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LETTERS

SPEECH THERAPY AFTER STROKE

Authors' reply to Enderby, Meteyard, and Thornton

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It is encouraging to see the Royal College of Speech and Language Therapists supporting randomised controlled trials (RCTs).[1 2] Meteyard worries that RCTs will not cope with the complexity inherent after stroke.[3] However, many RCTs have demonstrated the effectiveness of a range of complex interventions for heterogeneous populations (for example, stroke unit care, occupational therapy).

As Enderby notes, the Cochrane review finds benefit of therapy compared with nothing. However, like us it also finds no benefit over attention control.[4] So "some is better than none,"[5] but we must be open minded about what is done and by whom. Despite Meteyard's concerns we can rule out those activities provided only to the intervention group (such as one to one impairment based therapy). In the first four months of stroke they added nothing to the outcome for participants from any measured perspective.[1]

Meteyard is wrong to say that treatment was unconstrained and that we examined variation in current practice. Each site altered its previous practice by adopting manualised assessment and treatment pathways, tools, and techniques as agreed by consensus. As Enderby recommends, our therapists targeted therapy to those most likely to benefit and selected appropriately tailored interventions.

We are grateful to Enderby for quoting our cautionary warnings about misinterpreting the findings, especially given Thornton's reaction.[6] Our nested qualitative study showed people with stroke valued increased early support (regardless of whether therapy or control).[7] Interaction with a good communicator may be as beneficial as formal therapy. We recommend evaluating reorganised early services that retain therapists to supervise increased time with less qualified staff, with therapists directly involved for persisting problems.

In response to Thornton,[6] the funding supported a series of studies with more than 700 participants, including studies on developing patient centred outcome measures that have had good international uptake.[8 9]

Competing interests: See original article www.bmj.com/content/345/bmj.e4407.

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3 Meteyard L. Trial shows only that practice varies. *BMJ* 2012;345:e6022.
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