. Rating was completed using Measure of Skill in provided Supported Conversation for Adults with Aphasia (M)SCA (5 areas rated on 9 point likert scales) and the Measure of the Aphasic Adult's Participation in Conversation (M)APC ( 2 areas rated on 9 point likert scales)
Two questionnaires (factual and strategic) developed specifically for the study were completed by the volunteers pre and post. The first was developed by the author and checked by 2nd author. The second questionnaire contained a list of 28 strategies. It was administered to a control group to informally assess reliability.

Method: Participants (where relevant note number of participants, inclusion/exclusionary criteria, characteristics of participants in experimental group and control group/s):
6 volunteers recruited from an Aphasia group. (4 female mean age 65 SD 4) 
6 people with moderate-severe aphasia recruited from the same group (4 male mean age 67 SD 9). Minimum of 1 year post stroke (range 1-13) and not receiving formal SP services. 

All participants were recruited from the same aphasia group which reduces the external validity of the study. Unlikely to be a representative sample of volunteers. All participants familiar with each other.

Results: The results of the were analysed using one-factor within subjects ANOVA. There was a significant main effect (p<0.001) Significant difference in means between the 2nd clip and the 3rd clip only. Significant correlation between (M)SCA and (M)APC 
Significant improvement in the factual questionnaire pre and post training on a t-test (p<0.05)
Comparison of the control group and the treatment group of volunteers strategic questionnaires was completed using a two-factor (time and groups) mixed design ANOVA. There was a significant main effect for time for the trained volunteers 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) ___________________________
   (ii) score ______________________

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 accommodate limitations in clinical practice?)

This study could be easily replicated with the appropriate course training materials within existing aphasia groups.
3hrs of training is clinically feasible and justifiable given the significant improvement demonstrated in knowledge, interaction and participation for volunteers and people with aphasia.

Additional comments

Clear well written study.

Appraised By: Kerrie Strong
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