Parallel Sessions

Friday 16th December
12:00 – 13:00

Please note: Each parallel session – and discussions within each parallel session – will run concurrently for one hour.
Round table discussion A1:
Measuring outcomes of communication partner training of health care professionals: How do we evaluate outcomes with feasible, valid and reliable methods?

Location:
Isaksen, Jytte¹ and Jensen, Lise Randrup²
¹Dept. of Language and Communication, University of Southern Denmark, Odense, Denmark
²Dept. of Nordic Studies and Linguistics, University of Copenhagen, Copenhagen, Denmark

Background: People with aphasia have greater risks of experiencing adverse events or medical errors in health care settings [1, 2]. Furthermore, people with aphasia often depend crucially on health care professionals’ ability to support their participation in information sharing, decisions about health care, and other communicative exchanges associated with appropriate health care [3]. As a consequence of these challenges in patient-provider communication, implementation of evidence-based methods of communication partner training is becoming increasingly frequent in different health care settings with frequent contact to people with aphasia [4, 5]. In Denmark, for example, the method of Supported Conversation of Adults with Aphasia (SCATM) is in the process of being implemented in more than five hospitals [6, 7]. This raises the question of how the outcomes of training and implementation are best measured in research and in clinical practice in a valid, reliable and feasible manner.

Rationale: Research studies have used a variety of outcome measures, including blind ratings of videotaped interactions or self-rating questionnaires for staff [8]. Video rating does not seem feasible with large groups of trainees, e.g. all staff from a ward. Self-rating questionnaires, however, present another set of issues when used as outcome measures, including the need to examine their content validity, reliability and sensitivity to change [9]. This work appears to be lacking for most of the available questionnaires. However, it is important in order to lay the groundwork for future studies, which compare the efficacy and outcome of different methods of implementing conversation partner training in clinical practice.

Aims:
The overall purpose of this round table is to:
1. provide an overview of outcome measures used in research studies of communication partner training in health care settings [4, 7];
2. present results from three different questionnaires used with health professionals in Denmark before and after communication partner training in order to compare their sensitivity to change; and
3. discuss and brainstorm, how we may design outcome measures for use in both research and clinical practice?

Questions to be addressed:
1. How are researchers and clinicians currently assessing the outcomes of communication partner training in professional contexts such as hospitals?
2. How does this match the intended outcomes of communication partner training in health care settings?
3. What are our requirements to outcomes measures after communication partner training in professional contexts, regarding feasibility, validity, reliability and sensitivity? Do clinicians and researchers have different needs?

Implications for clinical practice: There is a need to develop different types of outcome measures for communication partner training in the health care context, including questionnaires for health care staff, which address generally agreed-upon problem areas in patient-provider communication and are reliable as measurements as well as sensitive to change after training.
Round table discussion A2:  
**What are the key components of successful Community Aphasia Groups?**

**Location:**

Attard, Michelle¹, Lanyon, Lucette¹, Togher, Leanne², Worrall, Linda³ & Rose, Miranda¹  
¹La Trobe University, Melbourne, Australia  
²The University of Sydney, Sydney, Australia  
³The University of Queensland, Brisbane, Australia

**Background:** People living with chronic aphasia report an ongoing need for psychological and social support, information, and opportunities for participation including communication. Community aphasia groups are places where meaningful activity and social relationships are possible and where self-identity can be positively renegotiated. Therefore, it is argued that these groups offer one tangible method to prevent negative psycho-social outcomes, increase life participation for people with aphasia, and reduce health costs to society. Empirical quantitative evidence suggests that community aphasia groups are efficacious for improving various aspects of communication and psychological functioning. Recent qualitative findings of consumers’ experiences of community aphasia groups provide insight into positive impacts of attendance on psychological wellbeing. Some participants also reported negative experiences and withdrew from groups.

**Rationale:** While numerous community aphasia group models exist around the world, empirical research on their efficacy is limited and there is a dearth of research investigating the specific mechanisms and processes inherent to their relative success.

**Aims:**

1. To promote exploration of programming and process components of community aphasia groups and the potential interactions between the components, in order to consider what contributes to successful community aphasia groups.  
2. To consider the drivers underpinning decisions concerning group programming and processes in participants' local service provision contexts.

**Questions to be addressed:** Using the headings who, what, when, where, why, and how as a framework, we plan to address the following questions:

1. What are the components of community aphasia groups? Consider a group you have been part of to help you come up with these (e.g., facilitators, activities of focus, member presentation, location, time, dosage, etc.)
2. What are some different applications of a single component? (e.g., facilitators: speech-language pathologist, person with aphasia, both, etc.).
3. What are the pros and cons to such applications?
4. What feedback have group members (e.g., members with aphasia, family/friends) provided about groups you/others have been a part of?
5. Along with consumers, what other stakeholder feedback exists? (e.g., what feedback do you have about community aphasia groups? What feedback have other staff provided about groups?)

These questions should stimulate discussion to address the key focus of the session:

1. How might these group components interact? Could particular combinations of specific components lead to more successful groups than others? (e.g., facilitation: speech-language pathologist, consumer type: members with aphasia only, number: 10 or less members, etc.)

**Implications for clinical practice:** Clinicians will be challenged to consider a) how they conceptualise community aphasia groups, and b) the potential interactions between components of community aphasia groups for optimal group member outcomes. These considerations will allow clinicians to reflect on their current community aphasia group processes and may impact the way clinicians adapt and develop community aphasia groups in the future.
The inception of Aphasia Bank almost ten years ago has radically altered the empirical foundation of work on aphasia by providing a large number of transcripts based on use of a standard protocol. Currently Aphasia Bank contains transcribed protocol data from 293 English-speaking PWAs and 193 English-speaking controls. In addition, we have 124 repeat administrations with PWAs and 9 with controls. Aphasia Bank also contains data from Cantonese, French, German, Italian and Spanish speakers, using protocols translated into each of those languages.

Each of these transcripts is linked to its audio-video media. Each transcript has been analysed for morphosyntactic features, and coded for error type. Researchers can test their own theories, methods, and analyses against this large publicly shared database of transcripts linked to video. There are now 170 papers based on the use of the database, with many more in preparation. All 619 discourse samples are fully transcribed in CHAT (MacWhinney, 2000) with careful attention to detailed features of aphasic language, such as errors, pauses, neologisms, and retraces. Transcripts are linked directly to their video at the utterance level to facilitate immediate playback of each utterance for closer analysis. After initial transcriptions, each transcript is double-checked by an experienced transcriber with advanced SLP training. All transcripts are automatically supplemented by a complete morphological analysis of each word for part-of-speech, affixal morphology, and lexical features. Gestures and non-verbal acts are coded at a general level. Because all transcripts are freely available, individual projects are encouraged to further modify or elaborate transcripts for their own analytic purposes. If they note anything incorrect or missing in the transcripts, they can report this and the originals will be modified.

This presentation will describe the database, research and educational applications currently resulting from Aphasia Bank. We will stress those features with strongest clinical relevance. These will include 1) the EVAL program which provides researchers and clinicians with a highly automated method for comparing individual persons with aphasia to specific subgroups of the Aphasia Bank database, to non-aphasic controls, and as a method to measure pre-post treatment change; 2) educational resources concerning videotaped examples of various aphasia presentations and paraphasic errors, and 3) a number of recent clinically-relevant publications.

Information will be made available on how to join Aphasia Bank, a project made available through the auspices of the National Institutes of Health Grant R01-DC008525for 2007-1017.
Round table discussion A4:

What role for Speech and Language Therapists in addressing psychosocial well-being in aphasia? Results from an on-line survey and focus groups

Location:
Sarah Northcott¹, Alan Simpson², Becky Moss¹, Nafiso Ahmed² & Katerina Hilari¹
¹Centre for Language and Communication Science, School of Health Sciences, City University London
²Centre for Mental Health Research, School of Health Sciences, City University London and East London NHS Foundation Trust

Background and Aims: Following stroke and aphasia people are at increased risk of becoming depressed and isolated. We explored UK speech and language therapists’ (SLTs’) experiences of addressing the psychosocial needs of people with aphasia, including their experiences of working with mental health professionals.

Method: A 22-item on-line survey distributed to UK SLTs, via British Aphasiology Society; focus groups with SLT stroke teams. On-line survey analysed using descriptive statistics; focus groups analysed using Framework Analysis.

Results: We conducted six focus groups with 23 SLTs in both acute and community settings; a further 124 SLTs took part in the on-line survey. Survey results found that UK SLTs considered that addressing social participation (99%) and psychological well-being (93%) was part of their role. While 73% felt confident addressing the social needs of their clients, only 42% felt confident in addressing psychological needs. Highest ranked barriers to addressing psychosocial well-being were time/caseload pressures (72%) and feeling under-skilled/lack of training (64%). Highest ranked barriers to referring on to mental health professionals (MHPs) were that MHPs were perceived as under-skilled working with people with aphasia (44%) and were difficult to access (41%). Focus group findings echoed these survey results. Most SLTs felt their role included addressing emotional well-being. However, SLTs often found it challenging: it was sometimes hard to document ‘outcomes’; some felt guilty or conflicted if they spent session time addressing emotional distress rather than focusing on other SLT goals; and it could be emotionally difficult for the SLT particularly if they felt under-skilled. Time and caseload pressures were also factors. SLTs were better able to support the psychological well-being of clients when they felt well-supported by their SLT and MDT peers, where the whole team had a strong holistic ethos, and where SLTs received training and on-going support in psychosocial approaches. Stroke-specialist clinical psychologists were most valued when they worked closely with SLTs; acquired skills in aphasia; and offered more than just assessment. Where SLTs felt supported by a psychologist or specialist SLT they were less likely to avoid addressing client distress, as they perceived they had ‘back up’ if they started to feel out of their depth.

Discussion: The vast majority of SLTs consider the psychosocial well-being of their clients. It is, however, of concern that many SLTs feel they lack confidence and receive insufficient training and support in addressing psychological well-being.

Implications for clinical practice: Strong leadership that prioritises holistic goals is likely to encourage SLTs to feel it is permissible to spend time addressing emotional distress. Having structures in place that promote collaborative working and peer support, as well as enabling SLTs to access specialist training, is also likely to increase SLT confidence.

Conclusions. People with aphasia are at risk of receiving inadequate psychological support, as SLTs often lack the necessary time, training and support, and MHPs often lack skills in working with people with aphasia. More collaborative working between SLTs and MHPs is likely to increase skill sets which may improve the psychological services available to people with aphasia.
Round table discussion A5:

Successful intervention techniques to facilitate the implementation of evidence based practice within aphasia rehabilitation

Location:

Trebilcock, Megan¹, Shrubsole, Kirstine¹ & Worrall, Linda¹
¹School of Health and Rehabilitation Sciences, University of Queensland, Brisbane, Australia

Background: Knowledge translation and practice change have been identified as complex processes within the field of aphasia rehabilitation. The factors influencing the implementation of evidence based practice are both diverse and multifaceted. Speech pathology best practice guidelines provide recommended levels of service for obtaining optimal outcomes for individuals with aphasia. Unfortunately these guidelines have been proven insufficient in ensuring a change in clinical practice. It is essential for the implementation challenges to be identified in order for relevant intervention strategies to be developed in an attempt to overcome these barriers. To ensure implementation intervention techniques are effective within routine clinical practice, it is vital for speech pathologists to be involved within the process of intervention development.

Rationale: Current literature has identified barriers and facilitators to implementing evidence based practice within aphasia rehabilitation. Although there is clearly an evidence-practice gap, it is necessary to explore both the enabling and hindering factors in order to facilitate the development of successful intervention strategies. Through obtaining speech pathologists’ perspectives and experiences of implementing evidence based practice further steps can therefore be taken to ensure the development of effective intervention techniques tailored to both the individual clinician and therapy service.

Aims: To identify speech pathologists’ experiences and perceptions of intervention techniques in facilitating the implementation of evidence based practice within aphasia rehabilitation.

Questions to be addressed:

1. What are the barriers and facilitators experienced by speech pathologists to implementing evidence based practice within aphasia rehabilitation?  
2. What implementation interventions have previously been adopted by speech pathologists to facilitate the implementation of evidence based practice in aphasia rehabilitation?  
3. Were these interventions successful or unsuccessful in facilitating the implementation of evidence based practice and what were the reasons for this outcome?

Implications for clinical practice: The discussion will provide clinician and context specific experiences of implementing evidence based practice within aphasia rehabilitation. The information obtained in relation to successful and unsuccessful intervention techniques will assist the identification of further strategies for supporting speech pathologists’ implementation of clinical guidelines. The content discussed will also provide guidance for the structure and development of future aphasia professional development and associated change in clinical practice.
Background: Improving Research Outcome Measurement in Aphasia (ROMA) is a program of research which aims to increase standardisation in research outcome measurement through the development and implementation of a core outcome set (COS) (an agreed, minimum set of outcomes and outcome measures). A COS was developed in three stages: (1) a trilogy of consensus studies examining stakeholder perspectives on outcomes of importance; (2) a systematic review of the measurement properties of aphasia assessments; and (3) an international consensus conference. This project now moves to an implementation phase.

Rationale: The effective implementation of a COS hinges on stakeholder awareness and uptake (Schmitt et al., 2015). Including key stakeholders (i.e. aphasia clinicians and researchers) in the discussion of barriers and facilitators to COS use will form an essential component in development and actualisation of the COS implementation plan.

Aims:
1. To briefly report the result of a recent international consensus conference that gained final consensus on outcome domains and outcome measures for a COS for aphasia treatment research.
2. To discuss barriers and facilitators to the implementation of a COS in aphasia treatment research.
3. To further develop the COS implementation plan.

Questions to be addressed:
1. What are potential barriers and facilitators to the implementation of a COS for aphasia treatment research?
2. How can barriers be overcome?
3. How can facilitators be used to maximise the uptake of the COS?
4. What are essential components of an implementation plan?

Implications for clinical practice: Inconsistent outcome measurement practices across treatment trials have negatively impacted the quality and strength of evidence for aphasia interventions. COSs are increasingly being used to maximise the quality, relevancy, transparency, and efficiency of health treatment research. The implementation of a COS for aphasia research may improve the quality of research evidence for aphasia treatments and assist clinicians to compare findings across various aphasia treatment studies.
Round table discussion A7:

Towards an asset-based approach to living with aphasia: exploring the relevance and implications for people with aphasia and families

Location:

Horton, Simon¹, Pearl, Gill², Soskolne, Varda³, Olenik, Dafna⁴, Haaland-Johansen, Line⁵, Isaksen, Jytte⁶, Jagoe, Caroline⁷ & Shiggins, Ciara¹  
¹School of Health Sciences, University of East Anglia, Norwich, UK  
²Speakeasy, Bury, UK  
³School of Social Work, Bar-Ilan University, Ramat Gan, Israel  
⁴Adler Centre, Jerusalem, Israel  
⁵Statped, Oslo, Norway  
⁶Department of Language and Communication, University of Southern Denmark  
⁷School of Linguistic, Speech and Communication Science, Trinity College Dublin
**Background:** The undeniable improvements in acute stroke care over recent years have not been matched by more effective post-hospital support for stroke survivors generally or for those living with aphasia. In addition, the long-term consequences of stroke have not yet been addressed adequately: patients commonly experience social exclusion and feelings of isolation in the months after hospital discharge. Social isolation is associated with a wide variety of long-term emotional responses – for example, depression and anxiety have been reported up to five years after onset. There is also evidence that this influence on physical and mental health is significant for family caregivers of people with aphasia. Researchers have begun to turn their attention to understanding factors which promote more positive outcomes and which are associated with the concept of ‘living successfully with aphasia’. Over a number of years alternatives to a deficit model, which has tended to dominate the stroke and aphasia literature, have influenced both therapy and research. One theoretical approach that may be helpful in understanding the positive factors associated with living well or successfully with aphasia is salutogenesis – people’s resources and capacity to create health as opposed to the usual focus on risks, ill-health and disease. Salutogenesis provides the theoretical underpinning for the asset-based community development (ABCD) approach that has become a recent and widespread focus of interest among community and health service agencies and providers. Assets can be anything from the practical skills, capacity and knowledge of local people, their passions and interests that give them energy for change, or the networks and connections in a community, including friendships and neighbourliness.

**Rationale:** Asset-based or asset-focused approaches have the potential to provide coherent strategies for people with aphasia and their families to live well and successfully with aphasia. Asset-focused approaches have the potential to be developed through a fundamental transformation of the patient-caregiver relationship into a collaborative partnership in order to promote health and well-being for people with aphasia and their families.

**Aims:** In this round table discussion we will present an overview of asset-based (ABCD) theory and approaches, together with brief summaries of exploratory studies undertaken in the UK, Norway, Israel, Ireland and Denmark, to illustrate how asset-focused approaches may work in practice.

**Questions to be addressed:**
1. What is the relevance and potential of an asset-focused approach for people with aphasia and their families as a means for promoting living well and successfully with aphasia?
2. How could an asset-focused approach complement other (e.g. clinical / therapy) approaches?
3. How could this approach be developed and implemented in a collaborative partnership?
4. Timing – when is the optimum time to introduce this approach?

**Implications for clinical practice:** The findings of our exploratory studies showed feasibility of the asset-focused approach and preliminary relevance for people with aphasia and their families. Service providers (health, 3rd sector etc.) may undertake initiatives to explore the potential of this approach with people with aphasia and their families in clinical or other settings, and with colleagues in services.
Round table discussion A8:


Location:

Hickin, Julie¹ and Dipper, Lucy²
¹School of Allied and Public Health, Australian Catholic University, Melbourne, Australia.
²Division of Language and Communication Science, City University London, UK.

Background: Assessment of and therapy for mild aphasia has received little attention in the research literature. This is presumably because it is not regarded as a priority for treatment, despite evidence indicating that mild language impairment may nevertheless have a severe impact on activity, participation and well being (e.g. Cruice, Worrall, & Flickson, 2006). There is also uncertainty about the deficits which underlie mild aphasia – cognitive, linguistic or both - and how these need to be taken into account in assessment and treatment.

Rationale: Since the turn of the millennium there have been a small number of papers published which begin to cast light on the deficits underlying mild aphasia and effective ways to treat it. These mostly constitute papers investigating the impact of cognitive deficits (e.g. Murray, Holland, & Beeson, 1998). However there are pioneering papers investigating the impact of mild aphasia on real life conversation (e.g. Armstrong, Fox & Wilkinson, 2013) and rare therapy studies which indicate that mild aphasia can be successfully treated (e.g. Hickin, Mehta, & Dipper, 2015).

Aims: This Round Table Discussion would bring together interested parties to i) review the contribution of recent papers to our understanding of mild aphasia and ii) produce recommendations on a) current best practice for assessment and treatment of people with mild aphasia and b) suggestions for productive avenues for future research.

Questions to be addressed:

1. What constitutes current best practice for assessment and treatment of people with mild aphasia?
2. How can we develop reliable and sensitive tests of the:
   a. linguistic impairments underlying mild aphasia? (e.g. sensitive tests of mild anomia; language production tasks which would stimulate the use of complex language).
   b. cognitive impairments which may underlie aphasia and of how these interact with linguistic impairments? (e.g. the impact of deficits of selective attention on language comprehension and production).
   c. functional impact of mild aphasia (e.g. on conversation) and its impact on activity, participation and well-being (e.g. self-efficacy, confidence in communication skills).
3. What are the most likely productive avenues for future research?

Implications for clinical practice: People with mild aphasia are acknowledged to likely be underdiagnosed and underserved. The development of sensitive and reliable assessments, and effective treatments, will help to address this disparity.
Round table discussion A9:

“We see so many people whose mood is so low we don’t quite know what to do.”: Is stepped care a solution to the current psychological management of people with aphasia?

Location:

Ryan, Brooke¹, Baker, Caroline¹, Worrall, Linda¹, Rose, Miranda² & Carragher, Marcella²

¹School of Health and Rehabilitation Sciences, The University of Queensland, Brisbane, Australia. ²School of Allied Health, La Trobe University, Melbourne, Australia

Background: For many reasons, the role of the speech pathologist in the management of post-stroke depression is considered a grey area. On one hand, speech pathologists’ with expertise in providing communication support and a comprehensive understanding of the impact of aphasia across patients’ lives may be in the best position to facilitate treatment. On the other hand, a lack of formal psychological training, and evidence based treatment options available to people with aphasia may mean speech pathologists’ feel limited in terms of scope of practice. However, within general mental health literature there is growing evidence for the implementation of a multidisciplinary “stepped care” model for prevention and treatment of depression which may offer a potential solution. Stepped care principles are starting to be implemented in countries such as the USA, UK and Australia across various mental health services. Stepped psychological care includes four levels of treatment that are matched to an individual’s level of need. Level one care may be provided to all people with stroke with input from all multidisciplinary stroke team members regardless of whether a clinical diagnosis of a mood disorder exists. However, there is currently little evidence for how stepped care may be implemented in stroke and aphasia rehabilitation, if it will improve access to services for people with aphasia, and the role speech pathologists should take in such a care model.

Rationale: Early detection and treatment of post stroke depression is important. In a study of 58 people with aphasia residing in Australia, 43% had depression at the end of the first year post stroke. Access to psychological care for people with aphasia after stroke, however is limited. New service delivery models need to be identified so that the psychological outcomes of people with aphasia and their families are improved.

Aims: To begin a dialogue about:
1. the role of speech pathologists in the psychological management of aphasia in the context of stepped care
2. how we can improve access to services within a stepped care model for people with aphasia and their families
3. a research agenda for this field.

Questions to be addressed:
1. Will stepped psychological care work for people with aphasia?
2. What is the speech pathologists role in stepped psychological care?
3. What is the best way to implement stepped psychological care for people with aphasia?
4. What evidence is required to support stepped psychological care for people with aphasia?
**Implications for clinical practice:** Speech pathologists are important drivers in the psychological care of people with aphasia and therefore have an important role to ensure the implementation of stepped care is successful within their multidisciplinary teams.
Workshop A10:

Using technology in aphasia therapy to facilitate reading and writing

Location:

Monnelly, Katie¹, Caute, Anna¹, Galliers, Julia², Wilson, Stephanie², Woolf, Celia¹, Cruice, Madeline¹ & Marshall, Jane¹

¹School of Health Sciences, City University London
²School of Mathematics, Computer Science and Engineering, City University London

Topic: Mainstream technologies may facilitate reading and writing in aphasia by circumventing the acquired dyslexia and dysgraphia through features such as text-to-speech, voice recognition and text prediction. For some people with aphasia (PWA), such technologies can enable them to return to reading and writing activities and increase their participation in social activities (e.g. Caute & Woolf, 2015). However, the features of these technologies which bring about this change and their accessibility to PWA have not yet been greatly explored.

Aims:

1. To present a series of comparative case studies, illustrating how four mainstream reading and writing technologies (Kindle Fire, Dragon voice recognition software, Write Online and Claro Read) have been used in the CommuniCATE aphasia therapy research project. The presentation will focus on clinical observations of the technologies’ accessibility for PWA, supplemented by results from a Human Computer Interaction (HCI) evaluation method, Aphasia Walkthrough Evaluation (AWE: Galliers & Wilson, in preparation).

2. To give attendees an opportunity to try using the assistive features of the technologies.

Expected learning outcomes:

1. Attendees will learn about how a number of individuals with aphasia have used and experienced the technologies.

2. Attendees will learn about novel HCI accessibility guidelines for people with aphasia (Galliers & Wilson, in preparation).

3. Attendees will gain hands-on experience of using mainstream reading and writing technologies.

Activities:

1. Presentation covering:
   a. Introduction to CommuniCATE project
   b. Case studies illustrating how research participants used key assistive features of the technologies
   c. Summary of an HCI method for evaluating the accessibility of technologies for people with aphasia.
2. Workshop stations- attendees will use technology to perform a communicative task (e.g. reading a newspaper article, writing an email) and consider the accessibility of the technology.

3. Discussion about opportunities and challenges of using assistive technologies to facilitate reading and writing in research and clinical settings.

Links to clinical practice: This workshop will be useful to clinicians and researchers who are interested in using technology to facilitate reading and writing, as they will gain experience of using specific technologies and learn about how these technologies have been incorporated into personalised therapy programmes. It will also be useful to clinicians who are interested in using technology more generally, as they will learn about key factors to consider when evaluating the accessibility of technology for people with aphasia. Clinicians and researchers will have an opportunity to discuss their experiences of using technology.
Workshop A11:

Conversation training in aphasia rehabilitation: The challenges of measuring outcomes

Location:

Beeke, Suzanne¹, Sirman, Nicola¹, Beckley, Firle¹, Edwards, Susan², Heilemann, Claudia¹, Johnson, Fiona³, Maxim, Jane¹, & Best, Wendy¹

¹Department of Language and Cognition, University College London, London, UK
²Psychology and Clinical Language Sciences, University of Reading, UK
³Homerton University Hospital NHS Foundation Trust, London, UK

Background: The inability to use language effectively to converse, and thus to maintain personal relationships and interact with the environment, has a major impact on people with aphasia and can lead to social isolation, depression and a reduced quality of life. Over recent years, conversation training programmes have proliferated in aphasia rehabilitation. Simmons-Mackie (2008) defines the approach as ‘direct, planned therapy that is designed to enhance conversational skill and confidence’. It is a complex intervention; it targets inter-dependent language behaviours of two people in a social context. There are multiple potential outcomes (conversation skill, participation, wellbeing) and it requires a high degree of tailoring to specific needs. Simmons-Mackie et al (2014) note a marked variation in reported outcome measures, and highlight a need for valid measures of natural conversation. Sirman (2013) in a first view of how conversation therapy is articulated in practice, found that speech and language therapists (SLTs) acknowledged the benefit of conversation therapy but felt they lacked the tools and skills needed to deliver it, with a key challenge centring on demonstrating effectiveness. Online resources such as Better Conversations with Aphasia (Beeke et al 2013) provide some guidance on outcome measures but it is unclear how much impact this is having on practice, and whether it fulfils the current needs of SLTs in this area.

Rationale: A focus on outcome measurement in the area of conversation training is warranted because SLTs want to use conversation therapy and desire clear outcome measures to demonstrate its effectiveness. There is an available (and growing) evidence base, and yet SLTs report that they don’t routinely access this, highlighting the ongoing difficulty of translating research into clinical practice.

Aims: The aims are to:

1. present a brief overview of the evidence base on outcome measures routinely used to monitor conversation training, and evaluate the benefits and challenges associated with them;
2. facilitate a group discussion of clinical practice around outcome measurement for conversation training.

Questions to be addressed:

1. How do SLTs decide on what types of outcomes should be measured after conversation training?
2. Do particular policies or guidelines influence the outcomes SLTs choose to measure as part of conversation training?
3. What tools are SLTs using to capture outcomes for people with aphasia and their communication partners after conversation training?
4. What are SLTs’ reflections on the utility of these tools?
5. What do SLTs want from their ideal outcome measure for change in conversation skills?

**Implications for clinical practice:** SLTs report that they wish to deliver conversation training but encounter a number of major challenges, one of which is how best to measure efficacy. Further collaboration between clinicians and researchers to uncover what is needed in practice, and what works on the ground, may help to overcome the challenges and establish conversation training as a routine intervention.