



Best Practice Recommendations for Aphasia Preamble

Aphasia is an acquired communication disability resulting from damage to the language areas of the brain, most often due to stroke, although other etiologies such as brain trauma or tumor can also cause aphasia. Aphasia is characterized by impairments in language modalities including speaking, understanding, reading and writing. Because of the pervasive importance of communication in daily life, aphasia typically has a negative impact on social relationships, participation and wellbeing. People with aphasia have preserved pre-onset intelligence, but intelligence can be masked by difficulty communicating. It should never be assumed that a person with aphasia is mentally incompetent. People with aphasia are typically able to make decisions and participate in activities if information or activities are made communicatively accessible.

People with aphasia have the right to be treated with dignity and respect and to participate in the same level of health care as nonaphasic individuals (including obtaining information and participating in personally relevant decision making). People with aphasia and their family members have the right to relevant services designed for the individual to enhance communication and participation in life activities of choice. Health care services for people with aphasia should be person-centered and collaborative.

Following are “best practice recommendations” for health care or community services involving people with aphasia. These have been compiled from a variety of sources around the world. Sources are cited along with the level of recommendations/evidence cited in the source. Sources have not been directly quoted; rather, themes across cited sources have been worded to be representative. For more details on the levels of evidence please refer to the original source documents. It should be noted that most recommendations draw from general stroke guidelines, rather than other etiologies or aphasia specific guidelines.

Aphasia United
Best Practice Recommendations for Aphasia

1. **All patients with brain damage or progressive brain disease should be screened for communication deficits.**^{1,2,3,5,7,8,9} (Level C)
2. **People with suspected communication deficits should be assessed by a qualified professional (determined by country); Assessment should extend beyond the use of screening measures to determine the nature, severity and personal consequences of the suspected communication deficit.**^{1,2,3,4,5,6,8,9} (Level B,C).
3. **People with aphasia should receive information regarding aphasia, etiologies of aphasia (e.g. stroke) and options for treatment.**^{1,5,6,7,8,9} (Level A- C) **This applies throughout all stages of health care from acute to chronic stages.**
4. **No one with aphasia should be discharged from services without some means of communicating his or her needs and wishes (e.g. using AAC, supports, trained partners) or a documented plan for how and when this will be achieved. (Level: Good Practice Point)**
5. **People with aphasia should be offered intensive and individualized aphasia therapy designed to have a meaningful impact on communication and life.**^{1,2,3,4,5,6,7,8,9} (Level A-GPP depending on approach, intensity, timing). **This intervention should be designed and delivered under the supervision of a qualified professional.**
 - a. **Intervention might consist of impairment-oriented therapy, compensatory training, conversation therapy, functional/participation oriented therapy, environmental intervention and/or training in communication supports or augmentative and alternative communication (AAC).**
 - b. **Modes of delivery might include individual therapy, group therapy, telerehabilitation and/or computer assisted treatment.**
 - c. **Individuals with aphasia due to stable (e.g. stroke) as well as progressive forms of brain damage benefit from intervention.**
 - d. **Individuals with aphasia due to stroke and other static forms of brain damage can benefit from intervention in both acute and chronic recovery phases.**
6. **Communication partner training should be provided to improve communication of the person with aphasia.**^{1,2,3,5,8} (Level A,B)

7. **Families or caregivers of people with aphasia should be included in the rehabilitation process.** ^{1,2,3,4,5,7,8,9} (Level A-C)
 - **Families and caregivers should receive education and support regarding the causes and consequences of aphasia.** (Level A)
 - **Families and caregivers should learn to communicate with the person with aphasia.** (Level B)
8. **Services for people with aphasia should be culturally appropriate and personally relevant.** ^{1,2,5,8} (Level: Good Practice Point)
9. **All health and social care providers working with people with aphasia across the continuum of care (i.e., acute care to end-of-life) should be educated about aphasia and trained to support communication in aphasia.** ^{2,3} (Level C)
10. **Information intended for use by people with aphasia should be available in aphasia-friendly / communicatively accessible formats.** ^{1,3,5,7,8} (Level C)

Levels of Recommendation / Evidence

- Level A: Body of research evidence can be trusted to guide practice
 Level B: Body of research evidence can be trusted to guide practice in most situations
 Level C: Body of research evidence provides some support for recommendation
 Level D: Body of research evidence is weak
 Good Practice Point: Recommendation is based on expert opinion or consensus

Primary Sources for Aphasia United Best Practice Recommendations for Aphasia

1. National Health and Medical Research Council Clinical Centre for Research Excellence in Aphasia Rehabilitation (CCRE) (2014). Australian Aphasia Rehabilitation Pathway. <http://www.aphasiapathway.com.au/>
2. Intercollegiate Stroke Working Party. *National clinical guideline for stroke*, 4th edition. London: Royal College of Physicians, 2012.
3. Lindsay MP, Gubitz G, Bayley M, Hill MD, Davies-Schinkel C, Singh S, and Phillips S. Canadian Best Practice Recommendations for Stroke Care (Update 2012). On behalf of the Canadian Stroke Strategy Best Practices and Standards Writing Group. Ottawa, Ontario Canada: Canadian Stroke Network
4. Miller, E., Murray, L., Richards, L., Zorowitz, R., Bakas, T., Clark, P. Billinger, S. (2010). Comprehensive Overview of Nursing and Interdisciplinary Rehabilitation Care of the Stroke Patient: A Scientific Statement from the American Heart Association. *Stroke*. 2010;41:2402-2448. Downloaded from <http://stroke.ahajournals.org/>
5. National Stroke Foundation Australia (2010) Clinical guidelines for stroke prevention and management. Melbourne Australia. http://strokefoundation.com.au/site/media/clinical_guidelines_stroke_management_2010_interactive.pdf
6. Royal College of Speech & Language Therapists (2005).RCSLT Clinical Guidelines

7. Scottish Intercollegiate Guidelines Network (2010) Management of patients with stroke: Rehabilitation, prevention and management of complications, and discharge planning A national clinical guideline. Edinburgh, Scotland. <http://www.sign.ac.uk/pdf/sign118.pdf>
8. Stroke Foundation of New Zealand and New Zealand Guidelines Group. Clinical Guidelines for Stroke Management 2010. Wellington: Stroke Foundation of New Zealand; 2010. <http://www.stroke.org.nz/resources/NZClinicalGuidelinesStrokeManagement2010ActiveContents.pdf>
9. US Veteran's Administration / Department of Defense (2010). Management of Stroke: VA/DoD Clinical Practice Guideline. <http://www.healthquality.va.gov/guidelines/Rehab/stroke/online/>