INSTITUTO NACIONAL DE ESTADISTICA

# Survey on Disability, Personal Autonomy and Dependency Situations. Resident Population in Centres 2023

# (EDAD Centres 2023)

## Methodology

April 2024

# Contents

# 1 Introduction

There is a clear consensus in society, both at home and abroad, of importance of research into the number, characteristics and situation of people with disability.

13 December 2006 marked the approval of the International Convention on the Rights of Persons with Disabilities. This Convention was the fruit of a lengthy process which saw the participation of UN member states, UN observers, UN bodies and organisations and the Special Rapporteur on Disability, plus national human rights institutions and non-governmental organisations, including organisation of persons with disabilities and their families, who played an important role. The convention also had an important Spanish contingent.

The purpose of the convention was to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms of persons with disabilities, and to promote their inherent dignity. Spain signed and ratified this Convention, which entered into force in our country on 3 May 2008, therefore, since that date this international body of regulations is fully part of the Spanish legal system.

In Article 31: “Collection of data and statistics”, the convention establishes the obligation of the signatory state to collect the appropriate information, including statistical and research data, which will allow them to formulate and apply policies to give the convention full effect. The same article states that the information obtained will be used as an aid to evaluate the compliance by Signatory States of their obligation under the convention, as well as to identify and eliminate the barriers faced by persons with disabilities in the exercise of their rights.

This treatment is reiterated by the Agenda 2030, in which there exists a clear relation between the sense of the SDGs and the purpose of the Convention. Disability is specifically referenced, in addition to the introduction, in various SDGs such as 4, on education; 8, on employment, 10, on reducing inequalities and 11 on the inclusiveness of cities and accessibility of transport. Agenda 2030 stresses the need for data itemised by disability as part of the monitoring of the SDGs.

In this sense, the Survey on Disability, Personal Autonomy and Dependency Situations (EDAD) 2008 produced by the INE, as well as previous macro-surveys (the Survey on Disabilities, Deficiencies and Handicaps - EDDM 1986 and the Survey on Disabilities, Deficiencies and State of Health - EDDS 1999) provided data, which supplied objective knowledge on the reality experienced by persons with disabilities in our country and met the demand for information on the phenomena of disability, dependency and ageing of the resident population in our country by the public administrations and many users, such as Third Sector organisations involved in social action.

The time transpiring from the publication of the last survey on disability and changes that have occurred in the population have led to the presentation of the Green Paper on the updating of the information of the EDAD 2008, as well as the demand for information coming from different Public Administrations and organisations in the Disability Sector.

In this same way, European institutions, through Eurostat, urges Member States to compile data and update information regarding persons with disability, obtaining not only information on their state of health and type of disability in the most detail possible, but also information regarding their socio-economic status, barriers in their social, educational and work environments, as well as possible cases of discrimination.

The 2020 Survey on Disability, Personal Autonomy and Dependency Situations in households and the 2023 survey in centres have been designed to meet the previously stated demands.

## 2 Concept of Disability for the purpose of the EDAD survey

Much like the EDAD 2008, the concept of disability in the EDAD 2020 household survey and 2023 centre survey is based on the International Classification of Functioning, Disability and Health (ICF), albeit with certain slight differences.

Although the ICF uses the umbrella term *disability* to group impairments, activity limitations and restrictions to participation, in the EDAD, the concept of disability has been identified with **major** limitations to performing the activities of daily life that have lasted or are expected to last over a year and that are resulting from a certain impairment.

In the ICF, it is hard to distinguish between “activities” and “participation”, which is why the classification provides a sole list of activities/participation, leaving it up the user, according to their own operational criteria, to decide upon the difference between the two concepts. In this line, the decision taken for the EDAD was to consider those activities listed in the first seven chapters of the nine which the ICF groups under the “Activities and Participation” component.

The two chapters which have been excluded are “Major Life Areas” (related to activities necessary to participate in education, work, employment and economic activities) and “Community, Social and Civic Life” (related to participating in free time and leisure activities, religious activities, political and public life, etc.).

However, the EDAD has researched the participation in these activities through a set of questions aimed at persons with disability on their involvement in economic activity, education, social network and contacts.

Once major limitations in the activity have been detected, it has been verified—by means of the degree of severity of each limitation indicated—whether these limitations comply with the disability criteria (major limitation on the activity) for the purposes of the EDAD, or do not comply due to being moderate or slight limitations. In this case, they are not considered a disability.

Regarding impairments, which the ICF considers under the umbrella term of disability, they too have been subject to study, but with a restriction: only those impairments that have led to a limitation in the person’s activity have been researched.

The following chart shows the relation between disability groups contemplated in the EDAD and the corresponding chapters of the ICF:

| EDAD | ICF Chapter (Activities and Participation) |
|---|---|
| 1. Sight | Body function (seeing functions) |
| 2. Hearing | Body function (hearing functions) |
| 3. Communication | 3. Communication |
| 4. Learning, applying knowledge and undertaking tasks | Part of chapter 1 (Learning and Applying Knowledge) and part of chapter 2 (General tasks and demands) |
| 5. Mobility | 5. Mobility |
| 6. Self-Care | 6. Self-Care |
| 7. Domestic Life | 7. Domestic Life |
| 8. Interactions and Interpersonal Relationships | 8. Interactions and Personal Relationships |

# 3 Working group

The objectives and content of the Disability, Personal Autonomy and Dependency Situations Survey had to meet the demand for information about persons with disabilities and their needs.

For this reason, a multidisciplinary Working Group was created made up of technicians from the INE and experts in the field of disability from the Ministry of Social Rights and Agenda 2030, specifically from the Institute for the Elderly and Social Services (IMSERSO), the Royal Trustees of Disability, and experts from the Spanish Committee of Representatives of People with Disabilities (CERMI), the ONCE Foundation and the NGO Plena Inclusion.

The work of this group focused on the revision of the EDAD 2008 questionnaires to adapt them to the new edition of EDAD 2020, taking into account the information needs, as well as the multi-channel collection method that would be used on this occasion (CAWI, CATI and CAPI); a novelty compared to EDAD 2008, where the information collection channel was exclusively the face-to-face interview with a paper questionnaire (PAPI).

The working group always considered the need to find a balance between the information requested and the reduced burden on the informant.

Once this adaptation of questionnaires was completed, the experts in disability in the Working Group provided assistance to the INE technical team with any conceptual doubts that may have arisen during the project's implementation. They also provided contacts of people with disabilities to conduct qualitative studies.

Starting from the decision that the concept of disability would remain the same as in EDAD 2008 as well as having the same number of questionnaires (Household, Disability, Limitations and Main Caregiver), the first objective was to review the household questionnaire, one whose purpose was to locate the homes where people with disabilities and/or children with limitations live, as well as obtain socio-demographic information on these households and their members; very valuable information that would provide a comparison of the characteristics of households where people with disabilities live with those which do not contain a person with a disability. The method of collecting this questionnaire would be either online (CAWI) or by telephone (CATI), which meant it was essential to reduce the number of questions, without endangering the objectives, in order for the interview time to be viable with the new collection channels. Once the two versions of the household questionnaire had been agreed upon, the INE conducted qualitative studies and a pilot survey to verify which of the two questionnaires designed best met the objectives sought.

The results and analysis of the pilot test were presented by the INE technicians in the Working Group. These results paved the way for preparing the final version of the Household Questionnaire.

The Expert Group also adapted the individual EDAD 2008 questionnaires to the information needs of 2020. This update was made both in the disability questionnaires (persons aged 6 and over) and limitations (children aged 2 to 5), and also in the questionnaire for the main caregiver.

In the case of individual questionnaires, the collection method would initially not undergo methodological changes; the interview would continue to be in person as in EDAD 2008, except that the paper questionnaire (PAPI) would be changed to an electronic questionnaire (CAPI). Hence, initially no pilot test was needed.

All members of the Working Group agreed on the importance of reducing proxy interviews and obtaining the direct informant, mainly in the individual questionnaire. For this reason, it was decided to make an **easy-to-read version of the disability questionnaire**[1] that would be offered to people with intellectual disabilities so that they could answer it themselves without the intervention of a proxy. The ONCE Foundation and the NGO Plena Inclusion conducted the work of translating the questionnaire into easy-to-read formats.

The work carried out by the Expert Group for EDAD 2020 households served as a starting point for the preparation of the questionnaire for EDAD 2023 centres.

The INE, taking into account the demand for information, the EDAD 2008 centres questionnaire and the individual questionnaire for people aged 6 and over from EDAD 2020 household survey, prepared a first draft of the person questionnaire for EDAD 2023 centres survey. This first version was presented to the Expert Group, who contributed considerable improvements.

The INE also designed the centres surveys and the Expert Group similarly had improvements to add, adjusting to the content to the need for information.

During the project development (field work, screening, etc.), the Expert Group was there to clear up any questions that might arise.

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[1] Easy-reading is the adaptation that allows for a simpler way of reading and understanding content. The method transforms complex sentences into short sentences and opts for easily understood vocabularies without changing the meaning of the initial text.

# 4 Methodological approach of the EDAD 2023 centres survey

The EDAD 2023 centres complements the information on disability, personal autonomy and dependency situations collected in the EDAD 2020 survey carried out in households.

It is addressed to the institutionalised population, that is, those persons residing in homes or group residences. The centres researched are centres for the elderly, centres for people with disabilities, long-stay psychiatric and geriatric hospitals, and sheltered and/or supervised housing. The latter are a novelty with respect to the EDAD 2008 centres edition.

The centres survey takes the same methodological approach as the household survey.

There is a questionnaire for the centre to compile its characteristics, plus an individual questionnaire intended for residents over 6 years of age.

As in the EDAD 2020 households survey, the EDAD 2023 centres survey has multi-channel collection, but only for the questionnaire for the centre. The preferred channel is the CAWI, but the telephone channel (CATI) and CAPI channel are available as necessary.

Due to the nature of the survey and in order to preserve the anonymity of the people interviewed, the individual questionnaire is done by personal interview (CAPI), on this occasion using tablets as the means of collection, instead of paper as was done in the 2008 edition.

In addition, in the case of personal interviews, in order to comply with the GDPR (EU Regulation 2016/679) regarding the protection of physical persons with regard to the processing of personal data and Law 12/1989 of 9 May of the Public Statistics Function, **data that allows for individuals' direct or indirect identification was not compiled**.

On the other hand, the questionnaire is consistent with the household questionnaire, and has been agreed upon by the expert group.

This is demonstrated in the reduced length of the questionnaire, affecting sociodemographic variable and question intended to record persons with disability or limitation and their type of disability, and in this case considerably reducing the number of questions.

The changes implemented also imply the change in the wording of the question, in order to record persons with disability or limitation and their disabilities or limitations with the same quality as the EDAD 2008 questionnaire.

Recommendations were also included on the compatibilities between disabilities, impairments and causes that have helped in the interpretation and screening of the information gathered.

In addition, the individual questionnaire was available in easy-reading format, a questionnaire with simplified language, for those persons with difficulty understanding or communicating. This questionnaire has been produced with the collaboration of ONCE and Plena Inclusión, which have adapted the questionnaire.

# 5 Objectives of the EDAD 2023 centres survey

The purpose of the EDAD 2023 centres is to study persons with disabilities residing in Spain, focusing the study of the resident population in collective housing, which is known as the institutionalised population, thus completing the portion not collected in the EDAD 2020 households, which conducted the study of family homes.

The EDAD 2020 households and EDAD 2023 centres edition has the purpose of updating the information from EDAD 2008, which is why it also contemplates the philosophy of the International Classification of Functioning, Disability and Health (ICF).

The **specific objectives** that this survey hopes to achieve are to:

1. Estimate the **number of persons with disability** in Spain residing in centres for the elderly, centres for people with disabilities, sheltered and/or supervised housing, and long-stay psychiatric and geriatric hospitals, as well as their geographic distribution.
2. Find out the **number and type of disabilities** of persons with disability.
3. Find out the **limitations on activity and participation restrictions** on the everyday lives of these people, as well as the severity of these limitations.
4. Find out the characteristics of the persons with disability and in a situation of dependency in these centres.
5. Identify the different types of **impairment that gives rise to the limitations**, as well as the cause of this impairment.
6. Evaluate the **discrimination of persons with disability** in different areas of everyday life.
7. Identify their **care needs and demands**, as well as the support they receive and its characteristics. Find out the use of technical aids, special adaptations, personal hygiene, etc.
8. Find out the **main characteristics of group centres where persons with disability live**, as well the services these provide
9. Perform an analysis of disability from a gender-based perspective
10. Find out the general state of health and certain diagnoses of persons with disability.
11. Find out the expense related to disability of persons residing in centres.
12. Find out information on the social contact made by persons with disability residing in centres.
13. Find out the accessibility problems from moving around both inside and outside the centres.
14. Find out the personal care they receive.

## 6 Phases of the Survey

The study has been performed in two phases:

**Phase One: Creation of the centre directory and survey to confirm the framework**

The centres considered in the survey are fundamentally those in which persons with disability are found, that is, residential homes for the elderly, residential homes for persons with disability and long-stay hospitals (geriatric and psychiatric).

In addition to these types of collective homes already studied in the previous edition, the study includes, for the first time, the so-called sheltered and/or supervised housing, which seems to be increasingly important; they are functional homes in which small groups of people who are in need of intermittent or limited support live together stably for a period of time in a partially self-managed regime. These homes require administrative authorisation and are usually owned by the regional or local administration or private associations.

One of the difficulties posed by the study is not having an adequate and updated directory of centres for the project at the national level at the time the study began, which is why it was necessary to create the directory[1] and confirm it exhaustively in the field. in addition to obtaining variables necessary for the sample design.

**Phase two: Survey of centres and people.**

Once the survey directory was determined, a random selection of centres was carried out and in each centre the number of people who ought to be interviewed was determined, as well as the probabilistic selection criterion, in order to guarantee the representativeness of the different types of centres and their territorial representativeness.

To collect the information, in the case of questionnaires addressed to the centres, a web questionnaire (CAWI) was available, although there was the possibility of completing the questionnaire with a personal interview (CAPI). Depending on the type of centre, a different questionnaire was created to adapt to its characteristics.

As indicated above, once the centre questionnaire was completed, the application indicated to the interviewer the number of people to interview. This number was determined based on the number of residents. The selection of people was carried out randomly and completely anonymously (without collecting identification data) to guarantee confidentiality. Participation was voluntary.

The individual interviews (people) were conducted through a personal interview (CAPI) with each selected person. If justifiably necessary, the interview could be done through another person sufficiently informed about the selected person, such as a caregiver or a family member (PROXY interview).

The main objective was, through the survey questions, to determine whether or not the people selected in the previous phase have any disability, and if so, their characteristics.

The survey was collected between the months of July and November 2023.

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[1] See Section 8. Creation of the Survey Framework

## 7 Research areas

- **Population scope**

  The research was conducted for the group of persons residing in residential centres (for the elderly and/or persons with disability, under 65 years of age), sheltered and/or supervised housing, and long-stay hospitals (psychiatric and/or geriatric). Children from 0 to 5 years of age were excluded from the study.

- **Geographical scope**

  The geographical scope is the entire national territory.

- **Temporal scope**

  The Phase 1 collection period devoted to the determination and correction of the Framework of Residential Centres and Supervised Housing ran from September 2022 to January 2023.

  The Phase 2 collection period, which consisted of gathering information from persons residing in centres, homes and hospitals subject to the survey, was conducted between July and October 2023.

## 8 Creation of the survey framework

The peculiarity of the work prior to performing the survey of the EDAD-Centres itself resided in the need to build a framework with the necessary information that would be able to properly extract the sample.

While in the EDAD household survey, the framework are the residency rolls, in the EDAD centre survey, there was no updated directory of centres at the national scale at the time the study began, one that would provide a list of all the centres subject to the statistical operation. Hence the need to create one in the project's initial phase.

To build the framework, an initial directory was created from sources available from IMSERSIO, CSIC and CERMI. These sources were complemented by available information. The office work was able to eliminate duplicates, standardise addresses, telephone searches, etc. The correct address, telephone and email were fundamental in contacting the centres.

The next phase in the process was to create a survey (framework file) for all the centres in the first directory to conform and correct the data available and add other important data such as the type of centre, the number of places, residents, gender and age distribution, and other essential characteristics needed to later make the sample design.

The framework file was made using the web questionnaire (CAWI). The data collection managers were experienced technicians from certain delegations of the INE, coordinated by the Data Collection Unit of INE Central Services. The technician encouraged participation by calling the centres and doing the survey over the phone where necessary. This activity ensured a high response percentage.[1]

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[1] See Response Rate document at www.ine.es in the Methodology section of EDAD 2023

The collection results were used to update the framework, removing centre which were no longer in operation and adding new centres which were not in the initial directory.

This framework file was produced between September 2022 and January 2023.

On the other hand, the data from the directory of supervised housing and assisted living centres was complemented by the list of geriatric hospitals and hospitals for people with mental illness obtained through administrative records from the NCH (National Catalogue of Hospitals).

Therefore, there were four types of centre: centres for the elderly, centres for people with disabilities, sheltered or supervised housing, and long-stay psychiatric and geriatric hospitals.

In the case of residential centres for the elderly, those that provide assistance to disabled people, dependent people and mixed residences (for disabled people and dependents) are included. In these centres there may be people under 65 years of age.

Prior to the selection of the sample, to avoid duplication in the collection of supervised homes, a cross-reference was made with the household survey framework, eliminating the homes that were included in the EDAD 2020 household framework, which guaranteed that the target population of households and centres did not overlap.

The information collected in this survey about the framework:

**Identification**

- Centre identification data (name, company name, Tax ID no., address, province, municipality, postal code, telephone, fax, email and website)
- Data on the contact person (name, surname, position at the centre, telephone and email)

**Centre characteristics**

- Ownership
- Type of financing
- Type of service provided: residential centre, day centre, sheltered or supervised housing, other service.
- Type of residential service (for residential centres)
- Type of sheltered or supervised housing (for assisted living services)
- Number of residential places
- Number of residents
- Age of the residents

**Information of the registrar data of the residents**

- The centre has an individualised registry or not

## 9 Sample Design

The aim of the survey is to provide information on the main characteristics of the study population by Autonomous Community and type of centre, so the sample design has made a distinction between Centres for the Elderly, Long-Stay Hospitals, Sheltered and/or Supervised Housing and specialised Centres for People with Disabilities.

### 9.1 SAMPLE TYPE

A stratified two-stage sampling process has been used. The first-stage units are the centres, while the second-stage units are the persons residing in these centres.

The stratification variables used were available in the directory and allowed for a more efficient design. The fundamental variables are considered to be the autonomous community, the type of centre and the centre size measured in the number of places (or beds, in the case of hospitals).

This way, the strata that were chosen are crossover of each autonomous community by the type of centre, considering the stratification of the following types: Centres for the Elderly, Hospitals, Large Supervised Housing (over 20 residents), Small Supervised Housing (20 residents or fewer), and Specialised Centres for Persons with Disability.

### 9.2 SAMPLE SIZE. ALLOCATION

To meet the objectives of the survey in providing a reliable estimate on the national and autonomous community level,

The size of the theoretical sample was approximately 14,000 people distributed in around 963 centres. The allocation of the sample into strata is proportional to the stratum size. Finally, an effective sample of approximately 12,500 people resulted from the initial theoretical sample of 14,000 people.

The number of persons interviewed in each centre is variable and was determined according to the type and size of the centre, as measured by the number of residents. In this way, at the end of the allocation stage, each centre had an assigned sample fraction indicating the percentage of people at the centre who should be interviewed.

The minimum number of second-stage units researched in each centre is two people in supervised housing and five people for the other types of centres.

### 9.3 SAMPLE SELECTION

In the first stage, the centres in each stratum were selected with a probability proportional to the number of residents in each centre, using a systematic design. The people at each centre were selected with an equal probability following the sample fractions for each centre after the sample allocation process.

The people selected for interview were taken from a list of all the residents in the centre, which was obtained by the interviewer at the time the interviews were to be done. A list of terminations was provided, associated with different sample fractions, in such a way that the persons whose number on the list ended in one of the terminations corresponding to their centre were selected for interview.

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## 9.4 ESTIMATORS

To estimate the main characteristics researched in the survey, the Horvitz-Thompson estimator has been used, applying calibration techniques to improve its efficiency and adjust for non-response.

The final estimator is obtained in several steps:

### 1. Estimator based on the sample design

As we have seen, the probability that centre i of stratum h is in the sample would be:

$$P(hi \in S) = n_h \cdot \frac{P_{hi}}{P_h}$$

Where $n_h$ is the theoretical sample of stratum h, $P_{hi}$ the number of people residing in centre i of stratum h, and $P_h$ the number of people residing in stratum h. Sometimes when a systematic is carried out with few population units, the previous quantity may be greater than 1 and thus would not be a probability. Therefore, it is necessary to make the following adjustment:

$$P(hi \in S) = \min\left\{n_h \cdot \frac{P_{hi}}{P_h}, 1\right\}$$

In this way the selection probabilities would be (where $f_{hi}$ is the sampling fraction of centre i of stratum h):

$$\pi_{hij} = P(hij \in S) = P(hij \in S \mid hi \in S) \cdot P(hi \in S) = f_{hi} \cdot \min\left\{n_h \cdot \frac{P_{hi}}{P_h}, 1\right\}$$

And the associated Horvitz-Thompson estimator is:

$$\hat{Y}_{HT} = \sum_h \sum_i \sum_j \frac{Y_{hij}}{\pi_{hij}}$$

### 2. Non-response reweighting

In this survey there may be a non-response from the centres and in from people of a centre in the effective sample. We start by looking at how to adjust for a non-response associated with each centre. In each stratum, if we denote from $S^*$the effective sample, we have

$$P(hi \in S^*) = \frac{n_h^*}{n_h} \cdot \min\left\{n_h \cdot \frac{P_{hi}}{P_h}, 1\right\}$$

Where $n_h^*$ is the number of centres in the effective sample in stratum h.

As the theoretical sample of people in each centre does not have to coincide with the effective one, in each centre the effective fraction of people sampled $f^*_{hi}$ does not have to coincide with the theoretical $f_{hi}$. However, we can easily calculate $f^*_{hi}$ as the ratio of people interviewed from the centre over the total residents of the centre. With this consideration, the probability that person j is in the effective sample would be:

$$\pi^*_{hij} = f^*_{hi} \cdot \frac{n^*_h}{n_h} \cdot \min\left\{n_h \cdot \frac{P_{hi}}{P_h}, 1\right\}$$

In this way we obtain the elevation factors $\frac{1}{\pi^*_{hij}}$ adjusted for non-response and the reweighted estimator would be:

$$\hat{Y}^{*}{}_{HT} = \sum_h \sum_i \sum_j \frac{Y_{hij}}{\pi^*_{hij}}$$

### 3. Calibrated estimator

The previously obtained factors are calibrated to the number of residents in each stratum, where hospitals have been excluded in the types of centres since the number of their residents was not available in the framework and there was only information on the number of beds. In the same way, all supervised housing is calibrated together and is not differentiated by size.

## 9.5 SAMPLING ERRORS

To estimate the sampling errors, the **Jackknife method** has been used, which allows obtaining the estimate of the variance of the estimator of a characteristic Y through the expression:

$$\hat{V}\left(\hat{X}\right) = \sum_h \frac{n_h - 1}{n_h} \sum_{i \in h} (\hat{X}_{(ih)} - \hat{X})^2$$

Where $\hat{X}_{(ih)}$ the estimate of the characteristic X obtained by removing centre i from stratum h, and $n_h$ is the number of centres in stratum h.

The tables publish the relative sampling error in percentage, coefficient of variation, whose expression is:

$$C\hat{V}\left(\hat{X}\right) = \frac{\sqrt{\hat{V}\left(\hat{X}\right)}}{\hat{X}} \cdot 100$$

The sampling error allows us to obtain the confidence interval, within which the true value of the estimated characteristic is found with a certain probability.

# 10 Collection of information in EDAD Centres 2023

## 10.1 FRAMEWORK FILE

The collection of the EDAD Centres study was organised in two phases. The first phase (phase 1) took place between the months of September 2022 and January 2023. This phase was carried out to verify the Framework, a few months before starting the survey. An update was made in the field by sending to all centres (except hospitals) a brief questionnaire – Framework File – in which each Centre was asked to verify/correct the identification data (name, address, telephone, e-mail, etc.) and the type of service they offer, ownership, type of management and financing, as well as their number of places, residents and distribution of these by gender and age, among other data.

Phase 2 would be the completion of the centre questionnaires and those given to individuals at the centres who were selected in the sample.

## 10.2 COLLECTION SYSTEM

The time period for collecting information spanned 12 weeks, between July and October 2023.

Two information gathering methods from the centre questionnaire were used, which were:

- Web Questionnaire: The centres logged in with a user and password which were given on the letter of presentation previously sent to the centres.
- Personal Interview: Completed by the interviewer when the centres had not filled in or finished the web questionnaire.

The information was provided by the person who the management of the centre had appointed for this purpose. Any questions that arose were handled by the interviewer in their subsequent visits to the centre to interview the persons selected to answer the individuals survey, complementing the interview by telephone in those instances when it was necessary to complete omitted data or correct erroneous information.

The information collection method used in the individuals survey was the personal interview, which was totally anonymous. The information was provided, wherever possible, by the individual. If this person could not answer themselves, this was done by another person (from the centre or a family member) who was sufficiently informed.

The interviewers visited the centres to finish completing the centres survey that were not filled in via the website and to do the individuals survey. The necessary visits to each centre were made in order to obtain the information required.

## 10.3 BASIC UNITS

- Residential centres (for the elderly and/or persons with disability, under 65 years of age)
- Sheltered and/or Supervised Housing

- Hospitals (long-stay psychiatric and/or geriatric facilities)

**Potential interviewee**: Persons older than 6 years of age residing in residential centres (for the elderly and/or persons with disability, under 65 years of age), sheltered and/or supervised housing, and long-stay hospitals (psychiatric and/or geriatric).

## 10.4 SAMPLE INCIDENCES AND PROCESSING

Two types of incidences could be defined due to the sample selection method:

- Centre-related Incidences.
- People-related Incidences.

### 1. CENTRE-RELATED INCIDENCES

**a) Unlocatable address.**

This incident was assigned when the centre could not be located from the information contained in the directory nor from any other spoken or written medium.

Prior to a centre being considered unlocatable, the interviewer must investigate this circumstance by all available means: Town council, telephone book, business associations, etc.

**b) Erroneously included.**

The centre, either because of the main activity it carried out or for another reason, did not belong to the scope of the survey study.

**c) Duplicate.**

The centre was found more than once in the study centre.

**d) No Activity.**

The centre was inactive during the reference period for some specific or seasonal reason but had the intention of continuing its activity when the circumstances that had caused this situation were resolved. That is, its reopening was expected.

The lack of activity during the reference period could have been due, for example, to closure for some specific reason, such as works or accidental circumstances (fire, flood, etc.).

**e) Permanent closure.**

The centre was no longer open in the survey reference period, there is some justification that accredits this situation or, in any case, there is sufficient evidence that indicates it has closed permanently.

**f) Negative.**

The management of the centre refused to collaborate in the survey for various reasons and/or does not provide access to complete the survey of the people selected therein.

g) **Respondent.**

Collaborating centre with a valid questionnaire whose centre survey was valid and facilitated the completion of the survey to the people selected therein.

## 2. INCIDENTS WHEN CONTACTING AND INTERVIEWING THE PERSON

Once the centre was considered Respondent, the following incidents could occur when contacting the selected people:

a) **Collaborator.**

The person was considered a Full Collaborator when all the mandatory questions of the surveyed have been answered provided the route leads to them. These questions may be consulted in the section on the survey.

b) **Negative.**

This incidence occurred when the person refused to provide any information.

c) **Incapacity.**

The person selected was incapable of answering the questionnaire, either due to disability or illness, not knowing the language or another circumstance, and there was no one sufficiently informed of their situation who could answer for them (proxy).

d) **Not applicable for interview.**

This incidence occurred when the person did not comply with the requirements to be interviewed (under 6 years old).

e) **Absent.**

The person selected was temporarily absent due to being admitted to hospital, on holiday, etc.

f) **Not Valid.**

The questionnaire did not reach the minimum number of responses, with a response other than “does not know/no answer”, to comply with the criteria to be considered valid.

**HANDLING OF INCIDENCES:**

– CENTRE-RELATED INCIDENCES

In principle, there is no plan to replace centres, given that the centre selection framework has been recently updated. However, some minor incidences occurred because some centres that were not planned had been added.

– PEOPLE-RELATED INCIDENCES

Persons not applicable for interview were replaced by their corresponding back-ups.

The interviewer should have tried to avoid the incidences with the instructions he/she had received. The negative interviewees were replaced by the back-up interviewees. In negative interviewees, proxy information was NOT admitted.

In situations of incapacity to respond, proxy information was admitted, who then were changed to Collaborators, but where this was not possible, they were replaced by the back-up interviewee.

In the case of absence, there was an attempt to ascertain how long this situation would persist in order revisit the centre when the absentee would return. If it was confirmed that the absence would be prolonged, which would have lasted at least the entire time dedicated to field work, it was asked if there was a proxy who could answer the questionnaire and if not, it was proceeded to replace the person for their back-up.

## 10.5 SELECTION OF INTERVIEWEES.

Each centre selected in the sample was associated a sample fraction, determined according to its size, which was measured by the number of residents. This fraction represented the percentage of residents who should be interviewed.

This interviewee selection process required an enumerated list of all the people who resided at the centre. This list should be obtained by the interviewer at the centre itself. Where possible, the interviewer should prevent the order of persons on the list from following any gender- or age-based pattern. More the random the order of the persons on the list in each centre, the better.

To make the selection, a list of terminations was provided, associated with different sample fractions of the centres in the sample, in such way that the persons whose number on the list ended in one of the terminations corresponding to their centre were interviewed.

**EDAD - CENTRES**

**People selection**

| SAMPLING FRACTION | TERMINATIONS | |
|---|---|---|
| 100% | All | |
| 50% | Even | |
| 40% | 2, 5, 6, 8 | |
| 30% | 1, 2, 5 | |
| 25% | 1, 5; 04, 22, 54, 70, 86 | (*) |
| 20% | 2, 6 | |
| 15% | 2; 15, 55, 71, 79, 88 | (*) |
| 10% | 3 | |
| 7% | 14, 21, 34, 38, 48, 61, 74, | |
| 5% | 02, 15, 35, 55, 75, | |
| 3% | 12, 41, 66 | |
| 2% | 22, 34 | |

(*) In the 15% and 25% sampling fraction, terminations of one and two digits were considered, to simplify the list.

In most cases the number of residents / number of beds were already completed thanks to the previous survey EDAD-C Framework File. And it was the application itself that informed the interviewer which people on the list to interview according to their position on it.

In cases where the number of residents had changed substantially, a new sampling fraction was automatically recalculated.

### Handling of unknown sampling fractions

In cases where there was no information on the number of residents or places in a centre selected in the sample, the associated sampling fraction was left blank.

A rule was used so that the new sampling fraction was as similar as possible to that of centres of a similar size.

In these cases, the interviewer had to proceed as usual, obtaining a numbered list of the people residing in the centre. Once the number of people in the centre was known, a previously given rule was applied to obtain the sampling fraction.

Subsequently, the selection rules given in the termination table were followed according to the case.

### Selection of people in centres to replace incidences

In the event that a centre had a total or partial lack of response from the selected people, contact was retried in the following manner: starting from the terminations that had been investigated and adding one to them. From all the terminations obtained, those that had already been chosen were eliminated and the retries began with the lower termination and continued until the sample was complete.

In case of completing all the terminations obtained by adding 1 without having reached the necessary sampling fraction, the method was repeated by adding 1 again to the previous terminations, always ensuring that those obtained had not previously come up; in this case they were removed from the possible terminations.

### Selection of people in sheltered and/or supervised housing grouped to replace incidences

In the case of working with grouped sheltered and/or supervised housing, where the same centre could be divided among several housing units, the procedure was as follows.

The interviewer made, as always, a numbered list of all the people associated with the group of sheltered and/or supervised housing, even if they resided in different homes. In this case, it was important that the list had the home of each person located; if possible, cohabitants should appear together on the list. In this way the homes were also ordered in the list.

Once the list was obtained, the procedure followed the same course as in the first sample. In the event that any person was a non-respondent, the following procedure was used: in the homes that were visited sequentially to interview the selected people, an attempt was made to survey as many additional people as there was a cumulative loss of sample until that moment. To do this, we added 1 to the terminations obtained for the home visited and kept those people who had not been interviewed in the home. If necessary, subsequent terminations were continued to be researched until the accumulated non-response was completed. If all the planned homes had been visited without being able to recoup all the incidences that had occurred, the first home of those that had not been visited was chosen and the first person in the home was selected. The second person was then selected, and so on, in case that person did not respond either.

If, upon completion of all the homes, any incidence was left unreplaced, a non-response would be assumed.

### 10.6 VOLUNTARY NATURE OF THE SURVEY

This statistical operation investigates variables included in Article 11.2 of the LFEP (ethnic origin, political opinions, religious or ideological convictions and any that affect personal or family privacy) and is therefore voluntary.

## 11 Structure of the survey questionnaires and characteristics under study[1]

### Description and structure

The survey is conducted in two parts:

- The first part consists of interviewing the selected centre (residence / supervised housing / hospital), which must be answered using a questionnaire (CAWI).

  Depending on the type of centre, the content of the survey is different.

  Once the survey is answered, according to the number of residents, the number of people to interview is determined and they are selected.
- The second part consists of personal interviews (CAPI) conducted with the selected people.

Below is a description of the structure and characteristics of the study subject in each of the 4 questionnaires:

1. Questionnaire for residential centres
2. Questionnaire for sheltered or supervised homes
3. Questionnaire for hospitals
4. Questionnaire for interviewees

### PART 1. QUESTIONNAIRE FOR CENTRES

Each centre must answer the questionnaire that corresponds to their type of centre.

- Questionnaire for Residential Centres
- Questionnaire for Sheltered and/or Supervised Homes
- Questionnaire for Hospitals

In Phase One, information is requested by questionnaire, a different one for each type of centre, auto-filled, on different characteristics of that centre. Firstly, for all types of centres, it requests the centre identification data (name, business name, Tax ID, address, etc.) and a contact person to address any consultations, clarifications, etc. (Name and surname, position, telephones, email) and then they will be asked the following sections:

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[1] The questionnaires are available on the INE website

### Centre questionnaire structure

The structure of the centre questionnaire is as follows:

**Residential centres:**

a) General data of the centre: Type of centre, specialisation, ownership, management and financing.

b) Allocation of residential places and rooms.

c) Characteristics of the centre residents.

d) Services offered at the centre.

e) Action protocols used by the centre (care for the control of types of diets, for the use of restraints, for the use of diapers, etc.)

f) Human resources available at the centre.

g) Remarks.

**Sheltered and/or supervised housing:**

a) General data on the homes: Type of home, specialisation, ownership, management and financing.

b) Allocation of home and residential places.

c) Characteristics of the residents of these homes.

d) Services offered in the homes (including number of hours per week devoted to these services)

e) Action protocols used by the homes (care for the control of types of diets, for the use of restraints, for the use of diapers, etc.)

f) Human resources available at the homes.

g) Remarks.

**Hospitals:**

a) General data of the hospital (Purpose of the hospital, ownership, management and financing)

b) Allocation of beds.

c) Characteristics of the hospital residents.

d) Human resources available at the hospital.

e) Remarks.

Each one of these questionnaires will be completed with the random selection of people who should answer the questionnaire for interviewees (start of Phase 2).

Once completed the people who will answer the questionnaire in phase two are selected. The selection of possible replacements is considered.

## PART 2. INDIVIDUAL QUESTIONNAIRE OF INTERVIEWEES.

A personal interview will be conducted for people aged 6 or older and selected within the centre, which will be the same for all people regardless of the type of centre.

The main objective of this second phase is to determine whether or not the people selected in the previous phase have a disability. A personal interview will be conducted with each selected person (or another person who is sufficiently informed) to try to determine if they have a disability and which it is. In this questionnaire, they are also asked about other aspects of their health and information related to discrimination, social network and contacts, personal autonomy, accessibility of the centre, the personal care received and expenses incurred in disability.

This questionnaire must be answered, whenever possible, by the person being interviewed. In this case, the completion of the questionnaire begins by asking for information identifying the person and certain socio-demographic variables. Next, they are asked about the disabilities they have, the degree of severity of each disability, the age of onset, the impairment that each has caused them and whether they receive supervision or personal assistance or make use of any external technical help. Likewise, information is requested regarding their state of health and a set of diagnosed diseases.

There are also sections related to discrimination, social network and contacts, personal autonomy, accessibility, personal care and expenses derived from their disability.

### Easy-reading questionnaire

For those people with problems of comprehension or communication—provided the person who answers the questionnaire is the person the interview is being conducted for and is not a Proxy (caregiver, partner, family member, etc.)—there is the option of collecting the questionnaire in easy-reading mode. This questionnaire has simplified and adapted wording.

Ideally, it should only be used when necessary, never generally, since being simplified it cannot capture all the nuances included in the wording of the question or answers.

### Interviewee questionnaire structure

The structure of the individual questionnaire is as follows:

### SECTION A. Identification and demographic information.

Characteristics of the informant: sex, age, relation of the informant with the selected person, reason for the response by means of an informant.

Characteristics of the selected person: sex, age, civil status, nationality, highest level of education completed, employment status

Degree of disability and situation of dependency: Has or does not have a degree of disability,

Recognised degree of disability, Has or does not have a situation of dependency,

Recognised degree of dependency

## SECTION B AND C. Study of disabilities and impairments of origin.

### DISABILITY

The **difficulties or limitations** covered in the questionnaire must meet two requirements:

- That they have lasted or are expected to last more than a year (for example, small accidents such as minor injuries that are overcome in months would be ruled out); or those that occur periodically in acute phases, such as migraines, asthma, etc.
- That the origin of the limitation or difficulty is a health problem or disability

To answer, the person must consider the situation when not using aids or supervision. If someone overcomes their limitation because they are using a certain aid or receiving supervision, it should be considered that they do have the corresponding difficulty. For example, if a person can only eat when another person helps him/her, he/she does have a limitation. However, an exception is made in the case of sight difficulties (myopia, astigmatism, etc.): If the person has these difficulties and overcomes them with glasses or contact lenses, it is considered that he/she does not have the limitation.

The following disability areas are researched:

**Sight**

- Complete lack of vision
- General visual tasks
- Detailed visual tasks
- Other vision problems

**Hearing**

- Total hearing loss
- Hears loud noises
- Hears what is said in a conversation

**Communication**

- Utters spoken phrases
- Receives spoken phrases
- Communicates via written messages
- Communicates via gestures, signs or symbols
- Limitations to communication due to specific problems of a cognitive or intellectual nature
- Communicates via telephone
- Communicates via remote written communication systems (email, WhatsApp or social media)

**Learning, knowledge application and task development**

- Pays attention by looking or listening

- Learns simple things
- Performs simple tasks due to a mental problem or intellectual disability
- Performs complex tasks due to a mental problem or intellectual disability

**Mobility**

- Changes basic body postures
- Maintains position of the body
- Moves around inside the centre
- Moves around outside the centre
- Moves around using transport as a passenger
- Drives vehicles
- Handles, picks up and moves objects
- Has fine motor skills

**Self-Care**

- Washes by oneself
- Basic body care
- Personal intimate hygiene
- Gets dressed and undressed
- Eats and drinks
- Cares for one's own health: follows medical prescriptions
- Avoids hazardous situations

**Domestic life (only for persons over the age of 12)**

- Administers the household budget
- Prepares meals
- Takes care of household chores

**Interactions and Interpersonal Relationships**

- Shows affection or respect towards others
- Relates with unfamiliar people
- Relates with centre staff
- Relates with friends and other familiar people
- Relates with family members

For each area or type of disability (sight, hearing, communication, learning and task development, mobility, self-care, domestic life and personal relations), the following is studied:

- If they have the disability or not
- Level of difficulty without aid

- If they have or do not have any type of technical aid
- Level of difficulty with aid

### AID AND IMPAIRMENTS

**Aids**, when we talk about aids we refer to two types: technical aids and personal aids.

- **Technical aid** is considered to be any external product or device used or intended for a person with a disability, which compensates or alleviates the limitation. For example: hearing aids, illuminated glasses, external prostheses, canes, wheelchairs, lifts, oxygen, cutlery with grip adaptations, access ramps, guide dogs, etc.
- **Personal aid** is understood as any collaboration from another person necessary to carry out an activity. Supervision is considered the need for a person to be aware of what another is doing, in case problems arise in a certain activity of daily life.

**Impairments** are problems in physiological functions (including mental functions) or body structures (organs or limbs), such as a significant deviation or loss thereof. Impairment is related to deficiency or "lack of something".

There are various types of impairment: physical (physical problem or organ functioning problem), psychological (mental health problem), sensory (one of the senses) and intellectual.

For each disability group, the following is studied:

- If they consider that the technical aids they receive or use are sufficient
- If they consider that they need more technical aids
- Age at which difficulties began
- The impairment or impairments of origin of the disability
- The main impairment that has caused the disability
- The cause or problem that caused the impairment
- The age at which the impairment was reported

### OTHER VARIABLES

In this section, there are also question about specific topics:

- Use of Braille
- Diagnosed vision diseases
- Hearing implant

### CLASSIFICATIONS USED

In the section on the study of disabilities and impairments of origin, the following classifications are used:

1. Classification of disability groups:

- Sight
- Hearing
- Communication

- Learning, knowledge application and task development
- Mobility
- Self-Care
- Domestic life (only for persons over the age of 12)
- Interactions and Interpersonal Relationships

2. Classification of **impairments**:

- Mental impairments
  - Developmental delay
  - Profound and severe intellectual deficiency
  - Moderate intellectual deficiency
  - Mild intellectual deficiency
  - Borderline intelligence
  - Dementia
  - Mental illness
  - Other mental disorders
- Visual impairments
  - Total blindness
  - Poor vision
- Hearing impairments
  - Prelingual deafness
  - Postlingual deafness
  - Poor hearing
  - Balance disorders
- Language, speech and voice impairments
  - Muteness (not due to deafness)
  - Difficult or incomprehensible speech
- Osteoarticular impairments
  - Head
  - Spine
  - Upper extremities
  - Lower extremities
- Nervous system impairments
  - Paralysis of an upper extremity
  - Paralysis of a lower extremity

- Paraplegia
- Quadriplegia
- Disorders of movement coordination and/or muscle tone
- Other nervous system deficiencies

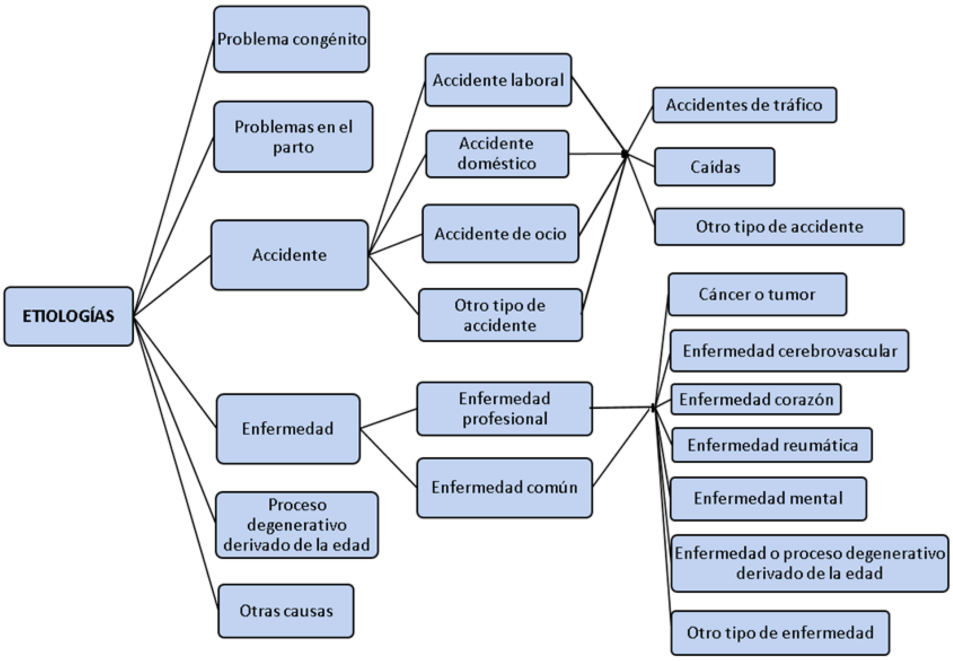
– Visceral impairments

- Respiratory system
- Cardiovascular system
- Digestive system
- Genitourinary system
- Endocrine-metabolic system
- Hematopoietic system and immune system

– Other impairments

- Skin
- Multiple impairments
- Impairments not classified elsewhere

3. Classification of aetiologies (origin of impairment)



If the person has a disability, the study continues by collecting information on health and diagnoses, discrimination, social network and contacts, personal autonomy, accessibility, personal care and expenses

**SECTION D. Health and diagnosis.**

Characteristics researched:

- Self-perceived general state of health
- Diagnosed diseases, on a closed list, which include the following:
    1. Laryngectomy
    2. Cancer / Malignant tumour
    3. Diabetes
    4. Schizophrenia
    5. Bipolar disorder
    6. Chronic depression
    7. Chronic anxiety
    8. Autism spectrum disorders (includes Autism, Asperger Syndrome, pervasive developmental disorder, etc.)
    9. Multiple sclerosis
    10. Amyotrophic lateral sclerosis (ALS)
    11. Parkinson's
    12. Alzheimer's Disease
    13. Other types of dementia
    14. Epilepsy
    15. Muscular dystrophy
    16. Cerebral palsy
    17. Hydrocephalus/Spina bifida
    18. Spinal cord injury
    19. Brain damage due to cerebrovascular accident (stroke, etc.)
    20. Brain damage due to traumatic brain injury
    21. Heart attack
    22. Arthritis
    23. Arthrosis
    24. Fibromyalgia
    25. Chronic kidney disease
    26. Agenesis/Amputations
    27. Down's Syndrome
    28. Other disease associated with disability
    29. Rare disease
- Remains permanently bedridden

**SECTION E. Information related to discrimination.**

Characteristics researched:

- If the person was discriminated against because of their disability in the last 12 months
- Situation or area in which they have felt discriminated against: health consultations or services, in education, in the workplace, when moving around or travelling, in social relationships, social participation and leisure activities, and in other situations.

**SECTION F. Information related to social network and contacts.**

- Frequency they have met with family and friends. In the last twelve 12 months
- Frequency in which they have had contact with family, friends, neighbours or acquaintances, via telephone, mobile messages, mail/email or social media. In the last 12 months.
- Assessment of contact kept with family, friends and acquaintances
- Activities done in their free time

**SECTION G. Personal autonomy.**

Characteristics researched:

- Participates in the decisions of daily life: about getting up or going to bed, about what to wear, about when to wash, about what to eat and when, about how to manage their money, about who they share their room with, about when to go out and enter the centre, about where and with whom to spend their free time, and about decorating their room with their own things.

**SECTION H. Accessibility.**

Characteristics researched:

- Places where, due to barriers or lack of adaptations to the environment, it is difficult to function normally: in the room, in the bathroom, in common areas, at the entrances and exits of the centre, outside the centre (means of transport, buildings, public roads, etc.)
- Difficulty due to their disability in being able to use information and communication technologies (mobile, computer, ATMs, etc.)

**SECTION I. Information related to personal care.**

Characteristics researched:

- If they receive personal assistance or care other than that provided by the centre
- Persons that provide assistance or care other than those provided by the residential centre.
- If personal assistance or care received other than that provided by the centre entails an economic expense
- If the personal care or assistance meets their needs

**SECTION J. Expenses.**

- Approximate monthly expense related to the disability or limitations.

This takes into account the expenses of the residence, medications and additional services paid by the person and paid by family members, etc.

Discounts, exemptions or rate or tax reductions must be deducted from these expenses.

**SECTION K. Remarks.**

**Conditions for considering a questionnaire valid**

As most of the questions of the survey are variables included in Article 11.2 of the LFEP (ethnic origin, political opinions, religious or ideological convictions and any that affect personal or family privacy), they are therefore voluntary. However, there is a minimum of answered questions required in order to consider a person as a collaborator. The conditions that a questionnaire must have are as follows:

- Sections B and C: The questions that provide information on whether there is a disability or not are the questions about difficulty (BXX.1). At least 2/3 of these questions must be different from DK/DA.
- Sections D to J: less than 60% of the questions that are in the questionnaire according to the flow must be other than DK/NC.

## 12 Processing of information

As the information is collected via electronic survey, the data is first cleaned using errors implemented in the application itself, which allows inconsistencies to be detected and provides strange value warnings when responses are being entered. In this way, the correction/confirmation of the information is carried out at the same time as the questionnaire is completed.

Once the information is available in the INE database, the processing and quality analysis of the received information begins. This processing consists of the following phases:

- *Coverage Phase*: It detects duplicates, compares the number of questionnaires theoretically collected (according to the computer application for monitoring fieldwork) and effectively received for each household.
- *Quality Control Phase*: It is verified that the information collected does not contain inconsistencies or serious errors used in the questionnaire.
- *Filtering and Imputation Phase:* Consists of detecting inconsistencies that have not been included in the electronic questionnaire, as well as obtaining marginal tables, variable analysis tables, etc. The correction of possible mismatched or lost values is carried out automatically and, where applicable, manually.

Once all the sample information has been collected and refined, it is aggregated and results are obtained according to the previously designed tabulation plan. To do this, several tasks are performed:

- *Calculation of raising factors and estimators*: Ratio estimators, to which reweighting techniques will be applied, will be used to estimate the sample's characteristics. Additional information used will depend on the characteristic under study.
- *Tabulation of the results*: According to the theoretic tabulation plan initially designed as per the survey objectives, the raised table are obtained using the calculated factors. These tables are refined by adding categories, eliminating or deleting cells from the final tabulation in those tables that do not have enough sample information to provide estimates with a minimum of statistical reliability.
- *Sample error calculation:* Variation coefficients will be calculated for the main variables studied and disaggregation. These tables will be published, along with the methodology, in order to replicate their calculation and be able to apply it to any other variable.
- *Non-response analysis*: a report is made with the basic characteristics of the units that did not collaborate in the survey.

## 13 Dissemination of results

The results of the Survey on Disabilities, Personal Autonomy and Situations of Dependency in Centre 2023 is published in April 2024 on the web page of the National Statistics Institute (www.ine.es).

When the data are released, users will be provide with the following publications:

a) Statistics tables at the national and autonomous community level, distributed in 3 modules:
   - Disability
   - Residential Centres, Supervised Housing and Hospitals[1].
   - Indicators of disability

b) Sample error tables.

c) Response rate

d) Methodology report.

e) Questionnaires.

f) Anonymised microdata from the survey. Each personal record also includes characteristics of the centre in which they reside, which have been obtained in the centre questionnaire.

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[1] The information on this module comes from the analysis of the framework directory

# ANNEX I. GLOSSARY OF TERMS AND DEFINITIONS

## On centres

**Social Residential Care Centres** are centres intended for temporary or permanent accommodation of the elderly and people with physical and intellectual disabilities, who receive comprehensive and continuous assistance through interprofessional socio-health care.

There are various types of Residential Centres in accordance with the profile of the person they serve (they may be aimed at elderly people in a situation of dependency and/or elderly people who can take care of themselves) although their essential, therapeutic, comprehensive care and accommodation functions are common to all. There are also centres for people with physical or intellectual disabilities.

**Sheltered and/or supervised housing** are functional homes in which small groups of people in need of intermittent or limited support live together stably over time, and in a partially self-managed system.

The **ownership of the centre** refers to the public or private nature of the entity that owns the centre, regardless of who runs it.

- The **ownership is public** if it corresponds to an administrative entity dependent on one or several public administrations. This may be:
  - State-based. The ownership pertains to the General Administration of the State.
  - Of the autonomous community. The ownership pertains to the Administration of the Autonomous Community.
  - Of the Provincial council / Cabildo. The ownership pertains to the administration of provincial council or island cabildo.
  - Municipal-based. The ownership pertains to the municipal administration.
- The **ownership is private** if the entity that owns the centre is a private entity, whether commercial or otherwise, and whether or not it has profit-making purposes. This may be:
  - For profit. If the ownership entity of the centre seeks to make a profit for the activity conducted.
  - Non-profit. If the ownership entity of the centre does not seek to make a profit for the activity conducted.

**Financing of the centre**, the economic contribution to the centre is distinguished between:

- **Public**. The entity receives public financing if provided by administrative body dependant on the General Administration of the State, the Autonomous Community or Local Administration
- **Mixed**. If the entity receives financing from one or various public administrations and also from a private entity, for-profit or non-profit, where the financing conditions are established by mutual agreement, accord or concertation among the different entities.
- **Private**. If the places in the centre are financed strictly by private means.

**Residential places**, total number of places in the centre regardless whether they are occupied or not. This only concerns residential places, so places under the DAY unit shall be excluded, if there are any.

**On people**

**Disability:** Disability is understood, for the purposes of the survey, as any significant limitation in performing the usual activities of daily living that has lasted or is expected to last more than 1 year and is due to a disease(s) or health problem(s), and is estimated as such by the subject themselves. In this sense, it is considered that a person has a disability even though the limitations is overcome with the use or external technical aid or the aid or supervision of another person.

**Impairment**. These are problems in physiological functions (including mental functions) or body structures (organs or limbs) as a significant deviation or loss thereof. Impairment is related to deficiency or "lack of something". There are different types of impairment:

- Physical: an impairment that limits or impedes a person’s motor skill or functioning of their organs. The causes of physical disability may be from birth, or as a result of an accident (for example, a spinal cord injury), or a health problem (for example, a stroke).
- Psychological: these are mental health problems that involve difficulties in relationships with others or in adapting to society (for example, schizophrenia or bipolar disorder). This is commonly known as "Mental Illness".
- Sensory: the total or partial absence of hearing or seeing (blindness, deafness).
- Intellectual: problems in intellectual development that imply difficulties in understanding or learning at expected levels. This is commonly known as "Mental Retardation" and is frequent in people with Down syndrome, or Autism.

  Activity. Understood as the nature and functional performance of a person. Activities may be limited in their nature, duration and quality. An activity is considered severely limited when so determined by the subject themselves.

**Usual activities**. Considered both those related to the main activity (self-care tasks, housework, work, studies, volunteer activities, etc.) and those that take place in free time (relationships with friends, sports practice, attendance at shows, etc.).

**Limitation of usual activities.** Usual activities are considered limited when said limitation is due to illness or health problem(s), and when so determined by the subject themselves.

**Technical aid** is any external product or device used or intended for a person with a disability, which compensates or alleviates the limitation. For example: hearing aids, illuminated glasses, external prostheses, canes, wheelchairs, lifts, oxygen, cutlery with grip adaptations, access ramps, guide dogs, etc.

**Personal aid** is any collaboration from another person necessary to carry out an activity.

**Supervision** entails the need for a person to be aware of what another is doing, in case problems arise in a certain activity of daily life.

The typology of supervised housing, as well as their characteristics and condition to access them, are determined by considering the different types of disability.

Supervised housing can be owned by the autonomous community, local entities or entities and associations under private initiative or by those affected, with the corresponding administrative authorisation.

**Housing or residential services**. These are centres that offer comprehensive care and permanent housing to the elderly or people with disability, both those who can look after themselves and those in a situation of dependency who require help from another person to carry out the activities of daily living due to their health, family, social or economic problems.

**Occupational centres**. Occupational Centres are establishments whose purpose is to provide occupational therapy and personal and social adjustment services to people with disabilities, when they cannot find work in a company or access a special employment centre.

**Other social services.** These are services intended for the elderly or people with disability not previous covered, such as personal assistants, shelters, etc.

**Economic dependency benefits.** This is money a person receives when, due to some impairment, they need the aid of another person every day. Such economic benefits can be “PEVS” (economic benefits linked to service), when a private service is used because they cannot access a public one, and the “Benefit for care in the family environment and support for non-professional caregivers” which is granted to family caregivers until the third degree of kinship and at the time the benefits is applied for, they have been providing care for more than one year.

**Other periodic monetary benefits**. These are other economic benefits, such as the mobility allowance offered to people with disability who have severe difficulty using public transport.

**Accessibility.** Accessibility is the characteristic that objects, environments, places, buildings, transport, products, services, tools and devices must have to allows all people to understand and use them easily, in conditions of safety and comfort, and in the most efficient, autonomous and natural way possible.

Accessibility, therefore, refers to the degree or level to which any human being, regardless of his or her physical condition or cognitive faculties, can use a thing, enjoy a service or make use of an infrastructure.

**Primary caregiver.** The main caregiver is the person who assumes the daily care and support of the person with a disability and/or in a situation of dependency, as well as the greatest responsibility in caring for them.