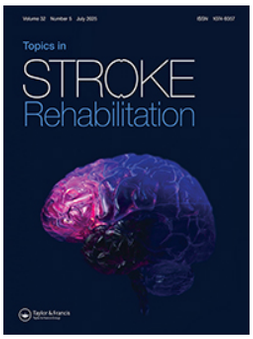

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Communication partner training (CPT) in Australian post-stroke aphasia services: a national survey investigating implementation barriers, facilitators and training needs

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ABSTRACT

Background: Communication Partner Training (CPT) is an intervention where multidisciplinary healthcare staff are trained to use supportive strategies to communicate with people with communication disabilities such as aphasia. CPT is an evidence-based recommendation in high-quality international stroke guidelines, but there are large evidence-practice gaps that need to be addressed.

Objectives: This study explored a) current CPT practice, b) barriers and facilitators influencing CPT implementation, and c) preferences on ideal CPT.

Methods: Australian stroke clinicians (speech pathologists: SLPs; the multidisciplinary team: MDT) working with people with aphasia across acute, rehabilitation and community settings completed an online cross-sectional survey based on the Theoretical Domains Framework. Data were analyzed using descriptive statistics, frequency distributions, total barriers scores and qualitative content analysis.

Results: Final analyses included 206 surveys (105 SLPs 105; 101 MDT). Both groups (SLP 98%; MDT 71%) agreed CPT is beneficial to patients with aphasia. However, less than 20% of MDT respondents reported receiving CPT. While 87% of SLPs reported providing CPT, only 36% reported alignment with best practice. Key barriers included insufficient systems-level support, training opportunities and staff availability, and the MDT lacked knowledge and confidence in using communication strategies. Training preferences included flexible delivery, interactive approaches, and protected time.

Conclusions: Current Australian CPT practice does not align with best practice guidelines and the stroke MDT have unmet training needs. Despite SLPs valuing interactive training with demonstration and practice, time constraints often reduce CPT to basic education. A targeted implementation strategy addressing key barriers is needed to sustainably improve healthcare experience and communication outcomes.

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Implementation; aphasia; evidence-based practice; communication partner training; stroke

Introduction

Aphasia is an acquired language impairment that affects up to 38% of stroke survivors.[1] In healthcare settings, aphasia can disrupt communication between individuals and care providers, negatively impacting care and rehabilitation.[2] For example, healthcare staff have been found to avoid and limit conversations with people with aphasia, due to negative staff experiences of communication breakdowns and not knowing how to help.[2,3] For stroke survivors with aphasia, these communication challenges can subsequently result in difficulties communicating their healthcare needs[4] and pose significant risks including inpatient complications and increased length of stay.[5]

Communication Partner Training (CPT) provides a potential solution to these challenges. CPT is an intervention where communication partners, such as family, friends and healthcare staff, are trained to use supportive communication strategies during interactions with people with communication difficulties as a result of stroke,[6] traumatic brain injury[7] and dementia.[8] In stroke, CPT has been shown to be

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effective in improving communication partner skill and enhancing participation of people with aphasia.[6] CPT typically includes education about communication and supportive strategies, in addition to skill-building techniques through videos and role-play,[9] though it has been noted that few published programs are sufficiently described.[10] Provision of CPT to healthcare staff is recommended in high-quality stroke guidelines internationally,[11] including those from Canada,[12] Australia,[13] the United Kingdom,[14] and the United States.[15] These recommendations contain similar wording (see[11]), with the Australian guidelines stating: "*CPT should be provided to health professionals or volunteers who interact with people with aphasia.*"[13]

However, despite the guideline recommendations, CPT is not consistently provided to healthcare staff. Australian audit data reveals that healthcare CPT is provided in only 35% of acute and 49% of rehabilitation stroke services,[16] with similar gaps identified in the UK,[17] Europe[18] and North America.[19] There is a recognized need to close this evidence-practice gap, with healthcare CPT identified as a national priority for improved practice from the perspectives of healthcare professionals, researchers, and people with lived experience.[20]

To improve CPT in stroke settings, a theoretically informed implementation strategy tailored to the healthcare environment is needed. The development of implementation strategies tailored to the healthcare context is thought to be crucial for successful implementation of clinical best practice.[21] The first step in developing a strategy to enhance CPT implementation is to explore the current context and identify implementation barriers and facilitators.[22,23] While previous studies have explored speech-language pathologists' (SLPs') perspectives on delivering CPT to the multidisciplinary team (MDT) (e.g.,[24,25]) there is currently limited understanding of what the MDT perceive to be barriers and facilitators to CPT. In addition, the extent to which identified barriers align or differ between professional groups (i.e. SLPs and the MDT) is currently unknown, and there is limited knowledge of how CPT should be delivered to meet MDT needs. Therefore, this study aimed to a) explore current practice in providing CPT to the MDT working with people with post-stroke aphasia, b) determine preferences on CPT content and how it should be provided, and c) identify factors (i.e. barriers and facilitators) influencing CPT implementation from the perspectives of both SLPs and the MDT.

Methods

Design

A cross-sectional online mixed-methods survey was conducted using Qualtrics survey software (Provo, UT, Qualtrics, 2024) and reported in line with the Consensus-Based Checklist for Reporting of Survey Studies (CROSS)[26] and the Strengthening the Reporting of Observational studies in Epidemiology (STROBE) checklist for cross-sectional studies.[27]

Participants

Two participant groups were invited: (i) SLPs, and (ii) MDT members (e.g. nursing, medical, allied health professionals). Eligible participants were (1) healthcare professionals in Australia who had worked in acute, rehabilitation or community settings within the last 12 months, and (2) had experience working with at least one stroke survivor with aphasia.

Survey design

Two survey versions (supplementary file 1) were developed. Version 1 (42–52 items depending on item response pathways) was adapted from a previous SLP-focused survey,[24] and concentrated on providing CPT (e.g. "*I know how to provide CPT*"). Version 2 (56–57 items) was further modified for the MDT population and emphasized receiving CPT and using skills in practice (e.g. "*I know what strategies can support communication with people with aphasia*"). Both versions were based on a validated and reliable questionnaire[28] that aligned with Theoretical Domains Framework (TDF), a framework used to identify implementation determinants and develop behavior-change strategies.[29] The TDF is based on a synthesis of behavior-change theories and includes 14 theoretical domains (i.e.

Knowledge, Skills, Social/Professional Role and Identity, Beliefs about Capabilities, Optimism, Beliefs about Consequences, Reinforcement, Intentions, Goals, Memory, Attention and Decision Processes, Environmental Context and Resources, Social Influences, Emotion, Behavioural Regulation). The survey included multiple-choice, free-text questions, and a series of 5-point Likert scale items purposefully based on the TDF, with 1–3 items developed for each TDF domain (e.g. the statement "*I know how to provide CPT*" related to the Knowledge domain). The item order of the TDF statements was randomized to avoid an order effect. Pilot testing was conducted with four professionals (nursing, physiotherapy, speech pathology, occupational therapy) who completed the online survey and provided written feedback that was integrated by the research team; this resulted in item reduction and improved clarity of wording. The final surveys took approximately 15 minutes to complete.

Ethical considerations

Ethical approval was granted by The University of Queensland (approval number: 2024/HE000004). Participation was voluntary, responses were anonymous, and informed consent was obtained prior to survey commencement. Participants received a $20 e-voucher for their time, with contact details collected separately to preserve anonymity.

Data collection procedures

An expression of interest (EOI) to complete the survey was distributed via e-mail through professional networks and at a national stroke conference. To minimize fraudulent and bot responses, participants were asked to provide their institutional e-mail address and workplace postcode. After eligibility was verified, respondents received a unique survey link to the appropriate survey version. Non-respondents were sent up to two reminders. Data collection occurred between August and December 2024.

Data analysis

Data were screened for duplicates and incomplete responses. Descriptive statistics (means, medians, ranges) and frequency distributions were used for multiple-choice and Likert scale responses. For TDF-related statements, negatively worded items (e.g. "*I can forget to provide CPT amongst my other work tasks*") were reverse-scored so that all items were scored consistently (as per,[28] whereby scores were converted in the following way: 5 = 1; 2 = 4, 3 = 3, 2 = 4, 1 = 5). Then, domain scores were calculated by totaling the mean score per statement and dividing this by the number of statements within each domain (as per[30,31]). Responses were grouped as "Less than agreement" (ratings of 1–3) or "Agreement" (ratings of 4–5). Total barrier scores were calculated for each respondent as per Dyson et al.[32] Kruskal-Wallis and Mann-Whitney-U tests ($p \leq 0.05$) were used in SPSS[33] to analyze group differences between total barrier scores according to demographic factors (e.g. discipline, years of experience, setting) as normality was violated. SLP/MDT barrier scores were not directly compared as survey questions were worded differently. Open-ended responses were analyzed using qualitative content analysis,[34] where responses were read for overall understanding, then meaning units were identified, coded, and grouped into subcategories and categories. Open-ended responses relating to barriers/facilitators were then deductively mapped to the TDF.[29] Two members of the research team completed initial coding, with 30% of coding reviewed by a third author (KS) to ensure reliability.

Results

Participant sample

Of 250 EOIs completed, 243 (n = 124 SLPs; n = 119 MDT) were eligible and received survey access, and 218 (89.7%) commenced the survey. Twelve responses contained demographic data only and were excluded. Two SLP respondents completed the majority of items so their data were included. Data from 206 respondents (n = 105 SLPs; n = 101 MDT members; 84.8% survey completion rate) were analyzed; demographic information is provided in Table 1. Both SLP and MDT groups were

Table 1. Participant demographics.

	SLPs ($n = 105$)		MDT ($n = 101$)	
Variables	*N*	%	*N*	%
Profession				
Speech Pathologist	105	100%	n.a.	
Nurse	n.a.		27	27%
Dietitian	n.a.		12	12%
Social Worker	n.a.		6	6%
Physiotherapist	n.a.		22	22%
Occupational therapist	n.a.		19	19%
Pharmacy	n.a.		1	1%
Rehabilitation physician	n.a.		6	6%
Allied health assistant	n.a.		7	7%
Psychologist	n.a.		1	1%
Sex				
Man	5	5%	15	15%
Woman	99	94%	84	84%
Gender fluid	0	0%	1	1%
Non-binary	1	1%	0	0%
Prefer not to say	0	0%	1	1%
Age (years)				
20–30 years	39	37%	35	35%
31–40 years	43	41%	36	36%
41–50 years	18	17%	15	15%
51–60 years	5	5%	14	14%
61+ years	0	0%	1	1%
Years of experience working in stroke				
5 years or less	37	35%	43	43%
6–10 years	37	35%	27	27%
11–15 years	15	14%	13	13%
16–20 years	9	9%	9	9%
More than 20 years	7	7%	9	9%
Proportion of stroke caseload				
5% or less	4	4%	7	7%
6–10%	8	8%	16	16%
11–30%	14	13%	21	21%
31–50%	26	25%	23	23%
51–75%	28	27%	18	18%
More than 75%	25	24%	16	16%
Location				
New South Wales	50	48%	26	26%
Northern Territory	2	2%	0	0%
Queensland	28	27%	61	60%
South Australia	3	3%	10	10%
Tasmania	3	3%	1	1%
Victoria	11	10%	2	2%
Western Australia	8	8%	1	1%
Remoteness (ASGS 2021)				
Major Cities of Australia	73	70%	76	75%
Inner Regional Australia	23	22%	21	21%
Outer Regional	9	9%	4	4%
Remote Australia	0	0%	0	0%
Very remote Australia	0	0%	0	0%
Healthcare sector				
Public health	84	80%	86	85%
Private health	12	11%	2	2%
Both public and private health	8	8%	12	12%
Non-government organization	1	1%	1	1%
Clinical setting (predominantly work in or that participant chose to base answers on)				
Acute hospital setting	43	41%	44	44%
Inpatient rehabilitation setting	35	33%	41	41%
Outpatient hospital setting or community setting	27	26%	16	16%

Key: ASGS = Australian Statistical Geography Standard, MDT = Multi-disciplinary team, n.a. = Not applicable, SLP = Speech-language pathologist.

predominantly women and had similar age distributions, with the majority in the 20–40 age range. More than one third of respondents had 5 years or less experience working in stroke, with similar proportions having 6–10 and over 10 years of experience. Most were from the Australian states of New South Wales and Queensland. Respondents worked primarily in major cities in the public

healthcare sector. Most identified their main clinical setting as being an acute hospital, followed by inpatient rehabilitation and outpatient/community setting.

Current CPT practice and alignment with reported training needs and preferences

Table 2 summarizes current SLP practice and MDT preferences for CPT provision, and additional qualitative analysis is provided in supplementary file 2.

Current SLP practice:

Most (87%) SLPs provided CPT to healthcare professionals, primarily allied health (88%) and nursing staff (86%). Non-providers (13%) cited resource and organizational/process constraints and perceived MDT disinterest. Only 36% of SLPs indicated their CPT practice aligned with best practice.

MDT training needs:

Most (80%) MDT respondents reported they had not received CPT, with 52% reporting unmet training needs including lack of formal opportunities ($n = 27$) and access to CPT ($n = 13$) – see supplementary table 2.2 for further detail.

CPT provision, including content and structure:

All SLPs identified as primary CPT providers with minimal support from others. All MDT agreed SLPs should provide CPT but suggested people with aphasia (43%) and nursing staff (31%) could also provide CPT. Priority topics included general communication strategies (SLPs: 93%, MDT: 100%), information about aphasia (SLPs: 90%, MDT: 93%), and individualized strategies (SLPs: 86%, MDT: 89%). MDT wanted more content on aphasia consequences (78%) and services (75%) than SLPs provided. Less than 10% of SLPs used published CPT programs, including: Supported Conversation for Adults with Aphasia,[35] Better Conversations with Aphasia,[36] TBI Express,[37] TBI Connect,[38] and InteractABIlity.[39]

SLPs mainly used lecture-style teaching (73%) and group discussions (58%), with other methods such as video examples (46%), practice with a person with aphasia (26%) and role-play (16%) used less frequently. Most MDT respondents preferred teaching to include videos (93%) and practice with people with aphasia (73%) over other methods. SLPs predominantly delivered in-person CPT (97%), matching MDT preference (91%). Online formats were rarely used by SLPs but desired by MDT (64%). Most SLPs (91%) provided single CPT sessions lasting under 30 minutes (66%), while MDT preferred multiple sessions (58%) of longer duration (73%). The majority of SLPs (70%) provided CPT on an ad-hoc basis, i.e. "when requested."

Barriers and facilitators to CPT (TDF agreement)

Figures 1 and 2 show domain agreement ranked in order of agreement (item-level data in supplementary file 3). Domains with ≥ 66.6% agreement were considered facilitators. For SLPs, 8/16 domains were barriers and eight were facilitators. For the MDT group, almost all domains were barriers, with only one facilitator identified. Below are the top five barriers/facilitators with illustrative quotes from open-ended responses (content analysis shown in supplementary files 4 and 5).

Key Barriers:

"Behavioural regulation" (i.e. anything aimed at managing or changing objectively observed or measured actions) was the main SLP barrier and second-greatest MDT barrier, showing a lack of CPT systems and policies (SLP: 84%; MDT: 95%). Both groups identified "skills" as a key barrier; 92% of the MDT reported limited training access and a lack of skills in using communication strategies.

Additional key SLP barriers included "reinforcement" (61% did not receive encouragement) and "social influences" (60% perceived MDT were often unwilling to attend). This perceived lack of MDT engagement was the second-most mentioned barrier ($n = 28$) in SLP free-text responses, for example, "*there is limited buy in from other staff.*" The "environmental context and resources" domain ranked 5th lowest for SLPs but was the most frequently reported barrier in free-text responses, characterized by time constraints ($n = 57$), staff unavailability ($n = 15$), lack of resources ($n = 14$), unsupportive organizational culture ($n = 12$), and competing demands ($n = 11$). Time limitations

Table 2. Current CPT practice (frequencies, $n = 105$ speech pathologists, $n = 101$ multi-disciplinary health professionals, unless otherwise specified).

	SLPs ($n = 105$)		MDT ($n = 101$)	
Question	*N*	%	*N*	%
1. *I would say my CPT is consistent with best practice.*				
Agree – Strongly agree	38	36.19%	n.a.	
Neutral – Strongly disagree	65	61.90%	n.a.	
No response (did not complete survey)	2	1.90%	n.a.	
2. *Do you provide/have you received CPT?*				
	Provide		*Receive*	
Yes	91	86.67%	20	19.80%
No	14	13.33%	81	80.20%
	SLPs ($n = 91$)		**MDT ($n = 101$)**	
	N	**%**	***N***	**%**
3. *Who do you provide CPT to (select all that apply)?*				
Nursing staff	77	85.56%	n.a.	
Allied health	79	87.78%	n.a.	
Doctors	31	34.44%	n.a.	
Food service staff	16	17.78%	n.a.	
Patient services/clinical assistants	12	13.33%	n.a.	
Volunteers	7	7.78%	n.a.	
Personal carers/support workers	7	7.78%	n.a.	
Administrative staff	6	6.67%	n.a.	
4. *Who does provide/do you think should provide CPT (select all that apply)?*				
	Provide		*Should provide*	
Speech pathologist	91	100.00%	101	100.00%
Person with aphasia	2	2.20%	43	42.57%
Nursing staff	0	0.00%	31	30.69%
Allied health assistant	5	5.49%	1	1.00%
Other trained healthcare staff	1	1.10%	8	7.92%
Family members of people with aphasia	1	1.10%	4	3.96%
5. *What topics do you include/should be included in CPT (select all that apply)?*				
	Included		*Should be included*	
General communication strategies	84	93.33%	101	100.00%
Information about aphasia	81	90.00%	94	93.07%
Individualised tailored communication strategies for a specific patient	77	85.56%	90	89.11%
Consequences of aphasia	55	61.11%	79	78.22%
Information about stroke	41	45.56%	46	45.54%
Information about useful services	24	26.67%	76	75.25%
6. *What teaching strategies do you use/should be used (select all that apply)?*				
Role plays	14	15.56%	49	48.51%
Practice with patients with aphasia	23	25.56%	74	73.27%
Didactic (lecture-style) teaching	66	73.33%	51	50.50%
Videos of communication examples	41	45.56%	94	93.07%
Group discussions	52	57.78%	69	68.32%
Other (e.g. written information)	11	11.22%	1	0.99%
7. *CPT is provided/should be provided in the following delivery methods (select all that apply):*				
In person/Face-to-face	87	96.67%	92	91.09%
Written format	35	38.89%	10	9.90%
Online meeting (e.g. Zoom/Teams)	18	20.00%	45	44.55%
Online modules	6	6.67%	65	64.36%
8. *CPT does/should include at least how many sessions?*				
1 session	82	91.11%	26	25.74%
2 sessions	7	7.78%	59	58.42%
3 or more sessions	1	1.11%	24	23.76%
9. *What is/should be the average length of each CPT session?*				
Less than 30 minutes	59	65.56%	21	20.79%
About 30–60 minutes	28	31.11%	74	73.27%
About 2 hours	3	3.33%	12	11.88%
10. *I provide CPT to healthcare workers:*				
Once a year	6	6.67%	n.a.	
Twice a year	4	4.44%	n.a.	
When requested	63	70.00%	n.a.	
Other (e.g. when clinically indicated)	17	18.89%	n.a.	

Key: CPT = Communication Partner Training, MDT = Multi-disciplinary team, n.a. = Not applicable, SLP = Speech-language pathologist. *Note: questions 3–10 were presented to the 91 SLPs who reported providing CPT.*

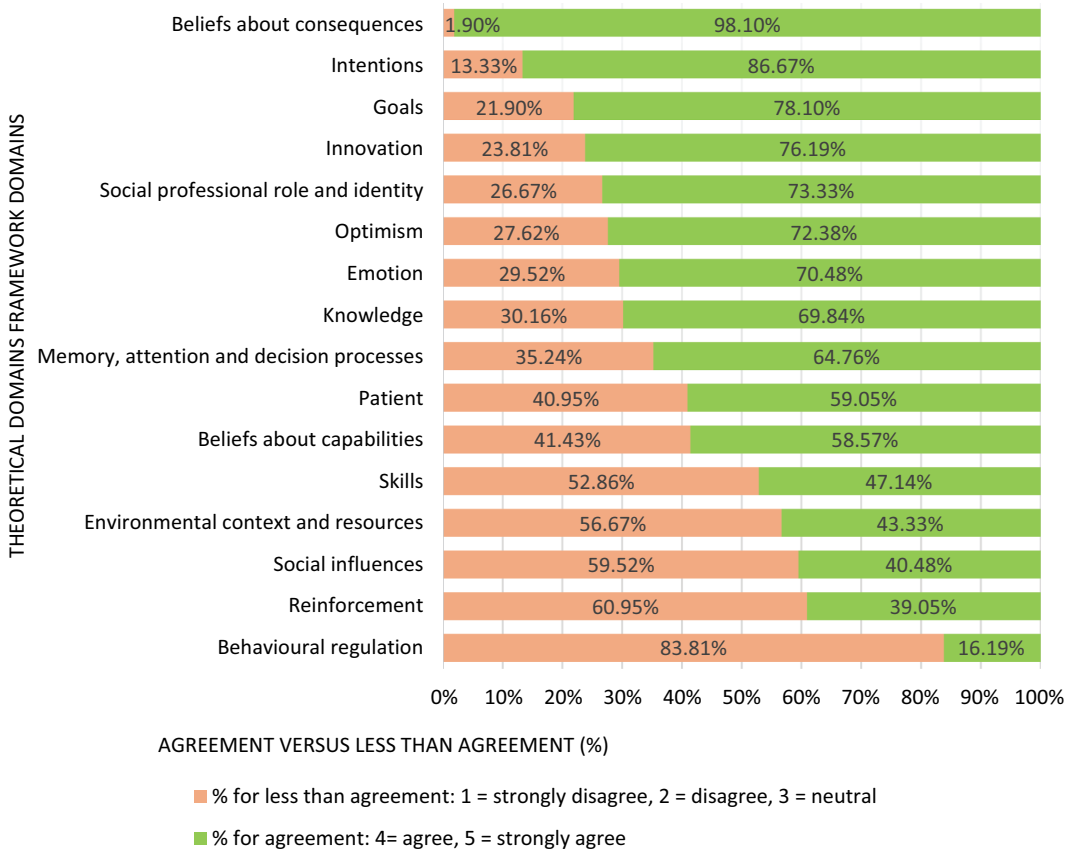

Figure 1. SLP agreement ratings for theoretical domains framework statements.

affected training quality: "*we are encouraged to keep (training) very short. . . exact examples or scenarios are beneficial . . . (but) if we are running out of time, they get missed.*"

MDT barriers included "beliefs about capabilities" (95% lacked confidence in strategy use), "knowledge" (92% lacked strategy knowledge), and "optimism" (91% lacked optimism about solving CPT issues). Though "environmental context and resources" ranked 10th lowest, it dominated free-text responses, with frequently reported MDT barriers including competing demands ($n = 32$), time constraints ($n = 26$), scheduling challenges ($n = 8$), staffing shortages ($n = 7$), and organizational processes ($n = 7$).

Key Facilitators:

"Beliefs about consequences" was the main facilitator for both groups (SLP: 84%; MDT: 95%), with high agreement that CPT improves healthcare professionals' ability to support communication of people with aphasia and leads to communication success. One MDT respondent explained, "*it can help me communicate with and support my patients.*"

Other key SLP facilitators included "intentions" (87% planned to provide CPT), "goals" (78% prioritized improving CPT), "innovation" (76% viewed CPT as compatible with usual practice), and "social/professional role and identity" (73% viewed CPT as part of their role). Sixteen SLP comments highlighted that CPT should be relevant to current caseloads (e.g. "*staff are much more engaged in training when it relates to a current patient and they can see the tangible impact of the training on their care of the patient*"), and needed to incorporate interactive elements such as modeling, demonstration and examples of success.

Group differences:

Total barrier scores (see Table 3) were significantly different between SLPs who did/did not provide CPT, and MDT who had/had not received CPT ($p = 0.018$); those who did not provide/receive CPT reported more barriers. For the MDT, there

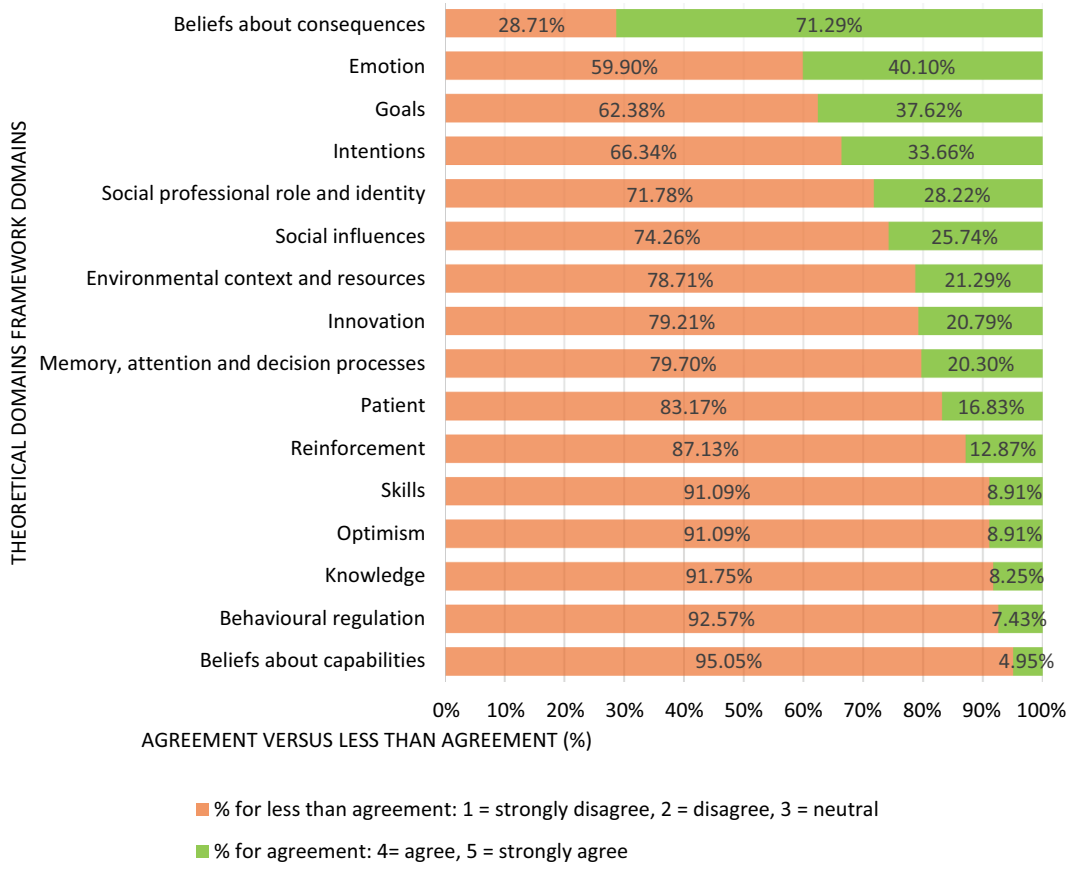

Figure 2. MDT agreement ratings for theoretical domains framework statements.

Table 3. Group differences in total barrier score per group and demographic factors.

		Demographic factor; Kruskal – Wallis test p-value					
Group	Total barrier score (SD; Range)	*Healthcare profession (Nursing/Allied health/ Other)*	*Years experience (5 or less, 6–10, 10+)*	*Remoteness (Metropolitan/ Rural)*	*Setting (Acute/Inpatient rehab/ Outpatient)*	*Sector (Public/ Private)*	*CPT provision/ Receipt (Yes/ No)*
SLP	99.13 (11.1; 70–129)	n.a.	0.839	0.096	0.545	0.577	**0.018***
MDT	81.78 (10.6; 59–114)	**0.029***	**0.029***	0.568	0.751	0.26	**0.018***

Key: CPT = Communication Partner Training, MDT = Multi-disciplinary team, n.a. = Not applicable, SD = Standard deviation, SLP = Speech-language pathologist, * = significant difference.

were significant differences according to healthcare profession ($p = 0.029$) and years of experience ($p = 0.029$). Pairwise comparisons revealed: nursing staff had significantly lower total barrier scores than allied health professionals ($p = 0.018$) and "other" staff including doctors ($p = 0.032$); and MDT respondents with 5 years or less of clinical experience had higher barrier scores than those with over 10 years of experience ($p = 0.010$). Total barrier scores did not significantly differ for the SLP group for other demographic factors (i.e. experience, remoteness, setting, sector).

Perspectives on "ideal" CPT and sustaining CPT

Respondents' perspectives on the ideal way to provide CPT are summarized in Table 4. The most frequently mentioned recommendations to sustain CPT (presented in supplementary table 5) included online modules/e-learning ($n = 31$), annual refreshers ($n = 32$), regular in-services ($n = 23$), supportive communication materials/resources ($n = 20$), integrating CPT into mandatory training requirements ($n = 17$), and champions/train-the-trainer models ($n = 14$). This was reflected in one MDT response, "*when I leave a CPT session I feel confident, unfortunately as time*

Table 4. Perspectives on ideal CPT provision per group.

Category (count)	Subcategory	Frequency count		Description
		MDT (n = 86)	*SLP (n = 101)*	
Delivery Format and Location *(n = 135)*	Face-to-face/in-person	26	32	Both groups favored in-person training, with smaller numbers recommending inclusion of online and blended learning opportunities. Both groups commented that CPT should occur in groups/teams, with MDT respondents highlighting the need for training to occur in the workplace.
	Online/Digital Learning	16	6	
	Blended Learning	7	9	
	Group/team-based training	8	14	
	Workplace training	17	n.a.	
Interactive learning approaches *(n = 90)*	General interactive methods	5	n.a.	Interactive learning approaches and practice-based learning were valued by both groups, with emphasis that CPT should ideally have direct input from people with aphasia. SLPs frequently mentioned the importance of including specific teaching approaches such as demonstration, role-play, and providing feedback.
	Role-play/Interactive Practice	n.a.	16	
	Modelling or Video Demonstration	n.a.	26	
	Practice opportunities with feedback	5	9	
	Discussion/Reflection	n.a.	8	
	Direct input from person with aphasia in CPT	6	15	
Content/ Structure of sessions *(n = 78)*	Structured sequential learning	7	8	Both groups indicated that practical strategies should be included, with SLPs emphasizing the importance of relating content to specific case examples. A small number indicated training should be structured over multiple sessions to "consolidate learning."
	Inclusion of Practical Strategies	9	22	
	Case-specific content	2	30	
Organisational/ Process supports *(n = 59)*	Brief/Targeted Sessions within existing processes	5	7	Both acknowledged the need for organizational processes to support the MDT to attend training, such as having protected time, regular training schedules, and integrating training into existing processes (e.g. mandatory training).
	Regular/Routine Refreshers	2	10	
	Protected Time/ Scheduling considerations	11	8	
	Integration with mandatory training processes	6	6	
	Management Support	4	n.a.	
Mechanisms for follow-up support *(n = 16)*	Access to Resources	3	5	Both groups mentioned the value of accessible post-training resources, and a number of SLPs emphasized ways to provide ongoing workplace support to trainees.

Key: CPT = Communication Partner Training, MDT = Multi-disciplinary team, n.a. = Not applicable, SLP = Speech-language pathologist.

goes by, I start to forget skills . . . I would be prepared to attend undergo a 30-minute refresher module each year to keep my skills up to date."

Discussion

This survey explored current CPT practice in Australian stroke services, preferences for CPT provision, and perceived implementation barriers and facilitators, with a view to inform future implementation efforts. A clear majority of SLPs (87%) reported they provide CPT to healthcare professionals who work with people with aphasia, and most respondents (98% SLPs; 71% MDT) believed CPT would improve patient-staff communication. However, although both groups recognized the value of CPT, and SLPs strive to provide CPT to healthcare staff, current practice does not reflect routine prioritization of CPT.

An evidence-practice gap

A large evidence-practice gap was identified. Only about one third (36.2%) of SLPs agreed their CPT was consistent with best practice, and very few used active practice opportunities such as role-play. In addition, few reported providing CPT to some professional groups who regularly interact with patients, such as doctors and clinical assistants. Results showed that current CPT is mostly delivered in a single training session of less than 30 minutes, whereas total treatment duration in published literature is significantly longer, ranging from 75 minutes[40] to 2 days.[19] Similar practice patterns were identified by Chang et al,[24] where single short CPT sessions were provided "as requested," and few SLPs (approximately 10%) used published CPT programs. Findings from the present survey indicate that more SLPs identified

gaps in their CPT practice (64%) compared to a previous survey (54%, see[24]), demonstrating that SLPs face ongoing challenges in providing CPT.

The evidence-practice gap was reflected in the large proportion (80%) of stroke MDT respondents who had not received CPT. Moreover, current practice did not align with identified MDT training needs and preferences. Most MDT professionals (73%) preferred multiple, longer training sessions with interactive elements and practice opportunities. This finding is in line with previous CPT research indicating that effective training requires both theoretical knowledge and practical experience,[41] supplemented with ongoing support to improve staff communication skills.[42] In addition, MDT respondents valued online and blended CPT opportunities, yet these were rarely used (7%). Blended[43] and online[44] CPT packages are effective and could be more systematically used in stroke settings.

Barriers and enablers to best-practice CPT, and future implications

Consistent with previous research,[2,42] MDT respondents' individual-level barriers included a lack of sufficient knowledge, skills, and confidence communicating with people with aphasia. Similarly, SLPs identified that they lacked skills and self-efficacy for CPT implementation, in line with previous barriers.[24] The primary facilitator for both groups was a positive belief in CPT benefits. Nearly all SLPs (98%) believed CPT would improve patient-staff communication, representing a substantial increase from Chang et al.'s earlier survey,[24] where only one-quarter of SLPs recognized this benefit. This improved expectation of benefit may be leveraged to facilitate future implementation.

Many barriers (e.g. behavioral regulation, reinforcement, social influences, and the environmental context and resources) were identified at the level of the healthcare system/organization. This finding reinforces evidence from hospital-based stroke-team CPT implementation studies that leadership, culture, and work environment influence CPT implementation.[17–19] There is a need to develop systems and processes to promote adherence to CPT best practice and align with national safety and quality standards,[45] that could be led by governing bodies/organizations. For example, routine audit and feedback on CPT practice could be conducted, as this is an effective implementation strategy in stroke care[46,47] shown to enhance alignment with guidelines and improve patient outcomes.[46,48] Furthermore, identified training needs, such as regular, flexible, relevant and interactive training opportunities, alongside engaged and motivated healthcare staff as recipients, underscore the importance of SLPs working collaboratively with the MDT to deliver CPT. Future development of implementation strategies should include collaborative approaches underpinned by an integrated Knowledge Translation approach,[49] driven by engagement across disciplines and management levels, which may facilitate stakeholder buy-in[50] and increase implementation success.[51]

Sustainable CPT approaches are also needed. Sustaining CPT programs within healthcare settings is challenging, particularly when there is high staff turnover,[52] and when training is reliant on a single discipline or individual SLP.[42] Our study provides additional evidence that current CPT approaches do not meet the needs of the stroke MDT in the Australian context, necessitating reconceptualization of delivery methods. Potential solutions include non-SLP delivery through train-the-trainer models and/or designated CPT "champions" who facilitate implementation within the clinical environment,[53–55] a strategy linked to improved care processes and outcomes in conditions such as delirium.[56] Emerging evidence supports the feasibility of nursing-led train-the-trainer CPT models in other contexts,[57] warranting further exploration of such approaches. Future CPT will likely require a combination of online learning approaches with authentic practice opportunities and integrated workplace support from skilled individuals to ensure sustainable practice change.

Limitations

Self-selection bias is a potential limitation,[58] as respondents may have had a more positive attitude toward CPT than nonparticipating clinicians. There was less representation from clinicians working in rural locations and the private sector, however, this is typical of the Australian healthcare workforce.[59] The use of the validated TDF[29] to characterize

barriers and facilitators was a strength, as this framework enables tailoring to implementation strategies.[23] As survey responses are based on clinicians' self-report, it is recommended that future studies seek to triangulate reported practice with observational methods such as audits or patient interactions. Future research should also explore why allied health professionals and staff with ≤5 years' experience reported more barriers than nursing staff and those with > 10 years' experience, respectively.

Conclusion

A large and pervasive evidence-practice gap exists for CPT in Australian stroke services. Despite recognizing the value of CPT, clinicians reported a range of implementation barriers at the organizational and individual level and highlighted unmet MDT training needs. Results suggest the need for a sustainable implementation strategy that addresses barriers across all stakeholder groups. To improve alignment with best practice and enhance both clinician and patient experience, a multidisciplinary approach to CPT is recommended, to ensure training meets MDT requirements and clinicians receive support to apply skills in practical settings.

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Data availability statement

The data that support the findings of this study are available within the supplementary material.

Disclosure statement

The authors report there are no competing interests to declare.

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