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## The self-rated health of British adults with intellectual disability

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### ABSTRACT

People with intellectual disability have significantly higher age-adjusted rates of mortality and morbidity than their non-disabled peers. While self-rated health status is commonly used as an indicator of the health status of populations of interest, few studies have explored the self-rated health of adults with intellectual disability. We undertook secondary analysis of de-identified cross-sectional data from the first waves of two contemporary UK surveys: the *Life Opportunities Survey* ( $n = 37,513$ ) and *Understanding Society* ( $n = 50,976$ ). In the *Life Opportunities Survey* we identified 316 participants age 16–49 (1.7% of the age-restricted sample) as having intellectual disability. In *Understanding Society* we identified 415 participants age 16–49 (1.5% of the age-restricted sample) as having intellectual disability. Participants with intellectual disability were significantly more likely to report having fair or worse health than their peers (*Life Opportunities Survey*  $OR = 8.86$  (6.54–12.01),  $p < 0.001$ ; *Understanding Society*  $OR = 13.14$  (10.65–16.21),  $p < 0.001$ ). However the strength of this association was significantly attenuated when risk estimates were adjusted to take account of the increased rates of exposure of participants with intellectual disability to socio-economic disadvantage and (in the *Life Opportunities Survey*) exposure to discrimination and violence.

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### 1. Introduction

People with intellectual disability have significantly higher age-adjusted rates of mortality and morbidity than their non-disabled peers (Emerson & Hatton, 2014; Heslop et al., 2013; Krahn & Fox, in press). This evidence, when combined with exposés of failings in healthcare systems (Heslop et al., 2013; Mencap, 2007, 2012; Michael, 2008) and increased attention to the human rights of disabled people (United Nations, 2006), has led regulatory bodies and governments to stress the importance of reducing the health inequalities experienced by people with intellectual disability (Department of Health, 2007; Disability Rights Commission, 2006; Krahn, Fox, Campbell, Ramon, & Jesien, 2010; Parliamentary and Health Service Ombudsman and Local Government Ombudsman, 2009; US Department of Health and Human Services, 2002).

While self-rated health status is commonly used as an indicator of the health status of populations of interest (DeSalvo, Bloser, Reynolds, He, & Muntner, 2006; Idler & Benyamini, 1997, 1999; Jylha, 2009), few studies have explored the self-rated health of adults with intellectual disability (Emerson & Hatton, 2014; Fujiura, 2012). Of these, only three have employed relatively robust population-based sampling frames (Emerson & Hatton, 2008; Haider, Ansari, Vaughan, Matters, & Emerson,

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2013; Larson, Lakin, Anderson, & Kwak, 2001) and only two of these collected information on the self-rated health of participants with and without intellectual disability (Haider et al., 2013; Larson, Lakin, Anderson, & Kwak, 2001). Larson and colleagues identified 3076 respondents with predominantly mild intellectual disability in the disability supplements to the 1994–95 US National Health Interview Survey (NHIS) (Larson, Lakin, & Anderson, 2003; Larson, Lakin, Anderson, & Kwak, 2001; Larson, Lakin, Anderson, Lee, et al., 2001). They reported that adults with intellectual disability were markedly more likely to rate their health as fair or poor (24%) than their peers without intellectual disability (10%). More recently, Haider and colleagues undertook a telephone survey of the health of 897 adults with intellectual disability in the State of Victoria, Australia (Haider et al., 2013). They reported that adults with intellectual disability were markedly more likely to rate their health (or have their health rated by a proxy) as fair or poor (24%) than their peers without intellectual disability (18%).

Current knowledge indicates that the reasons for the poorer health of people with intellectual disability primarily fall within two broad spheres (Emerson & Hatton, 2014). First, a range of secondary health conditions is associated with some specific causes of intellectual disability (e.g., higher rates of congenital heart defects in children with Down syndrome). Second, people with intellectual disability are much more likely than their non-disabled peers to be exposed to a range of well-established social determinants of poorer health (e.g., poverty, social exclusion, discrimination, reduced access to timely and effective healthcare).

To date no study has examined the extent to which the poorer self-rated health of adults with intellectual disability may reflect their increased rates of exposure to common social determinants of poorer health. However, previous research has demonstrated that: (1) poorer self-rated health among adults with intellectual disability is related to increased rates of exposure to indicators of socio-economic disadvantage and discrimination (Emerson, 2010; Emerson & Hatton, 2008); and (2) the poorer maternal-rated health of children with intellectual disability can be partially accounted for by their increased rates of exposure to indicators of socio-economic disadvantage (Emerson & Hatton, 2007a, 2007b).

The aims of the present paper are: (1) to describe the self-rated general health status of British adults with intellectual disability; and (2) to examine the extent to which any between-group differences in health status may reflect between-group differences in rates of exposure to socio-economic disadvantage and discrimination.

## 2. Methods

We undertook secondary analysis of de-identified cross-sectional data from the first waves of two contemporary UK surveys; the *Life Opportunities Survey* (LOS) (Office for National Statistics, 2011) and *Understanding Society* (McFall & Garrington, 2011). Data were downloaded from the UK Data Archive (<http://www.data-archive.ac.uk/>). Full details of the surveys' development and methodology are available in a series of reports (Boreham, Boldyevaite, & Killpack, 2012; Buck & McFall, 2012; Dawe, 2011; Howe, 2010; McFall, 2012; McFall & Garrington, 2011; Office for Disability Issues, 2011), key aspects of which are summarised below.

### 2.1. Samples

LOS is a new longitudinal study focusing on the life experiences of disabled people in Great Britain (Dawe, 2011; Howe, 2010; Office for Disability Issues, 2011). In the first wave of data collection (undertaken between June 2009 and March 2011), random unclustered sampling from the small users Postcode Address File identified 34,004 eligible households. Interviews were completed with 37,513 individuals aged 16 or older from 19,951 households, giving a household response rate of 59% (Cuddeford, Duncan, Howe, & Glen, 2008; Dawe, 2011; Howe, 2010; Office for Disability Issues, 2011).

*Understanding Society* is a new longitudinal study focusing on the life experiences of UK citizens. In the first wave of data collection (undertaken between January 2009 and December 2011), random sampling from the Postcode Address File in Great Britain and the Land and Property Services Agency list of domestic properties in Northern Ireland identified 55,684 eligible households. Interviews were completed with 50,976 individuals aged 16 or older from 30,117 households, giving a household response rate of 54% (Boreham et al., 2012; Buck & McFall, 2012; McFall, 2012; McFall & Garrington, 2011).

### 2.2. Procedures

Data collection was primarily undertaken using Computer Assisted Personal Interviewing.

### 2.3. Measures

#### 2.3.1. Intellectual disability

Neither survey included information on the formal diagnosis of intellectual disability. As a result, we identified adults with intellectual disability on the basis of self-reported difficulties in learning or understanding coexisting with low self-reported educational attainment. Low self-reported educational attainment was used as a selection criterion for two reasons: (1) to exclude from the intellectual disability group respondents with specific learning disabilities such as dyslexia; and (2) as evidence that the person's self-reported difficulty may have originated in childhood. Due to historical changes in educational qualifications and attainment in the UK, we further restricted our analysis to the age range 16–49.

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