Letters to the Editor

Commission’s report, based in part on our findings and in part on parallel local inquiries, is an example of how this problem can be solved. Like our report, it makes no claims to truth other than its congruity with the reader’s experience. That experience can be powerful. What is the ‘poignant quote’ other than a statement about an identity undermined by practitioner clumsiness? What is discharge ‘for rehabilitation’ when it is experienced as discharge to free a bed?

Third, qualitative research is difficult to describe in the confines of a traditional medical paper, but its contents may well be of interest to a medical audience. The inevitable result is a truncation of both methods and findings, but this can be remedied by reading the papers on methodology [1], commissioning services [2], dementia [3], social work [4], adult protection [5] and rural communities [6]. Our findings on ethnicity and the cultural sensitivity of services, experiences of hospital care, and of general practice, older people as research colleagues, and nursing roles, are in the pipeline. Lastly, we note that the NSFOP was wider than a health service policy, including, as it did, the activities of local councils, both linked with local NHS services but also touching on other areas of life. This explains the broad focus of the study, and participants frequently alluded to this need to view older people in the context of wider civic society and not as pawns in health policy.

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Individual and community fall prevention strategies

SIR—The article by Campbell and Robertson [1] makes a very important contribution to the translation of the growing falls prevention evidence base to sensible policy decisions. The suggestion that single interventions are as effective as multifactorial interventions is intriguing and does indeed warrant close examination.

Campbell and Robertson posit that interactions between interventions may actually reduce their effectiveness when combined, and cite their falls prevention trial in visually impaired older people, in which interactions were observed, as evidence in support of this explanation. However, in our multifactorial falls prevention trial among relatively healthy community dwelling older people, we found no evidence of negative interactions among the interventions [2]. One of the three tested interventions (exercise) reduced falls when delivered on its own, and there was a trend towards increased effectiveness when exercise was combined with either home hazard modifications or vision correction interventions. All three delivered together had the largest effect.

Campbell and Robertson also suggested that multiple interventions may decrease compliance. We found only slightly lower exercise attendance rates in those in the exercise-only group compared with those in the all intervention group (Table 1, chi-square 2.397, $P = 0.30$).

It could be that the occurrence of interactions between falls interventions, and the acceptance of multiple interventions, may depend on the types of interventions and the specific population of older people. Therefore, the comparison of single and multiple interventions for preventing falls does not appear to be straightforward and further research is required to determine optimal intervention strategies for both general and frailer populations of older people.

**Table 1. Exercise class attendance**

<table>
<thead>
<tr>
<th>Class attendance</th>
<th>Exercise management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exercise</strong></td>
<td><strong>Exercise plus vision</strong></td>
</tr>
<tr>
<td><strong>Exercise plus home hazard</strong></td>
<td></td>
</tr>
<tr>
<td>Attended 0–7 classes</td>
<td>15</td>
</tr>
<tr>
<td>Attended 8–15 classes</td>
<td>89</td>
</tr>
<tr>
<td>Missing data</td>
<td>31</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>135</strong></td>
</tr>
</tbody>
</table>
In our two interventions, home-based exercise and home safety, significant negative interaction (P = 0.016) between the two interventions, home-based exercise and home safety. In our Age & Ageing paper [1], in which we describe the lack of difference in the number of falls prevented by single interventions compared with multifactorial interventions, we have offered some possible explanations for this, such as confusion with advice from different health professionals. This may have been more likely to occur in the VIP trial where both the exercise programme and the home safety programme were delivered at home [2]. In the study by Day et al. [3] there was a group exercise programme away from home and home hazard management at home. In this study most participants rated their health as ‘good to excellent’ whereas participants in the VIP trial were older and had severe visual impairment.

Although single interventions may be more cost effective and reach the greatest numbers in population-based fall prevention strategies, clinicians seeing individual patients will advise intervention in a number of areas. We suggest that with individual patients the interventions are introduced only as rapidly as acceptance and adherence allow.

The study of Day et al. [3] was not included in our meta-analysis because they used ‘time to first fall’ rather than the total number of falls as the primary outcome measure in fall prevention trials. Analysis of efficacy using the total number of falls uses information on all fall events, increases the power of the study and has clinical relevance [4].

The loss of power using ‘fallers’ as the outcome measure can be seen by comparing the significant results of our meta-analysis of multifactorial interventions in the community setting [1] with one published concurrently using number of ‘fallers’ as the outcome measure and showing no significant benefit [5]. Such meta-analyses showing no benefit due to lack of statistical power do not help the promotion of falls prevention. This is disappointing when there is clear evidence of significant benefit when comprehensive, clinically important outcome measures are used.


Letters to the Editor

Delirium in older people: an epiphenomenon of incipient death or a separate biological process?

SIR—The paper by Adams et al., published in Age and Ageing [1], shows that Mini Mental State Examination (MMSE) scores, albumin serum levels and biomarkers of inflammation, but not delirium, are associated with 6-month mortality of medical inpatients. We would discuss this topic with our data, referring to 1,811 patients (≥65 years) discharged from a Rehabilitation and Aged Care Unit (RACU) between May 2003 and April 2006, and followed up...