

|                                     |  |
|-------------------------------------|--|
| Carer identified                    | <input type="checkbox"/> Yes → <input type="checkbox"/> Informal <input type="checkbox"/> Formal |
|                                     | <input type="checkbox"/> No  |
| Okay to contact carer               | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Carer's details completed           | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Carer consents to Kaiāwhina Study   | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 'Your Reflections' page included    | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Return questionnaire to participant | <input type="checkbox"/> Yes <input type="checkbox"/> No   |

# LILACS NZ



## Life and Living in Advanced Age: A Cohort Study in New Zealand

Te Puāwaitanga o Ngā  
Tapuwae Kia Ora Tonu

~ WAVE 6 ~

This questionnaire has been developed by the LiLACS NZ research team and is for the purpose of the LiLACS NZ project. For queries, please contact Professor Ngaire Kerse at the LILACS NZ research base.

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# Visit record form

VISIT 1

Date: 

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(dd) (mm) (yyyy)

Start Time: (24 hour time) 

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 Finish Time: (24 hour time) 

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Who provided the responses to this questionnaire?   
 1=Participant      2=Family member      3=Other .....

Reason for proxy completing questionnaire .....

If a proxy completed the questionnaire, who answered most of the questions?   
 1=Participant told proxy the answers      2=Proxy used their own judgement

Place of interview:   
 1=Residence (own home)      2=Medical Centre      3=Research Centre      4= Other.....

Language used to answer questions:   
 1=English      2=Te reo Māori/bilingual      3=Other .....

VISIT 2

Date: 

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(dd) (mm) (yyyy)

Start Time: (24 hour time) 

|  |  |  |  |
|--|--|--|--|
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 Finish Time: (24 hour time) 

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|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

Who provided the responses to this questionnaire?   
 1=Participant      2=Family member      3=Other .....

Reason for proxy completing questionnaire .....

If a proxy completed the questionnaire, who answered most of the questions?   
 1=Participant told proxy the answers      2=Proxy used their own judgement

Place of interview:   
 1=Residence (own home)      2=Medical Centre      3=Research Centre      4= Other.....

Language used to answer questions:   
 1=English      2=Te reo Māori/bilingual      3=Other .....

# Visit record form

VISIT 3

Date:   .   .      
(dd) (mm) (yyyy)

Start Time: (24 hour time)      
 Finish Time: (24 hour time)

Who provided the responses to this questionnaire?   
 1=Participant      2=Family member      3=Other .....

Reason for proxy completing questionnaire .....

If a proxy completed the questionnaire, who answered most of the questions?   
 1=Participant told proxy the answers      2=Proxy used their own judgement

Place of interview:   
 1=Residence      2=Medical Centre      3=Research Centre      4= Other.....  
(own home)

Language used to answer questions:   
 1=English      2=Te reo Māori/bilingual      3=Other .....

VISIT 4

Date:   .   .      
(dd) (mm) (yyyy)

Start Time: (24 hour time)      
 Finish Time: (24 hour time)

Who provided the responses to this questionnaire?   
 1=Participant      2=Family member      3=Other .....

Reason for proxy completing questionnaire .....

If a proxy completed the questionnaire, who answered most of the questions?   
 1=Participant told proxy the answers      2=Proxy used their own judgement

Place of interview:   
 1=Residence      2=Medical Centre      3=Research Centre      4= Other.....  
(own home)

Language used to answer questions:   
 1=English      2=Te reo Māori/bilingual      3=Other .....

# Life and Living in Advanced Age: A Cohort Study in New Zealand Te Puāwaitanga o Ngā Tapuwae Kia Ora Tonu

Name .....

Interviewer: .....

Site Number: .....

(1=Opotiki/Te Kaha, 2=Whakatane, 3=Rotorua Māori, 4= Rotorua non-Māori, 5=NMO PHO, 6=WBOP)

Date:   .   .      
(dd) (mm) (yyyy)

## 1. Contact Details

I would like to check some of the details you have previously given us

**AA1. Do you still live at ... (refer sheet for previous address)**

No = 0 **(Record new address)** Yes = 1 **(Go to AA2)**

Full Address .....

.....

..... Phone .....

**AA2. Is ..... (refer sheet) still someone we could contact if we cannot get hold of you? If for example, you moved or were away or have died?**

No = 0 **(Record new details below)** Yes = 1

Name .....

Phone .....

Address .....

.....

Relationship.....

*Answer the following for the above or previously named contact*

**AA2a. Can be contacted if I moved or were away** No = 0 Yes = 1

**AA3. Is ..... (refer sheet) still someone we could contact if we cannot get hold of you?**

No = 0 **(Record new details below)** Yes = 1

Name .....

Phone .....

Address .....

.....

Relationship.....

*Answer the following for the above or previously named contact*

**AA3a. Can be contacted if I moved or were away** No = 0 Yes = 1

**Interviewer:** If only one contact recorded please ask if there is anyone else. Record new contact details









## 2. Personal History

AB1. Is your GP still ... *(refer sheet for previous GP)*

No = 0 *(Record new contact)* Yes = 1 *(Go to AB2)*

If no please tell me your GP's name and address:

GP's Name ..... Phone .....

GP's Practice .....  
 .....

**Interviewer:** *If no GP was recorded, please ask and record in the space*

AB2. Has your marital status changed since the last interview about a year ago?

No = 0 *(Go to AB3)* Yes = 1 *(Go to AB2a)*

AB2a. What is your current marital status?

|                    |               |           |          |                          |
|--------------------|---------------|-----------|----------|--------------------------|
| Married/ partnered | Widow/Widower | Separated | Divorced | <input type="checkbox"/> |
| 2                  | 3             | 4         | 5        |                          |

AB3. Who do you live with most of the time?

- 1 = alone
- 2 = with spouse/partner only
- 3 = with spouse and child/other relative
- 4 = with spouse and non-relatives
- 5 = with child (not spouse)
- 6 = with other(s) not spouse or children
- Who? .....

AB3a. **If not living alone**, how many people, including you, live in your residence/ household most of the time?

AB4. What best describes your home?

- 1 = private dwelling, stand-alone house
- 2 = private unit or apartment - independent
- 3 = unit or apartment on site with family dwelling
- 4 = retirement village - villa or own unit
- 5 = rest home *(Go to AB12)*
- 6 = private hospital (own or shared room) *(Go to AB12)*
- 7 = Marae or iwi based housing
- 8 = other.....

IA4. I'd like to check how this accommodation is owned or rented. Do you...

- 1 = Own it outright yourself or with spouse/partner
- 2 = Still pay a mortgage or loan yourself or with spouse/partner
- 3 = Rent (Private)
- 4 = Rent (Public) e.g. State or local council
- 5 = Pay part rent and part mortgage (shared ownership)
- 6 = Live here rent free (e.g. relative, friend's property)
- 7 = Other .....

The next questions are about culture and language.

**AB12. How much do you disagree or agree with this statement:**

**“I have a strong sense of belonging to my own ethnic group(s)”**

|                   |          |         |       |                |                          |
|-------------------|----------|---------|-------|----------------|--------------------------|
| Strongly disagree | Disagree | Neutral | Agree | Strongly agree |                          |
| 0                 | 1        | 2       | 3     | 4              | <input type="checkbox"/> |

**AB5. How often have you been to a Marae over the last 12 months?**

|                           |      |             |               |                        |                          |
|---------------------------|------|-------------|---------------|------------------------|--------------------------|
| Not in the last 12 months | Once | A few times | Several times | More than once a month |                          |
| 0                         | 1    | 2           | 3             | 4                      | <input type="checkbox"/> |

This question considers your contacts with Māori.

**AB6. In general, would you say that your contacts are with ...**

|              |            |           |          |                          |
|--------------|------------|-----------|----------|--------------------------|
| Mainly Māori | Some Māori | Few Māori | No Māori |                          |
| 1            | 2          | 3         | 4        | <input type="checkbox"/> |

|  |            |          |            |      |           |
|--|------------|----------|------------|------|-----------|
| <i>Māori only to answer this section, others to go to question AC1</i> |            |          |            |      |           |
|  | Not at all | A little | Moderately | Very | Extremely |
| <b>AB9. How important is your hapū to your wellbeing?</b>              | 1          | 2        | 3          | 4    | 5         |
| <b>AB10. How important is your iwi to your wellbeing?</b>              | 1          | 2        | 3          | 4    | 5         |
| <b>AB11. How well do you understand your tikanga?</b>                  | 1          | 2        | 3          | 4    | 5         |

**LANGUAGE AND CULTURE**

**AC1. In which language(s) could you have a conversation about a lot of everyday things?**

*(read all options and mark answers with a No = 0 Yes = 1)*

- |   |                          |                               |                          |
|---|--------------------------|-------------------------------|--------------------------|
| 1 = Māori   | <input type="checkbox"/> | 2 = English                   | <input type="checkbox"/> |
| 3 = Samoan  | <input type="checkbox"/> | 4 = New Zealand Sign Language | <input type="checkbox"/> |
| 5 = Cook Island Māori   | <input type="checkbox"/> | 6 = Niue                      | <input type="checkbox"/> |
| 7 = Tokelau   | <input type="checkbox"/> | 8 = Other Pacific Language    | <input type="checkbox"/> |
| 9 = Other language(s), for example GUJARATI, CANTONESE, GREEK | .....                    |                               | <input type="checkbox"/> |

*If only English is spoken/understood go to AC4*

*If Māori or other non-English language is spoken or understood answer the following questions for the most significant other language*

**AC3a. Where do you speak Māori/other language?**

No = 0 Yes = 1

|  |                          |
|--|--------------------------|
| <i>Don't speak it</i>                                    | <input type="checkbox"/> |
| <i>On the Marae</i>                                      | <input type="checkbox"/> |
| <i>In my community</i>                                   | <input type="checkbox"/> |
| <i>At home</i>   | <input type="checkbox"/> |
| <i>In meetings or at work (includes volunteer work )</i> | <input type="checkbox"/> |
| <i>Other.....</i>  | <input type="checkbox"/> |

**AC3b. Do you seek out opportunities to listen to Māori/other language?**

No = 0 *(Go to AC4)* Yes = 1

**AC3c. If yes, how often do you seek out opportunities to listen to Māori/other language?**

| Every day | Every week | Every month | Occasionally |                          |
|-----------|------------|-------------|--------------|--------------------------|
| 1         | 2          | 3           | 4            | <input type="checkbox"/> |

**AC3d. Where do you listen to Māori/other language?**

No = 0 Yes = 1

|   |                          |
|---|--------------------------|
| <i>On the Marae</i>                                     | <input type="checkbox"/> |
| <i>In my community</i>                                  | <input type="checkbox"/> |
| <i>At home</i>  | <input type="checkbox"/> |
| <i>In meetings or at work (includes volunteer work)</i> | <input type="checkbox"/> |
| <i>On Māori TV</i>                                      | <input type="checkbox"/> |
| <i>On Māori/iwi radio</i>                               | <input type="checkbox"/> |
| <i>Other.....</i>                                       | <input type="checkbox"/> |

**AC4. How important is your language and culture to your wellbeing?**

| Not at all | A little | Moderately | Very | Extremely |                          |
|------------|----------|------------|------|-----------|--------------------------|
| 1          | 2        | 3          | 4    | 5         | <input type="checkbox"/> |

**MODIFIED MINI MENTAL STATE EXAMINATION (3MS)**

I'd like to ask some questions that measure your attention, memory and ability to understand instructions. Some of the questions will be easy; others may be more difficult.

*Interviewer: Even if a proxy is in attendance, remember to ask this section of the participant themselves. Remind them they do not have to answer all the questions.*

*Use the PAGE 15 to help answer AE12, AE13, AE14 and the Clock Drawing Test*

**AE1. When were you born?**

|                 |    |
|-----------------|----|
| Year            | /1 |
| Month           | /1 |
| Day             | /1 |
| Town            | /1 |
| Province/Region | /1 |

*(Score 1 point for each correct answer)*

**Where were you born?**

**AE2. I would like to test your memory. I am going to say 3 words. Repeat them after I have said all three. Now keep those words in mind. I'm going to ask you to say them again in a few minutes.**

|         |    |
|---------|----|
| Socks   | /1 |
| Blue    | /1 |
| Charity | /1 |

*(When repeating back, allow up to 6 tries to remember, score 1 point for each correct answer)*

**AE3. Please count from 1 to 5. Now count backwards from 5 to 1.**

|    |
|----|
| /2 |
|----|

*(Accurate – score 2; 1 or 2 errors – score 1)*

**AE4. Please spell the word 'WORLD' backwards.**

|   |    |
|---|----|
| D | /1 |
| L | /1 |
| R | /1 |
| O | /1 |
| W | /1 |

*(Give only one chance, score 1 point for each letter in correct order)*

**SUB SCORE**

|     |
|-----|
| /15 |
|-----|

**AE5. Please repeat back the three words I asked you to remember.**

|         |    |
|---------|----|
| Socks   | /3 |
| Blue    | /3 |
| Charity | /3 |

*(For each word: spontaneous recall – score 3, prompt – score 2, multiple choice – score 1)*

**AE6. What year is this?** *(Accurate = 8, miss by 1 = 4, miss by 2-5 = 2)*

|      |    |
|------|----|
| Year | /8 |
|------|----|

**What season is it?** *(Accurate or within 1 month = 1)*

|        |    |
|--------|----|
| Season | /1 |
|--------|----|

**What month is it?** *(Accurate or within 5 days = 2, miss by 1 month = 1)*

|       |    |
|-------|----|
| Month | /2 |
|-------|----|

**What is the date?** *(Accurate = 3, miss by 1-2 days = 2, miss by 3-5 days = 1)*

|      |    |
|------|----|
| Date | /3 |
|------|----|

**What day of the week is it?** *(Accurate = 1)*

|     |    |
|-----|----|
| Day | /1 |
|-----|----|

**SUB SCORE**

|     |
|-----|
| /24 |
|-----|

**AE7. Where are we now?** (Or what room are we in?) *(Accurate - score 1)*

**What region are we in?** *(Accurate - score 2)*

**What district is this?** *(Accurate - score 1)*

**What city (town) is this?** *(Accurate - score 1)*

|                 |    |
|-----------------|----|
| Room            | /1 |
| Province/Region | /2 |
| District        | /1 |
| City            | /1 |

**AE8. What is this?**

*(Point to the item or body part. Score 1 for each correct answer, approximate answers such as 'pen', 'arm', 'hand' are not acceptable)*

|          |    |
|----------|----|
| pencil   | /1 |
| watch    | /1 |
| shoulder | /1 |
| elbow    | /1 |
| knuckle  | /1 |

**SUB SCORE**

**AE9. You have thirty seconds to answer this next question. Naming as many as you can, what animals have 4 legs?** *(1 point each. Discontinue after 30 seconds)*

.....

.....

.....

**SUB SCORE**

**AE10. In what way are an arm and a leg alike?**

**In what way are laughing and crying alike?**

**In what way are eating and sleeping alike?**

|                         |    |
|-------------------------|----|
| e.g. Body part, limb    | /2 |
| e.g. feeling, emotion   | /2 |
| e.g. essential for life | /2 |

*(Accurate - score 2 each example, less correct - score 1 for each)*

**AE11. Please repeat the following - "no ifs, ands or buts"**

*Allow only 1 trial*

correct



**AE12. Please read this and do what it says.**

*(Obey without prompt - score 3, prompt - score 2, can read aloud and obey - score 1)*

**AE13. Please write a sentence - it can say anything you like.**

*The sentence must contain a subject, a verb and be sensible. Correct grammar and punctuation are not necessary. Prompts permitted if necessary. Score 5 for a complete sentence.*

**SUB SCORE**

**AE14. Please copy this drawing exactly as it is. (Ignore tremor and rotation)**

/10

- *For each figure: approximately equal sides = 4, 5 unequal sides = 3, other enclosed figure = 2, 2 or more lines = 1)*
- *4 corner enclosure: 4 corners = 2, not 4 corners = 1 or 0*

*Hold out a piece of paper (use the blank side of diagram page) to the participant.*

**AE15. Take this paper in your right hand, fold it in half, and hand it back to me**

|           |    |
|-----------|----|
| R hand    | /1 |
| fold      | /1 |
| Gave back | /1 |

**AE16. What three words did I ask you to remember earlier?**

|         |    |
|---------|----|
| Socks   | /3 |
| Blue    | /3 |
| Charity | /3 |

**SUB SCORE** /22

**TOTAL 3MS SCORE** /100

## CLOCK DRAWING

**AE17. Please imagine this circle is a clock. I would like you to place the numbers in the correct position then place the hands to indicate a time of 'ten past eleven'**

No errors = 0                      minor spacing errors = 1                      other errors = 2                     

Comments .....

.....

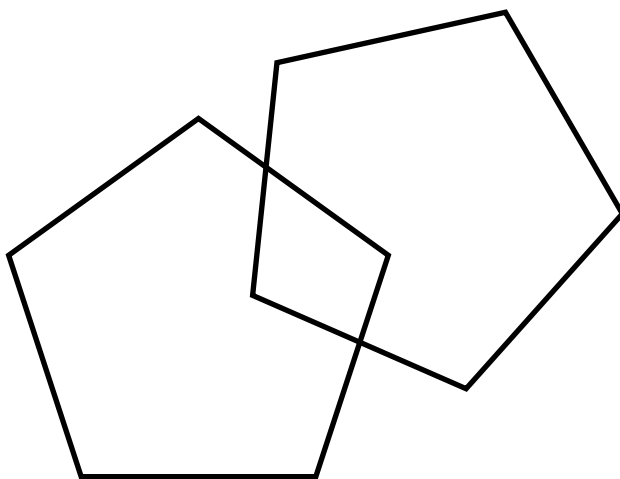
.....

***Interviewers:** For those who have a score of less than 65 on the 3MSE it is strongly recommended that they are supported by a family member or friend to help answer the questions. If no-one is available and the interview is going well, please continue.*

*Tear along dotted line*

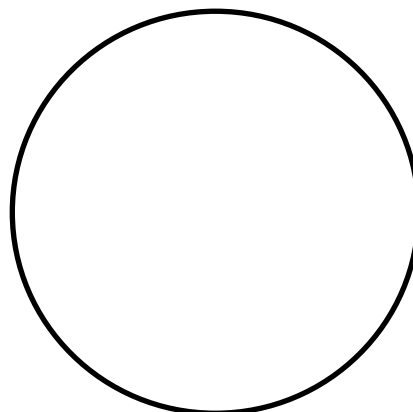
Please write a sentence about anything.

.....  
.....  
.....  
.....



---

*Instructions: Please imagine this circle is a clock. Place the numbers in the correct position then place the hands to indicate a time of 'ten past eleven'*







**OCCUPATION**

The next questions ask about the work you may have done, both paid and unpaid.

**AG10. During the past 7 days, did you work for pay or as a volunteer?**

| Neither<br><i>(Go to AG11)</i> | Yes,<br>for pay | Yes,<br>as a volunteer | Yes, both for<br>pay and as a volunteer |                          |
|--------------------------------|-----------------|------------------------|---|--------------------------|
| <b>1</b>                       | <b>2</b>        | <b>3</b>               | <b>4</b>                                | <input type="checkbox"/> |

**AG10a. How many hours in the last 7 days did you work for pay or as a volunteer?**

|   |  |  |
|---|--|--|
| a. Hours in the last 7 days worked for pay          |  |  |
| b. Hours in the last 7 days worked as a volunteer   |  |  |
| TOTAL hours in the last 7 days <i>(Go to AG10b)</i> |  |  |

**AG10b. Which of the following categories best describes the amount of physical activity required on your job/volunteer work?**

*(Answer this for the job you do spend most hours doing)*

1 = Mainly sitting with slight arm movements. (E.g. office worker, watchmaker, seated assembly worker, bus driver, marae spokesperson).

2 = Sitting or standing with some walking. (E.g. cashier, general office worker).

3 = Walking, with some handling of materials weighing less than 50 pounds/20kg. (E.g. postie, waiter / waitress).

4 = Walking and heavy manual work often requiring handling of materials weighing over 50 pounds/20kg. (E.g. forestry, farm or general labourer).

**AG11. If you haven't worked for pay or as a volunteer in the last week, during the past MONTH, did you work for pay or as a volunteer?**

| Neither<br><i>(Go to next section)</i> | Yes,<br>for pay | Yes,<br>as a volunteer | Yes, both for<br>pay and as a volunteer |                          |
|--|-----------------|------------------------|---|--------------------------|
| <b>1</b>                               | <b>2</b>        | <b>3</b>               | <b>4</b>                                | <input type="checkbox"/> |

**AG11a. How many hours in the last month did you work for pay or as a volunteer?**

|  |  |  |
|--|--|--|
| a. Hours in the last month worked for pay        |  |  |
| b. Hours in the last month worked as a volunteer |  |  |
| TOTAL hours in the last month                    |  |  |

**Comments**

.....

.....

.....

.....

### 3. Physical Health

SF-12

These next questions ask for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. If you are unsure about how to answer a question, please give the best answer you can.

**BA1. In general, would you say your health is:**

|          |           |           |      |      |      |  |
|----------|-----------|-----------|------|------|------|--|
| <b>2</b> | Excellent | Very Good | Good | Fair | Poor |  |
|          | 1         | 2         | 3    | 4    | 5    |  |

**BA2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

|   | Yes,<br>limited a<br>lot | Yes,<br>limited<br>a little | No, not<br>limited at<br>all |  |
|---|--------------------------|-----------------------------|------------------------------|--|
| <b>a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf</b> | 1                        | 2                           | 3                            |  |
| <b>b. Climbing several flights of stairs</b>  | 1                        | 2                           | 3                            |  |

**BA3. During the PAST 4 WEEKS, how much of the time have you had any of the following problems with your work or other regular daily activities AS A RESULT OF YOUR PHYSICAL HEALTH?**

|          |  |                    |                     |                     |                         |                     |  |
|----------|--|--------------------|---------------------|---------------------|-------------------------|---------------------|--|
| <b>3</b> |  | All of<br>the time | Most of<br>the time | Some of<br>the time | A little of<br>the time | None of<br>the time |  |
|          | <b>a. Accomplished less than you would like</b>                | 1                  | 2                   | 4                   | 5                       | 6                   |  |
|          | <b>b. Were limited in the kind of work or other activities</b> | 1                  | 2                   | 4                   | 5                       | 6                   |  |

**BA4. During the PAST 4 WEEKS, how much of the time have you had any of the following problems with your work or other regular daily activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?**

|  | All of the<br>time | Most of<br>the time | Some of<br>the time | A little of<br>the time | None of<br>the time |  |
|--|--------------------|---------------------|---------------------|-------------------------|---------------------|--|
| <b>a. Accomplished less than you would like</b>            | 1                  | 2                   | 4                   | 5                       | 6                   |  |
| <b>b. Did work or activities less carefully than usual</b> | 1                  | 2                   | 4                   | 5                       | 6                   |  |

**BA5. These questions are about how you feel and how things have been with you DURING THE PAST 4 WEEKS For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS.**

|   | All of the time | Most of the time | Some of the time | A little of the time | None of the time |                          |
|---|-----------------|------------------|------------------|----------------------|------------------|--------------------------|
| a. Have you felt calm and peaceful?         | 1               | 2                | 4                | 5                    | 6                | <input type="checkbox"/> |
| b. Did you have a lot of energy?            | 1               | 2                | 4                | 5                    | 6                | <input type="checkbox"/> |
| c. Have you felt downhearted and depressed? | 1               | 2                | 4                | 5                    | 6                | <input type="checkbox"/> |

**BA6. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?**

| Not at all | Slightly | Moderately | Quite a bit | Extremely |                          |
|------------|----------|------------|-------------|-----------|--------------------------|
| 1          | 2        | 3          | 4           | 5         | <input type="checkbox"/> |



**BA7. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc)?**

| All of the time | Most of the time | Some of the time | A little of the time | None of the time |                          |
|-----------------|------------------|------------------|----------------------|------------------|--------------------------|
| 1               | 2                | 3                | 4                    | 5                | <input type="checkbox"/> |

**SLEEPING AND HEALTH PROBLEMS**

**CD1. Do you have trouble with your sleeping (on at least 3 nights per week) such that it interferes with your activities the following day (e.g. un-refreshed in the morning, fatigue, poor concentration or irritability)?**

No = 0 (Go to BB1) Yes = 1

**CD2. Do you have any of these sleeping problems? (read all options)**

(No = 0 Yes = 1)

- Waking up in the early hours of the morning
- Lying awake for most of the night
- Taking a long time to get to sleep
- Worry keeping you awake at night
- Sleep walking/ sleep talking
- Snoring
- Getting up at night to go to the toilet

On average, how many times a night .....

Other sleeping problem .....

The next questions ask about conditions you have had for 6 months or more

**BB1. Does a HEALTH PROBLEM, or a condition you have (lasting SIX MONTHS or more) cause you difficulty with, or stop you doing:** (No = 0 Yes = 1)

- Everyday activities that people your age can usually do
- Communicating, mixing with others or socialising
- Any other activity that people your age can usually do

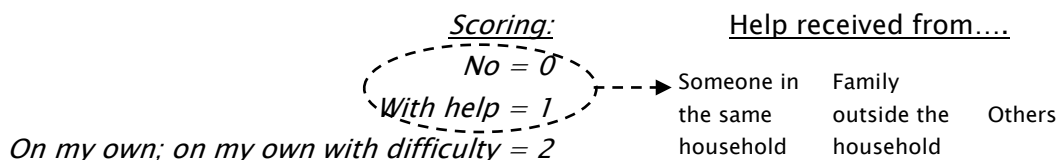
**BB3. In general, compared with other people your age, would you say your health is:**

|          |           |           |      |      |      |                          |
|----------|-----------|-----------|------|------|------|--------------------------|
| <b>2</b> | Excellent | Very Good | Good | Fair | Poor |                          |
|          | 1         | 2         | 3    | 4    | 5    | <input type="checkbox"/> |

### NOTTINGHAM EXTENDED ACTIVITIES OF DAILY LIVING

The next questions ask about a few more common everyday activities. For each question please tell me whether you do the activity on your own, on your own with difficulty, with help from someone else, or whether you don't do the activity at all. We are interested in whether you have actually DONE the activity in the last few weeks, not whether you CAN do it.

**Interviewer:** ask all the questions first. Then go back to all activities the person said they have help to do. For each activity they said they have help to do, find out who helps.



|      | Mobility  |                          |                          |                          |                          |
|------|---|--------------------------|--------------------------|--------------------------|--------------------------|
| BC1. | a. Do you walk around outside?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | b. Do you climb stairs?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | c. Do you get in and out of the car?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | d. Do you walk over uneven ground?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | e. Do you cross roads?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | f. Do you travel on public transport?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| BC2. | In the kitchen  |                          |                          |                          |                          |
|      | a. Do you manage to feed yourself?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | b. Do you manage to make yourself a hot drink?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | c. Do you take hot drinks from one room to another?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | d. Do you do the washing up?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | e. Do you make yourself a hot snack?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| BC3. | Domestic tasks  |                          |                          |                          |                          |
|      | a. Do you manage your own money when you are out?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | b. Do you wash small items of clothing?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | c. Do you do your own housework?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | d. Do you do your own shopping?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | e. Do you do a full clothes wash?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| BC4. | Leisure activities  |                          |                          |                          |                          |
|      | a. Do you read newspapers or books?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | b. Do you use the telephone?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | c. Do you write letters?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | d. Do you go out socially?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | e. Do you manage your own garden?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | f. Do you drive a car?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| BC5. | Other   |                          |                          |                          |                          |
|      | a. Do you manage your personal care for instance brushing your teeth and hair, washing your hands and face? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | b. Do you manage to go to the toilet?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | c. Do you get in/out of bed?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | d. Do you shower/bath yourself?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | e. Do you dress yourself?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

We are interested in any aids you use to help you get around

**BC7. How often do you use any of the following mobility aids?**

|                          | None of the time | Some of the time | Most of the time | All of the time |                          |
|--------------------------|------------------|------------------|------------------|-----------------|--------------------------|
| a. Cane or stick?        | 0                | 1                | 2                | 3               | <input type="checkbox"/> |
| b. Walking frame?        | 0                | 1                | 2                | 3               | <input type="checkbox"/> |
| c. Wheelchair?           | 0                | 1                | 2                | 3               | <input type="checkbox"/> |
| d. Mobility scooter      | 0                | 1                | 2                | 3               | <input type="checkbox"/> |
| e. Other (specify) ..... | 0                | 1                | 2                | 3               | <input type="checkbox"/> |
| .....                    |                  |                  |                  |                 |                          |

**TECHNOLOGY**

Now I'm going to ask you some questions about your use of modern technology

**JD1. How comfortable are you with new technology, mobile phones and computers?**

| Very uncomfortable | Mainly uncomfortable | Neither uncomfortable nor comfortable | Mainly comfortable | Very comfortable |  |
|--------------------|----------------------|---------------------------------------|--------------------|------------------|--|
| 1                  | 2                    | 3                                     | 4                  | 5                |  |

|  |        |         |                          |
|--|--------|---------|--------------------------|
| JD2. Do you use the Internet?  | No = 0 | Yes = 1 | <input type="checkbox"/> |
| JD3. Do you use a mobile phone?  | No = 0 | Yes = 1 | <input type="checkbox"/> |
| JD4. Do you watch Sky television?  | No = 0 | Yes = 1 | <input type="checkbox"/> |
| JD5. Do you use a computer for email?                                      | No = 0 | Yes = 1 | <input type="checkbox"/> |
| JD6. Do you use a computer to see family far away (e.g., Skype, Facebook)? | No = 0 | Yes = 1 | <input type="checkbox"/> |
| JD7. Do you use a computer for anything else?                              | No = 0 | Yes = 1 | <input type="checkbox"/> |
| Please specify.....  |        |         |                          |

## 4. Medical History

In this section I would like to find out about things to do with medication and your medical history.

### MEDICATIONS

The first questions are about medications and non-prescribed products you might use as well as any health problems you may have. Remember that any question you are not happy to answer, you may leave.

**Interviewer:**

Ask the following questions and record all medications and health products, whether they are prescribed or not, in the table to the right. Include inhalers, suppositories, creams, eye drops and fortified foods such as fortisip, complan etc. You may need to prompt the participant about these more unusual products.

Ask if you can look at the medication packets and fill in as much information as you can. See the procedure manual for further guidance on completing this section.

5

CA1. Do you currently take any medications prescribed by the doctor?

No = 0 (Go to CB1) Yes = 1

|   | Never | Rarely | Sometimes | Often | Very often |                          |
|---|-------|--------|-----------|-------|------------|--------------------------|
| CA1a. Sometimes people forget to take their medicines. How often do <i>you</i> forget to take your medication(s)?   | 1     | 2      | 3         | 4     | 5          | <input type="checkbox"/> |
| CA1b. Sometimes people alter the way they take their medication, that is take them at a different time or take less or more of a medication. How often do <i>you</i> alter you medication(s)? | 1     | 2      | 3         | 4     | 5          | <input type="checkbox"/> |

CA3. Do you currently take any over the counter medicines that are not prescribed?

No = 0 Yes = 1

CA4. Do you currently take any nutritional supplements?

No = 0 Yes = 1

CA5. Do you take any “natural” or “herbal” products or traditional medicines?

No = 0 Yes = 1

CA6. Do you take any rongoā Māori medicines?

No = 0 Yes = 1

CA6c. Do you use rongoā Māori healing practices?

No = 0 (Go to CA7) Yes = 1

4

**CA6d. How much do Māori healing practices contribute to your quality of life?**

|            |          |            |             |           |                          |
|------------|----------|------------|-------------|-----------|--------------------------|
| Not at all | Slightly | Moderately | Quite a bit | Extremely |                          |
| 1          | 2        | 3          | 4           | 5         | <input type="checkbox"/> |

**CA6e. Which rongoā Māori healing practices do you use (e.g. plants, mirimiri, karakia etc.)?**

Please specify.....

**CA7. Do you use any aid to help you take your *prescribed* medication?**

No = 0 (*Go to medication table*)

Yes = 1

**CA7a. What type of aid do you use?**

(No = 0 Yes = 1)

- Blister pack
- Weekly medication boxes
- Yellow card
- Other.....
- .....

*Please remember to **fill in the medication table**. If there is **NO** medication, please put a line through the following table.*







**MEDICATION ASSISTANCE AND HEART HEALTH**

**CA10a. Who helps you take your medication?**

*(No = 0 Yes = 1)*

- a. General Practitioner/Practice Nurse
- b. Whānau or Family member
- c. Formal Carer
- d. Friend or neighbour
- e. District Nurse
- f. Pharmacist
- g. Other

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.....  
 .....

**CA10b. How do they help?**

Give the medication      Reminder to take the medication      Fill the medication box

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**CB1. Since your last LILACS NZ interview about a year ago, have you been told by a doctor that you have had:**

*No = 0 Yes = 1 Don't Know = 2*

- a. Heart attack/myocardial infarction
- b. Angina
- c. Stroke
- d. Transient Ischemic Attack / mini stroke
- e. High Blood Pressure
- f. Atrial fibrillation or irregular heartbeat
- g. Congestive heart failure
- h. Intermittent claudication (pain in calves when walking), peripheral vascular disease
- i. Rheumatic Fever
- j. Other heart or circulatory problem

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**CB3. Were you in hospital for this?**

*No = 0 Yes = 1*

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|  |

Specify.....

### MAJOR LIFE EVENTS

These next two questions ask about major health events you may have experienced

**FD1. Have you had a major injury or health event that has affected you since your last LILACS NZ interview about a year ago?**

No = 0 *(Go to FD2)* Yes = 1

**FD1a. What was it?** .....

.....

**FD2. Have you had a major psychological stress event that has affected you since your last LILACS NZ interview about a year ago? For example the unexpected loss of a family member or moving house.**

No = 0 *(Go to CF1)* Yes = 1

**FD2a. What was it?** .....

.....

### FALLS, CONTINENCE, AND HEALTH HABITS

The next questions are about falls

**CF1. How many times have you fallen in the last 12 months?**

|                          |     |              |              |                          |
|--------------------------|-----|--------------|--------------|--------------------------|
| None <i>(Go to CF11)</i> | One | Two or three | Four or more | <input type="checkbox"/> |
| 0                        | 1   | 2            | 3            |                          |

**CF1a. Have you sought medical attention because of your fall/s?**

No = 0 Yes = 1

**CF1b. When you fell during the last 12 months?**

No = 0 Yes = 1

a. Did you have a fracture

b. Did you have some other kind of injury (please describe)

.....  
c. Were you admitted to hospital?

**CF11. Have you had any fracture not from a fall since your last LILACS NZ interview about a year ago?**

No = 0 *(Go to CF2)* Yes = 1

**CF11a. Cause of fracture** .....

.....

**CF2. How confident are you that you can do all your daily activities without falling?**

|                      |                 |                      |                          |
|----------------------|-----------------|----------------------|--------------------------|
| Not at all confident | Quite confident | Completely confident |                          |
| 0                    | 1               | 2                    | <input type="checkbox"/> |

I want to ask you about any bladder and bowel problems you might have

**CF3. Do you have a problem with losing control of urine when you don't want to?**

No = 0 (Go to CF4) Yes = 1

**CF3a. How much of a problem would you say you have with losing control of urine?**

|                   |                     |                             |                          |
|-------------------|---------------------|-----------------------------|--------------------------|
| Severe<br>problem | Moderate<br>problem | Mild<br>problem (Go to CF4) |                          |
| 1                 | 2                   | 3                           | <input type="checkbox"/> |

**CF3b. Have you sought help for this from ...?**

|   |                                      |
|---|--------------------------------------|
|   | No = 0 Yes = 1                       |
| Your GP <input type="checkbox"/>        | Pharmacy <input type="checkbox"/>    |
| District nurse <input type="checkbox"/> | Other ..... <input type="checkbox"/> |

**CF4. Do you have a problem with losing control of your bowels when you don't want to?**

No = 0 Yes = 1

**CC1. Do you smoke cigarettes?**

No = 0 (Go to DE1) Yes = 1

**CC1c. On average, how many cigarettes do you smoke per day?**

One pack is 20 cigarettes

|  |  |
|--|--|
|  |  |
|--|--|

**DE1. How often do you have a drink containing alcohol?**

|       |                 |                              |                              |                              |                          |
|-------|-----------------|------------------------------|------------------------------|------------------------------|--------------------------|
| Never | Monthly or less | Two to four<br>times a MONTH | Two to three<br>times a WEEK | Four or more<br>times a WEEK |                          |
| 0     | 1               | 2                            | 3                            | 4                            | <input type="checkbox"/> |

**PAIN**

I'd like to ask a few questions about pain now. I'm going to ask for some detail about each area that you have pain in. Use the following scale to determine the level of pain.

**Example**



**CG0. Do you have any pain now?**

No = 0 (Go to CG6) Yes = 1



**Where is it?** (Interviewer: Use the scale and map supplied to code all pain mentioned by area and write each area in the table below)

| Area | CG1 | CG2 | CG3 | CG4 | CG5 |
|------|-----|-----|-----|-----|-----|
| a.   |     |     |     |     |     |
| b.   |     |     |     |     |     |
| c.   |     |     |     |     |     |
| d.   |     |     |     |     |     |
| e.   |     |     |     |     |     |
| f.   |     |     |     |     |     |
| g.   |     |     |     |     |     |
| h.   |     |     |     |     |     |

*Interviewer* – ask these questions about each area before you go on to the next

**CG1. What is your pain RIGHT NOW?**

**CG2. What is your TYPICAL or AVERAGE pain?**

**CG3. What is your pain level AT ITS BEST (How close to '0' does your pain get at its best)?**

**CG4. What is your pain level AT ITS WORST (How close to '10' does your pain get at its worst)?**

**CG5. How many days over the last month have you had this pain?**

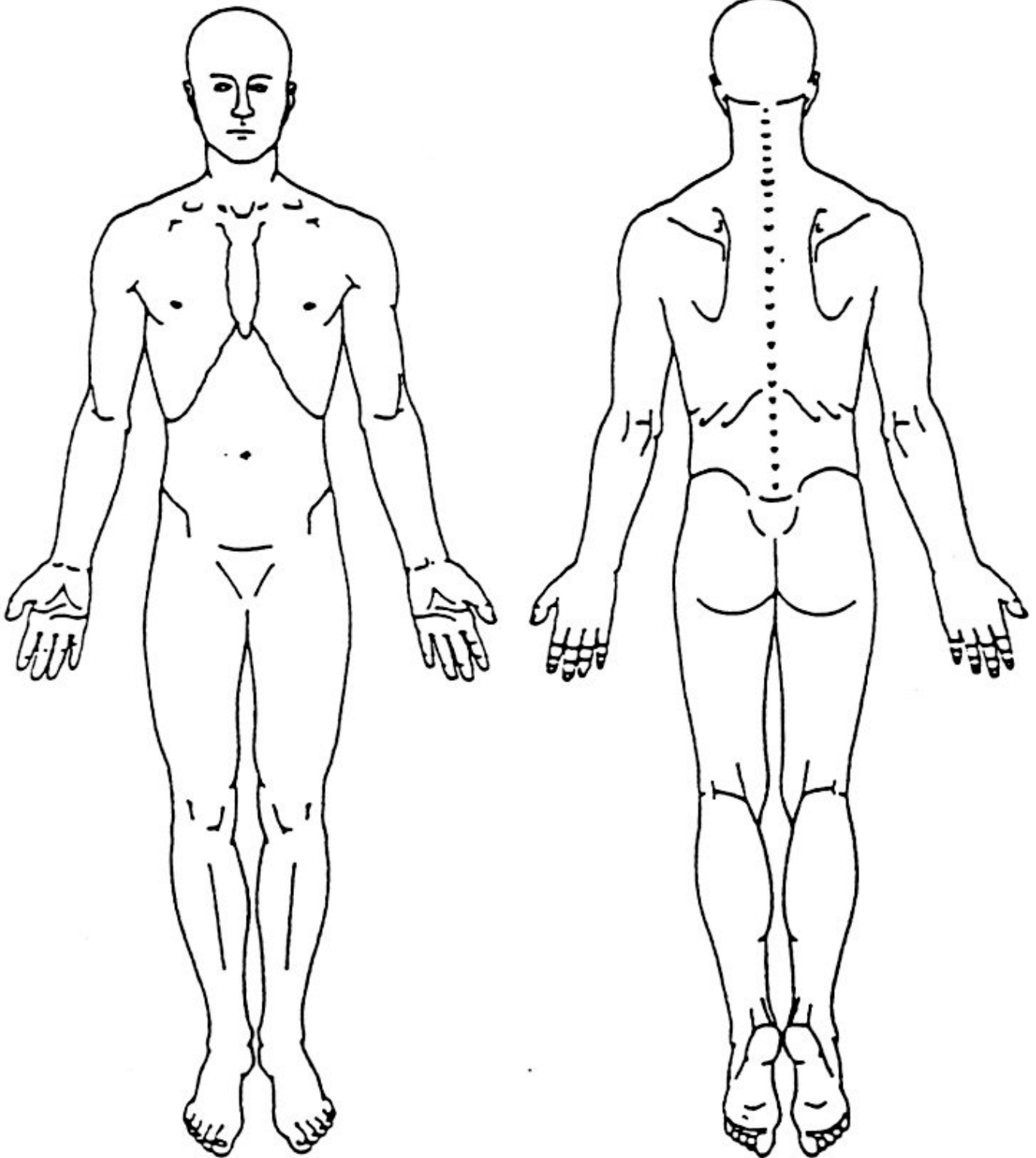
**CG6. Are there any other areas you sometimes have pain but do not have pain right now?**

No = 0 (Go to next section) Yes = 1

*Interviewer*, code other areas of pain and ask CG2–CG5 above for each area mentioned

| Area | CG1 | CG2 | CG3 | CG4 | CG5 |
|------|-----|-----|-----|-----|-----|
| i.   | 0   |     |     |     |     |
| j.   | 0   |     |     |     |     |
| k.   | 0   |     |     |     |     |
| l.   | 0   |     |     |     |     |
| m.   | 0   |     |     |     |     |
| n.   | 0   |     |     |     |     |
| o.   | 0   |     |     |     |     |

*Ask participant to shade or circle the location of each area of pain. Place letter of area (a - o) beside shading or circle.*



## 5. Mental Health

Please answer the following questions about yourself. Be as honest as you can, and try not to let your response to one question influence your response to other questions

| EA17   | Strongly agree | Agree | Unsure | Disagree | Strongly disagree |
|--|----------------|-------|--------|----------|-------------------|
| a. There is not enough purpose in my life                | 1              | 2     | 3      | 4        | 5                 |
| b. To me, the things I do are all worthwhile             | 1              | 2     | 3      | 4        | 5                 |
| c. Most of what I do seems trivial and unimportant to me | 1              | 2     | 3      | 4        | 5                 |
| d. I value my activities a lot                           | 1              | 2     | 3      | 4        | 5                 |
| e. I don't care very much about the things I do          | 1              | 2     | 3      | 4        | 5                 |
| f. I have lots of reasons for living                     | 1              | 2     | 3      | 4        | 5                 |

### GERIATRIC DEPRESSION SCALE (15-items)

The next questions are from a scale used in many studies and are about how you have been feeling lately. Please choose the best answer to describe how you have felt over the past WEEK.

No = 0 Yes = 1

|   |  |
|---|--|
| EA1. Are you basically satisfied with your life?                                |  |
| EA2. Have you dropped many of your activities and interests?                    |  |
| EA3. Do you feel that your life is empty?                                       |  |
| EA4. Do you often get bored?  |  |
| EA5. Are you in good spirits most of the time?                                  |  |
| EA6. Are you afraid that something bad is going to happen to you?               |  |
| EA7. Do you feel happy most of the time?  |  |
| EA8. Do you often feel helpless?  |  |
| EA9. Do you prefer to stay at home, rather than going out and doing new things? |  |
| EA10. Do you feel you have more problems with memory than most?                 |  |
| EA11. Do you think it is wonderful to be alive now?                             |  |
| EA12. Do you feel pretty worthless the way you are now?                         |  |
| EA13. Do you feel full of energy?   |  |
| EA14. Do you feel that your situation is hopeless?                              |  |
| EA15. Do you think that most people are better off than you are?                |  |



## 6. Support needs

### VISITS TO HEALTH PROFESSIONALS

Thank you for answering the questions about medical conditions. I'd now like to ask you about visits to health professionals.

**GA1. If you have any health problems, which one would you most like to be fixed?**

.....  
*(if no problems Go to GA4)*

**GA1b. Who is helping /trying to help you with this problem?**

No = 0 Yes = 1

|                      |                          |                         |                          |
|----------------------|--------------------------|-------------------------|--------------------------|
| General Practitioner | <input type="checkbox"/> | Practice Nurse          | <input type="checkbox"/> |
| Pharmacist           | <input type="checkbox"/> | Carer                   | <input type="checkbox"/> |
| Dentist              | <input type="checkbox"/> | Whānau or family member | <input type="checkbox"/> |
| Friend or neighbour  | <input type="checkbox"/> | Other .....             | <input type="checkbox"/> |

**GA4. When you have a health problem, how easy is it for you to get help with it?**

10

|            |          |            |      |           |                          |
|------------|----------|------------|------|-----------|--------------------------|
| Not at all | Somewhat | Moderately | Very | Extremely |                          |
| 1          | 2        | 3          | 4    | 5         | <input type="checkbox"/> |

**GA2. Since your last LILACS NZ interview about a year ago, have you visited, or had a visit from, any of the following health professionals? How many times in the last 12 months?**

8

|  | Not at all | About once a year | About every 6 months | About every 3 months | About every month | About every week | Don't know |
|--|------------|-------------------|----------------------|----------------------|-------------------|------------------|------------|
| a. General practitioner  | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| d. Practice nurse  | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| b. Hospital based doctor or private specialist                 | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| c. After hours medical clinic                                  | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| e. Pharmacist/chemist  | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| f. Dentist   | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| g. Podiatrist – feet   | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| h. Audiologist – ears/hearing                                  | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| i. Optometrist – eyes glasses                                  | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| j. District Nurse  | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| k. Physiotherapist   | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| l. Occupational Therapist                                      | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| m. Dietician   | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| n. Social worker   | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| o. Community worker  | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| p. Whānau Ora worker   | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| q. Alternative health professional e.g. Naturopath / Homeopath | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| r. Tohunga / Māori healer                                      | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |
| s. Other health professional. Specify .....                    | 0          | 1                 | 2                    | 3                    | 4                 | 5                | 6          |

**LA3. Have you ever been treated unfairly (e.g. treated differently, kept waiting) by a health professional (e.g. doctor, nurse, dentist etc.) because of your ethnicity in New Zealand?**

(No = 0 Yes = 1)

Within the past 12 months

More than 12 months ago

**An important thing for older people is the way they get on with their doctor. Would you now please answer the following questions? Thinking about when you have last consulted your GP, How do you rate the following?**

9

|  | Very Poor | Poor | Fair | Good | Very Good | Excellent |
|--|-----------|------|------|------|-----------|-----------|
| DR3a. How well the doctor listens to what you have to say?                       | 0         | 1    | 2    | 3    | 4         | 5         |
| DR3c. How well the doctor explains your problems or any treatment that you need? | 0         | 1    | 2    | 3    | 4         | 5         |
| DR3e. The doctor's care and concern for you?                                     | 0         | 1    | 2    | 3    | 4         | 5         |
| DR3f. The doctor's respect for your culture                                      | 0         | 1    | 2    | 3    | 4         | 5         |

I'd like to ask you about things which might help you understand your health better

**GA5. When you are seeing the doctor what method have you used and is it useful?**

Have you used...

No = 0 Yes = 1

|  | Used | Useful |
|--|------|--------|
| Written medical information from the doctor?           |      |        |
| GP follow-up (phone or visit)?                         |      |        |
| Taking a whānau or family member or advocate with you? |      |        |
| Practice Nurse follow-up (phone or visit)?             |      |        |
| Other .....  |      |        |

*if no methods used go to GA7*

**GA6. Which method was most useful?**

- 1 = Written medical information from the doctor
- 2 = GP follow-up (phone or visit)
- 3 = Taking a whānau or family member or advocate with you
- 4 = Practice Nurse follow-up (phone or visit)
- 5 = Other .....

**GA7. Have you been admitted to hospital to stay overnight or longer in the last 12 months?**

No = 0 *(Go to GB1)* Yes = 1

**GA7a. If yes, how many nights did you stay? .....**

Think of the last time (refer to GA7) you were admitted to hospital and stayed overnight.

**GA8. Before you were discharged from hospital did someone talk to you about going home and how your care would be after discharge?**

No = 0 *(Go to GA9)* Yes = 1

**GA8a. If yes, who was this? No = 0 Yes = 1**

- Nurse
- Doctor
- Māori liaison
- Social Worker
- Someone else

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GA9. On your last hospital admission how well informed were you about...

|  | Very Poor | Poor | Fair | Good | Very Good | Excellent | Not needed |
|--|-----------|------|------|------|-----------|-----------|------------|
| a. Your medications  | 0         | 1    | 2    | 3    | 4         | 5         | 6          |
| b. Treatments that might happen at home e.g. physiotherapy                     | 0         | 1    | 2    | 3    | 4         | 5         | 6          |
| c. Whether you would see a hospital doctor again                               | 0         | 1    | 2    | 3    | 4         | 5         | 6          |
| d. Arrangements for care at home e.g. home help, personal care or meal support | 0         | 1    | 2    | 3    | 4         | 5         | 6          |

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GA10. Overall how satisfied were you with the care you received...

|                                  | Extremely dissatisfied | Very dissatisfied | Somewhat dissatisfied | Satisfied most of the time | Satisfied all of the time |
|----------------------------------|------------------------|-------------------|-----------------------|----------------------------|---------------------------|
| a. In hospital                   | 0                      | 1                 | 2                     | 3                          | 4                         |
| b. At home after hospitalisation | 0                      | 1                 | 2                     | 3                          | 4                         |

**HEARING/VISION/TEETH**

I'd like to ask a couple of questions about your hearing and your eyesight now.

GB1. How much does your hearing interfere with normal day-to-day functioning?

| 10 | Not at all | Somewhat | Moderately | Very | Extremely |
|----|------------|----------|------------|------|-----------|
|    | 1          | 2        | 3          | 4    | 5         |

GB2. Do you have a hearing aid?

No = 0 (Go to GB3) Yes = 1

GB2a. How often do you use it?

|  | None of the time | Some of the time | Most of the time | All of the time |
|--|------------------|------------------|------------------|-----------------|
|  | 0                | 1                | 2                | 3               |

GB3. How much does your eyesight interfere with normal day-to-day functioning?

| 10 | Not at all | Somewhat | Moderately | Very | Extremely |
|----|------------|----------|------------|------|-----------|
|    | 1          | 2        | 3          | 4    | 5         |

GB4. How much do your teeth interfere with normal day-to-day functioning?

|  | Not at all | Somewhat | Moderately | Very | Extremely |
|--|------------|----------|------------|------|-----------|
|  | 1          | 2        | 3          | 4    | 5         |

**SOCIAL SUPPORT**

Now I'd like to ask you some questions about your social network and social relationships.

**GC1. When you need some extra help, can you count on anyone to help with daily tasks like grocery shopping, cooking, house cleaning, telephoning, give you a ride?**

|                |     |                   |                      |
|----------------|-----|-------------------|----------------------|
| No (Go to GC3) | Yes | I don't need help |                      |
| 0              | 1   | 2                 | <input type="text"/> |

**GC2. In the last year who has been most helpful with these daily tasks?**

- |                    |  |                     |
|--------------------|--|---------------------|
| 1 = Spouse         | 2 = Daughter                                     | 3 = Son             |
| 4 = Sibling        | 5 = Other relative                               | 6 = Your neighbours |
| 7 = Co-workers     | 8 = Church members                               | 9 = Club members    |
| 10 = Professionals | 11 = Any friend not included in these categories |                     |
| 12 = No-one        | 777 = Don't Know                                 |                     |

**GC3. Could you have used more help with daily tasks than you received? Would you say...**

|       |               |      |   |                      |
|-------|---------------|------|---|----------------------|
| A lot | A little help | Some | None at all<br>(received sufficient help) |                      |
| 1     | 2             | 3    | 4   | <input type="text"/> |

**GC4. Can you count on anyone to provide you with emotional support? (e.g. talking over problems or helping you make a difficult decision)**

|                |     |                   |                      |
|----------------|-----|-------------------|----------------------|
| No (Go to GC6) | Yes | I don't need help |                      |
| 0              | 1   | 2                 | <input type="text"/> |

**GC5. In the last year who has been most helpful in providing you with emotional support?**

- |                    |  |                     |
|--------------------|--|---------------------|
| 1 = Spouse         | 2 = Daughter                                     | 3 = Son             |
| 4 = Sibling        | 5 = Other relative                               | 6 = Your neighbours |
| 7 = Co-workers     | 8 = Church members                               | 9 = Club members    |
| 10 = Professionals | 11 = Any friend not included in these categories |                     |
| 12 = No-one        | 777 = Don't Know                                 |                     |



**GC6. Could you have used more emotional support than you received? Would you say...**

|       |               |      |   |                      |
|-------|---------------|------|---|----------------------|
| A lot | A little help | Some | None at all<br>(received sufficient help) |                      |
| 1     | 2             | 3    | 4   | <input type="text"/> |



**GC15. Regardless of how you answered the previous questions, who has provided you the most help, care and support in the last 3 months? (You can identify up to two persons)**

- |                         |  |                     |    |                      |
|-------------------------|--|---------------------|----|----------------------|
| 1 = Spouse              | 2 = Daughter                                     | 3 = Son             | 1. | <input type="text"/> |
| 4 = Sibling             | 5 = Other relative                               | 6 = Your neighbours | 2. | <input type="text"/> |
| 7 = Co-workers          | 8 = Church members                               | 9 = Club members    |    |                      |
| 10 = Professionals      | 11 = Any friend not included in these categories |                     |    |                      |
| 12 = No-one (Go to GC7) | 777 = Don't Know (Go to GC7)                     |                     |    |                      |

*If no Kaiāwhina carer was interviewed prior, ask GC15a, otherwise go to GC15e*

**GC15a. Are you comfortable for us to contact this person to speak to about the ways he/she has given you the help, care and support in the last 3 months?**

No=0 (Go to GC18); Yes=1

*If prior Kaiāwhina carer was interviewed;*

**GC15e. Last year we contacted ..... (refer to participant detail sheet). Is this the same person?**

No=0 (go to GC15b) Yes=1 (Go to GC15b-2)

**GC15b. Can I have his/her contact details to ask if he/she would be willing to take part in a study of their experience of providing this help, care and support to you?**  
(check that we already have them in the system)

| No (Go to GC15c) | Yes | Don't know details |
|------------------|-----|--------------------|
| 0                | 1   | 2                  |

GC15b-1 Name of the carer: .....

Address: .....

Phone: .....

Other comments: .....

**GC15b-2.**

Record previous Kaiāwhina ID No. or assign a new ID No.

*Refer to participant detail sheet to check previous Carer ID number*

**GC15c. Is there anyone else you would like to name if perhaps the other carer is not available? (particularly if the first named carer is a paid "formal care worker")?**

No=0 (Go to GC18); Yes=1

**GC15d. If 'yes', can I have his/her contact details?**

| No (Go to GC18) | Yes | Don't know details |
|-----------------|-----|--------------------|
| 0               | 1   | 2                  |

GC15d-1 Name of the carer: .....

Address: .....

Phone: .....

Other comments: .....

**GC15d-2.**

Record previous Kaiāwhina ID No. or assign a new ID No.

*Refer to participant detail sheet to check previous Carer ID number*

**Instruction for interviewer:**

- (i) Please tick boxes "☑" on the front page whether 1) a carer (formal or informal) is identified, 2) participant agrees for us to contact the carer and 3) carer's contact details are provided.
- (ii) Remember to contact the identified carer if they are not present to inform them about the KAIĀWHINA (LOVE & SUPPORT) STUDY and to obtain a written informed consent.

**GC18. How well informed are those providing care for you about your healthcare needs?**

|            |          |            |             |           |                      |
|------------|----------|------------|-------------|-----------|----------------------|
| Not at all | Slightly | Moderately | Quite a bit | Extremely | <b>4</b>             |
| 1          | 2        | 3          | 4           | 5         | <input type="text"/> |

**GC7. Does it seem that your family and friends (i.e. people who are important to you) understand you?**

|                  |             |                  |                  |                 |                      |
|------------------|-------------|------------------|------------------|-----------------|----------------------|
| None of the time | Hardly ever | Some of the time | Most of the time | All of the time | <input type="text"/> |
| 1                | 2           | 3                | 4                | 5               | <input type="text"/> |

**GC8. How satisfied are you with the kinds of relationships you have with your family?**

|                        |                   |                       |                            |                           |                      |
|------------------------|-------------------|-----------------------|----------------------------|---------------------------|----------------------|
| Extremely dissatisfied | Very dissatisfied | Somewhat dissatisfied | Satisfied most of the time | Satisfied all of the time | <b>11</b>            |
| 1                      | 2                 | 3                     | 4                          | 5                         | <input type="text"/> |

**GC9. How satisfied are you with the kinds of relationships you have with your friends?**

|                        |                   |                       |                            |                           |                      |
|------------------------|-------------------|-----------------------|----------------------------|---------------------------|----------------------|
| Extremely dissatisfied | Very dissatisfied | Somewhat dissatisfied | Satisfied most of the time | Satisfied all of the time | <input type="text"/> |
| 1                      | 2                 | 3                     | 4                          | 5                         | <input type="text"/> |

**GC16. What funded/subsidised government/community services are available for older people in your area? (Do not prompt for answers)**

|                                       |                      |                         |                      |
|---------------------------------------|----------------------|-------------------------|----------------------|
| Buses/taxis                           | <input type="text"/> | Meal support            | <input type="text"/> |
| Home help (cleaning)                  | <input type="text"/> | Age Concern             | <input type="text"/> |
| Home Help (shopping)                  | <input type="text"/> | Stroke Foundation       | <input type="text"/> |
| Home Help (gardening)                 | <input type="text"/> | Foundation of the Blind | <input type="text"/> |
| Home Help (lawn mowing)               | <input type="text"/> | Alzheimer's Association | <input type="text"/> |
| Personal Care (bathing/dressing etc.) | <input type="text"/> | Other .....             | <input type="text"/> |
| Other .....                           | <input type="text"/> | Other .....             | <input type="text"/> |

(No=0; Yes=1)

**GC20. What are the most useful sources of information about services for older people?**

|                                 |                      |                          |                      |
|---------------------------------|----------------------|--------------------------|----------------------|
| 1 = Medical Practice            | <input type="text"/> | 2 = General Practitioner | <input type="text"/> |
| 3 = Friends                     | <input type="text"/> | 4 = Whānau or family     | <input type="text"/> |
| 5 = Paid caregiver or home help | <input type="text"/> | 6 = The internet         | <input type="text"/> |
| 7 = Written material            | <input type="text"/> | Other .....              | <input type="text"/> |

(No=0; Yes=1)

**GC21. How well informed are you about accessing services to assist you?**

|            |          |            |             |           |                      |
|------------|----------|------------|-------------|-----------|----------------------|
| Not at all | Slightly | Moderately | Quite a bit | Extremely | <b>4</b>             |
| 1          | 2        | 3          | 4           | 5         | <input type="text"/> |

**GC22. How confident are you about accessing services to assist you?**

|            |          |            |             |           |                      |
|------------|----------|------------|-------------|-----------|----------------------|
| Not at all | Slightly | Moderately | Quite a bit | Extremely | <b>4</b>             |
| 1          | 2        | 3          | 4           | 5         | <input type="text"/> |

GC17. Do you use a medical alarm?

No=0; Yes=1

*If living in a rest home or private hospital Go to GC12*

GC10. Do you receive any regular support service, such as home help?

No = 0 (Go to GC12) Yes = 1

GC11. Do you receive any of the following support services?

**IF Yes:** How often? Who funds this help?

*Interviewer: For each service received, ask who the support is received from. Record the frequency in the appropriate column - there may be more than one service provider*

|   |  |   |
|---|--|---|
| <p><b>A. Receive</b><br/>No = 0<br/>Yes = 1</p> | <p><b>B. Frequency</b><br/>1 = Several times a day<br/>2 = Once a day<br/>3 = One or more times a week<br/>4 = Less than once a week</p> | <p><b>C. Support provided by</b><br/>1 = public system<br/>2 = part of accommodation cost<br/>3 = respondent pays<br/>4 = family pays</p> |
|---|--|---|

|  |  |  |  |
|--|--|--|--|
| a. Any meal service                      |  |  |  |
| b. Home Help (cleaning)                  |  |  |  |
| c. Home Help (shopping)                  |  |  |  |
| d. Home Help (gardening)                 |  |  |  |
| g. Home Help (lawns)                     |  |  |  |
| e. Personal Care (bathing/dressing etc.) |  |  |  |
| h. Bus/taxi                              |  |  |  |
| i. Age Concern                           |  |  |  |
| j. Stroke Foundation                     |  |  |  |
| k. Foundation for the Blind              |  |  |  |
| l. Alzheimers Foundation                 |  |  |  |
| f. Other .....                           |  |  |  |

GC12. How often do you currently provide care or assistance for other people?

|       |                                    |             |                             |                                      |                          |
|-------|------------------------------------|-------------|-----------------------------|--------------------------------------|--------------------------|
| Never | Occasionally<br>(less than weekly) | Once a week | Two to five<br>times weekly | Daily<br>(six to seven times weekly) |                          |
| 0     | 1                                  | 2           | 3                           | 4                                    | <input type="checkbox"/> |

GC23. How confident are you filling out forms by yourself?

|        |       |           |              |       |                          |
|--------|-------|-----------|--------------|-------|--------------------------|
| Always | Often | Sometimes | Occasionally | Never |                          |
| 1      | 2     | 3         | 4            | 5     | <input type="checkbox"/> |

Comments .....

.....

.....



# 8. Physical performance measures

## SHORT PHYSICAL PERFORMANCE BATTERY

| Reason not attempted or not completed          |      |   |      |
|--|------|---|------|
|  | CODE |   | CODE |
| Tried but unable                               | 1    | Participant unable to understand instructions | 5    |
| Participant could not hold position unassisted | 2    | Other (specify) .....                         | 6    |
| Not attempted, you felt unsafe                 | 3    | Participant refused                           | 7    |
| Not attempted, participant felt unsafe         | 4    |   |      |

Now I'd like to ask you to do some physical performance tests. I will first describe and show each movement to you. Then I'd like you to try to do it. If you cannot do a particular movement or you feel it would be unsafe to try to do it, tell me and we'll move on to the next one. Let me emphasise that I do not want you to try to do any exercise that you feel might be unsafe.

### BALANCE TEST

**Instructions:** Start with B: Semi-tandem stand. If the person cannot hold the position for 10 seconds, ask them to attempt A: Side-by-side stand. If they manage the semi-tandem stand for 10 seconds, go straight to C: Tandem stand.

|  | Number of seconds held:   | Held for 10 sec<br>No = 0<br>Yes = 1 | If not attempted or failed, enter reason:<br>(Code box above) |
|--|---|--------------------------------------|---|
| A. Side-by-side stand<br>I want you to try to stand with your feet together, side by side, for about 10 seconds. | <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> | <input type="checkbox"/>             | <input type="checkbox"/><br>.....<br>.....                    |

*If not attempted or not held for 10 seconds, end balance tests and go to gait speed test*

|  | Number of seconds held:   | Held for 10 sec<br>No = 0<br>Yes = 1 | If not attempted or failed, enter reason:<br>(Code box above) |
|--|---|--------------------------------------|---|
| B. Semi-Tandem Stand<br>Now I want you to try to stand with the side of the heel of one foot touching the big toe of the other foot for about 10 seconds. You may put either foot in front, whichever is more comfortable for you. | <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> | <input type="checkbox"/>             | <input type="checkbox"/><br>.....<br>.....                    |

*If not attempted or not held for 10 seconds, end balance tests and go to gait speed test*

|  | Number of seconds held:   | Held for 10 sec<br>No = 0<br>Yes = 1 | If not attempted or failed, enter reason:<br>(Code box above) |
|--|---|--------------------------------------|---|
| C. Tandem Stand<br>Now I want you to try to stand with the heel of one foot in front of and touching the toes of the other foot for about 10 seconds. You may put either foot in front, whichever is more comfortable for you. | <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> | <input type="checkbox"/>             | <input type="checkbox"/><br>.....<br>.....                    |

**GAIT SPEED TEST**

Now I am going to observe how you normally walk. This is our walking course. I want you to walk to the other end of the course at your usual speed, just as if you were walking down the street to go to the store. Walk all the way past the other end of the tape before you stop.

|   |        |         |                          |       |                          |
|---|--------|---------|--------------------------|-------|--------------------------|
| Test was attempted  | No = 0 | Yes = 1 | <input type="checkbox"/> |       | <input type="checkbox"/> |
| Time for 3 metres (seconds)   |        |         | <input type="text"/>     | .     | <input type="text"/>     |
| Aids for walk<br>(None = 1, Cane = 2, Walker = 3, Other = 4)        |        |         | <input type="text"/>     |       | <input type="text"/>     |
| If not attempted or failed, enter reason<br><i>(Code box above)</i> |        |         | <input type="text"/>     | ..... | <input type="text"/>     |

*If not attempted or failed, go to chair stand test*

**CHAIR STAND TEST**

Let's do the last movement test. Do you think it would be safe for you to try to stand up from a chair without using your arms?

So let's do the test. This test measures the strength in your legs. First, fold your arms across your chest and sit so that your feet are on the floor; then stand up keeping your arms folded across your chest.

**(Single Chair Stand Test)**

|  |                          |  |
|--|--------------------------|--|
| Safe to stand without help (No = 0, Yes = 1)                       | <input type="checkbox"/> |  |
| Results  | <input type="checkbox"/> | <i>Go to Repeated Chair Stand Test</i> |
| Participant stood without using arms                               | <input type="checkbox"/> | <i>End test</i>                        |
| Participant used arms to stand                                     | <input type="checkbox"/> | <i>End test</i>                        |
| Test not completed   | <input type="checkbox"/> | <i>End test</i>                        |
| If not attempted or failed, code reason<br><i>(Code box above)</i> | <input type="text"/>     | .....                                  |

Please stand up as QUICKLY as you can 5 times without stopping in between. After standing up each time, sit down and then stand up again. Keep your arms folded across your chest. I'll be timing you with a stopwatch.

**(Repeated Chair Stand Test)**

|  |                          |
|--|--------------------------|
| Safe to stand five times (No = 0, Yes = 1)                         | <input type="checkbox"/> |
| Time to complete five stands (in seconds)                          | <input type="text"/>     |
| If not attempted or failed, code reason<br><i>(Code box above)</i> | <input type="text"/>     |

## 9. Housing and Environment

We know that people’s living environments are closely related to their health and well-being. We also know that people often move as they get older. The next questions now are about your house and about changing where you live.

**IB1. Has your place of residence changed since your last LILACS NZ interview about a year ago?**

No = 0 *(Go to IB6)* Yes = 1

*If ‘Yes’ to question IB1... and if more than one move, ask about last move only*

**IB2. When did you move?**

Date or best estimate

|      |  |   |      |  |   |        |  |  |  |
|------|--|---|------|--|---|--------|--|--|--|
|      |  | . |      |  | . |        |  |  |  |
| (dd) |  |   | (mm) |  |   | (yyyy) |  |  |  |

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**IB3. Why did you choose your current residence?**

No = 0 Yes = 1

- |  |                          |
|--|--------------------------|
| Size of home                                     | <input type="checkbox"/> |
| Better safety and security                       | <input type="checkbox"/> |
| To free up money or equity                       | <input type="checkbox"/> |
| Easier maintenance of house and or gardens       | <input type="checkbox"/> |
| Closer to shops, post office, or other amenities | <input type="checkbox"/> |
| Closer to health services eg. your GP            | <input type="checkbox"/> |
| Nicer environment eg view, climate, weather      | <input type="checkbox"/> |
| To be near or with children                      | <input type="checkbox"/> |
| To be near or with other relatives               | <input type="checkbox"/> |
| To be near or with friends                       | <input type="checkbox"/> |
| Returning to family/whānau land                  | <input type="checkbox"/> |
| Other .....                                      | <input type="checkbox"/> |

**IB4. Was there any one event that made it important to move?**

No = 0 Yes = 1

*If ‘No’, go to IB14*

*If ‘Yes’ to question IB4:*

**IB5. What event was that?** *Do not read, Do not prompt but put a 1 for each event identified*

- |   |                          |
|---|--------------------------|
| Death or illness of spouse or partner     | <input type="checkbox"/> |
| Death or illness of another family member | <input type="checkbox"/> |
| Sudden worsening of health e.g. stroke    | <input type="checkbox"/> |
| Gradual worsening of health or function   | <input type="checkbox"/> |
| Fear, e.g. of criminal behaviour          | <input type="checkbox"/> |
| Something else .....                      | <input type="checkbox"/> |
| Something else .....                      | <input type="checkbox"/> |

*Then go to IB14*

*Ask the following questions only if 'No' to Question IB1*

**IB6. Since your last LILACS NZ interview about a year ago, have you seriously considered moving house?** No = 0 (Go to IB19) Yes = 1

**IB7. Was there any one event that made it important to move?** No = 0 (Go to IB9) Yes = 1

*If 'Yes' in question IB7:*

**IB8. What event was that?** Do not read, Do not prompt but put a 1 for each event identified

- Death or illness of spouse or partner
- Death or illness of another family member
- Sudden worsening of health e.g. stroke
- Gradual worsening of health or function
- Fear, e.g. of criminal behaviour
- Something else .....
- Something else .....

**IB9. Was a decision made about moving?**

| No,<br>still considering | Yes,<br>will stay here for now<br>(Go to IB14) | Yes,<br>will move soon but haven't<br>decided where to<br>(Go to IB14) | Yes,<br>will move soon<br>(Go to IB11) |                          |
|--------------------------|--|--|--|--------------------------|
| 1                        | 2  | 3  | 4                                      | <input type="checkbox"/> |

*Only those still considering*

**IB10. Who was it that first raised the issue of a move?**

(No = 0 Yes = 1)

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- You
- Your spouse/partner
- Your child or close family
- Neighbour or friend
- Your GP
- Hospital doctors
- Other care providers
- Someone else.....

*Now go to IB15*

**IB11. Where will you move to?**

- 1 = private dwelling, stand-alone house
- 2 = private unit or apartment - independent
- 3 = granny flat unit or apartment on site with family dwelling
- 4 = retirement village - villa or own unit
- 5 = rest home (Go to IB13)
- 6 = private hospital (Go to IB13)
- 7 = marae or iwi based housing
- 8 = other.....

*If not 'rest home' or 'private hospital' in question IB11:*

**IB12. Who will you live with most of the time after moving?**

- 1 = alone
- 2 = with spouse/partner only
- 3 = with spouse and child/other relative
- 4 = with spouse and non-relatives
- 5 = with child (not spouse)
- 6 = with other(s) not spouse or children
- Who? .....

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**IB13. Why did you choose to move to there?**

*No = 0 Yes = 1*

- For smaller home
- For larger home
- Better safety and security
- To free up money or equity
- Easier maintenance of house and or gardens
- Closer to shops, post office, or other amenities
- Closer to health services eg. your GP
- Nicer environment eg view, climate, weather
- To be near or with children
- To be near or with other relatives
- To be near or with friends
- To receive the care that I need
- Returning to family/whānau land
- Other .....

15

**IB14. Who was it that first raised the issue of a move?**

*No = 0 Yes = 1*

- |   |  |
|---|--|
| You <input type="checkbox"/>                        | Your spouse/partner <input type="checkbox"/> |
| Your child or close family <input type="checkbox"/> | Neighbour or friend <input type="checkbox"/> |
| Your GP <input type="checkbox"/>                    | Hospital doctors <input type="checkbox"/>    |
| Other care providers <input type="checkbox"/>       | Someone else..... <input type="checkbox"/>   |

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**IB15. Who has contributed to the decision (to stay or move)?**

*Yes = 1 for all that apply*

- |   |  |
|---|--|
| You <input type="checkbox"/>                        | Your spouse/partner <input type="checkbox"/> |
| Your child or close family <input type="checkbox"/> | Neighbour or friend <input type="checkbox"/> |
| Your GP <input type="checkbox"/>                    | Hospital doctors <input type="checkbox"/>    |
| Other care providers <input type="checkbox"/>       | Someone else..... <input type="checkbox"/>   |

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**IB16. How much was it your decision (to stay or move)?**

|                       |                       |                           |                           |                           |                          |
|-----------------------|-----------------------|---------------------------|---------------------------|---------------------------|--------------------------|
| Wholly<br>my decision | Mostly<br>my decision | About half<br>my decision | Not really<br>my decision | Not at all<br>my decision |                          |
| 1                     | 2                     | 3                         | 4                         | 5                         | <input type="checkbox"/> |

**IB17. How satisfied are you now with the decision (to stay or move)?**

|           |                      |              |  |           |                   |  |
|-----------|----------------------|--------------|--|-----------|-------------------|--|
| <b>12</b> | Very<br>dissatisfied | Dissatisfied | Neither<br>satisfied nor<br>dissatisfied | Satisfied | Very<br>satisfied |  |
|           | 5                    | 4            | 3  | 2         | 1                 |  |

**IB18. Did you consider any of the following as alternatives to moving?**

*Yes = 1 for all that were considered or received*

|           |  |                   |                 |
|-----------|--|-------------------|-----------------|
| <b>10</b> |  | <i>Considered</i> | <i>Received</i> |
|           | Modifications to the home eg ramps or rails                                  |                   | Don't Ask       |
|           | More support from family   |                   |                 |
|           | More support from neighbours &/or friends                                    |                   |                 |
|           | Start home help &/or personal care   |                   |                 |
|           | Increase home help &/or personal care  |                   |                 |
|           | Better treatment for health conditions, e.g. surgery, therapy or medications |                   |                 |
|           | Something else .....   |                   |                 |
|           | None, no other options considered  |                   |                 |

**IB19. How likely are you to move (again) in the near future?**

|           |            |          |            |      |           |  |
|-----------|------------|----------|------------|------|-----------|--|
| <b>10</b> | Not at all | Somewhat | Moderately | Very | Extremely |  |
|           | 1          | 2        | 3          | 4    | 5         |  |

*Ask of those not in rest home or private hospital, otherwise Go to IC6*

**IB20. Have there been any renovations or changes to your current home since your last LILACS**

**NZ interview about a year ago?** No = 0 (*Go to IC6*) Yes = 1

**IB20a. Please look at this list. Tell me what was done**

No = 0 Yes = 1

|   |   |
|---|---|
| Redecorated                                 | 1 |
| Added or extended rooms                     | 1 |
| Improved access e.g. rails, ramps, flooring | 1 |
| Improved heating or insulation              | 1 |
| Improved bathroom                           | 1 |
| Outside garden / fencing improvements       | 1 |
| Other? (Please describe) .....              | 1 |

*Ask of everyone*

**IC6. In the area where you live, do you have access to the following?**

**IC7. Are you satisfied with the access you have to ...?**

No = 0    Yes = 1

No = 0    Yes = 1

- a. Safe footpaths and streets to get around
- b. Safety from personal and property crime or disturbance
- c. Public or appropriate transportation
- d. Shops and services
- e. Medical and related healthcare
- f. Options for entertainment, recreation and learning
- g. Private transport provided by someone else

|                          |                          |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

*If yes, please specify (relationship/role rather than name):*

.....  
 .....  
 .....

**IC5. How difficult is it for you to get to the shops?**

10

|            |          |            |      |           |                          |
|------------|----------|------------|------|-----------|--------------------------|
| Not at all | Somewhat | Moderately | Very | Extremely | <input type="checkbox"/> |
| 1          | 2        | 3          | 4    | 5         |                          |

**IC2. Thinking about your current neighbourhood, how well do you like it?**

10

|            |          |            |      |           |                          |
|------------|----------|------------|------|-----------|--------------------------|
| Not at all | Somewhat | Moderately | Very | Extremely | <input type="checkbox"/> |
| 1          | 2        | 3          | 4    | 5         |                          |

**AB7. Do you live in the same area as your hapū /extended family /**

No = 0                      Yes = 1                      Don't know = 2

Now I would like to ask about discrimination in New Zealand

**LA2. Have you ever been the victim of an ethnically motivated attack (verbal or physical abuse to the person or property) in New Zealand?**

*(No = 0    Yes = 1)*

Verbal within the past 12 months   
 Physical within the past 12 months

## 10. Everyday Interests and Activities

We are interested in activities that you spend time doing. First I want to ask you about activities you have done over the last week, that is since last .....

*(Interviewer substitute the day of the week).*

18

| Over the past 7 days, how often did you....   | 0 = Never<br>1 = Seldom<br>(1-2 days)<br>2 = Sometimes<br>(3-4 days)<br>3 = Often<br>(5-7 days) | A. What were these activities? | B. On average, how many hours per day did you engage in these activities?<br>1 = Less than one hour<br>2 = 1 - 2 hours<br>3 = 2 - 4 hours<br>4 = More than 4 hours |
|---|---|--------------------------------|--|
| JA1...participate in sitting activities such as reading, watching TV or doing handicraft?   | <input type="checkbox"/>  |                                | <input type="checkbox"/>   |
| JA2...take a walk outside your home or yard for any reason? For example, for fun or exercise, walking to work, walking the dog etc.?  | <input type="checkbox"/>  |                                | <input type="checkbox"/>   |
| JA3...engage in light sport or recreational activities such as light gardening e.g. using a ride-on mower, bowling, golf with a cart, shuffleboard, fishing from a boat or pier or similar activities?                            | <input type="checkbox"/>  |                                | <input type="checkbox"/>   |
| JA4...engage in moderate sport and recreational activities such as moderate gardening e.g. using a motor mower, double tennis, ballroom dancing, hunting, ice skating, golf without a cart, softball or other similar activities? | <input type="checkbox"/>  |                                | <input type="checkbox"/>   |
| JA5...engage in strenuous sport and recreational activities such as heavy gardening e.g. using a hand mower, jogging, swimming, cycling, singles tennis, aerobic dance, skiing or other similar activities?                       | <input type="checkbox"/>  |                                | <input type="checkbox"/>   |
| JA6...do any exercises specifically to increase muscle strength and endurance, such as lifting weights or push ups etc?   | <input type="checkbox"/>  |                                | <input type="checkbox"/>   |



**JA7. How often do you speak or do something with:**

|  | Daily | 2-3 times a week | At least weekly | At least monthly | Less often | Never/ I have none |                          |
|--|-------|------------------|-----------------|------------------|------------|--------------------|--------------------------|
| <b>e. Your spouse</b>  | 1     | 2                | 3               | 4                | 5          | 6                  | <input type="checkbox"/> |
| <b>a. Any of your children or other relatives?</b>                 | 1     | 2                | 3               | 4                | 5          | 6                  | <input type="checkbox"/> |
| <b>b. Any friends in your community/neighbourhood?</b>             | 1     | 2                | 3               | 4                | 5          | 6                  | <input type="checkbox"/> |
| <b>c. Any of your neighbours?</b>                                  | 1     | 2                | 3               | 4                | 5          | 6                  | <input type="checkbox"/> |
| <b>d. Any friends living outside your community/neighbourhood?</b> | 1     | 2                | 3               | 4                | 5          | 6                  | <input type="checkbox"/> |

**HOUSEHOLD ACTIVITIES AND INTERESTS**

Now I'd like to know about household activities you've done over the last 7 days

**BC6. During the past 7 days, did you engage in any of the following activities?**

(Please answer 'Yes' or 'No' for each item)

No = 0 Yes = 1

- a. Any light housework, such as dusting or washing dishes
- b. Heavy housework or chores, such as vacuuming, scrubbing floors, washing windows or carrying wood
- c. Home repairs like painting, wall papering, electrical work etc.
- d. Lawn work or yard care, including snow or leaf removal, wood chopping, etc.
- e. Outdoor gardening
- f. Caring for another person, such as children, dependent spouse or another adult.

**JA10. What kind of interests have you dropped during the last 12 months? Have there been any?**

0 = No interests dropped (Go to JA11)

1 = One or more interests dropped (list below)

.....

.....

.....

**JA10a. Which of these were reasons for dropping some of your interests?**

*(Code all that apply No = 0 Yes = 1)*

- a. Personal capacity; such as reduced strength or energy, limited mobility, vision impairment, hearing impairment, health or other limitation
- b. Motivation; such as lack of motivation, "it was time to give up", not appropriate or proper to continue
- c. Time use; such as lack of time, doing it takes longer
- d. Security; such as not confident about own limits or abilities, fear of doing things outside the home
- e. Physical environment; such as limited accessibility (e.g. Steps, seating, toilets, parking), or restricted environment (e.g. age limited, car access only)
- f. Social circumstance; such as caring for other/s, loss of partner or friend, Relocation
- g. Economic conditions; such as restricted finances or cost
- h. Other .....

**JA11. During the last 4 weeks how often have you .....?**

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|  | Every day | Every week | Once | Not at all | If less than monthly<br>Occasionally |                          |
|--|-----------|------------|------|------------|--------------------------------------|--------------------------|
| a) Spent time on a hobby (including handcrafts)  | 1         | 2          | 3    | 4          | 5                                    | <input type="checkbox"/> |
| b) Gone to the shops   | 1         | 2          | 3    | 4          | 5                                    | <input type="checkbox"/> |
| c) Visited or been visited by family and friends   | 1         | 2          | 3    | 4          | 5                                    | <input type="checkbox"/> |
| d) Gone to the doctor  | 1         | 2          | 3    | 4          | 5                                    | <input type="checkbox"/> |
| e) Taken care of pets?   | 1         | 2          | 3    | 4          | 5                                    | <input type="checkbox"/> |
| f) Attended meetings of any community /neighbourhood or social groups, such as old people's clubs, lectures or anything like that? | 1         | 2          | 3    | 4          | 5                                    | <input type="checkbox"/> |
| g) Attended any religious meetings?  | 1         | 2          | 3    | 4          | 5                                    | <input type="checkbox"/> |
| h) Been a spectator at a sports event  | 1         | 2          | 3    | 4          | 5                                    | <input type="checkbox"/> |
| i) Gone to an entertainment or arts event (such as concert, theatre or cinema)   | 1         | 2          | 3    | 4          | 5                                    | <input type="checkbox"/> |
| j) Gone to a restaurant, café, pub or bar  | 1         | 2          | 3    | 4          | 5                                    | <input type="checkbox"/> |
| k) Gone to a TAB (betting shop) or casino  | 1         | 2          | 3    | 4          | 5                                    | <input type="checkbox"/> |
| l) Attended a family event   | 1         | 2          | 3    | 4          | 5                                    | <input type="checkbox"/> |
| m) Attended a social occasion (such as a barbeque or hangi)  | 1         | 2          | 3    | 4          | 5                                    | <input type="checkbox"/> |
| n) Gone to the library or museum   | 1         | 2          | 3    | 4          | 5                                    | <input type="checkbox"/> |
| o) Participated in an outdoor activity (such as cycling, walking or gardening)   | 1         | 2          | 3    | 4          | 5                                    | <input type="checkbox"/> |

**JA12. Thinking of how you spend your time, would you say, “Most days I.....”**

|                         |                       |                                       |                          |
|-------------------------|-----------------------|---------------------------------------|--------------------------|
| Don't have enough to do | Just keep busy enough | Always have more than enough<br>to do |                          |
| 1                       | 2                     | 3                                     | <input type="checkbox"/> |

**JA14. How much time do you spend by yourself? Are you ...**

|              |             |              |             |                          |
|--------------|-------------|--------------|-------------|--------------------------|
| Always alone | Often alone | Seldom alone | Never alone |                          |
| 1            | 2           | 3            | 4           | <input type="checkbox"/> |

**JA14a. And would you say that you ...**

|                    |                   |                       |                   |                          |
|--------------------|-------------------|-----------------------|-------------------|--------------------------|
| Always feel lonely | Often feel lonely | Sometimes feel lonely | Never feel lonely |                          |
| 1                  | 2                 | 3                     | 4                 | <input type="checkbox"/> |

# 11. Financial Situation

The next couple of questions will ask you about your income and how you manage your money. I will not ask you how MUCH money you have. Remember that any information you give to us will be treated in strictest confidence.

*No = 0 Yes = 1*

|   |                          |
|---|--------------------------|
| KA1. Do you have a SuperGold Card?          | <input type="checkbox"/> |
| KA2. Do you have a Community Services Card? | <input type="checkbox"/> |
| KA3. Do you have a High User Health Card?   | <input type="checkbox"/> |
| KA4. Do you have a Total Mobility Card?     | <input type="checkbox"/> |
| KA5. Do you have private Health Insurance?  | <input type="checkbox"/> |

KA6. Thinking of your money situation right now, would you say:

|                        |                                    |                  |                          |
|------------------------|------------------------------------|------------------|--------------------------|
| I can't make ends meet | I have just enough to get along on | I am comfortable | <input type="checkbox"/> |
| 1                      | 2                                  | 3                |                          |

KA7. Thinking of your money situation in the future, would you say, I expect that:

|  |   |                       |                          |
|--|---|-----------------------|--------------------------|
| I will not have enough to make ends meet | I will have just enough to get along on | I will be comfortable | <input type="checkbox"/> |
| 1  | 2                                       | 3                     |                          |

KA10. Do you receive any of the following financial assistance?

*No = 0 Yes = 1*

|                              |                          |
|------------------------------|--------------------------|
| Living Alone allowance       | <input type="checkbox"/> |
| Disability allowance         | <input type="checkbox"/> |
| Discount on your rates       | <input type="checkbox"/> |
| Discount on your electricity | <input type="checkbox"/> |
| Disability parking card      | <input type="checkbox"/> |
| Other financial aid .....    | <input type="checkbox"/> |

## 12. Overall Views about growing older

The final questions I want to ask you are about your overall views about growing older and what you have thought about this questionnaire.

**MA2. On the whole has growing older been a positive or negative experience for you?**

**20**

|               |                 |                               |                 |               |
|---------------|-----------------|-------------------------------|-----------------|---------------|
| Very positive | Mainly positive | Neither positive nor negative | Mainly negative | Very negative |
| 1             | 2               | 3                             | 4               | 5             |

**MA1. How much do you agree or disagree with the statement “There is a lot you can do to keep healthy in old age? “**

**21**

|                |       |        |          |                   |            |
|----------------|-------|--------|----------|-------------------|------------|
| Strongly agree | Agree | Unsure | Disagree | Strongly disagree | Don't know |
| 1              | 2     | 3      | 4        | 5                 | 6          |

**FA1. All things considered, how satisfied are you with your life as a whole these days**

|                   |              |                                    |           |                |
|-------------------|--------------|------------------------------------|-----------|----------------|
| Very dissatisfied | Dissatisfied | Neither satisfied nor dissatisfied | Satisfied | Very satisfied |
| 1                 | 2            | 3                                  | 4         | 5              |

**FA2. How would you rate your quality of life?**

|           |      |                       |      |           |
|-----------|------|-----------------------|------|-----------|
| Very poor | Poor | Neither good nor poor | Good | Very good |
| 1         | 2    | 3                     | 4    | 5         |

**Anything that you would like to say or areas of your way of life that have not been covered?**

.....

.....

.....

.....

.....

.....

## THANK YOU

Thank you for being part of this study. The information you have shared is much appreciated and is very important as it will help us find out how life is now for older New Zealanders.

*Interviewer to answer the following:*

| How well do you rate the...                  | Very poor | Poor | Neither good nor poor | Good | Very good |  |
|--|-----------|------|-----------------------|------|-----------|--|
| Reliability of the respondent's responses?   | 1         | 2    | 3                     | 4    | 5         |  |
| Participant's understanding of the questions | 1         | 2    | 3                     | 4    | 5         |  |
| Participant's level of interest?             | 1         | 2    | 3                     | 4    | 5         |  |
| Participant's level of stamina               | 1         | 2    | 3                     | 4    | 5         |  |

**Other comments the Interviewer would like to make:**