UNIVERSITY OF KENT AT CANTERBURY
CENTRE FOR RESEARCH IN SOCIAL SCIENCES

HEALTH SERVICES RESEARCH UNIT

THE CANTERBURY SURVEY OF HANDICAPPED PEOPLE

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C O N T E N T S

INTRODUCTION

The Canterbury Survey of Handicapped People was initiated by the City Council and as described in Section 1 of this report was organised through a Steering Committee by an Honorary Organiser. Members of the staff of the Health Services Research Unit were pleased to be able to help with the survey and take part in a project which aimed to combine the giving of service with research activity and to involve many people and many organisations within the local community.

This report describes in sections 1 and 2 the organisation of the survey and the response to it from the people of Canterbury. The subsequent sections present the findings of the survey and discuss some of their implications. The report does not describe the activities relating to the central purpose of the survey - the help given to handicapped people. This is described in separate reports written by Miss A.D. Kelly, O.B.E., Social Work Adviser to the City and Miss K. Wells, Deputy Director of Social Services to Kent County Council and the City Council.

Although this report is the responsibility of the author, it is obviously based on the work of very many people. The author wishes to thank them all very sincerely; special reference must be made to Mrs. E. Mary Rothermel, the Honorary Organiser of the Survey, Mrs. Joan L. Warren, the Honorary Assistant Organiser, Miss K. Wells, Deputy Director of Social Services, Mrs. Mary Keith-Lucas and Councillor Mrs. H.M.E. Barber, successive chairmen of the Social Services Committee for considerable help and permission to publish the data from the survey, and to Mrs. Agnes Corfield for all the computing. In addition to those already mentioned, John Bevan, John Butler, Robin Dowie and Robert Lee of the Health Services Research Unit have commented on drafts of this report and made many helpful suggestions. Finally, special thanks are due to Mrs. Shirley Woodward who typed all the drafts and the final report.

THE CANTERBURY SURVEY

SUMMARY

1. The Council of the City and County of Canterbury decided in February 1972 to sponsor a survey of every household in the City in order to:-

   (a) Identify each physically and sensorily handicapped person living at home who might be in need of some form of social service.

   (b) produce estimates of the needs for the relevant services in the City, and

   (c) collect data which could be used for the partial evaluation of services.

2. The survey was carried out during 1972 under the direction of an Honorary Organiser guided by a Steering Committee, consisting of the Chairman and a member of the City's Social Services Committee, the Honorary Organiser and Honorary Assistant Organiser, the Deputy Director of Social Services for Kent County Council and the City Council, the City Treasurer, an Administrative Assistant, and the Honorary Adviser to the survey. About 300 people contributed to the work and the local Hospital Management Committee loaned two rooms as a headquarters. Kent County Council, many voluntary organisations, and the Health Services Research Unit at the University of Kent at Canterbury, cooperated throughout with the City Council.

3. The survey followed the recommendations contained in a memorandum which accompanied a government circular sent out in September 1971, and used the recommended forms and questionnaires (with only slight modifications).

4. The survey was conducted in three stages:-

   1. Delivery and collection by volunteers of a one page form to every household. A further copy of the same form was sent by post to every householder who had not responded to the approach by the volunteers.

   2. Short (or screening) interviews with all persons stating they had some impairment or difficulty in movement on the forms returned during stage 1.

   3. Longer (assessment) interviews with all persons found during the shorter interviews to be appreciably incapacitated and/or having certain defined impairments.

5. As a result of the house-to-house approach and of the postal follow-up, analysable forms were received from 92 per cent of the City's households.

6. There were 1,446 forms completed which indicated the presence of at least one impaired person in the household, and in some households more than 1. In all 1,625 people were indicated as impaired; of these 1,534 persons had a screening interview. The remainder either refused to cooperate or had moved away, been admitted to hospital or other institution, or had died.

7. The overall prevalence rate of impaired persons was found to be 5 per cent of the population. This figure is of the same order as that found in similar surveys in other parts of the country.

8. The commonest causes of impairment were arthritis and rheumatism (26 per cent), strokes (7 per cent), heart disease (7 per cent) and mental handicap (7 per cent - although the Survey was concentrating on physical handicaps).

9. Not all impaired people are handicapped by their impairment. The handicapped are those impaired people who experience disadvantage or restriction of activity as a result of their impairment. The screening interview identified 770 handicapped people (2.5 per cent of the population).

10. Two-thirds of the 770 handicapped people were women; 72 per cent were aged 65 years or more; 60 per cent were single, widowed or divorced and 31 per cent lived alone.

11. Fifty per cent of all the handicapped people had relatives nearby who could help if required, and 75 per cent considered that their friends and neighbours were able and willing to assist when necessary.

12. Among the physical aids, gadgets and adaptations that can be provided to make life easier for handicapped people, the ones most frequently requested were bath rails (16 per cent) and bath seats (11 per cent), kitchen aids (8 per cent) and shoe and stocking aids (7 per cent). The housing of the handicapped people seemed to reflect the general situation in the City.

13. Although 220 handicapped persons (29 per cent) were already having chiropody, another 147 (19 per cent) wanted this service.

14. Two hundred and two handicapped persons (26 per cent) were interested in going away on holiday.

15. Almost half of all handicapped people were already receiving some help with shopping and housework - usually from relatives, friends or neighbours. Sixty nine (7 per cent) wanted more help with housework and 41

16. Two activities that many handicapped people found difficult were gardening and cleaning their windows; 109 (14 per cent) wanted help with the former, 88 (11 per cent) with the latter. Eighty five (11 per cent) wanted help with transport to attend clubs.

17. One hundred and twenty six handicapped people (16 per cent) would welcome a mobile library.

18. Services wanted by a small number of handicapped people, but probably of great benefit to those few, were day or night attendant (14 people), incontinence pads (21 people) and laundry service (13 people).

19. Twenty one handicapped people (3 per cent) were interested in doing paid work at home; 12 in working in a sheltered workshop.

20. The features and needs of four special groups of handicapped people were looked at - the housebound, those living alone, the blind and partially sighted and the deaf and hard of hearing. Many of the features and needs of these special groups were similar because the main finding was that no less than 82 individuals were in at least three of the categories. This multiple-handicapped group, of whom 79 per cent were aged 65 years or over needs special attention and a combination of skills on the part of the social workers.

21. The features and needs of handicapped people were similar whether they were in contact with doctors, nurses, health visitors, social workers or clubs. Again, there was overlap between the groups. Although there was a tendency for the doctors and nurses to be more concerned with people with progressive or intermittent chronic illness and for the social workers and clubs to be more concerned with people with static disabilities, the distinction was not marked. In both groups of patients and clients there were unmet needs.

22. Plans are in hand for a follow-up study during 1974-75 and for a detailed examination of the purpose and effectiveness of the registers of handicapped people.

23. From the start of the Survey, plans were included to meet the needs of the handicapped people identified; the professional staff to do this was appointed and increased as need built up. The integration of service and research was a special feature of the Survey. Meeting the needs of the handicapped people is described in another paper by Miss A.D. Kelly, O.B.E. and Miss K. Wells.

THE CANTERBURY SURVEY

SECTION 1

THE ORGANISATION OF THE SURVEY

INTRODUCTION

In May 1971 the first two volumes were published of a report of a study carried out on behalf of the Department of Health and Social Security by the Office of Population Censuses and Surveys (Part I Handicapped and Impaired in Great Britain by Amelia Harris; Part II Work and Housing of Impaired Persons in Great Britain by Judith Buckle. 1971. London: H.M.S.O.). The study covered a sample of people in Great Britain aged 16 and over living in their own homes and who experienced difficulty in performing certain specified activities of daily living due to physical impairment. The study revealed considerable unmet needs for social services and regional variations in the numbers of handicapped in the population and in the quantity and quality of their needs. In the following September the Department of Health and Social Security issued a circular (Circular 45/71) to all Social Services Departments drawing attention to the more important findings of the national study and the implications of these for the local authority health and social services and invited local authorities to plan the expansion of their services.

On 1st October, 1971, Section 1 of the Chronically Sick and Disabled Persons Act, 1970 came into force requiring local authorities to know the numbers and needs of handicapped persons living within their areas. The Department's Circular 45/71 gave guidance on the implementation of this section. It recognised that some authorities would not be able to proceed at once to identify all those people who both need and want services and that, in view of the very heavy burden of work which such programmes involve, some authorities, as a first step, would wish to carry out sample surveys to indicate the needs of the handicapped and nature of services required. To assist authorities wishing to carry out sample surveys the Circular enclosed a handbook of guidance prepared by Amelia Harris and Elizabeth Head of the Office of Population Censuses and Surveys on the basis of the experience gained in carrying out the national survey. The handbook included copies of questionnaires that might be used.

During October, 1971, the Chairman of Canterbury City's Social Services Committee discussed with the Deputy Director of Social Services (to whom full responsibility had been delegated) and later with the Director of the Health Services Research Unit at the University of Kent at Canterbury, the possibilities of conducting a survey in Canterbury. The Health Services Research Unit had been established in June 1971 and although already committed to a full programme of research projects, welcomed this opportunity to work with the local authority on a combined service and research study. The Director of the Unit had a special personal interest in the proposed study as he had been associated with some of the preliminary work for the national study.

From the start,it was realised that the relatively small size of the county borough of Canterbury (total population was 33,145) offered an opportunity to consider a survey of every household within the City, so that every handicapped person could be identified and given help if desired and required. At the same time accurate figures for planning would be obtained. The purposes of the suggested survey were:-

1. To identify each handicapped person who might be in need of some form of social service, and then refer his or her name and address to the Social Services Department.

2. To produce estimates of the needs for the relevant services in the City by adding together the details and needs of each handicapped person, in order to plan the direction and the rate of the development of the City's services.

3. To collect data which could be used as a basis for the partial evaluation of the services and combined with other data for further research into the needs for and organisation of social and voluntary services for handicapped people.

PRELIMINARY PLANNING

An important contribution to the success of a survey of the extent proposed is the attention (and time) given to the preliminary planning and to obtaining widespread goodwill and cooperation. During the next four months the Chairman of the Social Services Committee had detailed discussions with the Deputy Director of Social Services (who prepared a memorandum) and informal discussions with other councillors, the chief officers of the local authority and members of voluntary organisations. Mrs. E. Mary Rothermel (a councillor for 10 years up to 1971, a former Sheriff and Deputy Mayor and the chairman of the council's health committee for eight years) was approached

about the possibility of her becoming the Honorary Organiser, if a survey should be approved by the council, and, indeed, she began to think about the planning and organisation before the end of 1971.

The Social Services Committee approved the idea of carrying out a survey at its meeting on 17th January, 1972. On the assumption that volunteers would be involved extensively in the various stages, the City Treasurer estimated the City's expenditure at £1,000. (The total "cost" of the survey if the contributions from other authorities, the Health Services Research Unit, and a notional value of all the voluntary help are taken into account was very much higher.) At its meeting, the Committee agreed to request additional expenditure of £4,000 to meet the cost of the survey and the salaries of a qualified social worker and a social work assistant who would be required to meet the needs of the large number of handicapped people that it was expected would be found. The Committee recommended that a steering committee should be formed to organise the project.

The proposed survey was considered at the next meeting of the Finance and Establishment Committee and subsequently at the Council Meeting on 16th February. On both of these occasions doubts were expressed about the need for a survey of every household in the City, about the use of volunteers to collect the data, and about possible leakages of confidential information. Attention was drawn to the survey being conducted by Kent County Council. This was to be a survey of a sample of households, the first approach being by means of a postal questionnaire (rather than by volunteers as proposed for Canterbury) and the next approach by volunteers carrying out screening interviews (which was the same as in the Canterbury proposals). The arguments in favour of the complete survey proposed for Canterbury were that all the handicapped could be helped as far as services permitted (although it was realised that some may not have wished to identify themselves or receive help) and that the relatively small size of Canterbury would require a large sample size for reliable figures to be produced for planning. Both Kent and Canterbury proposed the use of volunteers and both planned to brief the volunteers and stressed the importance of maintaining the confidentiality of any information obtained. The more extensive use of volunteers in Canterbury was also seen as a way of enabling many interested people to become involved and of creating informed and interested public opinion. At the end of the debate the recommendation of the Social Services Committee was supported, so that the Council agreed to go ahead with the full survey.

Following this decision a Steering Committee (see table 1.1) was set up and Mrs. Rothermell became the Honorary Organiser of the survey, and the Director of the Health Services Research Unit agreed to be the Honorary Adviser. By good fortune, the Canterbury Hospital Management Committee had temporarily unoccupied premises in a central position (43 New Dover Road) and as its contribution to the survey, generously agreed to provide two rooms as the headquarters of the survey. The provision of a central focus and adequate space undoubtedly facilitated the running of the survey.

On March 3rd, 1972, only 16 days after the Council meeting, the Steering Committee met and the preliminary work done by the Chairman of the Social Services Committee, the Honorary Organiser and the Deputy Director of Social Services was reported. Afterwards a press conference was held at which full details of the proposals were explained. The appointment of the Honorary Organiser was announced as well as the loan of the rooms by the Hospital Management Committee. The starting date was announced for early May, immediately after the Council elections, as it was considered necessary to avoid delivering the survey forms at the same time that electioneering leaflets were being distributed. It was explained that voluntary organisations and individuals would be asked to help with the delivery and collection of the forms; they would be instructed to ensure the privacy of people and there would be no interviewing or questioning on doorsteps. A meeting of all the voluntary organisations was announced for the end of March and a public meeting was planned for the end of April. Meanwhile anyone interested in helping with the survey was asked to contact the Honorary Organiser.

THE ORGANISATION OF THE SURVEY

The Steering Committee arranged a meeting with the local statutory and voluntary organisations in order to explain the purpose and conduct of the survey, and to seek all possible help, advice and experience available in the City. The meeting was held on the evening of March 23rd. About 60 organisations were asked by the Chairman of the Social Services Committee to send a representative and slightly more than this number of people came to the meeting. At the meeting the Chairman of the Social Services Committee discussed the need for and purpose of the survey and the Honorary Organiser outlined the proposed procedure and indicated the roles of the volunteers required. These short introductory talks were followed by discussion and

questions, answered by the two people already mentioned and the Deputy Director of Social Services and the Honorary Adviser. At the end of the meeting additional volunteers were recruited to help with the survey.

Details about the preparation of the forms to be used by the interviewers in the later stages and the precise procedure for the delivery and collection of the household form were discussed at a meeting of the Steering Committee on March 28th. It was decided to follow the three-stage (two-interview) procedure as recommended in the D.H.S.S. Guide (distributed with circular 45/71):-

Stage 1 - Delivery and collection by volunteers of a one page form to every household. A further copy of the same form was sent by post to every householder who did not respond to the approach by the volunteers.

Stage 2 - Short (or screening) interviews with all persons stating they had some impairment or difficulty in movement on the forms returned during stage 1. These were screening interviews.

Stage 3 - Longer interviews with all persons found to be appreciably incapacitated and/or having certain defined impairments as a result of the shorter interviews. The longer interviews recorded the possible needs of the 'handicapped' for services.

Kent County Council was following the same plan, but had decided to enlarge the second interview questionnaire in order to cover all the services that the Social Services Department provided. The Canterbury Steering Committee agreed to use the same forms as Kent County Council, so that results could be compared. Subsequently, the County Council agreed to print the interviewers' forms for use in Canterbury, but to change the heading to "Canterbury Survey of the Handicapped". The Honorary Organiser and Adviser were asked to liaise with the County staff in order to decide on the final content of these forms and to check proofs. It is important to emphasise that the Canterbury survey used the recommended forms and questionnaires (with the few additions already mentioned). This enabled the full survey to get underway very quickly as no time had to be taken for preliminary tests of the forms. Furthermore, the decision to use the nationally recommended forms created an opportunity to examine aspects of this experiment in issuing national guidance to the conduct of a local survey. However, some interviewers criticized, in the light of their experience, the sense and adequacy of some of the questions and a few questions produced data that were difficult to analyse.

During the latter part of March and throughout April intensive preparations for the survey were underway. Personal contacts and the meeting already referred to, produced a nucleus of voluntary helpers; some of these volunteers brought forward more helpers. The chairman of the Social Services Committee and the Honorary Organiser continued to explain the purposes of the survey, to seek cooperation and to allay any fears at meetings of a number of organisations, particularly of the old and the handicapped. During the three weeks preceding the delivery of the forms publicity was obtained in the local press. In the middle of April the local papers carried an announcement of a forthcoming public meeting to which all who were interested in hearing about the survey or in giving voluntary assistance during May and June were invited. One paper drew attention to the meeting in a small news item and the following week (April 21st) carried a three-column wide report of an interview with the Honorary Organiser. The public meeting was held on April 28th and reported in the papers the following week - that is during the first week in May when the first forms were delivered throughout the City. The meeting was addressed by Mr. David Crouch, Canterbury's M.P., the Chairman of the Social Services Committee, the Honorary Organiser and the Honorary Adviser. Over 70 people attended and further volunteers were recruited at the end of the meeting.

On the 4th May, 1972, the City Council elections were held; the results produced a change in the control of the Council. The Labour party won a majority on the Council and Mrs. H.M.E. Barber became Chairman of the Social Services Committee (and the next year was elected Mayor), and assumed the chairmanship of the survey's Steering Committee. Mrs. Keith-Lucas (the previous Chairman of the Social Services Committee) was not re-elected to the Council, but was invited to continue to serve on the Social Services Committee.

STAGE 1 - PREPARATION, DELIVERY AND COLLECTION OF FORMS

Meanwhile, considerable activity was going on at the office and in many private homes in connection with the survey. Using the Electoral Roll (dated February, 1972) as a nominal roll, forms and explanatory letters were prepared to be delivered by the volunteers to every household in the City (a total of 11,288). The forms were individually addressed and given a "district" code by typing a label for every householder. Nine people, using their own typewriters and in their own spare time, completed this task within two weeks. In order to get a "master register", a carbon copy of each label was taken so that a loose-leaf register could be compiled. The labels were then stuck

onto the forms which together with a covering letter, were put into envelopes. A staff of 15 office workers, including two part-time paid secretaries, undertook this tedious chore working at staggered hours in the two rooms at 43 New Dover Road.

The 11 sub-divisions of the City were taken as 11 districts for the purpose of organising the survey. Fourteen volunteers took on the job of arranging the delivery and collection of the forms in the districts. These district organisers attended a briefing session on the morning of Saturday, April 22nd and on the following Saturday all the prepared envelopes were distributed to them. The district organisers then had to distribute the envelopes to the members of their teams of helpers, so that delivery to the householders could begin on May 6th. Over 150 people had become available to help in the enormous task of delivery and collection of forms. As well as individual volunteers, all the senior schools in Canterbury gave a great deal of help - each school working under the direction of a master or mistress. The Longbridge Youth Club also provided a team of helpers working under one of the leaders. As the Electoral Roll is never completely up-to-date, every helper was asked to make a note of any house or household not on the register, of any houses recently built and in occupation, of empty houses and of any that had been demolished. New houses, additional households and addresses left off the register were added to the master register and forms were delivered. After a week the helpers returned to collect back the form, sealed in an envelope. They were so thorough and enthusiastic that the first collection yielded an 85 per cent return.

The office staff opened and sorted the returned forms and they and the district organisers prepared the postal reminder forms and letters for all those householders from whom the helpers had failed to get back a form. There were 1,668 reminders sent out by post and of these 1,243 were returned (74 per cent). The final result of both stages of contacting every householder was a return of 96 per cent of all households. There was little variation in the return rate between the districts; in one district the response rate was 85 per cent, in all of the others it varied only between 93 per cent and 98 per cent. These figures include any form of response to the questionnaire (i.e. refusals and the return of blank forms). The proportion of all of the City's householders who returned forms which could be used to effect was 92 per cent. The details and numbers of the forms returned and of the identification of persons who were impaired are discussed in section 2 of this report. Suffice it to say here that there were 1,496 "positive" forms (i.e. declaring the presence of an impaired person in the household) which identified 1,631 who were apparently eligible for interview.

STAGE 2 - SCREENING INTERVIEWS

The next stage in the survey was to interview all the people who had been indicated on the household form as having some impairment or disability. These screening interviews were intended to discover who were the more severely handicapped among all the impaired people mentioned on the forms (see section 2). Fifty-eight volunteers undertook these interviews after they had been told about the purposes of the survey, the ethics and principles of interviewing and been taken through the interview schedule by a Research Fellow in the Health Services Research Unit (Miss Gail Baker) who had also helped with the training of the volunteers for the Kent County Council Survey. Three sessions were held at the Kent Postgraduate Medical Centre (kindly loaned for the purpose) in early June 1972. Interviewing commenced in the second week in June and it was hoped to finish by the end of July. However due to the effects of holidays on subjects and interviewers, the screening interviews were not completed until September.

During July a progress report was presented to the Social Services Committee and the Steering Committee met and considered the tactics for the final stage of the ascertainment part of the survey. It was apparent that the second longer interviews should start as soon as possible and due to the intervention of the holidays that they should start before the completion of the second stage of the survey. Furthermore, the Social Services Committee was experiencing difficulty in recruiting the additional professional staff, who it had been intended, would carry out the second interviews. It was therefore decided to give further training in interviewing to selected volunteers for the purpose of carrying out the second interviews and that these volunteers would be joined by the social workers as soon as the Social Services Committee could appoint them. It was agreed that the interviewers for the second interviews would be paid £1 per interview, unless debarred because of other appointments held.

STAGE 3 - SECOND INTERVIEWS

Some of the interviewers for the second stage agreed to interview for the third stage, so it was possible in the latter part of stage 2 to do the 'first' and 'second' interviews during one visit. (This proved satisfactory, indeed preferable to the double interview procedure.) The interviewers were selected and trained; most of them had had experience in some form of voluntary or social work and many had had previous experience of

interviewing people. The 22 people who helped during this phase attended further briefing sessions and special sessions in the Occupational Therapy Unit in Nunnery Fields Hospital where the Head Occupational Therapist (Miss J.B. Bright) demonstrated aids and equipment for the use of handicapped people. All the second interviews were completed by October 31st. In all, 770 physically handicapped people were identified, although as is discussed in later sections of the report, this figure is likely to understate the number as there were some impaired people who declined a second interview and inevitably in a survey spread over months a few people will have died, been admitted to hospital, or left the district and others will become handicapped after the initial contacts are made and before the interviews are completed. Some handicapped persons may have either refused to complete the initial household form or returned a "negative" form.

The Steering Committee met on August 24th and again on September 14th when final decisions were taken about the coding and punching of the interview forms. A further progress report was presented to the Social Services Committee and the appointments were announced of a part-time social work adviser (Miss A.D. Kelly, O.B.E.), a social worker (Mrs. P. Kane), and a social work assistant (Miss E. Mould). Later, a part-time occupational therapist (Mrs. S. Gordon) joined the team.

CODING, PUNCHING, ANALYSES

Even before all the second interviews were completed the results of those which had been done were checked and coded. Six coders were briefed and trained on August 30th by the research officer who organised the sample survey for Kent County Council (Mrs. E. Humphreys). The Honorary Organiser and the Honorary Assistant Organiser undertook the editing and checking of all the schedules and did some of the coding. The other coders only handled checked schedules. The coding of the diagnoses was done by two state-registered nurses who had been trained as coders. The International Classification of Diseases was used in conjunction with the groupings used in the national survey. The last schedule was coded on November 1st, the day after the last interview.

The coded data had to be transferred to cards so that the mass of data accumulated could be analysed using the computer at the University. The punching of the cards was carried out by staff of the Kent County Council at Maidstone. Whilst the Canterbury data were being punched, the Kent County

data were being tabulated by staff of the Health Services Research Unit using the computer. Thus, when the punched cards containing the Canterbury data were returned from Maidstone, it was possible to produce the basic tables very quickly - so quickly that a complete set of "printed-out" tabulations was delivered to the City's Social Services Department on November 8th. This was not the first information available. A system had been devised whereby the needs of handicapped people shown on the completed interview schedules were entered on Analysis Sheets by the office staff before the forms were coded. In this way approximate totals of needs for services were available to the City in time for decisions to be taken about expenditure in the next financial year.

The conclusion of the survey was marked by a civic reception attended by over 60 of the 300 or so people who had helped in one way or another. Prior to the reception, a press conference had been held and the main findings of the survey discussed.

SERVICES TO THE HANDICAPPED PEOPLE AND THE FURTHER DEVELOPMENT OF SERVICES IN CANTERBURY

Activity did not cease with the completion of the survey. The help given to the handicapped people identified in the survey and to many others referred to the Social Services Department as well as the extension of other services and the development of new services are described by Miss A.D. Kelly and Miss K. Wells in their report. The main features are summarised in table 1.2.

FURTHER RESEARCH

The survey was envisaged and planned as primarily a service project. Some of the findings of the survey are presented in sections 3 - 6 of this report; they are of some national significance in that the data, obtained from a survey of every household, are in agreement with the regional data from the national sample survey. The data can be used as a base-line for follow-up studies, as is mentioned below. The survey has also provided information about the organisation and methodology used. Some of the features of the Canterbury survey that the writer considers were crucial to its success are listed in table 1.3. Some people will say that the Steering Committee and Organisers were lucky, and certainly there were some unplanned strokes of good fortune. But these were combined with astute serendipity, the determination of many people to complete the survey, and

the complete trust and cooperation that developed between the local authorities, voluntary organisations, the volunteers and the University. It will be for another observer and writer to analyse the dynamics of the organisation and the impetus of the survey in a more detached way at a later date.

In January, 1973, a meeting was held at the University of most of the interviewers who had carried out second interviews. The schedules were discussed in detail and recommendations to improve and simplify the order, lay-out and wording of the questions made. A revised and shorter schedule which combines the first and second interview has been produced and used with success in a survey of the handicapped in another part of Kent. So the design and methodology of surveys of the handicapped have gained from the experience of the Canterbury Survey.

On completion of the field work a Sub-Committee of the City's Social Services Committee with coopted representatives from the Health Services Research Unit was set up to coordinate further joint research activities. This sub-committee has met on a number of occasions and has considered drafts of this report of the survey. The sub-committee has helped with the planning and carrying out of a study of the records of a number of statutory and voluntary services in the City in order to find out how many people found in the survey were already known to the services, and were already receiving help. The Department of Health and Social Security has agreed to support the Health Services Research Unit in a follow-up study of the 1972 survey, involving the re-visiting of everyone identified as impaired or handicapped at that time in order to see how they have progressed and to check that the needs they mentioned then to the interviewers have been confirmed by the professional social workers and where possible have been met. The sub-committee has helped in the planning of this new study.

THE CANTERBURY SURVEY

SECTION 2

THE RESPONSE TO EACH STAGE OF THE SURVEY

The survey, as mentioned in the previous section, was carried out in three stages:-

Stage 1 - Delivery and collection by volunteers of a one page form to and from every household. Another copy of the form was sent by post to every householder who had not responded to the approach by the volunteers.

Stage 2 - Short, screening interviews (first interviews) with all persons stated to have some impairment or difficulty in movement on the forms returned during stage 1.

Stage 3 - Longer interviews (second or assessment interviews) with all persons found to be appreciably incapacitated and/or having certain defined impairments as a result of the screening interviews. Those interviews identified possible needs for services.

This section discusses the response from all the households and people approached at each stage. Section 3 presents some details of the persons interviewed in stage 2 (referred to as "the impaired") and Section 4 gives more details about the persons interviewed in stage 3 (referred to as "the handicapped") and discusses their expressed needs.

STAGE 1 - THE HOUSEHOLD SURVEY

The survey was concerned only to identify physically impaired people who were living in private households; so that impaired people living or temporarily resident in institutions (e.g. hospitals, nursing homes, hotels, and "homes") were excluded. The electoral roll (dated February, 1972) was used as the basic list of households in the City, but the volunteers were instructed to add in (and to deliver a form with covering letter) all occupied houses which were not on the register either because they had been built and occupied recently) or because the occupier had not registered for voting (perhaps, for example, because he was a foreigner) and any additional households identified in cases of multiple occupation. In all, 11,288 households were identified in this way. From this total the 328 houses that were unoccupied or had been demolished (also identified by the volunteers) had to be subtracted, so that the volunteers actually delivered forms to 10,960 households.

Of this number 9,075 forms were collected back; and 217 householders stated they did not want to participate. Another form with a stamped addressed envelope for its return to the survey headquarters was sent to the remaining 1,668 households; of these 1,238 (74 per cent) were returned. The final result of both collections was a return of 10,313 forms of which 154 were incomplete and could not be used for analysis. If the verbal refusals are added to the total number of forms returned, it can be said that some sort of response was obtained from 96.1 per cent of all households approached. Adequately completed forms were obtained from 10,159 households, that is 92.7 per cent of all the households. These figures are summarised below:-

1.	Number of households identified by volunteers	= 10,960
2.	Number of forms collected back by volunteers	= 9,075)
3.	Number of households expressing a wish not to participate	= 217) = 10,960
4.	Number of households sent a reminder by post	= 1,668)
5.	Number of forms returned by post	= 1,238 (74% of no. sent)
6.	Total number of forms returned, (2) + (5)	= 10,313 (94.1%)*
7.	Total number of households "responding", (6) + (3)	= 10,530 (96.1%)*
8.	Number of inadequately completed forms	= 154
9.	Number of completed forms, (6) - (8)	= 10,159 (92.7%)*

*refers to the number of households identified.

The response did not vary greatly between the different districts in the City (see table 2.1). The percentage of householders approached who returned completed forms that could be analysed varied between 86.7% at the lowest to 96.2 at the highest. There are no data readily available about the people who did not respond or about those who expressed a wish not to participate in the survey.

Each householder was asked to state on the form whether anyone in the household was blind or had very bad eyesight; deaf or very hard of hearing; had lost the whole or part of any limb; was unable to get out of bed or out of the house; had difficulty in walking, bending or caring for themselves; whether there was anyone living in the household aged 75 years or more and whether the person lived alone. The householder was also asked to state the name of any person experiencing one or more of the difficulties or disabilities listed. A form on which the householder indicated the presence of an impaired person or of a person aged 75 years or more and living alone (but not impaired)

was classified as a "positive" form. There were 1,919 "positive" forms returned. These were made up of 1,446 forms relating to impaired people (of whatever age) and 473 forms relating to people over 75 years of age, who were living alone but at that time were not impaired. The names and addresses of these elderly people living alone were given to the medical officer of health so that the health visitors would be aware of these people. No further action was taken by the survey team in respect of these people, although later on, many were visited by the City's social workers.

The 1,446 forms relating to people with impairments referred to 1,631 people as some households contained more than one impaired person. There were no data obtained that would indicate whether households from which negative forms were received did, in fact, contain impaired people. The experience of other surveys and information from other sources in Canterbury (e.g. the register of handicapped people and lists of people attended by district nurses) suggest that at least a few of these households did contain impaired people. Some impaired people would not wish to identify themselves and some of these may have returned negative forms, some will have declined at the first stage to participate in the survey and some will not have responded to the postal reminder. Some people may not have interpreted the form in the way intended; indeed, it is believed that some people suffering from a chronic illness considered themselves "sick" rather than impaired or handicapped and therefore did not think that the survey referred to them. The conclusion must be that the number of impaired people identified is less than the total number of impaired people in the City not only for the reasons given above, but also because the survey was limited to people living in private households.

STAGE 2 - SCREENING INTERVIEWS

The household survey identified 1,631 persons who apparently qualified for a screening interview. Further enquiry, prior to starting a screening interview, established that 23 of these people were, in fact, not eligible within the structure of the survey for screening interviews. Eight of the 23 people had misunderstood the form, 6 had had a temporary illness only, 5 were temporary visitors to households within the City and the remaining 4 were patients in a nursing home which had been wrongly included in the survey. Of the remaining 1,608, 1,534 (95.4%) had a screening interview. The reasons for not interviewing the others (74 people) were as follows:

Died before interviewer made contact	30
Admitted to hospital or "home"	14
Moved from address given	8
Refused	22
	74

Of the 1,534 persons interviewed, 836 qualified for the second interview or the third and final stage of the survey.

The first or screening interview form contained 13 questions, some with subsidiary questions. The first 5 questions referred to statements made on the household form. In addition there were questions about diagnosis, other illnesses, household composition and about eyesight, hearing and daily activities such as getting in and out of bed, using the W.C., bathing, washing, dressing and feeding. People were asked whether they could carry out each activity without difficulty or supervision, with difficulty or not at all and scores were allocated to the answers. If the person could manage without difficulty but by using certain types of aids or appliances already supplied, then he or she was coded (with a few exceptions, e.g. use of hoist) as coping without difficulty. Qualification for an assessment interview depended partly on the over-all "score" of difficulty in carrying out the self-care activities and partly on other factors. Thus, in regard to the scores already mentioned, any person aged 70 years or over experiencing any difficulty in self-care had a second or assessment interview, as also did all the bedfast, the housebound, the registered deaf and hard of hearing, children attending special schools, those who were unable to recognise people or read when wearing their spectacles and those who were found at interview to be unable to hear ordinary conversation even when using a hearing aid if available. It is this group of people with various types and degrees of impairment that were referred for the assessment interviews. The group totalled 836, and contained 70 people aged 70 years or more with only minor difficulties in self-care. Of the 1,534 people who had a screening interview, no further action was taken with 698, and arrangements were made for an assessment interview for the 836 referred to above. Of the 698 who did not qualify for a second interview, 29 were on the handicap registers and 26 of these were under the age of 70 years.

THIRD STAGE - SECOND OR ASSESSMENT INTERVIEW

In conducting a survey over a period of time, and especially when concerned with a group of people which contains some very ill people, it is inevitable that some of the people will be admitted to hospital or even die before the survey can be completed. As has already been mentioned, the actual number of people who had a screening interview was less than the number who qualified on the basis of the answers to the household forms. Similarly, of the 836 people who qualified for an assessment interview 770 were interviewed. The reasons for not interviewing the remaining 66 were essentially similar to those for not carrying out the first interview. They were:-

Died before second interview	7
Admitted to hospital or "home"	12
Moved from the address given	8
Qualified, but missed out	8*
Refused second interview	31
	66

*These only came to light after the completion of the survey. The names were immediately referred to the social workers.

The increase in the number of refusals is noticeable, but, perhaps, not surprising when it is remembered that this was the third enquiry being made; five of the people who refused second interviews were on the register of handicapped people. For this and other reasons, mentioned in section 1, it was concluded that in future surveys of this nature, stages 2 and 3 should be combined.

The next section discusses the findings of stage 2 of the survey. It examines the prevalence of impairments among people in private households, the causes of impairments and the household structure of the impaired people.

THE CANTERBURY SURVEY

SECTION 3

IMPAIRED PEOPLE

There are no standard definitions of the terms 'impairment' and 'handicap'. Operational definitions must be decided for use in each survey; inevitably these will reflect the objectives of that survey, but as far as possible the definitions used should be the same as those used in other surveys with similar objectives. Within a dictionary's definition of impairment, an impaired person is any person with some defect, however minor, of any organ or bodily system. In a survey of visual impairments, any person who lacks perfect vision (including full perception of colour) should be counted (or ascertained) as 'impaired'. Obviously, in a survey concerned with the welfare of chronically sick and disabled persons, minor visual defects are not by themselves of primary interest. It is therefore necessary to limit the definitions of the terms. The definitions used in the Canterbury Survey follow those used by Miss Amelia Harris in her national survey of the handicapped and impaired in Great Britain ("Handicapped and Impaired in Great Britain", SS418, 1971. London: H.M.S.O.), and in her recommendations to local authorities ("Sample Surveys in Local Authority Areas with Particular Reference to the Handicapped and Elderly". A.I. Harris and E. Head. SS477. 1971, O.P.C.S.). They are as follows:-

Impairment is

(1) lacking part or all of a limb or having a defective limb, or
(2) having a defective organ or bodily system which stops or limits getting about, working, or self-care, or
(3) is blind, or has very bad eyesight, or
(4) wears a hearing aid or is so hard of hearing that he or she cannot hear ordinary conversation.

Handicap is the presence of disadvantage or restriction of activity caused by the impairment. A handicapped person is therefore a person who is restricted in some way by his or her impairment. Many factors in addition to the presence of the impairment may contribute to the degree of handicap; these include lack of services available to ameliorate the handicap, the environmental factors (e.g. steps), social factors (e.g. local employment opportunities, transport facilities) and the personality, intelligence, education and motivation of the person concerned.

"Impaired" and "handicapped" are not divorced categories but different levels of a continuum. All handicapped people are impaired, but not all impaired people are handicapped. An individual's ranking can change with time, and in either direction. Furthermore, because so many personal, social and environmental factors are involved in the state of being handicapped, it is possible (and quite commonly occurs) for one person to be more handicapped than another person, even although the latter person has a greater degree of severity of impairment. For these reasons, this Section presents details about all the impaired people.

Operationally in the Canterbury Survey, all those persons who had a first interview are defined as impaired and all who had a second interview as handicapped (see section 2). Throughout this report, it must be borne in mind that the term handicap refers to the presence of an impairment combined with restriction of some activity.

NUMBERS OF IMPAIRED PEOPLE

The numbers of impaired people in age and sex groupings who had a screening (first) interview are set out in table 3.1. All of the 1,534 impaired people were brought to the notice of the survey team by means of the household form filled in by a member of a household (see section 2). All of these people had a screening interview, the purpose of which was to identify the handicapped among the impaired; the data presented in this section were obtained at the screening interviews.

The total of 1,534 persons understates the real position for the 74 persons who should have had a first interview but didn't (see section 2) are obviously not included in the analyses in this Section, and inevitably some others will have been missed for a variety of reasons. The group considered here is made up of a heterogeneous mixture of persons with various impairments and some with handicaps. It contains the majority of all those persons living at home who at a point in time (May, 1972) had appreciable impairments and includes those requiring help for handicaps arising from their impairments (see section 4) or who were thought to be likely to require some form of help in the near future.

The last column of table 3.1 sets out prevalence rates of impaired persons calculated as rates per 1,000 of the population for each age and sex group. The Canterbury Survey obtained responses from 92% of all households in the City.

The rates in table 3.1 are calculated on the assumption that sex for sex and age for age, the people in the 92% of responding households represents 92% of the entire population; this may or may not be true in relation to the representativeness of the households responding to all households. The numbers of impaired in table 3.1 and throughout this report refer only to those persons living at home and therefore under-represent the total number of impaired in the City population as they omit impaired people who were either patients, residents or staff in institutions, and undoubtedly there were impaired people among the 8% who did not respond to the survey. Table 3.1, therefore, shows figures which for planning and operational purposes must be considered to be somewhat less than the full picture. There are, however, no reasons to presume that the general trend of the figures presented is distorted in any way.

The overall prevalence rate of impaired persons of all ages living in private households in the City of Canterbury was found to be 50 per thousand (5%) of the population. The national survey, which has a close affinity to the Canterbury Survey, was limited to persons over the age of 16 years; recalculating the Canterbury prevalence figures after excluding those persons aged less than 15, the total prevalence figure is 61 per 1,000 population compared to the figure derived from the national survey for the whole of South-East England of 67.

PREVALENCE OF SPECIAL CATEGORIES OF IMPAIRMENTS

Blind and Partially Sighted

Eighty seven people among the 1,534 persons who had a first interview stated that they were registered as blind (51) or partially sighted (36), giving a combined registration rate in the population of 2.9 per 1,000 people, a figure identical with the national rate (table 3.2). In response to questions about ability to recognise people across the street (Q.10) and ability to read ordinary print, with or without spectacles (Q.11) a further 170 (5.6 per 1,000 population) claimed difficulty with recognising people and 137 (4.5 per 1,000 population) had difficulty with reading; some of these people, of course, had difficulty with both. These figures differ from those discussed in Section 4 which refer to the handicapped only and take into account the further information obtained.

Deaf and Hard of Hearing

Only 16 people (0.5 per 1,000 population which is identical to the national rate) stated that they were registered deaf and a further 17 people (giving a rate somewhat higher than the national one) that they were registered as hard of hearing. Seventeen people were too deaf to be interviewed (so that the interview had to be conducted with a proxy). Ninety seven people stated that they had difficulty in hearing (Q.12), and the interviewers noted that a further 127 people seemed to experience difficulty in hearing ordinary conversation although they stated that they could hear. This suggests that there were 224 (7.3 per 1,000 population) persons with difficulty in hearing, in addition to those registered as deaf or hard-of-hearing.

Physically Impaired

At the first interview 11 people were confined to bed, 14 were chair-bound and 175 were house-bound, although they could get around their house. In all, therefore, 200 people (6.6 per 1,000 population) were house-bound, 12.5 per cent of these being confined to their bed or chair. Another 945 people (31 per 1,000 population) confirmed that they were having some difficulty moving about, taking care of themselves or getting out of their house. These figures produce rates very much higher than the rate of people registered as physically handicapped and, in part, reflect confusion and differing policies about registration and problems of definition.

DIAGNOSES

To many handicapped people amelioration of the handicap and adjustments to the environment are more important and more urgent than precise diagnosis of the underlying medical conditions. However all would agree that curable conditions should be cured and preventable conditions prevented, and for each accurate diagnosis is essential. Furthermore, a diagnostic label indicates, although within a large range of variability, the likely prognosis and chronicity of the impairing condition. For these reasons some indication of the nature of the medical conditions underlying the impairments is necessary. All the persons interviewed in the Survey were asked what their doctor had said was wrong with them or what they thought was the matter (Q.6). Table 3.3 summarises the answers within major diagnostic groupings. A later study in the Paddock Wood area of Kent investigated the "matching" of the person's statement of diagnosis with the opinion of the general practitioner

and close agreement was found in regard to almost all conditions. So there is no reason to presume that within the broad diagnostic categories used, there is any serious inaccuracy; and, as will be mentioned later, for some conditions, the prevalence as found in the Canterbury survey matches the prevalence expected from other studies.

Major Causes of Handicaps and Impairments

Perhaps the most striking feature of table 3.3 is the dominant role of disease processes rather than injuries in the causation of impairments. This is in great part, a reflection of the predominance of older people among the impaired.

Diseases of the musculo-skeletal system,mainly one or other form of arthritis or rheumatism, were the main cause of more than 1 in every 5 of the impairments discovered, and were present in one third of all impaired people. Arthritis and rheumatism are relatively common complaints among the entire population; they do not often cause death and therefore are not prominent among the causes of mortality which in the past have had considerable influence on the development of medical services. Arthritis and rheumatism are serious disabling conditions and this survey, once more, highlights the social importance of these conditions.

Diseases of the central nervous system include strokes (76 of which 64 are the main condition and 12 the additional), poliomyelitis (20), paralysis agitans (18), cerebral palsy (11), multiple sclerosis (8) and paraplegia and hemiplegia (5). This group of diseases were the main cause of the impairment in over one tenth of the impaired people. As Harris (1971) showed in the national sample survey, this group of diagnoses was associated with the more severe degrees of impairment and of handicap. A detailed study of this group highlights the importance of understanding the implications of the diagnosis. Strokes are a common cause of death as well as of disability. Their incidence has been increasing, partly as a concomitant of the rise in the number of elderly persons in the population and partly as part of the rise in arterio-sclerotic disease. Some patients with strokes, like some with terminal conditions, will be severely handicapped for a variable, but short, period before death; there will, therefore, be a larger number of persons who receive help during any one year, than are found in a short-term prevalence survey. Data are now available which suggest that some strokes may be preventable by the control by drugs of high blood pressure and schemes to do this are underway. A great success

story of modern medicine is the prevention of poliomyelitis; this infection, which often afflicted healthy and physically active children and young adults was a major cause of diability. Now poliomyelitis should seldom occur, but, of course, some of yesterday's victims are still with us, as the 20 persons so impaired in Canterbury indicate. Of these 20 people, there were none under the age of 15 years, but after this age there were about 3 per ten year age group up to the age of 85. The present outlook is not so hopeful for the other central nervous system conditions mentioned previously. Modern drug treatment, under careful medical supervision, can alleviate some of the distressing and handicapping symptoms of paralysis agitans; some forms of cerebral palsy can be avoided, but neonatal care and resuscitation may save the life of other children with cerebral palsy; multiple sclerosis has not been elucidated, but considerable research into its cause and pathogenesis continues.

The third group of diseases in table 3.3 is the cardiovascular group - mainly made up of heart diseases. Disease of the coronary arteries (sometimes manifest as the "heart attack") is the commonest cause of death in this country and throughout Europe and North America. The incidence has increased remorselessly in the last 50 years and a tremendous amount of research work is devoted to studying the cause and hence possibility for prevention and the cure and rehabilitation of patients with these conditions.

The prevalence of respiratory diseases as causes of impairment was lower in Canterbury than in industrial areas, as could be expected bearing in mind the aggravation of these conditions by dusty occupations and atmospheric pollution. The absence of tuberculosis as a dominating cause among this group reflects another of the recent great discoveries in medicine - the curative effect of streptomycin and anti-tubercular chemotherapy.

Psychological disorders do not figure especially high in table 3.3, although they are a very prevalent and serious cause of impairment and of unhappiness and distress. The figure given in the table refers only to psychological disorders causing some form of physical impairment; the figure, therefore, cannot be taken in any was as an assessment of the prevalence of psychological disorder in the community.

Congenital malformations cause obvious distress and life-long handicap. They have also been a focal point for discussion about the ethical and social problems arising from energetic resuscitation and surgery. As shown

in table B in Appendix 1, congenital malformations were mentioned by 40 people as primary or additional conditions present; of these 40, in 8 cases they were considered to be the primary cause of a handicapping impairment.

These figures of prevalence presented here can be compared with the results of the national sample survey findings (Harris, 1971) and with the results of other surveys, although lack of agreement of figures does not necessarily mean that one or other set of figures is inaccurate, it could equally indicate that the Canterbury experience is atypical. Mention has already been made of the agreement between the Canterbury findings and the national average findings in many respects and this continues to be broadly true of the prevalence of conditions; the Canterbury figures tend to be somewhat below the figures in the national survey in respect of all impaired persons, but somewhat higher in respect of handicapped persons. Thus, on the basis of the findings of the national survey, 41 persons handicapped by strokes would be expected, in fact 52 were identified; with rheumatoid arthritis (a condition likely to be confused by patients with other forms of arthritis) 20 handicapped persons would be expected, 28 were identified.

THE AGE AND SEX OF THE IMPAIRED PEOPLE

So far only the types of impairments and the underlying diagnoses have been considered; other important parts of the total picture are the personal and social details of the impaired people. How old are they? Are they married? With whom are they living? And how often is it, that two or more impaired people are living in the same household?

The age and sex distribution of the impaired people are shown in table 3.1. Thirty nine per cent of all the impaired are male. Sixty two per cent are aged 65 years or more; 82 per cent are aged 50 years or more. Thirteen per cent were aged between 15 and 49 years and 5 per cent were children. Of the children $\frac{2}{3}$rds, were boys, the reason for this large preponderance of young boys is not clear. It will, however, be noticed from table 3.1 that up to the age of 49 years, more males were reported as impaired than are females, but after this age more females were reported. This is largely due to the fact that women live longer than men, so that the number of women in each age group in the population increases after the age of 50 years. In the Canterbury population, as is seen in table 3.1, there are more males than females up to the age of 29 years, but from that age on, there are larger and larger numbers of females relative to males. If this observation is

taken into account, and the prevalence of impairments is calculated as rates per 1,000 people in each age and sex group (see last column in table 3.1) then it will be seen that except for the greater likelihood of males being impaired at ages under 29 years, the sexes were about equally affected.

Table 3.1 also shows that the prevalence of impairments rose steeply with increase in age. Three in every 10 persons over the age of 75 years were impaired, whereas in middle life the figure was nearer 1 in every 50. For both girls and boys, there was apparently a drop in prevalence among the school-leavers. This finding may reflect the careful ascertainment carried out at school and the concern of parents for their impaired children, thus ensuring very full coverage among children at school. It may also reflect possible weaknesses in the continuing care of the handicapped school leaver; deficiencies in these services have been widely observed over many years.

This study of the age and sex of all the impaired people taken together with the study of the diagnoses shows clearly how age and diagnosis are related. The predominantly impairing conditions were those which are most common among elderly people. It follows then that services for impaired people must reflect these findings and future plans, as well as taking account of different causes of impairment, must distinguish between (1) the needs of the majority of impaired people who have reached or are approaching retirement age; a group that will increase in number during the next 20 years as the number of people over 75 years of age continues to increase. (2) the needs of the minority in working life, and (3) the needs of children. Overwhelmingly the largest component overlaps with the problems of old age generally and must be considered in conjunction with the provision of geriatric services. At the other end of life, the problems of the impaired and handicapped children must be considered in conjunction with the education services and the child health and paediatric services. For the age group in between the children and the elderly plans have to be formulated in conjunction with employment services and occupational health services.

THE HOUSEHOLDS OF IMPAIRED PERSONS

The predominating factor of age, besides being related to the main causes of impairment and to the larger number of women among the impaired, also affects the household composition. If, as does happen, men die younger than do women, then there must be more widows in each age group

as age increases. With increasing widowhood, there is more likelihood of living alone. It is not therefore surprising to find (table 3.4) that 35 per cent of all the impaired were widowed (or divorced) and that 29 per cent lived alone. These figures are very much higher than would apply to the total population, but if allowance is made for the preponderance of the older people and the deficiency of children in the impaired group, then much of the excess of widows is found to be due to the inevitable effect of age. Forty-five per cent of all impaired people were married and the majority lived with their spouse; again, age affects the situation as the older the couple the more likely was it that both will be impaired. It was found that 11 per cent of all impaired people were living with another handicapped person (defined as having a second interview).

The next section discusses the needs of the 770 handicapped persons who were interviewed in the third stage of the survey.

THE CANTERBURY SURVEY

SECTION 4

HANDICAPPED PEOPLE AND THEIR NEEDS

THE IMPAIRED AND HANDICAPPED

At the beginning of the previous Section a distinction was made between the handicapped and the impaired. To be handicapped a person must be impaired, but an impaired person is not necessarily handicapped. The handicapped form a sub-group among the impaired; a sub-group that is restricted in some way. The total of 1,534 impaired persons can be divided into three groups. Firstly there is a group of 770 handicapped people who agreed to have a second, detailed interview about their problems. Secondly there are 66 persons who were originally eligible for a second interview, but for the reasons set out in Section 2 did not have a second interview and therefore there is no further information available about them. Impaired people eligible for second interviews and therefore operationally defined as handicapped were all those in the following categories:-

1. The severely handicapped as assessed by restriction of mobility or of self-care activities, based on the score obtained in Q.13 and answers to Q.4 of screening interview.

2. Those with very poor vision (estimated as the equivalent of less than 6/60 Snellen), based on answers to Q.1, 10 and 11.

3. Those with poor hearing and those who are not able to communicate with the interviewer due to deafness, speech inadequacies or mental conditions, based on answers to Q.2 and 12.

4. Children needing special care or educational facilities, based on the household survey item 11.

5. Persons over the age of 70 years who are impaired but not necessarily as handicapped as in (1) above, but had at least some score on Q.13.

The third group are those self-identified impaired people (totalling 698) who at first interview did not fulfil the criteria for a second interview.

The third group should comprise younger people (because there was "weighting" given to persons over 69 years of age with impairments), those with less extensive impairments and those who although having more extensive impairments were coping to their own satisfaction. From the data in tables C and E of appendix 1 these three groups can be compared in respect

of sex, age, civil state, household composition and the self-care scores. The self-care scores are taken from the responses to question 13 in the first interview schedule (see appendix 2). The group for whom no second interview was indicated were indeed younger (only 49 per cent were aged 65 years or more) and consequently there were relatively fewer females, fewer widowed and divorced people, fewer living alone. By definition, none had a self-care score above 6, as any with such a score would have been eligible for a second interview and therefore come into one of the other categories.

The group of 66 persons who were eligible for a second interview but did not get it are similar in most respects to the persons who had a second interview. The importance of this small group is that it represented one section (of the order of about 9 per cent of the number interviewed) of the handicapped who needed help. About one third either died or were admitted to hospital or a home after completion of the first interview and before a second interview could be arranged. Therefore the group probably contained a disproportionately large number of very severely handicapped persons and certainly had a larger proportion of older people than did the handicapped group. In planning services, allowances must be made for this group and the numbers discussed in the next section must be seen as under-estimates perhaps of the order of 10 per cent.

AGE AND SEX

The group of handicapped persons comprised 2.5 per cent of the population and contained many more older people, women, widows, and people living alone than did the population as a whole. For convenience, the age and sex structure and the civil state and household data of the handicapped group who were interviewed in the third stage of the survey are presented in tables 4.1 and 4.2. Five hundred (65 per cent) of the 770 handicapped persons who had a second interview were female (table 4.1), but up to the age of 29 years there were more males than females,particularly were there more schoolboys than schoolgirls. In the older age groups the females increasingly predominated so that they formed 70 per cent of the age group 75 to 84 years and 76 per cent of those aged 85 or more. Men and women aged 65 years or more formed 72.5 per cent of all of the handicapped persons; again the preponderance of older women was shown - men of this age group formed 60 per cent of all handicapped men, whilst women of the same age group formed 79 per cent of all handicapped women.

Throughout the rest of this Section, in examining the distribution of factors among age groups of handicapped persons, five age groups are used - persons aged 0-14 years, 15-49 years, 50-64 years, 65-74 years and 75 years or more. The prevalence of handicapped persons is similar within the sub-groups forming these main groups and as already mentioned in Section 3 the dominant problems of each main group differ. For the first group (aged 0-14 years with a prevalence of 8 handicapped persons per 1,000 of the population of that age and sex) the problems are of development and education; for the second group (aged 15-49 years with a prevalence of 5 per 1,000 of the population) they are of employment and of forming and bringing up a family; for the third group (aged 50-64 years with a prevalence of 21 per 1,000 people) they still relate to employment and family, but are often of a different quality; the next (fourth) group (aged 65-74 years with a prevalence of handicapped persons of 73 per 1,000 persons of the same age) the problems are compounded with those of retirement, whilst the fifth group (aged 75 years or more, of whom 198 in every 1,000 (or almost 20%) are handicapped) are afflicted with many of the problems of decreasing mobility and activity associated with ageing. There is, obviously, overlap of needs between the groups and some needs are common to all handicapped persons.

In planning services and especially in estimating the quantity of services required and in comparing the provision of services between one area and another, and between one authority and another, it is essential to take account of the distribution of the population between these five age groups.

MARITAL STATUS AND HOUSEHOLD STRUCTURE

Twenty per cent (154 persons - see table 4.2) of all handicapped people had never been married. This is the same proportion as among all the impaired group. Almost one third of these single people were children; just over a quarter were aged 75 years or more forming 11 per cent of that age group, the same proportion that the single people form of the 65-74 years age group but lower than in the 50-64 years age group (16 per cent) or the younger (15-49 years group) where single people make up 47 per cent of the total. These figures suggest that a substantial impairment makes marriage less likely for the person concerned. The figures in table 4.2 show the increasing likelihood of widowhood as age increases and a comparison of these figures with those of the impaired people who are not handicapped

(appendix 1, table C) confirms that more widows and widowers than the married of the same age groups were likely to be handicapped.

Part of the explanation for these findings of an excess of widows among the handicapped is that many live alone and have no one to hand who can help them. This is supported by the findings in regard to the number of persons in the household (table 4.2). Thirty two per cent (243 persons) of the handicapped lived alone, and 93 per cent of these were aged 65 years or more. Most of the younger handicapped (and all of the children) were living in households of three persons or more. The second largest group in table 4.2 are those who were married and lived with their spouses only (209); this is a group that can be in a precarious situation as ill-health in the more active partner can precipitate difficulties for both. One hundred and forty seven of all of the handicapped (19 per cent) were living with their unmarried (108) or married (39) independent children. The other handicapped people were living with friends (45), with their spouses and dependant children (24) or with brothers or sisters (23). These figures underline the help, that is sometimes taken for granted, that the relatives and friends give to the handicapped. The handicapped, themselves, are often very conscious of this and of the limitations their presence causes a household. No data relating to these problems were gathered, but indications of possible stress on the relatives and the awareness of this by the handicapped are seen in the requests for holidays and short stay admissions presented in a later part of this Section.

DIAGNOSIS

The most frequently stated diagnoses (table 4.3) are arthritis and rheumatism; taking this group of unspecified arthritis and adding to it those with rheumatoid arthritis and osteo-arthritis, it is found that no less than 198 persons (26 per cent of all handicaps) stated these conditions as a main cause of their handicap. Other causes stated were mental or psychological handicap, strokes and heart diseases, each of these groups accounted for almost 7 per cent of all handicapped persons. As has already been mentioned in Section 3, the number of persons in the community with mental and psychological handicaps is higher than the figures given here, as the Canterbury Survey was concerned with physical handicap and only considered mental and psychological handicap when this contributed to the physical handicap. Two neurological conditions are included in

table 4.3 - multiple sclerosis and paralysis agitans. The extent to which these conditions cause handicap is emphasised by the finding that 6 of the 8 impaired people with multiple sclerosis were found to be "handicapped" and 15 of the 18 with paralysis agitans (see table B, appendix 1). Similarly, 52 of the 64 persons with strokes were in the handicapped group.

In most of the diagnostic groupings there were proportionately as many females (i.e. 65 per cent) as there were in the whole group of handicapped people. There were however a few interesting divergencies from this. All the persons handicapped by multiple sclerosis were females and there were preponderances of females with paralysis agitans, unspecified heart troubles, arthritis, and fractures, almost all of these reflect the greater number of females in the oldest age groups. There were disproportionately more males in the mentally handicapped group (already remarked upon) and, as would be expected from other national data of mortality and morbidity, in the diseases of the respiratory system.

Among the children, the major handicapping condition was mental subnormality, accounting for the diagnosis of 65 per cent of all the 49 children; cerebral palsy was given as the cause in regard to 5 children, epilepsy (4 children), other central nervous system (2 children) and congenital malformations (2 children).

In the age group 15-49 years mental or psychological handicap was stated as the cause of the handicap in respect of 13 people, various forms of arthritis, 8, multiple sclerosis in respect of 6 people, congenital malformations 4, epilepsy 2 and various other conditions were mentioned once only. It is, of course, possible for people to have more than one main condition and this was observed, so that the figures presented in table 4.3 and discussed above refer to somewhat fewer people than the numbers of diagnoses given.

This review of the diagnoses of the handicapped people shows a somewhat similar picture to that of the diagnoses of all impaired people. It does however bring out the serious handicapping consequences of neurological disorders and the widespread restriction of activity caused by arthritis in all its various forms.

MOBILITY

Social services must be particularly concerned about the needs of persons who are permanently housebound. To what extent are the lives of such people unnecessarily restricted and their interests limited? Is there any avoidable burden falling on relatives and friends? Are the housebound people able to care for themselves if and when they are alone? Who are they and how many

are there? These paragraphs present data on the number of housebound and of others whose movement is restricted. More details about the housebound are given in later parts of this Section.

In Canterbury 246 people (32 per cent of the handicapped) were permanently housebound, and a further 32 people were temporarily housebound at the time of the survey. Of the permanently housebound 4 persons were permanently restricted to their beds and another 6 persons to bed or chair (table 4.4); a further 16 persons stayed in a chair almost all the time but could with great difficulty move from it, or were temporarily confined to a chair.

Twenty six people had wheel chairs and 72 people used tripods, crutches or other equipment in order to get about. Another 347 people had some difficulty in walking. This difficulty would be manifest at home, in the garden, in the streets nearby and in the centre of towns, at public halls and places of entertainment and in visiting friends. Indeed the difficulty is always present and in the same way that the proverbial sore thumb is always drawing attention to itself, so those with difficulties in mobility are always finding unnecessary steps and changes in levels, often amounting to a prohibitive obstruction. Thus do the able-bodied unthinkingly exclude the handicapped from many ordinary activities, and hence the importance of Sections 4-7 of the Chronically Sick and Disabled Persons Act, 1970 on access to premises open to the public.

THE HOUSING OF THE HANDICAPPED

One way to extend and ease the access of handicapped people to all the rooms in their own accommodation, is to have all such rooms on one floor, either in a bungalow, a ground floor flat or a higher flat with lifts. Table 4.5 shows the numbers of handicapped persons in different types of accommodation and shows that only a few people (56 or 7% of all handicapped) were in flats on the first or higher floors; this must partly reflect the lack of any high-rise developments in Canterbury. Sixty four per cent of the handicapped lived in dwellings with internal stairs, a figure close to that of the entire population.

Just over 40 per cent of the handicapped either owned their accommodation or lived with relatives who owned the accommodation. Just under 40 per cent were tenants of the City Council. Almost 15 per cent were in privately rented unfurnished accommodation. The ownership of the accommodation is important in a number of ways; it is sometimes thought that owner-occupiers

may be unwilling to give up their property to move to purpose-designed accommodation but that they may be more prepared than private landlords to adapt their property. People in rented, furnished accommodation probably have least scope for making changes in their present tenancy. Tenants of the Council may be offered a choice of alternative accommodation and the Council may be able to carry out adaptations to the property. All people, especially the elderly, may be reluctant to leave familiar surroundings and will require help in deciding and then settling in, if a move is indicated. What are the needs and wishes of the handicapped in these respects?

Among all the handicapped people 74 (almost 10 per cent) had had adaptations done to their accommodation. Eight, all elderly people, were living in accommodation built specially for handicapped people.

Two hundred and thirty one (30 per cent) of the 770 handicapped people stated they had some difficulty in getting around their accommodation. Of these 231 persons 71 (31 per cent) said that they would be prepared to move to more convenient accommodation if it was impracticable for their present accommodation to be altered. Twenty three of the 71 persons prepared to move were aged 75 years or more, but 91 others in this age group who were experiencing difficulty in their present accommodation were not prepared to move. Thus altogether, 49 per cent of all persons experiencing difficulty in their accommodation (114 out of 231) were aged 75 years or more, but only 20 per cent of these (23 out of 114) were prepared to move. However 166 (29.5 per cent) of the handicapped people aged 65 years or more were interested in moving; 62 people (11 per cent of the elderly handicapped) only to special sheltered accommodation; 51 (9 per cent) only to a residential home, and 53 (9.5 per cent) to one or the other. So that almost 30 per cent of this age group are interested in one or other form of special accommodation.

Table 4.6 shows the distribution of the elderly handicapped persons interested in special accommodation by the type of tenancy or ownership of their present accommodation. Owner occupiers as a group were only marginally less interested in moving to sheltered accommodation or a residential home than were the council tenants. Tenants of privately rented unfurnished accommodation had views similar to those of the owner occupiers. There was a marked difference in the type of special accommodation each group was most interested in. Twelve per cent of the owner occupiers and 18 per cent of the private tenants were interested in sheltered accommodation, but only 7 per cent of the council tenants. Eighteen per cent of the council tenants were

interested in moving into a residential home compared to 5 per cent of the owner-occupiers and 3 per cent of the private tenants; however these figures should be added to those interested in residential homes as well as in sheltered accommodation, when the percentages are 25 per cent of elderly handicapped council tenants, 16 per cent of elderly handicapped owner occupiers, and 11 per cent of elderly handicapped private tenants.

The handicapped people were asked about certain basic household amenities - piped cold water supply, piped hot water, toilet and a fixed bath. Table 4.7 sets out the numbers of persons lacking piped cold water, piped hot water, or a fixed bath and the number with an outside toilet only, by the type of tenancy of their accommodation. The lack of such amenities among the council tenants is extremely low; the two tenants lacking piped hot water had back boilers, but had difficulty using these and wanted immersion heaters. The major deficiencies were among those in private tenancies; thirty four per cent had an outside toilet only and the same percentage lacked a piped hot water supply. As already mentioned there are obvious difficulties in adapting the accommodation in these tenancies. It is therefore not surprising to find that 19 of the 115 people (16.5 per cent) renting privately (either unfurnished or furnished accommodation) were on the Council's waiting list for re-housing compared to 2.5 per cent of the owner-occupiers. Two tenants of the Council were awaiting alternative accommodation and 2 of the tenants of voluntary agencies and 1 person in tied accommodation were also on the housing waiting list.

CONTACTS AND ISOLATION

To everyone, but perhaps more especially to handicapped people, contact with relatives and friends forms a large part of social life. Sixty per cent (table 4.8) of all of the handicapped people had relatives living nearby, and this did not vary appreciably between the different age groups. (This is a figure one would expect to be lower in the coastal retirement towns.) About fifty per cent of all the handicapped in each age group (except those under 15 and those aged 50-64 years) had relatives nearby who could help if required. The figure for the youngest age group refers to a somewhat different situation; and that is whether the parent has relatives nearby able to help with the care of the child. Seventy two per cent of all the handicapped persons had relatives or friends on the 'phone who would be able to help if necessary. Seventy five per cent considered that their friends and neighbours were able and willing to assist if required. In many ways this is an encouraging picture of mutual concern, however it does mean

that 25 per cent of the handicapped felt that their friends and neighbours could or would not help and 50 per cent had no relatives who were able to help, indeed 40 per cent had no relatives nearby - a fact that must be kept in mind when planning services.

How often do the handicapped have visitors to the house? Thirty two per cent had a visitor at least once a day, and a further 39 per cent at least once a week. These figures refer to all the handicapped people, not just to those who are housebound or live alone. Many therefore had daily family and other contacts with people. However an indication of possible social deprivation is given in table 4.8 in regard to the younger age-groups. Eighteen of the 49 children were visited in their homes less often than once a week (many of these children were mentally subnormal) and 24 of the 55 younger adults also had visitors less often than once a week.

The last section of table 4.8 shows the number of handicapped people who were usually alone during the day and night, during the day only or during the night only. Thirty one per cent were alone during the day and the night and a further 11 per cent were alone during the day only. One per cent had companionship during the day, but were alone at night. The proportion who were alone during the day and the night rises with age; whereas less than 2 per cent of the age group 15-49 years were alone, the percentage rises to 17 for the next age group, 34 for those aged 65-74 years and 41 for the oldest group.

Friends and relatives are not the only personal contacts that handicapped people make. An appreciated element in the receipt of a number of the professional services is the contact with the person concerned whether it be a nurse, a social worker, a chiropodist or a person delivering a hot meal. Table 4.9 sets out the number of handicapped people who <u>stated</u> they were in contact with each of the listed services. (A later paper will look at these contacts as recorded by the services.) The service in the home listed in table 4.9 that was most frequently mentioned by the handicapped is the home nursing service. The next is the social worker and third is the chiropodist. In fact, as will be discussed later, the general practitioner is the person in contact with most of the handicapped (39 per cent).

Some of the services will be in contact with the same patient or client, so there will be overlap. From the point of view of contact and of avoiding isolation and neglect, this overlap can be beneficial if done knowingly and with close cooperation between the services. As is discussed

later the doctor and the district nurse are likely to be concerned with many of the same patients and there is overlap between those visited by the social worker and those attending clubs. The doctor and nurse will be more concerned with the chronically sick whilst the social workers and clubs will be (and were found to be) more concerned with people handicapped by blindness or restricted movement. Not only are these contacts of the handicapped people with the services relevant to considerations of isolation and loneliness, but also they raise the possibility of using present contacts as a source of information for the need for help and services. This is analysed and discussed later in this Section.

To be alone day and night or to be one of an elderly couple can give rise to certain anxieties. All the handicapped people were asked whether they were anxious about intruders, being unable to summon help in an emergency, of being lonely or of any combination of these anxieties (table 4.10). Two hundred and thirteen persons (28 per cent) had one or other or a combination of such anxieties. The majority were worried about summoning help (16 per cent of all the handicapped), 13 per cent were worried about loneliness and 11.5 per cent about intruders. There was little difference between the age groups in these distributions.

NEEDS OF THE HANDICAPPED

The following paragraphs of this Section discuss the "needs" of the 770 handicapped people identified and interviewed in the Canterbury Survey. The term "needs" requires defining. In the second interview of the survey each handicapped person (or a proxy) was asked if he or she thought that "it would make it easier for you to ...." and then some function was stated followed by a suggestion of the provision of some aid, gadget or equipment (e.g. "... get in and out of bed if they could fix a hoist or support bar"); if he or she would like help or more help with various household chores; if he or she was interested in certain services which might be brought to his or her home; and whether he or she would be interested in going to a club or centre. Thus the following tables and discussion are based on the handicapped person's expressed need for a service. The discussion is not based on a professional assessment of each person's situation; that is, it is not based on professionally defined needs. Furthermore, the discussion is not based on administratively defined needs (or criteria for eligibility for the supply of a service) nor on the then current availability of services. In regard to the professional assessments of each situation, it is hoped that the Health Services Research Unit will revisit each handicapped person during 1974 and check the extent to which the expressed needs were confirmed

by the professional workers. The administrative definitions of eligibility and of priorities are political and administrative decisions which are and have been influenced by the preliminary findings of the Survey and must inevitably reflect the resources available and all the other needs in the community.

In the following paragraphs, the expressed needs of the handicapped persons are divided into two large groups. The first comprises the provision of aids, gadgets and adaptations and the second comprises services usually involving regular contact with a third party. The first group of needs therefore reflect a back-log of requirements with probably a much smaller quantity required on a continuing basis; the second group reflect more nearly the continuing size of the needs. For example, in the first group is included the need for a ramp to get in or out of a house; once this is provided, no further ramp would be needed by that person. In the second group, one of the needs considered is a "regular visitor" and clearly here one visit leads to the next and the supply of the service does not reduce the need for it by the handicapped person concerned.

AIDS, GADGETS AND ADAPTATIONS

Table 4.11 sets out the expressed needs of the handicapped people for various aids, gadgets and adaptations and also shows the number of handicapped persons who already have such help. The number who already had the aid, gadget or adaptation refers only to the number among the 770 handicapped persons and not to the total number of persons within the City who have had such help. The largest expressed need was for bath rails and the second was for bath seats. Although the older people predominate in respect of these needs, it is by no means only the elderly who feel they could be helped in these ways. Indeed for almost every gadget or help listed in the table, an appreciable number of persons in the age group 50 to 64 years expressed interest. The sort of difficulties that are likely to be helped by the aids and adaptations are those most frequently associated with arthritic and neurological disorders. It is to these areas of need that occupational therapists have much to contribute not only in making the assessments but also in recommending the right aid and, most importantly, training the handicapped person in its correct use. It is gratifying to know that the City have appointed an occupational therapist to the staff of the Social Services Department and that she has close links with the hospital occupational therapy department.

NEEDS FOR PERSONAL SERVICES

The figures in table 4.12 reveal a formidable amount of needs that were unmet at the time of the Survey; a situation, of course, that was common throughout the country at that time. Like all such studies, this survey reveals unmet need for chiropody, particularly among the elderly. Whilst 220 (29 per cent) handicapped persons were currently having chiropody (about half of these at home and half at a clinic), another 147 (19 per cent) persons wanted it (most of these, 110, wanted it at home). Two hundred and two handicapped persons (29 per cent) were interested in going away on holiday, although the nature of the help required (financial, transport, choice of place or continuance of some form of personal care) was not elucidated; for all age groups this was the most frequently mentioned need. One hundred and forty one people (18 per cent) expressed interest in having someone to visit them at home. For children incontinence pads and laundry service were wanted for more children than for old people.

Almost half of all of the handicapped people were already receiving some help with shopping and housework - usually from relatives, friends or neighbours. Even so a substantial number wanted help or more help with the housework (e.g. from the home-help service), somewhat fewer with shopping and only 19 with cooking. Rather surprisingly, as it is unlike the findings in other surveys, very few (only 10) people said they would like to receive meals-on-wheels and this despite the finding that only 35 of the handicapped people stated they were currently getting this service. Two activities that many handicapped people find difficult if not impossible are keeping the garden tidy and cleaning their windows; the scope for volunteers to help here should obviously be explored. It is interesting to note that at least one authority (London Borough of Wandsworth) has set up a scheme in conjunction with the Parks Section of the Borough's Technical Services Department for gardeners to help such handicapped people. Another service that would help a substantial number of handicapped people would be a mobile library service or some similar arrangement that would enable severely handicapped people to obtain and change library books. Attention should also be drawn to the need for more transport to enable persons to attend clubs.

Other services listed in table 4.12 may not be so pressing numerically as those discussed above, but many of them indicate urgent and severe needs in terms of relieving probable discomfort. Fourteen persons expressed a

need for a day and/or night attendant. This is likely to be a short-term need, but while it is present. it is probably very pressing. Facilities already exist for short-term admissions of certain handicapped people to hospital and data from other sources (J. Pritchard, personal communication) show that these are extensively used by elderly patients (although interestingly this is not apparent in the Survey's findings).

Although only 12 handicapped people stated they wanted help with lighting fires, this question revealed another problem and urgent requirement - and that is help during power cuts. Often such heating will be by electricity or gas or both and so the problem becomes one of help (and instant help at that) at times of power cuts. By and large it is probable that very many more old people than is suggested by the figures in table 4.12 need various forms of assistance (often financial) in adequately heating their accommodation.

A service about which no question was asked is dental treatment for the homebound and severely restricted handicapped people. For some the problem may only be one of transport, but for others it may be necessary to think of more complex arrangements, including perhaps some special sessions set aside for severely handicapped people. Future surveys should include questions about dental treatment.

TELEPHONE

The telephone is an obvious means of contact between the homebound and other severely handicapped people and their relatives and friends. There are, however, problems for some handicapped people associated with its use and for all there are the costs of installation, the rental and of the calls. Telephones can be adapted in different ways to aid they use by those with impaired use of their hands and for the deaf. Two hundred and seventy seven handicapped people (36 per cent) had telephones (table 4.13), but of these 57 handicapped people (including 12 children) did not use it. Thus, only between a quarter and one third of all the handicapped people both had and used telephones. Of the 493 handicapped people who did not have telephones, just under half (235) stated that they would find a telephone useful and the remainder (258), half of whom were 75 years old or more, did not want a telephone.

RADIO AND TELEVISION

Other links with the world outside the home are the radio and television. Eleven of the handicapped people (10 of them aged 65 years or more) had neither radio nor television (table 4.14). One hundred and eight (14 per cent), of whom 92 were aged 65 years or more, had only radios. Six of the children are stated to have had access to radio only, but it is possible that the question was misunderstood and taken to refer to the children's own sets, rather than their parents'. Seventy three people (9 per cent) had television only, but no radio.

Obviously some blind people will not be able to see television and some deaf people cannot hear the radio. Three blind or partially sighted people (none registered) had neither radio nor television, 56 (22 of whom were registered) had radios only and 24 (4 of whom were registered) had television only. Among the deaf and hard of hearing 8 had neither radio nor television, 42 (5 of whom were registered) had radio only and 28 (8 of whom were registered) had television only. Therefore, those without radio and television were entirely among the unregistered blind, partially sighted, deaf or hard of hearing. Almost all (98 out of 108) of those with radio only were also among these groups of handicapped people, and 52 out of the 73 handicapped people with television only were in these groups. (There may be some element of double-counting in these figures as 86 people had both impaired vision and impaired hearing and the presence of radio and television sets is affected by other people in the household.)

The conclusion is that there was a small number of handicapped people who might have liked a radio or a television set (with in some cases special head-phone sets for the deaf). The supply of these sets might be taken up by a voluntary body in conjunction with the Social Services Department. To the majority of the handicapped on restricted incomes, the greater problem is probably the cost of the licence fee; however, no questions about income or expenditure were asked in this survey, so no data can be presented on this aspect of the problem.

ATTENDANCE AT CLUBS AND SOCIAL CENTRES

Unfortunately the design of the questions about clubs and social centres allowed for too much interpretation and therefore variation in answers, so that clear-cut estimates of need and probable use cannot be made. Two hundred and fifteen people (28 per cent) stated they were attending clubs or centres

of one sort or another (table 4.15). Ninety three of these people (see appendix 1, table H) were living alone, 80 were blind or partially sighted and 64 deaf or hard of hearing (the categories are not exclusive). These findings reflect, and reflect very creditably, the deliberate development of Club services in Canterbury.

The main reason given for attending or wanting to attend clubs was to meet other people (122 persons stated this) and to have a cup of coffee or tea (101 persons). Eighty two persons mentioned having a midday meal and 60 the pursuit of a hobby. Only 20, but significantly half of these were in the age group 15 to 49 years, mentioned doing paid work. Again, each handicapped person could give a number of reasons for going or wanting to go to a club so the figures given cannot be summed.

The probability is that as clubs are sited throughout the community, as transport problems are solved and as the variety of activities is increased, the use of clubs will rise. However, the impression must not be given that the need is for clubs exclusively for the handicapped. It may well be better to plan for neighbourhood centres where all sorts of activities for all age groups and for all interests are carried on, and include special sessions for those with sensory impairments. The findings of the survey demonstrate that very many of the older people have limitations of movement; therefore the policy should be in providing any facility to design it so that it can be used by the impaired elderly. Although occasionally people with similar handicaps wish to meet together to exchange experience and help each other, more often, handicapped people want to take part in the general run of activities (e.g. go to the cinema, rather than a special film show under improvised conditions; join a chess club; attend bingo or a whist drive with everyone else). The implications of this are therefore to ensure access to public buildings for handicapped people and access to toilets and refreshments as well as to develop certain clubs and special meetings. Access to public buildings by the handicapped means providing an entrance at ground level by means of a sloping ramp instead of steps or stairs; having level walks within the building; access to lifts for the handicapped and having lifts large enough to take a wheel-chair and attendant; doors that are at least 32 inches wide and open easily (preferably using doors opening both ways); at least one toilet with wide stall and grab bars; and safe parking for the handicapped close to the building. The importance of this problem of access is underlined by figures quoted in Section 3 - almost 30 per cent of all people aged 75 years or more and 10 per cent of all people aged between 65 years and 74 years have some difficulty in getting about.

EMPLOYMENT AND SHELTERED EMPLOYMENT

The presence of employment problems is obviously related to the age and position of the people concerned; 617 of the 721 handicapped people aged 15 years or more (85 per cent) did not consider themselves available for employment (table 4.16). Thirty eight people were in open employment, 26 working full-time and 12 part-time. Seven people were in some form of sheltered employment. Only 4 people were unemployed and actively seeking work. Forty eight people of working age (29 per cent of the age group) considered themselves as permanently disabled and unable to work in open employment; 12 of these people were interested in working in a sheltered workshop and 21 in work at home. Forty seven of the handicapped were registered as disabled persons with the Department of Employment and 33 had been but were not currently registered.

USE OF SERVICES

At the end of the interview each handicapped person was asked whether he or she would want to make use of the services relevant to their needs if they were available. Ninety one per cent said that they would want to use such services; the remainder would prefer to carry on without any additional. So the figures given in the preceding tables of expressed needs are close to those who would be prepared to use the services mentioned.

CASEWORK

An important activity that was not asked about in the survey was the counselling and advising of handicapped people and their relatives. It is not possible to collect reliable data about this activity using the broad approach that was adopted for this survey. However, some of the data presented have implications for the need for casework (e.g. possible stress on relatives, loneliness and anxieties) and the crude numbers of impaired and handicapped persons in the community give some indication of the possible requirements.

THE CANTERBURY SURVEY

SECTION 5

COMPARISONS OF HANDICAPPED PERSONS LIVING ALONE, HOUSEBOUND, BLIND OR PARTIALLY-SIGHTED, OR DEAF OR HARD OF HEARING

Section 4 presented data relating to all of the 770 handicapped people, and compared the differences in prevalence of handicaps, diseases and in needs for services between 5 age groups. Tables 5.1 to 5.5 present data about many of the factors already discussed but related to four sub-groups of the handicapped - the 243 handicapped persons living alone, the 246 who were housebound (defined as unable to leave house and garden without substantial help from another person), the 255 with substantial difficulties in seeing and the 238 with substantial difficulties in hearing. These four groups are examined because all four are groups of people whom society is anxious should not be neglected, and in addition the blind have some special problems, special services and separate registration, and the deaf, because of their difficulties of communication, can become isolated and neglected, and can also have special registration.

The striking feature about these four groups of people was the overlap between them - the common factor being old age. Ninety eight of those living alone (40 per cent) had substantial difficulties in vision and 76 (31 per cent) substantial difficulties in hearing. Thirty per cent of people living alone were housebound, as were 30 per cent of those with substantial visual impairment and 26 per cent of those with substantial difficulty in hearing. The four sub-groups were dominated by older people (i.e. those aged 75 years or more) who formed over 60 per cent of each sub-group. Two thirds of each group were women.

The scores of difficulties experienced in self-care show that among the housebound 37 per cent had high scores (indicative of impaired movement of joint and limb). Among those living alone, there was the same proportion (20 per cent) with intermediate scores as among all the handicapped, but a lower proportion (8 per cent) of persons with high scores. Those with substantial impairment of vision and hearing had proportionately fewer people with intermediate or high self-care scores.

All four groups were housed in similar conditions to those of all of the handicapped, except that a higher percentage of those living alone were in flats and a lower percentage in houses - an obvious association with

living alone. Interestingly, in the light of this last observation there were no substantial differences in the percentages of each group who were owner-occupiers or council tenants. Between 10 and 13 per cent of each group lacked a hot water supply, a figure slightly in excess of that for all the handicapped. A somewhat higher percentage of persons living alone were interested in both sheltered accommodation and residential homes, and 12 per cent of the housebound were interested in residential homes. The percentages were lower for the visually and auditorily handicapped.

Among the housebound, 74 (30 per cent) were living with their independent children (compared to 19 per cent of all of the handicapped) and 67 (27 per cent) (the same as for all handicapped) were living with their spouse only. Seventy four (30 per cent) were living alone. Twenty two of the housebound had outside toilets only.

With the exception of the doctor, the clubs were in touch with the greatest number of persons living alone (38 per cent) and of the sensorily handicapped (31 per cent of the visually handicapped and 27 per cent of the auditorily handicapped). Nineteen per cent of the housebound also attended clubs, but of course needed considerable help and special transport in order to do this. The home nurse was attending 21 per cent of those living alone and 35 per cent of the housebound. The health visitor was attending between 6 and 8 per cent of each of the groups and the social worker 14 per cent of those living alone, 15 per cent of the housebound, 21 per cent of the visually handicapped and 10 per cent of those with poor hearing. The chiropodist was attending 19 per cent of those living alone, 23 per cent of the housebound and a lower percentage of the sensorily handicapped.

As far as relatives and friends are concerned, they were stated to be as available and as willing to help the people in the four groups as are the relatives and friends of all handicapped people. It is encouraging to find that 80 per cent of handicapped people living alone reckoned they had friends willing to help them as do 79 per cent of persons with impaired hearing. The figure for all of the handicapped was 75 per cent. Forty four per cent of handicapped persons living alone were visited at least once a day by a relative, friend or representative of one of the services; a further 42 per cent were visited at least once per week; but 14 per cent (34 persons) were visited less frequently. Among the housebound the percentage being visited frequently was slightly lower than among those living alone, but higher than for the sensorily handicapped, whose distribution was similar to that of all the handicapped persons together.

The expressed needs (table 5.4) of each of these four groups were similar by and large to those of all the handicapped with the exception that more of the housebound needed adaptations to their houses. The sensorily handicapped expressed, as a group, less need for aids, gadgets, adaptations and help with shopping and housework than did all the handicapped, whilst the housebound expressed more needs in these respects. Again as would be expected, proportionately more handicapped people living alone expressed interest in receiving visitors, going away on holidays, receiving meals on wheels, getting help with the garden and cleaning windows, and attending clubs in order to meet other people and have a meal or a cup of tea. However, the differences were not marked and this reflected the multiplicity of handicaps and therefore of needs that became increasingly common with rising age.

There was little difference between the groups in the percentages who had certain fears, except that a higher percentage of those living alone complained of loneliness (22 per cent) and of difficulty in summoning help (21 per cent), although this latter figure was similar among the housebound (20 per cent).

What emerges from these comparisons is the existence of a number of severely handicapped persons with physical and sensory handicaps, the majority aged over 75 years and a substantial proportion of them living alone and housebound. Others are living with an equally elderly spouse or with their independent children. Seven people (all women) were housebound, living alone and had poor vision and poor hearing, another 22 were housebound and living alone and had poor vision (15) or poor hearing (7), another 21 were housebound and had poor vision and poor hearing but were not living alone, and 32, whilst not being housebound were living alone and had poor vision and poor hearing. In all, 82 people (11 per cent of all handicapped people) had at least three of the four factors considered here - housebound, living alone, blind or poor vision, and deaf or hard of hearing. This is clearly a special category of very severely handicapped persons about whom the services must be concerned. This is a group with whom contact must be kept. The analyses so far have not suggested any simple, single way of getting in touch with these people, but they do highlight the need for wide training and experience of social workers so that the problems of the blind or the deaf, for example, are not seen as exclusively separate from each other or from the problems of physical impairment so common among the older old people. At the same time the specific problems created by certain handicapps must not be ignored or obscured by a too general approach. These findings also raise questions about the procedures of registration of the different categories of handicapped people.

THE CANTERBURY SURVEY

SECTION 6

CONTACTS WITH DOCTORS, NURSES, HEALTH VISITORS, SOCIAL WORKERS AND CLUBS AND REGISTRATION

Each handicapped person was asked whether he or she saw his or her doctor regularly, if so, how often and if not when he or she had last seen him; whether the district nurse, the health visitor and the social worker visited them; and whether he or she had any contact with clubs. By identifying all those handicapped people who had any such contacts, it is possible to examine the survey findings in relation to a professional group with whom the handicapped person stated he or she had contact. Information about two further aspects of the general problem is obtained in this way. Firstly a picture of the handicapped people in touch with each professional group can be derived and secondly the expressed needs of handicapped people whilst currently in touch with a professional group can be examined. Such data help to show the extent to which one group of professional workers might act as the referrers to another group and to estimate the likely benefit from any action in this direction, always bearing in mind the problems of professional confidentiality, and the wishes of the handicapped people themselves.

DOCTORS

No distinction was drawn in the questionnaire between hospital doctors and general practitioners so the data that follow refer to both. Two hundred and fifteen (28 per cent of all the handicapped) had regular contact with a doctor (table 6.1), and 155 of these people saw a doctor at least once a month. There is little difference in the proportions of each age group who had regular contact, except that more people in the age group 50 to 64 years (42 per cent) had regular contact than persons in the other age groups. A further 144 handicapped people (19 per cent) had seen their doctor within the last month, but were not seeing him at regular intervals. Almost a third of all handicapped people aged 75 years or more who were not seeing their doctor regularly, had nevertheless seen him within the last month. Taking together those handicapped people who had seen their doctor, either as a result of a regular contact or a special one, there were a total of 299 handicapped persons (39 per cent of all of the handicapped) who had seen their doctor within the last month.

Continuing to look at the contacts between all of the handicapped people and their doctors, for 397 persons (51 per cent) the contacts usually occurred in their own homes, for a further 259 people (34 per cent) the contacts were in the doctor's surgery and for the remaining 114 (15 per cent) it might be in either place. These figures suggest that the local doctors are very prepared to visit incapacitated people in their own homes.

As already mentioned, 299 handicapped people stated that they had seen their doctor within the month preceding the interview. Just over a half of these people (154) were aged 75 years or more (see table 6.2) and this group of people seen constituted 43 per cent of all of that age group. Thirty six per cent of all handicapped persons aged 65 - 74 years had been seen, 43 per cent of persons aged 50 - 64 years, 24 per cent of persons aged 15 - 49 years and 29 per cent of the children. In regard to diagnoses, the doctors had seen within the last month about a half or more of the handicapped people who stated that the primary causes of their impairment were strokes, heart disease, unspecified arthritis, fractures, asthma, bronchitis or paralysis agitans, and a lower proportion of persons giving other diagnoses. They had seen during the same period a half of all the handicapped people with the highest scores on the self-care ratings, about 40 per cent of those with lower scales and 28 per cent of those with no score, 41 per cent of the homebound and 31 per cent of those living alone. Just over half of the handicapped people being attended by the district nurse had seen their doctor within the last month. The group, therefore, being seen by their doctor contained proportionately more elderly people, and more people with the somewhat more acute medical conditions, and more people with severer limitations than the whole group of the handicapped. As far as the general social characteristics are concerned there was little difference between those seen recently by their doctor and the others, except such differences as would be expected from the higher proportion of the older group of retired people among the doctors' recent patients.

The expressed needs of those handicapped people who had recently seen their doctor reflected some of the characteristics of the group. Proportionately more of this group expressed needs for aids, gadgets, and adaptations and about the same proportions expressed need for or an interest in the other services compared to all of the handicapped people. About a half of all those handicapped people who wanted some aid, gadget or adaptations had seen their doctor within the last month. Clearly there is scope for developing further the liaison between the local authority occupational therapists and

the local doctors. (The scope of modern occupational therapy has not been well taught to medical students and is probably not familiar to many hospital doctors and general practitioners.)

HOME OR DISTRICT NURSES

The general practitioner and the district nurse work closely together. Just over a half of the handicapped persons attended by the home nurse had been seen by the doctor in the preceding month. The nurse will be concerned with the more severe and acute medical conditions and this is confirmed by the findings. However she is also concerned with general nursing functions particularly for the terminally ill, the incontinent, the bed-fast and chair-bound, and some other very severely restricted people. This is partly reflected in the finding that 63 per cent of the handicapped attended by the home nurse was aged 75 years or more, 83 per cent were aged 65 years or more, and 59 per cent were housebound. Proportionately more of the handicapped people attended by the nurse were also receiving meals on wheels, seeing the health visitor and the chiropodist but less were seeing the social worker or attending clubs. As in the case of the handicapped people recently seen by the doctor, proportionately more of those attended by the nurse expressed needs for aids, gadgets and adaptations than did all of the handicapped - again this reflects the nature and severity of the underlying handicapping condition. It also reflects the same need for close liaison between the nurses and the occupational therapists, so that as the services are developed they can be effectively used. In the case of both the doctors and the nurses it is not necessarily ignorance of their patients' needs that gives rise to these findings, it can also be due to a lack of the service required. The survey provides no data as to whether a request had already been made by a doctor or nurse for a service. The point being made here is the necessity as shown by the Survey findings to develop the relevant social services in conjunction with and with the full understanding and cooperation of the doctors and nurses.

HEALTH VISITORS

The health visitors were stated to be in contact with 13 of the 49 handicapped children, but only 39 of the 558 handicapped people aged 65 years or more. In all they were stated to be in contact with 66 of the 770 handicapped people. This must reflect the earlier role and training of the health visitor and the continuing need for meeting the more traditional demands made on her time for advice on child-care and for health education.

Some suggestions about the future work of health visitors have paid insufficient attention to the number of health visitors that are available and those aspects of her work, particularly in health education in all its aspects, that cannot and are not carried out by other professional workers. The findings of the Survey suggest that the health visitors had contact with the smallest number of the handicapped. The health visitors' major contribution as revealed in the study was in the care of severely handicapped children and of severely handicapped mothers. This is supported not only by consideration of the ages of the people she was in contact with, but by the fact that she saw proportionately more people living in households of 3 or more, more with the higher self-care scores but only about the average proportion of housebound. Twenty one per cent of the handicapped people she was in contact with were also in contact with a social worker. The expressed needs of the handicapped people in contact with the health visitor follow the general pattern of the needs of all the handicapped.

SOCIAL WORKERS

The social workers were stated to be in contact with 115 handicapped people, containing proportionately more people under the age of 65 years and therefore fewer old people than the group as a whole. Less than 60 per cent of the handicapped persons in contact with the social workers (and the same figure applies to the health visitors) were aged 65 years or more, compared to 75 per cent for the group seeing the doctor and 83 per cent for the group attended by the nurse. The main diagnostic groups mentioned by the handicapped people who were in contact with social workers were mental and psychological conditions and unspecified arthritis. Like the health visitors, the social workers were stated to be in contact with relatively fewer people living alone or living with their spouse only, but with relatively more of the severely restricted among the physically handicapped, and the more isolated, e.g. only 40 per cent (compared to 60 per cent of all the handicapped) stated they had relatives willing to help. Proportionately more of the handicapped people in contact with social workers attended clubs. The social workers' "group" are therefore younger and apparently less in need of medical and nursing care than the doctors' and district nurses' "groups"; they resemble more those in contact with the health visitors and as will be seen below, those attending the clubs. As regards their expressed needs, the handicapped people in contact with the social workers stated a range of needs in line with that stated by all of the handicapped.

SOCIAL CLUBS

The characteristics of the 209 handicapped people attending social clubs were distributed proportionately between those of the handicapped people attended by the doctors and nurses and between those attended by the social workers. The clubs saw more old people than the social workers but fewer children, and there was not the same number of mental and psychological conditions present. The clubs were in contact with the highest proportion of people living alone (45 per cent of handicapped people attending the clubs and 38 per cent of all handicapped people living alone) but, obviously, the people attending the clubs had fewer activities restricted by their impairments. Even so 45 housebound people were being enabled to attend the clubs, and this represented 22 per cent of all handicapped people attending. Proportionately fewer of the handicapped people attending the clubs were also being attended by district nurses, but proportionately more were attended by social workers. The expressed needs followed the general pattern except that proportionately more stated an interest in having help with their gardens and with cleaning their windows, in home visitors and in holidays - no doubt, a reflection of their generally greater but nevertheless still restricted level of activities.

The results of these subsidiary analyses suggest a trend, which other studies have confirmed, that "chronically sick and disabled persons" (to quote the title of the 1970 Act) embrace one group of people whose underlying condition is static and another group whose condition is deteriorating or who have developed a second condition in addition to the static one. The social workers and clubs at the time of the Survey (1971) were more concerned with the former group and the doctors and nurses with the latter. However the distinction between the two categories is very far from being clear so that the very closest cooperation between the social services and the health services is an absolute requirement for any services designed to overcome the disadvantages of physical, sensory or mental impairment.

REGISTERS

Table 6.5 presents figures comparing selected characteristics of those handicapped people who had substantial impairments of vision who were registered as blind or as partially sighted with those who were not on either register, and similarly for those who had substantial impairments of hearing. The registered blind and partially sighted contained fewer people over the age of 75 years and more aged between 50 and 64 years, had

fewer who also had impaired hearing, fewer who were alone day and night, but more who had a home visitor, attended a club and were in contact with social workers than the unregistered group. The registered deaf and hard of hearing also contained proportionately fewer of the older old people, fewer with impaired sight and with physical disability, but more who attended clubs than did the group who were not registered. Only 25 of the 238 handicapped people with some difficulty in hearing had been visited by social workers and only 2 of the 25 were registered as deaf or hard of hearing.

It may well be that the unregistered handicapped people were not eligible for registration on any of the four registers referred to above. The Survey provides no data on this point. The comparisons and findings presented here, however, suggest the need for a reconsideration of the purposes served by registration. Some aspects of these problems will be discussed in a later paper which will consider the Canterbury Survey findings in the context of other studies and will discuss the relationships of the quantitative data now available to future policy and development.

.....

The data presented about the operation of certain of the services at the time of the Survey are insufficient for any conclusions to be drawn about what is right or wrong or for any valued judgements to be made about the quality of the work of the groups of people concerned. For example, as far as the data go, it could be that the amount of contact between handicapped person and the service was exactly appropriate to the existing conditions and policies of the services. Equally, it may not be so. The 1974 follow-up survey will throw some light on this. The present expansion of services available to handicapped people must necessitate changes. The data presented can be (and some has already been) used for planning those changes. Furthermore all the citizens of Canterbury whose needs have been identified can be helped, because the Canterbury Survey was both a survey to identify people as well as a survey to provide quantitative data for planning.

TABLE 1.1

MEMBERS OF THE STEERING COMMITTEE

Councillor Mrs. Hettie M.E. Barber, Chairman of the Social Services Committee from May 1972; Chairman of Steering Committee from July 1972. Mayor of the City 1973-74.

Mr. F. Fowler, Administrative Assistant, Town Clerk's Office (Member until his retirement in July 1972).

Mr. E.C.S. Hutt, City Treasurer.

Mrs. Mary Keith-Lucas, City Councillor and Chairman of the Social Services Committee until May 1972, subsequently a coopted member of the Social Services Committee.

Mrs. E. Mary Rothermel, Honorary Organiser of the Canterbury Survey of the Handicapped.

Mrs. Joan Warren, Assistant Organiser, member of Steering Committee from July 1972.

Professor Michael D. Warren, Honorary Adviser to the Canterbury Survey; Director of the Health Services Research Unit, University of Kent.

Miss Kay Wells, Deputy Director of Social Services, Kent County Council and Canterbury City Council.

TABLE 1.2.

CANTERBURY SURVEY

COROLLARIES OF THE SURVEY

1. Help given to the handicapped people identified.

2. Increase in the staff of the Social Services Department; especially the appointment of social workers and an occupational therapist.

3. Data available for local planning of services.

4. Appointment of the Volunteer Liaison Officer and the establishment of the Canterbury Volunteer Bureau.

5. Establishment of the Canterbury Association of Voluntary Societies.

6. Further development of the Home Help Service.

7. Formation of a Sub-Committee of the Social Services Committee to liaise with the University on research matters.

8. Provision of data for use in further research into the needs for and effectiveness of services for the handicapped.

9. Improvements in the forms and questionnaires used and in the methodology recommended for this type of survey.

10. Arousal of local public interest in the needs of handicapped people. (This can only be an impression, but one that is reflected in the coverage in the local newspapers, the response to appeals for help and the larger number of handicapped people now referred to the Social Services Department.)

TABLE 1.3

CRUCIAL FEATURES IN THE CONDUCT OF THE CANTERBURY SURVEY

1. Five months spent on preparation, planning and obtaining widespread goodwill and cooperation.

2. Experienced and extremely competent organisation prepared to work long hours to carry through the survey, and given the complete backing and personal involvement of the successive chairmen of the Social Services Committee.

3. An exceptional degree of cooperation and collaboration between voluntary and statutory bodies and in particular between the City Council, Kent County Council, the voluntary organisations, and the Health Services Research Unit.

4. Use of large numbers of voluntary helpers, prepared to help under supervision, and be trained for their tasks.

5. Limited span of supervision with clear delegation of responsibility - Honorary organiser, assistant organiser and district organisers.

6. Detailed and prompt checking of the quality of the work by the scrutiny of all forms as they were returned to the office.

7. Provision of two rooms as a headquarters and two part-time professional secretaries to support the voluntary administration.

8. Use of previously developed forms and questionnaires (although there were some adaptations to the latter).

9. The size of Canterbury County Borough.

TABLE 1.4

CHRONOLOGY OF THE MAIN EVENTS

1971	May	Publication of the results of the national survey of the impaired and handicapped.
	September	Circular 45/71 sent to local authorities, drawing their attention to the above report and suggesting local surveys.
	October	Section 1 of the Chronically Sick and Disabled Persons Act, 1970, came into force. Discussions between the chairman of the Canterbury City Social Services Committee and the Deputy Director of Social Services; first approach to the Director of the Health Services Research Unit, University of Kent.
	November and December	Possibility of a total household survey discussed at meetings and reported in the local press. Continuation of informal discussions; first approach made to the prospective Honorary Organiser, and tentative plans for the survey outlined. Hospital Management Committee approached.
1972	January	Social Services Committee approve plans for a survey of every household.
	February	Council endorse the Social Services Committee's plans for a full survey, after debate. Appointment of Honorary Organiser. Provision of premises by Hospital Management Committee. Formation of Steering Committee.
	March	Press conference. Addressing of envelopes and forms. Meeting of voluntary organisations. Recruitment of helpers. Chairman of Social Services Committee and Honorary Organiser meet groups and discuss survey. Printing of interview schedules.
	April	Press interview Honorary Organiser Public meeting addressed by Mr. David Crouch, M.P. Briefing and distribution of forms to district organisers.
	May	Council elections - change of Chairman of Social Services Committee. Delivery and collection of forms.

TABLE 1.4 (continued)

1972	June	Postal reminders to householders who had not responded to the hand delivery. Screening interviews start, after briefing of interviewers.
	July	Screening interviews continue. Briefing and training of interviewers for third stage.
	August	Second interviews (third and final stage of field work) started. Screening interviews continue. Coders trained.
	September and October	Social Services Department appointed additional social workers and other staff. Field work completed. Coding and punching completed. Tables produced from analysis sheets.
	November	Preliminary data presented to the Social Services Committee and the Finance and Establishments Committee. Computer print-out tables available. Press Conference and Civic Reception.
	December	Social workers start visiting the handicapped identified in the survey.
1973	January	Meeting of interviewers to discuss experience in using the schedules.
	February	Sub-Committee for Research Liaison set up by Social Services Committee.
	June	Appointment of Volunteer Liaison Officer.
	September	Establishment of the Canterbury Volunteer Bureau.
	December	Canterbury Association of Voluntary Societies formed.

N.B. Throughout 1973 the social workers and their colleagues completed the visits to every handicapped person found in the survey, who agreed to be visited.

TABLE 2.1

RESPONSE AND NUMBERS OF NEGATIVE AND POSITIVE FORMS RETURNED BY ELECTORAL DISTRICTS

District	No. Households on register & other occupied houses	Empty, or Demolished houses	Actual No. Households approached	Verbal Refusals	Results from volunteers and postal approach				No reply from postal reminder	Percent returning completed forms
					Spoiled Papers	Negative	Positive Impaired	Positive not impaired Elderly alone		
1	1,461	24	1,437	21	21	1,070	175	83	67	92.4
2	1,166	12	1,154	34	12	852	184	38	34	93.1
3	794	20	774	27	8	523	128	42	46	89.5
4	800	18	782	23	18	556	129	28	28	91.2
5	1,068	48	1,020	5	4	789	130	62	30	96.2
6	993	45	948	15	22	718	130	33	30	92.9
7	1,672	112*	1,560	36	29	1,175	200	72	48	92.8
8	669	1	668	9	4	504	69	6	76	86.7
9	515	24	491	6	4	360	58	34	29	92.1
10	1,542	9	1,533	27	30	1,232	166	49	29	94.4
11	608	15	593	14	2	461	77	26	13	95.1
TOTALS	11,288	328	10,960	217	154	8,240	1,446	473	430	92.7

*A number of "pre-fabs" had recently been demolished in this area

TABLE 3.1

THE CANTERBURY SURVEY

PREVALENCE OF IMPAIRED PEOPLE
BY AGE AND SEX

	AGE GROUP YEARS	POPULATION 1971 CENSUS	NO. ASCERTAINED AS IMPAIRED	AGE - SEX SPECIFIC PREVALENCE RATE (BASED ON 92% of POP'N)
Men	0 - 4	1,220	10	9
	5 - 14	2,565	39	16
	15 - 29	4,380	38	9
	30 - 49	3,360	69	22
	50 - 64	2,610	134	56
	65 - 74	1,135	154	147
	75+	555	156	305
	Not Known	-	1	
	All Ages	15,825	601	41
Women	0 - 4	1,115	5	5
	5 - 14	2,190	22	11
	15 - 29	4,020	23	6
	30 - 49	3,660	67	20
	50 - 64	3,070	168	59
	65 - 74	1,855	244	143
	75+	1,410	402	310
	Not Known	-	2	
	All Ages	17,320	933	58
Total M & F		33,145	1,534	50

TABLE 3.2

THE CANTERBURY SURVEY

POINT-PREVALENCE OF IMPAIRMENTS

IMPAIRMENT	NO. FOUND IN CANTERBURY SURVEY	RATE PER* 1000 POP'N.	NATIONAL+ REG'N FIGURES
REG. BLIND	51	1.7	2.1
REG. PARTIALLY SIGHTED	36	1.2	0.8
DIFFICULTY IN DISTANT VISION	170	5.6	-
DIFFICULTY IN READING	137	4.5	-
REG. DEAF	16	0.5	0.5
REG. HARD OF HEARING	17	0.5	0.4
OBS. HARD OF HEARING	224	7.3	-
HOUSEBOUND	200	6.6	)
DIFFICULTY IN SELF-CARE/ GETTING ABOUT	945	31	) 5.1)

*Rates are based on 92% of the population of Canterbury, enumerated in the 1971 Census.

+From "Health and Personal Social Services Statistics" D.H.S.S., 1972. London: H.M.S.O.

Note:- As an individual may have more than one type of impairment (e.g. physically impaired with very poor eyesight), the total number of impaired people is less than the sum of the number of all impairments.

TABLE 3.3

THE CANTERBURY SURVEY

GROUPINGS OF DIAGNOSES. ALL IMPAIRED

(Figures in Brackets = per cent of all 1543 impaired)

DIAGNOSTIC GROUP	MAIN CONDITION STATED	TOTAL* PERSONS MENTIONING CONDITION
MUSCULO-SKELETAL	350 (22.7)	497 (32.2)
CENTRAL NERVOUS	172 (11.1)	230 (14.9)
CARDIOVASCULAR	145 (9.4)	257 (16.6)
PSYCHOLOGICAL	87 (5.6)	118 (7.6)
RESPIRATORY	76 (4.9)	188 (12.2)
INJURIES	71 (4.6)	116 (7.6)
AMPUTATIONS	54 (3.5)	54 (3.5)
OTHER	195 (12.7)	377 (24.5)
NONE STATED++	393 (25.5)	

*Totals more than 100% as more than one condition may be present per person.

++Refers particularly to persons who only stated their impairment, e.g. "blind", "poor vision", "deaf".

TABLE 3.4

CANTERBURY SURVEY

MARITAL STATUS, HOUSEHOLD COMPOSITION, PRESENCE OF OTHER HANDICAPPED PERSONS* IN HOUSEHOLD. ALL IMPAIRED PERSONS

FACTOR	NUMBER AMONG IMPAIRED	PER CENT
MARITAL STATUS		
MARRIED	697	45
SINGLE	299	20
OTHER	538	35
HOUSEHOLD COMPOSITION		
ALONE	440	29
1 OTHER PERSON	601	39
2 OTHERS OR MORE	493	32
OTHER HANDICAPPED PERSON*		
PRESENT	170	11

*Defined as another member of the household having a second interview in the Survey

TABLE 4.1

CANTERBURY SURVEY

AGE AND SEX OF HANDICAPPED PERSONS

AGE GROUP YEARS	MALES	FEMALES	TOTAL	AGE SPECIFIC PREVALENCE RATES	
				MALES	FEMALES
0 - 4	6 (2.2)	3 (0.6)	9 (1.2)	5	3
5 - 14	27 (10)	13 (2.6)	40 (5.2)	11	6
15 - 29	15 (5.5)	10 (2.0)	25 (3.2)	4	3
30 - 49	14 (5.2)	16 (3.2)	30 (3.9)	4	5
50 - 59	25 (9.3)	28 (5.6)	53 (6.9)	18	23
60 - 64	19 (7.0)	36 (7.2)	55 (7.1)		
65 - 74	63 (23.0)	137 (27.4)	200 (26.0)	60	80
75 - 84	78 (28.9)	182 (36.4)	260 (33.8)	198	198
85+	23 (8.5)	75 (15.0)	98 (12.7)		
Total	270 (100)	500 (100)	770 (100)	18.5	31.4

Figures in brackets show percentage of each sex by age group.

TABLE 4.2

CANTERBURY SURVEY

MARITAL STATUS AND HOUSEHOLD COMPOSITION
OF THE HANDICAPPED BY AGE

AGE GROUP YEARS	MARITAL STATUS			NUMBER IN HOUSEHOLD		
	SINGLE	MARRIED	OTHER	ALONE	TWO	THREE +
0 - 14	49	0	0	0	0	49
15 - 49	26	29	0	1	8	46
50 - 64	17	74	17	16	54	38
65 - 74	21	100	79	69	105	26
75+	41	104	213	157	133	68
Total	154	307	309	243	300	227

TABLE 4.3

CANTERBURY SURVEY

SELECTED DIAGNOSES BY AGE GROUP

(HANDICAPPED PERSONS)

DIAGNOSES	AGE GROUP - YEARS					TOTAL
	0-14	15-49	50-64	65-74	75+	
STROKES	0	1	12	20	19	52
MULTIPLE SCLEROSIS	0	6	0	0	0	6
PARALYSIS AGITANS	0	1	5	5	4	15
CORONARY DISEASE	0	1	3	6	9	19
HEART (UNSPEC.)	0	0	1	11	19	31
RHEUMATOID ARTH.	0	3	11	6	8	28
OSTEO-ARTHRITIS	0	0	6	2	10	18
OTHER ARTHRITIS	0	2	15	40	95	152
BRONCHITIS. EMPH. ASTHMA	1	0	6	8	10	25
MENTAL SUBN. PSYCHON.	32	13	2	2	4	53

TABLE 4.4

CANTERBURY SURVEY

MOBILITY OF THE HANDICAPPED BY AGE GROUPS (Q.22 & 23)

CATEGORY	AGE GROUP IN YEARS 0-14	15-49	50-64	65-74	75+	TOTAL
GETTING OUT OF HOUSE						
PERM. BEDFAST	1	0	1	1	1	4
PERM. CHAIRBOUND	0	0	1	2	3	6
PERM. HOUSEBOUND	1	6	30	50	149	236
TEMP. HOUSEBOUND	0	1	6	5	20	32
USUALLY GETS OUT	47	48	70	142	185	492
TOTAL	49	55	108	200	358	770
MOBILITY*						
STAYS IN CHAIR**	0	1	3	1	11	16
WHEEL CHAIR	2	3	6	10	5	26
USE TRIPOD, CRUTCHES	0	6	7	16	43	72
WALKS WITH DIFFICULTY	4	11	46	89	197	347
NO DIFFICULTY	40	34	44	81	98	297
TOTAL	46	55	106	197	354	758

*Excludes Bedfast and Chairbound given in first part of table and two toddlers.

**Includes those temporarily confined to a chair, and those who are very limited in mobility but not chairbound.

TABLE 4.5

CANTERBURY SURVEY

TYPES AND OWNERSHIP OF ACCOMMODATION OF THE HANDICAPPED BY AGE GROUPS (Q.56 & 58)

TYPE OF ACCOMMODATION	AGE GROUP IN YEARS					TOTAL	
	0-14	15-49	50-64	65-74	75+	NO.	PERCENT
BUNGALOW	0	3	11	26	58	98	(12.7)
HOUSE	47	44	69	124	209	493	(64.0)
GROUND FLOOR FLAT	1	6	19	36	[illegible]	123	(16.0)
FIRST FLOOR FLAT	0	2	7	12	27	48	(6.2)
FLAT ABOVE 1ST FLOOR	1	0	2	2	3	8	(1.0)
TOTAL	49	55	108	200	358	770	
OWNERSHIP							
OCCUPIER	18	22	39	69	173	321	(41.7)
LOCAL AUTHORITY	26	28	55	91	103	303	(39.3)
VOLUNTARY AGENCY	0	1	1	3	5	10	(1.3)
PRIVATE - UNFURNISHED	3	3	10	30	59	105	(13.6)
PRIVATE - FURNISHED	1	1	2	2	4	10	(1.3)
RENT FREE - TIED	1	0	1	5	14	21	(2.7)
TOTAL	49	55	108	200	358	770	

TABLE 4.6

CANTERBURY SURVEY

INTEREST OF PERSONS AGED 65 YEARS OR MORE IN MOVING TO SPECIAL ACCOMMODATION BY TYPE OF PRESENT ACCOMMODATION

OWNERSHIP OF ACCOMMODATION	NOT INTERESTED	INTERESTED IN			TOTAL OVER 65 YRS.
		SHELT.ACC. ONLY	RES.HOME ONLY	BOTH	
OCCUPIER	173 (71)	30	12	27	242
COUNCIL	131 (68)	13	34	14	192
RENT FROM VOL. AGENCY	8	0	0	0	8
RENT PRIVATELY UNFURNISHED	63 (71)	16	3	7	89
RENT PRIVATELY FURNISHED	2	0	0	4	6
RENT FREE	13 (68)	3	2	1	19
TOTAL	390	62	51	53	556

(Per cent in brackets)

TABLE 4.7

CANTERBURY SURVEY

HOUSING OF THE HANDICAPPED -
LACK OF AMENITIES BY OWNERSHIP OF ACCOMMODATION

TYPE OF TENANCY	LACKS PIPED COLD WATER	LACKS PIPED HOT WATER	LACKS FIXED BATH	OUTSIDE W.C. ONLY	TOTAL NUMBER IN GROUP
OWNER OCCUPIER	1	18	13	19	321
COUNCIL	0	2	0	0	303
RENT FROM VOL. AGENCY	0	1	2	1	10
RENT PRIVATELY UNFURNISHED	0	36	45	36	105
RENT PRIVATELY FURNISHED	0	1	1	0	10
RENT FREE	0	4	4	3	21
TOTAL	1	62	65	59	770

TABLE 4.8

CANTERBURY SURVEY

CONTACTS WITH RELATIVES AND FRIENDS OF THE HANDICAPPED PEOPLE BY AGE GROUPS (Q.34 - 38 and 42)

	AGE GROUP IN YEARS 0-14	15-49	50-64	65-74	75+	TOTAL NO.	PERCENT*
AVAILABILITY OF RELATIVES, FRIENDS, NEIGHBOURS							
RELATIVES NEARBY	26	36	62	129	208	461	(60)
NO " "	23	19	46	71	150	309	(40)
RELATIVES ABLE TO HELP	19	26	47	106	184	382	(49.6)
NO " " " "	30	29	61	94	174	388	(50.4)
RELATIVES ON 'PHONE & ABLE TO HELP	30	34	67	146	274	551	(72)
NO " " " " " " "	19	21	41	54	84	219	(28)
NEIGHBOURS ABLE TO HELP	34	45	78	142	282	581	(75)
NO " " " "	15	10	30	58	76	189	(25)
FREQUENCY OF VISITORS							
AT LEAST DAILY	15	11	23	54	146	249	(32)
AT LEAST WEEKLY	16	20	47	78	142	303	(39)
LESS OFTEN	18	24	38	68	70	218	(28)
NUMBERS ALONE DURING DAY OR NIGHT							
ALONE DAY AND NIGHT	0	1	18	68	148	235	(31)
ALONE DURING DAY ONLY	0	11	24	19	32	86	(11)
ALONE DURING NIGHT ONLY	0	0	4	2	4	10	(1)
NOT ALONE DURING DAY OR NIGHT	49	43	62	111	174	439	(57)
TOTAL NUMBERS IN EACH AGE GROUP	49	55	108	200	358	770	

*Percentage of all (770) handicapped

TABLE 4.9

CANTERBURY SURVEY

CONTACTS OF THE HANDICAPPED WITH SERVICES BY AGE GROUPS (Q.39 and 40)

SERVICE IN CONTACT	AGE GROUP IN YEARS 0-14	15-49	50-64	65-74	75+	TOTAL NO.	PERCENT*
MEALS ON WHEELS	0	0	3	5	27	35	(5)
HOME NURSE	1	5	17	26	84	133	(17)
HEALTH VISITOR	13	10	4	12	27	66	(9)
SOCIAL WORKER	15	14	22	18	46	115	(15)
OCC. THERAPIST	0	1	0	0	1	2	-
CHIROPODIST	0	2	8	11	86	107	(14)
CLUBS	8	15	29	58	99	209	(27)

*Percent of all (770) handicapped

TABLE 4.10

CANTERBURY SURVEY

ANXIETIES OF THE HANDICAPPED BY AGE GROUP (Q.41)

ANXIETY ABOUT	AGE GROUP IN YEARS					TOTAL
	0-14	15-49	50-64	65-74	75+	
INTRUDERS	2	5	1	12	17	37
SUMMONING HELP	2	8	13	14	22	59
INTRUDERS AND HELP	0	0	4	5	7	16
LONELINESS	2	3	4	13	21	43
INTRUDERS AND LONELINESS	0	0	1	4	5	10
HELP AND LONELINESS	0	0	5	8	9	22
INTRUDERS, HELP, LONELINESS	1	2	4	9	10	26
ALL ANXIOUS ABOUT INTRUDERS	3	7	10	30	39	89
" " " HELP	3	10	26	36	48	123
" " " LONELINESS	3	5	14	34	45	101
NOT ANXIOUS ABOUT THE ABOVE	42	37	76	135	267	557

TABLE 4.11

CANTERBURY SURVEY

EXPRESSED NEEDS OF THE HANDICAPPED BY AGE GROUPS

PERSONAL AIDS AND HOUSE ADAPTATIONS

AID OR SERVICE	AGE GROUP IN YEARS 0-14	15-49	50-64	65-74	75+	TOTAL WANTING	TOTAL ALREADY HAVING
HOIST	0	1	2	2	4	9	1
SUPPORT BAR	1	0	7	8	11	27	4
WIDEN W.C. DOORS	0	1	0	0	1	2	1
RAISE W.C. SEAT	1	1	8	5	8	23	12
W.C. RAILS	1	1	11	6	10	29	24
BATH RAILS	1	9	26	36	50	122	74
SITZ BATH	2	0	0	0	5	7	1
SHOWER	2	5	10	16	11	44	7
BATH SEAT	1	3	11	34	35	84	57
SHOE & STOCKING AID	1	5	12	8	25	51	16
SPECIAL CLOTHING	3	6	13	11	15	48	6
FEEDING GADGETS	1	3	4	4	4	16	6
KITCHEN AIDS	0	5	15	23	17	60	10
STAIR RAILS	1	1	9	12	23	46	-
RAMP	3	4	6	7	13	33	10
SICKROOM EQUIPMENT	1	3	7	4	11	26	15

TABLE 4.12

CANTERBURY SURVEY

EXPRESSED NEEDS OF THE HANDICAPPED BY AGE GROUPS

HELP FROM OTHER PEOPLE AND SERVICES

SERVICE	AGE GROUP IN YEARS 0-14	15-49	50-64	65-74	75+	TOTAL WANTING	TOTAL ALREADY HAVING
CHIROPODY AT HOME	0	4	10	30	66	110	103
CHIROPODY AT CLINIC	2	2	5	13	15	37	117
HOLIDAY	14	20	27	71	70	202	28
VISITOR	4	7	21	41	68	141	28
HELP WITH SHOPPING	2	3	8	12	16	41	301
HELP WITH HOUSEWORK	1	7	12	14	35	69	313
HELP WITH COOKING	0	1	3	6	9	19	154
HELP WITH GARDENING	0	3	8	26	72	109	48
HELP WITH WINDOW CLEANING	0	5	14	26	43	88	15
HELP TO LIGHT FIRES	0	0	2	6	4	12	6
HELP TO COLLECT LAUNDRY	0	1	1	2	3	7	31
HELP TO MOVE DUSTBINS	0	0	2	7	9	18	24
LAUNDRY SERVICE	5	1	3	3	1	13	2
INCONTINENCE PADS	8	2	2	3	6	21	10
MOBILE LIBRARY	2	4	20	44	56	126	10
MEALS ON WHEELS	0	0	0	4	6	10	35
BATH ATTENDANT	0	0	1	2	7	10	23
DAY/NIGHT ATTENDANT	3	0	3	3	5	14	1
SHORT-TERM ADMISSION	4	4	4	5	16	33	3
TRANSPORT TO:							
MEDICAL TREATMENT	4	2	10	6	11	33	-
CLUBS	2	5	18	17	43	85	-

TABLE 4.13

CANTERBURY SURVEY

POSSESSION AND USE OF TELEPHONE BY THE HANDICAPPED

	AGE GROUP IN YEARS					TOTAL
	0-14	15-49	50-64	65-74	75+	
HAS 'PHONE AND USES IT	6	15	28	51	120	220
HAS 'PHONE, DOESN'T USE	12	7	4	7	27	57
WOULD FIND 'PHONE USEFUL	18	24	44	66	83	235
DOESN'T WANT 'PHONE	13	9	32	76	128	258

TABLE 4.14

CANTERBURY SURVEY

ACCESS TO RADIO AND TELEVISION OF HANDICAPPED PERSONS BY AGE GROUPS

	AGE GROUP IN YEARS					TOTAL
	0-14	15-49	50-64	65-74	75+	
HAS NEITHER RADIO NOR T.V.	0	0	1	3	7	11
HAS RADIO ONLY	6	0	10	23	69	108
HAS T.V. ONLY	0	5	14	19	35	73
HAS BOTH	43	50	83	155	247	578

TABLE 4.15

CANTERBURY SURVEY

ATTENDANCE AND INTERESTS IN CLUBS AND SOCIAL CENTRES OF THE HANDICAPPED BY AGE GROUPS

	AGE GROUP IN YEARS					TOTAL
	0-14	15-49	50-64	65-74	75+	
ATTENDING CLUB OR CENTRE	11	20	25	63	96	215
REASONS FOR ATTENDING OR WANTING TO ATTEND:						
MEET OTHER PEOPLE	4	16	21	38	43	122
HAVE MIDDAY MEAL	1	8	13	31	29	82
HAVE COFFEE/TEA	2	13	19	28	39	101
PURSUE HOBBIES	4	15	14	16	11	60
DO PAID WORK	0	10	5	5	0	20
HELP HANDICAPPED PEOPLE	0	6	5	14	7	32

TABLE 4.16

CANTERBURY SURVEY

EMPLOYMENT OF THE HANDICAPPED BY AGE GROUPS

	AGE GROUP IN YEARS 15-49	50-64	65-74	75+	TOTAL
CURRENTLY EMPLOYED					
FULL TIME - OPEN EMPLOYMENT	12	12	1	1	26
PART TIME - OPEN EMPLOYMENT	2	6	2	2	12
FULL TIME - SHELTERED EMPLOYMENT	3	1	0	0	4
PART TIME - AT A CENTRE	3	0	0	0	3
NOT AVAILABLE FOR EMPLOYMENT*	14	51	197	355	617
NOT EMPLOYED					
UNEMPLOYED - WANTS WORK	2	2	0	0	4
PERM. DISABLED - UNABLE TO WORK	15	33	0	0	48
TEMP. DISABLED - OFF SICK	4	3	0	0	7
TOTAL	55	108	200	358	721
EXPRESSED NEEDS OF THE 43 PERMANENTLY DISABLED					
SHELTERED WORKSHOP	2	10	0	0	12
WORK AT HOME	5	16	0	0	21
REGISTRATION AS DISABLED**					
HAS BEEN REGISTERED	4	8	18	3	33
STILL IS REGISTERED	18	28	1	0	47

*Still at school, other education, housewife, retired, etc.

**Registered with Department of Employment as distinct from registration with Social Services Dept.

TABLE 5.1

CANTERBURY SURVEY

ANALYSES OF HANDICAPPED BY AGE, SENSORY IMPAIRMENT, DIAGNOSES, LIVING ALONE, HOUSEBOUND, BLIND & DEAF GROUPS

FACTOR ANALYSED	ALL 770 HANDICAPPED		LIVING ALONE (243)		HOUSE-BOUND (246)		BLIND PART.SIGHT.(255)		DEAF HARD HEAR.(238)	
	No.	%	No.	%	No.	%	No.	%	No.	%
AGE IN YEARS										
0-14	49	(6.4)	0	(0)	2	(1)	0	(0)	6	(2.5)
15-49	55	(7.1)	1	(0.5)	6	(2.5)	9	(3.5)	10	(4)
50-64	108	(14.0)	16	(7)	32	(13)	28	(11)	19	(8)
65-74	200	(26)	69	(28)	53	(21)	63	(25)	56	(24)
75+	358	(46.5)	157	(65)	153	(62)	155	(61)	147	(62)
TOTAL	770		243		246		255		238	
HANDICAP - SENSES										
REGISTERED BLIND	45	(6)	13	(5)	-		45	(18)	10	(4)
REGISTERED PART.SIGHTED	32	(4)	10	(4)	-		32	(13)	6	(2.5)
DIFFICULTY IN READING	178	(23)	75	(31)	-		178	(70)	70	(29)
REGISTERED DEAF	15	(2)	5	(2)	-		2	(1)	15	(6)
REGISTERED HARD OF HEAR.	14	(2)	7	(3)	-		4	(1.5)	14	(6)
SOME DEAFNESS STATED	209	(27)	64	(26)	-		80	(31)	209	(88)
DIAGNOSES (PRIMARY)										
A1 STROKES	52	(7)	9	(4)	31	(13)	13	(5)	8	(3)
B-1 MENTAL & PSYCHONEUROTIC	53	(7)	2	(1)	5	(2)	2	(1)	4	(1.5)
B2,3,4,7 HEART CONDITIONS	60	(8)	31	(13)	29	(12)	17	(6)	14	(6)
C0,1,2 ALL ARTHRITIS	198	(26)	76	(31)	87	(35)	39	(15)	43	(18)
D5 ALLERGIC/METABOLIC	19	(2.5)	8	(3)	6	(2.5)	11	(4)	7	(3)
SELF CARE SCORE										
CAT										
2 SCORE 6-11	158	(20)	48	(20)	59	(24)	34	(13)	30	(13)
1 SCORE 12 OR MORE	165	(22)	20	(8)	91	(37)	31	(12)	21	(9)
MOBILITY (C0,1,2,4)										
PERM. HOUSEBOUND	246	(32)	74	(30)	246	-	77	(30)	61	(26)

TABLE 5.2

CANTERBURY SURVEY

HOUSING CONDITIONS OF HANDICAPPED PERSONS

LIVING ALONE, HOUSEBOUND, BLIND, DEAF

HOUSING FACTOR	ALL 770 HANDICAPPED		LIVING ALONE (243)		HOUSE-BOUND (246)		BLIND PART.SIGHT.(255)		DEAF HARD HEAR.(238)	
	No.	%	No.	%	No.	%	No.	%	No.	%
TYPE OF ACCOMMODATION										
0 BUNGALOW	98	(13)	37	(15)	30	(12)	36	(14)	30	(13)
1 HOUSE	493	(64)	95	(39)	152	(62)	153	(60)	152	(63)
2 GROUND FLOOR FLAT	123	(16)	75	(31)	49	(20)	47	(18)	32	(13)
3 FIRST FLOOR FLAT	48	(6)	34	(14)	13	(5)	16	(6)	21	(9)
4 FLAT ABOVE 1ST FLOOR	8	(1)	2	(1)	2	(1)	3	(1)	3	(1)
OWNERSHIP										
1 OCCUPIER	321	(42)	88	(36)	113	(46)	96	(38)	102	(43)
2 COUNCIL	303	(39)	98	(40)	97	(39)	99	(39)	82	(34)
3 VOLUNTARY ASSOCIATION	10	(1)	10	(4)	1	(0.5)	3	(1)	3	(1)
4 PRIVATE UNFURNISHED	105	(14)	33	(14)	29	(12)	43	(17)	40	(17)
5 PRIVATE FURNISHED	10	(1)	2	(1)	1	(0.5)	5	(2)	4	(2)
6 RENT FREE	21	(3)	12	(5)	5	(2)	9	(3)	7	(3)
LACK OF AMENITIES										
NO COLD WATER	2	-	0	-	1	-	0	-	1	-
SHARES TAP FOR COLD WATER	4	-	1	-	1	-	3	-	2	-
NO HOT WATER	63	(8)	31	(13)	20	(8)	31	(12)	24	(10)
SHARES SUPPLY HOT WATER	4	-	1	-	1	-	3	-	2	-
INTERESTED IN (OVER 65)										
SHELTERED ACCOMMODATION	62	(11)	31	(14)	15	(7)	22	(9)	24	(10)
RESIDENTIAL HOME	51	(9)	27	(12)	24	(12)	14	(5.5)	17	(7)
BOTH	53	(9.5)	21	(9)	11	(5)	24	(9)	19	(8)
(TOTAL OVER 65)	556	(72)	225	(93)	204	(83)	218	(85)	203	(85)
LIVING WITH										
1 SPOUSE ONLY	209	(27)	-		67	(27)	-		-	
2,3,6,7 INDEPENDANT CHILDREN	147	(19)	-		74	(30)	-		-	
OTHERS	171	(22)	-		31	(13)	-		-	
0 ALONE	243	(32)	243		74	(30)	-		-	

TABLE 5.3

CANTERBURY SURVEY

SOURCES OF HELP, CONTACT, AND FEARS OF HANDICAPPED
LIVING ALONE, HOUSEBOUND, BLIND, DEAF

FACTOR	ALL 770 HANDICAPPED		LIVING ALONE (243)		HOUSE-BOUND (246)		BLIND PART.SIGHT.(255)		DEAF HARD HEAR.(238)	
	No.	%	No.	%	No.	%	No.	%	No.	%
RELATIVES AND FRIENDS										
RELS. LIVE NEARBY	461	(60)	149	(61)	148	(60)	151	(59)	140	(59)
RELS. WILLING TO HELP	382	(50)	126	(52)	120	(49)	132	(52)	123	(52)
FRIENDS WILLING TO HELP	581	(75)	195	(80)	174	(71)	190	(74)	187	(79)
RELS. ON 'PHONE & CAN HELP	551	(72)	177	(73)	182	(74)	187	(73)	174	(73)
CONTACT WITH										
MEALS ON WHEELS	35	(4.5)	21	(9)	16	(6.5)	15	(6)	12	(5)
HOME NURSE	133	(17)	51	(21)	86	(35)	42	(16)	33	(14)
HEALTH VISITOR	66	(9)	17	(7)	21	(8.5)	20	(8)	14	(6)
SOCIAL WORKER	115	(15)	34	(14)	37	(15)	53	(21)	25	(10)
CHIROPODIST	107	(14)	46	(19)	56	(23)	39	(15)	28	(12)
CLUB	209	(27)	93	(38)	46	(19)	80	(31)	64	(27)
VISITOR	28	(4)	14	(6)	11	(4.5)	16	(6)	9	(4)
FEARS										
NONE	557	(72)	151	(62)	166	(67)	183	(72)	189	(79)
INTRUDERS	89	(12)	37	(15)	32	(13)	28	(11)	29	(12)
DIFFICULTY IN SUMMONING HELP	123	(16)	52	(21)	48	(20)	40	(16)	27	(11)
LONELINESS	101	(13)	53	(22)	32	(13)	32	(13)	23	(10)
ALONE DURING										
1 BOTH DAY AND NIGHT	235	(31)	229	(94)	68	(28)	92	(36)	74	(31)
2 DAY ONLY	86	(11)	1	(0.5)	35	(14)	26	(10)	27	(11)
3 NIGHT ONLY	10	(1)	7	(3)	4	(2)	5	(2)	5	(2)
0 NEITHER	439	(57)	6	(2.5)	139	(56)	132	(52)	132	(55)

TABLE 5.4

CANTERBURY SURVEY

NEEDS OF HANDICAPPED WHO WERE LIVING ALONE, HOUSEBOUND, BLIND, OR DEAF

NEED	ALL 770 HANDICAPPED		LIVING ALONE (243)		HOUSE-BOUND (246)		BLIND PART.SIGHT.(255)		DEAF HARD.HEAR.(238)	
	No.	%	No.	%	No.	%	No.	%	No.	%
AIDS										
HOIST	9	(1)	0	-	7	(3)	0	-	1	-
SUPPORT BAR	27	(3.5)	6	(2.5)	17	(7)	3	(1)	1	-
WIDEN W.C. DOORS	2	-	0	-	2	(1)	0	-	0	-
RAISE W.C. SEAT	23	(3)	5	(2)	14	(6)	1	-	3	(1)
W.C. RAILS	29	(4)	7	(2.5)	19	(8)	2	(1)	3	(1)
BATH RAILS	122	(16)	32	(13)	43	(17)	24	(9)	34	(14)
SITZ BATH	7	(1)	2	(1)	3	(1)	2	(1)	0	-
SHOWER	44	(6)	14	(6)	16	(6.5)	4	(1.5)	6	(2.5)
BATH SEAT	84	(11)	26	(11)	30	(12)	16	(6)	25	(10.5)
BATH ATTENDANT	10	(1)	3	(1)	5	(2)	3	(1)	2	(1)
SHOE, STOCKING AIDS	51	(7)	15	(6)	15	(6)	9	(3.5)	13	(5.5)
SPECIAL CLOTHING	48	(6)	10	(4)	20	(8)	9	(3.5)	7	(3)
FEEDING GADGETS	16	(2)	2	(1)	11	(4.5)	5	(2)	1	-
HELP WITH SHOPPING	41	(5)	6	(2.5)	1	-	6	(2)	3	(1)
" " HOUSEWORK	69	(9)	17	(7)	10	(4)	9	(3.5)	9	(4)
" " COOKING	19	(2.5)	6	(2.5)	6	(2.5)	6	(2)	1	-
REQUIRES M. ON W.	20	(2.5)	16	(7)	10	(4)	7	(3)	5	(2)
NEEDS KITCHEN AIDS	60	(8)	23	(9)	18	(7)	17	(7)	10	(4)
HELP TO LIGHT FIRES	12	(1.5)	6	(2.5)	6	(2.5)	4	(1.5)	3	(1)
HELP TO CLEAN WINDOWS	88	(11)	39	(16)	40	(16)	29	(11)	21	(9)
HELP TO GARDEN	109	(14)	54	(22)	42	(17)	42	(16)	34	(14)
"HOUSE ADAPTATIONS"	231	(30)	55	(23)	129	(52)	56	(22)	48	(20)
HOME VISITOR	141	(18)	58	(24)	63	(26)	49	(19)	37	(16)
HOLIDAY	202	(26)	72	(30)	55	(22)	66	(26)	48	(20)
DAY/NIGHT ATTENDANT	14	(2)	2	(1)	7	(3)	6	(2)	4	(1.5)
SHORT ADMISSION	33	(4)	4	(2)	20	(8)	9	(3.5)	7	(3)
TELEPHONE (CAT.7)	235	(31)	67	(28)	77	(31)	75	(29)	57	(24)
REQUIRING 1 of "AIDS"	-		32	(13)	47	(19)	38	(15)	31	(13)
" 2-5 " "	-		35	(14)	51	(21)	17	(7)	24	(10)
" 6-9 " "	-		0		1	-	0		0	
" 10-13 " "	-		0		0		0		0	

TABLE 5.5

CANTERBURY SURVEY

INTEREST IN CLUBS

INTERESTED TO	ALL 770 HANDICAPPED		LIVING ALONE (243)		HOUSE-BOUND (246)		BLIND PART.SIGHT.(255)		DEAF HARD HEAR.(238)	
	No.	%	No.	%	No.	%	No.	%	No.	%
MEET OTHER PEOPLE	122	(16)	45	(18)	28	(11)	42	(16)	34	(14)
HAVE MIDDAY MEAL	82	(11)	36	(15)	22	(9)	30	(12)	17	(7)
HAVE COFFEE/TEA	101	(13)	40	(16)	22	(9)	34	(13)	29	(12)
PURSUE HOBBIES	60	(8)	12	(5)	11	(4.5)	17	(7)	13	(5.5)
DO PAID WORK	20	(2.5)	-				-		-	
HELP HANDICAPPED PEOPLE	32	(4)	-				-		-	

TABLE 6.1

CANTERBURY SURVEY

CONTACTS OF THE HANDICAPPED WITH DOCTOR

	AGE GROUP IN YEARS 0-14	15-49	50-64	65-74	75+	TOTAL
REGULAR CONTACT						
1 PER WEEK OR MORE	2	0	6	4	8	20
1 PER MONTH OR MORE	5	8	29	35	58	135
OTHER PERIOD	5	5	10	17	23	60
NO REGULAR CONTACT - BUT LAST CONTACT						
WITHIN 1 WEEK	1	3	6	6	21	37
WITHIN 1 MONTH	6	2	5	27	67	107
WITHIN 3 MONTHS	11	10	15	34	53	123
WITHIN 6 MONTHS	2	8	7	29	43	89
WITHIN 1 YEAR	8	8	12	25	42	95
MORE THAN 1 YEAR AGO	9	11	18	23	43	104
TOTAL	49	55	108	200	358	770
USUAL PLACE OF CONTACT						
DOCTOR'S SURGERY	25	30	49	74	81	259
PERSON'S OWN HOME	8	16	43	92	238	397
EITHER	16	9	16	34	39	114

TABLE 6.2

CANTERBURY SURVEY

AGES, DIAGNOSES, HOUSEHOLDS AND MOBILITIES OF THE HANDICAPPED

GROUPED BY PERSONS ATTENDING

FACTOR ANALYSED	ALL HANDICAPPED		ATTENDED BY								ATTENDING CLUB	
			DOCTOR		HOME NURSE		HEALTH VISITOR		SOCIAL WORKER			
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
AGE IN YEARS												
0-14	49	(6.4)	14	(4.7)	1	(0.7)	13	(19.7)	15	(13.0)	8	(3.8)
15-49	55	(7.1)	13	(4.3)	5	(3.8)	10	(15.1)	14	(12.2)	15	(7.2)
50-64	108	(14.0)	46	(15.4)	17	(12.8)	4	(6.1)	22	(19.1)	29	(13.9)
65-74	200	(26.0)	72	(24.1)	26	(19.5)	12	(18.2)	18	(15.7)	58	(27.7)
75+	358	(46.5)	154	(51.5)	84	(63.2)	27	(40.9)	46	(40.0)	99	(47.4)
TOTAL	770		299		133		66		115		209	
DIAGNOSIS (PRIMARY)												
A1 STROKES	52	(7)	24	(8)	15	(11)	5	(8)	7	(6)	6	(3)
A3 PARALYSIS AGITANS	15	(2)	7	(2)	5	(4)	2	(3)	1	(1)	0	(0)
B-1 MENTAL/PSYCH.	53	(7)	14	(5)	0	(0)	9	(14)	24	(21)	11	(5)
B2 CORONARY	19	(2)	11	(4)	4	(3)	0	(0)	3	(3)	5	(2)
B7 HEART (UNSPEC.)	31	(4)	18	(6)	13	(10)	5	(8)	3	(3)	12	(6)
B9 DIGESTIVE SYSTEM	13	(2)	7	(2)	6	(5)	0	(0)	3	(3)	2	(1)
C-1 INJURIES	24	(3)	9	(3)	9	(7)	2	(3)	2	(2)	6	(3)
CO RHEUMATOID ARTHRITIS	28	(4)	9	(3)	8	(6)	3	(5)	4	(3)	9	(4)
C1 OSTEO ARTHRITIS	18	(2)	7	(2)	2	(1.5)	1	(1.5)	1	(1)	8	(4)
C2 OTHER ARTHRITIS	152	(20)	73	(24)	32	(24)	8	(12)	19	(17)	35	(17)
C7 FRACTURES	19	(2)	9	(3)	7	(5)	1	(1.5)	3	(3)	4	(2)
D2 ASTHMA	11	(1)	7	(2)	5	(4)	0	(0)	0	(0)	3	(1.5)
DO BRONCHITIS	12	(1.5)	6	(2)	0	(0)	0	(0)	2	(2)	2	(1)
D5 ALLERGIC/METABOLIC	19	(2)	7	(2)	4	(3)	0	(0)	2	(2)	5	(2)
HOUSEHOLD												
0 LIVES ALONE	244	(32)	93	(31)	51	(38)	17	(26)	34	(30)	93	(45)
1 LIVES WITH SPOUSE ONLY	209	(27)	91	(30)	37	(28)	17	(26)	21	(18)	50	(24)
OTHER	317	(41)	115	(39)	45	(34)	32	(48)	60	(52)	66	(31)
SELF-CARE SCORE												
2 SCOPE 6-11	158	(20)	65	(22)	33	(25)	10	(15)	11	(10)	39	(19)
1 SCORE 12 OR MORE	165	(22)	82	(27)	53	(40)	22	(33)	36	(31)	36	(17)
MOBILITY C												
HOUSEBOUND (CATS.2 & 4)	236	(31)	98	(33)	79	(59)	20	(30)	37	(32)	45	(22)

TABLE 6.3

CANTERBURY SURVEY

SOURCES OF HELP AND CONTACT - SPECIAL GROUPS

FACTOR	ALL HANDICAPPED		ATTENDED BY								ATTENDING CLUB	
			DOCTOR		HOME NURSE		HEALTH VISITOR		SOCIAL WORKER			
	No.= 770	%	No.= 299	%	No.= 133	%	No.= 66	%	No.= 115	%	No.= 209	%
RELATIVES AND FRIENDS												
RELS. LIVE NEARBY	461	(60)	183	(61)	76	(57)	43	(65)	62	(54)	126	(60)
RELS. WILLING TO HELP	382	(49.6)	147	(49)	62	(47)	37	(56)	46	(40)	97	(46)
FRIENDS WILLING TO HELP	581	(75)	236	(79)	99	(74)	53	(80)	86	(75)	162	(78)
RELS. ON 'PHONE & CAN HELP	551	(72)	227	(76)	104	(78)	47	(71)	81	(70)	157	(75)
CONTACTS												
MEALS ON WHEELS	35	(5)	17	(6)	20	(15)	2	(3)	6	(5)	8	(4)
HOME NURSE	133	(17)	72	(24)	-	-	19	(29)	20	(17)	23	(11)
HEALTH VISITOR	66	(9)	30	(10)	19	(14)	-	-	14	(12)	15	(7)
SOCIAL WORKER	115	(15)	36	(12)	20	(15)	14	(21)	-	-	44	(21)
CHIROPODIST	107	(14)	50	(17)	48	(36)	11	(17)	18	(16)	28	(13)
CLUB	209	(27)	76	(25)	23	(17)	15	(23)	44	(38)	-	-

TABLE 6.4

CANTERBURY SURVEY

NEEDS OF HANDICAPPED GROUPED BY ATTENDANTS

NEED	ALL HANDICAPPED		ATTENDED BY								ATTENDING CLUB	
			DOCTOR		HOME NURSE		HEALTH VISITOR		SOCIAL WORKER			
	No.= 770	%	No.= 299	%	No.= 133	%	No.= 66	%	No.= 115	%	No.= 209	%
1. HOIST	9	(1)	5	(2)	5	(4)	1	(2)	0	-	3	(1)
2. SUPPORT BAR	27	(3.5)	19	(6)	8	(6)	4	(6)	1	(1)	10	(5)
3. WIDEN W.C. DOORS	2	-	0	-	1	(1)	0	-	1	(1)	1	-
4. RAISE W.C. SEAT	23	(3)	13	(4)	3	(2)	3	(5)	5	(4)	1	-
5. W.C. RAILS	29	(4)	17	(6)	6	(5)	2	(3)	5	(4)	9	(4)
6. BATH RAILS	122	(16)	58	(19)	17	(13)	9	(14)	14	(12)	29	(14)
7. SITZ BATH	7	(1)	4	(1)	2	(2)	1	(2)	1	(1)	2	(1)
8. SHOWER	44	(6)	23	(8)	5	(4)	4	(6)	7	(6)	20	(10)
9. BATH SEAT	84	(11)	38	(13)	11	(8)	3	(5)	7	(6)	22	(11)
10. BATH ATTENDANT	10	(1)	8	(3)	1	(1)	1	(2)	3	(3)	7	(3)
11. SHOE, STOCKING AIDS	51	(7)	21	(7)	14	(11)	6	(9)	6	(5)	14	(7)
12. SPECIAL CLOTHING	48	(6)	24	(8)	9	(7)	5	(8)	11	(10)	15	(7)
13. FEEDING GADGETS	16	(2)	3	(1)	7	(5)	3	(5)	3	(3)	2	(1)
HELP WITH SHOPPING	41	(5)	3	(1)	1	(1)	0	-	2	(2)	5	(2)
HELP WITH HOUSEWORK	69	(9)	12	(4)	4	(3)	1	(2)	5	(4)	16	(8)
HELP WITH COOKING	19	(2.5)	5	(2)	5	(4)	1	(2)	1	(1)	2	(1)
REQUIRED M on W.	20	(2.5)	9	(3)	7	(5)	2	(3)	4	(3)	10	(5)
NEEDS KITCHEN AIDS	60	(8)	28	(9)	9	(7)	5	(8)	8	(7)	23	(11)
HELP TO LIGHT FIRES	12	(1.5)	6	(2)	5	(4)	3	(5)	2	(2)	6	(3)
HELP TO CLEAN WINDOWS	88	(11)	39	(13)	21	(16)	7	(11)	14	(12)	37	(18)
HELP TO GARDEN	109	(14)	44	(15)	25	(19)	11	(17)	13	(11)	35	(17)
HOUSE ADAPTATIONS (CAT 0 & 1)	231	(30)	109	(36)	60	(45)	23	(35)	28	(24)	53	(25)
HOME VISITOR	141	(18)	73	(24)	42	(32)	13	(20)	21	(18)	51	(24)
HOLIDAY	202	(26)	79	(26)	35	(26)	18	(27)	28	(24)	72	(34)
DAY/NIGHT ATTENDANT	14	(2)	6	(2)	5	(4)	1	(2)	2	(2)	1	-
SHORT ADMISSION	33	(4)	12	(4)	13	(10)	2	(3)	6	(5)	6	(3)

TABLE 6.5

CANTERBURY SURVEY

COMPARISON OF REGISTERED AND UNREGISTERED PERSONS WITH SENSORY IMPAIRMENT

FACTOR	BLIND AND PARTIALLY SIGHT.				DEAF AND HARD HEARING			
	REGISTERED		NOT REGISTERED		REGISTERED		NOT REGISTERED	
	No.	%	No.	%	No.	%	No.	%
AGE IN YEARS								
0-14	0	(0)	0	(0)	1	(3)	5	(2)
15-49	3	(4)	6	(3)	4	(14)	6	(3)
50-64	20	(26)	8	(4)	4	(14)	15	(7)
65-74	19	(25)	44	(25)	5	(17)	51	(24)
75+	35	(45)	120	(67)	15	(52)	132	(63)
TOTAL	77		178		29		209	
STATE IMPAIRED HEARING	16	(21)	70	(39)	-		-	
STATE IMPAIRED SIGHT	-		-		6	(21)	70	(33)
SELF CARE SCORE 6 - 11	5	(6)	29	(16)	1	(3)	29	(14)
" " " 12+	13	(17)	18	(10)	1	(3)	20	(10)
NEED BATH RAILS	5	(6)	19	(11)	0	-	34	(16)
NEED BATH SEAT	6	(8)	10	(6)	0	-	25	(12)
HELP WITH HOUSEWORK	4	(5)	5	(3)	1	(3)	8	(4)
NEEDS KITCHEN AIDS	6	(8)	11	(6)	2	(7)	8	(4)
HELP TO CLEAN WINDOWS	10	(13)	19	(11)	2	(7)	19	(9)
HELP WITH GARDEN	9	(12)	33	(19)	1	(3)	33	(16)
HOME VISITOR - NEEDS	12	(16)	37	(21)	3	(10)	34	(16)
HOME VISITOR - HAS	9	(12)	7	(4)	2	(7)	7	(3)
HOLIDAY - NEEDS	17	(22)	49	(28)	3	(10)	45	(22)
HOLIDAY - HAS HAD	4	(5)	6	(3)	1	(3)	9	(4)
TELEPHONE (CAT 7)	25	(32)	50	(28)	6	(21)	51	(24)
ATTENDS CLUB	30	(39)	50	(28)	11	(38)	53	(25)
CLUB TO MEET OTHER PEOPLE	9	(12)	33	(19)	6	(21)	28	(13)
ALONE DAY AND NIGHT	20	(26)	72	(40)	12	(41)	62	(30)
VISITED BY SOCIAL WORKER	39	(51)	14	(8)	2	(7)	23	(11)

APPENDIX 1 - TABLE A

CANTERBURY SURVEY

AGE AND SEX OF ALL IMPAIRED PERSONS ASCERTAINED IN HOUSEHOLD SURVEY

AGE GROUP	1ST AND 2ND INTERVIEWS COMPLETED (=770)			FIRST INTERVIEWS ONLY						TOTALS		
				2ND INTERVIEW NOT COMPLETED			2ND INTERVIEW NOT INDICATED					
	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
0 - 4	6 (2.2)	3 (0.6)	9 (1.2)	2	0	2 (3.0)	2 (0.6)	2 (0.5)	4 (0.6)	10 (1.7)	5 (0.5)	15 (1.0)
5 - 14	27 (10)	13 (2.6)	40 (5.2)	1	0	1 (1.5)	11 (3.4)	9 (2.4)	20 (2.9)	39 (6.5)	22 (2.4)	31 (4.0)
15 - 29	15 (5.5)	10 (2.0)	25 (3.2)	0	2	2 (3.0)	23 (7.2)	11 (2.9)	34 (4.9)	38 (6.3)	23 (2.5)	61 (4.0)
30 - 49	14 (5.2)	16 (3.2)	30 (3.9)	0	1	1 (1.5)	55 (17.2)	50 (13.2)	105 (15.0)	69 (11.5)	67 (7.2)	136 (8.9)
50 - 59	25 (9.3)	28 (5.6)	53 (6.9)	0	4	4 (6.0)	50 (15.7)	54 (14.2)	104 (14.9)	75 (12.5)	86 (9.2)	161 (10.5)
60 - 64	19 (7.0)	36 (7.2)	55 (7.1)	1	1	2 (3.0)	39 (12.2)	45 (11.9)	84 (12.0)	59 (9.8)	82 (8.8)	141 (9.2)
65 - 74	63(23.0)	137(27.4)	200(26.0)	4	9	13 (19.7)	87 (27.3)	98 (25.8)	185 (26.5)	154 (25.6)	244 (26.1)	398 (25.9)
75 - 84	78(28.9)	182(36.4)	260(33.8)	4	25	29 (43.9)	40 (12.5)	87 (22.9)	127 (18.2)	122 (20.3)	294 (31.5)	416 (27.1)
85+	23 (8.5)	75(15.0)	98(12.7)	0	12	12 (18.2)	11 (3.4)	21 (5.5)	32 (4.6)	34 (5.7)	108 (11.6)	142 (9.3)
U.K.	0	0	0	0	0		1 (0.3)	2 (0.5)	3 (0.4)	1 (0.2)	2 (0.2)	3 (0.2)
TOTAL	270	500	770	12	54	66	319	379	698	601	933	1,534
% BY SEX	(35)	(65)	(100)	(18)	(82)		(46)	(54)		(39)	(61)	

Figures in brackets show percentage of age group by sex.
Percentages are not given where the totals are less than 60.

APPENDIX 1 - TABLE B

CANTERBURY SURVEY

STATED DIAGNOSES OF THE PHYSICALLY IMPAIRED

DIAGNOSIS	FIRST AND SECOND INTERVIEW COMPLETED		FIRST INTERVIEW ONLY				TOTALS		
			2ND NOT COMPLETED		2ND NOT INDICATED				
	PRIMARY	ADDITIONAL	PRIMARY	ADDITIONAL	PRIMARY	ADDITIONAL	PRIMARY	ADDITIONAL	BOTH
MUSCULO-SKELETAL SYSTEM									
RHEUMATOID ARTHRITIS	28	2	0	0	15	3	43	5	48
OSTEO ARTHRITIS	18	6	0	0	9	0	27	6	33
OTHER ARTHRITIS	152	62	9	2	59	23	220	87	307
OSTEOMYELITIS	0	0	0	0	2	0	2	0	2
ANKYLOSING SPONDYLITIS	1	2	0	0	0	0	1	2	3
SLIPPED DISC	6	7	0	0	10	7	16	14	30
MUSCULAR DYSTROPHY	2	0	0	0	1	0	3	0	3
OTHER BONE AND JOINT DISEASES	18	22	2	0	18	11	38	33	71
CENTRAL NERVOUS SYSTEM									
STROKES	52	9	5	1	7	2	64	12	76
POLIOMYELITIS	6	0	0	0	14	0	20	0	20
PARALYSIS AGITANS	15	0	0	0	3	0	18	0	18
MULTIPLE SCLEROSIS	6	0	1	0	1	0	8	0	8
CEREBRAL PALSY	6	1	0	0	4	0	10	1	11
PARAPLEGIA/HEMIPLEGIA	3	0	0	0	2	0	5	0	5
EPILEPSY	6	10	1	0	21	1	28	11	39
DIZZINESS	1	13	0	1	1	4	2	18	20
SCIATICA/NEURITIS	4	3	1	1	3	3	8	7	15
OTHER CNS	9	9	0	0	0	0	9	9	18
CARDIOVASCULAR SYSTEM									
CORONARY ARTERY DISEASE	19	6	0	1	20	5	39	12	51
ARTERIOSCLEROSIS	6	1	0	1	8	2	14	4	18
HYPERTENSION	4	19	0	0	9	12	13	31	44
CONGENITAL HEART	0	0	0	0	2	0	2	0	2
RHEUMATIC FEVER	0	0	0	0	2	2	2	2	4
"HEART TROUBLE" (UNSPEC.)	31	29	1	3	17	6	49	38	87
ARTERIAL DISEASE	4	0	0	0	2	1	6	1	7
VARICOSE VEINS	8	5	0	0	4	1	12	6	18
OTHER CVS	6	7	0	0	2	11	8	18	26
PSYCHOLOGICAL DISORDERS									
MENTAL ILLNESS & SUBNORMALITY	53	13	1	1	1	3	55	17	72
SENILITY	2	4	2	0	28	10	32	14	46
RESPIRATORY SYSTEM									
BRONCHITIS	12	27	1	1	13	34	26	62	88
EMPHYSEMA	2	3	1	0	8	0	11	3	14
ASTHMA	11	7	0	1	12	5	23	13	36
PNEUMOCONIOSIS	1	0	0	0	1	1	2	1	3
OTHER R.S.	10	22	1	2	3	9	14	33	47
INJURIES, ETC.									
INJURIES (UNSPEC.)	24	18	4	2	3	0	31	20	51
HEAD INJURIES	1	0	0	1	4	5	5	6	11
FRACTURES	19	5	2	1	10	3	31	9	40
SPRAINS & BACKACHE	1	5	0	0	3	5	4	10	14
OTHER GROUPS									
DIGESTIVE SYSTEM	13	29	0	3	17	25	30	57	87
GENITO-URINARY SYSTEM	2	20	2	0	30	13	34	33	67
ENDOCRINE, METABOLIC & ALLERGIC	19	22	2	1	20	12	41	35	76
SENSE ORGANS	15	18	0	0	9	0	24	18	42
CONGENITAL MALFORM.	8	1	3	0	23	5	34	6	40
BLOOD SYSTEM	7	9	0	2	2	5	9	16	25
CANCER	9	3	2	1	2	2	13	6	19
INFECTIONS	6	3	0	0	4	1	10	4	14
SKIN	0	2	0	0	0	5	0	7	7

APPENDIX 1 - TABLE C

CANTERBURY SURVEY

MARITAL STATUS, HOUSEHOLD COMPOSITION, PRESENCE OF OTHER HANDICAPPED PERSONS IN HOUSEHOLD FOR ALL IMPAIRED PERSONS

FACTOR	1ST & 2ND INTERVIEW COMPLETED = 770	FIRST INTERVIEW ONLY		TOTAL = 1,534	CANTERBURY POPULATION
		SECOND NOT COMPLETED = 66	SECOND NOT INDICATED = 698		
MARITAL STATUS					
MARRIED	307 (40)	25 (38)	365 (52)	697 (45)	(47)
SINGLE	154 (20)	12 (18)	133 (19)	299 (20)	(44)
OTHER	309 (40)	29 (44)	200 (29)	538 (35)	(9)
HOUSEHOLD COMPOSITION					
ALONE	244 (32)	20 (30)	176 (25)	440 (29)	
1 OTHER PERSON	299 (39)	27 (41)	275 (40)	601 (39)	
2 OTHERS OR MORE	227 (29)	19 (29)	247 (35)	493 (32)	
OTHER HANDICAPPED PERSON*					
PRESENT	119 (15)	2 (3)	49 (7)	170 (11)	

(Per cent in brackets)

*Defined as another member of the household having a second interview in the Survey.

APPENDIX 1 - TABLE D

CANTERBURY SURVEY

MARITAL STATUS - AT AGES OVER 15 YEARS

MARITAL STATUS	CANTERBURY POPULATION	1ST & 2ND INTERVIEW COMPLETED	FIRST INTERVIEW ONLY		CANTERBURY AGE/SEX RATES APPLIED TO IMPAIRED POPN.	CANTERBURY AGE/SEX RATES APPLIED TO HANDICAPPED POPN. ONLY
			SECOND NOT COMPLETED	SECOND NOT INDICATED		
MARRIED	15,525(60)	307 (42)	25 (40)	365 (54)	765 (53)	331 (46)
SINGLE	7,470(29)	106 (15)	9 (14)	109 (16)	223 (15)	114 (16)
OTHER	3,020(11)	308 (43)	29 (46)	200 (30)	467 (32)	276 (38)
TOTAL = 100	26,015	721	63	674	1,455	721

Percentages are shown in brackets

APPENDIX 1 - TABLE E

CANTERBURY SURVEY

"SELF-CARE" SCORES - ALL IMPAIRED PERSONS

SCORE	1ST & 2ND INTERVIEW COMPLETED = 770	FIRST INTERVIEW ONLY		TOTAL = 1,534
		SECOND NOT COMPLETED = 66	SECOND NOT INDICATED	
0 FOR ALL AGES) 1-5 IF UNDER 70)	257 (33)	30 (45)	698	985 (64)
1-5 IF 70 OR OVER	190 (25)	9 (14)	0	199 (13)
6-11	158 (20)	10 (15)	0	168 (11)
12 OR MORE	165 (22)	17 (26)	0	182 (12)

(Figures in brackets = percentages)

CANTERBURY SURVEY OF THE HANDICAPPED

43 NEW DOVER ROAD
CANTERBURY

May, 1972.

Dear Householder,

The Council is now reviewing its plans for the provision of health and welfare services, and, to do this, needs to know how many people there are in Canterbury who may need help, and how support can best be provided.

We are interested in people of all ages. Some children may need to have more done for them than others because of some physical or mental condition. The elderly, though accepting that their movements are a bit restricted, may not be able to do as much for themselves as they would like. There are also younger people who, because of physical handicap, may need special provisions to help them lead as full a life as possible. There are services, too, for the blind and the deaf, as well as for those with physical and mental complaints.

We are therefore asking if you would help us by completing the attached simple form for **everyone** living in your household. PLEASE DO NOT pass the form on to others outside your household who may have difficulties, as this could lead to duplication.

As you will appreciate, we are anxious to get as complete a picture as possible. Even if the answer to all the questions is 'No,' we should like you to tell us so on the form.

You need not answer any questions if you don't want to, but we can assure you that any information you give us will be used solely for the purpose of planning services, and will be regarded by everyone working with us as **strictly confidential.**

When you have completed the form, please refold it so that the return address is showing and put it in the envelope. **Then seal the envelope and keep it until our helper calls to collect it.**

Thank you for your co-operation,

Yours faithfully,

Hon. Survey Organiser

CANTERBURY SURVEY OF THE HANDICAPPED

Name of Householder or Tenant _____

	Please write "Yes" or "No" in this column for each question	If the answer is "Yes" please write in age and name of person having difficulty
EYESIGHT		
1. Is there anyone in this household who is blind?		
2. or has very bad eyesight even when wearing glasses?		
HEARING		
3. Is there anyone in this household who is deaf, or has to wear a hearing aid?		
4. or is so hard of hearing he or she cannot hear ordinary conversation?		
LOSS OF LIMBS, etc.		
5. Has anyone lost the whole or part of an arm, leg, hand or foot by having an accident, amputation, or by being born like that?		
MOVING ABOUT		
6. Is there anyone, apart from babies, who has been unable to get out of bed, or unable to get out of the house, for the past 3 months?		
7. Is there anyone, apart from babies and young children, who has difficulty walking without help, going up and down stairs, or kneeling and bending?		
SELF-CARE		
8. Is there anyone, apart from babies and young children, who has difficulty washing, feeding or dressing themselves?		
9. Is there anyone, apart from babies, who has difficulty gripping or holding things, or using arms, hands or fingers?		
BABIES AND YOUNG CHILDREN		
10. Are there any young children who need more help than usual for children of the same age, in washing and dressing themselves, walking without help, going up and down stairs, etc.?		
11. Are there any school-age children who cannot go to an ordinary school because of physical or mental handicap?		
IF NO-ONE IN HOUSEHOLD HAS ANY OF THE ABOVE DIFFICULTIES		
GENERAL		
12. Is there anyone who has some other permanent mental or physical condition, including epilepsy, etc. which makes it difficult for them to go to school or work, take care of themselves, or get about?		
ELDERLY		
13. Is there anyone living here aged 75 or over?		
14. Do you live alone?		