



Wave 3 Pre-Interview Questionnaire: Confidential

Intellectual Disability Supplement to The Irish Longitudinal Study on Ageing (IDS-TILDA)

IDS-TILDA ID NUMBER:

W

3

GENDER:

FEMALE

☐

MALE

☐

FOR OFFICE USE ONLY

INTERVIEW DATE:

		/			/		
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INTERVIEWER ID NUMBER

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IDS-TILDA

*Working to Make Ireland the Best
Place to Grow Old*

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INSTRUCTIONS

This questionnaire is part of WAVE 3 of The Intellectual Disability Supplement to TILDA. Thank you for taking part in this study. Your answers are very important to us to help ensure the needs of people with an intellectual disability are met as they grow older.

WHAT TO DO IF YOU NEED HELP.

If you need support filling in the questionnaire ask a family member, a key worker or a friend who knows you at least 6 months to help.

HOW TO FILL IN THE QUESTIONNAIRE.

Please answer the questions by:

Ticking a box like this



Or writing a number in a box like this



Sometimes you will find an instruction telling you which questions to answer next like this

YES

NO



IF 'NO' GO TO QUESTION

3

HOW TO RETURN THIS QUESTIONNAIRE

Please give the questionnaire to the interviewer on the day of your interview. If you have any questions about the questionnaire, please call us at 01 8963186 or 01 8963187.

SECTION A: How you spend your free time

1. How often if at all, do you do any of the following activities



FOR EACH ACTIVITY TICK ONE BOX THAT APPLIES

Activity	Daily/ Almost Daily	Once a week or more	Twice a month or more	About once a month	Every few months	About once or twice a year	Don't Know	Never
Go to cinema								
Theatre, Concert, Opera								
Eat Out								
Go to an art Gallery or museum								
Go to church or other place of worship								
Go to pub for a drink								
Go to a coffee shop for light refreshments								
Go Shopping								
Participates in sports activities / events								
Go to sports events								
Go to library								

FOR EACH ACTIVITY TICK ONE BOX THAT APPLIES



Activity	Daily/ Almost Daily	Once a week or more	Twice a month or more	About once a month	Every few months	About once or twice a year	Don't Know	Never
Go to social clubs (i.e. bingo, play cards)								
Go to Hairdressers								
Perform in local art groups and choirs								
Spend time on hobbies or creative activities								
Visit family and friends in their home								
Talk to family and friends on the telephone								
Do voluntary work								
Other activities outside of the home please specify								

Where do you spend your free time

2. Thinking of the activities you ticked in section one, please let us know if you do these activities within the community setting, within an ID service setting or both settings

FOR EACH ACTIVITY TICK ONE BOX THAT APPLIES



Activity	Within the community setting	Within ID Service Setting	Both within the community and ID setting	Don't Know	Never
Cinema					
Theatre, Concert or Opera					
Eat Out					
Goto an art Gallery or museum					
Go to church or other place of worship					
Go to a pub for a drink					
Go to a coffee shop for light refreshments					
Go Shopping					
Participates in sports activities / event					
Go to Sports events					
Go to Library					
Go to social clubs (e.g. bingo, play cards)					
Go to the hairdressers					
Perform in local art groups and choirs					
Spend time on hobbies or creative activities					
Visit family and friends in their home					



FOR EACH ACTIVITY TICK ONE BOX THAT APPLIES

Activity	Within the community setting	Within ID Service Setting	Both within the community and ID setting	Don't Know	Never
Talk to family and friends on the telephone					
Do voluntary work					
Other activities outside of your home					

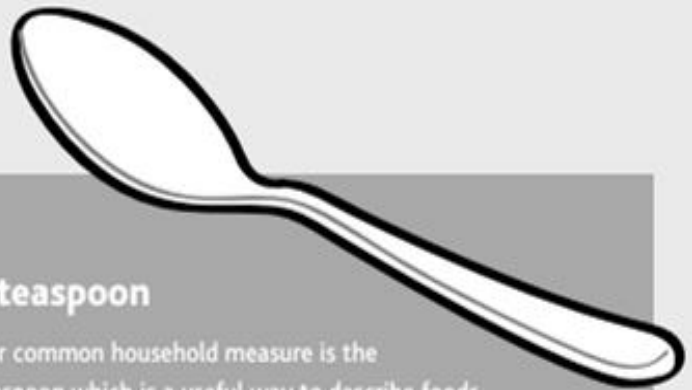
Other (Please Specify)

Section B: What you like to Eat and Drink



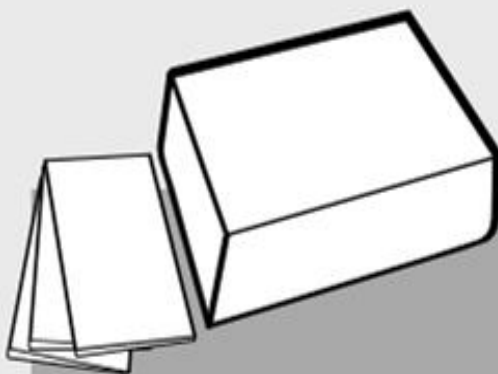
200ml Disposable Cup

When consumers were shown a plastic disposable cup (200ml), most agreed that this was the best way to describe servings of many foods such as cereal, cooked pasta, cooked rice, cooked or tinned fruit and cooked vegetables and pulses (peas, beans, lentils).



5ml teaspoon

Another common household measure is the 5ml teaspoon which is a useful way to describe foods such as peanut butter which provides a light meal serving from the Meat, Fish and Alternatives Food Group.



Matchbox Size Piece of Cheese

Another simple serving size description that is easy for people to visualise is the matchbox size piece of cheese.



SECTION B: What do you like to eat and drink

THIS IS AN EXAMPLE OF HOW TO COMPLETE THIS SECTION

Thinking about the food that you eat, we would like you to tell us how often you usually eat the following foods.

For each food there is an amount shown, either what we think is a “medium serving” or a common household unit such as a slice or teaspoon. Please put a tick in the box to indicate how often, on average, you have eaten the specified amount of each food (To the nearest whole number) during the past year, i.e. from when you receive this questionnaire to the same month the previous year.

Examples:

The following are examples on how to estimate how often and how much meat/meat alternatives you ate over the past year. Please estimate your food intake for all foodstuffs in the same way.

Meat: if you ate a medium serving of stew once a week over the past year, put a tick in the box “one a week”. If you think you usually ate more or less than a medium serving, please try to estimate which box suits best.

EXAMPLE HOW TO COMPLETE THE FOOD SECTION ‘WHAT YOU EAT AND DRINK’

	Never/less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Meat and meat alternatives (medium serving)									
Beef roast									
Beef: steak									
Beef: mince									
Beef: stew			☒						

PLEASE START NOW TO TELL US ABOUT THE FOOD YOU EAT AND WHAT YOU DRINK

3. Please tell us the usual amount of food you eat.

Please answer every question, do not leave any lines blank.

	Never/ less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Meat and meat alternatives (medium serving)									
Beef roast									
Beef: steak									
Beef: mince									
Beef: stew									
Beef burger (1 burger)									
Pork: roast									
Pork: chops									
Pork: slices/steak/escalopes									
Lamb: roast									
Lamb: chops									
Lamb: stew									
Chicken portion OR other poultry e.g. turkey: roast									
Breaded chicken, chicken nuggets, chicken burger									
Bacon									
Ham									
Corned beef									
Luncheon meats									
Sausages, Frankfurters (1 sausage)									

	Never/ less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Savoury pies (e.g. meat pie, pork pie, steak & kidney pie, sausage rolls)									
Heart, kidney									
Fish fried in batter, as in fish and chips									
Fish fried in bread crumbs									
Oven baked/grilled fish (in bread crumbs OR batter)									
Fish fingers/fish cakes									
Other white fish, fresh OR frozen (e.g. cod, haddock, plaice, sole, halibut, colli)									

A. FISH AND POULTRY (Medium serving – the size of a deck of cards OR palm of hands without fingers)

	Never /less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Oily fish (fresh) - (e.g. mackerel, kippers, tuna, salmon, sardines, herring)									
Oily fish (canned) - (e.g. mackerel, kippers, tuna, salmon, sardines, herring)									

	Never /less than once a month	1-3 per mont h	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Shellfish (e.g. crab, prawns, mussels)									
Canned Sardines									

Please check that you put a tick (✓) on every line

B. BREAD AND SAVOURY BISCUITS (One slice OR one biscuit)									
	Never /less than once a month	1-3 per mont h	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
White bread and rolls (including ciabatta and pannini bread)									
Brown bread and rolls									
Wholemeal bread and rolls									
Cream crackers, cheese biscuits									
Crisp bread, e.g. Ryvita									
Pancakes, muffins, oatcakes									
Baguette									

Please check that you put a tick (✓) on every line

C. Cereals (One medium sized bowl)									
	Never/less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Porridge, Readybrek									
All Bran, Weetabix, Shredded Wheat									
Branflakes, Bran Buds									
Fortified Oatmeal									
Cornflakes, Rice Krispies									
Muesli (e.g. Country Store, Alpen, sugar coated, Granola)									
Sugar Coated Cereals (e.g. Frosties, Crunchy Nut Cornflakes, Crunchy Sugar Coated Muesli)									
Fortified Cereal									

Please check that you put a tick (✓) on every line

D. Potatoes, Rice and Pasta (Medium serving – about a cupful)									
	Never/ less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Boiled, instant or jacket potatoes									
Mashed potatoes									
Chips									
Roast potatoes									
Potato Salad									
White rice									
Brown rice									
White/yellow/gre en pastas (e.g. spaghetti, macaroni, noodles)									
Wholemeal pasta									
Lasagne (meat based)									
Lasagne (vegetarian)									
Moussaka									
Pizza									
Macaroni Cheese									

Please check that you put a tick (✓) on every line

E. Dairy Products and Fats									
	Never/less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Cream (1 tablespoon)									
Full-fat yoghurt OR Greek- style Yoghurt (125g carton)									
Dairy desserts (125g carton)									
Cheddar cheese (medium serving)									
Low-fat cheddar cheese (medium serving OR 1 slice - 25g)									
Eggs as boiled, fried, scrambled, poached (1)									
Quiche (medium serving)									
Light salad cream OR light mayonnaise (1 tablespoon)									
Salad cream, mayonnaise (1 tablespoon)									
Other salad dressing									

F: The following on bread OR Vegetables

	Never/less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Butter (1 teaspoon)									
Light Butter e.g. Dawn light, Connacht Gold (teaspoon)									
Sunflower margarine e.g. Flora (1 teaspoon)									
Low-fat margarine e.g. low- low (1 teaspoon)									
Cholesterol lowering spreads e.g. Flora Pro Active, Dairy Gold Heart (1 teaspoon)									
Cream and vegetable oil spread e.g. Golden Pasture, Kerrymaid, Dairy Gold (1 teaspoon)									
Olive oil spread e.g. Golden Olive (1 teaspoon)									

Please check that you put a tick (✓) on every line

G: Fruit (1 fruit OR medium serving)									
	Never/less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Apples									
Pears									
Oranges, Satsuma, mandarins									
Grapefruit									
Bananas									
Grapes									
Melon									
Peaches, plums									
Apricots									
Strawberries, raspberries, kiwi fruit									
Tinned fruit									
Dried fruit e.g. raisins									
Frozen fruit									

Please check that you put a tick (✓) on every line

H: Vegetables Fresh, frozen OR tinned (Medium serving – 2 tablespoons OR 4 desert spoons)

	Never/ less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Carrots									
Spinach									
Broccoli, spring greens, kale									
Brussel sprouts									
Cabbage									
Peas									
Green beans, broad beans, runner beans									
Courgettes									
Cauliflower									
Parsnips, turnips									
Leeks									
Onions									
Garlic									
Mushrooms									

	Never/ less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Sweet peppers									
Beansprouts									
Green salad, Lettuce									
Cucumber, celery									
Tomatoes									
Sweetcorn									
Beetroot									
Coleslaw									
Baked beans									
Dried lentils, beans, peas									
Tofu, soya meat, TVP, veggieburger									

Please check that you put a tick (✓) on every line

I: Sweets and Snacks (Medium serving)									
	Never/ less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Chocolate coated sweet biscuits e.g. digestive (1)									
Plain sweet biscuits e.g. Marietta, Digestives, Rich									
Tea (1)									
Cakes e.g. fruit, sponge									
Buns, pastries e.g. croissants, doughnuts									
Fruit pies, tarts, crumbles									
Sponge puddings									
Milk puddings e.g. rice, custard, trifle									
Ice cream, choc ices, Frozen desserts									
Chocolates, single OR square									
Sweets, toffees, mints									
Sugar added to tea, coffee, cereal (1 teaspoon)									

	Never/ less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Sugar substitute e.g. Canderel added to tea, coffee, cereal (1 teaspoon)									
Crisps OR other packet snacks									
Peanuts OR other nuts									

Please check that you put a tick (✓) on every line

J: Soups, Sauces and Spreads

	Never/l ess than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Vegetable soups: homemade/fr esh (1 bowl)									
Vegetable soups: tinned/packet (1 bowl)									
Meat OR cream soups: homemade/fre sh (1 bowl)									
Meat OR cream soups: tinned/packet (1 bowl)									
Sauces e.g. white sauce,									
cheese sauce, gravy (1 tablespoon)									

	Never/less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Tomato based sauces e.g. pasta sauces									
Curry-type sauces									
Pickles, chutney (1 tablespoon)									
Marmite, Bovril (1 tablespoon)									
Jam, marmalade, honey, syrup (1 tablespoon)									
Peanut butter (1 teaspoon)									

Please check that you put a tick (✓) on every line

K: Drinks	Never/less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Tea (cup)									
Coffee instant (cup)									
Coffee ground (cup)									
Coffee, decaffeinated (cup)									
Coffee whitener e.g. coffee-mate (teaspoon)									

	Never/ less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Cocoa, Hot Chocolate (cup)									
Horlicks, Ovaltine (cup)									
Low calorie OR diet soft fizzy drinks (glass)									
Fizzy Soft drinks e.g. Cocoa Cola (glass)									
Pure fruit drinks e.g. orange juice (small glass)									
Fruit squash (small glass)									

L: Other food items

It is difficult to ask about all the food you have eaten. Please write down the names of any food items you have eaten and that you have not yet been asked.

	Never/les s than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day

4	How often have you had the following meals per week Please tick ONE answer on EACH line (A snack is a smaller meal consisting of for example, a fruit, biscuit, bun, cake, yoghurt or sweets/candy)				
		Every Day	1-3 times a week	4-6 times a week	Never
	Breakfast				
	Morning snack				
	Lunch				
	Afternoon snack				
	Dinner				
	Night snack				
	Any other meal				
5	How many glasses of water would you say you drink per day/each day (small glass)? See picture on page 6 for sample				
	None				
	1-2 glasses				
	More than 2 and less than 4 glasses				
	More than 4 and less than 6 glasses				
	More than 6 and less than 8 glasses				
	More than 8 and less than 10 glasses				
	More than 10 glasses per day				

	Other Other (Please specify)														
6	What type of milk do you use most often? PLEASE TICK ON BOX <table border="1" data-bbox="263 1028 1457 1675"> <tr> <td data-bbox="263 1028 1278 1122">None</td> <td data-bbox="1278 1028 1457 1122"></td> </tr> <tr> <td data-bbox="263 1122 1278 1211">Whole/full fat</td> <td data-bbox="1278 1122 1457 1211"></td> </tr> <tr> <td data-bbox="263 1211 1278 1301">Low fat</td> <td data-bbox="1278 1211 1457 1301"></td> </tr> <tr> <td data-bbox="263 1301 1278 1391">Skimmed</td> <td data-bbox="1278 1301 1457 1391"></td> </tr> <tr> <td data-bbox="263 1391 1278 1480">Super/Fortified</td> <td data-bbox="1278 1391 1457 1480"></td> </tr> <tr> <td data-bbox="263 1480 1278 1570">Soya</td> <td data-bbox="1278 1480 1457 1570"></td> </tr> <tr> <td data-bbox="263 1570 1278 1675">Other</td> <td data-bbox="1278 1570 1457 1675"></td> </tr> </table> Other (please specify)	None		Whole/full fat		Low fat		Skimmed		Super/Fortified		Soya		Other	
None															
Whole/full fat															
Low fat															
Skimmed															
Super/Fortified															
Soya															
Other															

7 How much milk do you use each day?

PLEASE TICK ONE BOX

Less than half a pint	☐
250ml (half pint)	☐
568ml (1 pint)	☐
One litre	☐
More than one litre	☐

8 How often do you eat fried food (i.e. use of oil or other fats when cooking)?

Never	☐
Less than once a month	☐
One or several times a month	☐
One or several times a week	☐
Every day	☐

9 How often do you add salt to food while cooking?

Always	
Usually	
Sometimes	
Rarely	
Never	

10 How often do you add salt to food while at the table?

Always	
Usually	
Sometimes	
Rarely	
Never	

11	What type of spread do you usually use on bread? (Please tick all that apply or use the most)	
	Butter or hard margarine	☐
	A low fat spread	☐
	A Polyunsaturated spread	☐
	None	☐
	Other (Please describe)	☐
12	What type of fat/oil would you usually use for cooking? (Please tick all that apply OR use most often)	
	Vegetable oil	☐
	Sunflower oil	☐
	Olive oil	☐
	Coconut oil	☐
	Rapeseed oil	☐
	Lard or dripping	☐
	Butter (or hard margarine)	☐
	None	☐
	Other	☐

	Other (please specify)
--	------------------------

Section C: Weight

Question 13: What is your weight without clothes?

Stones Pounds
(e.g. 10) (e.g. 2)

Or

Pounds
(e.g. 142)

Or

Kilos
(e.g. 64.4)

Don't know

Section D: The Exercise you do

Rapid Assessment of Physical Activity

Physical Activities are activities where you move and increase your heart rate above its resting rate, whether you do them for pleasure, work, or transportation.

The following questions ask about the amount and intensity of physical activity you usually do. The intensity of the activity is related to the amount of energy you use to do these activities.

Light activities 1. your heart beats slightly faster than normal 2. you can talk and sing	 Walking Leisurely  Stretching  Vacuuming or Light Yard Work
Moderate activities • your heart beats faster than normal • you can talk but not sing	 Fast Walking  Aerobics Class  Strength Training  Swimming Gently
Vigorous activities • your heart rate increases a lot • you can't talk or your talking is broken up by large breaths	 Stair Machine  Jogging Running  Tennis, Racquetball, or Pickleball or Badminton

14. How physically active are you?

(Please circle or tick the answer that applies to you on each line)

I Rarely or never do any physical activities	YES	NO
I do some light or moderate physical activities, but not every week	YES	NO
I do some light physical activity every week	YES	NO
I do moderate physical activities every week, but less than 30 minutes a day or 5 days a week	YES	NO
I do vigorous physical activities every week, but less than 20 minutes a day or 3 days a week	YES	NO
I do 30 minutes or more a day of moderate physical activities, 5 or more days a week	YES	NO
I do 20 minutes or more a day of vigorous physical activities, 3 or more days a week	YES	NO
I do activities to increase muscle strength , such as lifting weights or calisthenics, once a week or more	YES	NO
I do activities to improve flexibility, such as stretching or yoga, once a week or more.	YES	NO

Section E: Medical Tests and screening

15 Please indicate if you have received any of the following medical tests in the last year.

Please tick one box per line

	YES	NO	Don't know
Have you had flu injection?			
Have you had a Hepatitis B Vaccine?			

16 Please indicate if you have received any of the following medical tests
Please tick one box per line

	YES, within the last 2 years	YES, Over 2 years ago	NO	Don't Know
Have you ever had a blood test for cholesterol?				
Have you ever had your blood pressure measured?				
Have you ever had a thyroid function test?				
Have you ever had a blood glucose test (sugar test)?				
Have you ever been screened or assessed from memory impairment / Dementia?				
Have you had a bone density test? (e.g. DXA scan)				

17	Did your mother or father ever have any of the following? Please tick all that apply	
	Osteoporosis (Brittle bone)	☐
	Hip Fracture	☐
	Colon cancer	☐
	Breast cancer	☐
	Dementia	☐
	Diabetes	☐
	Don't know	☐
18	Have you ever had any of the following tests? Please tick all that apply	
	CT Brain Scan	☐
	CT Scan (other than brain)	☐
	MRI Brain scan	☐
	MRI Scan (other than brain)	☐
	EEG	☐
	Don't know	☐

Section F:**Women only questions****19**

Have you gone through or are you currently going through the menopause?

Please tick one box

YES, gone through the menopause already

YES, currently going through the menopause

NO

Don't know

20

About how old were you when it started?

I was years old?

Don't know

21	Since menopause have you used prescription hormone (e.g. HRT, estrogen) Please tick one box <table><tr><td>YES, currently taking hormones</td><td>☐</td></tr><tr><td>YES, but no longer taking hormones</td><td>☐</td></tr><tr><td>NO</td><td>☐</td></tr><tr><td>Don't know</td><td>☐</td></tr></table>	YES, currently taking hormones	☐	YES, but no longer taking hormones	☐	NO	☐	Don't know	☐
YES, currently taking hormones	☐								
YES, but no longer taking hormones	☐								
NO	☐								
Don't know	☐								
22	For how many years have you been taking prescription hormones? (for example..... <table><tr><td>0</td><td>3</td></tr></table> years) For <table><tr><td></td><td></td></tr></table> years Don't know <table><tr><td></td></tr></table>	0	3						
0	3								
23	For how many years did you take prescription hormones? (for example..... <table><tr><td>0</td><td>3</td></tr></table> years) For <table><tr><td></td><td></td></tr></table> years Don't know <table><tr><td></td></tr></table>	0	3						
0	3								

24	Do you check your breasts for lumps regularly? <table><tr><td>YES</td><td></td></tr><tr><td>NO</td><td></td></tr><tr><td>Don't Know</td><td></td></tr></table>	YES		NO		Don't Know	
YES							
NO							
Don't Know							
25	Has the GP or nurse checked your Breasts for lumps? <table><tr><td>YES</td><td></td></tr><tr><td>NO</td><td></td></tr><tr><td>Don't Know</td><td></td></tr></table>	YES		NO		Don't Know	
YES							
NO							
Don't Know							
26	Have you had a mammogram or x-ray of the breast, to search for cancer? <table><tr><td>YES</td><td></td></tr><tr><td>NO</td><td></td></tr><tr><td>Don't Know</td><td></td></tr></table>	YES		NO		Don't Know	
YES							
NO							
Don't Know							
27	Have you had a Cervical smear test? <table><tr><td>YES</td><td></td></tr><tr><td>NO</td><td></td></tr><tr><td>Don't Know</td><td></td></tr></table>	YES		NO		Don't Know	
YES							
NO							
Don't Know							

Section G:



Men only questions

29

Do you check your testicles for lumps regularly?

YES

NO

Don't Know

30

Has the GP checked your testicles for lumps?

YES

NO

Don't Know

31

Have you had an examination of your prostate to screen for cancer?

YES

NO

Don't Know

32

Have you had a blood test (PSA) to screen for prostate cancer?

YES

NO

Don't Know

Section H: Health Services Utilisation

33 Are you covered by any of the following?

Please tick one box

Full medical card or equivalent	
GP visit card	
Private medical insurance – in my own name	
Private medical insurance, as the spouse of a subscriber	
Private medical insurance, as the relative of a subscriber	
None of the above	
Don't know	

34 Do you visit your GP at an office/surgery

In the community		Go to Q35
In service provider setting		Go to Q36
GP visits me at home		Go to Q37

35	In the last year, about how often did you visit your GP in the community or did your GP visit you?	
	Number of visits	
	Don't know	
36	In the last year, about how often did you visit your GP in Service provider setting or did your GP visit you?	
	Number of visits	
	Don't know	
37	In the last year, about how often did your GP visit you at home?	
	Number of visits	
	Don't know	
38	In the last year, how many times did you visit a hospital emergency department	
		Please write the number of visits in the box

39 If you attended A&E for treatment in the last year, what was the reason?

Please tick all that apply

Has not visited A&E in last year	
Multiple injuries	
Broken or fractured bone(s)	
Burn(s)	
Dislocation(s)	
Sprain or strain(s)	
Cut(s) or Open wound	
Scrape, bruise, blister(s)	
Concussion or other head/brain injury	
Poisoning	
Internal injuries(s)	
Pneumonia	
Epilepsy	
Don't know	
Other	

40 In the last year, about how many visits did you make to a hospital out-patient clinic?

Number of visits		Please write the number of visits in the box
Don't know		

41	In the last year, how many nights did you spend in an Acute/general hospital? <table border="1" data-bbox="169 360 1201 499"> <tr> <td data-bbox="169 360 549 439">Number of nights</td> <td data-bbox="549 360 671 439"></td> <td data-bbox="671 360 1201 439">Please write the number of nights in the box</td> </tr> <tr> <td data-bbox="169 439 549 499">Don't know</td> <td data-bbox="549 439 671 499"></td> <td data-bbox="671 439 1201 499"></td> </tr> </table>		Number of nights		Please write the number of nights in the box	Don't know																		
Number of nights		Please write the number of nights in the box																						
Don't know																								
42	Please tell us the name of the hospital you were in. for example (St James Hospital Dublin OR Louth County, Dundalk) <table border="1" data-bbox="169 734 1528 1413"> <thead> <tr> <th data-bbox="169 734 847 779">Name of Hospital</th> <th data-bbox="847 734 1528 779">Location of Hospital</th> </tr> </thead> <tbody> <tr> <td data-bbox="169 779 847 824">Example: St James Hospital</td> <td data-bbox="847 779 1528 824">Dublin</td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>		Name of Hospital	Location of Hospital	Example: St James Hospital	Dublin																		
Name of Hospital	Location of Hospital																							
Example: St James Hospital	Dublin																							
43	In the last year, how many nights did you spend in an acute/psychiatric hospital due to mental health problems? <table border="1" data-bbox="169 1720 1201 1859"> <tr> <td data-bbox="169 1720 549 1798">Number of nights</td> <td data-bbox="549 1720 671 1798"></td> <td data-bbox="671 1720 1201 1798">Please write the number of nights in the box</td> </tr> <tr> <td data-bbox="169 1798 549 1859">Don't know</td> <td data-bbox="549 1798 671 1859"></td> <td data-bbox="671 1798 1201 1859"></td> </tr> </table>		Number of nights		Please write the number of nights in the box	Don't know																		
Number of nights		Please write the number of nights in the box																						
Don't know																								

44	In the last year, how many nights did you spend in a nursing / convalescent home?		
	Number of nights		Please write the number of nights in the box
	Don't know		

45	In the last year, how many nights did you spend in respite (excluding nights spent in a nursing home)?		
	Number of nights		Please write the number of nights in the box
	Don't know		

46	If you have spent nights in respite please tell us where?		
	In a community setting		
	In a service provider setting		
	In both community and service setting		
	Don't know		

47	In the last year did you use Meals on wheels?		
	Service	Yes	No
	Meals on Wheels		
	On a typical week, please tell us how many times per week do you receive meals on wheels 		

48 In the last year did you use Home Help?

Service	Yes	No
Home Help		

On a typical week, please tell us how many hours per week do you receive home help

_____ Hours

49 In the last year did you use a Personal Care Attendant?

Service	Yes	No
Home Help		

On a typical week, please tell us how many hours per week did you use a personal care attendant?

_____ Hours

50

The next two questions are about the health services you use, where you use them and how many times in the last year you attended. The first one asks you to tell us the services you used that were paid for using your medical card or health insurance, the second question asks you to tell us the services you paid for out of your own pocket.

In the last year, did you receive any of the following services?
(WITH YOUR MEDICAL CARD or YOUR PRIVATE HEALTH INSURANCE)

Tell us if you attended the health service in the community or in the service provider / service setting or both

PLEASE TELL US TO THE BEST OF YOUR ABILITY HOW MANY TIMES YOU ATTENDED

TICK ALL THAT APPLY

	Community setting / mainstream	Service provider setting	Both	How many times did you attend
General Practitioner (GP)				
Public Health or community nurse				
Occupational therapy				
Chiropody services				
Physiotherapy services				
Social work services				
Psychological / counselling services				
Home Help				
Optician services				
Hearing services				
Dental Services				
Pharmacist				
Dietician Services				
Speech & Language services				
Day centre services				
Neurological services				
Psychological services				
Endocrinology services				
Dermatology services				
Palliative home care services				
Palliative day care services				
Don't know				
Other				
Other (please tell us)				

**51 In the last year, did you receive any of the following services?
(WHICH YOU PAID FOR YOURSELF OUT OF YOUR OWN POCKET)**

Tell us if you attended the health service in the community or in the service provider / service setting or both

PLEASE TELL US TO THE BEST OF YOUR ABILITY HOW MANY TIMES YOU ATTENDED

TICK ALL THAT APPLY

	Community setting / mainstream	Service provider setting	Both	How many times did you attend
General Practitioner (GP)				
Public Health or community nurse				
Occupational therapy				
Chiropody services				
Physiotherapy services				
Social work services				
Psychological / counselling services				
Home Help				
Optician services				
Hearing services				
Dental Services				
Pharmacist				
Dietician Services				
Speech & Language services				
Day centre services				
Neurological services				
Psychological services				
Endocrinology services				
Dermatology services				
Palliative home care services				
Palliative day care services				
Don't know				
Other				
Other (please tell us)				

52 Are there any services that you think you would benefit from that you are not receiving at present?

Please tick one box

YES	☐
NO	☐
Don't Know	☐
If YES please specify	

Section I: How happy are you with your health services

The next few questions ask how satisfied or happy you are with the service you get from your doctor and dentist and the people who work there.

53 Are the staff at the doctors/GP surgery (including the doctor) nice and polite to you?

Please tick one box

Yes, all staff	☐
Yes, some staff	☐
No	☐

54 Do you like your GP and the way you are treated in appointments?

Please tick one box

Yes	☐
No	☐
Not sure	☐

55 When you want to go to the GP surgery, do you have the support and transport to get there?

PLEASE TICK ONE BOX

A. Support

Almost never	☐
Sometimes	☐
Almost always	☐

B Transport

Almost never	☐
Sometimes	☐
Almost always	☐

56	Are the staff at the dentist office (including dentist) nice and polite to you? PLEASE TICK ONE BOX <table border="1"> <tr> <td>Yes, all staff</td> <td>☐</td> </tr> <tr> <td>Yes, some staff</td> <td>☐</td> </tr> <tr> <td>No</td> <td>☐</td> </tr> </table>	Yes, all staff	☐	Yes, some staff	☐	No	☐						
Yes, all staff	☐												
Yes, some staff	☐												
No	☐												
57	Do you like your dentist and the way you are treated in appointments? PLEASE TICK ONE BOX <table border="1"> <tr> <td>Yes</td> <td>☐</td> </tr> <tr> <td>No</td> <td>☐</td> </tr> <tr> <td>Not sure</td> <td>☐</td> </tr> </table>	Yes	☐	No	☐	Not sure	☐						
Yes	☐												
No	☐												
Not sure	☐												
58	When you want to go to the dentist, do you have a way to get there? PLEASE TICK ONE BOX A Support <table border="1"> <tr> <td>Almost never</td> <td>☐</td> </tr> <tr> <td>Sometimes</td> <td>☐</td> </tr> <tr> <td>Almost always</td> <td>☐</td> </tr> </table> B Transport <table border="1"> <tr> <td>Almost never</td> <td>☐</td> </tr> <tr> <td>Sometimes</td> <td>☐</td> </tr> <tr> <td>Almost always</td> <td>☐</td> </tr> </table>	Almost never	☐	Sometimes	☐	Almost always	☐	Almost never	☐	Sometimes	☐	Almost always	☐
Almost never	☐												
Sometimes	☐												
Almost always	☐												
Almost never	☐												
Sometimes	☐												
Almost always	☐												
59	Are the staff in the General Hospital (including Doctors/Nurses, other staff such as reception/security) nice and polite to you? Please tick one box <table border="1"> <tr> <td>Yes, all staff</td> <td>☐</td> </tr> <tr> <td>Yes, some staff</td> <td>☐</td> </tr> <tr> <td>No</td> <td>☐</td> </tr> </table>	Yes, all staff	☐	Yes, some staff	☐	No	☐						
Yes, all staff	☐												
Yes, some staff	☐												
No	☐												

60	Do you like the staff in the General Hospital (including Doctors/Nurses, Other staff such as reception/security) and the way you are treated in appointments? Please tick one box <table border="1"> <tr> <td>Yes</td> <td>☐</td> </tr> <tr> <td>No</td> <td>☐</td> </tr> <tr> <td>Not sure</td> <td>☐</td> </tr> </table>	Yes	☐	No	☐	Not sure	☐
Yes	☐						
No	☐						
Not sure	☐						
61	When you want to go to the General Hospital, do you have a way to get there? Please tick one box <table border="1"> <tr> <td>Almost never</td> <td>☐</td> </tr> <tr> <td>Sometimes</td> <td>☐</td> </tr> <tr> <td>Almost always</td> <td>☐</td> </tr> </table>	Almost never	☐	Sometimes	☐	Almost always	☐
Almost never	☐						
Sometimes	☐						
Almost always	☐						
62	Can you think of anything you asked for help with but didn't get? Please tick one box <table border="1"> <tr> <td>Yes</td> <td>☐</td> </tr> <tr> <td>No</td> <td>☐</td> </tr> </table> IF YES (Please specify)	Yes	☐	No	☐		
Yes	☐						
No	☐						

63

Please tell us the main thing that stops/prevents you from getting this service or services?

Don't know

☐

Not for distribution - CONFIDENTIAL

Section J: Information on Health

64 Have you ever received any information on the following.....?

Please tick all that apply

	Easy Read (written health promotion document)	Education / guidance / seminar (Verbal information)
Exercise		
Counselling		
Diabetes		
Epilepsy		
Heart Health		
Bone Health		
Bowel Cancer		
Diabetic Retinopathy		
Breast check		
Prostate check		
Cervical check		
Nutrition/Healthy eating		
Sexually transmitted infection check		
Lung Health Test (Spirometry)		
None of the above		
Don't know		

65 Please tell us who you received easy to read information from.

Other may include family, friends, support or key workers or any other person or group not listed here.

Please tick all that apply

	Specialist	GP	Pharmacist	Public Health Nurse	RNID	Other
Bone Health						
Bowel Cancer						
Diabetic Retinopathy						
Breast Check						
Prostrate Check						
Cervical Check						
Nutrition/Healthy Eating						
Sexually transmitted infection check						

Other (Please specify)

Please get your Carer/Key worker/Support person to complete this section

Section K: IQ Code

Please indicate how long you know the participant: _____ Years

The following section should ideally be completed by a person who knows the participant 10 years or more, if you don't know the participant 10 years or more please refer to someone who does, otherwise complete to the best of your knowledge.

Now we want you to remember what your friend or relative was like 10 years ago and to compare it with what he/she is like now. 10 years ago was in 20____.

Below are situations where this person has to use his/her memory and we want you to indicate whether this has improved, stayed the same or got worse in that situation over the past 10 years.

Note the importance of comparing his/her present performance with 10 years ago. So if 10 years ago this person always forgot where he/she had left things, and he/she still does, then this would be considered "Hasn't changed much".

66

PLEASE INDICATE THE CHANGES YOU HAVE OBSERVED BY CIRCLING THE APPROPRIATE ANSWER.

Compared with 10 years ago how is this person at:

	1	2	3	4	5
Remembering things about family and friends e.g. occupations, birthdays, addresses	Much Improved	A bit improved	Not much change	A bit worse	Much worse
Remembering things that have happened recently	Much Improved	A bit improved	Not much change	A bit worse	Much worse
Recalling conversations a few days later	Much Improved	A bit improved	Not much change	A bit worse	Much worse
Remembering his/her address and telephone number	Much Improved	A bit improved	Not much change	A bit worse	Much worse
Remembering what day and month it is	Much Improved	A bit improved	Not much change	A bit worse	Much worse

	1	2	3	4	5
Remembering where things are usually kept	Much Improved	A bit improved	Not much change	A bit worse	Much worse
Remembering where to find things which have been put in a different place from usual	Much Improved	A bit improved	Not much change	A bit worse	Much worse
Knowing how to work familiar machines around the house	Much Improved	A bit improved	Not much change	A bit worse	Much worse
Learning to use a new gadget or machine around the house	Much Improved	A bit improved	Not much change	A bit worse	Much worse
Learning new things in general	Much Improved	A bit improved	Not much change	A bit worse	Much worse
Following a story in a book or on TV	Much Improved	A bit improved	Not much change	A bit worse	Much worse
Making decisions on everyday matters	Much Improved	A bit improved	Not much change	A bit worse	Much worse
Handling money for shopping	Much Improved	A bit improved	Not much change	A bit worse	Much worse
Handling financial matters e.g. the pension, dealing with the bank	Much Improved	A bit improved	Not much change	A bit worse	Much worse
Handling other everyday arithmetic problems e.g. knowing how much food to buy, knowing how long between visits from family or friends	Much Improved	A bit improved	Not much change	A bit worse	Much worse

		1	2	3	4	5
	Using his/her intelligence to understand what's going on and to reason things through	Much Improved	A bit improved	Not much change	A bit worse	Much worse
67	Any other Information (Cognitive Domains):					

Please get your Carer/Key worker/Support person to complete this section

Section L: Behaviours that Challenge

IWER: TO BE COMPLETED BY INTERVIEWER

Instructions

68

Below you will find broad definitions followed by specific items for three types of behaviour problems:

- self-injurious behaviours (items 1-8),
- aggressive/destructive behaviours (items 9-18), and
- stereotyped behaviours (items 19-30).

Indicate which behaviours you have observed in this individual *during the past two months* by circling the number in the appropriate boxes (1) how often a described behaviour typically occurs and (2) how serious a problem the behaviour is. If the behaviour has not occurred during the past two months and therefore poses no problem check “never/no problem” (“0”). If the behaviour has occurred, rate the approximate frequency of its occurrence and its severity (use the definitions below; note, no severity scale is provided for stereotyped behaviour.)

SELF-INJURIOUS BEHAVIOUR

	Mild Problem	Moderate Problem	Severe Problem
Self-Injurious Behavior	Behaviour occurs but does not inflict significant damage on the individual (e.g., temporary reddening of the skin, very light bruising)	Behaviour may inflict moderate damage on the individual (e.g., moderate bruising, scratching through the skin, repeatedly picking scabs)	Behaviour may inflict moderate to severe damage on the individual (e.g. biting through the skin, eye gouging, fracturing bones) minor or major medical intervention required
Aggression/ Destruction	Behaviour occurs but does not inflict significant damage on other people (e.g., temporary reddening of the skin, very light bruising); or disruption or mild damage to property, e.g., objects thrown, furniture tipped, doors slammed, meals spoiled, paint scratched. Item does not	The behaviour may inflict moderate damage on other people (e.g., moderate bruising, scratching through the skin, repeatedly picking scabs; or moderate damage to property (e.g., curtains torn, furniture partly broken). Item requires repair but can be used.	The behaviour may inflict moderate to severe damage on other people (e.g. biting through the skin, eye gouging, fracturing bones) minor or major medical intervention required; or significant damage to property. Item requires repair and cannot be used.

Self-injurious behavior (SIB) causes damage to the person's own body; i.e., damage has either already occurred, or it must be expected if the		Never /no problem	Average Frequency of				Severity of the Problem		
			Monthly	Weekly	Daily	Hourly	Mild	Moderate	Severe
1	Self-biting	0	1	2	3	4	1	2	3
2	Head hitting	0	1	2	3	4	1	2	3
3	Body hitting (except for the head) with own hand	0	1	2	3	4	1	2	3
4	Self-scratching	0	1	2	3	4	1	2	3
5	Pica (ingesting non-food)	0	1	2	3	4	1	2	3
6	Inserting objects in nose,	0	1	2	3	4	1	2	3
7	Hair pulling (tearing out	0	1	2	3	4	1	2	3
8	Teeth grinding (evidence of ground teeth)	0	1	2	3	4	1	2	3

AGGRESSIVE/DESTRUCTIVE BEHAVIOUR

Aggressive or destructive behaviors are deliberate overt attacks directed towards other individuals or property.		Never /no problem	Average Frequency of Occurrence				Severity of the Problem		
			Monthly	Weekly	Daily	Hourly	Mild	Moderate	Severe
9	Hitting others	0	1	2	3	4	1	2	3
10	Kicking others	0	1	2	3	4	1	2	3
11	Pushing others	0	1	2	3	4	1	2	3
12	Biting others	0	1	2	3	4	1	2	3
13	Grabbing and pulling others	0	1	2	3	4	1	2	3
14	Scratching others	0	1	2	3	4	1	2	3
15	Pinching others	0	1	2	3	4	1	2	3
16	Verbally abusive with others	0	1	2	3	4	1	2	3
17	Destroying things (e.g., rips clothes, throws chairs, smashes tables)	0	1	2	3	4	1	2	3
18	Bullying - being mean or cruel (e.g., grabbing toys or food from others)	0	1	2	3	4	1	2	3

STEREOTYPED BEHAVIOUR

<i>Stereotyped behaviors look unusual, strange, or inappropriate to the average person. They are voluntary acts that occur repeatedly in the same way over and over again, and they are characteristic for that person. However, they do NOT cause physical damage.</i>		Never /no problem	Average Frequency of Occurrence			
			Monthly	Weekly	Daily	Hourly
19	Rocking, repetitive body movements	0	1	2	3	4
20	Sniffing objects, own body	0	1	2	3	4
21	Waving or shaking arms	0	1	2	3	4
22	Manipulating (e.g., twirling, spinning)	0	1	2	3	4
23	Repetitive hand and/or finger	0	1	2	3	4
24	Yelling and screaming	0	1	2	3	4
25	Pacing, jumping, bouncing, running	0	1	2	3	4
26	Rubbing self	0	1	2	3	4
27	Gazing at hands or objects	0	1	2	3	4
28	Bizarre body postures	0	1	2	3	4
29	Clapping hands	0	1	2	3	4
30	Grimacing	0	1	2	3	4

Section M: Medications

69. We would like to record all medications that you take on a regular basis, take every day or every week. This will include prescription and non-prescription medications, over -the- counter medicines, vitamins and herbal and alternative

PLEASE WRITE DOWN ALL MEDICATIONS/TABLETS YOU TAKE AND HOW OFTEN YOU TAKE THEM, PLEASE

USE ONE LINE PER MEDICATION

Don't know what medication I take, record by proxy

PLEASE COMPLETE MEDICATION FORM

Don't take any medication

☐

Go to Question 53

Name of Medication	Dosage strength	Frequency	Route	Date Prescribed	Doctors	Others

Name of Medication	Dosage strength	Frequency	Route	Date Prescribed	Doctors	Others

70	Have you ever received any easy to read information leaflets about your medication? Please tick one box <table border="1"> <tr> <td data-bbox="303 436 686 488">Yes</td> <td data-bbox="686 436 802 488"></td> </tr> <tr> <td data-bbox="303 488 686 539">No</td> <td data-bbox="686 488 802 539"></td> </tr> <tr> <td data-bbox="303 539 686 589">Don't know</td> <td data-bbox="686 539 802 589"></td> </tr> </table>	Yes		No		Don't know							
Yes													
No													
Don't know													
71	If you have received information leaflets about your medication, please tell us who gave you these leaflets from the list below. PLEASE TICK ALL THAT APPLY <table border="1"> <tr> <td data-bbox="303 797 1109 891">General Practitioner</td> <td data-bbox="1109 797 1283 891"></td> </tr> <tr> <td data-bbox="303 891 1109 983">Pharmacist</td> <td data-bbox="1109 891 1283 983"></td> </tr> <tr> <td data-bbox="303 983 1109 1075">Public Health Nurse</td> <td data-bbox="1109 983 1283 1075"></td> </tr> <tr> <td data-bbox="303 1075 1109 1167">RNID</td> <td data-bbox="1109 1075 1283 1167"></td> </tr> <tr> <td data-bbox="303 1167 1109 1258">Don't know</td> <td data-bbox="1109 1167 1283 1258"></td> </tr> <tr> <td data-bbox="303 1258 1109 1350">Other</td> <td data-bbox="1109 1258 1283 1350"></td> </tr> </table> Other (please tell us)	General Practitioner		Pharmacist		Public Health Nurse		RNID		Don't know		Other	
General Practitioner													
Pharmacist													
Public Health Nurse													
RNID													
Don't know													
Other													

SECTION N: Sources of Income (SI)

This section asks questions about the money you get and how much money you have to spend on things you like to do.

72 Did you receive any of these payments in the last year?

PLEASE TICK ALL THE PAYMENTS THAT YOU HAVE RECEIVED.

Disability allowance	
Mobility allowance	
Disability benefit (previously known as illness benefit)	
Retirement pension from former employment	
Contributory state pension (previously known as Non-Contributory old age pension)	
Transition state pension (previously known as retirement pension)	
Invalidity pension	
Widow's or Widower's contributory pension	
Private pension	
Jobseeker's allowance (previously known as unemployment assistance)	
Jobseeker's benefit (previously known as unemployment benefit)	
Supplementary welfare allowance	
Other (please specify)	
Not applicable – did not receive any of these payments	

73	Do you receive money from any other sources (not previously mentioned)? <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Yes</td> <td style="width: 20%;"></td> </tr> <tr> <td>No</td> <td></td> </tr> </table> (IDS-TILDA) (From CAPI SI_9.3)	Yes		No																																															
Yes																																																			
No																																																			
74	Once you have paid all of your bills, how much money do you have every week? € _____ Total amount (From CAPI SI_30.3 new q)																																																		
75	Thinking about the last year could you tell us, if you had or did any of the nine things listed below. If you did not have or could not do any of these items, was this because you could not afford these things or because you did not want them. Please indicate an answer for the item on each line in the table <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 45%;"></th> <th style="width: 15%;">I had this item</th> <th style="width: 15%;">I did not have as I could not afford it</th> <th style="width: 15%;">I did not have as I did not want it</th> <th style="width: 10%;">Don't know / not sure / not applicable</th> </tr> </thead> <tbody> <tr><td>New clothes</td><td></td><td></td><td></td><td></td></tr> <tr><td>New shoes</td><td></td><td></td><td></td><td></td></tr> <tr><td>Food</td><td></td><td></td><td></td><td></td></tr> <tr><td>Heating</td><td></td><td></td><td></td><td></td></tr> <tr><td>Telephone friends and family</td><td></td><td></td><td></td><td></td></tr> <tr><td>Going out</td><td></td><td></td><td></td><td></td></tr> <tr><td>Visits to pub or club</td><td></td><td></td><td></td><td></td></tr> <tr><td>A hobby or sport</td><td></td><td></td><td></td><td></td></tr> <tr><td>A holiday</td><td></td><td></td><td></td><td></td></tr> </tbody> </table> (Emerson's the measurement of poverty and socioeconomic position in research involving people with intellectual disability)		I had this item	I did not have as I could not afford it	I did not have as I did not want it	Don't know / not sure / not applicable	New clothes					New shoes					Food					Heating					Telephone friends and family					Going out					Visits to pub or club					A hobby or sport					A holiday				
	I had this item	I did not have as I could not afford it	I did not have as I did not want it	Don't know / not sure / not applicable																																															
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A hobby or sport																																																			
A holiday																																																			

76	Have you ever had an assessment of financial capacity undertaken with you? Financial capacity is when someone asks you questions about how you manage your money and how you make decision about spending or saving your money to check if you would need some support with making these decisions? These may be decisions about how to spend your money on everyday items like buying food and drink, as well as decisions about buying bigger things such as television, a care, a house <table border="1" data-bbox="301 734 802 887"> <tr> <td>Yes</td> <td></td> </tr> <tr> <td>No</td> <td></td> </tr> <tr> <td>Don't know</td> <td></td> </tr> </table>	Yes		No		Don't know					
Yes											
No											
Don't know											
77	Do you have your own bank account? <table border="1" data-bbox="301 1003 802 1155"> <tr> <td>Yes</td> <td></td> </tr> <tr> <td>No</td> <td></td> </tr> <tr> <td>Don't know</td> <td></td> </tr> </table>	Yes		No		Don't know					
Yes											
No											
Don't know											
78	Who has access to your bank card? Tick all that apply <table border="1" data-bbox="301 1433 802 1839"> <tr> <td>Myself</td> <td></td> </tr> <tr> <td>Family</td> <td></td> </tr> <tr> <td>Keyworker</td> <td></td> </tr> <tr> <td>Service provider</td> <td></td> </tr> <tr> <td>Friend(s)</td> <td></td> </tr> </table>	Myself		Family		Keyworker		Service provider		Friend(s)	
Myself											
Family											
Keyworker											
Service provider											
Friend(s)											

Section O: Transport

79

Within a typical month, have you used any of the following means of transport?

Please tell us to the best you can remember how many times you used that means of transport

TICK ALL THAT APPLY

	Yes	How many times
Bicycle / Motorbike		
Drive myself		
Driven as a passenger by family		
Driven as a passenger by friends		
Driven as a passenger by staff service		
Public bus (city or urban)		
Public bus (intercity)		
Public bus (rural)		
Taxi/Hackney		
Dart/Luas		
Train (commuter train)		
Train (intercity)		
Bus operating as part of the rural transport scheme		
Not applicable – haven't used any forms of transport in the last year		
Don't know		
Other (please specify)		

80	On a typical journey how many kilometres do you travel? _____ Metres/Kilometres								
81	Would you like to use more public transport? <table border="1"> <tr> <td data-bbox="331 573 715 622">Yes</td> <td data-bbox="715 573 831 622"></td> </tr> <tr> <td data-bbox="331 622 715 672">No</td> <td data-bbox="715 622 831 672"></td> </tr> <tr> <td data-bbox="331 672 715 721">Don't know</td> <td data-bbox="715 672 831 721"></td> </tr> </table>	Yes		No		Don't know			
Yes									
No									
Don't know									
82	Do you feel there is a lack of transport facilities in your area? <table border="1"> <tr> <td data-bbox="331 956 715 1005">Yes</td> <td data-bbox="715 956 831 1005"></td> </tr> <tr> <td data-bbox="331 1005 715 1055">No</td> <td data-bbox="715 1005 831 1055"></td> </tr> <tr> <td data-bbox="331 1055 715 1104">Don't know</td> <td data-bbox="715 1055 831 1104"></td> </tr> </table>	Yes		No		Don't know			
Yes									
No									
Don't know									
83	Does the lack of transport facilities in your area affect your lifestyle? Code ONE that applies <table border="1"> <tr> <td data-bbox="331 1352 715 1402">A great deal</td> <td data-bbox="715 1352 831 1402"></td> </tr> <tr> <td data-bbox="331 1402 715 1451">To some extent</td> <td data-bbox="715 1402 831 1451"></td> </tr> <tr> <td data-bbox="331 1451 715 1500">Not at all</td> <td data-bbox="715 1451 831 1500"></td> </tr> <tr> <td data-bbox="331 1500 715 1550">Don't know</td> <td data-bbox="715 1500 831 1550"></td> </tr> </table>	A great deal		To some extent		Not at all		Don't know	
A great deal									
To some extent									
Not at all									
Don't know									

84	What would you consider are the most important improvements that could be made to the transport options available to you?
85	Any other Information (Transport)

Section P: How did you find filling out the questionnaire

86

How long did it take you to fill out this questionnaire?

Please tick one box

Less than 30 minutes	☐
30 minutes – 1 hour	☐
1 – 2 hours	☐
2 -3	☐

87

In general, did you find it easy to understand the questions?

Please tick one Box

Yes	☐
No	☐
Don't know	☐

88

Please tell us which questions did you find most difficult to understand?

--

89

Please tell us if you have any other comments about the questionnaire?

--

90	Has anyone supported you to fill out this questionnaire? Please tick one box <table border="1"> <tr> <td>Yes</td> <td>☐</td> </tr> <tr> <td>No</td> <td>☐</td> </tr> <tr> <td>Don't know</td> <td>☐</td> </tr> </table>	Yes	☐	No	☐	Don't know	☐
Yes	☐						
No	☐						
Don't know	☐						
91	Name of the person supporting you First Name _____ Surname _____						
92	Is this the same person who gave you support in the previous interview? <table border="1"> <tr> <td>Yes</td> <td>☐</td> </tr> <tr> <td>No</td> <td>☐</td> </tr> <tr> <td>Don't know</td> <td>☐</td> </tr> </table>	Yes	☐	No	☐	Don't know	☐
Yes	☐						
No	☐						
Don't know	☐						

93	What is their relationship to you?	
	Boyfriend/Girlfriend/Partner	☐
	Parent	☐
	Sibling	☐
	Key worker/Support worker	☐
	Friend	☐
	Other (Please tell us)	
94	How long do you know the person supporting you?	
	Less than 6 months	☐
	Between 6 months & a year	☐
	More than a year	☐
	Don't know	☐

**THANK YOU VERY MUCH FOR TAKING THE TIME TO FILL IN THIS
QUESTIONNAIRE.**

**PLEASE BRING IT WITH YOU TO YOUR INTERVIEW AND GIVE IT TO THE
INTERVIEWER.**

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