

CONFIDENTIAL



## Twelve Month Follow-up Questionnaire

Participant's trial ID number:	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Date questionnaire sent:	<input type="text"/>	/	<input type="text"/>	/	2	0	<input type="text"/>	<input type="text"/>
	<i>Day</i>		<i>Month</i>		<i>Year</i>			

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NHS Foundation Trust

0225581328

**PLEASE READ ALL THE INSTRUCTIONS BEFORE COMPLETING THE QUESTIONNAIRE**

Thank you for agreeing to take part in this study. The responses you give in this questionnaire will help us find out which is the best way to improve mental well-being amongst those over the age of 65.

Please answer ALL the questions. Although some of the questions may not seem relevant to yourself or may appear similar, they do give us valuable information.

If you find it difficult to answer the question, please give the best answer you can.

Please follow the instructions for each section carefully.

For each section, if you are asked to put a cross in the box, please use a cross rather than a tick, as if you were filling out a ballot paper.

For example in the following question, if your answer to the question is yes, you should place a cross firmly in the box next to yes.

Do you drive a car?      **Yes**

**No**

If you are asked to write your answer, please do so by entering your answer in the box provided, for example:

How old are you?    

7	5
---	---

 years

Please use a black or blue pen for all the questions.

Please do not use a pencil or any other coloured pen.

If you have any queries or problems completing this questionnaire please contact your local study centre:

Dr Helen Lewis  
CASPER Trial Coordinator



Phone: [REDACTED]  
E-mail: [REDACTED]

Please enter the date you are completing this questionnaire:

<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Day</i>		<i>Month</i>		<i>Year</i>			

### SECTION 1

This section is about how you have been feeling over the **last 2 weeks**.  
Answer each question by placing a cross in the box that best describes your answer.

1. Little interest or pleasure in doing things

Not at all

Several days

More than half the days

Nearly every day

2. Feeling down, depressed, or hopeless

Not at all

Several days

More than half the days

Nearly every day

3. Trouble falling or staying asleep, or sleeping too much

Not at all

Several days

More than half the days

Nearly every day

4. Feeling tired or having little energy

Not at all

Several days

More than half the days

Nearly every day

5. Poor appetite or overeating

Not at all

Several days

More than half the days

Nearly every day

6. Feeling bad about yourself - that you are a failure or have let yourself or your family down

Not at all

Several days

More than half the days

Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television

Not at all

Several days

More than half the days

Nearly every day

8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual

Not at all

Several days

More than half the days

Nearly every day

9. Thoughts that you would be better off dead, or of hurting yourself in some way

Not at all

Several days

More than half the days

Nearly every day

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

1. Feeling nervous, anxious or on edge

Not at all

Several days

More than half the days

Nearly every day

2. Not being able to stop or control worrying

Not at all

Several days

More than half the days

Nearly every day

3. Worrying too much about different things

Not at all

Several days

More than half the days

Nearly every day

4. Trouble relaxing

Not at all

Several days

More than half the days

Nearly every day

5. Being too restless that it is hard to sit still

Not at all

Several days

More than half the days

Nearly every day

6. Becoming easily annoyed or irritable

Not at all

Several days

More than half the days

Nearly every day

7. Feeling afraid as if something awful might happen

Not at all

Several days

More than half the days

Nearly every day

## SECTION 2

This section is about any physical health problems you may be experiencing.  
Please cross one box for each health problem.

During the **past 4 weeks**, how much have you been bothered by any of the following problems?

1. Stomach pains

Not bothered at all

Bothered a little

Bothered a lot

2. Back pain

Not bothered at all

Bothered a little

Bothered a lot

3. Pain in your arms, legs, or joints (e.g. knees, hips)

Not bothered at all

Bothered a little

Bothered a lot

4. Headaches

Not bothered at all

Bothered a little

Bothered a lot

5. Chest pain

Not bothered at all

Bothered a little

Bothered a lot

6. Dizziness

Not bothered at all

Bothered a little

Bothered a lot

7. Fainting spells

Not bothered at all

Bothered a little

Bothered a lot

8. Feeling your heart pound or race

Not bothered at all

Bothered a little

Bothered a lot

9. Shortness of breath

Not bothered at all

Bothered a little

Bothered a lot

10. Pain or problems during sexual intercourse

Not bothered at all

Bothered a little

Bothered a lot

11. Constipation, loose bowels, or diarrhoea

Not bothered at all

Bothered a little

Bothered a lot

12. Nausea, gas, or indigestion

Not bothered at all

Bothered a little

Bothered a lot

13. Feeling tired or having low energy

Not bothered at all

Bothered a little

Bothered a lot

14. Trouble sleeping

Not bothered at all

Bothered a little

Bothered a lot

### SECTION 3

This section asks you about how you've been feeling.

Answer each question by placing a cross in the box that best describes your answer.

1a. I tend to bounce back after illness or hardship

Not true  
at all

Rarely  
true

Sometimes  
true

Often  
true

True nearly all  
of the time

1b. I am able to adapt to change

Not true  
at all

Rarely  
true

Sometimes  
true

Often  
true

True nearly all  
of the time

## SECTION 4

This section asks for your views about your health. This information will help us keep track of how you feel and how well you are able to do your usual activities.

Answer each question by placing a cross in the box that best describes your answer.

1. In general, would you say your health is:

*(please cross one box only)*

Excellent

Very Good

Good

Fair

Poor

2. During a typical day does **your health** limit you in **moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling or playing golf? If so, how much?

*(please cross one box only)*

Yes, limited a lot

Yes, limited a little

No, not limited at all

3. During a typical day does **your health** limit you in climbing **several** flights of stairs? If so, how much?

*(please cross one box only)*

Yes, limited a lot

Yes, limited a little

No, not limited at all

4. During the **past 4 weeks**, how much of the time have you accomplished less than you would like in regular daily activities **as a result of your physical health**?

*(please cross one box only)*

All of the time

Most of the time

Some of the time

A little of the time

None of the time

5. During the **past 4 weeks**, how much of the time have you been limited in performing any kind of work or other regular daily activities **as a result of your physical health**?

*(please cross one box only)*

All of the time

Most of the time

Some of the time

A little of the time

None of the time

6. During the **past 4 weeks**, how much of the time have you accomplished less than you would have liked in your work or any other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

*(please cross one box only)*

All of the time

Most of the time

Some of the time

A little of the time

None of the time

7. During the **past 4 weeks**, how much of the time have you done work or other activities less carefully than usual **as a result of any emotional problems** (such as feeling depressed or anxious)?

*(please cross one box only)*

All of the  
time

Most of  
the time

Some of  
the time

A little of  
the time

None of  
the time

8. During the **past 4 weeks**, how much did **pain** interfere with your normal work (both outside the home and housework)?

*(please cross one box only)*

Not at all

A little bit

Moderately

Quite a bit

Extremely

9. This question is about how you feel and how things have been with you during the **past 4 weeks**. Please give the one answer that comes closest to the way you have been feeling. How much during the **past 4 weeks** have you felt calm and peaceful?

*(please cross one box only)*

All of the  
time

Most of  
the time

Some of  
the time

A little of  
the time

None of  
the time

10. This question is about how you feel and how things have been with you during the **past 4 weeks**. Please give the one answer that comes closest to the way you have been feeling. How much during the **past 4 weeks** did you have a lot of energy?

*(please cross one box only)*

All of the  
time

Most of  
the time

Some of  
the time

A little of  
the time

None of  
the time

11. This question is about how you feel and how things have been with you during the **past 4 weeks**. Please give the one answer that comes closest to the way you have been feeling. How much during the **past 4 weeks** have you felt downhearted and depressed?

*(please cross one box only)*

All of the  
time

Most of  
the time

Some of  
the time

A little of  
the time

None of  
the time

12. During the **past 4 weeks** how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting friends, relatives etc.)?

*(please cross one box only)*

All of the  
time

Most of  
the time

Some of  
the time

A little of  
the time

None of  
the time



## SECTION 5

This section also asks about your health in general.

By placing a cross in one box in each group below, please indicate which statements best describes your own **health state today**.

### Mobility

- I have no problems in walking about
- I have some problems in walking about
- I am confined to bed

### Self-Care

- I have no problems with self-care
- I have some problems washing or dressing myself
- I am unable to wash or dress myself

### Usual Activities (e.g. work, study, housework, family or leisure activities)

- I have no problems with performing my usual activities
- I have some problems with performing my usual activities
- I am unable to perform my usual activities

### Pain/Discomfort

- I have no pain or discomfort
- I have moderate pain or discomfort
- I have extreme pain or discomfort

### Anxiety/Depression

- I am not anxious or depressed
- I am moderately anxious or depressed
- I am extremely anxious or depressed

**SECTION 6**

This section is about any medication you have been prescribed to improve your mental well-being.

Are you **currently** prescribed any of the medicines listed below?

Yes  No  Don't know

**If 'Yes', please cross all that apply.**

Dosulepin  Sertraline  Venlafaxine

Lofepramine  Fluoxetine  Duloxetine

Citalopram  Paroxetine  Trazodone

Mirtazapine  Other  *please list any other medications below*

1.  2.

3.  4.

5.  6.

7.  8.

9.  10.

If you **are** prescribed one of these medicines but have stopped taking it for any reason please place a cross in this box.

## SECTION 7

This final section is about any health care you have received as a patient **for any reason** (please do not include any visits to your GP practice).

Answer each question by placing a cross in the box that best describes your answer.

### Attending hospital

1a. During the **last 8 months** have you stayed overnight in hospital?

Yes

No  
 (go to 2a)

Don't know

1b. On how many separate occasions did you stay overnight in hospital?

Please provide some details for each occasion you stayed in hospital (e.g. hip replacement, fall).

(If you have stayed more than 2 occasions, we will contact you for further details)

#### 1c. First hospital visit

1d. After your hospital visit were you:

Transferred to community hospital  
(e.g. for rehabilitation)

Discharged back to your home

Other (please state)

#### 1e. Second hospital visit

1f. After your hospital visit were you:

Transferred to community hospital  
(e.g. for rehabilitation)

Discharged back to your home

Other (please state)

**Other visits to hospital**

2a. Have you attended Accident and Emergency in the **last 8 months**?

Yes

No  
 (go to 3a)

Don't know

2b. If 'Yes', how many times have you attended Accident and Emergency in the **last 8 months**?

--	--

3a. Have you attended Hospital Outpatients in the **last 8 months**?

Yes

No  
 (go to 4a)

Don't know

3b. If 'Yes', how many times have you attended Hospital Outpatients in the **last 8 months**?

--	--

4a. Have you attended hospital as a day case/procedure patient in the **last 8 months**?

Yes

No  
 (go to 5a)

Don't know

4b. If 'Yes', how many times have you attended hospital as a day case/procedure in the **last 4 months**?

--	--

**NHS transport services**

5a. Have you used a '999' emergency ambulance in the **last 8 months**?

Yes

No  
 (go to 6a)

Don't know

5b. If 'Yes', how many times have you used a '999' emergency ambulance in the **last 8 months**?

--	--

6a. Have you used the Patient Transport Service in the **last 8 months**?

Yes

No  
 (go to 7a)

Don't know

6b. If 'Yes', how many times have you used the Patient Transport Service in the **last 8 months**?

--	--

**Other NHS services**

7a. Have you gone to an NHS Walk-in Centre in the **last 8 months**?

Yes

No  
 (go to 8a)

Don't know

7b. If 'Yes', how many times have you been to an NHS Walk-in Centre in the **last 8 months**?

--	--

8a. Have you called NHS Direct (the NHS telephone helpline) in the **last 8 months**?

Yes

No  
 (go to 9a)

Don't know

8b. If 'Yes', how many times have you called NHS Direct (the NHS telephone helpline) in the **last 8 months**?

### Support services

9a. Do you receive any home help?

Yes

No  
 (go to 10a)

Don't know

9b. Thinking about the **last 8 months**, of these how many months did you have home help? (please count any month where you have had a visit)

0 months	1 month	2 months	3 months	4 months	5 months	6 months	7 months	8 months
<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"/>

9c. Thinking about the **last 8 months**, typically, how many times a week did home help visit?

0 days	1 day	2 days	3 days	4 days	5 days	6 days	7 days
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10a. Does a care worker visit you at home?

Yes

No  
 (go to 11a)

Don't know

10b. Thinking about the **last 8 months**, of these how many months did a care worker visit you at home? (please count any month where you have had a visit)

0 months	1 month	2 months	3 months	4 months	5 months	6 months	7 months	8 months
<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"/>

10c. Thinking about the **last 8 months**, typically, how many times a week did a care worker visit?

0 days	1 day	2 days	3 days	4 days	5 days	6 days	7 days
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11a. Do you use meals on wheels?

Yes

No  
 (go to 12a)

Don't know

11b. Thinking about the **last 8 months**, of these how many months did you use meals on wheels? (please count any month where you have had a visit)

0  
months

1  
month

2  
months

3  
months

4  
months

5  
months

6  
months

7  
months

8  
months

11c. Thinking about the **last 8 months**, typically, how many times a week did you use meals on wheels?

0 days

1 day

2 days

3 days

4 days

5 days

6 days

7 days

12a. Do you go to any community centres?

Yes

No

Don't know

12b. Thinking about the **last 8 months**, typically, how many times a week do you go to a community centre?

0

1-2

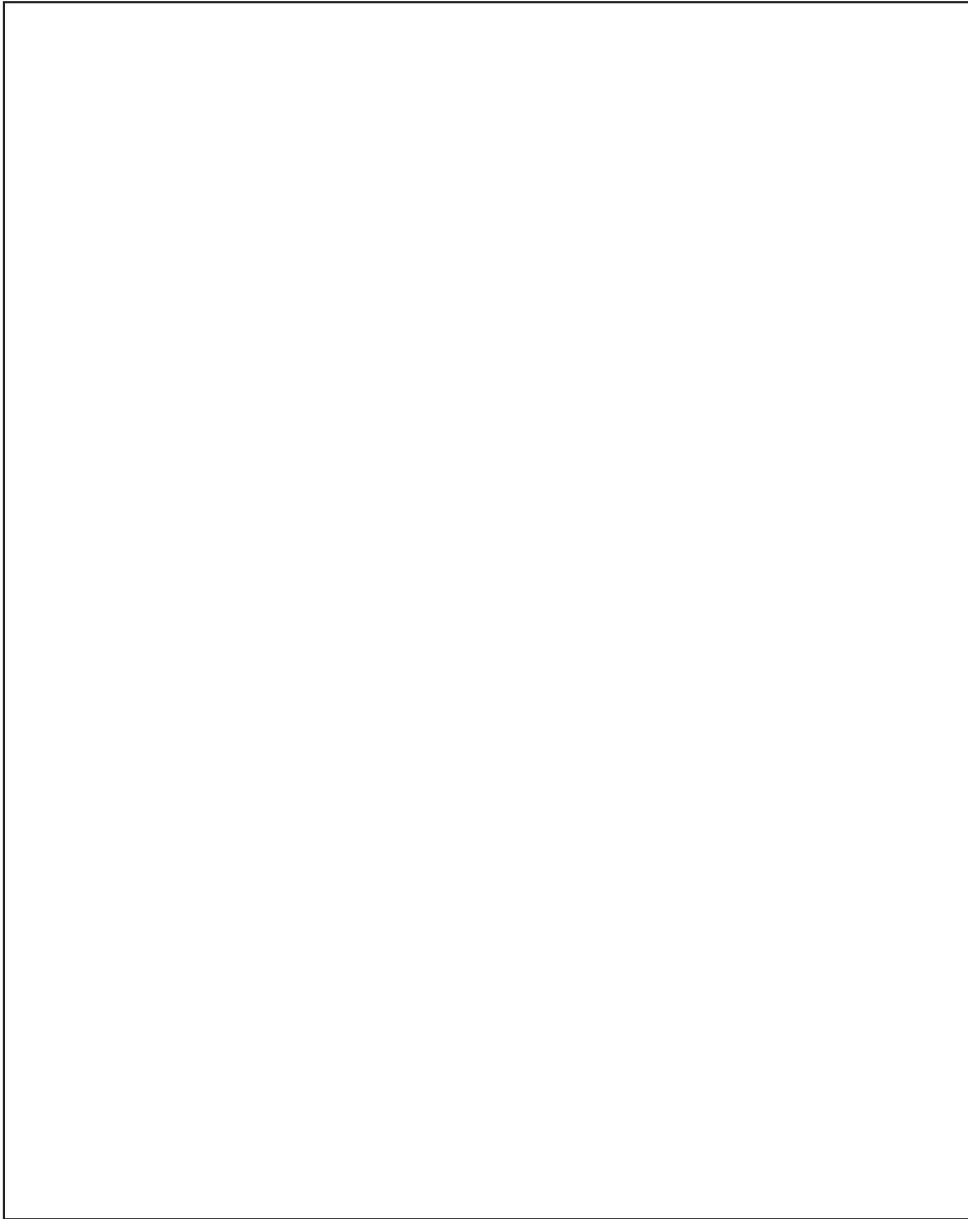
2-3

3-4

4+

12c. Which community centres do you attend?

If you have any general comments about the study, or this questionnaire, please write them below.



**Thank you for completing this questionnaire.  
Please return it in the pre-paid envelope provided.**