



Wakefield District Adult Health Survey 2023

BMG Research is conducting a survey on behalf of Wakefield Council on Adult Health. As this survey is about sensitive health information, if there are any questions that you do not wish to answer, please leave these blank. The survey will take approximately **20 minutes** and you can complete this survey in three ways:

Online by going to www.WakefieldDistrictAdultHealthSurvey2023.com

Or by scanning the QRC code to the right using a smart phone or tablet and enter the following ID



XXXXXXXXXX

By telephone by calling the BMG freephone helpline on 0800 358 0337 and using the ID shown above.

By post by completing this survey and using your FREEPOST envelope and returning to BMG.

To help us process your completed questionnaire, please follow the guidelines below:

- 1) The questionnaire should be completed by a person in the household, over the age of 18 who most recently had their birthday.
- 2) Please use black or blue ink & mark your answer with a cross in the box (x).
- 3) Completely 'colour in' any boxes crossed in error.
- 4) Please do not write outside the boxes provided.
- 5) Please use all available boxes when writing a number, using zeros if necessary.

0	6
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For example, to write the age of a six year old child please write 0 6

All of the responses you provide will be treated in the strictest confidence and you won't be identified in any information BMG pass on to Riverside or One Housing. BMG Research abides by the Market Research Society Code of Conduct at all times. You can find out more information about BMG surveys and what they do with the information they collect in their Privacy Notice www.bmgresearch.co.uk/privacy.

By completing and returning this survey to BMG, they will take this as your consent for them to process and analyse the data you have provided.

About You

- 1. What is your sex?** Please put a cross (x) in one box only
- Female Male..... Prefer not to say

- 2. How old are you in years?** Please specify in the box below

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years

3. How tall are you (without shoes)? Please write in an estimate of your height either in feet and inches or in meters and centimeters

<input style="width: 40px; height: 40px;" type="text"/>	feet	<input style="width: 40px; height: 40px;" type="text"/>	inches		<input style="width: 40px; height: 40px;" type="text"/>	metres	<input style="width: 40px; height: 40px;" type="text"/>	cm
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4. What do you weight? Please write in an estimate of your weight either in stones and pounds or in kilograms

<input style="width: 40px; height: 40px;" type="text"/>	stones	<input style="width: 40px; height: 40px;" type="text"/>	pounds		<input style="width: 40px; height: 40px;" type="text"/>	kg
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We will use your height and weight measurements to calculate your Body Mass Index. If you would like to lose some weight you can get free support from the Aspire Health Team at Wakefield Council
www.wakefield.gov.uk/sport-health-and-leisure/healthy-living/aspire-healthy-weight Tel: 01924 307811

Your Health

5. How is your health in general? Please put a (x) in one box only

Very Good	Good	Fair	Bad	Very Bad
<input style="width: 30px; height: 30px;" type="checkbox"/>	<input style="width: 30px; height: 30px;" type="checkbox"/>	<input style="width: 30px; height: 30px;" type="checkbox"/>	<input style="width: 30px; height: 30px;" type="checkbox"/>	<input style="width: 30px; height: 30px;" type="checkbox"/>

6. Below are some statements about feelings and thoughts. Please cross the box on each line that best describes your experience of each over the last two weeks.

Please put a cross (x) in one box only for each of the following

	Never	Rarely	Some of the time	Often	All the time
I've been feeling good about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling relaxed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been dealing with problems well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been thinking clearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been feeling close to other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I've been able to make up my own mind about things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Short Warwick-Edinburgh Mental Well-being Scale © NHS Health Scotland, University of Warwick and University of Edinburgh, 2007, all rights reserved)

7. Do you currently have any health conditions or illnesses lasting, or expected to last, 12 months or more? (These could be physical health conditions, mental health conditions or both.)

Please put a (x) in one box only

Yes **Go to Q8** No..... **Go to Q11**

8. Which of the following health conditions or illnesses do you have or have you had in the last 12 months? Please put a cross (x) in one box only for each of the following

	In the last 12 months it has affected my daily life a lot	In the last 12 months it has affected my daily life a little	I have had it in the last 12 months but it has not affected my daily life	I have not had this condition in last 12 months Go to Q11
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit Hyperactivity Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism spectrum disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD (e.g., emphysema, chronic bronchitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contenance problems (leakage of your bladder or bowel)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dyspraxia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal / rheumatological problems (e.g., arthritis, tendinitis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuromuscular condition (e.g., Parkinson's, MS, epilepsy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain long-term (lasting more than 3 months) not including backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain short-term (lasting less than 3 months) not including backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-traumatic stress and/or PTSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychosis/schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reproductive/gynaecological health issues (other than menopause)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sciatica, lumbago or recurring backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other physical health condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other mental health condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If in Q8 you crossed "I have not had this condition in last 12 months" for all health conditions or illnesses, go to Q11. If you have any condition please continue to Q9.

- 9. How confident are you that you can manage your condition (or conditions)?** Please put a (x) in one box only
- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Very confident | Fairly confident | Not very confident | Not at all confident | Don't know |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- 10. In the last 12 months have you had problems accessing support for your health conditions when needed?** Please put a (x) in one box only
- | | | | | | |
|--------------------------------------|--------------------------|--------------------------------------------------------|--------------------------|---------------------------------------------------|--------------------------|
| No problems accessing support..... | <input type="checkbox"/> | A lot of problems accessing support | <input type="checkbox"/> | I have not sought help in the last 12 months..... | <input type="checkbox"/> |
| Some problems accessing support..... | <input type="checkbox"/> | I don't know what types of support are available | <input type="checkbox"/> | | |
- 11. Do you have any of the following health conditions or illnesses?** Please put a (x) in all that apply
- Vision conditions (problems not corrected by glasses or contact lenses)**
- | | |
|------------------------------------|--------------------------|
| Sight impaired / partially sighted | <input type="checkbox"/> |
| Severely sight impaired / blind | <input type="checkbox"/> |
- Hearing conditions**
- | | |
|----------------------------------|--------------------------|
| Mild / moderate hearing problems | <input type="checkbox"/> |
| Severe / profound deafness | <input type="checkbox"/> |
- Other**
- | | |
|-----------------------------------------------------|--------------------------|
| Learning, understanding or concentrating conditions | <input type="checkbox"/> |
| None of the above | <input type="checkbox"/> |
- 12. Thinking generally about your independence, are you able to get out of the house and carry out day to day activities as and when you want?** Please put a (x) in one box only
- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Always | Most of the time | Sometimes | Rarely | Never |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- 13. How often do you visit a dentist for a check-up?** Please put a (x) in one box only
- | | | | |
|----------------------------------|--------------------------|-----------------------------------------|--------------------------|
| Once every 6 months..... | <input type="checkbox"/> | Less than once every 24 months..... | <input type="checkbox"/> |
| Once every 12 months..... | <input type="checkbox"/> | I only visit when I have a problem..... | <input type="checkbox"/> |
| Once every 12 to 24 months | <input type="checkbox"/> | I have never been to the dentist..... | <input type="checkbox"/> |
- 14. Which of these best describes your situation?** Please put a (x) in one box only
- | | | | |
|------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------|--------------------------|
| I am registered with an NHS dentist | <input type="checkbox"/> | I am not registered with any dentist..... | <input type="checkbox"/> |
| I am registered with a private dentist..... | <input type="checkbox"/> | Not sure | <input type="checkbox"/> |
| I would like to register with an NHS dentist but can't find one taking new patients..... | <input type="checkbox"/> | | |

15. During the past month, how would you rate the quality of your sleep overall? Please put a (x) in one box only

Very good	Fairly good	Fairly bad	Very bad	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. At the moment, what would you say are your three main concerns or worries?
 (Please write your three main concerns in each of the boxes below. These concerns don't have to be about your health, we are interested in what's important to you and causing concern).

First Concern

Second Concern

Third Concern

No concerns or worries

17. Sometimes people have thoughts about hurting themselves, has this ever been the case for you?
 Please put a (x) in one box only

No	Yes, but I have never acted on those thoughts	Yes, and I have acted on those thoughts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you or anyone you know has been affected by self-harm then support is available from groups such as the Samaritans (www.samaritans.org tel: 116 123), Mind (www.mind.org.uk tel: 0300 123 3393) or by talking to your GP.

18. We know that for some people, events in their childhood can be difficult or distressing. Has this been your experience? Please put a (x) in one box only

Yes..... No

If you or anyone you know has been affected by distressing events in childhood then support is available from groups such as the NSPCC www.nspcc.org.uk (tel: 0808 800 5000) or by talking to your GP.

Menopause (If your sex is Male please go to Q22)

Menopause is when your periods stop due to lower hormone levels. This usually happens between the ages of 45 and 55. It can sometimes happen earlier naturally. Or for reasons such as surgery to remove the ovaries (oophorectomy) or the uterus (hysterectomy), cancer treatments like chemotherapy, or a genetic reason. Sometimes the reason is unknown.

Perimenopause is when you have symptoms before your periods have stopped. You reach menopause when you have not had a period for 12 months.

Menopause and perimenopause can cause symptoms like anxiety, mood swings, brain fog, hot flushes and irregular periods. These symptoms can start years before your periods stop and carry on afterwards.

Menopause and perimenopause symptoms can have a big impact on your life, including relationships and work.

19. Do you believe you are currently in perimenopause or menopause, or that you have already been through it? Please put a (x) in one box only

Yes **Go to Q20** No..... **Go to Q22** I'm not sure..... **Go to Q20**

20. Does, or did, the perimenopause or menopause negatively affect your health or wellbeing? Please put a (x) in one box only

Yes No.....

21. Have you sought help for the perimenopause or menopause in any of the following ways? Please put a cross (x) in one box only for each of the following

	Yes	No	I'm thinking about it
Seen your GP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taken HRT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accessed a local support group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you or anyone you know has been affected by the menopause then information and support is available from groups such as Women's Health Concern www.womens-health-concern.org , Daisy Network www.daisynetwork.org (premature menopause) or by talking to your GP.

Covid -19

22. Would you describe yourself as having 'long COVID', that is, you are still experiencing symptoms more than 12 weeks after you first had COVID-19, that are not explained by something else? Please put a (x) in one box only

Yes No Not sure Prefer not to say

Exercise

23. We'd like to know how physically active you are at two different intensity levels:
Moderate – this will raise your heart rate, make you breathe faster and feel warmer (e.g., brisk walking, riding a bike at an easy pace, pushing a lawnmower, hiking).
Vigorous – this will make you breathe hard and fast (e.g., running, swimming, riding a bike fast or up hills, sports like football, rugby and netball).
 If you're unsure of the difference, being able to talk but not sing indicates moderate intensity activity, while having difficulty talking without pausing is a sign of vigorous activity.
In total, how many minutes of physical activity do you do in an average week? If you don't do moderate / vigorous activity, please write a '0' in the appropriate box.

Moderate intensity				Minutes
Vigorous intensity				Minutes

24. In an average week, how often do you do some form of muscle strengthening activity? (This could be physical exercise specifically designed to strengthen your muscles, e.g. lifting weights, press-ups or sit-ups), or other physical exercise where the effort was enough to make your muscles feel some tension, shake or feel warm). Please put a (x) in one box only

Never	Less than one day a week	One day a week	Two days a week	More than two days a week
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. We'd like to know more about cycling and swimming: Please put a cross (x) in one box only for each of the following

	Yes	No	Not Sure	Not Applicable
Can you swim?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Can you ride a bicycle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If you have children or grandchildren				
would you feel confident teaching them to ride a bicycle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
would you feel confident teaching them to swim?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. In an average week, how many days do you walk or cycle for travel (where arriving at a destination is the purpose of the journey, and not simply for exercise)? Please put a cross (x) in one box for each of the following

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

27. What, if anything, would help you to become more active? Please put a cross (x) in all that apply

- Having more time
- Having someone to go with
- Knowing that activities are suitable for someone like me
- Knowing what activities / facilities / clubs / groups exist in the local area
- Increased or improved access to local greenspaces
- Feeling safer in public open spaces
- Free or affordable local facilities or activities.....
- Easier access to local facilities or activities
- More flexible opening times and / or programming of activities and facilities
- Different types of activity or facility to broaden the choice
- Better disabled access at local facilities
- Understanding what support there is for someone with my health condition(s)
- Better access to cycling equipment
- Increased access to or improved safety of local cycling / walking routes
- Nothing - I am already very active.....
- Other (please write in the box below)

Diet

28. How many portions of fruit and vegetables do you eat a day? (A portion is a handful) Please put a (x) in one box only

- 5 a day or more.. 3 - 4 a day 1 - 2 a day I don't eat fruit or vegetables.....

29. To what extent do you agree or disagree with the following statements? Please put a cross (x) in one box only for each of the following

	Agree	Disagree	Not sure
I would like to eat more healthily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would like my family/friends to eat more healthily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what a healthy diet consists of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I understand the impact that my diet has on my health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what a sustainable/environmentally friendly diet consists of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I understand the impact that my diet has on the environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. What would help you eat more fruit and vegetables? Please put a cross (x) in all that apply

Nothing, I eat a healthy amount of fruit and vegetables already	<input type="checkbox"/>
Knowing more about the benefits of fruit and vegetables	<input type="checkbox"/>
More choices of fruit and vegetables in the shops	<input type="checkbox"/>
More time to prepare fruit and vegetables.....	<input type="checkbox"/>
Cheaper fruit and vegetable prices	<input type="checkbox"/>
Ideas how to encourage children to eat fruit and vegetables.....	<input type="checkbox"/>
Less unhealthy food advertising	<input type="checkbox"/>
Other (please write in the box below)	<input type="checkbox"/>

31. During the last year ... Please put a cross (x) in one box only for each of the following

	Yes	No
Have you lost more than one stone in weight in a 3-month period?	<input type="checkbox"/>	<input type="checkbox"/>
Have you made yourself be sick because you felt uncomfortably full?	<input type="checkbox"/>	<input type="checkbox"/>
Did you worry you had lost control over how much you eat?	<input type="checkbox"/>	<input type="checkbox"/>
Did you believe yourself to be fat when others said you were too thin?	<input type="checkbox"/>	<input type="checkbox"/>
Would you say food dominated your life?	<input type="checkbox"/>	<input type="checkbox"/>

Smoking and Vaping

32. Which of the following types of tobacco use, smoking or vaping have you used? Please put a cross (x) in one box only for each of the following

	Currently using Go to Q33	Use occasionally Go to Q33	Have used before, but now stopped Go to Q34	Never used Go to Q34
E-cigarettes/vaping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand rolled tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chewing tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pipe smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If not currently using or using occasionally, go to Q34

33. Which of the following statements best describes your feelings about stopping smoking? Please put a cross (x) in one box only

I intend to stop smoking within the next 6 months

I would like to stop smoking sometime in the future

I don't want to stop smoking

Drinking

34. In a typical week, how many days do you drink alcohol? put a cross (x) in one box only

0 days

Go to Q38

1 day

2 days

3 days

4 days

5 days

6 days

7 days

I don't drink alcohol

Go to Q38

If 0 days or you don't drink alcohol, jump to Q37



Pint of beer/lager 4% ABV
2.3 units



Can of beer/lager 440ml 5% ABV
2.2 units



175ml medium glass of wine 12% ABV
2 units



250ml large glass of wine 12% ABV
3 units



25ml single spirit and mixer 40% ABV
1 unit



50ml double spirit & mixer 40% ABV
2 units



750ml bottle of wine 12% ABV
9 units

35. How many units do you have in a typical week? Please refer to the unit guide above and write the number of units below

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Units

36. Which of the following best describes your feelings about the amount of alcohol you drink? Please put a cross (x) in one box only

I am not concerned about the amount I drink.

I am concerned but don't want to reduce it....

I am concerned, and I plan to reduce it.....

I am concerned, and I need help to reduce it...

37. Within the last 6 months has anyone else expressed concern to you about the amount of alcohol you drink? Please put a cross (x) in one box only

Yes

No.....

Not sure

If you are concerned about your drinking please visit Turning Point Inspiring Recovery www.turning-point.co.uk/services/wakefield or call 03001231912

Drugs and Gambling

38. Have you used, or are you using, any of the following drugs? Please put a cross (x) in one box only for each of the following

	No	I have tried it once or twice	Yes, less than once a month	Yes, at least monthly	Yes, at least weekly
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine (powder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy/MDMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nitrous Oxide (also know as NOS or balloons)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ketamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Image and performance enhancing drugs (e.g. steroids, melatonin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Illegally obtained prescription drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Synthetic cannabinoids (e.g. Spice, Mamba)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crack cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If 'No' to all listed above, please go to Q42

39. If you are using drugs which of the following best describes your thoughts about the amount you use? Please put a cross (x) in one box only

I am not concerned about the amount I use....	<input type="checkbox"/>	I am concerned but don't want to reduce	<input type="checkbox"/>
I am concerned, and I plan to reduce it.....	<input type="checkbox"/>	I am concerned, and I need help to reduce it...	<input type="checkbox"/>

40. Within the last 6 months has anyone else expressed concern to you about your drug use? Please put a cross (x) in one box only

Yes	<input type="checkbox"/>	No.....	<input type="checkbox"/>	Not sure	<input type="checkbox"/>
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41. Have you ever sought professional help for your drug use? Please put a cross (x) in one box only

Yes	<input type="checkbox"/>	No.....	<input type="checkbox"/>
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If you are concerned about your drug use please visit Turning Point Inspiring Recovery www.turning-point.co.uk/services/wakefield or call 0300 123 1912.

42. Have you spent money on gambling at least once a month over the past year? (e.g. National Lottery, scratchcards, slot machines, betting on sports events, casino games, bingo, etc.) Please put a cross (x) in one box only

Yes.....	<input type="checkbox"/>	Go to Q43	No	<input type="checkbox"/>	Go to Q44
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43. In the last 12 months... Please put a cross (x) in one box only for each of the following

	Never	Sometimes	Most of the time	Almost always	Don't know
have you bet more than you could really afford to lose?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
have people criticised your betting, or told you that you have a gambling problem, whether or not you thought it is true?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
have you felt guilty about the way you gamble or what happens when you gamble?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If at any time you feel like gambling may be becoming a problem for you or someone you know then GamCare can offer free information, support and counselling www.gamcare.org.uk (tel: 0808 8020 133)

Caring

44. Do you provide unpaid care for someone who has a long-term illness, health problem or disability that limits their daily activities or the work they do? (Care is still unpaid if the carer is receiving a state benefit, e.g. Carers Allowance) Please put a cross (x) in one box only

Yes, one person... **Go to Q45** Yes, more than one person **Go to Q45** No..... **Go to Q47**

45. What are the ages of the people you provide unpaid care for? Please write the age(s) of the person(s) you provide care for in the boxes below

<input type="text"/>	<input type="text"/>	<input type="text"/>	Age of Person 1
<input type="text"/>	<input type="text"/>	<input type="text"/>	Age of Person 2
<input type="text"/>	<input type="text"/>	<input type="text"/>	Age of Person 3

46. When you think about your personal experience of providing unpaid care, would you say it has... Please put a cross (x) in all that apply

strengthened your personal relationship with the person(s) you care for?..... <input type="checkbox"/>	caused stress in your family? <input type="checkbox"/>	been a positive experience in your life? <input type="checkbox"/>
weakened your personal relationships with the person(s) you care for?..... <input type="checkbox"/>	taken time away from your work or education?..... <input type="checkbox"/>	been a burden on your personal finances? <input type="checkbox"/>
	taken time away from your family life? <input type="checkbox"/>	

If you are a carer and would like free confidential information and support you can contact Carers Wakefield and District on www.carerswakefield.org.uk or on 01924 305 544.

Living in Wakefield District

47. Overall are you satisfied with your local area as a place to live? Please put a cross (x) in one box only

Very satisfied	Satisfied	Neither/ nor	Dissatisfied	Very dissatisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

48. In the last 12 months, how often have you used parks or other green spaces (e.g. fields, woods, countryside footpaths)? Please put a cross (x) in one box only

At least once a week	<input type="checkbox"/>	At least once in the last 12 months	<input type="checkbox"/>
At least once a month	<input type="checkbox"/>	Have not used these in the past 12 months	<input type="checkbox"/>

49. In the last 12 months, have you taken part in any volunteering? (Examples of volunteering could include helping run a local club or group or event, fundraising, giving time to a charity or cause, or improving your local area) Please put a cross (x) in one box only

Yes, I regularly volunteer (at least once a month)- continue to	<input type="checkbox"/>	Go to Q50	Yes, but not regularly (less than once a month)	<input type="checkbox"/>	Go to Q50
			No	<input type="checkbox"/>	Go to Q51

50. Reflecting on your experience of volunteering, how much do you agree with the following statements about the benefits and impacts volunteering has on you? Please put a cross (x) in all that apply

I enjoy it	<input type="checkbox"/>	It brings me into contact with people from different backgrounds and cultures..	<input type="checkbox"/>	It helps me feel less isolated	<input type="checkbox"/>
It gives me a sense of personal achievement	<input type="checkbox"/>	It improves my mental health and wellbeing	<input type="checkbox"/>	It improves my physical health	<input type="checkbox"/>
It makes me feel like I'm making a difference	<input type="checkbox"/>	It gives me more confidence	<input type="checkbox"/>	It improves my employment prospects.....	<input type="checkbox"/>
I meet new people.....	<input type="checkbox"/>	It gives me new skills and experience	<input type="checkbox"/>	None of the above	<input type="checkbox"/>
It broadens my experience of life	<input type="checkbox"/>				

51. How safe do you feel when outside in your local area? Please put a cross (x) in one box only for each of the following

	Very safe	Fairly safe	Fairly unsafe	Very unsafe	Don't know
During the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After dark	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

More about you and your household

52. Which of these activities best describes what you are doing at present? (Please select your main activity only. Only cross 'Looking after family/home' if this is your main activity and none of the other options apply) Please put a cross (x) in one box only

Working full-time (30 hrs or more per week)	<input type="checkbox"/>	Go to Q53	Unemployed and available for work	<input type="checkbox"/>	Go to Q55	Wholly retired from work	<input type="checkbox"/>	Go to Q55
Working part-time (Under 30 hrs per week)	<input type="checkbox"/>	Go to Q53	In full-time education at school, college or university	<input type="checkbox"/>	Go to Q55	Looking after family/home	<input type="checkbox"/>	Go to Q55
Self-employed or freelance	<input type="checkbox"/>	Go to Q53	Long-term sick or disabled.....	<input type="checkbox"/>	Go to Q55	Doing something else.....	<input type="checkbox"/>	Go to Q55

53. If you are in paid work, do you have one of the following types of contract? Please put a cross (x) in one box only

Zero-hours contract	Temporary contract	Agency worker	None of the above
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

54. If you are in work, how satisfied or dissatisfied are you with your present job overall? (If you have more than one job consider the job where you work the most hours.) Please put a cross (x) in one box only

Completely / mostly satisfied	Somewhat satisfied	Neither	Somewhat dissatisfied	Completely / mostly dissatisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

55. Which of these is the highest level of qualifications that you have? Please put a cross (x) in one box only

No qualifications	<input type="checkbox"/>	2+ A-levels / 4+ AS-levels or equivalent (e.g. GNVQ Advanced, Advanced Apprenticeship, BTEC / NVQ Level 3)	<input type="checkbox"/>
1 - 4 O-levels / CSEs / GCSEs (any grade) or equivalent (e.g. BTEC / NVQ Level 1)	<input type="checkbox"/>	Foundation Degree, Degree (BA, BSc), Higher Apprenticeship, Higher Degree (e.g. MA, PhD, PGCE), NVQ Level 4+ or equivalent.....	<input type="checkbox"/>
5+ O-levels / CSEs / GCSEs (grades A*- C or grades 9 to 4) or equivalent (e.g. an Intermediate Apprenticeship, BTEC / NVQ Level 2)	<input type="checkbox"/>	Other professional / vocational / work-related qualifications / technical skills	<input type="checkbox"/>

56. Do you own or rent your current home? Please put a cross (x) in one box only

Own, either outright or with a mortgage.	<input type="checkbox"/>	Rent from another registered provider (e.g. Housing Association or charity).	<input type="checkbox"/>
Part-own, part rent (shared ownership).....	<input type="checkbox"/>	Rent from a private landlord.....	<input type="checkbox"/>
Rent from WDH.....	<input type="checkbox"/>	Live rent free or with family.....	<input type="checkbox"/>

57. How many people are there in your household including yourself? Please write in a number for each age group. Write in '0' if there are none in that age group

--	--

Children aged 4 years and under

--	--

Children aged 5 to 11 years

--	--

Children aged 12 to 17 years

--	--

Adults aged 18 to 64 years

--	--

Adults aged 65 years and over

58. Overall, would you say your home/present accommodation is adequate for your household's need? Please put a cross (x) in one box only

Yes **Go to Q60**

No **Go to Q59**

59. Why is it not suitable? Please put a cross (x) in all that apply

- | | | | |
|---------------------------------|--------------------------|-----------------------------------------------|--------------------------|
| Too small | <input type="checkbox"/> | Not suitable for an elderly person | <input type="checkbox"/> |
| Too large | <input type="checkbox"/> | Not suitable for a disabled person..... | <input type="checkbox"/> |
| Rent/mortgage is too high | <input type="checkbox"/> | Too expensive to heat | <input type="checkbox"/> |
| Property needs repairs..... | <input type="checkbox"/> | Not suitable for someone in poor health | <input type="checkbox"/> |
| Too cold and damp..... | <input type="checkbox"/> | Not near to public transport | <input type="checkbox"/> |
| Not safe or secure enough..... | <input type="checkbox"/> | Insufficient outdoor space | <input type="checkbox"/> |

60. Do you have access to the internet? Please put a cross (x) in one box only

- | | | | |
|--------------------------------------------------|--------------------------|-------------------------------------------------------------------------------|--------------------------|
| Yes, and I am very confident using it | <input type="checkbox"/> | No, I do not have access to the internet..... | <input type="checkbox"/> |
| Yes, and I am somewhat confident using it | <input type="checkbox"/> | No, but family or friends help me if I need something from the internet | <input type="checkbox"/> |
| Yes, but I am not at all confident using it..... | <input type="checkbox"/> | | |

61. What is the total annual income of your household before tax (e.g. from earnings, benefits/allowances, pensions)? Please put a cross (x) in one box only

- | | | | | | |
|-------------------------|--------------------------|------------------------|--------------------------|-------------------------|--------------------------|
| Below £10,000 | <input type="checkbox"/> | £30,001 - £40,000..... | <input type="checkbox"/> | £60,001 - £70,000..... | <input type="checkbox"/> |
| £10,001 - £20,000 | <input type="checkbox"/> | £40,001 - £50,000..... | <input type="checkbox"/> | More than £70,000..... | <input type="checkbox"/> |
| £20,001 - £30,000 | <input type="checkbox"/> | £50,001 - £60,000..... | <input type="checkbox"/> | Prefer not to say | <input type="checkbox"/> |

62. Are you doing any of the following because of the recent cost of living increases? Please put a cross (x) in all that apply

- | | | | |
|-----------------------------------------------------------------|--------------------------|-----------------------------------------------------------------------------------------|--------------------------|
| I am shopping around more | <input type="checkbox"/> | I am using less fuel such as gas or electricity in my home | <input type="checkbox"/> |
| I am cutting back on food shopping and essentials..... | <input type="checkbox"/> | I am using my savings..... | <input type="checkbox"/> |
| I am cutting back on non-essentials..... | <input type="checkbox"/> | I am using credit more than usual, for example, credit cards, loans or overdrafts | <input type="checkbox"/> |
| I am cutting back on non-essential journeys in my vehicle | <input type="checkbox"/> | Other | <input type="checkbox"/> |
| | | None of these | <input type="checkbox"/> |

63. What is your ethnic group? Please put a cross (x) in one box only

White

- | | | | |
|---------------------------------------------------------|--------------------------|---------------------------------|--------------------------|
| English/ Welsh/ Scottish/ Northern Irish/ British | <input type="checkbox"/> | Gypsy or Irish Traveller..... | <input type="checkbox"/> |
| Irish | <input type="checkbox"/> | Roma | <input type="checkbox"/> |
| Eastern European | <input type="checkbox"/> | Any other White background..... | <input type="checkbox"/> |

Mixed/ Multiple ethnic groups

- | | | | |
|---------------------------------|--------------------------|----------------------------------------------|--------------------------|
| White and Black Caribbean | <input type="checkbox"/> | White and Asian..... | <input type="checkbox"/> |
| White and Black African..... | <input type="checkbox"/> | Any other Mixed/multiple ethnic background . | <input type="checkbox"/> |

Asian or Asian British

- | | | | |
|-----------------|--------------------------|---------------------------------|--------------------------|
| Indian | <input type="checkbox"/> | Chinese..... | <input type="checkbox"/> |
| Pakistani | <input type="checkbox"/> | Any other Asian background..... | <input type="checkbox"/> |

Bangladeshi.....

Black/ African/ Caribbean/ Black British

- | | | | |
|----------------|--------------------------|------------------------------------------------------|--------------------------|
| African | <input type="checkbox"/> | Any other Black/ African/ Caribbean background | <input type="checkbox"/> |
| Caribbean..... | <input type="checkbox"/> | | |

Other ethnic group

- | | | | |
|-----------------------------|--------------------------|------------------------|--------------------------|
| Arab..... | <input type="checkbox"/> | Prefer not to say..... | <input type="checkbox"/> |
| Any other ethnic group..... | <input type="checkbox"/> | | |

64. Is your gender identity the same as the sex you were registered at birth? Please put a cross (x) in one box only

- Yes, it's the same No, it's different..... Prefer not to say

65. Which of the following best describes your sexual orientation? Please put a cross (x) in one box only

- Straight/Heterosexual. Bisexual..... Prefer not to say
- Gay or lesbian Other - please specify

Thank you for taking the time to complete this questionnaire. Please put your survey into the reply-paid envelope provided and return to BMG Research by 9th April 2023. You do not need to add a stamp.