

HEALTH AND SOCIAL SERVICE NEEDS
OF
PEOPLE AGED 85 AND OVER
LIVING IN CITY & HACKNEY

MAIN REPORT

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INTRODUCTION

Robinson (1971), when discussing differential attitudes to ill-health among the social classes, stated that there is a "working-class tendency to see illness, however cruel and unfair, as a fact of life to be lived with". This tendency has also been assigned to the elderly, all of whom at some stage after the age of 65 will experience to some degree the degenerative process of old age:-

"Old people will often attempt to cure illness by themselves rather than consult a doctor, sometimes because of pride, or perhaps because of fear of complicated modern medical technology and jargon or because of their desire to admit illness, neither publicly nor to themselves."
(Age Concern, 1977).

To what extent are these beliefs about the elderly's perceptions of their health, in the broad physical, psychological and social meaning of the term, and underuse of services, grounded in evidence?

A number of studies have reported that people aged 65 and over tend to underconsult and would benefit from programmes designed to screen them for selected conditions. Williamson et al (1964) showed that people aged over 65 have an average of three disabling conditions, half of which were unknown to their GP, before screening was implemented, and the majority were treatable. A number of similar studies have been undertaken by GPs on their own patients. Williams (1974; 1984) found that 27% of his own patients studied were classified as benefiting from a yearly follow-up by their general practitioner. Pike (1976) claimed that such screening led to lower consultation rates. A study by Barber et al (1978) of a sample of their elderly patients also showed that serial assessments of the elderly can be worthwhile. Even among elderly patients known to their practice, an average of 6.4 health and social problems were detected upon initial screening. The proportion fell to 4.8 by the time of the second assessment. Since the 1960's there have been a number of similar findings (Burns, 1969; Williams et al, 1972; Currie et al, 1974; Pike, 1976).

The annual General Household Survey asks respondents about the presence of chronic sickness (longstanding illness and longstanding limiting illness). The data indicate the higher prevalence of both among older age groups as compared with other ages, and the higher proportion of elderly women sufferers. The proportions reporting limiting longstanding illness range from 27% for ages 45-64, 43% for ages 65-74 to 54% for people aged 75 and over. The proportions reporting longstanding illness vary from 44% for people aged 45-64, 61% for ages 65-74 and 69% for people aged 75 and over (OPCS 1984).

Harris' (1971) survey estimated that arthritis was the main cause of handicap for 40% of those aged 65 and over who were impaired. This survey was the first national survey of disability in Britain among people aged 16 and over living at home. It was reported that there were at least three million people with impairments in Britain, half of the men and two thirds of the women being over 65. The criteria for inclusion in the categories of impairment and handicap largely related to locomotor restrictions and self care measures, so that handicaps arising from conditions such as deafness were underestimated. The survey showed that 27% of people aged 65 and over suffer from some form of impairment which interfered with their daily life. Just over

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11% were regarded as appreciably handicapped to the extent that they needed help in performing routine self care tasks and might be able to go out with difficulty. For those over 75 the figures rise to 37% and 17% respectively. It can be estimated from the survey that about 5% of people aged 65+ are housebound, the proportion being highest at 13% for women aged 75+. The problems they experience vary with age, sex and social class, available help and facilities (i.e. those living further from shops and nearer busy roads may have more acute problems getting around outside if they have mobility restrictions).

On the other hand, those who are housebound still represent a small minority of the population of retired people (probably less than a third of those aged 80+ and only about 6% of those aged 65-74). Houseboundness itself is also sometimes a short term state, but which can lead to increased morbidity and mortality. The majority of people aged 65+ are not functionally impaired although this does increase with age, and certainly the majority of those aged 75+ reported longstanding illness in the special GHS on the elderly (OPCS 1983).

Surveys have also shown that most people in all age groups perceive their health to be good for their age (Luker and Perkins, 1987; OPCS, 1985; Cartwright and Anderson, 1981).

The elderly also tend to report better health as they get older, and it has been suggested that this is due to the attribution of ailments to ageing rather than declining health (Williamson et al, 1964; Anderson, 1978). It is possible that those who survive into later old age are healthier than the younger elderly due to selective mortality.

In relation to younger age groups, the elderly are heavy consumers of health and social services. About 15% of health and social services expenditure is devoted to services mainly for the elderly and physically handicapped (Office of Health Economics, 1977) and people aged over 65 account for about 45% of both hospital in-patients and general practitioners' patients (Brocklehurst and Hanley, 1976). The average number of consultations with a GP per person per year is 7 for people aged 75+, 6 for those aged 65-74 in comparison with 4 for ages 45-64 (OPCS 1984).

However, the place of screening programmes in general practice remains controversial. This is because a number of more recent studies have questioned the need for screening, presenting evidence showing few differences in morbidity between elderly people who consult their GP and those who do not (Ebrahim et al, 1984). Freedman et al (1978), in a study of their patients in a general practice population, noted that although many positive symptoms and physical signs were identified by medical examination, the majority were either known to the GP, or were not relevant to their health and well-being. Tullock and Moore (1979) reached the same conclusions in a similar survey, assessing 88% of their patients to be well adapted ("come to terms with") to their problems.

Again, Williams and Barley (1985) divided their patients aged 75+ into two groups according to the GP's knowledge about them, designated as "risk status known" and "risk status not known". The vast majority fell into the first category according to the perceptions of the GPs. On personal assessment it was found that those falling into the "risk status not known" group had appreciably less contact with their GPs but also had lower risk sources (e.g. number of hospital admissions, assessments of ability to cope), were less likely to be confined at home because of ill health, were less concerned about their health and

were less in need of nursing care.

Ford and Taylor (1985), sociologists in Scotland, took a random sample of people aged 60 and over from a random sample of general practices. They concluded on the basis of their findings that underconsultation among the elderly is exaggerated. They also found little evidence among their respondents for the suggestion that the elderly tend to wrongly ascribe their symptoms to ageing. They found close relationships between self rated severity of reported chronic conditions (e.g. arthritis/rheumatism) and consultation rates. Three quarters of those rating their problems as severe had consulted over them in the last year, in contrast to 29% rating them as mild. The authors concluded that for the majority of elderly the system of self referral operates better than previously supposed. They argued that the undetected problems of the elderly had been exaggerated partly due to continual reference to early studies which no longer described their situation. They argued that increasing use of age-sex registers by GPs has led to higher disease detection rates. Further, they suggested that there has been an uncritical use of consultation estimates based on the prevalence of disease rather than unreported illness, which neglects the distinction between the symptomatic and asymptomatic.

"Patients cannot be expected to consult for diseases of which they are unaware. Moreover, it is questionable whether they should be expected to consult for those illnesses which have little effect on their functioning and life style". (Ford and Taylor, 1985).

Other recent surveys carried out by social services and health authority departments have reported unmet need among the elderly. The discrepancy may be accounted for by GP surveys being largely disease orientated, ignoring wider health needs such as need for occupational therapy, physiotherapy, social and psychological needs such as loneliness and depression. Various surveys have found loneliness to be a problem for between a quarter and a half of the elderly (Jones et al, 1985; Bowling and Cartwright, 1982). This appears to be related to disability and loss of support (e.g. bereavement). On the other hand, this is a minority, but like Ford and Taylor's minority of underconsulters with severe problems (around a quarter) it is a large minority and their problems should not be underestimated. It appears that there are few discrepancies between surveys but, while some authors emphasise, and draw attention to the needs of the minority, others emphasise the well-being of the majority.

A survey funded by Newham Health Authority of people aged 65+, based on GP's age-sex registers and other registers, found that about a quarter of respondents were regarded by the health visitor interviewers as socially isolated, over a third reported experiencing illness in the last three months. 28% reported handicap in terms of getting around their homes and 78% reported a longstanding or chronic illness. Depression was reported for 15% of the sample. However, these problems were not necessarily unreported, in support of Ford and Taylor's conclusions: 83% had seen their GP within the past 12 months and 48% within the past month. There was no information about the content of their consultations, although a third reported having a general medical check-up in the past year and a half had their blood pressure taken. On the other hand, the health visitors assessed 36% as requiring follow-up visits by either health visitors on criteria such as age, chronic illness, severe disability or isolation. The authors recommended opportunistic screening by GPs and "selective screenings" of targetted "at risk" elderly people.

Although 36% was a minority it was a large minority. Possibly health visitors' criteria of need are different from those of GPs. Similar local surveys have produced comparable findings (Carpenter and Demopouls, 1985; Holmes and Mazells, 1986; Clarke et al, 1985). Clarke et al did comment that the level of unmet need was lower than expected and although a third of their sample had received chiropody in the past year, 21% had a home help and 80% had seen their GP, few other services were utilised (e.g. meals on wheels, health visiting). Possibly variation between surveys also reflects area, demographic and service provision differences.

Jayararatnam (1987) concluded on the basis of the Newham survey that so many problems were detected by the health visitor interviewers, despite respondents' high levels of contact with their GPs that the GP was not the best person to carry out comprehensive assessments of elderly people.

If need is defined yet more broadly to incorporate the needs of informal carers, further gaps in service provision would be found. Elderly people often enter institutional care due to stress on their carers, usually daughters (Townsend, 1965; Isaac, 1971). A number of studies have found that the family is the main source of care for the elderly and they, in turn, receive little support (Jones and Vetter, 1984; Bowling, 1985; Bowling and Salvage, 1985). A survey in City and Hackney of people on waiting lists for residential and long stay geriatric care estimated that provision of services such as home helps, meals on wheels, and carer relief for short periods might prevent institutionalisation of at least two thirds of the applicants to residential care. Voluntary visitors to relieve elderly people's loneliness was another major factor mentioned (Bowling and Salvage, 1985). On the other hand, the elderly in long stay institutions form the minority 5% of those aged 65+, although the proportion increases to 19% of those aged 85+ (OPCS, 1984).

Some health authorities have tried to screen their elderly populations. However, they have experienced difficulties tracing them even through Family Practitioner Committee lists and GPs' age/sex registers (Bowling, 1985). The recent Cumberlege Report on Community Nursing (DHSS 1986) recommended the use of FPC lists in order to identify service needs of local populations (e.g. by showing where people in different age groups live). But FPC lists, based on GPs lists, are not accurate and are out of date in terms of people who have moved or died. It is possible that those elderly people who have recently moved are in greater need of medical help (Graham and Livesy 1986).

AIMS OF SURVEY

The study of health and social services needs of people aged 85+ in City and Hackney, funded with joint finance, was commissioned by members of City & Hackney Health Authority and Social Services Department.

The Social Services member requested a complete census, rather than a random sample, of people aged 85 and over living at home in the borough, in order that services could be planned more precisely.

It was decided to concentrate the study on people aged 85 and over as the very elderly represent the fastest growing section of many Western Countries' populations (OPCS, 1985), and are an expensive group of consumers. Little is known about the health and social circumstances of the very elderly, despite a large number of surveys of all people aged 65+ (Bury, 1986).

There are approximately 10,000 people aged 75+ in City & Hackney -5.4% of the local population. About half of these (5,300) are aged over 80, and almost a fifth (1,700) are aged 85 and over, according to the last census, although 19% (300) of these would be living in institutions (OPCS, 1984). This leaves 1,400 living in their own homes.

Demographically, City & Hackney need to plan for a 2-3 per cent population growth in terms of planning services for the elderly, needs have to be substantiated by research in order to sustain the increase in service provision. Quantifiable data for planning purposes is now essential.

The survey aimed to identify people aged 85+ living in the borough and to:-

1. Measure need for health and social services
2. Measure disability
3. Measure life satisfaction
(Neugarten and 'Delighted-Terrible' Faces Scales)
4. Measure mental disturbance (General Health Questionnaire)
5. Measure level of informal support (Social Network Scale)

It was hypothesised, on the basis of previous surveys, that there would be a large minority of people aged 85+ with unmet needs for health and social services, a high level of informal support, and high levels of physical impairment.

The Family Practitioner Committee's records of general practitioners' patients in City and Hackney was used as the sampling frame (it was acknowledged that this would be somewhat out of date, but this was the best sampling frame available). The aim was to screen the sample with a questionnaire appropriate for detecting need and only interview those with more than one "risk" factor, to reduce the sample size for economic reasons. The screening questionnaire was based on that designed by Barber to identify certain 'risk' factors among the elderly, and which has been frequently used by researchers and GPs to identify vulnerable elderly people (Barber et al 1980).

The Barber screening questionnaire is a 9 item checklist derived from a longer screening instrument in use in the author's practice. 'Yes' and 'No' answers are simply ticked by respondents. The questions were selected by Barber et al to represent "important aspects of health and wellbeing":-

BARBER ET AL'S (1985) SCREENING QUESTIONNAIRE

Do you live on your own?	Yes	No
Are you without a relation?	Yes	No
Do you depend on someone for regular help?	Yes	No
Are there any days when you are unable to have a hot meal?	Yes	No
Are you confined to your home through ill health?	Yes	No
Is there anything about your health causing you concern or difficulty?	Yes	No
Do you have difficulty with vision?	Yes	No
Do you have difficulty with hearing?	Yes	No
Have you been in hospital during the past year?	Yes	No

Barber et al (1980) justify the use of broad questions by referring to the importance of biasing the screening instrument towards including false positives, in order to minimize the possibility that patients with "real and important" problems might go undetected.

We modified this questionnaire slightly for the present study (See Appendix A) - 'need for regular help' was confined to housework/shopping to make the question more meaningful for analysis. Ability to 'have a hot meal' was changed to ability to 'prepare hot meals for self' for the same reason. 'Confined to home' was extended to include 'other reasons' with ill health. The reasoning was that some elderly people might not define their immobility as 'ill health'. We included consultation with GP in the past 12 months as a further factor indicating 'need', given the previous literature.

The researchers had misgivings about the sensitivity of some of the questions - for example, many elderly people have difficulty with sight and hearing and, without asking about severity, their meaning as "risk factors" is unknown. It is uncertain whether such problems could be corrected. Moreover, although researchers list 'hospitalisation in the last year' as a 'risk factor' it is unknown what it is a 'risk' factor for (Ford and Taylor, 1985). The concept of 'risk' is rarely defined or critically analysed.

These questions were utilised for the screening study for comparative purposes. For the main study, respondents were asked about 'major illness, operations, accidents or falls' within the past 12 months instead of hospital stays. It was felt that all major health events - whether they occurred in the home or involved a transfer to hospital - should be analysed as a 'risk factor' indicating possible need for follow-up health care.

The researcher designed the interview questionnaire measuring need, quality and life satisfaction, mental state and social network. Measures used were taken from previous surveys of the elderly and well validated rating scales (Neugarten's Life Satisfaction Scale, Goldberg's General Health Questionnaire, Social Networks Scale, Delighted-Terrible Faces Scale, adapted versions of Katz ADL (1963) and Townsends ADL (1979) Scales (see Bowling and Salvage 1984)). The questionnaire took one hour to administer, although interviewers were frequently with respondents for between two and three hours. Respondents appeared to enjoy being interviewed and often thanked the interviewers for calling.

Names and addresses of people aged 85+ living in their own homes in City & Hackney (not institutions) were manually extracted from the card indexes held at the FPC. The cards are listed alphabetically by name of GP for the whole of City and East London FPC area. This took six weeks clerical help (full time).

The FPC lists were finally found to contain the names and addresses of 3,018 people living in their own homes.

According to the last census, the number of people aged 85+ living at home in City & Hackney was 1,400 - 46% of the number listed by the FPC.

People were then divided into those registered with health centre practices (n=1043) and those with other practices (1975). As it was known that local GPs in health centres often checked on their elderly patients, the Department of Community Medicine wished to obtain their agreement to include their patients in our study.

While agreement was being checked with health centres, all other patients were sent a postal screening questionnaire (n=1975). The mailing of these questionnaires, together with a stamped addressed envelope, a letter of translation into the other languages spoken in the borough, a covering letter, and the allocation of serial numbers took two months (full time) clerical help, plus additional assistance from a student attached to the Department.

Over the next two months over a thousand of the 1,975 screening questionnaires were returned by respondents, the GPO, or new occupants at the mailed address.

Table 1 shows the results of the screening questionnaire to the 1,975 non-health centre patients. The response rate was 56%.

Most patients who returned the questionnaire, who indicated that they did not wish to be interviewed, often commented that they were 'alright' or did 'not need anything'.

Table 1

RESULTS OF SCREENING QUESTIONNAIRE TO NON-HEALTH CENTRE PATIENTS

Basis 1975

<u>SCREENING PHASE</u>		
Post Office returns/ returned by new occupants at address		
Respondent returns:	278	14%
"Yes" to interview	682)	35%
) 826	
"No" to interview	144)	7%
Questionnaire was not returned/ no response	871	44%
<hr/>		
No. of screened patients:	1975	100%

The checking in of these questionnaires and compiling of address lists for interviewers by postal district occupied two clerical workers (full time) for the next two months. As the vast majority of respondents had three or more risk factors it was decided to include all those willing to be interviewed in the sample (See Table 2). Given that the non-response rate was fairly high (44%) it was also decided to attempt to personally contact and interview the non responders, so these people were also allocated to interviewers. In order to check whether people were still resident at the given addresses, patients were first checked on the electoral roll and only those listed were given to interviewers. Most elderly people are on the electoral register (Cartwright and Smith, 1987; Todd & Butcher, 1982) - the problem with registrations among the elderly being with blanks: people's names are not always removed from the roll after they die or move. This checking took four weeks' clerical help (full time). Health centre patients were all passed to interviewers except those no longer at the listed address on the electoral role. It was decided not to send them a screening questionnaire first in view of the poor response rate from non health centre patients.

Table 2 shows that around two thirds of respondents lived alone and a fifth said that they had no relative, friend or neighbour to turn to for help. Although this is a significant minority of people who had no one to turn to, the corollary is that the vast majority did have someone they could rely on.

Almost two thirds needed regular help with housework or shopping and

about a third reported that some days they were unable to prepare a hot meal. About half said they were confined to their homes through ill health or some other reason.

Forty per cent reported worries they wanted advice on, 56% had problems with eyesight and 48% with hearing. About a quarter had been in hospital during the past 12 months and around three quarters had seen their GPs in the last 12 months.

Most people (93%) reported three or more risk factors, and as Table 3 shows the risks asked about were fairly major (with the possible exception of problems with eyesight and hearing, the scale of these problems was not identified on the questionnaire). Just 1% of respondents who wanted to be interviewed had no 'risk' factors, 2% reported one, and 4% had two. Three per cent reported all 10 'risk' factors.

Although the proportion reporting they were housebound, and needed help with shopping/housework is large, this needs balancing against the 80% who did have a relative, friend or neighbour they could rely on for help. However, the screening questions were too general to give a precise indication of the degree of need. A recent collection of papers published by the Royal College of General Practitioners includes suggestions for refining the Barber questionnaire (Taylor & Buckley 1987). The exact nature of the situation of those reporting problems was measured more accurately by the interviewers.

The main survey found that slightly more respondents who were interviewed, than those returning the screening questionnaire, had consulted their GPs in the last 12 months (86%:76%), and more had relatives, friends or neighbours who they could rely on for help (93%:80%). It is possible, that some people exaggerated their problems on the screening questionnaire in order to ensure an interview. Under-estimation of problems during the interviews is unlikely due to their intensive nature and detailed measures used. Similar proportions lived alone, had problems with eyesight and hearing and were housebound. This suggests the need to identify the circumstances of the personal interview rather than reliance on a postal questionnaire.

Table 2

COMPLETED RESPONSES TO SCREENING QUESTIONNAIRES BY PEOPLE INDICATING THEY WANTED TO BE INTERVIEWED. (NON HEALTH CENTRE PATIENTS)

	No	%
Lives alone	365	65
Has no relative, friend or neighbour to rely on for help	111	20
Needs regular help with housework/shopping	332	60
Not always able to prepare hot meals for self	179	32
Confined to home through ill health/other reasons	270	52
Has worries would like advice on	197	40
Has problems with eyesight	311	56
Has difficulty with hearing	264	48
Has been in hospital during past 12 months	131	24
Has seen GP during last 12 months	417	76

Response per Question varied from 517-565*

*Total does not equal 682 as not all screening questionnaires were completed.

Checks were made on the representativeness of the non responders who refused an interview, and who were never in, in relation to the rest of the sample. Their GPs were asked to give us basic information about a random sample of 72 (19%) of the 379 non responders. The 72 patients had 39 GPs between them. Of these, GPs refused to provide the information without a signed consent form from the patient in 9 cases; 11 patients were no longer registered with the listed GPs (the GPs did not know whether they had moved or died), 3 had died and 1 had gone into Part III during the period of the study; 4 patients had not consulted the practice for some years (one was last seen in 1970) and the GP did not have any information about them. Information was provided for the 44 remaining patients (61% of the 72).

Table 3 compares the sample of non-responders with the responders to the study. The proportions reported to have problems with nerves/stress/depression and to have no family support were similar. The proportions of non-responders who were housebound and who had seen their GPs in the last 12 months was slightly higher than for responders.

Table 3

COMPARISON OF RESPONDENTS AND A RANDOM SAMPLE OF NON-RESPONDERS

	NON-RESPONDERS	RESPONDERS
	%	%
Housebound	41	31
Problems with nerves/stress	27	33
<u>Not</u> consulted GP in 12 months prior to interview/study date	7	14
Had no relative or friend to rely on for help	5	5
No. of people	44*	662

*Of these 44, 5 had recently died and 3 had recently moved into institutions (after study ended).

RESPONSE RATE

The final response rate is shown in Table 4. Although just over a fifth (22%) of the original FPC sample were interviewed, the original FPC list was inflated by about 50% with people who could not be traced (they had died or moved). If the response rate (number interviewed) is calculated out of the eligible number of people in the sample (1041), it increases to 64%. The figure 1,041 is also closer to the population figures from the last census - of 1,400 people aged 85+ living in City & Hackney - than the inflated figure of 3,018 from the FPC.* However, the proportion of the sample who had moved and who could not be traced are not represented in the sample. This is a serious bias which is unresolvable. It is possible that elderly people who have moved are in greater need of social support and health care (Ford and Taylor, 1984; 1985; Graham and Livesley, 1986; 1988). It also meant that the aim of documenting need by ward could not be achieved.

STATISTICAL ANALYSES

The completed questionnaires from people who were interviewed were coded and entered onto the computer at St Bartholomew's Hospital in November 1987. A magnetic tape of the data was obtained and the data transferred to London University, via St Bartholomew's Hospital Medical College, for analysis using the Statistical Package for the Social Sciences (Xth version). The analyses were completed in March 1988.

In the tables presented, the sample sizes are not always the same due to non-response to, or non-applicability of, individual questions.

Statistical tests of significance are not included in the tables in order to simplify the presentation. Attention has only been drawn to differences which are significant at least at the 0.05% level of confidence. The majority were highly significant at the 0.0000 level of confidence.

*FOOTNOTE ON BASE NUMBERS

Later OPCS population projections are only available for City & Hackney for people aged 80+. The London Research Centre's (formerly GLC Research Unit) population projection for the number of people aged 85+ living at home in City & Hackney, in 1986, is 1,700. There is an accepted discrepancy between OPCS and LRC projections, due to differences in age group sizes used in their calculation.

Table 4

RESPONDERS AND NON-RESPONDERS TO SCREENING QUESTIONNAIREINFLATED SAMPLE:

Not on electoral roll at address listed	1155)		38%
)		
Post office/new occupant returns - no longer at address listed	278)		9%
)		
Duplicates/listed twice on FPC records	45)		2%
)		
Moved - could not be traced	129)	1977	4%
)		
Moved - now outside Borough	39)		1%
)		
Moved - to hospital, old people's home, nursing home	122)		4%
)		
Not aged 85+	16)		1%
)		
No longer alive	193)		6%
<u>ELIGIBLE FOR INCLUSION IN SAMPLE</u>			
Written refusal to interview	144)		5%**
)		
Refusal when visited	112)		4%
)		
Visited at least 5 times/ never in	123)	1041	4%
)		
Interviews conducted	662)		22%
<hr/>			
SAMPLE SIZE	3018		100%
<hr/>			

* or 14% of 1,975 sent a screening letter

** or 7% of 1,975 sent a screening letter

Table 5 shows that City & Hackney's FPC lists of elderly people have a higher inflation rate (non-existent patients due to move and deaths) than other FPCs and lists of individual GPs in research practices. This is partly due to the older age of the sample in the City & Hackney study (leading to a higher death and institutionalisation rate) and to the fewer number of ancillary staff employed by GPs in Inner London in comparison with the rest of the UK (Jarman, 1981). Thus address records are less likely to be updated and details of moves and deaths less likely to be notified to the FPC.

Table 5

ACCURACY OF FPC'S AND GP'S RECORDS OF ELDERLY PEOPLE INFLATION DUE TO PEOPLE WHO HAVE MOVED OR DIED

	AREA					
	CITY & HACKNEY INNER LONDON (Bowling et al, 1988)	SOUTH GLAM. WALES (Salvage 1986)	MERTON & DULWICH SUTTON OUTER LONDON (Williams & Barley, 1985)	DULWICH OUTER LONDON (Graham & Live- sley, 1985)	ANDOVER HANTS (Carpenter & Demopoulos, 1985)	BORROWASH DERBYSHIRE (Ebrahim et al, 1984)
PATIENTS	%	%	%	%	%	%
UNTRACED:						
Moved: other address/ institution/ died/other untraced	65	22	14	18	13	7
TRACED:	35	78	86	82	87	93
Sample size	3018	360	877	545	699	396
Sampling frame	FPC lists	FPC lists	GPs' lists (one practice)	GPs' lists (one practice)	GPs' lists	GPs' lists (one practice)
Age of Sample	85+	75+	75+	75+	75+	65+

Age and Sex

Ninety per cent of the sample were female and 10% were male. According to the national data 80% of people in the UK aged 85+ are female (OPCS, 1983).

Three quarters were aged between 85 and less than 90, 21% were between 90 and less than 95, and 4% were aged 95 and over (two were over 100).

PERCEPTIONS OF AGE

Twenty six per cent said they felt themselves to be 'young', 30% felt 'middle aged' and 30% felt elderly (14% made various other comments).

When asked why they thought they had lived so long, the largest single group of responses related to 'looking after themselves' - e.g. 'having a clean, healthy life' (29%), followed by 'hard work' (25%), genetic factors - e.g. 'it's in the family' (15%), fate - e.g. 'God's will' - (10%), diet (8%), exercise/fitness (7%) and no smoking or drinking (6%).

We asked what the best things were about being their age and numerous different responses were made (e.g. 'sleeping'; 'got plenty of people to help'; 'great grand-children'; 'still can do things for myself'), 17% said 'nothing'. When asked what are the worst things about being their age, 15% said 'nothing', and 47% mentioned ill health, frailty and immobility and 24% mentioned loneliness and isolation. Twenty four per cent were uncertain and 3% mentioned other reasons (total does not equal 100% as respondents gave more than one reply).

Education and Occupational Status

Fifteen per cent had left school aged under 14, 80% had left between the ages of 14 and 16, and 5% left after this. Most, 93% held no educational qualifications.

Women who had been/were married were asked about their spouse's education.

Ninety five per cent of their husbands had left school without any educational qualifications; eleven per cent had left school before the age of 14, 86% between 14 and 16, and 3% left after this. The socio-economic status of respondents, and of married/previously married women's husbands, is shown in Table 6 (based on the Register General's Classification of Occupations). These figures approximately reflect national data (OPCS, 1983) which shows that, slightly more, 6% of males aged 65+ and 4% of females aged 60+ had higher educational qualifications (about half the national figure for all ages; slightly more, 2%, of retired people in the UK fall into social class 1).

Table 6

OCCUPATIONAL STATUS:

	Respondents	Husbands
I	*	*
II	9	13
III Manual	10	10
III Non Manual	36	47
IV	20	18
V	12	11
Other (e.g. housewife (females); armed forces (males))	12	1
No. of Respondents	640	423

* = Less than 1%

ACCOMMODATION

Most people had been living in their present homes for over ten years; 9% had been in their homes for less than five years; 14% for 5<10 years; 27% for 10<20 years; and 50% had been in their homes for 20 years or more.

About a fifth (21%) lived in sheltered housing (mostly with a warden on the premises); 14% lived in a house; 24% lived in a ground floor flat; 38% in an upper floor flat and 3% in other types of accommodation (e.g. bedsit).

Twelve per cent of people owned their homes (or had a mortgage); 63% were council tenants; 12% were private tenants; 4% lived in a relative or friend's home; and 9% had other arrangements.

Sixty one per cent lived alone, 16% lived with their spouse only; 20% with relatives; and 3% lived with friends or had a lodger. Three quarters of the people they shared their homes with were female, and 80% of their home sharers were aged over 60 years. In contrast, a third of people over retirement age (all 'elderly' people) in the UK live alone (OPCS, 1983). Unfortunately national comparisons are not available for age 85+.

In the current study, females were more likely to live alone than males (66%:56%).

FEELINGS ABOUT THEIR HOMES

Over two thirds (67%) said they liked living in the area, 21% disliked it and 12% were uncertain or had mixed feelings.

*Less than 1% were members of ethnic minority groups (excluding Jewish people), as expected from the last Census.

When asked what, if anything, they liked about the area 17% simply said they were familiar with it 'always lived here'; 14% said it was 'home'; 23% said their friends and family lived nearby; 13% said it was a quiet, pleasant or nice area; 21% said it was convenient for shops, buses and other conveniences; 17% gave a mixture of other reasons; 17% said there was nothing they liked about it. (The percentages total more than 100% as some people gave more than one reason).

THOSE WHO WANTED TO MOVE

Over a quarter, 27%, said they would like to move home. Thirty per cent of those wanting to move would like to stay in the same neighbourhood; 29% wanted to move elsewhere within London; 37% wanted to move outside London and 4% mentioned other places (e.g. abroad with relatives who had moved).

Few of those wanting to move wanted to move to a nursing home (7%) or to residential care (7%), although 32% wanted to move to sheltered accommodation, 35% wanted a flat somewhere else and 19% wanted to live in a house. This is consistent with previous studies showing that elderly people's stereotypes of institutional care are negative and, even of those who have applied for care, few look forward to the prospect (Bowling & Salvage, 1984; Salvage, 1986).

The vast majority, 82% of those living alone wanted to remain living alone, 12% wanted to live with their families and 6% with friends or others (e.g. lodger).

Few respondents were on a waiting list for hospital or residential care, 9%. Eight people were waiting for residential care, six were on an operation waiting list, five were waiting for another (not long stay) hospital bed, 18 for sheltered housing and 23 people for other rehousing.

PROBLEMS WITH TRANSPORT

Questions were asked about transport in the area: 84% felt it was not a problem, or if it was it did not affect them at all (although among these were those who were housebound and so who had little recent experience of transport). This leaves 16% who felt it was a problem and that it did restrict their activities.

We asked respondents if their homes were warm enough for them; 6% said rarely or never; 4% said sometimes; 12% said it could be but they could not afford to keep the heating on; 26% said usually and 52% said always warm enough. Most of the interviews were conducted in the cold winter months. Warmth was not a problem for most as 63% lived in council accommodation where central heating and hot water were provided and pre-paid within the rent.

Over half, 54%, said they had anxieties or fears about intruders, going out or opening the door at home.

A number of respondents had experienced upsets or upheavals in the last 12 months. 36% had suffered a major illness/operation/accident or fall; 25% had experienced the death of someone close; 9% had experienced a burglary or intruder and a further 3% had been assaulted; 1% had been in a fire and 2% had moved home. Seven per cent experienced various other 'life events'.

FAMILY AND FRIENDSHIP NETWORKS AND ACTIVITIES

Research has found that dense (integrated) networks, homogeneous in type, (e.g. in class, age, culture etc.) with strong ties, and narrow geographical spread, appear to best meet the needs of elderly people, especially when facing life events such as bereavement (Walker et al, 1977).

Townsend's (1963) early work on the elderly in Bethnal Green, and similar work by Willmott and Young (1957), and Marris (1958) showed that old peoples' contacts with adult children were more common than stereotyped images of the isolated elderly suggest. Research in other parts of the UK has also shown that it is rare for the family not to care for its members who are old and ill (Isaacs, 1971; Cartwright et al 1973; Finch and Groves 1980; Bowling 1984).

Much of the work in the East End of London was carried out before new developments in the East End, when people lived in houses rather than modern blocks of council flats. There is little current, large-scale research evidence of the nature of family support and kinship networks in the East End.

Research by Stokes (1983) suggests four dimensions that are important in measurement of social networks:

1. The size of the network, taking the definition of network as: people who are significant in the respondent's life and with whom the respondent interacts regularly.
2. The number of people in the network the respondent feels close to - how many one can confide in or turn to for help in an emergency. This is probably more important in terms of providing effective, satisfying, support than network size (Brown et al, 1979; Conner et al, 1979; Stokes, 1983).
3. The percentage of relatives in the network.
4. The density of the network (density refers to the degree to which network members are themselves interconnected).

A good measure of network size is the Social Network Scale adapted by Stokes, 1985, based on Hirsh (1980)'s work. This scale was used in the present study. The scale asks subjects to list in a matrix 'the initials of up to 20 people who are significant in your life and with whom you have contact at least once a month'. Subjects then put an X in those boxes of the matrix that connected people who were significant in each other's lives and who had contact with each other at least once a month. Subjects also indicated which persons in their lists were relatives and whom they felt close to and could 'confide in or turn to for help in an emergency'. This yields information on:

- a) The number of people listed
- b) The number of people the subject feels close to (confide in/turn to for help in an emergency)
- c) Percentage of relatives among network members
- d) Density - proportion of the number of possible social relationships out of the total possible among members in the network.

Several additional questions were asked about the extent of social activities and the quality of social relationships. The findings on networks will be reported after those on activities.

ACTIVITIES

Thirty per cent attended clubs (usually pensioners' clubs) or day centres. Of these, 16% went to a day centre and 81% attended clubs (3% went to both).

Table 7 shows how respondents usually spent their time during the day and evening - the most common activities were watching TV, listening to the radio and just sitting or sleeping. Crafts and games were not features of their lives, and over half never or rarely went out shopping, walking or visiting people.

Table 7

SOCIAL ACTIVITIES UNDERTAKEN

	Never/Rarely	Occas./Sometimes	Reg/Often
Watch TV	4%	10%	86%
Reading	30%	17%	53%
Crafts	78%	11%	11%
Games	83%	6%	11%
Walking	61%	13%	26%
Shopping	53%	14%	33%
Visiting people	55%	25%	20%
Other (e.g. Church, pub, visitors)	69%	9%	22%
Nothing, just sit	30%	25%	45%
Nothing, just sleep	32%	27%	41%
No of respondents varied from 631 to 656			

SOCIAL NETWORKS

Marital Status and Live Children

Seventy two per cent of the sample were widowed, 16% were married and 11% were single (1% were divorced or separated). As would be expected from life expectancy figures, more females than males were widowed, males being more likely to be married (Table 8). Females were also more likely to have been widowed for 10 years or more.

Table 8

SEX BY MARITAL STATUS

<u>Marital Status</u>	Males %	Females %
Married	37	7
Single	11	13
Widowed	52	79
Divorced/Separated	---	*
No of Respondents	54	507

* Less than 1%

The widowed/divorced and separated were asked how long they had been widowed or divorced/separated; 77% said 10 years or more, 13% between 5 and up to 10 years, 5% between 2 and up to 5 years, and 5% less than 2 years (one had been bereaved within the last six months).

Twenty nine per cent had no live sons or daughters, 24% had one, 22% had two, 12% had three and 13% had four or more. While 32% of those who were married had no live children, this proportion decreased to 11% for the married.

LONELINESS

When asked if they ever felt lonely, 9% said 'most of the time', 14% said 'often', 25% said 'sometimes' and 52% said 'rarely/never'. In contrast, the earlier survey of City & Hackney residents who had applied for residential care found that 40% said loneliness was a severe problem. Although the question wording differed between the surveys, the implication is that applicants for care perceived themselves to be more lonely.

FREQUENCY OF SOCIAL CONTACTS

Just under three quarters, 73%, spoke to a relative, friend or neighbour (personally or on the telephone) daily, 18% spoke less than daily but more than weekly, 6% spoke to someone at least weekly, 4% spoke to someone less often than this. No one said they never spoke to someone.

TELEPHONE CONTACTS

A large proportion of respondents, 81%, had their own telephone. All were asked, regardless of whether they had their own telephone, how often they spoke to relatives, friends or neighbours on the telephone: 31% spoke daily, 32% spoke less than daily but more than weekly, 13% spoke at least weekly, 18% less than weekly and 6% said 'never'.

FEELINGS ABOUT FREQUENCY OF CONTACTS

Most, 76%, said they had enough contact with their children, although 23 said they saw too little of them. One person said she saw too much of them.

Most, 70%, also said they saw enough of their friends, but 30% said they saw too little of their friends.

Fewer, 62%, although still the majority, said they saw enough of their other relatives and 38% saw too little of them.

When asked if they ever felt a burden to anyone 85% said no, and 15% said yes.

QUALITY OF SOCIAL SUPPORT AND THE SOCIAL NETWORK SCALE

In an attempt to assess the level of social support more meaningfully than simply totalling frequency of contact and activities, respondents were asked:

- A. "IF YOU NEEDED THE HELP OF A RELATIVE OR FRIEND DO YOU KNOW THERE IS ONE WHO WOULD HELP?"
- B. "DO YOU HAVE AT LEAST ONE FRIEND OR RELATIVE WHO UNDERSTANDS YOU?"
- C. "DO YOU HAVE AT LEAST ONE FRIEND OR RELATIVE WHO SHOWS THEY CARE ABOUT YOU?"

Well over 90% of respondents said they had someone at each of the questions (93% at A; 94% at B and 96% at C).

The Social Network Scale asked respondents about any relatives, friends or neighbour who are significant in their lives and with whom they had at least monthly contact. No one said no one and most mentioned four or more people.

Table 9

NUMBER OF SIGNIFICANT CONTACTS:

No. of people:	%	
One	8)	43%
Two	15)	
Three	20)	
Four	17	40%
Five	14)	
Six	10)	
Seven to Twenty	16)	
No. of respondents:	658	

RELATIVES

Ninety per cent said all or some of the people they were in contact with were related to them. Apart from the 10% who said no one was related, twenty two per cent said one of their contacts was a relative, 23% said two contacts were relatives, 18% said three and 13% said four were relatives. 14% said between five and 14 of their contacts were relatives.

Thirty two per cent of respondents had less than 50% of relatives on their networks, 40% had 50% to 100% of relatives in their networks and 28% had all relatives (100%) in their networks.

INTEGRATION (DENSITY) OF NETWORK

In order to assess the integration (density) of their networks, respondents were asked about which of the people significant to them, whom they had seen within the last month, were also significant in each other's lives and had monthly contact. Only four (less than 1%) respondents said none of their contacts knew each other in this way. Table 10 shows the density of their networks.

Table 10

NUMBER OF RESPONDENTS' (DENSITY) NETWORK MEMBERS SIGNIFICANT TO EACH OTHER AND IN AT LEAST MONTHLY CONTACT

% of Respondents			
None	*)	43%
One	*)	
Two	24)	
Three	19)	
Four	16)	26%
Five	10)	
Six	8)	
Seven	4)	
Eight	3)	31%
Nine	2)	
Ten to Twenty	14)	
No of Respondents:		654	

* Less than 1%

The potential integration (density) of each respondents' network was divided by its actual density. This calculation provided three graded degrees of density; 40% of respondents fell into the lowest density category, 24% into the middle category and 36% into the highest density category.

CONFIDANTES

The Social Network Scale asked respondents to indicate people they felt they could confide in and turn to for help in an emergency (confidantes). Just 5% said they could not identify anyone as a confidante.

The remainder, 95%, felt they could: 29% felt they could turn to at least one person, 24% to two people, 18% to three people, 12% to four people and 17% to five and more people.

MAIN HELPERS/SUPPORTERS

In terms of which person gave them the most help and support, 5% said none of the people mentioned did. Of the remaining 95% who mentioned someone, 74% mentioned a relative 22% a friend or neighbour and 4% mentioned both equally.

COMPARISONS WITH OTHER STUDIES OF INFORMAL SUPPORT

In summary, the level of informed support was extremely high, although the level of activity was low (the latter probably reflecting their frailty). The level of informal support compares with the high degree of family contacts in neighbouring Bethnal Green reported in the 1950s and 1960s (Willmot & Young, 1957; Townsend, 1963).

In contrast to the current survey, showing that around 95% of people aged 85+ were well supported, an earlier survey of elderly people on waiting lists for residential care (local authority Part III and private care) in City & Hackney showed that 23% had no regular contact with relatives, friends or neighbours. Their ages ranged from 60 to 94 (x:81). Further, 32% gave loneliness as a reason for their application for care (and 26% gave this as the main reasons). Possibly, one of the reasons why the elderly people (aged 85+) in the current study had survived in the community was due to the high level of informal support they received. In this older age group, geographical mobility among their sons and daughters and close relatives was probably lower than that of the next generation of elderly people (those currently in their 60's & 70's).

Further evidence that people aged 85+ living at home in City & Hackney may be atypical either of 'younger elderly people' or elderly people living elsewhere comes from the Health and Lifestyle Survey based on a national random sample of 9,003 people aged 18 and over (Cox et al, 1987), which used basic 'social integration' measures (index of roles and available attachments). The survey revealed fairly low support levels for people aged 76+. It also showed that females aged 76+ had lower 'role and attachment scores than males aged 76+. Of males aged 76+, 12% had 'very low' scores, 44% had low scores, and 44% had medium scores. Of females aged 76+, more had 'very low' (26%) and 'low' (58%) scores; 17% had medium scores (no one had high scores).

Females in City & Hackney survey, aged 85+, had fewer relatives in their social networks than males - 62% of females had less than four relatives in their networks in comparison with 46% of males. However, there were no other sex differences with the social support measures, the overall level of support appearing high for all but between 5-7% of the sample.

HEALTH

Table 11 (overleaf) shows the proportion of people with the listed health problem at the time of the interview, and the proportion consulting their GPs about the problem.

Thirty two per cent of respondents reported six to fifteen health problems, 39% reported three to five, 25% reported one to two, and 4% reported none. (The average number reported was 4.4). There were no differences with sex.

Although most had consulted their GPs about their problems, significant minorities had not consulted their GPs over some potentially serious and perhaps treatable symptoms, and very few of those with problems with forgetfulness and confusion had seen their GPs about these.

When asked an open question about what their biggest worry or problem was at the present time, 23% said their health, 6% mentioned financial problems, 30% mentioned a number of reasons and 41% said 'nothing'.

MEDICATION

Seventy nine per cent of respondents were taking an average of 2.7 prescribed medicines, pills and/or ointments; most were taking more than 2 types (see Table 12). There were no differences with sex.

Table 12NUMBER OF MEDICATIONS TAKEN

	% taking medications
None	22
One	18
Two	20
Three	18
Four	9
Five	5
Six or more	8
No. of respondents	637

Table 11

HEALTH PROBLEMS AND CONSULTATION WITH GP

Problem*	% with problem	% with problem and seen GP about
Aches/pains, stiffness in muscles/joints	70	80
Poor eyesight (+ with glasses on)	52	88
Trouble with feet	45	77
Poor hearing (+ with aid in)	40	65
Sleeplessness	37	61
Forgetfulness	35	19
Nerves/stress/depression	33	52
Constipation	33	76
Giddyness	33	64
Indigestion/heartburn	26	67
Incontinence/lack of control	29	82
Bronchitis	21	90
Chest pains/other heart trouble	21	93
Headaches	17	66
Loss of appetite	16	45
Confusion	16	35
Abdominal pain/discomfort	14	77
Piles	8	78
Alternatively constipated/loose	5	87
Passing blood or tar motions	4	91
Vomiting of blood	(4 people)	(3 people)
No. of respondents varied from 633 to 656		

* Respondents were asked about a checklist of these symptoms.

Table 13

TYPE OF PRESCRIBED MEDICATION TAKEN

<u>Preparation acting on the:</u>	<u>% of all respondents in study</u>	<u>% of all respondents taking medication</u>
Cardiovascular system/ diuretic	64	81
Psychotropic:		
Minor tranquillizer, sedative	17)	21)
Hypnotic))
Antidepressant/stimulant	3)	4)
Major tranquilliser/sedative) 48%) 61%
Hypnotic	**)	1)
Other psychotropic	3)	3)
Other nervous system preparation) 25)) 32)
Gastro-intestinal	27	34
Rheumatic	17	22
Nutrition/blood	13	17
Respiratory system/allergic	12	16
Skin/eye/mucous membrane	11	15
Endocrinological	6	8
Anti-microbial	2	2
Other	15	19
Unknown preparation	3	3
None taken	22	-
No. of respondents	637	504

* Coded according to British National Formulary

** Less than 1%

31

Preparations acting on the cardiovascular system and diuretics were the most frequent category of drugs taken, followed by psychotropics. Table 14 shows how long the medication had been taken. Two thirds of the psychotropics had been taken for more than two years.

Table 14

TYPE OF MEDICATION AND LENGTH OF TIME TAKEN FOR:-

How long taken for:	Cardiovascular/ diuretic %	Psychotropic %	Other nervous %	Gastro- intestinal %	Rheumatic %
< 6 months	15	13	24	31	30
6 < 12 mths.	6	6	8	7	5
1 < 2 years	15	15	19	17	16
2 < 5 years	28	27	22	22	25
5 < 10 years	18	8	15	9	10
10 < 15 yrs.	9	15	9	7	8
15 years +	10	16	3	7	5
No. of medications	310	95	103	121	79

How long taken for:	Nutrition/ blood %	Respiratory/ allergic %	Skin/Eye/ mucous membrane %	Endocrin- ology %	Anti- micro- bal (no.)	Other unknown prep- aration %
< 6 months	30	33	25	6	(2)	33
6 < 12 mths.	11	11	21	3	-	6
1 < 2 years	21	13	8	9	(2)	11
2 < 5 years	14	20	21	19	(1)	20
5 < 10 yrs.	9	15	19	22	(1)	11
10 < 15 yrs.	6	4	4	19	-	12
15 years +	9	4	2	22	-	8
No. of medications	70	54	48	32	6	46

* Total taken equal more than 100% as some respondents took more than one type within same category.

CONTACT WITH GPs

Most, 61%, had seen their GPs within the last three months (see Table 15), and few, 4%, had not seen their GPs within the last two years. The proportion consulting their GP within the last month (38%) approximately reflects the figure from the annual General Household Survey (1983) which reported that 42% of people, in the UK, aged 85+ had consulted their GPs in the last month.

Table 15

CONTACT WITH GENERAL PRACTITIONERS

Last saw GP:	%	
Within last 7 days	12)
)
More than 7 days ago but within last month	26)
)
More than a month ago but within last 3 months	23)
)
More than 3 months ago but within the last year	25	
Between one and 2 years ago	10)
)
More than 2 years ago	4)
)
		61%
		14%
No. of respondents	628	

Domestic Tasks and Mobility

A modified Activities of Daily Living Scale was used, extending the numbers of tasks asked about and including a more sensitive index of severity of disability than that used earlier by Katz et al (1963) Townsend (1979) (see Bowling and Salvage, 1984).

The tasks of daily living respondents were most likely to have difficulties with were bathing (51%), cutting toe nails (76%), washing hair (44%), filling in forms (47%), and, handling money (40%), and heavy household chores such as housework (75%), laundry (sheets etc) (75%), shopping (77%) and odd jobs (83%), as well as getting about outdoors (68%). However the degree of difficulty reported spanned 'slight' to 'unable to do at all'. Table 16 shows that the tasks respondents were most likely to be unable to do at all were odd jobs (61% were unable to do these), using public transport (57%), cutting toe nails (54%), and shopping (53%).

Many people were unable to do these things at all (Table 16). Almost a third were totally housebound and over two thirds had some difficulty getting about outside.

Table 17 compares results from the current survey of people aged 85+ (few of whom had applied for institutional care) with an earlier survey in City and Hackney of applicants to residential care (Bowling & Salvage, 1984). The table shows that the applicants for care were more likely to have difficulties with getting in/out of the bath, preparing/cooking food and laundry. They were also more likely to have "severe" difficulty with tasks, could only do them "with help", or were "unable to perform them at all". This would partly explain their applications for care. However, the table also shows that the applicants for care, who had difficulties with tasks, were less likely than people aged 85+ with difficulties, to receive help with most tasks (the exceptions being brushing hair and preparing/cooking food).

The low level of community health and social service provision for applicants to residential care was noted in the earlier report, along with a number of recommendations for prevention of admissions (Bowling & Salvage, 1984).

Table 16 ABILITY TO PERFORM ACTIVITIES OF DAILY LIVING

Activity of daily living:	On own without difficulty	On own with slight moderate severe difficulty			Only with help	Unable to do
	%	%	%	%	%	%
Get in/out bed	73	12	10	1	1	3
Rise from chair/ wheelchair	65	19	9	4	1	2
Climb steps/stairs	30	15	13	9	9	24
Use toilet/commode	86	7	3	1	1	2
Wash self	81	7	5	1	3	4
Bath self	49	6	6	4	9	26
Get in/out bath	33	8	7	5	9	38
Dress self	79	8	5	3	2	3
Brush/comb hair	89	4	3	1	1	2
Wash hair	56	6	4	2	9	23
Cut toe nails	24	5	4	7	6	54
Manage teeth/ dentures	95	1	*	1	*	3
Eat/cut up food	88	3	2	2	3	2
Prepare/cook food	58	7	7	3	6	19
Housework	25	6	9	4	21	36
Laundry (sheets etc)	25	5	9	4	12	46
Shopping	23	5	4	5	10	53
Handle pension/ money	60	2	3	1	8	26
Get about indoors	64	14	10	7	2	3
Get about outdoors	32	9	8	6	14	31
Use public transport	24	5	6	3	5	57
Odd jobs	17	3	4	3	12	61
Filling in forms/ writing	53	4	5	2	11	26
No. of respondents = 625						

* less than 1%

AND HELP RECEIVED.

Activity of daily living:	Proportion with any difficulty with tasks:-		Proportion with severe difficulty to cannot do task at all:-		Proportion with difficulties who have help:-	
	85+ Resp	Applicants for care**	85+ Resp	Applicants for care	85+ Resp	Applicants for care
Get in/out of bed	27%	46%	5%	29%	22%	16%
Rise from chair/ wheelchair	35%	41%	7%	22%	17%	17%
Climb steps/ stairs	70%	71%	42%	51%	21%	2%
Use toilet/ commode	14%	27%	4%	16%	27%	25%
Wash self	19%	22%	8%	19%	38%	36%
Bath self	51%	55%	39%	47%	45%	35%
Get in/out of bath	29%	71%	52%	63%	35%	28%
Dress self	21%	33%	8%	23%	36%	16%
Brush/comb hair	11%	18%	4%	12%	48%	65%
Wash hair	44%	54%	34%	46%	81%	63%
Cut toe nails	76%	73%	67%	69%	80%	65%
Manage teeth/ dentures	5%	14%	4%	12%	81%	25%
Eat/cut up food	12%	23%	7%	20%	57%	17%
Prepare/cook food	42%	70%	28%	59%	78%	98%
Housework	75%	78%	61%	65%	93%	92%

No. of respondents = 625 (85+ study); 77 (applicants for residential care study)

Table 17 (cont)

COMPARISON OF RESPONDENTS TO 85+ STUDY WITH RESPONDENTS TO EARLIER SURVEY OF APPLICANTS TO RESIDENTIAL CARE*: DIFFICULTY WITH ACTIVITIES WITH DAILY LIVING AND HELP RECEIVED

Activity of daily living:	Proportion with any difficulty with tasks:-		Proportion with severe difficulty to cannot do task at all:-		Proportion with difficulties who have help:-	
	85+ Resp	Applicants for care**	85+ Resp	Applicants for care	85+ Resp	Applicants for care
Laundry (sheets etc)	75%	87%	62%	77%	91%	82%
Shopping	77%	77%	68%	67%	95%	85%
Handle pension/ money	40%	46%	35%	41%	92%	66%
Get about indoors	36%	48%	12%	30%	17%	4%
Get about outdoors	68%	70%	51%	61%	42%	10%
Use public transport	76%	73%	65%	68%	12%	9%
Odd jobs	83%	78%	76%	76%	91%	67%
No. of respondents = 625 (85+ study); 77 (applicants for residential care study)						

* Bowling & Salvage (1984)

** Interviews with applicants and proxy interviews with carers of applicants too frail to be interviewed.

Tables 18a, b and c show the numbers of tasks people had difficulties with in varying degrees of severity. Although 21% had some difficulty (slight to cannot do) with 15-23 tasks (Table A), the proportion is reduced to 11% if just those with slight difficulties only are excluded (Table B), and to 8% if those with slight and moderate difficulties are excluded (Table C). Table C is probably more meaningful in terms of need as it incorporates those with the most severe problems, whereas the category 'slight' difficulty may not reflect real needs.

Females were more likely than males to report severe difficulties with/to cannot do at all 10 or more of the listed tasks.

Table 18

SEVERITY OF DIFFICULTY WITH ACTIVITIES OF DAILY LIVING BY NO. OF TASKS HAS DIFFICULTY WITH

<u>(Table A)</u>	<u>%</u>
No difficulties	3
Slight difficulty to cannot do:	
1-4 tasks	18
5-10 tasks	31
11-15 tasks	27
16-23 tasks	21
x : 10.32	

<u>(Table B)</u>	<u>%</u>
Slight/no difficulties with tasks	5
Moderate difficulty to cannot do:	
1-4 tasks	23
5-10 tasks	35
11-15 tasks	26
16-23 tasks	11
x : 8.76	

<u>(Table C)</u>	<u>%</u>
No/Slight/Moderate difficulties with tasks	8
Severe to cannot do:	
1-4 tasks	26
5-10 tasks	37
11-15 tasks	21
16-23 tasks	8
x : 7.46	

No. of respondents = 657

Table 19 (overleaf) shows that most people with difficulty with household tasks had help with these things. Less people had help with personal care (eg. bathing) and mobility (getting about). Relatives were most likely to be the helpers, rather than professionals, with the exceptions of bathing, cutting toe nails and housework.

Analysis of the four social services only (social work, occupational therapy, meals on wheels, home help), showed that 37% of the sample received none of these, 38% received one, 18% received two, and 7% received 3 - 4 (x:1).

Females were more likely to have help with four or more tasks than males: 71%: 55%, reflecting their greater functional disability. The General Household Survey (1984) also shows these sex differences in functional ability. Males in the GHQ (1984) were also twice as likely than women to say they could not manage small amounts of washing and preparation of a main meal, reflecting sex-role stereotypes. The 85+ study found no differences with sex and who helped with tasks of daily living (relatives, friends or professionals).

Analysing the seven health services separately (district/other nurse, health visitor, bathing service, physiotherapy, chiropody, incontinence laundry service), again 37% received none of these, 39% received one, 15% received two, and 9% received 3-7 (x:1). There were no differences with sex and number or type of services received.

Table 19 also shows that people with difficulties with personal tasks (such as getting in/out of bed, washing and dressing, getting to the toilet etc.) and mobility were less likely to receive help. Less than 40% of these people had help.

Further analysis showed that people with the severest degree of difficulty were those more likely to receive help (Table 20).

Of those with some difficulties just 3% had no help with anything, 32% had help with between 1-4 tasks, 40% with between 5-8 tasks and 25% with 9-23 tasks (x = 6.41).

Table 19

HELP GIVEN WITH ACTIVITIES OF DAILY LIVING

ADL Task:	Of those with difficulty: % receiving help	Who helps Relatives Friends Prof. % no. no.	Both: Relatives Friends & Prof- essionals no.
Get in/out bed (n.resp.:169)	22	88 3 6	3
Rise from chair/ wheelchair (n.resp.:206)	17	84 10 3	3
Climb steps/stairs (n.resp.:411)	21	63 11 20	6
Use toilet/commode (n.resp.:88)	27	88 8 -	4
Wash self (n.resp.:113)	38	66 3 29	2
Bath self (n.resp.:301)	45	33 2 60	5
Get in/out of bath (n.resp.:379)	35	35 2 58	5
Dress self (n.resp.:114)	36	76 7 10	7
Brush/comb hair (n.resp.:59)	48	74 - 22	4
Wash hair (n.resp.:274)	81	36 4 57	1
Cut toe nails (n.resp.:481)	80	18 2 79	1
Manage teeth/ dentures (n.resp.:26)	81	79 5 16	-
Eat/cut up food (n.resp.:46)	57	88 7 2	3
Prepare/cook food (n.resp.:260)	78	49 3 38	10
No. of overall respondents = 657			

* Number of respondents with difficulty with the task shown in brackets.

HELP GIVEN WITH ACTIVITIES OF DAILY LIVING

ADL Task:	Of those with difficulty: % receiving help	Who helps			Both: Relatives Friends & Prof- essionals no.
		Relatives %	Friends no.	Prof. no.	
Housework (n.resp.:479)	93	24	2	68	6
Laundry (sheets etc) (n.resp.:472)	91	52	7	39	2
Shopping (n.resp.:483)	95	45	7	33	15
Handle money/pension (n.resp.:251)	92	58	8	30	3
Get about indoors (n.resp.:215)	17	87	8	3	2
Get about outdoors (n.resp.:410)	42	57	14	21	8
Use public transport (n.resp.:426)	12	72	10	8	10
Odd jobs (n.resp.:521)	91	48	13	23	16
Filling in forms/ writing (n.resp.:291)	93	66	10	14	10
No. of overall respondents = 657					

Table 20

DIFFICULTIES WITH ADL AND LACK OF HELP

Of those with difficulty with ADL: Degree of difficulty

Of those with difficulty with ADL: Degree of difficulty		
	Slight/Moderate	Severe - Cannot do
	% <u>No</u> help	% <u>No</u> help
In/out bed	92	33
Rise: chair	92	42
Use WC	91	27
Wash self	90	20
Bath self	82	47
Dress self	93	23
Wash hair	62	8
Cu toe nails	76	14
Eat/cut up food	86	16
Prepare/cook meal	55	6
Housework	27	3
Laundry	36	3
Shopping	32	2
Handle pension/money	43	1
Get around indoors	94	57
Get around outdoors	81	51
Odd jobs	38	7
Filling in forms/ writing	28	3
No. of overall respondents = 657		

Just under half, 46%, of the total sample, wanted help or more help: 34% of the total sample wanted help/more help with just 1-2 tasks and 10% wanted help/more help with 3 tasks and 2% with 3-15 tasks. The average number of tasks people wanted help/more help with was 1.02. There were no differences with age and sex and demand for help.

Table 21 (overleaf) shows that the most common tasks people wanted help/more help with were: cutting toe nails (32%); managing teeth/dentures (19%); housework (15%); odd jobs around the house (14%); and help getting in/out of the bath (14%).

Respondents were asked if they received, and if they wanted help/more help, from a list of health and social services professionals.

Home helps, chiropodists and opticians were the largest group of professionals respondents were in contact with, followed by the meals on wheels service and the district nurse (although less than 20% were in contact with each of these two latter services) (Table 22 overleaf). The 1984 GHQ detailed survey of the elderly found that 26% of people aged 85+ in the UK receive district nursing services in any month, and 19% chiropody in a month (OPCS 1985). The current study found at least monthly contacts with district nurses and chiropodists to be lower. Few respondents said they wanted any other services, or the services more frequently if they were already receiving them. Thus, although 46% wanted help with an average of one task of daily living, they did not appear to want this help from professionals (except chiropody).

Table 23 shows that the majority received at least one of these professional services, the largest proportion received one or two. The average number received was 2. Those receiving services were more likely to be childless: 31% in comparison with 23% of those receiving no services.

Table 23 NUMBER OF SERVICES RECEIVED

No. of services	%	
None	21	
One	25)	49%
Two	24)	
Three	16)	
Four to five	10)	30%
Six to twelve	4)	
No. of respondents = 662		

Network size or type made no difference to the likelihood of receiving services, probably because of the high level of informal support received by almost all respondents.

However, those who had difficulties with, and who wanted help/more help with three or more tasks of daily living were more likely to have less than four relatives in their network.

	Daily	Less than daily, more than weekly	Weekly	Less than weekly, more than 2 wkly	Less often	Of all those with some difficulty - more/help needed
				%		
Get in/out of bed	97	3	-	-	-	5
Rise from chair/ wheelchair	97	3	-	-	-	4
Climb steps/stairs	21	12	9	5	53	6
Use toilet/commode	96	4	-	-	-	6
Wash self	63	13	21	3	-	12
Bath self	9	12	58	10	11	12
Get in/out of bath	5	11	58	12	14	14
Dress self	84	-	8	-	8	7
Brush/comb hair	76	4	4	16	-	7
Wash hair	4	2	28	22	44	7
Cut toe nails	2	*	3	4	91	32
Manage teeth/ dentures	75	-	13	-	12	19
Eat/cut up food	97	3	-	-	-	13
Prepare/cook food	85	14	1	-	-	6
Housework	15	47	36	1	1	15
Laundry (sheets etc)	5	14	61	7	13	9
Shopping	13	41	44	1	1	5
Handle pension/ money	7	10	73	2	8	3

No. of overall respondents = 657

	Daily	Less than daily, more than weekly	Weekly	Less than weekly, more than 2 wkly	Less often	Of all those with some difficulty - more/help needed
				%		
Get about indoors	88	6	3	-	3	5
Get about outdoors	4	14	22	4	55	10
Use public transport	2	15	9	-	74	4
Odd jobs	4	7	7	3	79	14
Filling in forms/ writing	2	2	5	5	87	3
No. of overall respondents = 657						

Table 22

OF THOSE IN CONTACT, FREQUENCY OF CONTACT WITH PROFESSIONALS:

Professional	% of sample in contact	Daily	Less than daily more than weekly	Weekly	Less than weekly more than monthly	Monthly	Less often
%							
Health Visitor	9	2	3	8	7	7	73
District Nurse	17	1	13	29	11	14	32
Other Nurse	4	15	11	11	11	11	30
Bathing Service	12	7	9	49	29	1	4
Carer relief/attendance	2	7	50	-	7	7	29
Social Worker	13	-	2	1	5	12	80
Occupational Therapy	5	-	4	4	4	3	85
Physiotherapist	5	-	14	20	3	3	60
Optician	37	*	*	-	-	*	99
Dentist	15	3	5	1	-	1	90
Meals on Wheels	19	55	36	4	-	2	3
Home Help	54	3	58	36	1	-	2
Chiropodist	44	-	1	1	3	5	90
Incontinence Laundry	4	-	11	21	32	7	29
Hospital Doctor	27	-	2	2	2	6	88
Voluntary Worker	10	11	27	15	14	6	25
Response to each item varied from 645 to 650.							

* less than 1%

Just 1% wanted the carer/relief attendant scheme (although had their relatives and other carers been asked this question, more needs may have been detected), a physiotherapist, occupational therapist, optician, dentist or meals on wheels. Three per cent wanted the bathing service, 4% a district or other nurse, and 6% wanted a home help. Less than 1% wanted a visit from a health visitor. Most popular were chiropodists, with 17% wanting to receive this service and voluntary visitors, with 12% wanting this service.

Given that few of the people with difficulties with activities of daily living wanted the professional services listed, analyses were carried out on those who wanted professional help. The last chapter on 'risk groups' shows that those with multiple functional problems and those who were housebound were most likely to want professional help, although the numbers were still small.

Further analyses showed that less than half of those with difficulty cutting their toenails and who wanted help, wanted chiropody (46% in comparison with 7% of respondents without difficulty); less than half of those who had difficulty with housework and who wanted help, wanted a home help (42% : 1%); 13% of those with difficulty cooking/preparing a meal and who wanted help, wanted meals on wheels (13% : 1%) and they were no more likely than other respondents to want a home help.

Respondents were asked what improvements, if any, they would like to see in any of these services; 57% could not think of anything, 23% said more frequent services, better staffing and funding of the service, 21% said better qualified staff, and 18% of these made other comments such as different timings of services.

In addition, 27% said there were things they would like help with but they did not like to ask for it, or they felt there was no point in asking, usually because services were known to be short staffed (although 18% were afraid of being a burden or losing their independence).

When asked if there was anything else that could be provided to make it easier for them to maintain their independence at home, most - 62% - said "no"; 16% mentioned home adaptations, 4% said mobility aids, 1% said nursing care, 4% said someone to do odd jobs, 1% said company and 3% said home helps (9% mentioned other types of help).

Respondents were asked if they knew where to apply for services. We included those already in receipt of services in order to find out if they knew where to go with a query. We checked the accuracy of their replies and only coded correct replies (an address of the professional/service concerned) as 'knowing where to go'. Table 24 shows the replies; the majority of people knew who to approach for most services. The exceptions were the carer relief/attendant scheme, day residential care and community transport.

Table 24

ACCURATE KNOWLEDGE OF WHERE TO APPLY FOR SERVICES

Service:	% who currently knew where to apply
Meals on wheels	63
Home Help	79
Social Worker	66
District Nurse	68
Mobility Aids	61
Financial Help	57
Housing Advice	64
Carer relief/attendant scheme	32
Day Centre	48
Residential Care	39
Community Transport -	39
Dial a Ride	
(Response varied from 637-649 to each item)	

Well-being and related measures of happiness, life satisfaction and morale have received much attention in gerontology. The reason is that indicators of these concepts are useful in assessing the mental health or well being of people. Life satisfaction, for example, has been related to mental health (Gurin et al, 1960; Bradburn, 1969).

A review of the literature indicates that well being has been measured by four major scales or global items: Life Satisfaction A (Neugarten et al, 1961); Philadelphia Geriatric Centre Morale Scale (Lawton, 1975); Bradburn Affect Balance Scale (Bradburn and Caplovitz, 1965; Bradburn, 1969), and global items of happiness and life satisfaction (Campbell et al, 1976; Smith, 1979).

The Neugarten Life Satisfaction Scale was used to assess life satisfaction and morale in the current study. This is a well tested scale, often used in the USA and is suitable for use with the elderly.

The Life Satisfaction Index A and the related scale, Life Satisfaction Index B were developed in order to produce a relatively short, self report measure of life satisfaction. The two scales differ only slightly in content, but greatly in form. Life Satisfaction A has a checklist of 20 items, statements with which the respondent either agrees or disagrees. Life Satisfaction Index B has several open ended questions that are given a score based upon the content of the answers. The two instruments can be used together or separately (Neugarten et al, 1961). Index A has been used more frequently than B, probably due to ease of administration and quantification of structured items, and was used in the present study.

A wide variety of content areas are tapped by each of these scales, ranging from happiness to satisfaction and level of activity. Scores are summed over all the items, thus ratings of each dimension are combined. The criticism of this is that the separate dimensions are confounded. However, these scales are the most commonly used to measure well-being in gerontological research (Larson, 1978; George and Bearon, 1980; Stull, 1985), and can be interpreted as a global index of happiness and satisfaction.

All versions of the index are easily administered, rest on a substantial amount of empirical support, have been well tested for validity and reliability, and are sensitive to change (Wood et al, 1969; Lohmann, 1977; Wylie 1970).

Each positive reply to the 20 items is scored 1, so each respondent can score between 0 and 20 (0 indicating low life satisfaction and 20 indicating high life satisfaction). The average score for the general population of all ages is 14. The average score for respondents in the present study was 13.37, which is close. As Table 25 shows, 33% of respondents scored over the average (14+), indicating high life satisfaction. A large proportion, 67%, scored at or below the average, probably reflecting lack of positive roles in old age.

TOTAL POSITIVE NEUGARTEN LIFE SATISFACTION SCORES:

	% of respondents
0	*
1 - 6 low satisfaction	15
7 - 9 low satisfaction	17
10 - 13 low satisfaction	34
14 - 17 average to high satisfaction	29
18 - 20 high satisfaction	4
No of respondents to individual items varied from 602-606	

* less than 1%

Table 26 shows replies to individual scale items which tap a number of different dimensions. Most people appeared satisfied with their past lives and achievements, but few had made plans for the future and about half felt that the present was the 'dreariest time of their lives' and that life could be 'happier'. More positively, just over half agreed that 'As I grow older, things seem better than I thought they would be'.

People with low life satisfaction scores are described in the section headed, 'The elderly at risk'.

Table 26
NEUGARTEN LIFE SATISFACTION SCALE:

Item:		% with positive reply indicating satisfaction
1.	As I grow older, things seem better than I thought they would be	54 (agree)
2.	I have had more luck in my life than most people I know	56 (agree)
3.	This is the dreariest time of my life	50 (disagree)
4.	I am just as happy as when I was younger	43 (agree)
5.	My life could be happier than it is now	48 (disagree)
6.	These are the best years of my life	20 (agree)
7.	Most of the things I do are boring and monotonous	71 (disagree)
8.	I expect some interesting and pleasant things to happen to me in the future	44 (agree)
9.	The things I do today are as interesting to me as they ever were	64 (agree)
10.	I feel old and somewhat tired	43 (disagree)
11.	I feel my age but it does not bother me	66 (agree)
12.	As I look back on my life, I am fairly well satisfied	89 (agree)
13.	I would not change my past life even if I could	73 (agree)
14.	Compared to other people my age, I've made a lot of foolish decisions in my life	28 (disagree)
15.	Compared to other people my age, I look smart when I am dressed to go out	82 (agree)
16.	I have made plans for things I'll be doing a month or a year from now	20 (agree)
17.	When I think back over my life, I didn't get most of the things I wanted	54 (disagree)
18.	Compared to other people I get down in the dumps too often	77 (disagree)
19.	I've had just about what I expected out of my life	76 (agree)
20.	In spite of what people say, the life of the average person is getting worse not better	36 (disagree)

No. of responses to individual items varied from 602 to 606.

DELIGHTED-TERRIBLE FACES SCALE

The delighted terrible faces scale was used as a further measure of satisfaction with the quality of aspects of life. Again, this has been shown to have good reliability and validity (Andrews & Withey, 1977). Respondents were shown seven faces (A to G). 'Here are some faces expressing various feelings. Below each is a letter. Which face comes closest to expressing how you feel about??' To depict how they felt about aspects of their lives Table 27 shows most people scored at the 'delighted' end of the scale, choosing happy ('delighted') faces to portray their feelings about their life as a whole, their accommodation, activities, independence, and loneliness. Few scored at the 'terrible' end of the scale.

FACES

Table 27DELIGHTED-TERRIBLE FACES SCALE

	<u>% selecting faces</u>						
	A Delighted	B	C	D N	E	F	G Terrible
Life as a whole	14	28	30	16	7	4	2
Accommodation	21	30	25	11	7	3	2
Activities	10	20	29	19	11	7	4
Independence	15	20	27	18	11	6	4
Loneliness	18	23	20	16	12	6	5
No of responses to items varied from 556-563							

The faces scale was rescored to give scores of 0 at the delighted (three faces) and neutral (one face) end of the scale, scores of 1 at the 'terrible' (three faces) end of the scale. The table below shows the number of people scoring 'terrible' on each of the five faces items:-

'DELIGHTED-TERRIBLE- FACES SCALE

Faces scores:-	% of respondents
Number of 'terrible' faces chosen:	
0 (All delighted/neutral scores)	59
1 - 3	35
4 - 5	6
No. of respondents to items varied from 556 to 563	

GENERAL HEALTH QUESTIONNAIRE

Finally, the General Health Questionnaire (GHQ) was administered to assess mental disturbance. The GHQ was designed by Goldberg (1967, 1972, 1978) to be a self administered screening test aimed at detecting psychiatric disorders among people in community settings. It does not attempt to detect mental subnormality, senile dementia or mania (most such individuals would not be able to complete the questionnaire). It was not intended to be used for the detection of functional psychoses (schizophrenia or psychotic depression), although these conditions are in fact detected (Goldberg, 1967, 1972, 1978). The GHQ concentrates on the detection of depression and anxiety. While not perfect it correlates well with psychiatric diagnoses of depression (Williams, 1987). The short version, which was used, is also manageable with an elderly population.

If the results of a population of GHQ scores are compared with independent psychiatric assessment, it is possible to state the number of symptoms where the probability that an individual will be thought to be a case exceeds 0.5. This is called a threshold score. The proportion of respondents with scores above this threshold is the probable prevalence of illness.

There are three versions of the GHQ: 60 item, 30 item and 28 item self completion questionnaires. The 28 item was chosen for use in the current study, although it is inevitably less sensitive, because of the need for as concise an instrument as possible for use with frail elderly people. Also, the 28 item GHQ can be split into subsections, giving scores for reported 'perceived health', - 'nerves/anxiety', 'self worth' and depression/suicidal thoughts'. Previous research has found no clear effects of age on GHQ score (Goldberg, 1978).

The first sub-section consists of seven items relating to feelings about health, the second sub-section of seven items relates to nerves/anxiety; the third sub-section of seven items relates to feelings of self-worth; and the final sub-section of seven items relates to depression/suicidal feelings. The scoring system used was the version which gives a score of 1 to admission of problems/more problems than usual and 0 to no problems/no more than usual. Each

sub-section carried total scores between 0 and 7 and the total from 0 to 28. The higher the score the higher the degree of mental disturbance indicated. Their mean score was 4.3, which is threshold level. The scores are shown in Table 26.

Table 29 shows that most people scored low on the GHQ (indicating no mental disturbance), although 27% scored over the threshold of 4-5 indicating disturbance.

Unfortunately there have been no other studies of people aged 85+ using the GHQ, thus there are no norms for comparisons. Research with younger age groups (15 to 69) has shown no clear effect of age on GHQ score, if anything, females' scores tend to decline with age. The proportion of men and women in their sixties with scores over 12 has been found in previous research to be 9%, which is comparable to the proportion found in the current study. However, previous research has also reported that these figures more than treble for those who are widowed, divorced or separated, and increases slightly for those leaving school at younger ages (see Goldberg, 1978).

The implication, given that most of the sample of people aged 85+ were widowed and also left school before the age of 16, is that their GHQ scores were lower than expected (i.e. their mental health was better). A previous health survey of the general population (of all ages) in City & Hackney using the 30 item version of the GHQ found the proportion of respondents scoring over the threshold to be 33% (Elliott, K. personal communication). The proportion of the current sample scoring over the threshold was 27% which is slightly below this. The figure for all adults scoring above the threshold, using the short version (30 item), from the Health and Lifestyle Survey of over 9000 British adults was 31% (27% males and 33% females). This survey found the figure for the elderly aged 75+ to be higher at 41% (39% males and 43% females: the gap between the sexes did reduce with age) (Cox et al 1987).

Attention has been focused in much of the primary care literature on the elderly 'at risk' of neglected needs for care (Taylor and Ford, 1983; Taylor, 1986). Table 30 shows the proportion of respondents in the present sample falling into previously identified 'risk' groups.

As would be hoped, if the questions were valid and reliable, the individual item in the symptom checklist asking about problems with nerves/stress/depression was significantly associated with GHQ score - 62% of those with a GHQ score over the threshold (cases) reported problems with nerves/stress/depression, as did 37% of those with a threshold score, in comparison with 15% of those with a low GHQ score.

Table 29

GENERAL HEALTH QUESTIONNAIRE SCORE MENTAL DISTURBANCE

Scores for A (health)		Scores for B (nerves/anxiety)	
	%		%
0	51	0	71
1	12	1	9
2	11	2	8
3	8	3	4
4	11	4	5
5	4	5	2
6	2	6	1
7	*		

Scores for C (self worth)		Scores for D depression/suicidal thoughts)	
	%		%
0	51	0	85
1	17	1	5
2	9	2	3
3	7	3	2
4	5	4	2
5	4	5	1
6	2	6	1
7	5	7	1

Total scores			
	%		
0-3	62		
4-5 threshold	11		
6-9	13		
10-16	11	27% mental disturbance	
17-28	3		

No. of responses to each item varied from 587-589

Mean score = 4.3 (Threshold level)

One aim of the research was to document the needs of the very elderly, in particular, those 'at risk'. Risk groups have been identified by a number of researchers. The following groups have often been selected as those in need of help.

- Those who have moved in the last 12 months
- Those who live alone
- The depressed
- The lonely
- The divorced/separated
- The very old
- The single and childless
- Those having a major illness/hospital stay in the last 12 months
- The bereaved in the last 12 months
- The housebound
- Those with difficulties with activities of daily living
- Those who have not seen their GPs for 12 months
- Those with no relatives or friends

'At risk' has not been defined by previous researchers. The current study defines it in terms of needs for health and social services, and unmet needs for these services.

Taylor (1986) has questioned the practicality of identifying these groups in terms of their liability of being 'at risk' as the numbers in some groups will be very small. In his survey of the elderly in Aberdeen, those who had recently (in last 12 months) moved comprised just 7% of the sample, those discharged from hospital just 6%, and the widowed just 4% (Taylor and Ford, 1985; Taylor, 1986).

Some groups - such as the single and childless and the home movers - were disadvantaged by one criteria only (e.g. reduced social support and poorer mental health respectively). Their survey also revealed important compensation effects - groups disadvantaged in one domain were compensated by advantage in another. For example, while the single and childless were, by definition, disadvantaged in terms of family support, they had more friends and confidantes. The identification of the elderly with particular problems ('risks') is often regarded as worthwhile by GPs, but this exercise is no longer accepted without questions (Taylor and Ford, 1983; Taylor and Buckley, 1987).

One reason for analysing respondents in such 'risk' groups is that physical frailty, lack of social support from relatives and loneliness have all been suggested as reasons for admission to institutional care (residential homes for the elderly) (Townsend, 1962; Bowling and Salvage, 1984). The numbers at 'risk' of future admission can be calculated from this study. While many respondents were frail, levels of support were high, and loneliness lower than in other studies, suggesting that these respondents will not be institutionalised except when it is unavoidable (e.g. for acute illness, falls, terminal care).

Table 31 shows possible 'risk factors' identified on the basis of the present and previous surveys, and the proportion of people in the current survey falling into each 'risk group'.

Table 30 confirms Taylor's (1986) fear that some 'risk groups' are too small to justify concentrating screening on them alone (e.g. those moving home), and others were too large to be selective (e.g. at or

below average life satisfaction scores). Concentration on groups with psychological (e.g. GHQ scores) and physical health problems would be a more productive use of resources.

The next section analyses each of the previously identified 'risk groups' in terms of physical, social and psychological characters in turn and is directed towards the issues of 'how many there are 'at risk', and "at risk of what?".

THE DISTRIBUTION OF RISK FACTORS AMONG RESPONDENTS

	% of Respondents Reporting Risk Factor During Interview
<u>In the past 12 months experienced:</u>	%
Major illness/operation/ accident/fall	36
Death of someones close	25
Widow(er)hood	3
Moved home	2
Not consulted GP	14
Childless	29
Widowed/divorced/separated/ single <u>and</u> childless	16
Feels lonely often/most/all time	23
Severe difficulty to cannot do:-	
cook/prepare food	28
housework	61
get outdoors	51
10+ ADL tasks	35
cannot get about outside at all	31
Self reported nerves/stress/depression	33
Difficulty seeing (even with glasses)	52
Difficulty hearing (even with aid)	40
Life Satisfaction Score at or below average	67
GHQ score over the threshold	27
Lives alone	61
Aged 90+	25
Wants to move home	27
Has no friend/relative or neighbour to rely on for help	7
No. of Respondents varied from 587 to 662	

* Less than 1%

NOTE: Major illness events were measured instead of in-patient stays.

RISK GROUPTHE HOUSEBOUND

Six percent of the sample had severe difficulty getting about outside, 14% could only get out with help and 31% could not get about outside at all. All these were defined as 'housebound' for the purposes of the analyses in Table 32. This reflects national figures, estimated from Harris' (1971) national survey of disability.

Females were more likely than males to have severe difficulty with, or be unable to get about outside: 52%:25%.

There were no differences with these respondents and those who could get about outside more easily and the amount of social support they had, nor with reported loneliness except they were more likely to say they saw too little of their friends (see Table 31). They were also more likely say they felt a burden to someone.

The housebound were, however, less active, reported more problems with tasks of daily living and their physical and mental health, but also received more help from social services and the bathing service. They were more likely to want to see a chiropodist, but no more likely to want visits from any other professional (not even a district nurse, although they were no more likely to be in contact with a district nurse than more mobile respondents). They were, moreover, no more likely to have more frequent help with tasks of daily living, except with housework - they were more likely to have help with this more than weekly (64% in comparison with 47% of those with slight to moderate difficulty in getting out and 38% of those with no difficulty).

They were less likely to score 'delighted' on the faces scales, more likely to score over the threshold on the GHQ and more likely to have an average or a low life satisfaction score on the Neugarten scale.

Although they were more likely to receive services, and no more likely to want any, or any more, services than those who were not 'housebound', they did have emotional needs. Given that they did not want many more services, it is difficult to specify how they could be helped.

However, looking at those who were totally housebound, (rather than those having severe difficulties going out) they were more likely to want help with tasks and help from specific services. However, the numbers wanting help from services were very small, except for chiropody. This was despite most of those who were housebound having at least severe difficulty with 10 or more tasks of daily living (Table 32).

Table 31

THOSE WITH DIFFICULTY GETTING ABOUT OUTSIDE (THE HOUSEBOUND)

	<u>None</u>	<u>Slight/ Moderate</u>	<u>Severe</u>	<u>Can only do with help/ cannot do at all</u>
	%	%	%	%
In the past twelve months experienced major illness/operation/accident	28	35	23	44
Things felt to be risky in life (e.g. falls)	35	56	58	60
Feels elderly	14	35	29	43
Infirmity is worst thing about current age	32	52	61	55
Sees too little of friends	19	27	43	37
Feels a burden to someone	5	13	8	24
Never/rarely went for a walk	29	43	74	88
Never/rarely went shopping	9	34	64	89
Never/rarely visited people	34	47	65	70
Regularly/often just sits	27	41	39	60
Regularly/often just sleeps	23	42	45	52

Table 31 (continued):

	<u>None</u>	<u>Slight/ Moderate</u>	<u>Severe</u>	<u>Can only do with help/ cannot do at all</u>
	%	%	%	%
Problems with feet	27	53	45	54
Problems nerves etc.	18	32	44	41
Urinary problems	17	26	32	37
Stiffness etc.	52	74	82	81
Sleeplessness	23	48	49	42
Taking medication	32	89	79	83
Receives bathing service	1	6	13	21
Sees social worker	5	10	38	15
Has meals on wheels	7	15	26	27
Has home help	33	59	56	66
Has at or below average life satisfaction score	47	70	72	80
Chose at least one terrible face to depict life	22	43	51	55
Has help with laundry	88	77	88	98
Has help with shopping	93	83	92	100
Would like chiropody	7	16	24	23
Over the threshold GHQ score	21	37	44	46
No of Respondents	87-203	90-104	32-39	235-262

Table 31 (Continued)

	<u>None</u>	<u>Slight/ Moderate</u>	<u>Severe</u>	<u>Can only do with help/ cannot to at all</u>
<u>NO DIFFICULTIES:</u>	%	%	%	%
Getting in/out of bed	96	77	56	56
Rise from chair	91	74	46	47
Get up/down stairs	62	21	81	25
Use WC	99	93	74	74
Washing self	99	87	77	66
Bathing self	82	48	42	24
Getting into the bath	67	32	30	11
Dressing self	99	86	64	64
Brush/comb hair	100	88	90	81
Washing hair	85	59	46	35
Cutting toenails	50	16	11	10
Manage teeth/dentures	98	100	39	91
Eat/cut up food	98	82	82	80
Cooking	91	60	46	36
Housework	61	11	11	6
Laundry	59	11	14	7
Shopping	65	11	-	1
Manage money etc.	85	69	59	41
Getting about indoors	99	75	36	39
Using public transport	69	15	-	*
Odd jobs in home	43	8	19	3
Filling in forms, writing etc.	76	50	39	39
No. of respondents	193-203	103-104	39	287-292

Table 32

ANALYSES WITH RESPONDENTS WHO WERE TOTALLY HOUSEBOUND (COULD ONLY GO OUT WITH HELP OR UNABLE TO DO AT ALL)

	<u>Not totally Housebound</u>	<u>Totally Housebound</u>
	%	%
Has difficulty with 10+ tasks of daily living	7	7
Has help with 9+ tasks of daily living	8	46
Wants more help with 3+ tasks of daily living	7	18
Has low life satisfaction (-6 scored)	12	20
GHQ score over threshold	23	34
Has district nurse	10	28
Has bathing service	5	22
Has meals on wheels	13	28
Has home help	45	66
Sees hospital doctor	24	35
Would like bathing service	1	5
Would like meals on wheels	4	8
Would like chiropody	12	23
Would like volunteer to visit	8	17
Reported 7+ (7-15) symptoms	14	32
No of respondents	273-320	268-284

RISK GROUP - THOSE WITH A BELOW AVERAGE (NEUGARTEN) LIFE
SATISFACTION SCORE

About two thirds of the sample had a life satisfaction score at or below the average of that scored by the general population. There were no differences with age or sex.

Table 33 shows that people with a low life satisfaction score, reported more mental and physical health problems, had less activities, reported more problems with loneliness and expressed more dissatisfaction with their homes (e.g. they wanted to move/live with others), and were more likely to live alone. There were no differences between groups in type of accommodation lived in. The low satisfaction groups' increased desire to move must be seen as a perceived solution to their problems (e.g. in some cases, loneliness) rather than physical problems with the accommodation itself. They were also more likely to feel they saw too little of their friends and relatives (other than children). As more of the people mentioned as significant in their lives were relatives rather than friends it appears that their friendship circles were smaller, but compensated for by their relatives. There were no differences between groups and whether the person mentioned as giving them most help was a relative, friend or neighbour. They also listed fewer people in their network scales.

There were no differences between groups in the frequency with which they spoke to friends or relatives nor were they any less likely to mention someone in reply to the questions asking about the quality of their social support e.g. a relative or friend they knew would help them, understood them, showed they cared about them, felt close to and could confide in and turn to help for an emergency. There were no differences with sex.

With a cross sectional survey of this type it is not possible to estimate the nature of the relationship - e.g. whether poor health and loneliness led to lower life satisfaction or whether personality type influenced life satisfaction and influenced perceptions of health, loneliness, accommodation etc. Presumably the associations operate in both directions.

They were more likely to say they would like help with something but did not like to ask for it or felt there was no point in asking, perhaps reflecting apathy. However, they were no more likely than others to want help from other professionals, except from a voluntary visitor.

Further analyses, controlling for functional disability level, found that those with below average life satisfaction who rarely/never went out shopping, visiting people, who regularly just 'sat' or 'slept' all day, and who had not seen their GPs within the last 3 months were also the frailest. Frailty, as well as the reduced motivation which accompanies low morale, thus explains the reduced level of activity.

The group with below average (low) levels of life satisfaction were no more or less likely to receive health or social services, but they were more likely to have help (usually from relatives) with tasks of daily living, and they were more likely, along with those with 'middle' satisfaction levels, to have seen their GPs within the past 12 months.

Further analyses have been conducted on those scoring very low life

satisfaction (scoring 0-6). These show that this group were similar to those scoring 7-13 with the exception of having higher GHQ scores and being more likely to choose 'terrible faces'.

This was a group which could be helped by more support. Although they wanted more help, they did not generally want this from professionals, apart from a voluntary visitor. Perhaps the provision of well organised and advertised voluntary visiting scheme could help overcome the ethical problem of service provision without imposition.

NEUGARTEN LIFE SATISFACTION SCALE

	Low - Average Satisfaction (0-6)	Low-Middle Score (7-14)	High Satisfaction Score (15+)
	%	%	%
Likes living in area	51	67	82
Major illness/accident in last 12 months	44	38	27
Infirmary worst thing about life	44	43	36
Lives alone	69	65	53
Wants to move	51	25	15
Lives alone but want to live with others	29	19	4
Feels elderly	50	31	13
Has live children	64	67	83
Feels lonely often/ most of the time	53	23	5
Sees too little of friends	57	29	14
Sees too little of relatives	68	39	15
Sees too little of children	40	24	16
Rarely/never goes shopping	57	56	34
Rarely/never goes walking	66	64	48
Rarely/never visits people	70	57	36
Speaks to relative, friend, neighbour at least daily	57	71	85
Less than 4+ relatives in network	80	72	61
Has less than 4 people to turn to (confidants)	81	72	60
No. of respondents	93-95	350-353	138-160

NEUGARTEN LIFE SATISFACTION SCALE

	Below Average Satisfaction (0-6)	Low-Middle Score (7-14)	High Satisfaction Score (15+)
	%	%	%
Listed less than four people in network scale	57	42	33
Lowest density network	65	46	41
Wants help/ more help with tasks of daily living	74	49	29
Has difficulties and has help with 5+ tasks of daily living	71	67	43
Seen GP in last 12 months	87	92	85
Has severe difficulty/ cannot do: cooking	36	27	13
shopping			
housework	76	70	52
get about outside	75	64	39
10+ tasks of daily living	45	37	15
Chose at least one 'terrible' face at 5 faces questions	89	44	10
Wants a voluntary worker	24	12	3
Reported 7+ (7-15) symptoms	38	26	9
No. of respondents	93-95	350-353	138-160

Table 33 (cont)

NEUGARTEN LIFE SATISFACTION SCALE

	Below Average Satisfaction (0-6)	Low-Middle Score (7-14)	High Satisfaction Score (15+)
	%	%	%
Regularly/often 'just sits'	61	48	23
Regularly/often 'just sleeps'	51	43	22
Wants chiropody	24	19	8
Problems seeing	60	55	37
Problems hearing	45	40	30
Problems: feet	47	48	29
bronchitis	28	23	10
forgetfulness	42	36	21
indigestion/ heartburn	39	28	13
aches/pains/ stiffness in joints	87	72	54
Problems: nerves/stress/ depression	57	36	7
GHQ score over the threshold	51	31	6
Sleeplessness	50	39	23
Mentioned something that could be provided to make it easier to maintain independence	49	37	18
Would like visits from a voluntary visitor	24	12	3
Would like help but do no like to ask/no point in asking	33	15	13
Mentioned a main worry in life (eg. health, money, loneliness, etc)	94	73	48
No. of respondents	93-95	350-353	138-160

There were no significant differences with people aged 85< 90 <95 and 95+ and scores on health problems nor consultations with their GP over specific symptoms, with one exception. Those aged 90+ were slightly more likely to say they had problems with forgetfulness (44%:32%), and older respondents were less able to perform certain tasks of daily living (see Table 34). This is not unexpected and is consistent with previous research (Jeffers and Nichols, 1961: Mellors and Edelman, 1988).

People aged 90+ were slightly more likely to have no live children.

Respondents aged 90+ were more likely than those aged 85<90 to feel that they saw too little of their relatives (other than children) and friends. Older respondents were also more likely to have smaller network sizes and mention only one person as a confidante, probably reflecting their age insofar as more of their friends and relatives have died.

In each age group most people's helpers were their relatives, except with bathing and help getting in/out of the bath, help with washing hair, cutting toenails and housework where professions were the largest group of helpers, followed by relatives (but equally for each age group).

The daily activities of the two age groups were also similar with the exception of going out shopping and visiting people: people aged 90+ were more likely to say they never/rarely went shopping (68%:48%) and never/rarely visited friends and family (69%:52%). Instead, they were more likely to 'just sit' all day (19% never/rarely did this in comparison with 33% of people aged 85<90), and 'just sleep' all day (52% never/rarely did this in comparison with 62% of people aged 85<90).

Slightly more, a third of people aged 95+ said they felt lonely often or most of the time, in comparison with about a fifth of younger 'elderly' people.

Over half of those in older age groups had a GHQ score over the threshold, in comparison with about a fifth of people aged 85<90.

The older age groups were more likely to have help with tasks of daily living (this was generally from relatives). Although older respondents were no more likely to want any more help from services, their relatives, who provided most of the care needed, may disagree.

It has been hypothesised that impaired mobility and loss of a viable social network are likely to be associated with a gradual decline in subjective well being and increase in loneliness among the elderly population (Huyck and Hoyer, 1982: Kivett, 1979). There is some evidence of this in the present study from the relationships between age and increasing frailty, loneliness, smaller network sizes and support.

The very elderly appear to be a group 'at risk' of increasing frailty, low psychological wellbeing and isolation, although they were no more likely to want any, or any more, professional help than other groups (overall the numbers wanting help were small).

Table 34

ABILITY TO PERFORM ACTIVITIES OF DAILY LIVING WITH AGE

	<u>Age</u>	85<90	90<95	95+
<u>ADL</u>	%	%	%	
Unable to bath self	24	28	52	
Unable to get in/out bath	36	43	67	
Unable to wash hair	20	30	36	
Unable to cut toenails	50	66	82	
Unable to prepare/cook meal	16	22	55	
Unable to do housework	33	42	68	
Unable to do laundry	43	51	73	
Unable to do shopping	48	64	82	
Unable to handle money/pension	23	33	41	
Unable to get around outdoors	28	39	68	
Unable to use public transport	52	66	86	
Unable to do odd jobs	57	71	77	
Severe difficulty/cannot do 10+ ADL tasks	31	47	82	
Has help with 9+ tasks	21	35	57	
No live children	27	31	54	
Sees too little of relatives	35		46	
Sees too little of friends	26		41	
Only one person mentioned as confidante	26	38	50	
Listed fewer than 4 people in their networks	41	48	67	
Feels lonely most of time/often		19	33	
GHQ score over the threshold	21	35	57	
No. of respondents	473-493	135-139	22-24	

Table 35 shows that people with GHQ scores over the threshold (high) indicating disturbance, were more likely than others to report problems with nerves/depression/stress, although they were less likely to have consulted their GPs about this despite being slightly more likely to have seen their GPs within the last year. They were also more likely to have experienced major illness/accident/operation over the last 12 months. GHQ scores increased with extreme old age.

They had more difficulties with tasks of ADL and were less active during the day/evening. They were more likely to express dissatisfaction with the frequency of their social contacts (although they were as likely as other groups to speak to a friend or relative daily).

Although they had fewer confidantes and lower density networks, their network sizes were no smaller than those with lower GHQ scores and there were no other differences with the support measures. They were also more likely to want to move. Moreover, all but two of the whole sample wanting to move to a nursing or residential home had a GHQ score over the threshold. Those with a high score had more difficulties with tasks, although they were more likely to have help with tasks. They were no more likely to be in contact with any health or social service professions, apart from their GPs (eg health visitor, nurse, home help, meals on wheels etc.). However, they were no more likely to want to see any of these people, although they were more likely to say they wanted help with tasks. The exception was with a voluntary visitor, a service they were more likely than other respondents to want. On the other hand, those with a GHQ score over the threshold were more likely to say they would like help with something but feel there is no point in asking. Although this was usually justified by reference to shortages of staff and service finances, it is perhaps reflective of the apathy often characteristic of depression/anxiety.

Respondents were asked about the extent of their agreement/disagreement with the statement: "There's a lot you can do to keep healthy in old age". Those with a GHQ score over the threshold were less likely to agree or strongly agree with this, again possibly reflecting their apathy.

When asked what their greatest worry or problem at the present time is, the group scoring over the threshold were less likely to say "nothing". The worry they were more likely to mention was their health: 31% of the group scoring over the threshold and 33% of those scoring at the threshold said this, in comparison with 17% of the low score group.

People with high GHQ scores were more likely to have Neugarten scores indicating low life satisfaction and to score 'terrible' on the faces scales, and they mentioned fewer confidantes in their lives.

What people say about their health and lives may be affected by their personality. There is a concern that a person with a certain type of personality might be more likely to report both illness and dissatisfaction with their level of social support and life generally, thus producing a spurious relationship.

Further analyses, controlling for functional disability level, found that those with a high GHQ score who rarely/never went out shopping or

visited people, who regularly just 'sat' or 'slept' were also the frailest. Frailty, as well as with the reduced motivation which characterises poor mental states (eg. depression), thus explains the reduced level of activity.

There were no differences with sex, suggesting that sex differences with anxiety, depression, reported younger age groups, are less evident in surveys of extreme old age (Goldberg, 1978). This is supported by Cox et al (1987), in the National Health and Lifestyle Survey, which reported that sex differences and reported anxiety/depression, although still apparent, declined with age.

However, it should be noted that the GHQ detects other conditions as well as depression. Twice as many females as males reported nerves/stress/depression in the symptoms check list, 36%:18%.

Table 35

RISK GROUP: GENERAL HEALTH QUESTIONNAIRE SCORES

	Low 1-3	Threshold 4-5	High 6+
	%	%	%
Reported nerves/stress/depression	15	37	62
Of those with nerves/stress/ depression: Seen GP about this	62	65	44
Feels a burden	9	16	24
Infirmity worst thing about age	37	53	61
Goes out shopping regularly/ often	42	21	
Goes out walking regularly/ often	42	21	
Sees too little of relatives (not children)	30	34	51
Sees too little of friends	20	33	43
Listed less than 4 people as confidantes	66	71	77
Low density network	44	47	55
Just sits all day regularly/ often	35	46	60
Just sleeps all day regularly/ often	33	38	52
Problems with sight (even with glasses)	46	55	62
Reported 7+ (7-15) symptoms	12	30	40
Seen GP in last 12 months	84	82	91
Feels lonely often/most of time	12	31	36
No. of respondents	290-353	46-64	130-158

Table 35

ASSOCIATIONS WITH GHQ (cont)

	Low 1-3	Threshold 4-5	High 6+
	%	%	%
Would like help with something but feels there is no point in asking	18	34	38
Strongly agrees/disagrees with the statement:- "There's a lot you can do to keep healthy in old age".	78	77	60
No greatest worry/or problem at present time	41	21	15
Below average life satisfaction score	52	77	91
Selected 1-5 terrible faces at 5 faces life satisfaction items	2	3	18
Experienced major illness/operation/accident/fall in past 12 months	24	50	
Aged 95+	20	24	32
Would like a voluntary visitor	8	15	19
Severe difficulty/cannot do:			
10+ ADL tasks	25	37	45
Cooking	20	26	40
Housework	50	71	75
Getting about outdoors	35	56	57
Has help with 9+ ADL tasks	19	25	28
More help needed with tasks	6	14	25
Is taking prescribed medication	71	81	89
No. of respondents	290-353	46-64	130-158

RISK GROUP: LOW LIFE SATISFACTION WITH THE PRESENT

74

A more immediate measure of life satisfaction than the Neugarten Scale, was provided by the 'delighted-terrible' faces items. Respondents were questioned about their satisfaction with specific aspects in their current lives (eg. accommodation, independence, activities, etc.), as well as overall satisfaction. Respondents selected a face to represent their feelings.

The responses to the faces were recoded for these analyses. The 'terrible' faces were given a score of one, and positive/neutral responses were scored 0. There were five faces questions, therefore respondents could score between 0 and 5.

Fifty nine percent of respondents scored 0 (no 'terrible' faces selected at any of the five questions), 35% selected between 1 and 3 'terrible' faces and 6% selected a terrible face at 4 to 5 of the 5 questions.

There were no differences with age and sex and selection of 'terrible' or 'delighted' faces.

Respondents selecting between 1 and 5 terrible faces were all equally more likely than those selecting none, to have experienced a major illness/operation/accident/fall in the past 12 months (Table 36).

They were more likely to have a GHQ over the threshold, a low general level of life satisfaction (as measured with the Neugarten scale), smaller and less dense social networks, more severe difficulties with tasks of daily living and to want more help with these (although they were as likely than those with positive-neutral scores to have help with tasks).

This group differed from other risks groups insofar as they wanted help. They were clearly 'at risk' of poorer mental and physical health, although they were no more likely to have more help than other less frail respondents. This finding is that screening elderly people for exceptionally low life satisfaction is probably worthwhile and supportive care could be provided.

RISK GROUP: SELECTION OF TERRIBLE FACES ON FIVE FACES QUESTIONS

	Selection of:-			
	No terrible faces %	1-3 terrible faces %	4 terrible faces %	5 terrible faces %
Below average life satisfaction score (Neugarten)	47	89	100	100
GHQ score above threshold	17	44	84	73
Lonely/often/most of time	8	37	78	93
Less than 4 people in network	36	48	63	64
Had two lowest density social network scores	43		66	
Severe difficulty to cannot do:				
10+ tasks	22	38	63	80
Cooking	17	27		53
Housework	40	70		88
Getting about outside	32	53		68
In past 12 months:- Experienced a major illness/operation/ accident/fall	30		43	
Reported 7+ (7-15) symptoms	14	32	35	55
Wanted help with tasks	6	13	26	53
No of respondents	281-329	156-198	16-19	12-14

Loneliness was measured by a question on frequency of loneliness and a question on the 'delighted-terrible' faces scale measuring cognitive feelings about severity. The two measures were highly significantly related, and the distributions of respondents identifying loneliness as a problem on each were similar. (Spearman's correlation: $r = .64$, $P < 0.0$).

The associations with other characteristics of respondents were similar for both measures. It was therefore decided to select one measure only for presentation here - the 'delighted-terrible' faces question about cognitive feelings of loneliness (given with severity of the feeling). Analyses of loneliness for other risk groups have been carried out using both measures, but only 'frequency' measures have been reported in previous - 'risk' sections.

It was reported earlier that 61% of respondents selected 'delighted' faces portraying their personal loneliness (ie. they were not lonely) and 16% selected a 'neutral' face. Twenty three percent selected 'terrible' faces. There were no differences with sex.

Table 37 shows that those who selected terrible faces to portray their level of loneliness were more likely to have smaller network sizes, less relatives in their networks, no live children and fewer main helpers. There was, however, no significant difference with number of confidantes listed in the scale - thus having one confidante appears to be as important as having several. There was also no difference with sex and reported loneliness.

Those selecting terrible faces were also most likely to have difficulties with more tasks of daily living, and to want help or more help. Analyses were carried out separately with difficulty cooking, with housework and getting about outside, as these represent essential tasks of life, and associations with loneliness were again highly significant. Those selecting terrible faces to depict their loneliness were also more likely to have a GHQ score above the threshold, to have a low life satisfaction score, and to live alone.

The lonely are thus another group in need of supportive care and are characterised by greater frailty, poorer mental health and they want more help, this is a group which could be identified and offered supportive care. Perhaps this should be a priority group in view of the associations reported between feelings of loneliness and applying for institutional care (Bowling & Salvage, 1984). On the other hand, they were no more likely than other respondents to want this help from professional services (few of the total number of respondents wanted professional help). Again an ethical problem regarding the imposition of services is raised. This also demonstrates that expressed need is not necessarily equated with demands for services.

Table 37

RELATIONSHIPS WITH LONELINESS ('DELIGHTED-TERRIBLE' (FACES SCALE ITEM))

	% of respondents selecting	
	Positive/Neutral face to depict loneliness	Terrible face to depict loneliness
In past 12 months experienced:	%	%
major illness/ operation/ accident/fall	33	43
bereavement (death of someone close)	21	34
Severe difficulty/cannot do:		
Cooking/prepare a meal	20	30
Housework	52	76
Get about outdoors	38	52
10+ tasks of daily living	27	40
Wants more help with tasks	39	63
GHQ score over the threshold	22	58
Below average life satisfaction score	56	94
Reported 7+ (7-15) symptoms	19	30
Lives alone	59	76
No live children	26	35
Listed less than four people in the network scale	37	56
Listed less than four people who were related in network scale	68	81
Had less than 4 people to turn to (confidantes)	67	79
Listed more than one person who was the most help to them	31	41
Lowest density network	43	66
Would like a voluntary visitor	7	25
No. of respondents	360-424	98-126

RISK GROUP: SEVERE DIFFICULTIES WITH 10+ TASKS OF DAILY LIVING
OR CANNOT DO THEM AT ALL

Over a third of the sample 35% had severe difficulties with 10 or more daily tasks, could only do them with help or not at all. 57% had such major difficulties with 1-9 tasks and 8% had no major difficulties of this type.

Females were more likely than males to have severe difficulties with or could not do at all, 10+ tasks: 41%:17% respectively. They were also more likely to want more help from professionals. Although the numbers wanting this help were tiny, the numbers wanting chiropody and voluntary visitors were larger (Table 38).

Table 38 shows those with major difficulties were more likely to have experienced a major illness/operation/accident/fall in the past 12 months and were more likely to receive help with tasks. They were more likely to have poorer emotional wellbeing, and the problems of severity of difficulties with tasks increases with age. There were no differences between groups and recency of contact with their GPs - 14% of those with major difficulties and 13% of those with no major difficulties had not seen their GPs for a year or more. The implication is that the submerged part of the clinical iceberg of disease is the same for both groups - but the consequences perhaps more serious for the group not in contact with their GPs. This is a group which could be easily identified with a disability measure and offered practical and supportive care.

Table 38

ASSOCIATIONS WITH DIFFICULTIES - WITH TASKS OF DAILY LIVING

% with severe difficulties - cannot do:			
	% none	1-9 tasks	10+ tasks
Would like:			
bathing service	-	1	7
social worker	-	3	8
home help	2	3	12
chiropody	4	13	24
voluntary visitor	4	9	20
Has/sees:			
hospital doctor	16	25	38
chiropodist	9	45	55
district nurse	6	12	30
bathing service	2	8	24
social worker	6	13	18
meals on wheels	7	16	29
home help	26	53	65
Reported 7+ (7-15) Symptoms	6	17	37
In past 12 months experienced:			
major illness/ operation/accident/ fall	19	31	48
Wants help/more help with daily tasks	24	42	57
Receives help with tasks	41		99
Aged 90+	19		33
Severe problem - cannot do:			
Cooking	-	11	60
Housework	-	47	96
Getting about outside	-	24	89
Very low life satisfaction score (0-6)	4	14	22
No. of respondents	52-55	342-373	184-229

ASSOCIATION WITH DIFFICULTIES - WITH TASKS OF DAILY LIVING

	% no	% with severe difficulties - cannot do:	
		1-9 tasks	10+ tasks
Selection of 1+ 'terrible' face depicting life satisfaction	17		47
GHQ score over threshold	11	31	51
Lonely often/ most of time	10	20	30
Never/rarely goes out to clubs/church etc.	55	67	75
Sees too little of friends	10	27	40
Listed less than 4 relatives in social network	69	72	68
No. of respondents	52-55	342-373	184-229

RISK GROUP: THOSE WANTING MORE HELP WITH TASKS OF DAILY LIVING

Almost half the respondents who had some difficulties with tasks, wanted help or more help with tasks (46%), although the numbers of tasks people wanted help with was small: 34% wanted help with 1-2 tasks and 12% with 3 or more tasks. Thus, interpreted in terms of packages of services, the demand for more care was fairly small (Table 39).

Those who wanted help or more help with tasks were less likely to have live children, although they had the same size of social network, network characteristics and household composition as other respondents. There was no relationship with age.

This group were also more likely to be housebound. This is another group who could be identified on a screening programme using simple measures of need, although they were no more likely than other respondents to want the help from health or social services.

Table 39

ASSOCIATIONS WITH RESPONDENTS WANTING HELP/MORE HELP WITH TASKS OF DAILY LIVING

	% wanting no help	% wanting help with 1-2 tasks 3+ tasks	
No live children	26	30	41
GHQ score over the threshold	28	43	62
Severe difficulty - cannot do: Get about outside	43	46	71
Average to low life satisfaction scores	59	76	87
Chosen 4-5 'terrible' faces at 5 faces items on life satisfaction	3	6	23
Lonely often/ most of time	5	10	24
Has help with 9+ tasks of daily living		24	38
Reported 7+ (7-15) symptoms	18	24	45
No. of respondents	294-330	172-210	60-73

Network Size

It was reported earlier that all respondents mentioned someone in the Social Network Scale as significant in their lives and with whom they were in at least monthly contact, although the sizes of networks varied:- 43% of respondents listed 1-3 people in their networks. 17% listed 4 people and 40% listed between 5 and 20. People aged 95 and over were more likely to have less than 4 people in their networks; 41% in comparison with 48% of people aged 90<95 and 67% of those aged 85<90.

Even the question "if you needed the help of a relative or friend do you know there is one who would help?", revealed only 7% who said "no". No more than 5% gave negative replies about the amount of help and support they had from relatives and friends at other questions.

The level of support was therefore quantitatively and qualitatively high. Differences were found, however, with size of network, number of confidantes, relatives and network density.

Network size was related to number of live children - 41% of those mentioning less than four people in their networks had no live children, in comparison with 22% of those mentioning four to five people and 17% mentioning six or more people.

Consistent with this, network size was related to marital status - those who were single had the smallest networks - 61% of single respondents mentioned less than four people in their networks in comparison with 41% of the widowed/separated and divorced and 36% of those who were married. Lack of relatives in old age is not compensated for by number of friends (friends are perhaps more likely to be in the same age group and therefore more likely to have died). There were no differences with sex.

Those with the smallest networks were more likely to pick at least one 'terrible' face at one of the seven faces questions relating to life satisfaction - 64% of those with a network size of one to three people picked a 'terrible' face, 41% of those with a network size of four to five people picked a 'terrible' face, and 30% of those listing six or more people picked a 'terrible' face.

Those with the smallest networks were also more likely to have average or less than average life satisfaction score using the Neugarten Life Satisfaction Scale - 72% of those mentioning one to three people, 69% mentioning four to five people and 56% of those mentioning six or more people had a low or average score.

People with the smallest networks were also more likely to say they were lonely often or most of the time - 30% of those with the smallest network of one to three people said this, in comparison with 21% of those with four to five people and 13% of those with six or more people in their networks. There were no relationships with network size and amount of help given with tasks of daily living, nor with whether help or more help was needed.

CONFIDANTE

It was reported earlier that 95% of respondents mentioned at least one confidante (someone whom they could confide in and turn to for help in an emergency). 53% listed 1-2 confidantes, 30% listed 3-4 and 17% 5 or more. There were no differences with sex.

There was a relationship between number of confidantes and GHQ score. Those with 6 or more people as confidantes were more likely to have a low (normal) GHQ score: 64% had a low GHQ score in comparison with 59% of those mentioning 5-3 confidantes and 50% of those mentioning less than 3 confidantes. They were also more likely to say they were lonely often or most of the time (80%:69%). Thus those having fewer confidantes have no more need for practical help but they appear to be more likely to need psychological help.

RELATIVES

It was pointed out earlier that 68% of respondents reported that between 50% and 100% of their social network members were relatives. It was also shown that relatives were the main helpers in most cases of those with difficulties of tasks of daily living.

Those respondents who were often/most of the time lonely were not only more likely to have less than four people in their social networks (see previous page), but they were also more likely to have less than four relatives in their networks (82%:66%).

Respondents with the highest proportion of relatives in their networks were more likely than others to have help with household tasks. Help with tasks was not related to network size nor to the other network measures (Table 42). Females were more likely to report less than 4 relatives in their networks than males (70%:50%).

Integration (density) of network

The calculation of density of network was explained in the earlier section on social networks. This showed that two-fifths of respondents had the lowest density network, about a quarter fell into the middle category and over a third into the highest density group. There were no differences with sex.

Almost a third of those (30%) within the two low density groups chose a 'terrible' face to depict how lonely they felt, in comparison with less than a fifth (16%) of those in the highest density group. Similarly, 17% of those in the highest density score group said they were often lonely, or lonely most of the time, in comparison with 30% of those in the two low density groups.

As with number of confidantes, density score was related to GHQ score - those with the highest density score were slightly more likely to have a low (normal) GHQ score, 57%, in comparison with 52% of lower density score groups.

Those in older age groups had the lowest density scores which may be reflective of their increasing age and the accompanying loss of friends and relatives through death - 17% of respondents aged 95+ had the highest density scores in comparison with 38% of younger age groups.

So do those with smaller networks have greater needs and unmet needs than those with larger networks? Between 40 and 50% of respondents had smaller networks, smaller density networks and smaller numbers of confidantes in their networks. They certainly had lower life satisfaction and were more likely to be lonely. Those with fewer confidantes and lower density networks were more likely to have GHQ scores over the threshold (indicating mental disturbance). This indicates that those with smaller networks, and those with qualitatively less supportive networks (as measured by density and by number of confidantes) have poorer emotional wellbeing.

On the other hand, those with smaller network sizes, low density networks, smaller numbers of relatives and confidantes in their networks were no less likely to be in contact with health and social services or with their GPs. There were no differences between groups in the numbers of tasks of daily living they had help with or wanted help with, or number of, or type of, services wanted.

The implication is that, although the less socially supported group had emotional needs, they were no more likely than those with emotional needs in more supportive networks, to want professional help. It was reported earlier, moreover, that very few respondents wanted any, or any more, professional services.

RISK GROUP: THOSE LIVING ALONE

Sixty one percent of the sample lived alone, this group were also analysed in terms of their social, physical and psychological characteristics.

There were no differences in network sizes nor numbers of confidantes listed by those living alone and those living with others, although those living alone were less likely to have live children: 62%:85%, and were less likely to mention 4 or more relatives in their networks (76%:60%). Their life satisfaction, and GHQ scores were no different from those of respondents living with others. There was no differences between these groups in terms of their ability to perform tasks of daily living, nor with help wanted, although the group living alone were less likely to have help with tasks of daily living (e.g. 18% had help with 9+ tasks of daily living in comparison with 36% of home sharers). This is probably explained by home sharers not existing to help them. In sum, those living alone are not a 'risk' group.

2

Table 40

PROPORTION OF RELATIVES IN SOCIAL NETWORKS AND HELP
GIVEN WITH HOUSEHOLD TASKS

	Up to 50% relatives in network %	50 < 100% of relatives in network %	100% of relatives in network %
Of those with difficulties with tasks and with help, who helps:			
PREPARE/COOK FOOD:			
Relatives	36	46	77
Friends	6	-	-
Professionals	51	40	16
Relatives & Friends	3	-	1
Relatives, Friends, Professionals	4	14	6
HOUSEWORK:			
Relatives	12	21	53
Friends	2	1	-
Professionals	80	71	38
Relatives & Friends	1	-	-
Relatives, Friends, Professionals	5	7	9
LAUNDRY:			
Relatives	33	61	76
Friends	12	4	1
Professionals	51	33	22
Relatives & Friends	2	-	-
Relatives, Friends, Professionals	2	2	1
No of Respondents	47-135	66-174	64-114

Table 40 (cont)

PROPORTION OF RELATIVES IN SOCIAL NETWORKS AND HELP
GIVEN WITH HOUSEHOLD TASKS

	Up to 50% relatives in network %	50 < 100% of relatives in network %	100% of relatives in network %
SHOPPING:			
Relatives	26	49	74
Friends	9	4	1
Professionals	46	27	19
Relatives & Friends	7	4	1
Relatives, Friends, Professionals	12	16	5
ODD JOBS:			
Relatives	30	56	75
Friends	22	5	2
Professionals	32	18	12
Relatives & Friends	4	5	4
Relatives, Friends, Professionals	12	16	7
No of Respondents	47-135	66-174	64-114

RISK GROUP: PEOPLE WITH PROBLEMS WITH SIGHT

About half (52%) of the sample reported problems with seeing (even with glasses on), and about half of these also had difficulty hearing. Analyses were carried out with those with problems seeing and social support, psychological and health measures. There were no differences between those who had problems seeing and those with no problems in terms of available social support. However, those with problems seeing were more likely to have a below average life satisfaction score, a GHQ score over the threshold, and to select 1-5 'terrible' faces regarding satisfaction with current aspects of their life. They were also more likely to be often lonely, or lonely most of the time. They were more likely to have 'severe difficulties' with 10+ tasks and also with cooking, housework and getting out (see Table 41). There was no significant difference with age. They were also more likely to have help with tasks of daily living, but also to want more help. This is a group which could easily be identified by opticians and GPs and assessed for need for psychological support and physical help, - although they were no more likely than other respondents to want professional help.

Table 41

DIFFICULTY WITH SIGHT

	% with difficulty seeing	% no difficulty seeing
Average or below life satisfaction score	73	61
GHQ score over the threshold	34	21
Selected 1-5 'terrible' faces to depict life	49	34
Lonely most of time/ often	27	18
Severe difficulties - cannot do:-		
10+ tasks of daily living	41	28
Housework	68	53
Get about outdoors	51	40
Has help with 9+ tasks of daily living	29	21
Wants help/more help	51	41
Difficulty hearing	50	29
No. of respondents	281-333	281-342

RISK GROUP: THOSE WITH DIFFICULTY HEARING

Forty percent of the sample had difficulties with hearing. Those with difficulty hearing were also more likely to have difficulties with their sight, major difficulties with tasks of daily living, including cooking and housework, but not with getting about outside. They were slightly more likely to have help with these tasks, but no more or less likely than other respondents to want any more help (Table 42).

There were no differences between this group and other respondents in terms of their GHQ or life satisfaction scores, or scores at the "delighted-terrible" faces questions, feelings of loneliness, or type and size of social network. Although this group could be screened for hearing problems, apart from mobility problems (which they were no more likely to want help with than other respondents), they were no more likely to have unmet needs than other respondents.

Table 42THOSE WITH DIFFICULTY HEARING (EVEN WITH HEARING AIDS)

	Hearing Problem %	No Hearing Problem %
Difficulty with eyesight (even with glasses)	66	44
Severe difficulty - cannot do:		
10+ tasks	41	31
Housework	68	56
Cooking	36	22
Has help with 9+ tasks	29	22
No. of Respondents	344-391	215-250

Fourteen percent of the sample had not seen their GPs for one year or more.

This group were less likely than those seeing their GPs more recently to have had experienced a major illness, operation, accident or fall in the past 12 months.

Table 43 shows that they reported fewer health problems than those consulting the GP within the past 12 months. There was no difference between groups with the other health problems not listed in the table.

Although they either had fewer or the same health problems than more frequent consulters, the group not seeing their GPs for a year or more were less likely to have reported their problems to their doctors. Table 43 shows these differences were considerable.

Respondents not seeing their GPs within a year were no more or less likely to be housebound or to have severe problems with/inability to do domestic, personal care or locomotor tasks. They were no more or less likely to be receiving other health and social services, nor to want them. They were no more or less likely to receive help (from relatives as well as professionals) with tasks of daily living.

There were no differences between consulting groups and network size, other measures of social support, household composition or social activities. The table shows, however, that their state of emotional wellbeing was more positive than that of more frequent consulters (they had a lower GHQ score and a higher degree of life satisfaction). There were no differences with age, sex and marital status. This conflicts with Williams (1984) analysis of non-consulters in his own practice - he found this group more likely to contain males and widowed/single people.

On the basis of the current study, those who have not seen their GPs for a year or more appear to be a fitter group than those consulting more frequently. On the other hand, for a number of reported conditions there were no differences between consulters and non-consulters, and the submerged part of the clinical iceberg of disease was apparent for both groups. This may be worth detecting in cases of poor sight and hearing, problems with nerves, stress, depression, incontinence and bowel problems, indigestion, headache, etc. Given that the table shows that, of those with health problems, the non-consulters were less likely to have reported them to their GPs than the case for surveillance is stronger. Thus, although non-consulters are fitter, they are more at risk of neglecting their health when they do have symptoms. This does raise the ethical question of whether this matters in extreme old age.

Their more positive mental health and outlook may prevent them consulting their GPs, and prevent them consulting when they need to.

Table 43

ASSOCIATION WITH CONTACT WITH GP

	Seen GP in past 3 months %	Seen GP between 3-12 mths %	Not seen GP for one year or more %
Suffered a major illness/ accident, fall or operation	41	30	22
Would like chiropody/ more chiropody	80	88	91
<u>Has severe problems to cannot do at all with:-</u>			
Cooking	32	35	50
Handling money etc.	61	70	75
Using public transport	61	70	75
Low (normal) GHQ score	48	65	
Average or high (14+) life satisfaction score	30	38	42
Reported 7+ symptoms (7-15)	28	18	8
<u>Of those with health problem, not told GP:-</u>			
Nerves/stress/depression	66	33	25
Bronchitis	92		67
Influenza	90	74	66
Constipation	82	66	50
No. of respondents	366-368	157-159	81

ASSOCIATION WITH CONTACT WITH GP

	Seen GP in past 3 months %	Seen GP between 3-12 mths %	Not seen GP for one year or more %
<u>Of those with health problem, not told GP:-</u>			
Piles	84	67	33
Indigestion/heartburn	70	77	44
Aches/pains/stiffness in muscles/joints	87	74	53
Sleeplessness	70		44
Abdominal pain/discomfort	82		65
Appetite loss	54		25
Headaches	77		40
<u>Has severe problems/ cannot do:-</u>			
Cut toe nails	71		62
Takes prescribed medication	88	64	56
<u>Problems with:-</u>			
Constipation	39	28	23
Chest pains/other heart trouble	24	20	11
Abdominal pain/discomfort	19	10	6
Giddyness	38	27	22
Aches/pains/stiffness in muscles/joints	74		63
Sleeplessness	42	35	21
No. of respondents	366-368	157-159	81

RISK GROUP: EXPERIENCED A MAJOR ILLNESS/OPERATION/ACCIDENT/FALL IN PAST 12 MONTHS

Over a third, 36%, of the sample, had experienced a major illness/operation/accident or fall over the past 12 months. Those who had experienced a major illness/accident/fall in the past 12 months were more likely to be housebound and have difficulties with more tasks of daily living. They were more likely to have help with these tasks, but also more likely to want more help (Table 44).

Their level of emotional wellbeing was also lower than that of other respondents. However, this group were more likely to have seen their GPs in the past 12 months (almost by definition). Again, they appear to be a group worth identifying, given the larger scale of their problems, and provided with help and support.

Table 44

RISK GROUP: EXPERIENCED A MAJOR ILLNESS/OPERATION/ACCIDENT/FALL IN PAST 12 MONTHS

	Experience of major illness etc. %	No Experience %
Seen GP in past 12 months	92	84
Severe difficulty to cannot do:		
10+ tasks	47	28
Cook/prepare meal	34	24
Housework	26	46
Get about outside	56	40
Has help with 9 or more tasks	32	40
Wants help/more help with 3 or more tasks	21	15
GHQ score above threshold	51	29
Average or below life satisfaction score	76	62
Selected 1+ terrible faces at face life satisfaction scale	50	37
Lonely: often/most of time	27	20
No. of respondents	196-230	363-418

In sum, the identified risk groups do appear worth identifying as they have multiple needs. However, they do not all want help, or more help. Thus, the desire for help must be measured, rather than attempting to impose services on pre-defined groups of people 'at risk'.

There are, of course, other 'risk' groups who have not been analysed - eg. those who have recently moved (although the sample did not include most of this group) and the recently widowed. There were insufficient numbers in the sample to yield valid analyses, although there is much existing literature on the poorer, emotional and physical health of the widowed (Bowling and Charlton, 1987).

1. Response rate the FPC register, although the only record of elderly people claiming to be complete, was highly inflated with people who had moved or died. Thus it is a poor sampling frame.
2. The Barber screening questionnaire did not produce a high response rate, although it has done so when used by individual GPs screening their own patients (Barber, et al, 1980).
3. More problems were evident among those returning the screening questionnaire than among the total sample of elderly people traced. This indicates bias among responders (ie. more of those with problems returned the screening questionnaire), and possibly the lack of sensitivity of the screening questionnaire. This is particularly evident in questions about being housebound. Over half the responders to the screening questionnaire indicated they were housebound. Results from the interview survey, using more sensitive measures, found that this figure represents those with severe problems getting about outside as well as those who can only get out with help and those who could not get out at all.

Although Barber et al (1980) justify the lack of sensitivity of the questionnaire, by pointing out it is better to include false positives than false negatives, it would be a more economic use of resources to test and use a more sensitive instrument.

Accommodation

One of the most striking findings of the study was that almost three quarters of respondents did not want to move away from their present homes, over two thirds liked living in the area and very few were on a waiting list for long stay care (8 people).

The vast majority of very elderly people still living in the community have decided against institutional care. This is consistent with previous research on attitudes among people aged 75+ (Salvage, 1986).

Social Contacts

The social networks of people aged 85+ living in City & Hackney were large and integrated. Most people's networks were comprised largely of relatives who provided most of the help with tasks of daily living. Over 90% of people answered positively at each question measuring availability and quality of social support.

Health

Over a third of respondents had suffered a major illness/operation/accident or fall in the past 12 months. The numbers reporting health problems and disability were high, as would be expected with a very elderly population.

Many people had severe difficulties with, or were unable to: bath themselves, cut their toe nails, perform heavy household chores and get about outdoors. Most people did, however, have help with these things, except with bathing and getting about outside, usually from relatives. The greater the severity of their difficulties, the more likely they were to have help.

On the other hand, help was less likely to be given to those with difficulties with personal care tasks (eg. washing themselves etc.)

It was notable that although about half of the respondents wanted more help with tasks of daily living, this was most often with one or two items only (usually with cutting toe nails; managing teeth/dentures; housework, odd jobs around the house and help getting in/out of the bath).

The professionals respondents most wanted to see was the chiropodist and a voluntary visitor (to help with loneliness).

Over a quarter of respondents scored over the threshold at the GHQ, indicating mental disturbance.

Just 14% had not seen their GPs within the last 12 months, but these appeared to be a physically fitter group, with better emotional wellbeing. On the other hand, those with reported health problems who had not seen their GPs for over a year were 'at risk' of their health being neglected. This raises the question of 'does this matter' in very old age.

Life Satisfaction

About two thirds of the sample scored at or below the general population average at the Neugarten Life Satisfaction Scale. This may be expected among older age groups, given that old age is a time of increasing loss (eg of roles, income, health, friends, relatives through death). However, the scale showed that most people were satisfied with their past lives and achievements. About half felt the present was a drearier, less happy, period than the past.

The 'delighted-terrible' faces scale, however, showed that a relatively small proportion chose 'terrible' faces to represent how they felt about specific aspects of their present lives, although more chose 'neutral' faces. The majority, however, chose 'delighted' faces.

Risk Groups

Further analyses were carried out of specific groups, identified at possible 'risk' (eg. health and social service needs).

These indicated that certain groups do have multiple physical, emotional and social problems: eg. the lonely, those with a low level of life satisfaction, those with a GHQ score over the threshold, the housebound and those with multiple difficulties with tasks of daily living, those with smaller networks (eg. the recently widowed, those moving house) but the numbers were too small for analysis.

The detection of multiple problems among these groups of elderly people, the groups inevitably overlapping, raises an ethical dilemma for health care and social service professionals: most people did not want more contact with health and social service professionals, although about half admitted wanting more help with tasks.

The population of the UK is 55,767,381, of whom 563,805 are aged over 85. Between 1981 and 2001 the proportion aged 85+ is estimated to increase by 79% (Age Concern, 1986).

The 1983 OPCS population projections estimate that people aged 85 and over will increase at a particularly fast pace over the medium term future. By the turn of the century, females aged 85 and over are projected to number half the current number in 1985. The numbers of males aged 85+ are projected to more than double.

The implications for health and social services are that similar increases in current levels of service provision for those aged 85+ will be needed.

However, the conclusion of this survey is that the demands likely to be made by people in this age group in City and Hackney are fairly limited; locally this is a group with a high level of social support, anxious to retain their independence without much more service provision although the level of provision of home helps was fairly high (54% received this service). On the other hand, it should be remembered that these are the elderly who have survived. They are fitter than 'younger' elderly people applying for residential care places. Undoubtedly they will have greater health service needs when terminally ill, but currently are not a group with infinite needs which they wish to express as service demands.

The implication, however, is that the burden on their carers who may also be elderly, could be considerable.

In summary, the services for which this study has greater implications are chiropody, a voluntary visiting service, and probably provision for relieving the carers of elderly people.

The situation of the younger elderly, those under 85, may be different - they are not the fittest who have survived, and they may be less likely to have close family members still living nearby. This is likely to affect their need for services if they survive into older age.

Screening questionnaire and letter (translated into languages spoken in City & Hackney).

Appendix II

Profiles of the Elderly

Case 1

A 94 year old widowed female, housebound, living in a second floor council flat. She never opened her door to strangers, and the interviewer gained access via a neighbour who had also been interviewed.

She felt the worst thing about her age was "loneliness - hours and hours and hours!". However, she spoke to relatives daily and had five people in her social network. Four of these she named as confidantes, three were relatives. Her daughter was named as the person who she felt she could depend on and who showed she cared about her. She felt she saw enough of her children, but little of her other relatives and friends.

Most of the time she just slept or sat, with the TV and/or radio on. She had poor sight and hearing, suffered from nerves/stress/depression and reported a number of symptoms, including joint stiffness and incontinence. She was unable to perform household tasks, bath herself, wash her hair or cut her toe nails.

Her joints were so stiff she was unable to write. She relied on her home help (every weekday), who even washed her hair. Her neighbour helped her at weekends. (She had the bathing service weekly.

She had only seen her GP about three times in the last 10 years. She did not want any more health or social services, but said she would like a voluntary visitor. Her main concern was: "that I would pass away at night and no one would know!"

She chose three 'terrible' faces to depict her satisfaction with aspects of her present life and the five 'faces' questions and her GHQ score was over the threshold. Although she felt her life was not worth living "rather more than usual", she had definitely not had suicidal feelings.

Case 2

An 89 year old widow, living alone in sheltered accommodation (no warden), with no relatives nearby. A neice and nephew lived some distance away and visited her about every six weeks. She said she would like a voluntary visitor: "someone to look forward to". She relied on her twice weekly home help for company and practical help. Her only other contact was an 82 year old, frail, neighbour. She had no telephone, and said she would like one. She spent her time "just sitting" or "sleeping" and occasionally knitting or watching TV. She had severe difficulty with household tasks and she was housebound, although was occasionally taken to a lunch club when transport was arranged. She felt there was no one who cared about her.

She had many health problems, including arthritis, but had seen her GP

within the last three months. Her greatest worry was loneliness, she had difficulty sleeping, and she had a GHQ score over the threshold. She was tearful during the interview, mainly because she was unable to do much for herself.

Case 3

A 90 year old widow, who was housebound and never went out. She lived alone in a private flat, and her daughter (her main helper) lived in the flat above her.

She spent the days alone, but saw one of two children most evenings and said she never felt lonely. She was determined to retain her independence.

She had problems with sleeplessness and incontinence, but had not told her GP about these. She spent her days simply listening to the radio, watching TV or just sitting /sleeping. She had severe problems with most listed tasks, or could not do them, but had help with everything (except going out) from her daughter and home help. She also had meals on wheels. She did not want any more services, and had a low GHQ score (indicating no psychological problems).

Case 4

A deaf and partially sighted 94 year old widow living in a self-contained flat owned by her son. Her son lived in the top flat with his family and her sister also lived in a flat in the same house.

She was housebound, but well supported by her family.

She had a number of health problems which she had not consulted her GP about, including incontinence, giddyness and headaches. She last saw her GP 6 months ago. She was unable to do any of the domestic tasks, although could perform the personal care tasks (except bathing). She had help from a home help and her relatives, and said no more help was needed.

Her greatest worry was "constant aches and pains in ankles and knee caps" which limited her activity. however, she had a high level of life satisfaction and a low GHQ score.

Case 5

An 86 year old Jewish widow, living alone in a 4th floor council flat. She liked her home, but often felt afraid: "sometimes I feel someone is trying my door at night". She did not know her neighbours:-

"I'm scared of dying alone, and the neighbours are cruel and cold .. There isn't one neighbour who rings my bell."

She reported many health problems, and she was housebound, had been in hospital in the last 12 months with a heart condition and felt: "I'm going to die soon, now that I'm housebound". She had not reported many of her symptoms to her GP, including her depression and forgetfulness. She last saw her GP five months ago.

She had no children, and no relatives or friends. She felt she had 'no one' to turn to.

She had low life satisfaction, and a GHQ score over the threshold. She

felt her life was not worth living and had thought of taking her own life. 100

She had difficulties with most of the tasks, and wanted more help with cooking, housework and personal care tasks, plus 'someone to speak to every day'. She did have a home help, but spent much time worrying 'whether my home help will turn up'.

Case 6

A 95 year old bedridden widow (arthritis), blind and partially deaf.

She lived alone in a 12 roomed house surrounded by empty houses. She was visited twice a day by her niece and nephew or a private nurse. She had no children or other relatives. She had home help and meals on wheels. She was unable to do anything for herself and also had bedsores, was incontinent and suffered from depression, confusion and forgetfulness, loss of appetite and many other symptoms. She said she was 'never' warm enough. However, she did not want any more help, except better heating.

Case 7

An 88 year old registered blind man, housebound and living with his wife. Both were partially sighted. He was incontinent of urine and faeces and his wife felt 'at breaking point'. They currently had a monthly visit from a nurse to help him bath, and a home help four times a week.

They lived in a ground floor council flat and did not want to move - his wife simply wanted 'respite care' to help her with her husband. Their only son lived in Australia. He felt no one understood him not even his wife. He had been to hospital with a hernia in the past 12 months.

More help was wanted with shopping and other household jobs. His greatest worry was 'losing my wife'. He had a GHQ score over the threshold.

Case 8

An 87 year old widow, living alone in a ground floor council flat. She said her right leg had been amputated below the knee a year ago, which was still a 'great shock' to her. She went out in a wheelchair.

She said she rarely felt lonely and spoke to someone most days. her son was her main helper and supporter and she had 7 other close friends and relatives. She had a cousin who she felt particularly 'cared' about her.

She was able to perform all the personal care tasks (except bathing and cutting her toe nails), but not domestic tasks. She had a home help, meals on wheels and the bathing service visited her fortnightly. She had a high level of life satisfaction and a GHQ score of 0.

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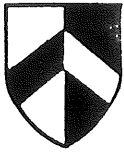
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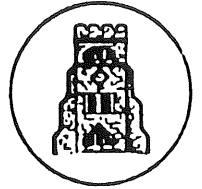
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THE CITY AND HACKNEY HEALTH AUTHORITY
Department of Community Medicine

APPENDIX I



St. Leonard's

Nuttall Street, Kingsland Road, London N1 5LZ
Telephone 01-739 8484

DEAR

WE ARE TRYING TO FIND OUT WHAT TYPE OF HEALTH AND SOCIAL SERVICES
ARE NEEDED BY PEOPLE WHO ARE 85 YEARS OLD AND MORE.

YOUR GP KNOWS THAT I AM SENDING YOU THIS SHORT QUESTIONNAIRE WHICH
WILL GIVE US SOME IDEA OF THE SERVICES YOU MIGHT FIND HELPFUL.

THE QUESTIONNAIRE IS CONFIDENTIAL AND WHEN YOU HAVE FILLED IT IN
PLEASE COULD YOU RETURN IT TO ME IN THE ENCLOSED STAMPED ADDRESSED
ENVELOPE. IF YOU NEED ANY HELP FILLING IN THE FORM, PLEASE CONTACT
ME AT ST LEONARD'S (TEL: 729 7161) AND I WILL BE VERY PLEASED TO HELP
YOU.

WE HOPE TO BE ABLE TO VISIT SOME OF THE PEOPLE WHO HAVE RETURNED THE
QUESTIONNAIRE IN ORDER TO TALK ABOUT POSSIBLE NEEDS IN MORE DETAIL.
THIS WILL HELP US ORGANISE THE MOST SUITABLE SERVICES WE CAN FOR PEOPLE
IN CITY AND HACKNEY.

WE HOPE THAT YOU WILL FEEL ABLE TO HELP US, BUT IF YOU DO NOT WANT TO
BE INTERVIEWED, PLEASE WRITE 'NO' IN THE BOX AT THE BOTTOM OF THIS
LETTER.

YOURS SINCERELY

DR JANE LEAVER
SPECIALIST
COMMUNITY HEALTH SERVICES



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NAME: _____

ADDRESS: _____

(NOTE: Although it would help us if you gave your name and address, you do not have to if you do not wish to)

PLEASE CIRCLE THE ANSWER
APPLICABLE TO YOU

e.g. DO YOU LIVE ON YOUR OWN?

YES

NO

DO YOU LIVE ON YOUR OWN?

YES

NO

DO YOU HAVE A RELATIVE, FRIEND OR
NEIGHBOUR WHO YOU CAN RELY ON FOR
HELP?

YES

NO

DO YOU NEED REGULAR HELP WITH
HOUSEWORK OR SHOPPING?

YES

NO

ARE THERE DAYS WHEN YOU ARE UNABLE
TO PREPARE A HOT MEAL FOR YOURSELF?

YES

NO

ARE YOU CONFINED TO YOUR HOME AT ALL
THROUGH ILL HEALTH OR ANY OTHER
REASONS?

YES

NO

DO YOU HAVE ANY WORRIES ABOUT YOUR
HEALTH THAT YOU MIGHT LIKE SOME
ADVICE ON?

YES

NO

DO YOU HAVE ANY PROBLEM WITH YOUR
EYESIGHT?

YES

NO

DO YOU HAVE ANY DIFFICULTY WITH YOUR
HEARING?

YES

NO

HAVE YOU BEEN IN HOSPITAL DURING THE
PAST TWELVE MONTHS?

YES

NO

HAVE YOU BEEN TO SEE, OR BEEN VISITED
BY, YOUR GP IN THE LAST TWELVE MONTHS?

YES

NO

THANK YOU FOR ANSWERING THESE QUESTIONS. WOULD YOU PLEASE
RETURN THIS FORM TO ME IN THE ENCLOSED STAMPED, ADDRESSED
ENVELOPE.
