# Deaf People in the Community

## Health and Disability

**Report prepared by Matthew Dye and Jim Kyle**

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The Project Team
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# 1 Health and Disability: Executive Report

Although we have always had deaf people in the community, we have never really worked with them to understand their way of life. Treated as a deviant minority with special needs, they have been the subjects of alternating neglect and charity with no investigation of whether either "treatment" is helpful or beneficial to their quality of life.

For the first time, with funding from the National Lottery Charities Board, we have been able carry out an extended study of deaf people through interviews with trained deaf representatives and to repeat this process six times in order to complete the whole picture of deaf lives in the UK today.

The DPIC project is a three-year research project (1997-2000), which focused on the social development of deaf people. It was designed to provide a detailed profile of deaf people's lives in a way which will be of great value to service providers into the 21st century.

There were three major components to this project:

- the collection of interview data twice a year, from a target group of 240 deaf people nationwide
- the provision of telecommunications tools to deaf people to allow them to connect with each other and
- the establishment of a dial-up information service

### Who are the Deaf People?

A quota sampling procedure was used to select 240 members of the UK Deaf community from an initial contact sample of over 300 persons. The quota was based upon the best available data: a study of the Deaf community in Avon (Kyle and Allsop, 1982), the GB Census (1991) and the General Household Survey (1996). In the GB Census (1991) there were 54,156,067 people resident in Great Britain. Of these 52% were women, and 48% were men. White people represented 95% of the population, with Black people at 2% and Asian people at 3%.

The make-up of the DPIC quota sample almost exactly mirrors these statistics. There is a slight deviation from the Census data in terms of age group. The quota sample contains a smaller proportion of 60-75 year olds (19% compared with 26% in the Census), and a greater proportion of 18-29 year olds (28%, with 15% in the Census).

This quota sample was interviewed six times in 2 years by trained Deaf interviewers. A series of reports will

present the data collected and analysed. Taken together these reports will offer a unique insight into the community of Deaf people in the UK today. This report concerns the demographic and baseline data.

The sample was 236 Deaf people aged 18 to 75 years, of whom, 53% were women. Minority ethnic groups were included in the sample, in the same proportions as in the General Household Survey (1998). In the sample, 54% were married or living with their partner, 24% were single and had never been married, and 22% were separated, divorced or widowed. The sample was structured to reflect population in 12 regions of the UK including Northern Ireland.

There were two main issues in this report and these are drawn from two interviews: Health and Deafness as Disability.

## Health

Deaf people tend to portray visits to the doctor as problematic and unwelcome, yet when assessed in the study, it can be seen that deaf people are much more likely to go to the doctor than are hearing people - 29% of the sample had visited their GP in the last 2 weeks, with women (31%) more likely than men (27%) to have made a visit. •Satisfaction within the Deaf sample was high - 88% men & 80% women (although we do not have the figures for hearing people). Satisfaction was lowest for younger respondents. Interestingly, Deaf more likely to be given prescriptions than hearing people, suggesting that doctors may provide this rather than verbal advice. In consultation with the doctor, Deaf men (24%) were more likely to use a professional sign language interpreter than were Deaf women (11%). Women (17%) were more likely to use a family member than Deaf men (8%).

In terms of specific health areas and areas where there is concern at government level, there are interesting differences between deaf and haring and even within the deaf community. Fewer Deaf men (22%) drink above these limits than do hearing men (27%). However, Deaf women (24% above the weekly recommended limit) drink more excessively than both hearing women and Deaf men. Older Deaf men (65+) drink 1½ times the amount of hearing men. Younger Deaf men drink 1½ times above the recommended weekly limit. Deaf women drink more than hearing women in all age groups and Deaf women aged 25 to 44 years drink twice as much as their hearing counterparts.

The more Deaf men earn, the less they drink. The opposite is true for Deaf women, as they drink more if they earn more. With a usual gross weekly income

of £400 or more, 43% of Deaf women drink more than is healthy.

These figures are of some concern and there is a need to probe more deeply. Responses as to why people drink and the indicators of alcoholism are not conclusive in determining why there is greater alcohol consumption.

Only 21% of Deaf people smoke in the whole of the Deaf sample. Both women and men aged 20–24 years, smoke most with the major difference being Deaf men aged 20-24 years smoke much more than do hearing. It seems that health education campaigns have been having an impact on the community as a whole but not among those in this age group.

We asked about sources of health advice. The most popular sources of health advice were magazines (46%, although this was mainly women), friends (42%), relatives (41%) and leaflets (41%). Educational level achieved seemed to most closely relate to the extent of information and advice sources which were used. One result of lack of information access and communication problems would normally be increased levels of stress. However, the questions asked did not indicate that deaf people experienced more stress than others.

Another issue of importance in the deaf community is the availability of deaf staff in service teams. When asked about the area of mental health, there was not a universal demand for deaf counsellors. In fact, the results indicate an ambivalence that relates to fears of unprofessional conduct, lack of experience and knowledge. Deaf advisers would be valued for the ease of communication.

## Disability

Part of the problem in understanding deaf choices for sources of advice is the issue of valuation of deaf people themselves. From a medical perspective, deaf people are handicapped and impaired; in a social sense, deaf people are to be registered as disabled but what do deaf people think themselves? Apart from students, all the socio-economic groupings indicated that they thought themselves to be disabled. The community as a whole see the lack of hearing as indicative of disability – which paradoxically then opens up a range of benefits. Deaf people are aware of the benefits system and do seem to use it in large numbers. They gain from Disability Living Allowance, from textphone rebates, and transport discounts. Most of the advantage from these benefits is seen in general quality of life. Since we know that deaf people receive lower incomes than other groups (see the Demographics

report) this might be seen as an adjustment on living costs within society.

There are many areas of this report that will need further examination and probing and areas where more data is needed in order to understand the situation.

However, the general picture is of the Deaf Community dealing with many intrinsic difficulties in order to achieve participation and as a result, they are aware of and are able to engage with the major systems of Health and Medical and Social Benefits.

# 2 Health of the Deaf Nation

Deaf people are usually *invisible* to the hearing community. Yet they live their lives in the *visual* modality and are not physically separated from the hearing community. They are generally observers of society and may be in the reach of a range of services but not really in contact with them. For deaf people, access to the rules and ways of working of the hearing community can be difficult. This difficulty comes into focus when there is a reason to use such services – as in the case of access to health information and health care or as access to provision on account of the *disability* itself. These are the issues that concern this report. A more extensive review of the background in health and disability can be found in the first report in the series: *Deaf People in the Community: the starting point*. The DPIC project is a three-year research and development study that focused on the social development of deaf people. By listening to deaf people, the project has allowed the users to express their concerns and also to indicate the pattern of use of services. . Two specific areas have been of great concern – the issues surrounding Deaf Health and the attitudes of Deaf people towards the concept of disability and their use of the services that support disabled people.

## 2.1 Approaching Deaf Health

Using the "available" services is not as simple as it might seem:

> *Rita does not like visiting her GP or the hospital, because of the communication problems. It has always been a nerve-wracking experience to go to see the doctor. She would prefer it if the doctor was deaf or was a hearing person with good sign language skills. On one occasion she did bring an interpreter but the interpreter was only translating the information, and it was not helpful in understanding what the doctor was saying. It is usually very stiff and unfriendly when she visits the doctor. It is often very awkward. Her doctor sometimes wrote things down, but Rita finds these brief notes frustrating and incomplete. Deaf people need to have more explained, just like hearing people. When she gets home, she is often still unsure of what the problem is. It can be very stressful and creates a lot of worry. Rita would prefer a more relaxed consultation with more time for the appointment itself. Also it would help to have deaf-friendly English (from the doctor) with visual, clear pictures and health leaflets to be provided. (Taken from interviews, names changed)*

Rita is not unusual. Her experiences and feelings illustrate the many reported problems of deaf people in contact with services. Although we can claim that services are provided, deaf people may not be able to use them.

The issues are rather complex involving the old adversaries: availability versus accessibility. Great progress has been made in health care in the UK but

evidence from, and discussion with, deaf people indicates that they have difficulties with the health care systems at all levels. The DPIC study set out to examine patterns of use of the Health Service and the awareness and satisfaction expressed by deaf people.

## 2.2 Deafness and Disability

Deafness can be constructed in many ways. The dominant philosophy has been medical/audiological (although it could have been religious, educational, or nowadays, social). This construction treats Deafness as a loss or lack of something – sound or hearing. Deafness is measured in terms of hearing loss (dB loss), and is 'treated' via amplification devices and speech/lip-reading training. This is not necessarily the best way to think of the Deaf community. The members of the DPIC sample, do not construct their own Deafness identity in this way. As members of the Deaf community, and users of British Sign Language, they consider their Deafness as a difference, not an absence of something. Deaf people often have little-or-no experience of sound and they do not consider hearing as having been lost. Rather they may consider themselves to be part of a linguistic minority – a distinct cultural group. This view is a step beyond the social model of disability, setting deaf people as full participants if only their linguistic rights were recognised. How far members of the Deaf Community agree with this is a question to be asked of our data.

At the moment because Deaf people are treated as a disabled group, with special needs, a range of benefits are available to them. These include Disabled Living Allowance, Severe Disability Allowance and Disabled Working Allowance, alongside more general benefits such as Job Seeker's Allowance and Housing Benefit. It is not clear, however, that the Deaf community is able to take up their disability benefits in full. The procedures and English-based forms may discourage members of the Deaf community from applying for such benefits.

Recent legislation (The Disability Discrimination Act, 1995) has given some protection to the rights of disabled people. Information in British Sign language and subtitling on television, are mentioned as examples of provision that employers should make. There have also been recent Government proposals on Special Educational Needs in school. It is not clear how the Deaf Community has dealt with these developments.

The first part of the Disability section explores how Deaf people describe themselves, whether they consider themselves to be physically or socially disabled, and examines membership of

disability organisations. The second part considers disability benefits, particularly Disability Living Allowance, Severe Disability Allowance and Disabled Working Allowance. To what extent do Deaf people claim these benefits, and how easily do they negotiate the various stages?

From these two themes, Health and Disability, we can describe the pattern of inclusion of Deaf people in the provision of society.

# 3 Guide to the Report

## Development and Content of the Study

There are several reports in this series, taken from data from the same sample of Deaf people. The data reported in these reports were collected between 1997 and 2000. The main data in this report was collected in 1998 - Health (October – December) Disability (April – June), with some additional information collected between February and April 2000.

The report is based upon an original sample of 236 people from the UK Deaf community, i.e. from England, Scotland, Wales and Northern Ireland. Trained Deaf representatives, in each of 12 regions, conducted the interviews in British Sign Language. The representatives entered responses on interview schedules for subsequent coding and analysis. The sample was selected according to quotas determined by best available data, that is, previous work on the Deaf Community, the Great Britain Census 1991 (henceforth Census 1991) and the General Household Survey 1996 and 1998 (henceforth GHS 1996 and GHS 1998). More information on the quota sample is given in the report Deaf People in the Community: Demographics of the Deaf Community in the UK alongside comparisons with data from the Census 1991 and GHS 1996/GHS 1998.

A total of 310 people were interviewed, from whom 240 were selected in order to best match the quota sampling criteria. Of these, four withdrew during the initial data collection.

## Structure of the Report

This report describes aspects of health in the sample of the British Deaf community. Topics covered include GP consultations, alcohol consumption, smoking, health advice, stress and counselling.

In this report, we have not attempted extensive interpretation of the findings. Instead the priority has been to give sufficient details so that others can make interpretations for themselves. To this end, the report contains large amounts of tabulated information in each chapter. This data is more extensive than the comments in the text. There is more work to be done.

## Notes and references

Notes are provided as footnotes throughout the report, and references are presented as an appendix. This work is ongoing.

## Explanatory Notes for Tables

The tables in this report present either frequencies (number of respondents who gave a particular response) or percentages. Frequencies and percentages are given as whole numbers. For this reason, the sum of the percentages in a column or row may not equal 100% exactly. Where percentages are reported, the number of respondents from whom data was collected is also displayed. Where the percentages are calculated in columns, the number of respondents is given at the bottom of the column. Where percentages are calculated across rows, the number of respondents is given at the end of the row.

# 4 Preparing the Study

## 4.1 Sampling Procedure

A quota sampling technique was employed in this project to construct the sample. Given the extent of knowledge of the Deaf Community and the difficulties of reaching the members, this approach was chosen in preference to random sampling.

Large-scale surveys often employ a random sampling technique. In random sampling, every member of the target population has an equal chance of being selected for inclusion. However, there is no register containing the names and addresses of all members of the Deaf community; nor does the community exist in a specific geographical location, as it is a linguistically and culturally defined group.

The target population was members of the British Deaf community. These are profoundly Deaf people living in the United Kingdom who are 'culturally Deaf' and are users of British Sign Language (BSL). A study conducted in Avon in 1981 (Kyle and Allsop, 1982) was used to help construct the sample. Although this study included all members of the Deaf community living in the Avon area, it is not clear that the Deaf community of Avon is completely representative of the Deaf community in other parts of the UK (particularly those with no urban concentration such as Bristol in Avon). Data from the GB Census 1991 and the GHS 1996 was therefore used to support the construction of the quota sample. This had the added advantage of allowing comparisons to be made between DPIC study data and data from other studies.

Using Census data, a relative quota (by population) was determined for each of twelve regions within the UK. Within each region, the quota detailed the number of participants to be included in terms of age, occupation, gender, ethnic group, location (urban-rural) and marital status. An additional requirement was that all people in the sample should be Deaf and proficient users of BSL. BSL proficiency was assessed using a picture description test. The test was designed to distinguish between BSL and English word ordering in a signed description. Only those who had learned to sign before the age of 5 years and who demonstrated BSL sign competence in terms of grammar and vocabulary were included.

There were up to three DPIC representatives assigned to each of the 12 geographical regions. The representatives were recruited by national adverts and were Deaf themselves. Their first task

after initial training was to recruit the quota sample in their area. After further training, they conducted the interviews. All interviews were conducted in BSL, and DPIC staff trained representatives in interview techniques and in the specific content of each interview.

There were training weekends for each interview. Once the representatives had conducted the initial quota sampling interviews, interview record sheets were returned to the DPIC office. Staff analysed these interview records, and selected those that produced the best match with the quota sampling criteria. The 240 selected people formed the DPIC quota sample. Four of these withdrew their participation during the first interview arrangements or shortly after having completed the interview. The nature of the procedures and interview arrangements on a national scale made their replacement difficult. The DPIC sample is 236 Deaf people.

## 4.2 Procedure

Within a 26-month period, six separate interviews were conducted. Each interview had a distinct theme:

(1) *Personal Data for Year 1* and Deaf*ness as Disability* (March-August 1998)

(2) *Health* (October-December 1998 and February-April 2000)

(3) *Communication* and *Personal Data -Year 2* (February-April 1999)

(4) *Lifestyle* (May-July 1999)

(5) *Adult Education* (September-November 1999)

(6) *Technology* and *Personal Data for Year 3* (February-April 2000)

There were also additional 'hot' themes incorporated within interviews, such as Disability Benefits, Driving Test Procedures and Digital Television.

For each interview, the same procedure was followed: questionnaire construction, pre-training preparation, training, field interviews, form checks, data coding and data entry, data checks and data analysis.

### 4.2.1 Questionnaire Construction

For each interview, an English-based paper schedule was constructed. Weekly meetings of the research team defined the aims and scope of the schedule, and team members then contributed relevant questions. These questions were organised in a coherent and thematic framework, and a pilot questionnaire was drafted. Questions were worded in a way that allowed easy translation into BSL. This questionnaire was piloted on small groups of Deaf staff members or students from the Centre for Deaf Studies at the University of Bristol, UK. As a result of the pilot interviews, the schedules were amended such that (a) ambiguous

questions were reworded or omitted, (b) the questions were easier to translate into BSL, and (c) the whole interview took between 60 and 90 minutes to administer.

### 4.2.2 Pre-training Preparation

Prior to training of the interviewers, a final paper draft of the questionnaire was created with a videotape of the interview translated into BSL (with a Deaf team member and a Deaf member of staff or student at the Centre for Deaf Studies). These materials were posted to the interviewers two weeks prior to the training date.

### 4.2.3 Interviewers and Training

Initially, twelve Deaf interviewers were recruited from different regions in the UK. Advertisements were placed on the BBC teletext pages for Deaf people (Read Hear) and Deaf individuals who had previous contact with the Centre for Deaf Studies were approached. Applicants had to complete an application form and attend an interview at the Deaf Studies Trust offices in Bristol. After interview, one applicant was selected for each of 12 regions covering the whole of the UK. Due to the extent of work and travel difficulties, the number of representatives was increased to 18 after the second interview, with some regions having three trained representatives.

Prior to each interview, these interviewers attended a two-day training session at the Deaf Studies Trust in Bristol. Team members conducted the training in BSL by, and covered administration, interview techniques and specific aspects of the current questionnaire. A question and answer session also took place; there was an opportunity for (a) feedback from the interviewers on previous interviews, and (b) feedback from team members on interviewer performance in previous questionnaires. Latterly, results were reported to this group at these meetings.

### 4.2.4 Field Interviews

After training, the interviewers were required to conduct interviews in their region within a 6-week target period (because of the initial unfamiliarity and learning curve for the interviews, the first interview took considerably longer overall). In practice, this 6-week target was not always possible due to illness or absence, and some interviews were conducted up to 2 weeks after this target period. Beyond this point, interviews (from the second interview onwards) were considered invalid.

Interviewers were responsible for contacting the quota sample within their region, and arranging a date and time for the interview. Interviewers were encouraged to conduct the interviews at

the respondent's home. In some cases, this proved to impracticable, and interviews were conducted in public places (such as restaurants and Deaf Clubs). Since all the participants were supplied with Nokia Communicators and free calls within the project, the second half of the project was much easier to arrange than the first as all people in the sample could be easily reached.

Interviews were conducted in BSL. The interviewers translated the English questions into BSL, attempting to keep as close as possible to translations provided on videotape and negotiated during the training weekends. Respondents replied in BSL, and the interviewers checked the appropriate box on the questionnaire. Most questions were 'closed', and the respondents were offered a restricted set of alternative responses.

### 4.2.5 Form Checks

Completed forms were returned by post to the Deaf Studies Trust in Bristol. Forms were checked for completion and logged. A team member then went through each form to check that it had been completed appropriately. For the original Quota Sample interview and the Personal Data interview, it was important to check that all questions had been answered. Each form was completed anonymously, with only a code number used to indicate the identity of the respondent. The code number was compared with the date of birth given on the interview form and that recorded in the project database. This was to ensure that the correct code number had been used, and that data from different interviews could be successfully linked.

### 4.2.6 Data Coding and Data Entry

For the closed questions, a numerical coding system was used to code the responses for entry into the computer database. Data was entered by trained staff, who were paid on a per form basis (with a guaranteed minimum hourly rate). A team member constructed a spreadsheet template that corresponded closely to the interview form. One spreadsheet file was used for each interview form; a numerical coding system was supplied to them. This generated one spreadsheet file per respondent per interview. These files were merged into a master spreadsheet file, which was then imported into a relational database. Prior to importing of the data into the database, the individual spreadsheet files were checked for accuracy of data input. The first 10 forms of each coder were checked, and then a sampling procedure was used to check future forms. Where errors were detected, that question was checked on all completed spreadsheets, and feedback was given to the coder in order to improve performance.

### 4.2.7 Data Checks

Once imported into the relational database, the integrity of the data was checked. This involved ensuring that all data within a given field were valid given the coding system employed. Out-of-range values were checked against the original forms, and mistakes were rectified.

### 4.2.8 Data Analysis

After checking the integrity of the data set, it was connected to other data sets within the relational database. Queries were then generated to produce data sets for analysis. Most analyses were conducted using pivot tables within a spreadsheet package. Even at this stage, errors detected within the data were recorded, and the relational database modified in order to correct the errors.

### 4.2.9 Reliability of Data Entry

The reliability of data entry and checking was measured by sampling respondents and questions. Twenty-five respondents were selected randomly, as were 10 questions from the current interview. This data was compared with the response sheets submitted by the interviewers and the percentage of errors calculated. For the data reported here, the percentage of errors was between zero and 0.4%, i.e. well below the predetermined criteria of 5.0%.

# 5 Primary Health Care

## 5.1 Deaf Health

The topic of Deaf health has been described in the first report in this series. The only addition here is to recognise the general context in which Deaf people's health has been assessed. In many circumstances the medical viewpoint has been that the *hearing loss* is the problem. There are many Deaf jokes surrounding visits to the doctor when misdiagnosis takes place due to the doctor being only able to deal with the hearing loss. Deaf people within the community have a general antipathy to the process of consultation, while at the same time believing it to be necessary when they feel ill. However, given that the sensation of illness is often not explained in childhood (it may be interesting to reflect on how *hearing* children develop their concept of illness and how much that depends on being able to communicate it in more than just gestures to their parents), the sense of illness among Deaf people may be different from that of hearing people.

We can therefore predict that Deaf people would be more wary of visits to the doctor and we can consider that the provision of interpreters might be a great advantage.

In terms of health information and personal well-being, all of what we have indicated in the first report suggests that Deaf people will have difficulties in obtaining information and applying it in their daily lives. Just as there have been concerns in the National Health Service that people need education for healthy lifestyles, we can predict that Deaf people will be bypassed by campaigns in the media and leaflets that are predominantly text-based.

This is also likely to be seen in adjustment, attitude and behaviour, and there have been concerns expressed that Deaf people's social and emotional problems are not adequately dealt with. While we are not able to assess this directly in this project, some of our responses may need to be interpreted in this light.

Deaf health is a topic of major significance to the community and this part of the report is only a first step in determining the pattern of contact with services.

Entry into the health system usually begins when you are or feel ill? Most people go to their doctor.

## 5.2 Visiting the Doctor and Other Professionals

Whenever a hearing person feels ill they can make an appointment to see their

General Practitioner (GP). A phone call is normally followed by an appointment within that week or the following one, resulting in a 5-10 minute consultation with the doctor. As a result, the patient will be examined, may receive advice, a prescription for medicine, or referral to a specialist or consultant.

For Deaf people, however, the process may not be as straightforward. Initially there is the problem of making the appointment - if the Health Centre has a textphone, staff have to be found who can use it. Once in the consultation there are other issues to face. One can safely predict that few GPs have signing skills adequate for a medical consultation, and the scarcity of professional sign language interpreters may mean that the Deaf person has to rely upon a family member or friend for communication support. Given these difficulties with communication, there is the worry that the GP may be more likely to issue a prescription, as reassurance, because the giving of health advice is impeded by communication difficulties.

This section looks at Deaf people's dealings with health professionals. Areas analysed and discussed are the use of the health services by the DPIC sample; their satisfaction with the services they received; communication support; likelihood of receiving prescribed medicines; and experiences of admission to hospital. These variables are analysed with respect to the age group, gender and social class of the respondents.

### 5.3 Attending Sessions with GP

The DPIC sample was asked how often they had visited their GP in the two weeks prior to interview. The responses are given in Table 5.1. Overall, 29% of the sample had visited their GP within this time period. Women (31%) were more likely than men (27%) to have made a visit, with those aged 65 years or older being the most likely to have gone to the doctor, for both men and women. Forty-four percent of older deaf men (65 years +) have been to the doctor in the last two weeks. This seems a very high figure.

For all age groups, the Deaf sample were approximately twice as likely to have visited their GP as the hearing sample as interviewed in the General Household Survey (1996). This seems to go against what we might have predicted as Deaf people commonly say that they dislike these consultations. However, it seems that the incidence of feeling unwell is greater and is sufficient to overcome any hesitation in going to see the doctor. It also seems likely that hearing people will have more access to information and advice about the feelings of illness and may have better pre- or self-diagnosis

possibilities.

The reported incidence of GP visits in the two weeks prior to interview, along with the frequency of such visits, was used to estimate the average number of GP consultations within the twelve month period. The results, by gender and age group, are reported in Table 5.2. Age trends are similar for the hearing and Deaf samples. The number of GP visits made by women does not vary greatly with age, but deaf women go much more frequently than hearing women. Interestingly, while deaf women's visits to the GP are marginally reduced by age – older women over 65 years have slightly fewer visits than younger women – older deaf men make twice as many visits as younger men. Deaf men seem to become much more concerned about health than hearing men and deaf women.

The projected number of visits within a year is two to three times higher for the Deaf sample compared to hearing people.

Table 5.3 sets out the pattern of GP visits across the UK. Many more people in Northern Ireland seem to go to the doctor than elsewhere and they tend to have more repeat visits. The South West area is next in frequency of visit and they tend to have the same number of repeat visits as Northern Ireland. People in Scotland followed by those in the North West and Wales are much less likely to go to the doctor.

In Table 5.4 we can see that although more white people go to the doctor, the ethnic minority groups tend to have higher numbers of visits per person. This implies the need to have further checks or consultations, possibly meaning that more reluctance at first leads to the delay in diagnosis and greater need for more visits.

Table 5.5 shows the site of GP consultations within the two-week reference period. Although the Deaf and hearing samples are equally likely to have visited a GP surgery (88% and 87% respectively), Deaf people are far less likely to have received a home visit from their GP (2% compared to 8% of the hearing sample from the GHS). (The GHS figure is odd in that it allowed people to make more than one entry – so people could make a telephone call and visit the surgery. Based on the more detailed figures for age, we can make a better comparable estimate for GHS of nearer 82% visit to surgery – i.e. Deaf people go more than hearing). In order for deaf people to have a consultation, they need to arrange for someone to accompany them, to act as interpreter and this may be easier to arrange at the surgery than at home. Contact at a distance is very similar for deaf and hearing people.

It seems that despite potential difficulties in making appointments and communicating with their GP, Deaf people are much more likely to have appointments than are hearing people. And they tend to go back more often. There are several possible reasons for this. Communication problems may result in Deaf people feeling "I still don't know what's wrong with me", and making repeat appointments. The same problems with communication may mean that diagnosis was less clear, the doctor may not have been able to understand the symptoms as reported, and the problem was never resolved. Or it may be possible that Deaf people are more likely to suffer from medical complaints than the majority hearing population. The first two explanations seem more likely, although further studies are required to establish the precise reasons for the larger number of GP visits by Deaf people.

### 5.3.1 Satisfaction with GP

Those who had consulted a GP in the 14 days prior to interview were asked if they were happy with their GP and the communication during the appointment. Levels of satisfaction within the population were generally high, with 88% of men and 80% of women expressing satisfaction with their GP (Table 5.6 and 5.7). Satisfaction was lowest for younger respondents (16-44 years old), although still high at 80% for young Deaf men and 72% for young Deaf women. The reported levels of satisfaction are higher than expected, although comparison figures for the hearing population were not available at the time of publication (these figures may in fact be low compared to hearing norms). The measure of satisfaction used in this study was not detailed, consisting of only one question. Clearly satisfaction with one's GP may depend upon a host of factors, including communication, doctor's manner, speed with which the problem was resolved and the quality of advice and reassurance given. These different areas must be separated out if we are to have a valid and reliable measure of Deaf people's satisfaction with their GP. In addition, it is possible that Deaf people's expectations are lower than those of hearing people given what they may see as a natural barrier in communication. More research is needed on this area.

### 5.3.2 Prescriptions

Those who had visited a GP within the two-week reference period were asked whether their GP had issued a prescription. The results are reported in Table 5.8. Men were more likely to receive prescriptions than women; older people were more likely to receive prescriptions than younger people; and Deaf people are more likely to be given a prescription by their GP than are their hearing peers.

This finding supports the hypothesis mentioned at the beginning of this chapter, that communication problems would lead to a greater reliance upon prescriptions and less upon the provision of advice and re-assurance.

### 5.3.3 Communication Support

The same group of respondents was asked whether they utilised communication support (i.e. interpreters or signing or text systems) during their GP consultation (Table 5.9). Only 36% of respondents reported doing so (Table 5.9). For those who did use some form of communication support, men were more likely to use a professional sign language interpreter (24%; 11% for women), and women were more likely to use a friend (17%; 8% for men). From Table 5.10, we can see that younger people (21%) are more likely to use an interpreter than older people (13%).

However, it leaves at least 60% of men and nearly 50% of women who went to the doctor in the last two week without support for communication. The DPIC sample was selected because of their language choice – BSL – which is not shared by the doctor. The implications for diagnosis and treatment are enormous and indicate that there could be serious problems to be dealt with here. Deaf people appear to struggle through in part speech and part lip-reading with some writing down of information.

Given the scarcity of professional sign language interpreters, particularly those qualified to a level suitable for medical consultations, these results are not surprising, at least in one respect – although we have no sense that Deaf people tried to find an interpreter and were unsuccessful. It is much more likely that interpreters simply cannot be provided for short consultations. One might also argue that Deaf people are reluctant to use an interpreter as the consultation may be of a personal and/or embarrassing nature. This is more likely to be the case for women, which may explain the marginally more frequent use of a friend for communication support.

## 5.4 Attending Sessions with Dentist

If the visit to the doctor can be problematic, the dentist is a likely to be a nightmare. If one imagines, the usual arrangement with a dentist sitting behind the patient and peering into his or her mouth, it is obvious that communication possibilities (by speech and lip-reading) are almost nil. In a routine check-up this may be less of a problem but in the case of extractions or fillings, the whole process is difficult.

Overall, 71% of respondents had visited their dentist in the year prior to interview

(Table 5.11), making an average of 0.77 visits. Women were more likely to visit a dentist than men, although this difference is attributable to the 16-44 year age group, where 82% of women and only 71% of men reported visiting their dentist (Table 5.11). Generally, attendance at the dentist declines with increasing age. Those on higher incomes are slightly more likely to have visited the dentist in the last 12 months (Table 5.12), reflected in the greater average number of visits (0.83).

The trend related to income is not surprising given the expense of dental treatment within the UK. Those on lower incomes may not feel they can afford dental treatment, and may also not be fully aware of the benefits payments available to cover some of the costs. Given the lower incomes reported for Deaf people in a previous report in this series (Deaf People in the Community: Demographics of the Deaf Community in the UK), this raises a concern that Deaf people may be taking less advantage of dental treatment than their hearing peers.

## 5.5 Attending Hospital

The DPIC population was also asked how often they had received outpatient treatment in the last 3 months. A breakdown by age and gender is given in Table 5.13. Except for those aged 65-74 years, Deaf respondents were more likely than their hearing peers to receive outpatient treatment in the last year. – ie the same trend as for visits to the doctor. Although the sample size for older deaf people is small, there does seem to be a tendency for fewer older deaf people to have outpatient treatment. Maybe older deaf people are less active than hearing older people, or perhaps the sample of cut-off for deaf people of 75 years, excludes those older than this who have to have treatment more often.

For day-patient treatment, Deaf respondents of all ages were three to five times more likely to have been into hospital (Table 5.14) than were hearing people. There is an increase in day-patient treatment with increasing age (as for the hearing population).

If Deaf people have limited access to health information or to information about how the health service works, they may be more likely to go directly to the hospital. They may also be more likely to build up problems that mean more serious treatment at hospital.

Table 5.15 shows the percentage of respondents receiving inpatient treatment in hospitals during the 12 months prior to interview. Overall, the figures for Deaf respondents are the same as those reported for the hearing population. There is a gender difference however. Young Deaf

men appear more likely to receive inpatient treatment than hearing men, although the reverse is true for Deaf and hearing women. This is also reflected in the average number of nights spent in hospital (Table 5.16). The problem here is that there are relatively few cases in these figures for Deaf people.

Nevertheless, it seems as if deaf people have the same extent of serious illness requiring hospitalisation as do hearing people but are far more likely to present as day patients or even as out-patients. Deaf people spend fewer nights in hospital than do hearing people.

## 5.6 Regional Variation

As with hearing people there are regional variations in use of the Health Service (Table 5.17). Most frequent outpatients are in Northern Ireland and least frequent are in Scotland (the same patterns as for GP consultations). However, the West Midlands seems to have greater use of the Health Service with 41% as out-patients and 45% as day patients – considerably more than any other region.

## 5.7 Satisfaction with Hospital Consultant

All respondents who reported receiving day-patient or inpatient treatment within the 12 months prior to interview were asked whether they were satisfied with their communication with the consultant. Overall, 66% were satisfied (Table 5.18), although this figure was higher for men (71%) than for women (59%). These satisfaction rates are lower than those for GP consultations, although again comparison figures are not available for hearing people. In reality, again we are dealing with small numbers of cases and these figures should not be taken as too firm. Also we should remember that the concept of "consultant" may not be so readily understood by Deaf respondents.

The same issue as highlighted in section 5.3.1 is also relevant here: the measure of satisfaction employed was crude, and provides only a general picture of Deaf people's experience of and satisfaction with their hospital consultant.

## 5.8 Summary

Anecdotal evidence suggests that Deaf people do not like visiting their GP, and try to avoid it as much as possible. However, results from this study suggest that Deaf people are more likely to visit their GP for a consultation, and more likely to receive day-patient treatment in hospital than are the population as a whole. The study also suggests that satisfaction rates are high. However, other data suggests that the picture is not as rosy as would first seem to be the case. Over half of the Deaf people go to the doctor without professional support for

communication. They are more likely to receive a prescription than their hearing peers. Taken together this is weak support for the view that poor communication between GPs and their Deaf patients may affect the pattern of health care. The satisfaction measure used (which has given apparently high ratings) may not have been specific enough to identify certain areas where satisfaction was low (such as communication), and may reflect lower expectations of services held by Deaf people.

**Table 5.1:** Consultations with a NHS GP in the 14 days before interview

| | GHS 1996 | DPIC 2000 | *Base (GHS)* | *Base (DPIC)* |
|---|---|---|---|---|
| | Percentage consulting GP | | | |
| **Men** | | | | |
| 16-44 | 10 | 20 | *4125* | *51* |
| 45-64 | 15 | 34 | *2479* | *32* |
| 65 and over | 20 | 44 | *1510* | *9* |
| Total | 13 | 27 | *8114* | *92* |
| **Women** | | | | |
| 16-44 | 20 | 32 | *4405* | *60* |
| 45-64 | 19 | 28 | *2605* | *39* |
| 65 and over | 22 | 38 | *1907* | *13* |
| Total | 20 | 31 | *8917* | *112* |
| **All persons** | | | | |
| 16-44 | 15 | 26 | *8530* | *111* |
| 45-64 | 17 | 31 | *5084* | *71* |
| 65 and over | 21 | 41 | *3417* | *22* |
| Total | 17 | 29 | *17031* | *204* |

**Table 5.2:** Average number of NHS GP consultations per person per year

| | GHS 1996 | DPIC 2000 |
|---|---|---|
| **Men** | | |
| 16-44 | 3 | 8 |
| 45-64 | 5 | 13 |
| 65-74 | 6 | 17 |
| **Women** | | |
| 16-44 | 7 | 11 |
| 45-64 | 6 | 9 |
| 65-74 | 7 | 10 |

**Table 5.3**: Visits to GP in two weeks prior to interview, by standard statistical region

| Standard Statistical Region | DPIC 2000 | Average number of visits | *Base = 100%* |
|---|---|---|---|
| | Percentage visiting GP | | |
| East Anglia | 17 | 0.50 | *6* |
| East Midlands | 31 | 0.31 | *16* |
| North | 20 | 0.33 | *15* |
| North West | 12 | 0.12 | *17* |
| Northern Ireland | 56 | 0.78 | *9* |
| Scotland | 6 | 0.06 | *18* |
| South East | 32 | 0.46 | *59* |
| South West | 47 | 0.79 | *19* |
| Wales | 13 | 0.25 | *8* |
| West Midlands | 39 | 0.43 | *23* |
| Yorkshire & Humberside | 39 | 0.56 | *18* |
| All persons | 30 | 0.42 | *208* |

**Table 5.4**: Visits to GP in two weeks prior to interview, by ethnic group

| Ethnic group | DPIC 2000 | Average number of visits | *Base = 100%* |
|---|---|---|---|
| | Percentage visiting GP | | |
| White | 58 | 0.41 | *195* |
| Asian | 29 | 0.71 | *7* |
| Black | 50 | 0.75 | *4* |
| Other | 0 | 0.00 | *2* |
| All ethnic minorities | 31 | 0.69 | *13* |
| All persons | 30 | 0.42 | *208* |

**Table 5.5:** Site of NHS GP consultation

*All DPIC and GHS respondents reporting a consultation within the two weeks prior to interview*

| | GHS 1996 | DPIC 2000 | |
|---|---|---|---|
| Surgery | 87 | 88 | |
| Home | 8 | 2 | |
| Telephone/Minicom | 9 | 7 | |
| Fax | -- | 2 | 11 |
| Not specified | -- | 2 | |
| Base = 100% | 3523 | 60 | |

**Table 5.6:** Satisfaction with GP by gender and age

*All DPIC respondents reporting a consultation within the two weeks prior to interview*

| | Satisfied with GP | Base = 100% |
|---|---|---|
| | % | |
| **Men** | | |
| 16-44 | 80 | 10 |
| 45-64 | 91 | 11 |
| 65 and over | 100 | 4 |
| Total | 88 | 25 |
| **Women** | | |
| 16-44 | 72 | 18 |
| 45-64 | 100 | 11 |
| 65 and over | 80 | 5 |
| Total | 80 | 35 |

**Table 5.7**: Satisfaction with GP by employment

*All DPIC respondents reporting a consultation within the two weeks prior to interview*

| Employment | Satisfaction with GP | *Base = 100%* |
|---|---|---|
| | Percentage satisfied | |
| **Economically active** | | |
| Non-manual | 100 | *10* |
| Manual | 81 | *27* |
| **Economically inactive** | | |
| Retired | 88 | *8* |
| Other | 79 | *14* |
| All persons | 85 | *59* |

**Table 5.8:** Prescriptions resulting from GP consultation by gender and age

*All DPIC and GHS respondents reporting a consultation with the two weeks prior to interview*

| | GHS 1996 | DPIC 2000 | Base (GHS) | Base (DPIC) |
|---|---|---|---|---|
| | Percentage obtaining prescription | | | |
| **Men** | | | | |
| 16-44 | 62 | 80 | 400 | 10 |
| 45-64 | 71 | 91 | 381 | 11 |
| 65 and over | 75 | 100 | 302 | 4 |
| Total | 69 | 88 | 1083 | 25 |
| **Women** | | | | |
| 16-44 | 66 | 79 | 869 | 19 |
| 45-64 | 73 | 73 | 507 | 11 |
| 65 and over | 76 | 100 | 421 | 5 |
| Total | 70 | 80 | 1797 | 35 |

**Table 5.9:** Communication support received, by gender

*All DPIC respondents reporting a consultation within the two weeks prior to interview*

| Communication support | Gender | | Total |
|---|---|---|---|
| | Men | Women | |
| | % | % | |
| Professional SLI | 24 | 11 | 17 |
| Family Member | 8 | 17 | 13 |
| Friend | 4 | 3 | 3 |
| Other | 0 | 6 | 3 |
| None | 60 | 46 | 52 |
| No Response | 4 | 17 | 12 |
| Base = 100% | 25 | 35 | 60 |

**Table 5.10:** Communication support received, by age group

*All DPIC respondents reporting a consultation within the two weeks prior to interview*

| | **Age group** | | **Total** |
|---|---|---|---|
| | 21-44 years | 45-75 years | |
| | % | % | % |
| Professional SLI | 21 | 13 | 17 |
| Family Member | 14 | 13 | 13 |
| Friend | 3 | 3 | 3 |
| Other | 1 | 3 | 3 |
| None | 45 | 58 | 52 |
| No Response | 15 | 10 | 12 |
| *Base = 100%* | *29* | *31* | *60* |

**Table 5.11:** Dentist consultations in year prior to interview and average number of appointments per year, by gender and age

| | **Dentist in last 12 months** | **Average number of visits** | **Base = 100%** |
|---|---|---|---|
| | % | | |
| **Men** | | | |
| 16-44 | 71 | 0.78 | 51 |
| 45-64 | 69 | 0.84 | 32 |
| 65 and over | 63 | 0.63 | 8 |
| Total | 69 | 0.79 | 91 |
| **Women** | | | |
| 16-44 | 82 | 0.84 | 57 |
| 45-64 | 63 | 0.68 | 38 |
| 65 and over | 54 | 0.54 | 13 |
| Total | 72 | 0.75 | 108 |

**Table 5.12:** Dentist consultations in year prior to interview and average number of appointments per year, by income band

| | Dentist in last 12 months | Average number of visits | Base = 100% |
|---|---|---|---|
| | % | | |
| **Income Band (£)** | | | |
| Low (0.01-200) | 66 | 0.69 | 70 |
| Medium (200.01-400) | 73 | 0.81 | 88 |
| High (400.01 and higher) | 76 | 0.83 | 41 |
| Total | 71 | 0.77 | 199 |

**Table 5.13:** Outpatient treatment in a 3-month reference period by gender and age

| | GHS 1996 | DPIC 2000 | *Base (GHS)* | *Base (DPIC)* |
|---|---|---|---|---|
| | Percentage receiving outpatient treatment | | | |
| **Men** | | | | |
| 16-44 | 13 | 25 | *4124* | *51* |
| 45-64 | 16 | 22 | *2480* | *32* |
| 65-74 | 20 | 11 | *884* | *9* |
| **Women** | | | | |
| 16-44 | 13 | 22 | *4405* | *60* |
| 45-64 | 18 | 26 | *2601* | *39* |
| 65-74 | 22 | 20 | *1052* | *10* |
| **All persons** | | | | |
| 16-44 | 13 | 25 | *8528* | *111* |
| 45-64 | 17 | 24 | *5079* | *71* |
| 65-74 | 21 | 16 | *1936* | *19* |

**Table 5.14:** Day-patient treatment in the 12 months before interview by gender and age

| | GHS 1996 | DPIC 2000 | Base (GHS) | Base (DPIC) |
|---|---|---|---|---|
| | Percentage receiving day-patient treatment | | | |
| **Men** | | | | |
| 16-44 | 5 | 14 | 4124 | 51 |
| 45-64 | 6 | 25 | 2482 | 32 |
| 65-74 | 7 | 33 | 884 | 9 |
| **Women** | | | | |
| 16-44 | 7 | 20 | 4406 | 60 |
| 45-64 | 8 | 18 | 2605 | 39 |
| 65-74 | 6 | 30 | 1053 | 10 |
| **All persons** | | | | |
| 16-44 | 6 | 17 | 8530 | 111 |
| 45-64 | 7 | 21 | 5087 | 71 |
| 65-74 | 7 | 32 | 1937 | 19 |

**Table 5.15:** Inpatient treatment in the 12 months before interview by gender and age

| | GHS 1996 | DPIC 2000 | Base (GHS) | Base (DPIC) |
|---|---|---|---|---|
| | Percentage receiving inpatient treatment | | | |
| **Men** | | | | |
| 16-44 | 5 | 8 | 4124 | 51 |
| 45-64 | 8 | 9 | 2482 | 32 |
| 65-74 | 13 | 11 | 884 | 9 |
| **Women** | | | | |
| 16-44 | 12 | 10 | 4406 | 60 |
| 45-64 | 10 | 8 | 2605 | 39 |
| 65-74 | 12 | 10 | 1053 | 10 |
| **All persons** | | | | |
| 16-44 | 9 | 9 | 8530 | 111 |
| 45-64 | 9 | 8 | 5087 | 71 |
| 65-74 | 12 | 11 | 1937 | 19 |

**Table 5.16**: Average number of nights spent as inpatient per stay in hospital by gender

| | GHS 1996 | DPIC 2000 | Base (GHS) | Base (DPIC) |
|---|---|---|---|---|
| Men | 7 | 6 | 724 | 7 |
| Women | 8 | 5 | 1132 | 11 |
| All inpatients | 7 | 5 | 1856 | 18 |

**Table 5.17**: Visits to hospital in two weeks prior to interview, by standard statistical region

| Standard Statistical Region | Out patient | Day patient | In patient | Average out patient visits | Average day patient visits | Average in patient visits | *Base = 100%* |
|---|---|---|---|---|---|---|---|
| | Percentage | | | | | | |
| East Anglia | 33 | 17 | 17 | 1.17 | 0.67 | 0.17 | *6* |
| East Midlands | 13 | 13 | 0 | 0.13 | 0.13 | --- | *15* |
| North | 20 | 13 | 0 | 0.27 | 0.13 | --- | *15* |
| North West | 24 | 12 | 0 | 0.53 | 0.12 | --- | *17* |
| Northern Ireland | 44 | 11 | 0 | 0.67 | 0.22 | --- | *9* |
| Scotland | 11 | 17 | 17 | 0.17 | 0.17 | 0.22 | *18* |
| South East | 19 | 18 | 14 | 0.49 | 0.63 | 0.14 | *57* |
| South West | 21 | 16 | 5 | 0.53 | 0.16 | 0.05 | *19* |
| Wales | 25 | 13 | 0 | 0.50 | 0.38 | --- | *8* |
| West Midlands | 41 | 45 | 9 | 0.82 | 1.86 | 0.09 | *22* |
| Yorkshire & Humberside | 33 | 28 | 28 | 0.44 | 1.00 | 0.28 | *18* |
| All persons | 24 | 20 | 10 | 0.49 | 0.57 | 0.10 | *204* |

**Table 5.18:** Satisfaction with consultant by gender

| | Satisfied with consultant | *Base = 100%* |
|---|---|---|
| | % | |
| Male | 59 | *17* |
| Female | 71 | *21* |
| Total | 66 | *38* |

# 6 Alcohol and Smoking

The Health theme in DPIC incorporated questions on alcohol consumption and cigarette smoking. Alcohol and smoking are major causes of illness within the UK, contributing to cancer, respiratory complaints, vascular disorders and neurological conditions. Alcohol can also cause social problems, such as homelessness, domestic violence and depression. Government campaigns are continue to point out the dangers to the public, through television advertisements, interventions in schools and posters displayed in GP surgeries, magazines and billboards. However, information in these campaigns is seldom disseminated in BSL. This raises the concern that awareness of the dangers of alcohol and smoking may not be as high within the Deaf community, and rates of alcohol consumption and smoking may not be sensitive to current health information and advice.

## 6.1 Alcohol

A series of questions were asked to establish levels of alcohol consumption within the Deaf community, as well as to investigate attitudes towards alcohol and alcoholism. Alcohol consumption level was examined using the methodology reported in the General Household Survey (1996). For five types of drink (shandy, lager and beer, spirits, sherries and ports, wine), respondents were asked how often during the year they drank that type of drink and how much of it they drank on a normal day when drinking it. More details can be found in Appendix A of the General Household Survey (1996).

### 6.1.1 Alcohol consumption level

Using the methodology outlined above, an estimate of the number of units of alcohol consumed each week was calculated for each respondent. The data reported here omit three respondents who reported consuming more than 150 units of alcohol per week, as their data was felt likely to have an inordinate influence on the results.

Table 6.1 reports the alcohol consumption level of the Deaf sample and the GHS (1996) sample by gender. Average consumption of units of alcohol is the same for deaf men and hearing men, but deaf women drink more. Of particular interest is the percentage of respondents who drink above the recommended number of units per week (21 units for men, and 14 units for women). Fewer Deaf men drink above these limits than do hearing men (22% compared to 27% of hearing men). However, Deaf women appear to drink more excessively than both

hearing women and Deaf men (24% drinking above the weekly recommended limit).

In Table 6.2, the mean weekly alcohol consumption (in units) of Deaf and hearing respondents is presented by gender and age group. Deaf men between the ages of 25 and 64 drink fewer units per week than hearing men of the same age. However, older Deaf men (65 years and over) drink 1.5 times the amount consumed by older hearing men. This is also true of younger Deaf men (under the age of 24 years), who drink an average of 34.6 units of alcohol per week (1.5 times above the recommended weekly limit). Deaf women drink more units of alcohol per week than hearing women across all age groups. The difference is most noticeable for 25-44 year olds, who on average drink almost twice as much as their hearing counterparts (although still under the weekly recommended limit of 14 units).

There is an interesting difference between the drinking patterns of Deaf men and women, related to usual gross weekly household income (Table 6.3). The more affluent the household of Deaf men, the less likely they are to drink excessively. However, the reverse is true for Deaf women; the more affluent their household, the more excessively they are likely to drink. Indeed, amongst those households with a usual gross weekly income of £400 or more, 43% of Deaf women drink excessively. Alcohol consumption also appears to be related to economic activity (Table 6.4), although the pattern is different for Deaf men and women. For men, the most excessive drinking is found amongst those who are unemployed (33% drink above the recommended limit), whereas for Deaf women the problem is located amongst those who are working (29% drinking above the recommended limit).

In terms of the region of the country (Table 6.5), there are noticeable differences – although some caution should be exercised as the re-arrangement of the figures into standard statistical regions (rather than DPIC sample regions), means certain regions have very few people. East Anglia and Northern Ireland seem to have the heaviest drinkers while the Scotland's figures are the lowest. Over half of the returns from East Anglia, East Midlands, Northern Ireland and South East have fairly or very high consumption of alcohol. Again this is an aspect that needs some further examination.

### 6.1.2 Alcohol and Addiction

The respondents were provided with four drinking behaviours, and asked whether these behaviours indicated 'addiction', 'danger of addiction' or 'normal'

behaviour. The responses for 'heavy' and 'moderate/light' drinkers are given in Table 6.6 to Table 6.9. 'Heavy' drinkers were defined as those who drank above the recommended weekly number of units; 'moderate/light' drinkers were all other respondents except non-drinkers.

For all four statements of drinking behaviours, heavy drinkers were marginally less likely to state that these statements indicated addiction or danger of addiction. Heavy and moderate/light drinkers agreed upon the severity of the behaviours in terms of indicating addiction. Drinking early in the morning was perceived as the best indicator of addiction, and drinking regularly was seen as the least likely to indicate addiction.

### 6.1.3 Reasons for Drinking

In light of the findings reported in section 6.1.1, particularly the alcohol consumption level of Deaf women, it is important to think about why the respondents engage in alcohol drinking behaviours. All alcohol drinkers were presented with eleven reasons for consuming alcohol (see Table 6.10) and asked to state if this reason applied to their drinking (frequently, sometimes or rarely/never).

The top three reasons given by heavy drinkers for drinking alcohol were (1) celebrations, (2) having fun, and (3) thirst. For moderate/light drinkers, the main reasons were celebrations, having fun, and because it is fashionable. As expected, heavy drinkers were more likely than moderate/light drinkers to give 'frequently' or 'sometimes' responses, and less likely to provide 'rarely or never' responses.

Table 6.11 and Table 6.12 show the same data split for women and men respectively. Given the high percentage of Deaf women who drink above the recommended levels (heavy drinkers), it is interesting to note any differences between male and female heavy drinkers. Women are less likely than men to drink alcohol for celebrations, because they are thirsty, because it is fashionable, due to peer pressure, or because they feel lonely. They are more likely than men to drink alcohol to forget frustrations, because of worries, stress or panic, and to drown their sorrows.

## 6.2 Smoking

In the sample as a whole, 21% are current regular smokers. For both men and women, smoking prevalence is highest among 20-24 year olds (Table 6.13). In this age group, Deaf men are substantially more likely to smoke than their hearing counterparts, whereas young Deaf women are less likely to be smokers than young hearing women. Deaf men aged 25-59 years are less likely to smoke than hearing men of the same age. The same is true of Deaf women aged 25-49 years.

A large proportion of the sample (66% of men and 76% of women) stated that they had never smoked regularly (Table 6.14). These figures are much higher than the corresponding data from the General Household Survey (1996). That is, deaf people smoke much less thane hearing people. However, those 20-24 year old Deaf males are markedly different as seen in Table 6.14 with much lower reporting of never having smoked than in the GHS (1996).

The vast majority of both male and female smokers reported consuming fewer than 20 cigarettes a day (Table 6.15). Comparison with GHS data suggests that Deaf smokers do not smoke as heavily as hearing smokers.

Finally, regular smokers and ex-smokers were asked at what age they started smoking regularly (Table 6.16). Nineteen percent of Deaf male 'smokers' reported starting smoking before the age of 16 years, along with 14% of the Deaf women 'smokers'. These figures are substantially lower than those reported in the GHS (1996).

### 6.2.1 Reasons for Smoking

The most common reasons given by regular smokers for their smoking were because it is soothing, it is fun/enjoyable, and because of frustration (Table 6.17). Very few reported smoking because it is fashionable or macho.

### 6.2.2 Smoking and Cancer

Awareness of smoking-related diseases was varied (Table 6.18). Most smokers and non-smokers were aware of the risk of lung cancer (100%/96%), breathlessness (100%/95%), coronary attack (81%/78%) and arterial thickening (72%/66%). Awareness of the risk of other forms of cancer (particularly cervical), stroke and thrombosis was much lower (33-53%). Where awareness was high, smokers tended to be slightly more aware of the risk than non-smokers. Where awareness was low, non-smokers were either more aware or awareness levels were equivalent for the two groups.

## 6.3 Summary

Most information about the risks associated with socially acceptable drugs is provided by health authorities in written English, in graphic leaflets and in television campaigns that use speech. Deaf people often have problems accessing written English, and there is a lack of information presented in British Sign Language. Even where there are videos it is unlikely that deaf people have seen them. It is therefore important to assess the level of use of such drugs within the Deaf community and to look at levels of risk awareness and attitudes towards these drugs.

## Alcohol

Two groups were identified where alcohol consumption levels were higher than in the general population: (1) 16-24 year old Deaf men, and (2) Deaf women of all ages. The Deaf women, at particular risk due to dangerous levels of alcohol consumption, were (a) employed Deaf women, and (b) Deaf women living in households with relatively large gross weekly incomes.

Heavy drinkers, those drinking above weekly recommended limits, were less likely to view behaviours linked to alcoholism as indicating addiction. All groups perceived drinking early in the morning as the best indicator of alcohol addiction, and drinking regularly as a poor indicator.

The top two reasons for drinking alcohol were for celebrations and for fun. Deaf women were less likely than Deaf men to drink for celebrations or because they were thirsty, and more likely to drink to forget frustrations, drown sorrows, or because of worries and stress.

## Smoking

Generally there are fewer current smokers in the Deaf population than in the UK population as a whole. In addition, more Deaf people reported never having smoked than the in the general population. Those Deaf people who did state they were current smokers, were found to smoke less than did smokers in the general population. These figures are encouraging, suggesting that smoking is less prevalent in the Deaf population. However, one sub-group of the Deaf population gives cause for concern. Two-thirds of Deaf young men (aged between 20 and 24 years) reported being current smokers. This can be compared to only 29% of those Deaf men aged 25-34 years, who smoke. An optimistic conclusion would be that this difference reflects a large number of young men quitting smoking in their late 20's and early 30's. However, such a large difference suggests that the 20-24 year old men are smoking more than older respondents did when they were the same age. Although campaigns have been mounted and might have targeted this age group, they have proved ineffective.

## Conclusions

This study suggests that, overall, Deaf people drink and smoke less than the population as a whole (as reported in 1996). This is encouraging given the relative paucity of health promotion literature available in BSL. However, certain groups appear to be at risk from diseases and conditions related to excessive alcohol consumption and smoking.

Deaf women who are employed, and/or in high income households are likely to drink above recommended weekly alcohol limits. The reasons for this appear to frustration,

sorrow and stress. Deaf young men (aged 20-24 years) are highly likely to be smokers, with the data also suggesting that this cohort are heavier smokers than previous generations when they were a similar age.

More research is urgently needed into alcohol abuse and smoking within the Deaf community. The sample sizes used in this study are small, but point to possible health dangers for Deaf working women from high-income households and Deaf men in their early 20's. Our study suggests that research should be targeted on these groups.

**Table 6.1:** Alcohol consumption level (AC level) by gender

| Alcohol consumption level (units per week) | GHS 1996 | | DPIC 2000 | |
|---|---|---|---|---|
| | % | | % | |
| **Men** | | | | |
| Non-drinker | 7 | | 6 | |
| Very low (under 1) | 8 | | 8 | |
| Low (1-10) | 35 | | 34 | |
| Moderate (11-21) | 23 | | 30 | |
| Fairly high (22-35) | 15 | | 10 | |
| High (36-50) | 7 | 27 | 7 | 22 |
| Very high (51+) | 6 | | 5 | |
| Mean weekly units | 16.0 | | 15.7 | |
| *Base = 100%* | *6902* | | *83* | |
| **Women** | | | | |
| Non-drinker | 13 | | 8 | |
| Very low (under 1) | 20 | | 11 | |
| Low (1-7) | 37 | | 41 | |
| Moderate (8-14) | 16 | | 16 | |
| Fairly high (15-25) | 9 | | 16 | |
| High (26-35) | 2 | 14 | 4 | 24 |
| Very high (36+) | 2 | | 4 | |
| Mean weekly units | 6.3 | | 9.5 | |
| *Base = 100%* | *8284* | | *104* | |

**Table 6.2:** Mean weekly alcohol consumption in units, by gender and age

| Age | Men | | Women | | All persons | |
|---|---|---|---|---|---|---|
| | GHS 1996 | DPIC 2000 | GHS 1996 | DPIC 2000 | GHS 1996 | DPIC 2000 |
| 16-24 | 20.3 | 34.6 | 9.5 | 11.1 | 14.7 | 22.2 |
| 25-44 | 17.6 | 14.4 | 7.2 | 12.7 | 11.9 | 13.5 |
| 45-64 | 15.6 | 12.4 | 5.9 | 7.0 | 10.5 | 9.4 |
| 65 and over | 11.0 | 15.0 | 3.5 | 4.9 | 6.8 | 8.2 |
| Total | 16.0 | 15.7 | 6.3 | 9.5 | 10.7 | 12.2 |
| ***Bases = 100%*** | | | | | | |
| *16-24* | *881* | *8* | *969* | *9* | *1850* | *17* |
| *25-44* | *2628* | *38* | *3182* | *44* | *5810* | *82* |
| *45-64* | *2215* | *30* | *2509* | *37* | *4724* | *67* |
| *65 and over* | *1445* | *7* | *1836* | *14* | *3281* | *21* |
| *Total* | *7169* | *83* | *8496* | *104* | *15665* | *187* |

**Table 6.3:** Alcohol consumption level by gender and usual gross weekly household income

| AC level (units per week) | Usual gross weekly household income (£) | | | | | | Total | |
|---|---|---|---|---|---|---|---|---|
| | 0.01-200 | | 200.01-400 | | 400.01 and over | | | |
| | % | | % | | % | | % | |
| **Men** | | | | | | | | |
| Non-drinker | 5 | | 5 | | 11 | | 6 | |
| Very low (under 1) | 14 | | 5 | | 11 | | 8 | |
| Low (1-10) | 29 | | 40 | | 26 | | 34 | |
| Moderate (11-21) | 24 | | 28 | | 42 | | 30 | |
| Fairly high (22-35) | 10 | | 12 | | 5 | | 10 | |
| High (36-50) | 5 | 29 | 9 | 23 | 5 | 10 | 7 | 22 |
| Very high (51+) | 14 | | 2 | | 0 | | 5 | |
| Mean weekly units | 19.6 | | 15.4 | | 12.1 | | 15.7 | |
| *Base = 100%* | *21* | | *43* | | *19* | | *83* | |
| **Women** | | | | | | | | |
| Non-drinker | 12 | | 5 | | 5 | | 8 | |
| Very low (under 1) | 12 | | 12 | | 5 | | 11 | |
| Low (1-7) | 40 | | 49 | | 29 | | 41 | |
| Moderate (8-14) | 14 | | 17 | | 19 | | 16 | |
| Fairly high (15-25) | 10 | | 15 | | 33 | | 16 | |
| High (26-35) | 10 | 22 | 0 | 17 | 0 | 43 | 4 | 24 |
| Very high (36+) | 2 | | 2 | | 10 | | 4 | |
| Mean weekly units | 8.4 | | 8.3 | | 13.8 | | 9.5 | |
| *Base = 100%* | *42* | | *41* | | *21* | | *104* | |

**Table 6.4:** Alcohol consumption level by gender and economic activity status

| AC level (units per week) | Economic activity status | | | Total |
|---|---|---|---|---|
| | Working | Unemployed | Inactive | |
| | % | % | % | % |
| **Men** | | | | |
| Non-drinker | 5 | 17 | 6 | 6 |
| Very low (under 1) | 8 | 0 | 12 | 8 |
| Low (1-10) | 38 | 17 | 24 | 34 |
| Moderate (11-21) | 27 | 33 | 41 | 30 |
| Fairly high (22-35) | 12 | 0 | 6 | 10 |
| High (36-50) | 5 | 33 | 6 | 7 |
| Very high (51+) | 5 | 0 | 6 | 5 |
| | 22 | 33 | 18 | 22 |
| Mean weekly units | 15.4 | 21.6 | 14.6 | 15.7 |
| *Base = 100%* | *60* | *6* | *17* | *83* |
| **Women** | | | | |
| Non-drinker | 6 | 13 | 8 | 8 |
| Very low (under 1) | 6 | 20 | 14 | 11 |
| Low (1-7) | 40 | 33 | 47 | 41 |
| Moderate (8-14) | 21 | 13 | 11 | 16 |
| Fairly high (15-25) | 19 | 7 | 17 | 16 |
| High (26-35) | 4 | 7 | 3 | 4 |
| Very high (36+) | 6 | 7 | 0 | 4 |
| | 29 | 21 | 20 | 24 |
| Mean weekly units | 11.4 | 8.8 | 6.9 | 9.5 |
| *Base = 100%* | *53* | *15* | *36* | *104* |

**Table 6.5:** Alcohol consumption level by standard statistical region

| Standard Statistical Region | | Non-drinker | Low-Moderate | Fairly high-Very high | Mean units per week | *Base = 100%* |
|---|---|---|---|---|---|---|
| East Anglia | % | 0 | 33 | 67 | 23.77 | *6* |
| East Midlands | % | 33 | 8 | 58 | 19.4 | *12* |
| North | % | 7 | 64 | 29 | 16.92 | *14* |
| North West | % | 6 | 53 | 41 | 16.61 | *17* |
| Northern Ireland | % | 13 | 38 | 50 | 23.69 | *8* |
| Scotland | % | 0 | 56 | 44 | 14.78 | *18* |
| South East | % | 6 | 43 | 52 | 20.97 | *54* |
| South West | % | 0 | 63 | 38 | 21.78 | *16* |
| Wales | % | 0 | 63 | 38 | 21.85 | *8* |
| West Midlands | % | 6 | 63 | 31 | 16.48 | *16* |
| Yorkshire | % | 12 | 47 | 41 | 16.19 | *17* |
| All persons | % | 7 | 48 | 45 | 19.06 | *186* |

**Table 6.6:** Addiction risk of drinking regularly by alcohol consumption rating

*All respondents except non-drinkers*

| Drinking regularly | AC rating | | Total |
|---|---|---|---|
| | Heavy | Moderate/Light | |
| | % | % | % |
| Addicted (2) | 9 | 6 | 6 |
| Danger of addiction (1) | 22 | 31 | 29 |
| Normal (0) | 69 | 63 | 65 |
| ***Base = 100%*** | *45* | *156* | *201* |

**Table 6.7:** Addiction risk of drinking excessively by alcohol consumption rating

*All respondents except non-drinkers*

| **Drinking excessively** | **AC rating** | | **Total** |
|---|---|---|---|
| | Heavy | Moderate/Light | |
| | % | % | % |
| Addicted (2) | 31 | 40 | 38 |
| Danger of addiction (1) | 60 | 51 | 53 |
| Normal (0) | 9 | 9 | 9 |
| ***Base = 100%*** | *45* | *156* | *201* |

**Table 6.8:** Addiction risk of drinking every time there is a problem by alcohol consumption rating

*All respondents except non-drinkers*

| **Drinking every time there is a problem** | **AC rating** | | **Total** |
|---|---|---|---|
| | Heavy | Moderate/Light | |
| | % | % | % |
| Addicted (2) | 22 | 30 | 28 |
| Danger of addiction (1) | 49 | 47 | 47 |
| Normal (0) | 29 | 23 | 24 |
| ***Base = 100%*** | *45* | *156* | *201* |

**Table 6.9:** Addiction risk of drinking early in the morning by alcohol consumption rating

*All respondents except non-drinkers*

| **Drinking early in morning** | **AC rating** | | **Total** |
|---|---|---|---|
| | Heavy | Moderate/Light | |
| | % | % | % |
| Addicted (2) | 80 | 83 | 82 |
| Danger of addiction (1) | 18 | 14 | 15 |
| Normal (0) | 2 | 3 | 3 |
| ***Base = 100%*** | *45* | *154* | *199* |

**Table 6.10:** Reasons for drinking alcohol, by alcohol consumption rating

*All respondents except non-drinkers*

| Reason for drinking alcohol | Heavy drinkers | | | *Base = 100%* | Moderate/Light drinkers | | | *Base = 100%* |
|---|---|---|---|---|---|---|---|---|
| | Frequently | Sometimes | Rarely or never | | Frequently | Sometimes | Rarely or never | |
| Celebrate | % 69 | 27 | 4 | *45* | % 45 | 46 | 9 | *127* |
| Fun | % 64 | 27 | 9 | *45* | % 40 | 47 | 13 | *127* |
| Thirsty | % 20 | 31 | 49 | *45* | % 6 | 31 | 63 | *125* |
| Forget frustrations | % 18 | 31 | 51 | *45* | % 2 | 20 | 77 | *127* |
| Fashionable | % 23 | 20 | 57 | *44* | % 12 | 20 | 68 | *127* |
| Worries | % 14 | 30 | 57 | *44* | % 2 | 13 | 85 | *126* |
| Stress | % 11 | 29 | 60 | *45* | % 2 | 19 | 79 | *127* |
| Peer pressure | % 9 | 31 | 60 | *45* | % 10 | 20 | 69 | *127* |
| Loneliness | % 9 | 23 | 67 | *43* | % 2 | 16 | 83 | *127* |
| Panic | % 11 | 9 | 80 | *45* | % 1 | 6 | 94 | *127* |
| Drown sorrows | % 7 | 16 | 78 | *45* | % 1 | 15 | 84 | *127* |

**Table 6.11:** Reasons for drinking alcohol, by alcohol consumption rating (women only)

*All respondents except non-drinkers*

| Reason for drinking alcohol | Heavy drinkers | | | *Base = 100%* | Moderate/Light drinkers | | | *Base = 100%* |
|---|---|---|---|---|---|---|---|---|
| | Frequently | Sometimes | Rarely or never | | Frequently | Sometimes | Rarely or never | |
| Celebrate | % 65 | 27 | 8 | *26* | % 45 | 44 | 11 | *71* |
| Fun | % 62 | 31 | 8 | *26* | % 38 | 49 | 13 | *71* |
| Thirsty | % 19 | 19 | 62 | *26* | % 6 | 21 | 73 | *71* |
| Forget frustrations | % 19 | 31 | 50 | *26* | % 1 | 20 | 79 | *71* |
| Fashionable | % 20 | 16 | 64 | *25* | % 10 | 23 | 68 | *71* |
| Worries | % 16 | 32 | 52 | *25* | % 3 | 14 | 83 | *71* |
| Stress | % 12 | 35 | 54 | *26* | % 1 | 17 | 82 | *71* |
| Peer pressure | % 8 | 19 | 73 | *26* | % 4 | 27 | 69 | *71* |
| Loneliness | % 8 | 17 | 75 | *24* | % 1 | 15 | 83 | *71* |
| Panic | % 12 | 12 | 77 | *26* | % 1 | 6 | 93 | *71* |
| Drown sorrows | % 4 | 23 | 73 | *26* | % 0 | 13 | 87 | *71* |

**Table 6.12:** Reasons for drinking alcohol, by alcohol consumption rating (men only)

*All respondents except non-drinkers*

| **Reason for drinking alcohol** | | **Heavy drinkers** | | | ***Base* = *100%*** | | **Moderate/Light drinkers** | | | ***Base* = *100%*** |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Frequently | Sometimes | Rarely or never | | | Frequently | Sometimes | Rarely or never | |
| Celebrate | % | 74 | 26 | 0 | *19* | % | 45 | 48 | 7 | *56* |
| Fun | % | 68 | 21 | 11 | *19* | % | 43 | 45 | 13 | *56* |
| Thirsty | % | 21 | 47 | 32 | *19* | % | 6 | 44 | 50 | *54* |
| Forget frustrations | % | 16 | 32 | 53 | *19* | % | 4 | 21 | 75 | *56* |
| Fashionable | % | 26 | 26 | 47 | *19* | % | 14 | 18 | 68 | *56* |
| Worries | % | 11 | 26 | 63 | *19* | % | 2 | 11 | 87 | *55* |
| Stress | % | 11 | 21 | 68 | *19* | % | 4 | 21 | 75 | *56* |
| Peer pressure | % | 11 | 47 | 42 | *19* | % | 18 | 13 | 70 | *56* |
| Loneliness | % | 11 | 32 | 58 | *19* | % | 2 | 16 | 82 | *56* |
| Panic | % | 11 | 5 | 84 | *19* | % | 0 | 5 | 95 | *56* |
| Drown sorrows | % | 11 | 5 | 84 | *19* | % | 2 | 18 | 80 | *56* |

**Table 6.13:** Prevalence of cigarette smoking by gender and age

| | GHS 1996 | DPIC 2000 | *Base (GHS) = 100%* | *Base (DPIC) = 100%* |
|---|---|---|---|---|
| | Percentage smoking cigarettes | | | |
| **Men** | | | | |
| 16-19 | 26 | --- | *406* | — |
| 20-24 | 43 | 67 | *471* | *9* |
| 25-34 | 38 | 29 | *1322* | *28* |
| 35-49 | 30 | 24 | *1947* | *25* |
| 50-59 | 28 | 17 | *1090* | *12* |
| 60 and over | 18 | 21 | *1936* | *19* |
| All aged 16 or over | 29 | 28 | *7172* | *93* |
| **Women** | | | | |
| 16-19 | 32 | --- | *403* | — |
| 20-24 | 36 | 30 | *567* | *10* |
| 25-34 | 34 | 17 | *1615* | *30* |
| 35-49 | 30 | 6 | *2321* | *36* |
| 50-59 | 26 | 28 | *1202* | *18* |
| 60 and over | 19 | 14 | *2393* | *21* |
| All aged 16 or over | 28 | 16 | *8501* | *115* |
| **Total** | | | | |
| 16-19 | 29 | --- | *809* | — |
| 20-24 | 39 | 47 | *1038* | *19* |
| 25-34 | 36 | 22 | *2937* | *58* |
| 35-49 | 30 | 13 | *4268* | *61* |
| 50-59 | 27 | 23 | *2292* | *30* |
| 60 and over | 18 | 18 | *4329* | *40* |
| All aged 16 or over | 28 | 21 | *15673* | *208* |

**Table 6.14:** Percentage who had never smoked cigarettes by gender and age

| | GHS 1996 | DPIC 2000 | *Base (GHS) = 100%* | *Base (DPIC) = 100%* |
|---|---|---|---|---|
| | Percentage who had never smoked regularly | | | |
| **Men** | | | | |
| 16-19 | 69 | --- | *406* | — |
| 20-24 | 47 | 33 | *471* | *9* |
| 25-34 | 49 | 68 | *1322* | *28* |
| 35-49 | 43 | 64 | *1947* | *25* |
| 50-59 | 31 | 83 | *1090* | *12* |
| 60 and over | 28 | 68 | *1936* | *19* |
| All aged 16 or over | 40 | 66 | *7172* | *93* |
| **Women** | | | | |
| 16-19 | 63 | --- | *403* | — |
| 20-24 | 54 | 60 | *567* | *10* |
| 25-34 | 53 | 83 | *1615* | *30* |
| 35-49 | 52 | 81 | *2321* | *36* |
| 50-59 | 49 | 61 | *1202* | *18* |
| 60 and over | 53 | 76 | *2393* | *21* |
| All aged 16 or over | 53 | 76 | *8501* | *115* |

**Table 6.15:** Smoking status by gender

| **Smoking status** | **GHS 1996** | **DPIC 2000** |
|---|---|---|
| | Percentages | |
| **Men** | | |
| Light (under 20 per day) | 17 | 26 |
| Heavy (20 or more per day) | 11 | 2 |
| Total | 29 | 28 |
| Base = 100% | 7172 | 93 |
| **Women** | | |
| Light (under 20 per day) | 19 | 12 |
| Heavy (20 or more per day) | 8 | 3 |
| Total | 28 | 16 |
| ***Base = 100%*** | *8501* | *115* |

**Table 6.16**: Age started smoking regularly by gender

*All present and past regular smokers*

| Age started smoking | GHS 1996 | | | DPIC 2000 | | |
|---|---|---|---|---|---|---|
| | Men | Women | All | Men | Women | All |
| | % | % | % | % | % | % |
| Under 16 | 41 | 32 | 37 | 19 | 14 | 17 |
| 16-17 | 27 | 28 | 28 | 13 | 21 | 17 |
| 18-19 | 17 | 17 | 17 | 25 | 11 | 18 |
| 20-24 | 11 | 13 | 12 | 22 | 18 | 20 |
| 25 and over | 4 | 9 | 6 | 6 | 11 | 8 |
| No response | --- | --- | --- | 16 | 25 | 20 |
| ***Base = 100%*** | *4295* | *3991* | *8286* | *32* | *28* | *60* |

**Table 6.17:** Reasons for smoking

*All DPIC current regular smokers*

| Reasons for smoking | | Frequency | | | *Base = 100%* |
|---|---|---|---|---|---|
| | | Frequently | Sometimes | Rarely or never | |
| Soothing | % | 51 | 31 | 18 | *45* |
| Fun | % | 43 | 36 | 21 | *47* |
| Frustration | % | 39 | 28 | 33 | *46* |
| Stress | % | 35 | 26 | 39 | *46* |
| Worry | % | 30 | 30 | 39 | *46* |
| Taste | % | 30 | 32 | 38 | *47* |
| Thinking | % | 30 | 28 | 41 | *46* |
| Panic | % | 20 | 26 | 54 | *46* |
| Fashionable | % | 9 | 20 | 72 | *46* |
| Macho | % | 4 | 2 | 93 | *45* |

**Table 6.18:** Awareness of smoking-related illness by smoking status

| Smoking-related illness | Smoking status | | Base = 100% | |
|---|---|---|---|---|
| | Smokers | Non-smokers | *Smokers* | *Non-smokers* |
| | Percentage aware of risk | | | |
| **Cancer** | | | | |
| Lung | 100 | 96 | *49* | *179* |
| Ovaries | 45 | 45 | *49* | *172* |
| Kidney | 43 | 53 | *49* | *178* |
| Liver | 43 | 51 | *49* | *177* |
| Bowel | 43 | 50 | *49* | *175* |
| Cervix | 33 | 34 | *49* | *172* |
| **Heart problems** | | | | |
| Breathlessness | 100 | 95 | *49* | *177* |
| Coronary attack | 81 | 78 | *48* | *177* |
| Arterial thickening | 72 | 66 | *47* | *174* |
| Stroke | 49 | 48 | *49* | *175* |
| Thrombosis | 46 | 46 | *46* | *174* |

# 7 Health Advice

Relatively little health advice is available in BSL. Most advice is in English, spoken or written, and accessed via health services or health education literature. Given problems Deaf people may experience accessing health advice in English, and issues highlighted in this report with respect to alcohol consumption, it is pertinent to ask how many sources of advice different sub-groups of Deaf people consult, and what these sources are.

## 7.1 Amount of Health Advice Sought

The DPIC sample was given a list of eight sources of health advice, and asked to indicate all of the sources that they consulted. Based upon the number of sources consulted, the sample was split into three groups: (1) high advice seekers (5-8 sources consulted), (2) medium advice seekers (2-4 sources consulted), and (3) low advice seekers (0-1 sources consulted). Table 7.1 displays the percentage of persons in each of these sub-groups, along with the average number of sources consulted. The information is broken down by gender, age group, socio-economic group, and highest qualification level attained. Generally speaking, there is not a high level of advice seeking in this sample.

One-fifth of Deaf women were high advice seekers, compared with only one-tenth of Deaf men. On average, women (2.92) consulted more sources of information than men (2.25). Younger (21-44 year old) and older (65 years and over) people consulted more advice sources than 45-64 year olds. Those from higher socio-economic groups consulted more advice sources than those from lower socio-economic groups. On average, professionals, managers and employers consulted 3.89 different advice sources, whereas unskilled manual workers consulted only 1.33 sources on average. Finally, those with formal qualifications (degrees, HNDs, 'A' levels and GCSE/'O' levels) consulted more advice sources than those with no or foreign/other qualifications. Only education level seemed to be a good guide to the extent of advice seeking. This is a result that parallels the hearing community.

## 7.2 Sources of Health Advice

As well as varying in how much advice they sought, these sub-groups also varied in the sources of advice they consulted (Table 7.2 to Table 7.5). Overall, the most popular sources of health advice were magazines (46%, although this was mainly women), friends (42%), relatives (41%) and

leaflets (41%). These were the top 4 sources for both men and women (Table 7.2). The same is true for all age groups analysed, although those aged 65 and over also showed a preference for obtaining advice from television (Table 7.3).

Professionals, employers and managers were most likely to obtain advice from friends (75%), doctors (75%), relatives and leaflets (Table 7.4). This professional group seem to quite markedly different in this respect. The other socio-economic groups tend to have less contact with information sources. Those with a higher education qualification preferred magazines, newspapers, relatives and leaflets (Table 7.5), and those with no qualifications preferred friends, relatives, magazines and doctors.

## 7.3 Summary

The sample varied in the extent to which they sought health advice. Those most likely to seek health advice were women, 21-44 year olds and those aged over 65 years, professionals, managers and employers, and those with higher education qualifications and other formal qualifications (such as 'A' levels and GCSEs). The least likely to seek health advice were men, 45-64 year olds, unskilled manual workers, and those with no or foreign/other qualifications.

The most popular sources of health advice were people know personally to the respondents (friends and relatives) and text sources (magazines and leaflets). Strangely TV was not a popular source. This overall pattern was consistent across most sub-groups of the sample. The only major deviation was on the basis of the highest qualification level obtained. Those with higher education qualifications showed a preference for text sources (the top 4 sources were magazines, newspapers, relatives and leaflets). Those with no qualifications, however, showed a preference for advice from people (the top 4 sources were friends, relatives, magazines and doctors).

**Table 7.1**: Amount of health advice sought by gender, by age group, by socio-economic group, and by highest qualification level attained

| | Advice seeking level | | | Mean sources of advice | *Base = 100%* |
|---|---|---|---|---|---|
| | High (5-8) | Medium (2-4) | Low (0-1) | | |
| **Gender** | | | | | |
| Men | 11 | 45 | 45 | 2.25 | *92* |
| Women | 21 | 45 | 34 | 2.92 | *109* |
| **Age group** | | | | | |
| 21-44 | 19 | 44 | 38 | 2.84 | *108* |
| 45-64 | 13 | 42 | 46 | 2.22 | *72* |
| 65 and over | 19 | 62 | 19 | 2.76 | *21* |
| **Socio-economic group** | | | | | |
| Professionals, managers and employers | 33 | 44 | 22 | 3.89 | *9* |
| Intermediate and junior non-manual | 17 | 45 | 38 | 2.70 | *47* |
| Skilled and semi-skilled manual | 15 | 40 | 46 | 2.34 | *68* |
| Unskilled manual | 0 | 17 | 83 | 1.33 | *6* |
| **Highest qualification level** | | | | | |
| Higher education | 20 | 40 | 40 | 3.20 | 10 |
| 'A' level | 24 | 35 | 41 | 2.88 | *17* |
| GCSE/'O' level | 19 | 49 | 31 | 2.76 | *67* |
| Foreign or other | 7 | 41 | 52 | 2.00 | 29 |
| None | 15 | 45 | 40 | 2.58 | 78 |
| **All persons** | 16 | 45 | 39 | 2.61 | *201* |

**Table 7.2:** Sources of health advice consulted by gender

| Source of health advice | Gender | | All persons |
|---|---|---|---|
| | Men | Women | |
| | Percentage consulting | | |
| Friends | 42 | 41 | 42 |
| Relatives | 37 | 44 | 41 |
| Magazines | 27 | 62 | 46 |
| TV | 22 | 33 | 28 |
| Newspapers | 25 | 26 | 25 |
| Doctors | 24 | 32 | 28 |
| Pharmacists | 7 | 12 | 9 |
| Leaflets | 41 | 41 | 41 |
| ***Base = 100%*** | *92* | *109* | *201* |

**Table 7.3:** Sources of health advice consulted by age group

| Source of health advice | Age group | | | All persons |
|---|---|---|---|---|
| | 21-44 | 45-64 | 65 and over | |
| | Percentage consulting | | | |
| Friends | 46 | 38 | 33 | 42 |
| Relatives | 49 | 28 | 43 | 41 |
| Magazines | 48 | 40 | 57 | 46 |
| TV | 27 | 26 | 38 | 28 |
| Newspapers | 27 | 24 | 24 | 25 |
| Doctors | 31 | 24 | 33 | 28 |
| Pharmacists | 11 | 7 | 10 | 9 |
| Leaflets | 45 | 36 | 38 | 41 |
| ***Base = 100%*** | *108* | *72* | *21* | *201* |

**Table 7.4:** Sources of health advice consulted by socio-economic group

| Source of health advice | Socio-economic group | | | | All persons |
|---|---|---|---|---|---|
| | Professionals, employers and managers | Intermediate and junior non-manual | Skilled and semi-skilled manual | Unskilled manual | |
| | Percentage consulting | | | | |
| Friends | 75 | 38 | 44 | 33 | 42 |
| Relatives | 63 | 43 | 37 | 33 | 41 |
| Magazines | 50 | 51 | 35 | 17 | 46 |
| TV | 25 | 32 | 24 | 17 | 28 |
| Newspapers | 38 | 32 | 21 | 0 | 25 |
| Doctors | 75 | 19 | 21 | 0 | 28 |
| Pharmacists | 50 | 4 | 10 | 0 | 9 |
| Leaflets | 63 | 45 | 43 | 33 | 41 |
| ***Base = 100%*** | *8* | *47* | *68* | *6* | *201* |

**Table 7.5:** Sources of health advice consulted by highest qualification level attained

| Source of health advice | Highest qualification level attained | | | | | All persons |
|---|---|---|---|---|---|---|
| | Higher education | A' level | GCSE/'O' level | Foreign or other | None | |
| | Percentage consulting | | | | | |
| Friends | 30 | 65 | 43 | 31 | 41 | 42 |
| Relatives | 40 | 47 | 36 | 48 | 41 | 41 |
| Magazines | 80 | 35 | 54 | 38 | 41 | 46 |
| TV | 30 | 29 | 28 | 21 | 29 | 28 |
| Newspapers | 50 | 24 | 27 | 10 | 27 | 25 |
| Doctors | 30 | 35 | 22 | 17 | 36 | 28 |
| Pharmacists | 20 | 12 | 9 | 0 | 12 | 9 |
| Leaflets | 40 | 41 | 57 | 34 | 31 | 41 |
| ***Base = 100%*** | *10* | *17* | *67* | *29* | 78 | *201* |

# 8 Stress

Stress is a major cause of illness, and responsible for many of the symptoms reported to GPs on a daily basis. The DPIC sample was asked how often they experienced stress in three areas of their lives: (1) at work, (2) at home, and (3) generally from pressures imposed upon them by society. Table 8.1 presents the frequencies with which stress was experienced from 17 different sources. At work, the four major sources of stress for Deaf people were (1) having too much work, (2) problems with their colleagues, (3) understaffing, and (4) being underpaid. However, more than half up to seventy percent of deaf people report never having experienced stress from travelling, overtime or being un-qualified. One can suggest that either the features are not present or the aspirations so low that these topics do not cause concern, or deaf people are employed at the correct level.

In the home, the major sources of stress were (1) financial problems, and (2) health problems. Deaf people also reported frequently experiencing stress due to pressure from society and the media. Again on the other hand, deaf people claim not have experienced stress from neighbours, partner and children. The first of these may be due to the limited communication that passes between them and their neighbours. Health problems seem not to be a source of stress either – which is odd, given the frequency of visits to the doctor.

For each of the three types of stress (work, home, societal), an aggregate stress score was calculated based upon the frequency rankings (see footnote to Table 8.2). These measures were used to compare the frequency of stressful experiences by gender, number of dependant children, income level, and alcohol consumption level.

Men were slightly more likely to report experiencing work stress than women, and less likely to report experiencing stress in the home. They also reported experiencing societal stress less often than women (Table 8.2). For respondents with dependant children a clear trend emerged (Table 8.2). As the number of dependent children increases, the frequency with which all three types of stress is reported also increases. The stress levels for families with 4 dependant children are higher than for any other sub-group (although sample size is small). Income level also has an effect on reported experience of stress (Table 8.3). Those from larger income households report less work stress, more home stress, and less

societal stress, than those from lower income households. Finally, heavy and moderate/light drinkers were compared (Table 8.3). Heavy drinkers reported experiencing more home stress and less societal stress. Work stress did not differ between the two groups.

The responses seem to imply that deaf people suffer much less stress than would be expected. A general prediction is that deaf life is inherently stressful in that there are always uncertainties in communication. We can support the notion that stress is greater at work than at home, but the responses throughout imply that deaf people do not experience the stress in situations which hearing people commonly report.

One possible explanation may be in the lack of clear definition of stress. A sign for *stress* that could be used in the interviews can also be glossed as *frustration*, which would alter the meaning in discussion or in the understanding of the concept. Society's views of stress have moved on a long way in recent years because of their constant discussion in the media. Deaf people will rarely have had the opportunity to take part in this discussion and the way the concept is understood may be different.

This section will support further analysis and can be cross-referenced with previous sections on alcohol and smoking.

**Table 8.1:** Sources of stress and frequency with which experienced

| Source of stress | | How often experienced | | | *Base = 100%* |
|---|---|---|---|---|---|
| | | Frequently | Sometimes | Rarely or never | |
| **Work stress** | | | | | |
| Too much work | % | 25 | 50 | 25 | *156* |
| Problems amongst colleagues | % | 17 | 38 | 44 | *156* |
| Understaffed | % | 19 | 34 | 46 | *155* |
| Underpaid | % | 25 | 25 | 50 | *155* |
| Boredom | % | 19 | 23 | 58 | *156* |
| Under-qualified | % | 13 | 28 | 60 | *152* |
| Overtime | % | 10 | 23 | 67 | *154* |
| Travel distance too far | % | 9 | 22 | 69 | *158* |
| **Home stress** | | | | | |
| Financial problems | % | 13 | 42 | 44 | *193* |
| Health problems | % | 9 | 32 | 59 | *195* |
| Problems with other family members | % | 7 | 32 | 61 | *192* |
| Problems with children | % | 8 | 29 | 63 | *169* |
| Problems with partner | % | 7 | 28 | 66 | *178* |
| Problems with neighbours | % | 2 | 11 | 87 | *193* |
| **Societal stress** | | | | | |
| Pressure from society | % | 11 | 44 | 45 | *194* |
| Pressure from media | % | 8 | 37 | 55 | *193* |
| Peer pressure | % | 4 | 33 | 63 | *190* |

**Table 8.2:** Stress scores* by gender and by number of dependant children

| Stress type | All persons | Gender | | Dependent children | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Men | Women | 0 | 1 | 2 | 3 | 4 |
| Work stress* | 0.66 | 0.69 | 0.63 | 0.65 | 0.73 | 0.59 | 0.7 | 0.88 |
| Home stress* | 0.44 | 0.41 | 0.46 | 0.4 | 0.41 | 0.56 | 0.55 | 0.78 |
| Societal stress* | 0.53 | 0.5 | 0.56 | 0.54 | 0.47 | 0.48 | 0.61 | 1 |
| *Base (work stress) = 100%* | *158* | *72* | *86* | *106* | *17* | *22* | *11* | *2* |
| *Base (home stress) = 100%* | *195* | *86* | *109* | *133* | *20* | *27* | *12* | *3* |
| *Base (societal stress) = 100%* | *194* | *86* | *108* | *132* | *20* | *27* | *12* | *3* |

*The stress score is the weighted sum of the responses for a sub-sample. 'Frequently' scores 2, 'sometimes' scores 1, and 'rarely or never' scores 0. The higher the stress score, the more frequently the sub-sample reported experiencing stress for that reason.

**Table 8.3**: Stress scores by income level and by alcohol consumption rating

| Stress type | Income level | | | AC rating | |
|---|---|---|---|---|---|
| | Low | Medium | High | Heavy drinkers | Light/Moderate drinkers |
| Work stress* | 0.77 | 0.61 | 0.63 | 0.65 | 0.66 |
| Home stress* | 0.44 | 0.41 | 0.5 | 0.48 | 0.43 |
| Societal stress* | 0.58 | 0.51 | 0.51 | 0.49 | 0.55 |
| *Base (work stress) = 100%* | *44* | *75* | *39* | *34* | *124* |
| *Base (home stress) = 100%* | *68* | *86* | *41* | *45* | *150* |
| *Base (societal stress) = 100%* | *68* | *86* | *40* | *44* | *150* |

* See footnote to Table 8.2.

**Table 8.4:** Stress scores by employment status

| Employment | Work stress* | Home stress* | Other stress* |
|---|---|---|---|
| | Average stress scores | | |
| Economically active | | | |
| Non-manual | 0.66 | 0.36 | 0.48 |
| Manual | 0.63 | 0.46 | 0.52 |
| Economically inactive | | | |
| Retired | 0.77 | 0.46 | 0.59 |
| Other | 0.7 | 0.49 | 0.59 |
| All persons | 0.66 | 0.44 | 0.53 |

* See footnote to Table 8.2.

# 9 Mental Health

The incidence of mental health problems is usually reported as higher in the Deaf population than in the UK population as a whole. This section does not attempt to attribute this higher incidence to communication difficulties, social isolation, or any other possible cause. Rather, it asks the Deaf DPIC population about which sources of help and advice they would prefer if suffering from mental ill health. It may be predicted on the one hand that communication problems mean that most would prefer a counsellor/therapist who is also Deaf but on the other hand, that the size of the Deaf community in Britain creates worries that confidentiality might not be respected. A Deaf professional would still be a member of the same community and could be subject to all the pressures for disclosure. The deaf client might be unhappy about seeing the counsellor in a social situation.

## 9.1 Preferred Source of Help and Advice

Younger respondents (aged 21-29 years) are the most likely (65%) to feel that professional help could alleviate depression (Table 9.1). Approximately one-third of participants from all age groups stated that they did not know whether professional help would be useful. To a large extent this may be due to the lack of provision that previously existed and the lack of awareness of mental health problems among the deaf community.

Almost half of the sample would have either a hearing or a deaf person as a counsellor and 42% wanted a deaf professional (Table 9.2). For those aged 21-44 years, there was a clearer preference for a Deaf professional than for older respondents. Since deaf professionals are a relatively recent addition to the mental health field, this is perhaps not surprising. However, the preferences figures are still less than one would imagine if we were dealing with other minority groups.

## 9.2 Reason for Preference

The respondents were also asked to write down the reason for their preference (see Table 9.3). These are explored below, categorised by expressed preference.

### 9.2.1 Prefer Deaf Person

The major reason given for preferring a Deaf professional was ease of communication (83%). No other reason was a as clear cut. Empathy (12%) was the only other reason offered by more than a few people. This result is highly predictable – the advantage of a deaf counsellor is that he/she will understand

their experiences and culture.

### 9.2.2 Prefer Hearing Person

The major reasons given for preferring a hearing professional were confidentiality (19%), more experience (19%), better information (13%) and trust (13%). The motivation for preferring a hearing professional seemed to have positive and negative aspects. On the one hand, hearing professionals were preferred because respondents felt there would be less trust of a Deaf professional, and that there may be breaches of confidentiality. On the other hand, there was a positive preference for hearing professionals because they were felt to be more experienced and to offer better information.

### 9.2.3 No Preference

Those who stated they were happy to consult either a Deaf or a hearing professional gave the reason that it provided the opportunity to obtain two different perspectives on the problem (41%). Communication was another key reason (25%) with respondents stating they were happy to see a hearing professional if that person had adequate sign skills. There was also a feeling that both Deaf and hearing counsellors would be professionals (12%) and that treatment was the most important thing, not who was providing it (5%). The overall motivation for this group seems to be a 'best of both worlds' approach.

## 9.3 Summary

Not surprisingly, this area needs more research. Minority communities would usually be expected to prefer their own community members to act as support professionals, rather those who do not understand the way of life. With deaf people, surrounded by hearing society at all times and since their earliest childhood, the choices are not so clear-cut.

Communication is the main factor in choosing a deaf person, while training, experience and confidentiality are what mark out the hearing professional. As deaf professionals become more effectively trained it will be interesting to see how this situation might change.

**Table 9.1:** Agreement that professional support can help *depression* by age group

| | Age Group | | | | All persons |
|---|---|---|---|---|---|
| | 21-29 years | 30-44 years | 45-59 years | 60 years and over | |
| | % | % | % | % | % |
| Yes | 65 | 49 | 57 | 48 | 54 |
| No | 7 | 16 | 9 | 10 | 11 |
| Don't know | 28 | 35 | 34 | 43 | 35 |
| ***Base = 100%*** | *43* | *63* | *53* | *40* | *199* |

**Table 9.2:** Preferred source of professional help by age group

| | Age Group | | | | All persons |
|---|---|---|---|---|---|
| | 21-29 years | 30-44 years | 45-59 years | 60 years and over | |
| | % | % | % | % | % |
| Deaf person | 47 | 52 | 28 | 40 | 42 |
| Hearing person | 4 | 3 | 21 | 18 | 11 |
| Either | 42 | 35 | 40 | 33 | 37 |
| Don't know | 7 | 10 | 11 | 10 | 9 |
| ***Base = 100%*** | *43* | *63* | *53* | *40* | *199* |

**Table 9.3:** Reasons for preference by preferred source of professional help

| Reason | Preferred source of advice | | | All persons |
|---|---|---|---|---|
| | Deaf person | Hearing person | Either | |
| | % | % | % | % |
| Communication | 83 | 13 | 25 | 54 |
| Empathy | 12 | 6 | 7 | 9 |
| Confidentiality | 1 | 19 | 3 | 4 |
| More Experience | 0 | 19 | 0 | 2 |
| Trust | 1 | 13 | 0 | 2 |
| Better Information | 1 | 13 | 5 | 4 |
| Different perspectives | 0 | 6 | 41 | 17 |
| Both are professionals | 0 | 0 | 12 | 5 |
| Treatment is more important | 0 | 0 | 5 | 2 |
| Availability | 0 | 6 | 3 | 2 |
| Bad Experiences In Past | 1 | 0 | 0 | 1 |
| More qualifications | 0 | 6 | 0 | 1 |
| ***Base = 100%*** | *61* | *83* | *16* | *160* |

# 10 Perceptions of Deafness and Disability

## 10.1 From Health to Disability

One of the reasons for the uncertainty in the choice of professionals who would work with deaf people with mental health problems is the view created about the capabilities of deaf people. There is a well-known relation between the status in society and the internalised values that deaf people have of themselves. Although deaf people do not have direct access to the speech of hearing people and the attitudes that they express, they nevertheless are able to detect the reflection of themselves in the patterns of behaviour of other people. Since a major part of having special needs is giving up your autonomy to others, who are mainly designated by society as professionals, then you are likely to develop a view of your own worth in the light of their approach to you. Deaf people in one sense probably think they are disabled; yet inside they do not feel disabled. To be disabled is to give up independence but it is also to recover benefits. If deaf people are a linguistic minority then they are not entitled to benefits but could have cultural grants. This is an area of dissonance that the interviews tried to deal with and which forms the bridge between the interviews on health and disability. In a health sense, deaf people are handicapped and impaired; in a social sense, deaf people are to be registered as disabled; but what do deaf people think themselves?

## 10.2 Is Being Deaf a Disability?

The DPIC participants were asked if they considered their Deafness to be a disability, and then asked to explain their answer. Fifty-six percent of the sample felt that they were disabled, and this result is independent of their economic activity (see Table 10.1). Apart from students, all the socio-economic groupings indicated that they thought themselves to be disabled. Thirty-six percent of students stated that they considered themselves to be disabled - nearly two thirds did not believe themselves to be disabled (Table 10.2). Young people were less likely to feel they were disabled, with only 38% of 18-29 year old women and 48% of men in the same age range stating they were disabled (Table 10.3). There seems to be a change in view being created in a single generation, partly as a result of better education and opportunities. Men are more likely to consider themselves disabled and there is a particularly high figure among those aged 45 to 59 years. Despite recent progress in campaigns and awareness raising, it seems

that the vast majority of deaf people when faced with a simple choice, have adopted the society's consensus view that they are disabled.

Such a view might not be negative in all cases. Those who considered themselves to be disabled were asked why they felt this way (Table 10.4). The majority in this group felt that they were disabled because they could not hear (86%) – i.e. they had taken the direct medical view. A further 4% felt that they were disabled because of limitations imposed by their inability to hear: an inability to speak (1%), having special needs (1%) or being disabled when outside of the home (2%). Of the remainder, 5% claimed to be disabled due to a physical impairment that was not hearing-related, and a further 5% felt disabled because of the way they were treated by the hearing community: discrimination in using BSL (4%), impaired access to information (< 1%), or an inability to find employment (< 1%). One participant took a pragmatic approach, feeling disabled because he was in possession of a disabled travel card (although this can also be seen as a case of disability being imposed upon the individual). Students were more likely to say that they were disabled because of discrimination in the area of sign language.

For those who did not consider themselves to be disabled, the reasons were simple – a matter of definition (Table 10.5). The major points made were twofold: (1) a concept of disability tied to 'physical', i.e. visible, impairments - so deaf people were not physically impaired and (2) a belief that Deaf people form a separate language group. Twenty-eight percent of the sample felt that Deaf people were the same as hearing people, with a further 27% saying that they had no physical impairment, 5% saying that Deafness is a hidden disability, and 1% saying they do not suffer (a total of 61%). Thirty-three percent felt they were not disabled because they belonged to a linguistic minority, 1% because they had communication problems only, and 5% because they felt 'Deaf' rather than disabled (a total of 39%). Deaf students were very clear that they were a linguistic minority (67%).

To summarise, 48% of respondents felt disabled because they could not hear, 4% because of limitations imposed upon them by their Deafness, and 4% because of the way they were discriminated against by society. Twenty-seven percent did not consider themselves to be disabled because Deafness did not fit within a physical concept of visible disability, and 17% because they identified themselves as members of a Deaf group distinct from those with other disabilities. If deaf people are a minority group or even if they are disabled, it would seem to be in their

interest to come together to create a political cohesion that would act to promote their case.

## 10.3 Membership of Disability Organisations

Since over half the deaf people agree that they are disabled it would not be unreasonable for them to be part of a disabled organisation. Membership of disability groups was low at only 8% (Table 10.6). It was slightly higher amongst the group who felt themselves to be disabled (10%) than amongst those did not feel disabled (6%). The groups themselves varied widely, with Local Disability Action Groups and Disabled Sports Groups featuring prominently, and service provision groups also represented (e.g. Usher UK, Social Service Joint Planning Group, and Council Disability Forum). But deaf people although prepared to use the term disabled are not yet ready to associate with other disabled people. The expression or use of the word, disabled, does not seem to have conviction. It seems that attitudes are more complex.

## 10.4 Attitudes Towards Deaf People

In order to explore the issue of attitude, further, statements were presented to the participants. There were four sets of statements: (1) discriminatory statements, (2) practical difficulty statements, (3) social interests/relations statements and (4) disability severity statements. In addition, respondents were asked to indicate the extent to which each of a set of adjectives described Deaf people. The DPIC sample of 236 Deaf respondents was compared with Bunting's (1981) large sample of hearing people who had been in contact with Deaf people. Although there is a considerable time difference, the Bunting study is still the largest survey of hearing attitudes to deaf people. A more recent comparison has also been made with hearing people interviewed as part of the Sign on Europe project but there is not enough space here to include this (see Dye and Kyle, forthcoming article).

The DPIC (1998) sample was further split into two groups based upon age. The first group was composed of Deaf people in the sample aged from 18 to 44 years, and the second group of those aged 45-75 years. These groups differ considerably on factors that may influence their attitudes towards Deafness and Deaf people: education level, employment and social class. See Table 10.7 to 10.9. These tables present the highest educational level attained, economic activity at interview, and social class of those in work at interview respectively. Clear differences emerge on all three factors. The younger Deaf group has higher levels of qualifications than the older Deaf group

(Table 10.7), are more likely to be in work (Table 10.8), and if in work tend to have jobs with a higher social status (Table 10.9).

### 10.4.1 Discriminatory Statements

Three discriminatory statements were given to respondents, and their extent of agreement with those statements was measured (Table 10.10). For all statements, Deaf people were more likely to agree than disagree with the statements (means less than 3.0). That is, Deaf people were more likely to be negative about deaf people's characteristics. Nearly 40% of Deaf respondents gave a negative response (certainly or probably false) for all three statements, compared to over 50% of hearing respondents (Bunting, 1981). Overall, the levels of agreement with discriminatory statements were greater than for the hearing respondents in Bunting's (1981) survey. Deaf people were more likely to agree that 'deaf people seem generally less intelligent' than hearing people, that 'deaf people seem to have more than the usual number of other physical complaints' and that 'deaf people frequently seem to behave rather oddly'.

Table 10.11displays the mean levels of agreement for Deaf respondents in two age categories: younger respondents (aged 18-44 years) and older respondents (aged 45-75 years). Younger Deaf respondents appear less likely than older Deaf respondents to agree with all three discriminatory statements.

As younger Deaf respondents showed closer agreement in rejecting discriminatory statements to hearing respondents, these two groups were compared. Differences between hearing and younger Deaf respondents were still evident for all three statements.

### 10.4.2 Practical Difficulty Statements

A further four statements were used to assess the degree to which respondents felt Deaf people experienced practical difficulties during their everyday lives (Table 10.12). Again, Deaf people were more likely to agree than disagree with these statements (means greater than 3.0); with the exception of 'deaf people have more difficulty in coping with everyday activities around the home than hearing people'. This mirrors the pattern of findings found by Bunting (1981) with hearing respondents.

However, there are differences between hearing and Deaf responses to these statements. While 87% of hearing respondents felt that 'deaf people face more hazards in travelling and getting about than hearing people', only 58% of Deaf respondents felt this was certainly or probably true. Deaf people do not

experience travel problems to the degree expected by hearing people. For the other three statements, the opposite pattern (or a small difference) was found. For the statement 'deaf people have more problems in banks, post offices, and shops than hearing people', 81% of hearing and 80% of Deaf respondents felt this was certainly or probably true. Fifty-three percent of hearing respondents felt that 'deaf people are less likely to take part in sports and games than hearing people', a statement agreed with by 56% of Deaf respondents. Finally, only 32% of hearing respondents felt that 'deaf people have more difficulty in coping with everyday activities around the home than hearing people', whereas 43% of Deaf respondents felt this was certainly or probably true. Age group of the Deaf respondents appears to have little effect on agreement with the practical difficulty statements (Table 10.13).

### 10.4.3 Social Relations/Interests Statements

The third set of four statements considered Deaf people's social relationships and interests (Table 10.14). The statements focused on isolation through communication problems, getting on with people at work, accessing information through news media and general interests. Deaf people showed a greater level of agreement with three of the four statements than hearing people, and overall tended to agree that the statements were more true than false (mean responses greater than 3.0).

Eighty-one percent of both the Deaf and hearing respondents agreed that 'deaf people feel very isolated because of the problems they have communicating'. For the statement 'deaf people have more difficulty getting on with people at work than hearing people do', 82% of Deaf respondents agreed compared with only 60% of hearing respondents in Bunting's (1981) survey. It seems that hearing people tend to believe relations are better than they are in deaf people's view.

Eighty-three percent of Deaf respondents agreed that 'deaf people are unable to keep up with what's going on in the world through the news media', compared with only 27% of hearing respondents. Finally, 57% of the Deaf respondents agreed that 'deaf people seem to have fewer interests than hearing people', with only 32% of hearing respondents showing similar levels of agreement. For all statements, the Deaf respondents appear to be more negative than hearing respondents.

Table 10.15 shows mean levels of agreement with the social relations/interests statements arranged by age group of the Deaf respondents. The effects of age group appear to be small but

consistent, with older Deaf respondents slightly more likely to agree with the statements than younger Deaf respondents (to be more negative).

It seems quite clear and the pattern is repeated in all areas of attitude that hearing people underestimate the extent of problem which deaf people perceive. It is as if hearing people feel that if the problems are identified, they must be being solved by professionals or by provision.

### 10.4.4 Severity of Deafness as a Disability

Respondents were asked to rank six disabilities in order of perceived severity. The six disabilities were: blindness, being confined to a wheelchair, total Deafness, epilepsy, having a heart condition and losing a leg. The titles were chosen in the Bunting Study and might be different if started from today. Responses from Bunting's (1981) hearing sample and the DPIC sample are given in Table 10.16.

Hearing respondents ranked blindness as the most severe disability (mean rank of 5.47), with 70% of individual respondents ranking it as the most severe. Other disabilities were ranked as similar in severity to each other, with losing a leg ranked as the least severe (mean rank of 2.10). Deaf respondents also ranked blindness as the most severe of the six disabilities (mean rank of 5.20, 62% of respondents assigning rank 1), but with total Deafness rated as the least severe (mean rank 1.27, 90% of respondents assigning rank 6).

It should be noted that ratings for the disabilities are not fully independent measures. Assigning a rank of 1 to blindness means that a respondent cannot assign a rank of 1 to another of the disabilities. Thus, the tendency of Deaf respondents to assign a rank of 6 to total Deafness means that mean rankings for other disabilities will be pushed in the opposite direction. This suggests that the difference between Deaf and hearing groups in their ranking of blindness is under-estimated. With independent ratings, one may find that Deaf respondents rate blindness as more severe than do hearing respondents with a much larger effect. Conversely for the disabilities where Deaf respondents assign a lower rank (more severe) than hearing respondents - independent rating may lead to these differences being reduced.

### 10.4.5 Describing Deaf People

Respondents were presented with a series of bipolar adjectival scales, and asked to indicate where they felt Deaf people generally fell on those scales (from 1 to 7, with 1 representing agreement with the left-hand adjective and 7 with the right-hand adjective). There were a total of nine

scales:

- sociable -- withdrawn
- calm -- excitable
- confident -- insecure
- alert-looking -- vacant-looking
- quiet – noisy
- self-reliant – demanding
- well-coordinated – clumsy
- precise -- vague
- respected -- shunned.

Mean responses of Deaf respondents, and their responses by age group, are reported in Table 10.17. These confirm the pattern identified earlier that younger deaf people tend to be more positive than older deaf people, but there remains a more negative image than that held by hearing people.

Figures 10.1 and 10.2 present profiles based upon responses to the adjectival rating scales. Data from Deaf respondents (DPIC) is presented in bold, with the profile of hearing respondents from Bunting (1981) in shadow. Deaf respondents showed a tendency to rate Deaf people as highly sociable (mean rating on sociable -- withdrawn = 2.95), and noisy (mean rating on quiet -- noisy = 5.09). Deaf people clearly differed from hearing people in responses to six of the adjectival scales. Deaf respondents rated Deaf people as more sociable, more excitable, more confident, more alert-looking, noisier and more demanding.

Figure 10.2 shows the adjectival rating profiles for the younger (18-44 years) and older (45-75 years) Deaf samples superimposed on the hearing profile (from Bunting, 1981). Profiles for younger and older Deaf respondents are very similar. The only noticeable difference is on the sociable -- withdrawn scale, with older Deaf respondents rating Deaf people as more withdrawn than did younger Deaf respondents.

## 10.5 Summary

We began this chapter with the question of what deaf people think of themselves? The answer seems to be… less than expected by hearing people. Throughout, deaf people seem to express the reality factor – this is what it is really like and it is much less satisfactory than hearing people wish to believe. Within our further analysis of hearing data collected in 1996-7, we can confirm without going into great detail here, that if anything, the hearing people's views have become more positive over time and the effects are more marked. There is greater divergence between deaf and hearing views. Although deaf people's situation has improved in material terms, they continue to express their situation more negatively. Disability is therefore a different concept for deaf people as compared to hearing. Once a problem is defined in hearing social terms, it has been addressed. For most people this seems to

imply that something is done and the problems is solved. Deaf attitudes seem to indicate that circumstances for deaf people are not improved and that the practicalities are still a problem. Disability is construct of the hearing society but a practical reality for deaf people.

**Table 10.1:** Perception of disability by economic activity

| Are you disabled? | Economic Activity | | Total |
|---|---|---|---|
| | Inactive | Active | |
| | % | % | % |
| No | 43 | 45 | 44 |
| Yes | 57 | 55 | 56 |
| ***Base = 100%*** | *67* | *165* | *232* |

**Table 10.2**: Perception of disability by socio-economic group

| Are you disabled? | Professionals, employers and managers | Skilled manual | Semi-skilled and unskilled manual | Home workers | Retired | Students | Unemployed | Total |
|---|---|---|---|---|---|---|---|---|
| | % | % | % | % | % | % | % | % |
| No | 44 | 39 | 44 | 39 | 42 | 64 | 50 | 44 |
| Yes | 56 | 61 | 56 | 61 | 58 | 36 | 50 | 56 |
| ***Base = 100%*** | *57* | *38* | *48* | *18* | *31* | *14* | *26* | *232* |

**Table 10.3**: Perception of disability by gender and age group

| Are you disabled? | Gender and Age Group | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | |
| | % | % | % | % | % | % | % | % | % |
| No | 63 | 40 | 52 | 52 | 52 | 43 | 15 | 33 | 44 |
| Yes | 38 | 60 | 48 | 48 | 48 | 57 | 85 | 67 | 56 |
| ***Base = 100%*** | *32* | *40* | *27* | *23* | *33* | *30* | *26* | *21* | *232* |

**Table 10.4**: Reasons for feeling disabled by socio-economic group

| **Why are you disabled?** | Professionals, employers and managers | Skilled manual | Semi-skilled and unskilled manual | Home workers | Retired | Students | Unemployed | **Total** |
|---|---|---|---|---|---|---|---|---|
| | % | % | % | % | % | % | % | % |
| Cannot hear | 88 | 91 | 85 | 91 | 78 | 80 | 85 | 86 |
| Discrimination from using BSL | 6 | 0 | 0 | 9 | 0 | 20 | 8 | 4 |
| Physical impairment (not Deafness) | 3 | 4 | 7 | 0 | 11 | 0 | 0 | 5 |
| Disabled outside home | 0 | 0 | 7 | 0 | 0 | 0 | 0 | 2 |
| Impaired access to information | 0 | 0 | 0 | 0 | 6 | 0 | 0 | 1 |
| Cannot speak | 0 | 0 | 0 | 0 | 6 | 0 | 0 | 1 |
| Cannot find a job | 0 | 0 | 0 | 0 | 0 | 0 | 8 | 1 |
| Have disabled card | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 1 |
| Have special needs | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| ***Base = 100%*** | *32* | *23* | *27* | *11* | *18* | *5* | *13* | *129* |

**Table 10.5**: Reasons for not feeling disabled by socio-economic group

| **Why are you not disabled?** | Professionals, employers and managers | Skilled manual | Semi-skilled and unskilled manual | Home workers | Retired | Students | Unemployed | **Total** |
|---|---|---|---|---|---|---|---|---|
| | % | % | % | % | % | % | % | % |
| Belong to linguistic minority | 29 | 40 | 34 | 29 | 15 | 67 | 31 | 33 |
| Deaf same as hearing | 38 | 47 | 19 | 29 | 23 | 22 | 15 | 28 |
| No physical impairment | 25 | 7 | 38 | 29 | 46 | 11 | 31 | 27 |
| Communication problems | 0 | 0 | 5 | 0 | 0 | 0 | 0 | 1 |
| Hidden disability | 0 | 0 | 0 | 0 | 8 | 0 | 0 | 1 |
| Do not suffer | 0 | 0 | 0 | 0 | 0 | 0 | 8 | 1 |
| Do not like the word | 0 | 0 | 0 | 14 | 0 | 0 | 0 | 1 |
| Unsure | 0 | 7 | 0 | 0 | 8 | 0 | 0 | 2 |
| I am Deaf | 8 | 0 | 5 | 0 | 0 | 0 | 15 | 5 |
| ***Base = 100%*** | *24* | *15* | *21* | *7* | *13* | *9* | *13* | *102* |

**Table 10.6**: Membership of disability organisations by perception of disability

| Are you disabled? | | Membership of Disabled Organisation | | Total |
|---|---|---|---|---|
| | | No | Yes | |
| | | % | % | % |
| I am not disabled | % | 94 | 6 | 100 |
| I am disabled | % | 90 | 10 | 121 |
| ***Base = 100%*** | % | *92* | *9* | *221* |

**Table 10.7**: Highest qualification level attained by DPIC respondents

| Highest Qualification Level | Age Group | | Total |
|---|---|---|---|
| | 18-44 years | 45-75 years | |
| | % | % | % |
| Degree or equivalent | 7 | 0 | 4 |
| HE below degree | 1 | 0 | 1 |
| GCE 'A' Level | 12 | 2 | 8 |
| GCSE A-C | 28 | 16 | 23 |
| GCSE D-E | 13 | 8 | 11 |
| Foreign or other | 13 | 15 | 14 |
| None | 25 | 58 | 39 |
| ***Base (=100%)*** | *137* | *98* | *235* |

**Table 10.8**: Economic activity at time of interview

| Economic Activity | Age Group | | Total |
|---|---|---|---|
| | 18-44 years | 45-75 years | |
| | % | % | % |
| Economically active | 20 | 41 | 29 |
| Economically inactive | 80 | 59 | 71 |
| ***Base (=100%)*** | *137* | *98* | *235* |

**Table 10.9**: Social class at time of interview

| Social Class | Age Group | | Total |
|---|---|---|---|
| | 18-44 years | 45-75 years | |
| | % | % | % |
| I | 3 | 0 | 2 |
| II | 28 | 12 | 23 |
| IIIN | 21 | 10 | 17 |
| IIIM | 23 | 40 | 29 |
| IV | 22 | 26 | 23 |
| V | 3 | 12 | 6 |
| ***Base (=100%)*** | *92* | *50* | *142* |

**Table 10.10**: Deaf (DPIC 1998) and hearing (Bunting 1981) responses to discriminatory statements

| Discriminatory statements | Study | Certainly/probably false | Neither true nor false | Certainly/probably true | *Base (=100%)* |
|---|---|---|---|---|---|
| | | % | % | % | |
| Deaf people seem generally less intelligent than hearing people | Bunting (1981) | 74 | 10 | 16 | *524* |
| | DPIC (1998) | 39 | 21 | 40 | *229* |
| Deaf people seem to have more then the usual number of other physical complaints | Bunting (1981) | 68 | 18 | 14 | *477* |
| | DPIC (1998) | 45 | 22 | 33 | *209* |
| Deaf people frequently seem to behave rather oddly | Bunting (1981) | 55 | 18 | 27 | *513* |
| | DPIC (1998) | 39 | 16 | 46 | *218* |

**Table 10.11**: Effects of age on agreement with discriminatory statements

| Discriminatory Statements | | Age Group | | All respondents |
|---|---|---|---|---|
| | | 18-44 years | 45-75 years | |
| Deaf people seem generally less intelligent than hearing people | Mean† | 2.82 | 3.04 | 2.91 |
| | (SD) | (1.47) | (1.50) | (1.49) |
| | N | 131 | 98 | 229 |
| Deaf people seem to have more then the usual number of other physical complaints | Mean | 2.57 | 2.88 | 2.70 |
| | (SD) | (1.40) | (1.45) | (1.43) |
| | N | 118 | 91 | 209 |
| Deaf people frequently seem to behave rather oddly | Mean | 2.76 | 3.23 | 2.96 |
| | (SD) | (1.39) | (1.46) | (1.44) |
| | N | 124 | 94 | 218 |

† Certainly false = 1, Probably false = 2, Neither true nor false = 3, Probably true = 4, Certainly true = 5

**Table 10.12**: Deaf (DPIC 1998) and hearing (Bunting 1981) responses to practical difficulty statements

| Practical difficulty statement | Study | Certainly/probably false | Neither true nor false | Certainly/probably true | *Base (=100%)* |
|---|---|---|---|---|---|
| | | % | % | % | |
| Deaf people face more hazards in travelling and getting about than hearing people | Bunting (1981) | 8 | 5 | 87 | *531* |
| | DPIC (1998) | 34 | 9 | 58 | *229* |
| Deaf people have more problems in banks, post offices, and shops than hearing people | Bunting (1981) | 16 | 3 | 81 | *529* |
| | DPIC (1998) | 14 | 6 | 80 | *228* |
| Deaf people are less likely to take part in sports and games than hearing people | Bunting (1981) | 38 | 9 | 53 | *512* |
| | DPIC (1998) | 29 | 15 | 56 | *222* |
| Deaf people have more difficulty in coping with everyday activities around the home than hearing people | Bunting (1981) | 59 | 9 | 32 | *525* |
| | DPIC (1998) | 42 | 14 | 43 | *222* |

**Table 10.13**: Deaf responses to practical difficulty statements about Deaf people as a function of age group

| Practical Difficulty Statements | | Age Group | | All respondents |
|---|---|---|---|---|
| | | 18-44 years | 45-75 years | |
| Deaf people face more hazards in travelling and getting about than hearing people | Mean | 3.29 | 3.54 | 3.39 |
| | (SD) | (1.69) | (1.59) | (1.65) |
| | N | 135 | 94 | 229 |
| Deaf people have more problems in banks, post offices, and shops than hearing people | Mean | 4.05 | 4.20 | 4.11 |
| | (SD) | (1.33) | (1.20) | (1.28) |
| | N | 133 | 95 | 228 |
| Deaf people are less likely to take part in sports and games than hearing people | Mean | 3.10 | 3.63 | 3.32 |
| | (SD) | (1.59) | (1.35) | (1.51) |
| | N | 129 | 93 | 222 |
| Deaf people have more difficulty in coping with everyday activities around the home than hearing people | Mean | 2.93 | 2.89 | 2.91 |
| | (SD) | (1.54) | (1.60) | (1.56) |
| | N | 128 | 94 | 222 |

† Certainly false = 1, Probably false = 2, Neither true nor false = 3, Probably true = 4, Certainly true = 5

**Table 10.14**: Comparison of Deaf (DPIC 1998) and hearing (Bunting 1981) responses to social relations/interests statements about Deaf people

| Social relations/interests statement | Study | Certainly/probably false | Neither true nor false | Certainly/probably true | *Base (=100%)* |
|---|---|---|---|---|---|
| | | % | % | % | |
| Deaf people feel very isolated because of the problems they have communicating | Bunting (1981) | 14 | 5 | 81 | *529* |
| | DPIC (1998) | 10 | 9 | 81 | *224* |
| Deaf people have more difficulty getting on with people at work than hearing people do | Bunting (1981) | 29 | 11 | 60 | *525* |
| | DPIC (1998) | 9 | 9 | 82 | *227* |
| Deaf people are unable to keep up with what's going on in the world through the news media | Bunting (1981) | 63 | 10 | 27 | *527* |
| | DPIC (1998) | 10 | 7 | 83 | *229* |
| Deaf people seem to have fewer interests than hearing people | Bunting (1981) | 51 | 17 | 32 | *521* |
| | DPIC (1998) | 29 | 14 | 57 | *221* |

**Table 10.15**: Deaf responses to social relations/interests statements about Deaf people as a function of age group

| Social relations/interests statements | | Age Group | | All respondents |
|---|---|---|---|---|
| | | 18-44 years | 45-75 years | |
| Deaf people feel very isolated because of the problems they have communicating | Mean† | 4.03 | 4.19 | 4.10 |
| | (SD) | (1.01) | (0.97) | (0.99) |
| | N | 128 | 96 | 224 |
| Deaf people have more difficulty getting on with people at work than hearing people do | Mean | 4.23 | 4.22 | 4.22 |
| | (SD) | (1.06) | (1.05) | (1.05) |
| | N | 131 | 96 | 227 |
| Deaf people are unable to keep up with what's going on in the world through the news media | Mean | 4.22 | 4.38 | 4.29 |
| | (SD) | (1.14) | (1.07) | (1.11) |
| | N | 132 | 97 | 229 |
| Deaf people seem to have fewer interests than hearing people | Mean | 3.27 | 3.60 | 3.42 |
| | (SD) | (1.54) | (1.45) | (1.51) |
| | N | 125 | 96 | 221 |

† Certainly false = 1, Probably false = 2, Neither true nor false = 3, Probably true = 4, Certainly true = 5

**Table 10.16**: Hearing (Bunting 1981) and Deaf (DPIC 1998) people's ranking of disabilities for severity

| Disability | M (SD) | *Base (=100%)* | M (SD) | *Base (=100%)* |
|---|---|---|---|---|
| | (Bunting 1981) | | (DPIC 1998) | |
| Blindness | 5.47 (1.00) | *534* | 5.20 (1.26) | *234* |
| Confined to wheelchair | 3.79 (1.44) | *532* | 3.65 (1.28) | *234* |
| Total Deafness | 3.72 (1.40) | *532* | 1.27 (0.94) | *234* |
| Epilepsy | 3.07 (1.57) | *533* | 3.68 (1.38) | *234* |
| Having a heart condition | 2.97 (1.47) | *533* | 3.62 (1.32) | *234* |
| Losing a leg | 2.10 (1.21) | *532* | 3.57 (1.37) | *234* |

**Table 10.17**: Rated characteristics of Deaf people by Deaf people on adjectival scales (DPIC 1998). Values represent level of agreement with adjective (1 = low agreement, 7 = high agreement)

| Adjectival Scales | | Age Group | | All respondents |
|---|---|---|---|---|
| | | 18-44 years | 45-75 years | |
| Withdrawn | M | 2.76 | 3.21 | 2.95 |
| | (SD) | (1.26) | (1.45) | (1.36) |
| | N | 136 | 98 | 234 |
| Excitable | M | 4.39 | 4.14 | 4.29 |
| | (SD) | (1.55) | (1.30) | (1.45) |
| | N | 136 | 98 | 234 |
| Insecure | M | 3.83 | 3.83 | 3.83 |
| | (SD) | (1.35) | (1.23) | (1.30) |
| | N | 135 | 98 | 233 |
| Vacant-looking | M | 3.19 | 3.29 | 3.23 |
| | (SD) | (1.38) | (1.57) | (1.46) |
| | N | 134 | 98 | 232 |
| Noisy | M | 5.03 | 5.17 | 5.09 |
| | (SD) | (1.51) | (1.46) | (1.49) |
| | N | 136 | 96 | 232 |
| Demanding | M | 4.45 | 4.52 | 4.48 |
| | (SD) | (1.50) | (1.42) | (1.47) |
| | N | 136 | 98 | 234 |
| Clumsy | M | 3.81 | 3.95 | 3.87 |
| | (SD) | (1.46) | (1.55) | (1.50) |
| | N | 135 | 97 | 232 |
| Vague | M | 4.01 | 3.80 | 3.93 |
| | (SD) | (1.32) | (1.32) | (1.32) |
| | N | 134 | 96 | 230 |
| Shunned | M | 3.92 | 3.65 | 3.81 |
| | (SD) | (1.40) | (1.37) | (1.39) |
| | N | 136 | 97 | 233 |

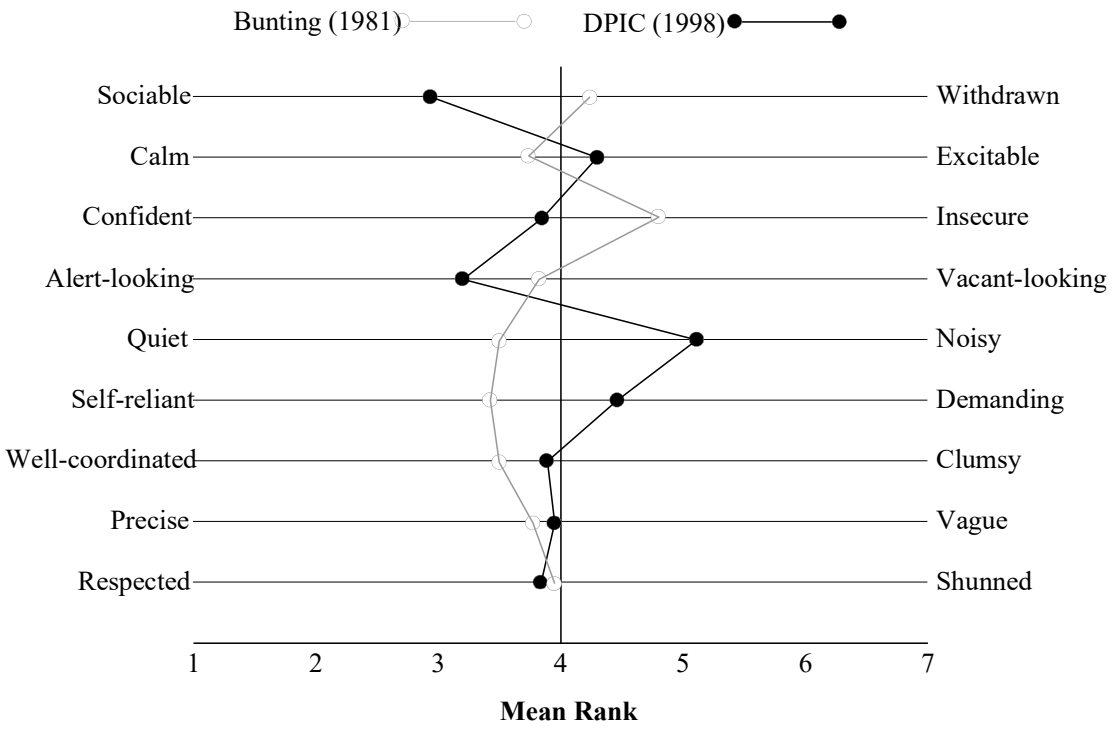


**Figure 10.1:** Adjectival rating profile for Deaf (DPIC 1998) and hearing (Bunting 1981) respondents

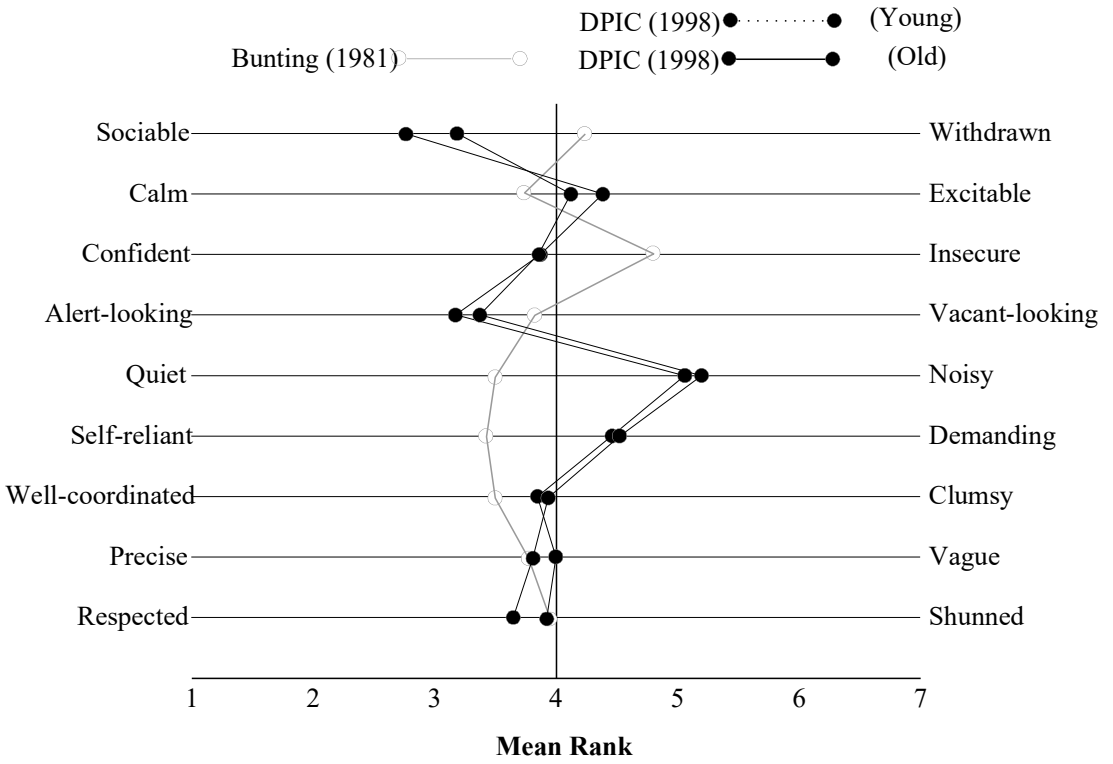


**Figure 10.2**: Adjectival rating profile for younger (18-44 years) and older (45-75 years) Deaf (DPIC 1998) and hearing (Bunting 1981) respondents

# 11 Social Services and Benefits

## 11.1 Social Service Registration

Understanding the attitude and theory of disability is one aspect of the way in which society deals with deaf people. There is also another aspect that offers the practical means of supporting disability – the benefits system. This is now a complex of inter-related benefits with financial rewards. The DPIC study also considered this aspect of deaf people's lives.

Of 230 participants who responded, 83% stated that they were registered as disabled with their local Social Services (Table 11.1). This figure was slightly higher for those who considered themselves to be disabled (86%) and lower for those who did not feel disabled (80%). The second figure is important in regard to the previous chapter and attitudes expressed by younger people. Of those who make a clear statement that they are not disabled, 4 out five are registered.

Older women were more likely than younger women to be registered (Table 11.2), although this pattern was reversed for men, with older men less likely to be registered as disabled. Nearly 90% of young deaf men were registered.

In registration, a classification is made (Table 11.3). Of those registered with their local Social Services, the majority (56%) did not know exactly how they were registered (Table 11.3). This was particularly evident for female respondents, particularly in the 18-29 and 60-75 year old groups (Table 11.4). Twenty-eight percent thought they were registered as 'Deaf without speech', with this figure being higher for those who had termed themselves 'disabled' (36%) than for the 'not disabled' group (18%). Fourteen percent thought they were registered as 'Deaf with speech', although this figure was lower for those who thought they were 'disabled' (9%) than for the 'not disabled' group (21%). Very few (2% overall) were registered as 'hard-of-hearing'. Middle-aged respondents (aged 30-59 years) were the most likely to be registered as 'Deaf without speech' (Table 11.4), and men were more likely than women to be registered in this way.

The issue of registration is a sensitive one as there are various means whereby a person can become registered. On the one hand a referral to social services can trigger a registration as part of the process while use of public transport where there are special discounts, necessitates a registration. It seems also that deaf people can claim to be not disabled but at the

same time present themselves for registration in order to claim a free travel card, in London, for example.

## 11.2 Disability Benefits

As well as data on registration with Social Services, respondents were asked about their familiarity with and experience of three disability benefits: Disabled Living Allowance (DLA), Severe Disability Allowance (SDA), and Disabled Working Allowance (DWA).

Awareness of DLA was high, with 97% of the sample reporting that they knew something about it (Table 11.5). This has featured in the Deaf press and has been the subject of appeals and court cases. SDA and DWA were much less well known, at 43% and 55% respectively.

Those who were aware of the benefits were asked whether or not they had claimed the benefit. A surprising eighty-one percent of the DPIC sample had claimed DLA with potentially another 5% planning to do so, 38% had claimed SDA and 12% had claimed DWA (Table 11.6). Those who had not made a claim mostly felt that they were not eligible for the benefit (DLA 7%, SDA 29% and DWA 50% - of all respondents aware of the benefit). A small number also stated that they did not know how to claim the benefit (DLA 4%, SDA 8% and DWA 14% of all benefit-aware respondents). For those who had made a claim for the benefits, more details about that claim are presented in the relevant subsection below.

**Disability Living Allowance** (DLA) is a tax-free benefit for people who need help with personal care or getting around, or both. Disability Living Allowance is split into two components:

- Care Component - for if you need help with personal care.
- Mobility Component - for if you need help with getting around.

**Severe Disablement Allowance** (SDA) is a tax-free benefit for people who have been unable to work for at least 28 consecutive weeks, but cannot get Incapacity Benefit because they have not paid enough National Insurance contributions. If you first became unable to work after your 20th birthday you can get SDA only if you are assessed at least 80 per cent disabled.

**Disability Working Allowance** (DWA; now called Disabled Person's Tax Credit) is a tax free, income-related benefit for people aged 16 or over who work at least 16 hours a week (on average) and have an impairment that limits their earning capacity. You must: be 16 or over **and** be working for 16 hours a week or more on average **and** have an impairment that puts you at a disadvantage in getting a job **and** you must also either be getting Disability Living Allowance, Attendance Allowance, War Disablement Pension or Industrial Injuries Disablement Benefit.

### 11.2.1 Disabled Living Allowance

Of those who were aware of DLA and had made a claim, 65% were currently in receipt of the benefit (Table 11.6). Six percent were awaiting a decision, and 29% had had their claims refused (14% after

two or more appeals). Of those in receipt of the benefit, 55% had had their claims successfully processed within 6 months of their application, although 30% had been required to wait over a year for a successful outcome (Table 11.7). Most of those on receipt of DLA used the benefit for general living expenses (46%), with 33% using the money for interpreters and 16% percent using it to purchase special equipment (Table 11.8). Some claimants were also receiving DLA for other disabilities, chiefly visual impairment, physical mobility and arthritis (Table 11.9).

### 11.2.2 Severe Disability Allowance

Of those who had made a claim for SDA, the majority (68%) was in receipt of the benefit (Table 11.6). SDA claims were processed more quickly than those made for DLA, with 88% of claims being successful within 9 months of the initial application (Table 11.7). The most common use of SDA was for general expenses (79%), with 25% using the money as compensation for extra stress (Table 11.8). A small number of respondents were claiming SDA for another disability, chiefly arthritis (Table 11.9).

### 11.2.3 Disabled Working Allowance

DWA was much less commonly claimed, with only a third of the 15 applicants receiving the benefit as a result of their claim (Table 11.6). All successful applications were dealt with in less than 3 months (Table 11.7). DWA was chiefly used for general expenses (2 recipients; Table 11.8), and two claimants were receiving DWA for another disability (visual impairment and a back problem; Table 11.9).

## 11.3 Other State Benefits

Deaf people are also entitled to claim non-disability benefits. These include (a) benefits related to children and families (Child Benefit, Family Credit, Statutory Maternity Pay), (b) benefits linked to housing and accommodation (Council Tax Benefit, Housing Benefit), (c) benefits tied to employment (Statutory Sick Pay, Employment Rehabilitation Allowance, Job Seekers Allowance), and (d) those benefits related to older age and retirement (Retirement Pension, Widow's Pension). Information regarding the existence of these benefits (and how to claim them) is seldom made available in BSL, and one cannot therefore be sure that benefit awareness is comparable in the hearing and Deaf populations. This survey asked the sample if they were aware of the existence of the above benefits, if they knew how to claim them, and whether they had in fact made a claim for the benefit.

### 11.3.1 Child Benefit

Child Benefit can be claimed by the legal

guardian of any child under the age of 16, or under the age of 19 and still in full-time education (studying for a qualification up to and including A level/(G)NVQ level 3). At the time of writing, the standard rate of benefit was worth £14.10 for the eldest or only child, and £9.60 for each additional child. Awareness of Child Benefit was high, with over 90% of the sample knowing about it (Table 11.10). Awareness was highest amongst 30-44 year old women (98%), and lowest amongst 60-75 year old women (70%). Interestingly, 60-75 year old men had a higher level of awareness (90%) than women in the same age range did. Knowledge of how to make a claim was lower (69%), with the pattern of findings mirroring those for awareness of the benefit. Claim rates were lower still, with 45% of respondents having made a claim but of course, the person has to have a child in order to claim. It seems likely that the vast majority of those with children would have claimed. However, it is typically paid to the mother. Claim rates were lowest amongst 18-29 year old men (15%), and highest amongst 30-59 year old women (63-64%). All respondents with dependent children knew what Child Benefit was, with 86% knowing how to claim it, and 83% having made a claim.

### 11.3.2 Family Credit

Family Credit, which was replaced on the 5 October 1999 by Working Families' Tax Credit, aims to provide financial help to families and lone parents with low and middle incomes. Families where one partner (or the sole parent) works, and who have one or more children aged under 16 years (or under 19 years and in full-time education) are eligible to receive the benefit. The amount of benefit varies, and is dependent upon the number of children, their ages, how many hours a week the adults work, and how much they earn. Fifty-seven percent of respondents knew what Family Credit (as it was called at the time of interview) was (Table 11.11), with 45% knowing how to claim it, and 7% having actually made a claim. Women were more aware of Family Credit than men, with 61% of women knowing about the benefit (52% of men), 49% knowing how to claim it (41% of men) and 9% having made a claim (5% of men). Overall, benefit awareness rates were highest amongst 30-44 year old women (80%), and lowest amongst 60-75 year old women (26%). The same was true for knowledge of how to make a claim (65% and 9%) and having made a claim (7% and 4%). Awareness of Family Credit, and claim rates, were higher among those respondents with dependent children (Table 11.12).

### 11.3.3 Statutory Maternity Pay

Statutory Maternity Pay is payable to any woman who has been in the same

employment without a break for at least 26 weeks up to and including the 15th week before the week the baby is due, and has ceased to work because of her pregnancy. Statutory Maternity Pay can start at any time between the 11th week before the week the baby is due and the week after the birth. In order to be eligible, the woman's average weekly earnings in the eight weeks up to and including the 15th week before the week the baby is due must have been at or above the amount where National Insurance Contributions have to be paid. The woman does not have to intend to return to work to get Statutory Maternity Pay. The first 6 weeks are payable at the higher rate (90% of average weekly earnings) and the remaining 12 weeks at the lower rate (£59.55).

Eighty-seven percent of respondents were aware of Statutory Maternity Pay, with the figure slightly higher for women than for men (Table 11.13). Knowledge about how to claim SMP was also higher among women, with 73% of 30-44 year old women and 79% of 45-59 year old women knowing how to claim it. Actual claims were highest for 45-59 year old women (men cannot claim SMP) at 54%, and lowest for 18-29 year old women at 16%.

### 11.3.4 Council Tax Benefit

Council Tax Benefit is intended to reduce the burden of Council tax payments for those on low incomes. In order to claim Council Tax Benefit, the claimant must be habitually resident, liable to pay Council Tax for the property where they are resident, and be on a low income. The amount of benefit received varies, and is a function of (a) the claimant's income, (b) the claimant's savings, (c) personal circumstances such as number of children and receipt of Income Support, and (d) the amount of Council tax due on the property.

Seventy percent of respondents knew what Council tax Benefit was, with 61% knowing how to claim it, and 32% having actually made a claim (Table 11.14). Awareness of Council Tax Benefit and how to claim it was highest amongst 18-44 year olds, with actual claims highest amongst 30-44 and 60-75 year old women. Those renting were more likely to claim Council Tax Benefit than homeowners (Table 11.15) and claims were more common among lower income households (gross weekly income less than £200 (Table 11.16).

### 11.3.5 Housing Benefit

Housing Benefit is payable to claimants who are (a) habitually resident, (b) occupy a dwelling as their home, (c) are liable to pay rent for that dwelling, and (d) are receiving Income Support or Jobseeker's Allowance, or are on a low income. The

amount of benefit received depends upon (a) income, (b) savings, (c) personal circumstances such as number of children or disability, and (d) how much rent is to be paid.

Seventy-five percent of the respondents knew what Housing Benefit was for, with 62% knowing how to claim it (Table 11.17). The number who had actually made a claim was much lower at 22%. Eighteen to 44 year olds were the most likely to know what Housing Benefit was for, and also the most likely to know how to claim it. Sixty to 75 year old women were the most likely to have made an actual Housing Benefit claim (35%), with 45-59 year old men being the least likely (8%). Those renting a property knew more about Housing Benefit and were more likely to claim it (Table 11.18). Those on lower incomes were less likely to know what Housing Benefit was, less likely to know how to claim it but more likely to be in receipt of it (Table 11.18).

### 11.3.6 Statutory Sick Pay

SSP is payable to any employee between the ages of 16 and 65 years who has been continuously sick for four or more calendar days. The employee must also earn enough to pay Class 1 National Insurance Contributions. The claimant is entitled to £59.55 per week, according to the number of qualifying dates during which they were off work due to illness.

Awareness of SSP was high at 87% of the sample (Table 11.19), with 75% knowing how to claim it and 47% having made a claim at some point in the past. Awareness of what SSP was for, was highest amongst 30-44 year old women (98%), 30-44 year old men (93%) and 60-75 year old men (95%). It was lowest for 60-75 year old women, of which only 65% knew what SSP was for. The levels of overall awareness were mirrored in the percentages of those who knew how to claim SSP. Actual claim rates were highest among 45-59 year old women (68%) and 60-75 year old men (71%), and lowest among 18-29 year old women (31%), 60-75 year old women (30%) and 18-29 year old men (30%). Awareness of SSP was higher among those economically active at the time of interview, although actual claim rates were similar to those of the economically inactive group (Table 11.20).

### 11.3.7 Employment Rehabilitation Allowance

The Work Preparation Programme is a rehabilitation programme for people with disabilities. It is designed to increase employment prospects by (a) improving readiness for work, job-finding skills and techniques, (b) offering help with employment related needs arising from a disability which prevents immediate employment or uptake of vocational

training, and (c) providing work experience where necessary. Customers involved in a Work Preparation Programme are considered to be actively seeking work, and cannot therefore also be in receipt of Incapacity Benefit or Severe Disablement Allowance. If they are in a programme for more than 21 hours a week, then customers are entitled to an Employment Rehabilitation Allowance of £38 per week. This payment is taken in account when calculating Income Support, Housing Benefit, and other benefits being claimed.

Overall awareness of ERA (Table 11.21) was low at only 18%. Awareness was higher amongst younger women and older men. This pattern was mirrored when looking at those who knew how to make a claim for ERA. Very few respondents (6 from 232) had ever made a claim for ERA.

### 11.3.8 Job Seekers Allowance

JSA is a benefit paid to those who are unemployed. Claimants must meet a set of criteria before they are considered eligible. A claimant must be: (a) available for employment, (b) entered into a Jobseeker's agreement, (c) actively seeking employment, (d) not engaged in paid work, (e) capable of working, (f) not in relevant education, (g) under the state pension age, and (h) resident in Great Britain. The basic personal allowances at the time of writing are £30.95 for those under the age of 18, £40.70 for 18-24 year olds, and £51.40 for those aged 25 years or over. These allowances may be modified or expanded due to family considerations, e.g. number and age of dependant children.

Overall, 63% of respondents knew what Jobseeker's Allowance was, 53% knew how to claim it, and 18% had made a claim at some point in their lives (Table 11.22). Awareness and claim rates were highest amongst older men (aged 60-75 years) and women aged 30-44 years. Only a third of those unemployed at interview had made a claim for Jobseeker's Allowance (Table 11.23), compared to 13% of those in work or economically inactive.

### 11.3.9 Retirement Pension

A retirement pension is payable to any man over the age of 65, or woman over the age of 60, who has paid sufficient National Insurance contributions. As of 10 April 2000, the level of the pension is set at £67.50, although this is modifiable according to particular circumstances.

Overall awareness of retirement pensions amongst the DPIC sample was high, with 91% knowing what it is for and 65% knowing how to claim it. These figures are higher for older respondents, and lower for younger respondents (Table 11.24). Eighty-seven percent of female respondents aged 60 or over had made a claim for a retirement pension. The

corresponding figure for men of the same age is 48%, presumably reflecting those men aged 60-64 years who were not yet eligible to claim.

### 11.3.10 Widow's Pension

The basic conditions for claiming a Widow's pension are (1) the claimant is a woman, (2) her late husband made sufficient National Insurance contributions, and (3) she was aged over 45 years when he died. As of 10 April 2000, the level of the Widow's Pension was set at £67.50.

Awareness of what a Widow's Pension is for was high overall (74%), with men being more aware than women, and older people more aware than younger people (Table 11.25). For knowledge of how to claim the benefit (overall, 41%), the age trend is the same but the gender difference reversed. Thirty percent of women aged 60-75 years had made a claim for Widow's Pension, as had 7% of women aged 45-59 years.

## 11.4 Non-State Benefits

There are a variety of benefits available to Deaf people that are not provided by Central Government. These include a relay service that allows textphone users to communicate with those using voice phones (BT TypeTalk), a rebate for the cost of calls made using a textphone, travel permits from local authorities, and discounted entry to leisure and arts (such as galleries, museums and sports centres).

### 11.4.1 TypeTalk

BT TypeTalk is a relay service that allows textphone users and voice phone users to communicate. British Telecom runs the service in collaboration with the Royal National Institute for Deaf People (RNID). To use the service, a deaf or hearing person calls a BT operator who has access to both a textphone and a voice phone. The operator relays the calls between the parties involved in the call. In order to use the service one must register, although registration is free to both Deaf and hearing customers.

A large number of respondents had used the service on at least one occasion (86%, Table 11.26). Men were slightly more likely to have used the service than women, and reported use decreased with greater age. Of the 86% who had used TypeTalk, 81% had registered for their own personal account and the other 5% had used another person's account to make their call(s).

The DPIC sample was also asked about how frequently they used the service (Table 11.27). Fifty-seven percent of respondents used the service on at least a weekly basis. Young women aged 18-29 years were the most frequent users (78% on at least a weekly basis), followed by 30-44 year old women and 18-29 year old men

(both 66%). Men aged 45-75 years were more frequent users of the service than women in the same age range.

### 11.4.2 BT Text Users Rebate Scheme

Textphone conversations typically take longer than voice calls. Because of this, the telephone bills of textphone users can be much larger than for those who use conventional voice telephones. Deaf people who own a textphone can apply for a BT textphone User's Rebate. This cuts the bill by 60% up to a certain maximum.

Most Deaf respondents (91%) were aware of this rebate scheme (Table 11.28), with awareness highest among men of all ages and younger women. Eighty-three percent of respondents had registered for a rebate (Table 11.29). Levels of registration were highest for 18-44 year old men and 18-59 year old women).

### 11.4.3 Permits and Passes

Finally, respondents were asked about travel permits and passes that allow free or reduced price entry into leisure and arts facilities. A majority of respondents (57%) possessed a metropolitan travel permit that allowed free or reduced cost travel in city areas (Table 11.30). A slightly smaller number (40%) had a Disability Railcard to provide discounts on rail travel. Over a third of respondents enjoyed free/reduced entry to sports facilities and entertainment, and approximately a quarter had the same reduced/free access to museums and arts events.

As in the previous chapter, these benefit claims take us into sensitive areas where clear dissonance is seen. Deaf young people do not see themselves as disabled and certainly not physically, yet the rate of claims and take-up of travel passes and sports passes is much higher than one would have expected.

## 11.5 Summary

Despite the original concerns that benefit information might be inaccessible to deaf people, it seems that over a wide range of benefits and allowances, deaf people are very aware and do consider that they can make application if necessary and will do so.

Nearly 60% of the sample was in receipt of DLA even though there had been specific exclusion of those who had additional difficulties, when the sample was chosen. It seems that knowledge of the benefit system is better developed in the deaf community, than was expected on the basis of the accessibility theories.

**Table 11.1**: Registration with Social Services by perception of disability

| Registration | Disability | | Total |
|---|---|---|---|
| | I am not disabled | I am disabled | |
| | % | % | % |
| Not registered | 20 | 14 | 17 |
| Registered | 80 | 86 | 83 |
| *Base = 100%* | *102* | *128* | *230* |

**Table 11.2**: Registration with Social Services by gender and age group

| Registration | Gender and age group | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | |
| | % | % | % | % | % | % | % | % | |
| Not registered | 19 | 17 | 14 | 13 | 12 | 14 | 19 | 24 | 16 |
| Registered | 81 | 83 | 86 | 87 | 88 | 86 | 81 | 76 | 84 |
| ***Base = 100%*** | *31* | *41* | *28* | *23* | *33* | *29* | *26* | *21* | *232* |

**Table 11.3**: Type of registration with Social Services by perception of disability

| Type of registration | I am not disabled | I am disabled | Total |
|---|---|---|---|
| | % | % | % |
| Deaf without speech | 18 | 36 | 28 |
| Deaf with speech | 21 | 9 | 14 |
| Hard of hearing | 2 | 1 | 2 |
| Not sure | 59 | 55 | 56 |
| ***Base = 100%*** | *82* | *109* | *191* |

**Table 11.4**: Type of registration with Social Services by gender and age group

| Type of registration | Gender and age group | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | |
| | % | % | % | % | % | % | % | % | % |
| Deaf without speech | 0 | 29 | 30 | 14 | 24 | 48 | 52 | 25 | 28 |
| Deaf with speech | 16 | 17 | 22 | 0 | 21 | 8 | 14 | 6 | 14 |
| Hard of hearing | 0 | 3 | 0 | 0 | 7 | 0 | 0 | 0 | 2 |
| Not sure | 84 | 51 | 48 | 86 | 48 | 44 | 33 | 69 | 57 |
| *Base = 100%* | 25 | 35 | 23 | 21 | 29 | 25 | 21 | 16 | 195 |

**Table 11.5**: Awareness of disability benefits

| Awareness of benefits | DLA | SDA | DWA |
|---|---|---|---|
| | % | % | % |
| Not aware | 3 | 57 | 45 |
| Aware | 97 | 43 | 55 |
| ***Base = 100%*** | *234* | *234* | *233* |

**Table 11.6**: Claim rates, success of claims and reasons for not claiming disability benefits

| Disabled Living Allowance | | Severe Disability Allowance | | Disabled Working Allowance | |
|---|---|---|---|---|---|
| | % | | % | | % |
| **Not claimed DLA** | **19** | **Not claimed SDA** | **62** | **Not claimed DWA** | **88** |
| *Cannot be bothered* | *2* | *Cannot be bothered* | *6* | *Cannot be bothered* | *7* |
| *Do not think will get it* | *7* | *Do no think will get it* | *29* | *Do no think will get it* | *50* |
| *Do now want to claim* | *3* | *Do not want to claim* | *8* | *Do not want to claim* | *3* |
| *Do not know how to claim* | *4* | *Do not know how to claim* | *8* | *Do not know how to claim* | *14* |
| *Never asked* | *1* | *Not severely disabled* | *2* | *Have PACT support* | *1* |
| *Plan to claim soon* | *1* | *Never thought about it* | *2* | *Do not have DLA* | *2* |
| *Too old to claim* | *1* | *On incapacity benefit* | *1* | *Too old to claim* | *2* |
| *Waiting to receive forms* | *1* | *Working* | *4* | *Not working* | *6* |
| | | | | *Claiming other benefit* | *2* |
| | | | | *Do not need it* | *2* |
| **Claimed DLA** | **81** | **Claimed SDA** | **38** | **Claimed DWA** | **12** |
| *Claim refused, not appealed* | *7* | *Claim refused, not appealed* | *4* | *Claim refused, not appealed* | *6* |
| *Claim refused after 1 appeal* | *6* | *Claim refused after 1 appeal* | *1* | *Claim refused after 1 appeal* | *1* |
| *Claim refused after 2-5 appeals* | *10* | *Receiving SDA* | *26* | *Receiving DWA* | *4* |
| *Claimed refused after 6+ appeals* | *1* | *Waiting for response* | *3* | *Waiting for response* | *1* |
| *Receiving DLA* | *53* | *Received in past* | *5* | | |
| *Waiting for response* | *5* | | | | |
| *Received in past* | *1* | | | | |
| *Base = 100%* | *226* | | *105* | | *127* |

**Table 11.7**: Time for form initial claim to receipt of disability benefits

| 'Initial claim to benefit receipt' period | DLA | SDA | DWA |
|---|---|---|---|
| | % | % | % |
| 1-3 months | 34 | 25 | 100 |
| 4-6 months | 21 | 38 | 0 |
| 7-9 months | 9 | 25 | 0 |
| 10-12 months | 5 | 6 | 0 |
| More than 1 year | 30 | 6 | 0 |
| *Base = 100%* | *117* | *16* | *5* |

**Table 11.8**: Use to which disability benefits are put

| Use to which benefit is put | DLA | SDA | DWA |
|---|---|---|---|
| | % | % | % |
| Interpreters | 33 | 4 | 25 |
| Special equipment | 16 | 4 | 25 |
| Compensation for extra stress | 8 | 25 | 25 |
| General expenses | 46 | 79 | 50 |
| Access to information | 1 | 0 | 0 |
| Health problems | 4 | 0 | 0 |
| Travel | 2 | 0 | 0 |
| ***Base = 100%*** | *125* | *28* | *4* |

**Table 11.9**: Benefit claims for other disabilities

| Other disability claimed for | DLA | SDA | DWA |
|---|---|---|---|
| | % | % | % |
| Visual impairment | 26 | 0 | 50 |
| Physical mobility | 31 | 20 | 0 |
| Arthritis | 13 | 40 | 0 |
| Colitis | 5 | 0 | 0 |
| Diabetes | 5 | 0 | 0 |
| Migraine | 5 | 0 | 0 |
| ME | 0 | 20 | 0 |
| Speech problems | 0 | 20 | 0 |
| Back problem | 3 | 0 | 50 |
| Other | 21 | 0 | 0 |
| ***Base = 100%*** | *39* | *5* | *2* |

**Table 11.10**: Child Benefit claims by gender and age group

| Child Benefit | Gender and age group | | | | | | | | Total | Families with dependent children |
|---|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | | |
| | % | % | % | % | % | % | % | % | % | % |
| Know what it is for | 91 | 98 | 93 | 70 | 91 | 93 | 92 | 90 | 91 | 100 |
| Know how to claim it | 81 | 85 | 79 | 52 | 55 | 60 | 65 | 67 | 69 | 86 |
| Have claimed it | 25 | 63 | 64 | 39 | 15 | 50 | 62 | 43 | 45 | 83 |
| ***Base = 100%*** | *32* | *41* | *28* | *23* | *33* | *30* | *26* | *21* | *234* | *63* |

**Table 11.11**: Family Credit claims by gender and age group

| Family Credit | Gender and age group | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | |
| | % | % | % | % | % | % | % | % | % |
| Know what it is for | 63 | 80 | 61 | 26 | 48 | 53 | 54 | 52 | 57 |
| Know how to claim it | 63 | 65 | 43 | 9 | 36 | 43 | 42 | 43 | 45 |
| Have claimed it | 6 | 15 | 7 | 4 | 3 | 7 | 8 | 5 | 7 |
| ***Base = 100%*** | *32* | *40* | *28* | *23* | *33* | *30* | *26* | *21* | *233* |

**Table 11.12**: Family Credit claims by dependant children

| Family Credit | Dependant Children | | Total |
|---|---|---|---|
| | Yes | No | |
| | % | % | % |
| Know what it is for | 77 | 53 | 58 |
| Know how to claim it | 68 | 40 | 46 |
| Have claimed it | 11 | 5 | 6 |
| ***Base = 100%*** | *47* | *154* | *201* |

**Table 11.13**: Statutory Maternity Pay claims by gender and age group

| Statutory Maternity Pay | Gender and age group | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | |
| | % | % | % | % | % | % | % | % | % |
| Know what it is for | 69 | 85 | 89 | 78 | 70 | 77 | 69 | 86 | 78 |
| Know how to claim it | 59 | 73 | 79 | 48 | 55 | 50 | 38 | 67 | 59 |
| Have claimed it | 16 | 37 | 54 | 39 | 0 | 0 | 0 | 0 | 24 |
| ***Base = 100%*** | *32* | *41* | *28* | *23* | *33* | *30* | *26* | *21* | *234* |

**Table 11.14**: Council tax benefit claims by gender and age group

| Council Tax Benefit | Gender and age group | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | |
| | % | % | % | % | % | % | % | % | % |
| Know what it is for | 63 | 78 | 71 | 61 | 64 | 76 | 69 | 81 | 70 |
| Know how to claim it | 56 | 71 | 61 | 52 | 45 | 69 | 62 | 71 | 61 |
| Have claimed it | 28 | 39 | 25 | 48 | 33 | 28 | 27 | 24 | 32 |
| ***Base = 100%*** | *32* | *41* | *28* | *23* | *33* | *29* | *26* | *21* | *233* |

**Table 11.15**: Council tax benefit claims by tenancy and by income level

| Council Tax Benefit | Tenancy | | | | Income Level | | | Total |
|---|---|---|---|---|---|---|---|---|
| | Home owners | Private renters | Council renters | Live with parents | Low (< £200) | Medium (£200-£400) | High (£400 +) | |
| | % | % | % | % | % | % | % | % |
| Know what it is for | 72 | 62 | 87 | 54 | 69 | 73 | 70 | 71 |
| Know how to claim it | 65 | 54 | 74 | 43 | 59 | 63 | 65 | 62 |
| Have claimed it | 30 | 54 | 53 | 9 | 48 | 23 | 23 | 32 |
| ***Base = 100%*** | *115* | *13* | *38* | *35* | *71* | *90* | *40* | *201* |

**Table 11.16**: Council tax benefit claims by dependent children

| Council Tax Benefit | Dependent Children | | Total |
|---|---|---|---|
| | Yes | No | |
| | % | % | % |
| Know what it is for | 71 | 71 | 71 |
| Know how to claim it | 61 | 63 | 62 |
| Have claimed it | 29 | 33 | 32 |
| ***Base = 100%*** | *62* | *139* | *201* |

**Table 11.17**: Housing benefit claims by gender and age group

| Housing Benefit | Gender and age group | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | |
| | % | % | % | % | % | % | % | % | % |
| Know what it is for | 81 | 80 | 61 | 70 | 82 | 77 | 65 | 76 | 75 |
| Know how to claim it | 56 | 73 | 46 | 48 | 70 | 73 | 42 | 76 | 62 |
| Have claimed it | 25 | 24 | 14 | 35 | 27 | 20 | 8 | 24 | 22 |
| ***Base = 100%*** | *32* | *41* | *28* | *23* | *33* | *30* | *26* | *21* | *234* |

**Table 11.18**: Housing Benefit claims by tenancy and by income level

| Housing Benefit | Tenancy | | | | Income Level | | | Total |
|---|---|---|---|---|---|---|---|---|
| | Home owners | Private renters | Council renters | Live with parents | Low (< £200) | Medium (£200-£400) | High (£400 +) | |
| | % | % | % | % | % | % | % | % |
| Know what it is for | 73 | 77 | 87 | 71 | 73 | 74 | 83 | 76 |
| Know how to claim it | 55 | 77 | 82 | 57 | 65 | 56 | 71 | 62 |
| Have claimed it | 10 | 54 | 50 | 14 | 30 | 19 | 12 | 21 |
| ***Base = 100%*** | *116* | *13* | *38* | *35* | *71* | *90* | *41* | *202* |

**Table 11.19**: Statutory Sick Pay claims by gender and age group

| Statutory Sick Pay | Gender and age group | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | |
| | % | % | % | % | % | % | % | % | % |
| Know what it is for | 78 | 98 | 89 | 65 | 82 | 93 | 88 | 95 | 87 |
| Know how to claim it | 69 | 90 | 86 | 57 | 70 | 67 | 69 | 86 | 75 |
| Have claimed it | 31 | 49 | 68 | 30 | 30 | 47 | 58 | 71 | 47 |
| ***Base = 100%*** | *32* | *41* | *28* | *23* | *33* | *30* | *26* | *21* | *234* |

**Table 11.20**: Statutory Sick Pay claims by economic activity

| Statutory Sick Pay | Economic activity | | Total |
|---|---|---|---|
| | Active | Inactive | |
| | % | % | % |
| Know what it is for | 92 | 79 | 88 |
| Know how to claim it | 79 | 71 | 77 |
| Have claimed it | 46 | 45 | 48 |
| ***Base = 100%*** | *146* | *56* | *202* |

**Table 11.21**: Employment rehabilitation allowance claims by gender and age group

| Employment Rehabilitation Allowance | Gender and age group | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | |
| | % | % | % | % | % | % | % | % | % |
| Know what it is for | 13 | 18 | 14 | 4 | 15 | 27 | 27 | 30 | 18 |
| Know how to claim it | 13 | 18 | 14 | 0 | 15 | 20 | 15 | 15 | 14 |
| Have claimed it | 0 | 5 | 4 | 0 | 5 | 0 | 4 | 5 | 3 |
| ***Base = 100%*** | *32* | *40* | *28* | *23* | *33* | *30* | *26* | *20* | *232* |

**Table 11.22**: Job Seeker's Allowance claims by gender and age group

| Job Seekers Allowance | Gender and age group | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | |
| | % | % | % | % | % | % | % | % | % |
| Know what it is for | 63 | 78 | 57 | 48 | 64 | 60 | 52 | 71 | 63 |
| Know how to claim it | 53 | 71 | 50 | 35 | 55 | 47 | 40 | 62 | 53 |
| Have claimed it | 13 | 24 | 18 | 9 | 24 | 17 | 12 | 29 | 18 |
| ***Base = 100%*** | *32* | *41* | *28* | *23* | *33* | *30* | *25* | *21* | *233* |

**Table 11.23**: Job Seeker's Allowance claims by current employment status

| Job Seekers Allowance | Employment Status | | Total |
|---|---|---|---|
| | Unemployed | All other | |
| | % | % | % |
| Know what it is for | 79 | 60 | 62 |
| Know how to claim it | 75 | 50 | 53 |
| Have claimed it | 33 | 13 | 17 |
| ***Base = 100%*** | *24* | *177* | *201* |

**Table 11.24**: Retirement pension claims by gender and age group

| Retirement Pension | Gender and age group | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | |
| | % | % | % | % | % | % | % | % | % |
| Know what it is for | 78 | 93 | 93 | 96 | 91 | 93 | 92 | 100 | 91 |
| Know how to claim it | 38 | 66 | 68 | 87 | 58 | 63 | 77 | 76 | 65 |
| Have claimed it | 0 | 0 | 7 | 87 | 0 | 0 | 4 | 48 | 14 |
| ***Base = 100%*** | *32* | *41* | *28* | *23* | *33* | *30* | *26* | *21* | *234* |

**Table 11.25**: Widow's Pension claims by gender and age group

| Widow's Pension | Gender and age group | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | |
| | % | % | % | % | % | % | % | % | % |
| Know what it is for | 59 | 71 | 82 | 78 | 61 | 80 | 80 | 90 | 74 |
| Know how to claim it | 34 | 44 | 54 | 52 | 30 | 37 | 32 | 52 | 41 |
| Have claimed it | 0 | 0 | 7 | 30 | 0 | 0 | 0 | 0 | 4 |
| ***Base = 100%*** | *32* | *41* | *28* | *23* | *33* | *30* | *25* | *21* | *233* |

**Table 11.26**: Use of TypeTalk by gender and age group

| Use of TypeTalk | Gender and age group | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | |
| | % | % | % | % | % | % | % | % | % |
| **Use TypeTalk** | **94** | **95** | **71** | **68** | **97** | **93** | **80** | **71** | **86** |
| *Have personal account* | *91* | *93* | *64* | *59* | *91* | *87* | *76* | *67* | *81* |
| *Use other person's account* | *3* | *2* | *7* | *9* | *6* | *7* | *4* | *5* | *5* |
| **Do not use TypeTalk** | **6** | **5** | **29** | **32** | **3** | **7** | **20** | **29** | **14** |
| ***Base = 100%*** | *32* | *41* | *28* | *22* | *32* | *30* | *25* | *21* | *231* |

**Table 11.27**: Frequency of TypeTalk use by gender and age group

| Frequency of TypeTalk Usage | Gender and age group | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | |
| | % | % | % | % | % | % | % | % | % |
| Every day | 25 | 37 | 7 | 0 | 19 | 27 | 19 | 14 | 23 |
| At least once a week | 53 | 29 | 7 | 14 | 47 | 47 | 23 | 14 | 34 |
| Once a month | 9 | 12 | 1 | 10 | 6 | 10 | 8 | 5 | 8 |
| Rarely | 6 | 15 | 2 | 33 | 19 | 7 | 23 | 14 | 15 |
| Never | 6 | 7 | 9 | 43 | 9 | 10 | 27 | 52 | 21 |
| ***Base = 100%*** | *32* | *41* | *26* | *21* | *32* | *30* | *26* | *21* | *229* |

**Table 11.28**: Awareness of BT Text Users Rebate Scheme by gender and age group

| Awareness of BT Rebate Scheme | Gender and age group | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | |
| | % | % | % | % | % | % | % | % | % |
| Not aware of scheme | 3 | 12 | 14 | 17 | 6 | 7 | 8 | 0 | 9 |
| Aware of scheme | 97 | 88 | 86 | 83 | 94 | 93 | 92 | 100 | 91 |
| ***Base = 100%*** | *32* | *41* | *28* | *23* | *32* | *30* | *26* | *21* | *233* |

**Table 11.29**: Registration with BT Text Users Rebate Scheme by gender and age group

| Registration with BT Rebate Scheme | Gender and age group | | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| | Women | | | | Men | | | | |
| | 18-29 | 30-44 | 45-59 | 60-75 | 18-29 | 30-44 | 45-59 | 60-75 | |
| | % | % | % | % | % | % | % | % | % |
| Registered in BT rebate scheme | 84 | 83 | 88 | 74 | 90 | 96 | 79 | 57 | 83 |
| Not registered in BT rebate scheme | 16 | 17 | 12 | 26 | 10 | 4 | 21 | 43 | 17 |
| ***Base = 100%*** | *31* | *36* | *24* | *19* | *30* | *28* | *24* | *21* | *213* |

**Table 11.30**: Other benefits received

| Other Disability Benefits | DPIC 1998 |
|---|---|
| | % |
| Disability Railcard | 40 |
| London Travel Permit | 14 |
| Other Metropolitan Travel Permit | 43 |
| Free/Reduced Entry to Sports | 37 |
| Free/Reduced Entry to Museums | 28 |
| Free/Reduced Entry to Arts | 21 |
| ***Base = 100%*** | *223* |

# 12 Disability Law

There have been recent changes and additions to the law in regard to people with disabilities and for those for whom special provision is made at school. These have a varying impact on those who are already well established in life and depending on age they will be of more or less interest. However, they are considered to be of great importance by deaf organisations and the participation in the legislation is seen as of great importance.

## 12.1 Disability Discrimination Act

The majority of deaf people claim to be aware of the DDA. This legislation not only deals with the rights of disable people in the workplace but it sets out examples of good practice which include interpreting and subtitling and so on. The legislation itself does not have as much force as some had hoped but it is of great significance.

Younger deaf people were more aware – nearly three quarters of them. Over the age of 45 years only just over half of the sample knew about this legislation.

However, people were less clear about what to do if they felt they had been unfairly treated and wished to make a claim under the Act. A quarter of older people would go to the social worker and around one fifth overall would go to a solicitor. One in ten would go to a Citizen's Advice Bureau, hardly more than the numbers who did not know or who would consult their family. It seems that there is no known common route to advice or support in making claims under the DDA. This may be understandable given the recency of this Act and the fact that case lore may take time to build up.

## 12.2 Special Education

An additional area of legislation is the series of Acts, Codes of Conduct and recent published government plans for Education. Traditionally, deaf people have no say in the education of deaf children other than through the few deaf parents who have deaf children. Since very little information is provided in BSL, the influence they have is minimal. In certain circumstances, the educators of the deaf tend to suggest that there is no reason to take into account the views of deaf people, as their experiences of school are now out of date. (It can be argued that those who leave school in the hearing community have no direct impact on the education system after they have left, other than through the political system). However, this denies the wealth of experience of deaf

students and omits the fact that the teachers are hearing and so themselves have no direct experience of receiving deaf education.

In the study, deaf participants were asked about their awareness of new developments in deaf education. Particularly significant is the published government Green Paper on Special Education that sets out plans for teaching, training and support services. All parties and individuals were invited to send comments. Given the general tone of the comments above, it is perhaps surprising to discover that 41% of younger people and 35% of older people claim to be aware of the Green Paper. Since the general consensus is that the deaf community is not highly politicized, this would seem to be a high figure. On the other hand, one could argue that a community should have mechanisms to deal with information of impact in terms of its growth and development and should be more aware and active in this respect. In specific terms, the Green Paper confirms a general pressure for Inclusive Practices in Education. Since this has the fundamental view that deaf children should be educated alongside hearing peers, it has the potential to affect all provision of Deaf Education.

When asked about their understanding of the impact of the Education Act, among those who had said they were aware of its existence, three quarters claimed to know that it would have an impact on deaf children.

Obviously, this is only a preliminary finding and more detail on education and educational experience is provided in the report that deals more specifically with deaf experiences. Within a community, we cannot expect all members to be involved in all political initiatives that affect them. Given the difficulties of achieving information access when it is not presented in one's preferred language, the figures for awareness are reasonable, although they seem not to be high enough to indicate a commitment to engagement which would produce change in the legislation.

## 12.3 Summary

This is a relatively brief examination of deaf awareness of legislation that may have an impact on community life. While deaf people are able to recognise the Disability Discrimination Act there seems to be as yet, little consensus on the mechanisms for using it. Smaller numbers are aware of the Education legislation.

**Table 12.1**: Awareness of Disability Discrimination Act (1998), by age group

| Aware of DDA | 18-44 years | 45-75 years | All persons |
|---|---|---|---|
| | % | % | % |
| Yes | 73 | 54 | 65 |
| No | 27 | 46 | 35 |
| *Base = 100%* | *136* | *98* | *234* |

**Table 12.2**: First point of contact if respondent felt discriminated against, by age group

| Point of contact | 18-44 years | 45-75 years | All persons |
|---|---|---|---|
| | % | % | % |
| Legal firm | 22 | 18 | 20 |
| Social worker | 16 | 27 | 20 |
| Friend | 15 | 15 | 15 |
| CAB | 11 | 9 | 10 |
| Do not know | 9 | 9 | 9 |
| Family | 9 | 5 | 8 |
| Union | 4 | 5 | 4 |
| Workplace | 5 | 2 | 4 |
| Mention DDA | 4 | 0 | 3 |
| BDA | 2 | 0 | 1 |
| EO Officer | 1 | 2 | 1 |
| Direct action/petition | 0 | 4 | 1 |
| RNID | 1 | 0 | 1 |
| Deaf Club | 1 | 0 | 1 |
| Interpreter | 0 | 2 | 1 |
| Job Centre | 1 | 0 | 1 |
| MP | 1 | 0 | 1 |
| Priest | 0 | 2 | 1 |
| *Base = 100%* | *102* | *55* | *157* |

**Table 12.3:** Awareness of Green Paper on Special Educational Needs, by age group

| Aware of Green Paper | 18-44 years | 45-75 years | All persons |
|---|---|---|---|
| | % | % | % |
| Yes | 41 | 35 | 38 |
| No | 59 | 65 | 62 |
| *Base = 100%* | *135* | *98* | *233* |

**Table 12.4**: Awareness of impact of Green Paper on the education of Deaf children, by age group

| Impact on Deaf children | 18-44 years | 45-75 years | All persons |
|---|---|---|---|
| | % | % | % |
| Yes | 74 | 77 | 75 |
| No | 26 | 23 | 25 |
| *Base = 100%* | *57* | *35* | *92* |

# 13 Implications

This report concerns the positioning of deaf people in society in regard to the fundamental services of health and disability provision. All members of society in the UK are in receipt of health care and there is a also a commitment to ensuring that all people are able to function in society. The systems that exist are complex and require knowledge and experience in order to negotiate them effectively.

We find that the DPIC participants are on the whole are users of these systems. Despite the fear that lack of access to information in BSL affects their ability to use the system, we find that deaf people go to the doctor and the hospital more than do hearing people. They are aware of relevant benefits and provision and the majority do make claims.

However, this generally positive gloss hides a number of problems that are evident in further questioning. Although deaf people go to the doctor more than do hearing people, they tend to have more prescriptions, attend for more check-ups and are less likely to be seen at home. It seems that extent of use may be symptomatic of inefficient use of the system, as there is no overall evidence to suggest that deaf people are less healthy than hearing people. Deaf people seldom use interpreters and often bring members of the family or friends. However, they do express satisfaction with the services they receive, even though in open questioning, deaf people typically offer a range of bad experiences in health care.

However, there is relatively clear-cut evidence that there are problems in alcohol and smoking, but only for certain sub-groups in the community. Deaf women appear to drink more than the recommended amounts and more so when there is higher income. Young deaf males tend to smoke more than the norm and are quite different from the rest of the sample who smoke much less than the hearing community.

Access to health advice varied according to educational level achieved, which is likely to be the same for the general population. And stress factors seem to be reported much less among the sample than would be expected. Access to health care seems more extensive than might have been predicted but there are suspicions that this access is inefficient and incomplete.

A second major consideration in this report was the view that deaf people had of themselves – do they consider

themselves disabled? Popular theories now concede that deaf people are a linguistic minority but when asked, the majority class themselves as disabled. Certain groups, e.g. young deaf people, tend to disagree and see the problems in terms of language access. However, the community as a whole see the lack of hearing as indicative of disability – which paradoxically then opens up a range of benefits. Deaf people are aware of the benefits system and do seem to use it in large numbers. They gain from Disability Living Allowance, from textphone rebates, and transport discounts. Most of the advantage from these benefits is seen in general quality of life. Since we know that deaf people receive lower incomes than other groups (see the Demographics report) this might be seen as an adjustment on living costs within society.

There are many areas of this report that will need further examination and probing and areas where more data is needed in order to understand the situation. However, the general picture is of the Deaf Community dealing with many intrinsic difficulties in order to achieve participation and as a result, they are aware of and are able to engage with the major systems of Health and Medical and Social Benefits.

# 14 Health Questionnaire

**Deaf People, Information and the Community**

**A new project for deaf people and their views**

Funded by the National Lottery and
managed by the Deaf Studies Trust

*Second Interview – Health*

Date of Interview: _____ Interviewer: _____
Start time: _____ end time: _____

---

***Questionnaire***

1. **Participant Record Number:** _____
2. **Male:** ❑ **Female:** ❑
3. **Date of Birth:** Day: _____ Month:_____ Year: 19_____

***a) GENERAL HEALTH***

**4. In general, would you say your health is:**
*Excellent* ❑ *Very good* ❑ *Good* ❑ *Fair* ❑ *Poor* ❑

**5. <u>Compared to one year ago</u>, how would you rate your health in general <u>now</u>?**
*Much better now than one year ago* ❑ *Better now than one year ago* ❑
*About the same* ❑ *Worse now than one year ago* ❑ *Much worse than one year ago* ❑

**If your health is better or worse?**
**a)** *Yes* ❑ *No* ❑ *Do not know* ❑
**b) What are the reasons?** _____

**7. How much of the time during the <u>past month</u> did you feel:**

| | *All the time* *1* | *Most of the time* *2* | *Some of the time* *3* | *A little of the time* *4* | *None of the time* *5* |
|---|---|---|---|---|---|
| *Full of life?* | | | | | |
| *Very nervous?* | | | | | |
| *Feel down that nothing could cheer you up?* | | | | | |
| *Calm and peaceful?* | | | | | |
| *Very energetic?* | | | | | |
| *Downhearted and low?* | | | | | |
| *Worn out?* | | | | | |
| *Happy?* | | | | | |
| *Tired?* | | | | | |
| *Your health has limited your social activities (like visiting friends or close relatives)?* | | | | | |

**8. People are more healthy now in UK, more than before – why?**
_____
_____

**9. What kind of exercise do you do?**
_____
_____
_____

**10. How often do you do exercise?**
_____
_____
_____

**11. Is there anything you would like to try?**

_____
_____
_____

**12. What stops you from trying?**

_____
_____
_____

**13. Do you think before you eat about whether the food is healthy?** *Yes* ❑ *No* ❑

**14. What kind of food do you eat and how often?**

| | *Every day* | *At least once a week* | *Once a month* | *Rarely* | *Never* |
|---|---|---|---|---|---|
| *Bread* | | | | | |
| *Fruit* | | | | | |
| *Vegetable* | | | | | |
| *Cereal* | | | | | |
| *Meat* | | | | | |
| *Fish* | | | | | |
| *Pasta* | | | | | |
| *Potatoes* | | | | | |
| *Other* _____ _____ _____ | | | | | |

**15. Is there anything in your life that has a good effect on your health?**

**a)** *Yes* ❑ *No* ❑ *Do not know* ❑

**b) What is it?** _____
_____
_____

**16. Do you think that a good income means better health?**

**a)** *Yes* ❑ *No* ❑ *Do not know* ❑

**b) Why or why not?** _____
_____
_____

**18. Do you agree/ disagree with the following statements:**

| | *Strongly agree 1* | *Agree 2* | *Do not know 3* | *Disagree 4* | *Strongly disagree 5* |
|---|---|---|---|---|---|
| *To have good health is the most important thing in life.* | | | | | |
| *I really do not have time to think about my health.* | | | | | |
| *I am more reluctant to go to see a doctor because of communication problems that arise.* | | | | | |
| *Deaf people die younger than hearing people because of limited access to health care or to information.* | | | | | |
| *Deaf people earn less than hearing people.* | | | | | |
| *Hearing people are more intelligent than deaf people.* | | | | | |
| *I would rather go to a deaf doctor than to a hearing doctor.* | | | | | |
| *It is sensible to do exactly what the doctor says.* | | | | | |
| *Being able to hear means that information can be better understood.* | | | | | |
| *The National Health Service is responsible for my health.* | | | | | |

**19. Do you think you are well, physically:**
*Very well* ❑ *Quite well* ❑ *Well enough* ❑ *Not very well* ❑

**20. Do you feel you are well "inside":**
*Very well* ❑ *Quite well* ❑ *Well enough* ❑ *Not very well* ❑

**21. If you felt really well, what would you feel like?**
*Healthy* ❑ *Happy* ❑ *Confident* ❑

**22. Would you say that:**

| | *Are well* | *Are well enough* | *Are not well* |
|---|---|---|---|
| *Most of your deaf friends* | | | |
| *Half of your deaf friends* | | | |
| *Not many of your deaf friends* | | | |

**23. Would you say that deaf people <u>of your age</u> are just as well as hearing people?**
*More well than hearing people* ❑ *About the same as hearing people* ❑
*Not as well as hearing people* ❑

**24. Would you say that deaf people <u>of your age</u> are just as fit as hearing people?**
*More fit than hearing people* ❑ *About the same as hearing people* ❑
*Not as fit as hearing people* ❑

**25. Is mental illness different from physical illness?** *Yes* ❑ *No* ❑ *Do not know* ❑

**26. How can mental health problems be treated? (can tick more than one)**
*Taking medication* ❑ *Talking to a professional in mental health (counsellor)* ❑
*Talk to a doctor* ❑ *Confide in family/ friends* ❑ *Talk to a Social Worker* ❑
*Sort it out yourself* ❑ *Talk to interpreter* ❑ *Other* ❑ _____

**27. If you discovered that a close deaf friend was diagnosed as mentally ill, what would be your <u>first</u> reaction?**
*Embarrassment* ❑ *Shock* ❑ *Support* ❑ *Other* ❑ _____

**28. What would you do if the above happened to you?**
*Leave them alone* ❑ *Go to talk to them* ❑ *Find out more about mental illness* ❑
*Other* _____
_____
_____

**29. Do you think that deaf people have more mental health problems than hearing people?**
*Yes* ❑ *No* ❑ *Do not know* ❑

**30. Would you use a minicom help-line (e.g. BDA Health Promotion help-line)?**
*Yes* ❑ *No* ❑ *Do not know* ❑

**31. If you were feeling depressed who would be the <u>first</u> person you would tell about the problem? (tick one only)**
*Family* ❑ *Close friend* ❑ *Doctor* ❑ *Social worker* ❑
*Professional in Mental Health* ❑ *Help-line* ❑ *Interpreter* ❑ *No one* ❑

**32. Do you think that professional help makes it better?** *Yes* ❑ *No* ❑ *Do not know* ❑

**33. Who would you prefer to have help from? (tick one only)**
**a)** *Deaf person* ❑ *Hearing person* ❑ *Both* ❑ *Do not know* ❑
**b)** *What is the reason?* _____
_____

**b) PHYSICAL HEALTH**

**34. How many times in the last 12 months have you visited:**

| | *Fewer than 5 times* | *5-9 times* | *10-15 times* | *16 or more times* | *Not at all* |
|---|---|---|---|---|---|
| *GP Surgery* | | | | | |
| *Dentist* | | | | | |
| *Chiropodist (foot expert)* | | | | | |
| *Chiropractor (back expert)* | | | | | |
| *Acupuncture (treatment with needles)* | | | | | |
| *Masseur (for massage)* | | | | | |
| *Clinic* | | | | | |
| *Hospital* | | | | | |
| *Physio (home or hospital – work with your body)* | | | | | |
| *Homeopathy (herbal medication)* | | | | | |
| *Alternative Medicine (non medical: no drugs)* | | | | | |
| *Nutritionist (special diet)* | | | | | |

**35. If you visited your GP fewer than 5 times in the past 12 months, were the visits generally for check-ups (e.g. smear tests, pregnancy tests, prostate, sports injuries)?** *Yes* ❑ *No* ❑

**36. Are you happy with your GP?** *Yes* ❑*No* ❑

*Comments* _____

_____

_____

**37. Have you been to the hospital in the past 12 months?** *Yes* ❑ *No* ❑

**38. Were you happy with the way of communication & the consultant?** *Yes* ❑ *No* ❑

**39. Have you been to the clinic in the past 12 months?** *Yes* ❑ *No* ❑

**40. Were you happy with the way of communication & the consultant?** *Yes* ❑ *No* ❑

**41. When was the last time you visited your GP?**
*Within the last month* ❑ *2-6 months ago* ❑ *7-12 months ago* ❑ *At least 12 months ago* ❑

**42. If you have you ever tried complementary/ alternative medicine, was this:**
*Instead of consulting your GP* ❑ *As well as consulting your GP* ❑

**43. Which of the following complementary/ alternative therapies have you tried? (can tick more than one)**

| | *Medicine tried* | | *Successful* | | *Side effects?* | |
|---|---|---|---|---|---|---|
| | *Yes* | *No* | *Yes* | *No* | *Yes* | *No* |
| *Reflexology (foot massage to recognise your health needs)* | | | | | | |
| *Acupuncture* | | | | | | |
| *Aromatherapy (oils for relaxing or stimulating body and mind)* | | | | | | |
| *Hypnosis (mind control)* | | | | | | |
| *Chinese herbalism (using Chinese herbs)* | | | | | | |
| *Spiritual healing (various ways)* | | | | | | |
| *Homeopathy (natural medication)* | | | | | | |
| *Crystal therapy (using crystals)* | | | | | | |
| *Osteopathy (bone problems)* | | | | | | |
| *Chiropractice* | | | | | | |

**Comments** _____
_____
_____

**44. Do you suffer from any allergies?** *No* ❑ *Yes* ❑
*Which?* _____
_____

**45. Where do you get your health advice from?**
*Friends* ❑ *Relatives* ❑ *Magazines* ❑ *TV & Radio* ❑ *Newspapers* ❑
*Doctors* ❑ *Pharmacists* ❑ *Leaflets* ❑

**46. Do you ever eat chocolate, fried food or other fatty/ sugary snacks?**
*Yes* ❑ *No* ❑ *(go to Q48)*

**47. If yes, how often?**
*Every day* ❑ *At least 2-3 times a week* ❑ *Less than once a week* ❑
*Rarely or never* ❑

**48. Do you have any particular food cravings?** *No* ❑ *Yes* ❑
**a)** *Which?* _____
**b)** *What is the reason?*_____
_____

**49. How often in the day do you drink caffeine (tea, coffee, coke)?**
*1-3 times* ❑ *4-6 times* ❑ *6 or more times* ❑ *Rarely or never* ❑

**50. On average, about how many hours do you sleep per night?**
*Fewer than 4 hours* ❑ *4-7 hours* ❑ *More than 8 hours* ❑

**51. Do you usually:**

| | *Frequently* | *Sometimes* | *Rarely/ never* |
|---|---|---|---|
| *Fall asleep as soon as you get to bed?* | | | |
| *Find yourself waking throughout the night?* | | | |
| *Suffer regularly from nightmares?* | | | |

**52. Do you describe yourself as a happy person generally?** *Yes* ❑ *No* ❑

**53. Do you ever feel as if you have lost some of your self-confidence?**
*Yes* ❑ *No* ❑ *(go to Q55)*

**54. If yes, is this:** *At work* ❑ *In your personal life* ❑ *Both* ❑

**55. Are you currently in a relationship?** *Yes* ❑ *No* ❑

**56. Are you happy about this?** *Yes* ❑ *No* ❑

**57. Do you find it difficult to form close relationships?** *Yes* ❑ *No* ❑

**58. Do you ever feel disappointed and let down by your friends?** *Yes* ❑ *No* ❑

**59. Have you ever experienced any trouble in your relationships (physical or emotional)?**
*Yes* ❑ *No* ❑ Comments _____
_____
_____

**60. Have you suffered a bereavement or loss within your immediate family in recent years?**
*Yes* ❑ *No* ❑

**61. During the past 2 or 3 years, has your personal situation changed as a result of:**
*Divorce* ❑ *Separation* ❑ *Widowhood* ❑

**62. Do you often feel that things get on top of you?** *Yes* ❑ *No* ❑

**63. If you are working, do you consider that you are happy in your job** *Yes* ❑ *No* ❑

**c) DRINKING**

**64. Do you know how many units of alcohol you drink in an average week? (one unit constitutes a glass of wine, a single measure of spirits or half a pint of beer)**
*Yes* ❑ *No* ❑ *(go to Q66)*

**65. If yes, on average, how many units do you drink per week?**
*Have stopped drinking* ❑ *1-5 units* ❑ *5-10 units* ❑ *10-15 units* ❑
*15-20 units* ❑ *20 + units* ❑

**66. Are you aware that people can get addicted to alcohol?** *Yes* ❑ *No* ❑

**67. Do you consider alcohol to be a drug?** *Yes* ❑ *No* ❑

**68. When do you think a person is addicted to alcohol?**

| | *Addicted* | *In danger of becoming addicted* | *Normal behaviour* |
|---|---|---|---|
| *When a person drinks regularly* | | | |
| *When a person drinks excessively* | | | |
| *When a person drinks each time there is a problem* | | | |
| *When a person drinks early in the morning* | | | |

**69. What is your favourite alcoholic drink?**

_____

**70. Do you think drinking has ever seriously affected your health or your relationship(s)?**
*Yes* ❑ *No* ❑ *Do not know* ❑

**71. What are your reasons for drinking alcohol?**

| | *Frequently* | *Sometimes* | *Rarely/ never* |
|---|---|---|---|
| *Stress* | | | |
| *Panic* | | | |
| *Worries* | | | |
| *Forget own frustrations* | | | |
| *Drown own sorrows* | | | |
| *Thirsty* | | | |
| *Enjoyable/ Fun* | | | |
| *Celebrate* | | | |
| *Fashionable* | | | |
| *Peer pressure* | | | |
| *Loneliness* | | | |
| *Do not know* | | | |
| *Other* _____ _____ _ | | | |

**72. Why do you think <u>deaf people</u> in general drink alcohol?**

| | *Frequently* | *Sometimes* | *Rarely/ never* |
|---|---|---|---|
| *Stress* | | | |
| *Panic* | | | |
| *Worries* | | | |
| *Forget their frustrations* | | | |
| *Drown their sorrows* | | | |
| *Thirst* | | | |
| *Enjoyable/ Fun* | | | |
| *Celebrate* | | | |
| *Fashionable* | | | |
| *Loneliness* | | | |
| *Peer pressure* | | | |
| *Do not know* | | | |
| *Other* _____ _____ _ | | | |

**73. Do you think deaf people drink more alcohol than hearing people?**

*Yes* ❑ *No* ❑ *Do not know* ❑

**74. Would you drink less if you knew too much drinking could harm your health?**

*Yes* ❑ *No* ❑ *I am not bothered* ❑ *Do not know* ❑

**75. If your partner drank too much on a regular basis, would you be concerned?**

*Yes* ❑ *No* ❑ *I am not bothered* ❑ *Do not know* ❑

**76. What would you do about it?**
*Talk to him* ❑ *Talk to his friends* ❑ *Talk to his parents* ❑
*Talk to a professional* ❑ *Other* ❑ _____

**d) SMOKING**

**77. Do you smoke?** *Yes* ❑ *No* ❑

**78. If no, have you ever smoked in the past?** *Yes* ❑ *No* ❑

**79. If yes, how much?**
*Occasional smoker* ❑ *Fewer than 10 a day* ❑ *10-20 a day* ❑ *21-40 a day* ❑
*40+ a day* ❑

**80. If you are an ex-smoker, how long ago did you quit?**
*10+ years ago* ❑ *5-10 years ago* ❑ *1-5 years ago* ❑ *Less than 1 year ago* ❑

**81. How did you quit?**
*Gave up immediately* ❑ *Nicotine gum/ patches* ❑ *Hypnotherapy* ❑
*Prescribed drugs* ❑ *Other* ❑ _____

**82. If you smoke, what is the reason?**

| | *Frequently* | *Sometimes* | *Rarely/ never* |
|---|---|---|---|
| *Stress* | | | |
| *Panic* | | | |
| *Worries* | | | |
| *Frustration* | | | |
| *Soothing* | | | |
| *Thinking* | | | |
| *Enjoyable/ Fun* | | | |
| *Fashionable* | | | |
| *Macho* | | | |
| *Like of the taste* | | | |
| *Cannot stop but would like to* | | | |
| *Do not know* | | | |
| *Other* _____ _____ __ | | | |

**83. Are you aware that smoking can cause cancer?** *Yes* ❑ *No* ❑

**84. Do you know that smoking can cause:**

| | *Yes* | *No* | | *Yes* | *No* |
|---|---|---|---|---|---|
| **Cancer of the:** | | | **Heart problems:** | | |
| *Lung* | | | *Coronary attack (heart attack)* | | |
| *Bowel* | | | *Thickening of coronary arteries* | | |
| *Ovaries* | | | *Stroke* | | |
| *Cervical* | | | *Thrombosis (blood clot anywhere in body)* | | |
| *Kidney* | | | *Breathlessness* | | |
| *Liver* | | | | | |

**85. Knowing this, are you going to stop smoking?** *Yes* ❑ *No* ❑ *Do not know* ❑

**86. Has anyone in your family or amongst your friends had cancer or heart problems from smoking?**
*Yes* ❑ *No* ❑

**87. You smoke but your partner is a non-smoker, does your partner mind?**
*Yes* ❑ *No* ❑ *Partner is not bothered* ❑ *Do not know* ❑ *I smoke anyway* ❑

**88. If your partner is a non-smoker, do you smoke in the house?**
*Yes, I smoke inside* ❑ *No, only when he is out* ❑ *No, I smoke outside* ❑

**89. If you have children, do you smoke in the house?**
*Yes, I smoke inside* ❑ *No, only when they are out* ❑ *No, I smoke outside* ❑

**90. Are you aware that your smoking can cause harm to your partner/ children?**
*Yes, I am aware and smoke outside* ❑ *Yes, I am aware but still smoke inside* ❑
*No, I am not aware* ❑

**91. If you are a smoker, your children are more likely to become smokers, too. Does that concern you?**
*Yes* ❑ *No* ❑ *Do not know* ❑

**92. Would you stop smoking if you knew you were pregnant?**
*Yes* ❑ *Yes, I would try* ❑ *No* ❑

**93. Your partner smokes but you are a non-smoker. Do you mind?**
*Yes* ❑ *No* ❑ *Sometimes* ❑

e) STRESS

**94. Do you consider yourself a well-balanced person? (For example with your work, or social life)** *Yes* ❑ *No* ❑ *It varies* ❑

**95. Do you think you handle stress well?**
*Always* ❑ *Most of the time* ❑ *Sometimes* ❑ *Not really* ❑ *Not at all* ❑

**96. How do you think deaf & hearing people in general release their frustrations/ stress?**

| | *Deaf people* | | *Hearing people* | | *Yourself* | |
|---|---|---|---|---|---|---|
| | *Yes* | *No* | *Yes* | *No* | *Yes* | *No* |
| *Shout into the air* | | | | | | |
| *Get into a fight* | | | | | | |
| *Drink alcohol* | | | | | | |
| *Smoke* | | | | | | |
| *Not talk to anyone* | | | | | | |
| *Talk to your partner* | | | | | | |
| *Talk to your best friend* | | | | | | |
| *Listen to music* | | | | | | |
| *Get involved in sport* | | | | | | |
| *Indulge in food/ sweets* | | | | | | |
| *Stop eating* | | | | | | |
| *Argue with someone* | | | | | | |
| *Use breathy system as part of relaxation* | | | | | | |
| *Punch someone* | | | | | | |
| *Take up exercise* | | | | | | |
| *Other* _____ _____ __ | | | | | | |

**97. Where do you experience stress?**

| | *Frequently* | *Sometimes* | *Rarely/ never* |
|---|---|---|---|
| **At work:** | | | |
| *Too much work* | | | |
| *Overtime* | | | |
| *Understaffed* | | | |
| *Underpaid* | | | |
| *Boredom (not enough work or overqualified)* | | | |
| *Under-qualified* | | | |
| *Problems amongst colleagues* | | | |
| *Travel distance too far* | | | |
| **At home:** | | | |
| *Problems with your partner* | | | |
| *Problems with your children* | | | |
| *Problems with other family members* | | | |
| *Problems with neighbours* | | | |
| *Financial problems* | | | |
| *Health problems* | | | |
| **Other:** | | | |
| *Pressure from society* | | | |
| *Pressure from media* | | | |
| *Peer pressure* | | | |
| *Do not know* | | | |
| *Other* _____ | | | |

**98. How do you react to stress in general?**
*Stay calm* ❑ *Become irritable* ❑ *Become aggressive* ❑ *Become withdrawn* ❑

**99. Do you think that stress & pressure can be harmful?**
*Always* ❑ *Most of the time* ❑ *Sometimes* ❑ *Not really* ❑ *Not at all* ❑

**100. How harmful would you say stress & pressure is in your life?**
*Not harmful* ❑ *Harmful* ❑ *Very damaging* ❑

**101. Do you think deaf people experience more stress in their lives than hearing people?**
*Yes* ❑ *No* ❑ *Sometimes* ❑

# 15 Supplementary Health Questionnaire

Deaf Studies Trust

Deaf People, Information and the Community

A new project for deaf people and their views

FUNDED BY THE NATIONAL LOTTERY AND
MANAGED BY THE DEAF STUDIES TRUST

**Sixth Interview – Additional Information**

DATE OF INTERVIEW: ____ / ____ / 2000 INTERVIEWER: _____
START TIME: ____ : ____ END TIME: ____ : ____

Questionnaire

Participant Record Number: ___ _____

Male: ☐ Female: ☐

Date of Birth: ____ / ____ / 19 ____

**Household**

**1. Is the person 'head of household'? (DPIC Rep decides)**

- ❑ *Yes*
- ❑ *No*
- ❑ *Unsure (give relevant details)*

_____
_____
_____

**2. How long have you lived in your current house/flat?**

- ❑ *Less than 12 months*
- ❑ *Less than 2 years*
- ❑ *Less than 3 years*
- ❑ *Less than 5 years*
- ❑ *Less than 10 years*
- ❑ *10 years or more*

**3. Has your house/flat been burgled in the last 12 months?**

- ❑ *No*
- ❑ *Yes, reported to the police*
- ❑ *Yes, not reported to the police*

**4. What was the value of the goods stolen?**

- ❑ *Nothing stolen, nil value*
- ❑ *Under £100*
- ❑ *Under £200*
- ❑ *Under £500*
- ❑ *Under £1000*
- ❑ *Under £2000*
- ❑ *Under £5000*
- ❑ *£5000 or more*

**5. Did you have insurance for the things that were stolen?**

- ❑ *All insured*
- ❑ *Some insured*
- ❑ *Nothing insured*
- ❑ *Nothing of value stolen*

**Alcohol Consumption**

**6. Do you drink shandy (lager or bitter mixed with lemonade)?**

- ❑ *Yes*
- ❑ *No*

**7. How often do you drink shandy?**

- ❑ *Almost every day*
- ❑ *5 or 6 days a week*
- ❑ *3 or 4 days a week*
- ❑ *Once or twice a week*
- ❑ *Once or twice a month*
- ❑ *Once every couple of months*
- ❑ *Once or twice a year*
- ❑ *Not at all in the last 12 months*

**8. On a day when you drink shandy, how many pints would you drink?**

_____

**9. Do you drink beer, lager, cider or stout?**

- ❑ *Yes*
- ❑ *No*

**10. How often do you drink beer, lager, cider or stout?**

- ❑ *Almost every day*
- ❑ *5 or 6 days a week*
- ❑ *3 or 4 days a week*
- ❑ *Once or twice a week*
- ❑ *Once or twice a month*
- ❑ *Once every couple of months*
- ❑ *Once or twice a year*
- ❑ *Not at all in the last 12 months*

**11. On a day when you drink beer, lager, cider or stout, how many pints would you drink?**

_____

**12. Do you drink short drinks (e.g. vodka, rum, whisky)?**

- ❑ *Yes*
- ❑ *No*

**13. How often do you drink short drinks?**

- ❑ *Almost every day*
- ❑ *5 or 6 days a week*
- ❑ *3 or 4 days a week*
- ❑ *Once or twice a week*
- ❑ *Once or twice a month*
- ❑ *Once every couple of months*
- ❑ *Once or twice a year*
- ❑ *Not at all in the last 12 months*

**14. On a day when you drink short drinks, how many single measures would you drink?**

_____

**15. Do you drink sherry, port or martini?**

- ❑ *Yes*
- ❑ *No*

**16. How often do you drink sherry, port or martini?**

- ❑ *Almost every day*
- ❑ *5 or 6 days a week*
- ❑ *3 or 4 days a week*
- ❑ *Once or twice a week*
- ❑ *Once or twice a month*
- ❑ *Once every couple of months*
- ❑ *Once or twice a year*
- ❑ *Not at all in the last 12 months*

**17. On a day when you drink sherry, port or martini, how many small glasses would you drink?**

_____

**18. Do you drink wine?**

- ❑ *Yes*
- ❑ *No*

**19. How often do you drink wine?**

- ❑ *Almost every day*
- ❑ *5 or 6 days a week*
- ❑ *3 or 4 days a week*
- ❑ *Once or twice a week*
- ❑ *Once or twice a month*
- ❑ *Once every couple of months*
- ❑ *Once or twice a year*
- ❑ *Not at all in the last 12 months*

**20. On a day when you drink wine, how many glasses would you drink?**

_____

**Smoking Behaviour**

**21. Do you smoke?**

- ❑ *Smoker*
- ❑ *Non-smoker*

**22. Have you ever smoked a cigarette, cigar or pipe?**

- ❑ *Yes, regularly*
- ❑ *Yes, just a few times*
- ❑ *No*

**23. How old were you when you started smoking regularly?**

_____

**24. How many cigarettes do you normally smoke a day at weekends?**

_____

**25. How many cigarettes do you normally smoke a day on weekdays?**

_____

**26. Which type of cigarette do you mainly smoke?**

- ❑ *Filtered*
- ❑ *Unfiltered*
- ❑ *Self-rolled (with filters)*
- ❑ *Self-rolled (without filters)*

**27. Which brand of cigarette do you normally smoke?**

**a. Brand (e.g. B&H, Marlboro Light) _____**
**b. Size (e.g. king-size, superking) _____**
**c. Tar level (if known) _____** *mg*

**Visiting GP/Hospital**

**28. In the last 2 weeks, did you go to a doctor (not including hospital)?**

❑ *Yes, ___ times*
❑ *No*

**29. Where did you consult the doctor?**

❑ *GP surgery*
❑ *At home*
❑ *By minicom*
❑ *Video conferencing on a computer*
❑ *NHS Helpline (via TypeTalk)*
❑ *Other (specify)* _____

**30. Have you used the WWW to tell you what is wrong with you?**

❑ *Yes*
❑ *No*

**31. Was there an interpreter?**

❑ *Yes, a professional sign language interpreter*
❑ *Yes, a family member*
❑ *Yes, a friend*
❑ *Yes, other* _____
❑ *No*

**32. Did the doctor give you a prescription?**

❑ *Yes*
❑ *No*

**33. In the last 3 months, did you attend casualty or an outpatient department?**

❑ *Yes, ___ times*
❑ *No*

**34. During the last year, have you been treated in hospital as a day patient?**

- ❑ *Yes, ____ times*
- ❑ *No*

**35. During the last year, have you been treated in hospital as an inpatient?**

- ❑ *Yes, ____ times*
- ❑ *No*

**36. For each stay as an inpatient, how many nights did you spend in hospital?**

____ ____ ____ ____ ____

**37. Have you ever asked a pharmacist for health advice?**

- ❑ *Yes*
- ❑ *No*

**38. When collecting a prescription, has a pharmacist given you information about the pills/tablets?**

- ❑ *Yes*
- ❑ *No*

**39. How did you communicate with the pharmacist?**

- ❑ *BSL*
- ❑ *BSL with English*
- ❑ *Speech*
- ❑ *Gesture*
- ❑ *Writing down*

**Housing**

**40. What kind of accommodation do you live in?**

- ❑ *Detached house*
- ❑ *Semi-detached house*
- ❑ *Terraced house*
- ❑ *Purpose-built flat/maisonette*
- ❑ *Converted flat/maisonette*
- ❑ *Business premises*
- ❑ *Other (specify)* _____

**41. Do you own your accommodation?**

- ❑ *Owned and paid for*
- ❑ *Owned, and paying mortgage*
- ❑ *Rented, from council*
- ❑ *Rented, from housing association*
- ❑ *Rented, with job*
- ❑ *Rented privately (part-furnished or unfurnished)*
- ❑ *Rented privately (furnished)*

**42. When was your accommodation built?**

- ❑ *Before 1919*
- ❑ *1919-1944*
- ❑ *1945-1964*
- ❑ *1965-1984*
- ❑ *1985 or later*
- ❑ *Do not know*

**43. Who lives in your house, and how old are they?**

| Person (e.g. Mother, Husband, Friend, Son) | Male or Female? | Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

***DPIC Office use only: Code Household Type*** _____

**44. How many rooms does your house/flat have?**

_____

**45. How many of those rooms are bedrooms?**

_____

**46. Does a married couple live in the house/flat?**

❑ *Yes* ❑ *No*

***DPIC Office use only: Code Bedroom Standard*** _____

# 16 Deaf as Disabled Questionnaire

**Deaf People, Information and the Community**

**A new project for deaf people and their views**

Funded by the National Lottery and
managed by the Deaf Studies Trust

*First interview – Deaf as "Disabled"*

Date of Interview: _____ Interviewer: _____

Start time: _____ End time: _____

---

***Questionnaire***

1. **Participant Record Number:** _____
2. **Male:** ❑ **Female:** ❑
3. **Date of Birth:** Day: _____ Month: _____ Year: 19_____

*a) Background*

**4. Do you consider yourself as "disabled"?**

| *Yes* | | *No* | |
|---|---|---|---|
| *Cannot hear - disabled* | | *Belong to linguistic minority* | |
| *Discrimination from using BSL* | | *Deaf same as hearing* | |
| *Physical impairment (not Deafness)* | | *No physical impairment* | |
| *Other* _____ | | *Other* _____ | |

**5. Are you a member of disability organisations (not Deaf organisations)?**

| *Name of Organisations:* |
|---|
| |
| |
| |

**6. Are you registered with your local Social Services department? What category are you registered under?**

*Yes, Deaf without speech* ❑ *Yes, Deaf with speech* ❑ *Yes, hard of hearing* ❑
*Yes, not sure which category* ❑ *No* ❑

*b) Disability Benefits – Social Security*

**7. Do you know what Disability Living Allowance (DLA) is?**

*Yes* ❑ *(go to Q8)* *No* ❑ *(go to Q16 on next page)*

**8. Have you claimed DLA?**

| *Yes* | | *No – why not?* | |
|---|---|---|---|
| *Receiving DLA (go to Q9)* | | *Cannot be bothered** | |
| *Waiting for response** | | *Do not think I will get it** | |
| *Claim refused** | | *Do not want to get it** | |
| *Claim refused, appealed ___ times** | | *Do not know how to get it** | |
| | | *Other _____** | |

*(* go to Q16 on the next page)*

**9. When did you start receiving DLA?**

_____ (month) _____ (year)

**10. When did you apply for DLA?**

_____ (month) _____ (year)

**11. Was your claim refused at first and you appealed?**

*No, got DLA without appealing* ❑ *Yes, got DLA after ___ appeals* ❑

**12. What do you use the DLA for?**

*Interpreters* ❑ *Special equipment* ❑ *Compensation for extra stress* ❑
*General expenses* ❑ *Other* ❑ _____

**13. What do you receive?**

| | *High rate* | *Middle rate* | *Low rate* | *Not sure, do not know* |
|---|---|---|---|---|
| *Care Component* | | | | |
| *Mobility Component* | | | | |

**14. Is there anything else apart from Deafness you are claiming DLA for?**

*Yes, visual impairment* ❑ *Yes, physical mobility related needs* ❑
*Yes, other* ❑ _____ _____ *No* ❑

***15. [INTERVIEWER USE ONLY]: Further notes on interviewee and DLA.***

_____

_____

**16. Do you know what Severe Disability Allowance (SDA) is?**

*Yes* ❑ *(go to Q17) No* ❑ *(go to Q24 on next page)*

**17. Have you claimed SDA?**

| *Yes* | | *No – why?* | |
|---|---|---|---|
| *Receiving SDA (go to Q18)* | | *Cannot be bothered** | |
| *Waiting for response** | | *Do not think I will get it** | |
| *Claim refused** | | *Do not want to get it** | |
| *Claim refused, appealed ___ times** | | *Do not know how to get it** | |
| | | *Other* _____* | |

*(* go to Q 24 on next page)*

**18. When did you start receiving SDA?**

_____ (month) _____ (year)

**19. When did you apply for SDA?**

_____ (month) _____ (year)

**20. Was your claim refused at first and you appealed?**

*No, got SDA without appealing* ❑ *Yes, got SDA after ___ appeals* ❑

**21. What do you use the SDA for?**

*Interpreters* ❑ *Special equipment* ❑ *Compensation for extra stress* ❑
*General expenses* ❑ *Other* ❑ _____

**22. Is there anything else apart from Deafness you are claiming SDA for?**

*Yes, visual impairment* ❑ *Yes, physical mobility related impairment* ❑
*Yes, other* ❑ _____ _____ *No* ❑

*23. [INTERVIEWER USE ONLY]: Further notes on interviewee and SDA.*

_____

_____

**24. Do you know what Disabled Working Allowance (DWA) is?**

*Yes* ❑ *(go to Q25) No* ❑ *(go to Q32 on next page)*

**25. Have you claimed DWA?**

| *Yes* | | *No – why not?* | |
|---|---|---|---|
| *Receiving DWA (go to Q26)* | | *Cannot be bothered** | |
| *Waiting for response** | | *Do not think I will get it** | |
| *Claim refused** | | *Do not want to get it** | |
| *Claim refused, appealed ___ times** | | *Do not know how to get it** | |
| | | *Other* _____* | |

*(* means go to Q32 on the next page)*

**26. When did you start receiving DWA?**

_____ (month) _____ (year)

**27. When did you apply for DWA?**

_____ (month) _____ (year)

**28. Was your claim refused at first and you appealed?**

*No, got DWA without appealing* ❑ *Yes, got DWA after ___ appeals* ❑

**29. What do you use the DWA for?**

*Interpreters* ❑ *Special equipment* ❑ *Compensation for extra stress* ❑
*General expenses* ❑ *Other* ❑ _____

**30. Is there anything else apart from Deafness you are claiming DWA for?**

*Yes, visual impairment* ❑ *Yes, physical mobility related impairment* ❑
*Yes, other* ❑ _____ _____ *No* ❑

*31. [INTERVIEWER USE ONLY]: Further notes on interviewee and DWA.*

_____

_____

*c) Other Benefits – Social Security*

**32. Do you know what this benefit is for:**

| *Type of Benefit* | *Do you know what this is for?* | | *Do you know how to get it?* | | *Have you claimed for it?* | |
|---|---|---|---|---|---|---|
| | *Yes* | *No* | *Yes* | *No* | *Yes* | *No* |
| *Child Benefit* | | | | | | |
| *Council Tax Benefit* | | | | | | |
| *Employment Rehabilitation Allowance* | | | | | | |
| *Family Credit* | | | | | | |
| *Housing Benefit* | | | | | | |
| *Jobseekers Allowance* | | | | | | |
| *Retirement Pension* | | | | | | |
| *Social Fund* | | | | | | |
| *Widows Pension* | | | | | | |
| *Statutory Maternity Pay* | | | | | | |
| *Statutory Sick Pay* | | | | | | |

*d) Disability Benefits – Other*

**33. Do you have an Typetalk account?**

*Yes* ❑ *No, do not use Typetalk* ❑ *No, use other person's account* ❑

**34. How often do you make Typetalk calls?**

*Every day:* ❑ *At least once a week:* ❑ *Once a month*: ❑ *Rarely*: ❑ *Never:* ❑

**35. Do hearing people call you through Typetalk?**

*Every day:* ❑ *At least once a week:* ❑ *Once a month*: ❑ *Rarely*: ❑ *Never:* ❑

**36. Do you know that BT offers a Text Users Rebate Scheme – 60% off your phone calls?**

*Yes, I am registered in scheme* ❑ *Yes, but not registered in scheme* ❑ *No* ❑

**37. Do you get any benefits that are generally available to disabled people (excluding Social Security benefits)?**

| *Type of Benefit* | *Received?* |
|---|---|
| *Workplace support from PACT* | |
| *Disability Railcard* | |
| *London Travel Permit* | |
| *Other Metropolitan Travel Permit* | |
| *Free or Reduced Price Entry into Sports Facilities* | |
| *Free or Reduced Price Entry into Museums* | |
| *Free or Reduced Price Entry into Arts Events* | |
| *Other* _____ | |
| *Other* _____ | |
| *Other* _____ | |
| *Other* _____ | |

*e) Disability Issues*

**38. Do you know that there is a Disability Discrimination Act 1995?**

*Yes* ❑ *(go to Q39)* *No* ❑ *(go to Q40)*

**39. If you felt that you were being discriminated against and it was against the DDA, what would you do?**

*Ask a friend* ❑ *Ask a social worker* ❑ *Ask my legal firm* ❑
*Other* ❑ _____ *Do not know* ❑

**40. Do you know about the green card for disabled people for employment?**

*Yes* ❑ *(go to Q41)* *No* ❑ *(go to Q42)*

**41. Are you aware that the green card is no longer used?**

*Yes* ❑ *No* ❑

**42. Are you aware of the government Green Paper on Special Education Needs?**

*Yes* ❑ *(go to Q43)* *No* ❑ *(go to Q44)*

**43. Are you aware that it could affect the education of Deaf children?**

*Yes* ❑ *No* ❑

*f) Views on Deafness*

**44. What do you think about Deaf people, are they:**

| | *Extremely* | *Very* | *Slightly* | *Neither nor* | *Slightly* | *Very* | *Extremely* | |
|---|---|---|---|---|---|---|---|---|
| | *1* | *2* | *3* | *4* | *5* | *6* | *7* | |
| *Interesting* | | | | | | | | *Boring* |
| *Sociable* | | | | | | | | *Withdrawn* |
| *Calm* | | | | | | | | *Excitable* |
| *Insecure* | | | | | | | | *Confident* |
| *Vacant-looking* | | | | | | | | *Alert-looking* |
| *Quiet* | | | | | | | | *Noisy* |
| *Self-reliant* | | | | | | | | *Demanding* |
| *Clumsy* | | | | | | | | *Well-coordinated* |
| *Precise* | | | | | | | | *Vague* |
| *Shunned* | | | | | | | | *Respected* |

**45. Would you say that deaf people go out to clubs, pubs and parties as often as hearing people:**

*As often as hearing people:* ❑ *Less than hearing people:* ❑

*More than hearing people:* ❑

**46. Do you think the following problems or difficulties deaf people may have are:**

| | *Certainly true* | *Probably true* | *Neither nor* | *Probably false* | *Certainly false* | *Do not know* |
|---|---|---|---|---|---|---|
| | *1* | *2* | *3* | *4* | *5* | *6* |
| *Deaf people feel very isolated because of problems they have communicating* | | | | | | |
| *Deaf people seem to have fewer interests than hearing people* | | | | | | |
| *Deaf people have more difficulty in coping with everyday activities around the home than hearing people* | | | | | | |
| *Deaf people are less likely to take part in sports and games than hearing people* | | | | | | |
| *Deaf people seem generally less intelligent than hearing people* | | | | | | |
| *Deaf people face more hazards in travelling and getting about than hearing people* | | | | | | |
| *Deaf people are unable to keep up with what is going on in the world through the news media* | | | | | | |
| *Deaf people seem to have more than the usual number of <u>other</u> physical complaints* | | | | | | |
| *Deaf people have more problems in banks, post offices, and shops than hearing people* | | | | | | |
| *Deaf people have more difficulty getting on with people at work than hearing people* | | | | | | |
| *Deaf people frequently seem to behave rather oddly* | | | | | | |

**47. When deaf people bring up their children, do they have:**

*Less problems than hearing parents* ❑ *More problems than hearing parents* ❑

*Same problems as hearing parents* ❑

**48. If you had a choice between those conditions, please rank from 1 to 6 which one you prefer, 1 being least preferred and 6 being most preferred:**

| | *1 to 6* |
|---|---|
| *Total deafness* | |
| *Blindness* | |
| *Epilepsy* | |
| *Confined to a wheelchair* | |
| *Losing a leg* | |
| *Having a heart condition* | |

**49. Do you think Deaf people usually have good jobs?**

*Very good jobs* ❑ *Good jobs* ❑ *Not sure* ❑ *Bad jobs* ❑ *Very bad jobs* ❑

**50. Do you agree with the following statements:**

| | *Yes* | *No* | *Unsure* |
|---|---|---|---|
| *Deaf people cannot really work equally to hearing people* | | | |
| *Deaf people are not as clever as hearing people and therefore get poorer jobs* | | | |
| *Deaf people are lazy at school and do not get school qualifications* | | | |
| *Deaf people should have factories to themselves like blind people* | | | |
| *Factories or offices which have some deaf workers should have an interpreter* | | | |
| *Factories or offices which have some deaf workers should let them interview other deaf people looking for jobs* | | | |
| *Hearing people never understand deaf people at work* | | | |
| *Although the job is explained, deaf people never work very hard* | | | |
| *Deaf people could go to night school to get more qualifications for the job* | | | |
| *Deaf people should learn to speak better to help them at work* | | | |
| *There should always be more than one deaf person in a factory or office so that they can explain the job to each other* | | | |
| *Deaf people never really try to talk to hearing people at lunchtime or tea breaks* | | | |

**51. Do you think deaf people could do the following jobs:**

| | *Yes* | *No* | *Do not know* |
|---|---|---|---|
| *Social Worker* | | | |
| *Chaplain* | | | |
| *Doctor* | | | |
| *Teacher* | | | |
| *Lawyer* | | | |
| *Bus or lorry driver* | | | |
| *Member of Parliament (MP)* | | | |
| *Shop Assistant* | | | |
| *Managing Director* | | | |
| *Civil Service* | | | |
| *Actor* | | | |
| *Engineer* | | | |
| *Supervisor in a factory* | | | |
| *Supervisor in an office* | | | |
| *Hair Stylist* | | | |
| *Nurse* | | | |