



# UNIVERSITY OF LEEDS

## The **ECO** study

### Health & wellbeing in people with a community order

#### HOW TO FILL IN THIS QUESTIONNAIRE

1. If you can, please answer all the questions.
2. Ask the researcher if you need help with any of the questions.
3. When you have finished please put the questionnaire in the envelope provided and hand back to the researcher.



#### **Please note:**

**Any information provided by you will be kept strictly confidential**  
**We will not share your information with anyone outside of the University of Leeds research team.**  
**Only information that you might hurt yourself will be passed to the Probation Officer**

**If you have any queries regarding the study, please contact:**

**Jenni Murray on 0113 343 0892**

Date of completion:	D	D	M	M	Y	Y
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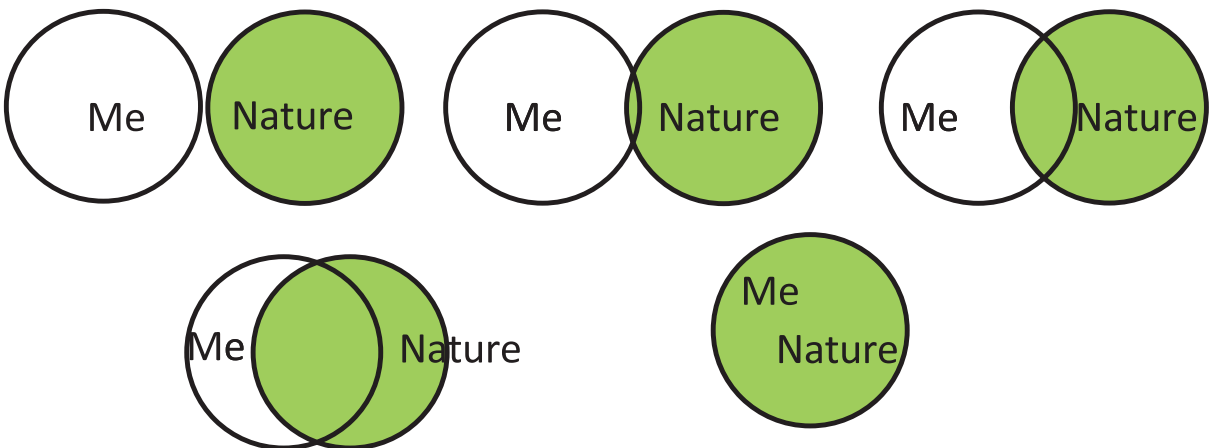
## SECTION 1. CONNECTING WITH NATURE

Please ✓ one box for each statement below

Statements:	Disagree strongly	Disagree a little	Neither agree or disagree	Agree a little	Agree strongly
1. My ideal holiday spot would be a remote, wilderness area.					
2. I always think about how my actions affect the environment.					
3. My connection to nature and the environment is a part of my spirituality.					
4. I take notice of wildlife wherever I am.					
5. My relationship to nature is an important part of who I am.					
6. I feel very connected to all living things and the earth					

### How interconnected are you with nature?

Please **circle** the picture below which best describes your relationship with the natural environment.



## SECTION 2. ABOUT YOUR MENTAL WELL-BEING

Below are some statements about feelings and thoughts.

Please tick the box that best describes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)

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## SECTION 3. ABOUT HOW YOU FEEL

### IMPORTANT – PLEASE READ THIS FIRST

This form has 34 statements about how you have been OVER THE LAST WEEK.

Please read each statement and think how often you felt that way last week.

Then tick the box which is closest to this.

*Please use a dark pen (not pencil) and tick clearly within the boxes*

Over the last week		Not at all	Only occasionally	Sometimes	Often	Most of the time
1	I have felt terribly alone and isolated	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
2	I have felt tense, anxious or nervous	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
3	I have felt I have someone to turn to for support when needed	<input type="checkbox"/> <sup>4</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>0</sup>
4	I have felt OK about myself	<input type="checkbox"/> <sup>4</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>0</sup>
5	I have felt totally lacking in energy and enthusiasm	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
6	I have been physically violent to others	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
7	I have felt able to cope when things go wrong	<input type="checkbox"/> <sup>4</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>0</sup>
8	I have been troubled by aches, pains or other physical problems	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>

## Over the last week

		Not at all	Only occasionally	Sometimes	Often	Most of the time
9	I have thought of hurting myself	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
10	Talking to people has felt too much for me	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
11	Tension and anxiety have prevented me from doing important things	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
12	I have been happy with the things I have done	<input type="checkbox"/> <sup>4</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>0</sup>
13	I have been disturbed by unwanted thoughts and feelings	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
14	I have felt like crying	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
15	I have felt panic or terror	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
16	I made plans to end my life	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
17	I have felt overwhelmed by my problems	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
18	I have had difficulty getting to sleep or staying asleep	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
19	I have felt warmth or affection for someone	<input type="checkbox"/> <sup>4</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>0</sup>
20	My problems have been impossible to put to one side	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
21	I have been able to do most things I needed to	<input type="checkbox"/> <sup>4</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>0</sup>

## Over the last week

		Not at all	Only occasionally	Sometimes	Often	Most of the time
22	I have threatened or intimidated another person	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
23	I have felt despairing or hopeless	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
24	I have thought it would be better if I were dead	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
25	I have felt criticised by other people	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
26	I have thought I have no friends	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
27	I have felt unhappy	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
28	Unwanted images or memories have been distressing me	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
29	I have been irritable when with other people	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
30	I have thought I am to blame for my problems and difficulties	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
31	I have felt optimistic about my future	<input type="checkbox"/> <sup>4</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>0</sup>
32	I have achieved the things I wanted to	<input type="checkbox"/> <sup>4</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>0</sup>
33	I have felt humiliated or shamed by other people	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>
34	I have hurt myself physically or taken dangerous risks with my	<input type="checkbox"/> <sup>0</sup>	<input type="checkbox"/> <sup>1</sup>	<input type="checkbox"/> <sup>2</sup>	<input type="checkbox"/> <sup>3</sup>	<input type="checkbox"/> <sup>4</sup>

**Over the last week**

health

Not at all

Only occasionally

Sometimes

Often

Most of the time

## SECTION 4. ABOUT THINGS TO DO WITH YOUR HEALTH

<p><b>1. In the past week, how many days have you done 30 minutes or more of physical activity, which was enough to raise your breathing rate? Physical activity can include a variety of activities such as walking, housework or structured exercise in a class or gym. Tick only one box</b></p>	
1.1. One day of 30 mins physical activity	Yes <input type="checkbox"/>
1.2. Two days of 30 mins physical activity	Yes <input type="checkbox"/>
1.3. Three days of 30 mins physical activity	Yes <input type="checkbox"/>
1.4. Four days of 30 mins physical activity	Yes <input type="checkbox"/>
1.5. Five days of 30 mins physical activity	Yes <input type="checkbox"/>
1.6. Six days of 30 mins physical activity	Yes <input type="checkbox"/>
1.7. Seven days of 30 mins physical activity	Yes <input type="checkbox"/>
1.8. No physical activity of 30 mins or more	Yes <input type="checkbox"/>
<p><b>2. Which substances have you used during the past 4 weeks? Please tick all that apply:</b></p>	
2.1. Solvents (glue, Tippex, lighter fuel)	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.2. Cannabis (marijuana, dope, pot, blow)	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.3. Ecstasy (E, dennis the menace)	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.4. Amphetamines (speed, uppers, whiz,)	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.5. LSD (acid, tabs, trips)	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.6. Poppers (amyl nitrates, liquid gold)	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.7. Tranquillisers sedatives and antidepressants	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.8. Heroin (morphine, smack, skag,)	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.9. Magic mushrooms (mushies, psilocybin)	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.10. Methadone (phy, meth)	Yes <input type="checkbox"/> No <input type="checkbox"/>



2.11. Crack (rock, sand, stone, pebbles)	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.12. Cocaine (coke, charlie)	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.13. Anabolic steroids	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.14. Nubain	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.15. None	Yes <input type="checkbox"/> No <input type="checkbox"/>
2.16. Don't Know	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>3. During the last 4 weeks, how often have you used the substances you just mentioned? Tick one box only.</b>	
3.1. Daily / almost daily	Yes <input type="checkbox"/>
3.2. Several times a week	Yes <input type="checkbox"/>
3.3. At least once a week	Yes <input type="checkbox"/>
3.4. Less often than once a week	Yes <input type="checkbox"/>
3.5. Don't Know	Yes <input type="checkbox"/>
<b>4. On how many days out of the last seven did you have an alcoholic drink? Tick one box only.</b>	
4.1. One day in the last week	Yes <input type="checkbox"/>
4.2. Two days in the last week	Yes <input type="checkbox"/>
4.3. Three days in the last week	Yes <input type="checkbox"/>
4.4. Four days in the last week	Yes <input type="checkbox"/>
4.5. Five days in the last week	Yes <input type="checkbox"/>
4.6. Six days of in the last week	Yes <input type="checkbox"/>
4.7. Seven days in the last week	Yes <input type="checkbox"/>
4.8. I have not drunk alcohol in the last 7 days	Yes <input type="checkbox"/>
4.9. I never drink alcohol	Yes <input type="checkbox"/>

<b>5. Do you smoke cigarettes at all nowadays? Tick only one box.</b>	
5.1. Yes	Yes <input type="checkbox"/>
5.2. No	Yes <input type="checkbox"/>
5.3. Don't Know	Yes <input type="checkbox"/>
<b>6. If you do smoke, how many do you normally smoke per day?</b>	
Please write the number of cigarettes/ roll ups per day:	<input type="text"/>
<b>7. 'Healthy foods are enjoyable' - how strongly do you agree or disagree? Please tick ONE box.</b>	
7.1. Strongly agree	Yes <input type="checkbox"/>
7.2. Agree	Yes <input type="checkbox"/>
7.3. Neither agree nor disagree	Yes <input type="checkbox"/>
7.4. Disagree	Yes <input type="checkbox"/>
7.5. Strongly disagree	Yes <input type="checkbox"/>

**8.** Have you used any of the following services during the past one month?

Health services	Have you used the service in the last month?	Total number of times in the last month?
a) GP	Yes <input type="checkbox"/> No <input type="checkbox"/>	
b) Practice or district nurse	Yes <input type="checkbox"/> No <input type="checkbox"/>	
c) Physiotherapist	Yes <input type="checkbox"/> No <input type="checkbox"/>	
d) Occupational therapist	Yes <input type="checkbox"/> No <input type="checkbox"/>	
e) Psychiatrist	Yes <input type="checkbox"/> No <input type="checkbox"/>	
f) Mental health counsellor	Yes <input type="checkbox"/> No <input type="checkbox"/>	

g) Drug and alcohol worker	Yes <input type="checkbox"/> No <input type="checkbox"/>	
h) Family planning service	Yes <input type="checkbox"/> No <input type="checkbox"/>	
i) Health trainer	Yes <input type="checkbox"/> No <input type="checkbox"/>	
j) Any other health service not including hospital visits (e.g. NHS direct)		
Health service: .....	Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>Social services</b>	<b>Have you used the service in the last month?</b>	<b>Total number of times in the last month?</b>
a) Social worker	Yes <input type="checkbox"/> No <input type="checkbox"/>	
b) Help-line (e.g.Samaritans)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
c) Family or patient support or self help groups	Yes <input type="checkbox"/> No <input type="checkbox"/>	
d) Any other social services	Yes <input type="checkbox"/> No <input type="checkbox"/>	

9. In the table below, please note any medications that you have been prescribed by a doctor or other health professional **in the past month**.

Medications	Number of times daily	Number of days used

10. Have you used any of the following hospital services during the last month?

Hospital stay in the last month	Have you used the service?	Total number of nights in the last month?

Hospital in-patient stay (staying in hospital overnight)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Number of nights <input type="text"/> <input type="text"/>
<b>Hospital visits in the last month</b>	<b>Have you used the service?</b>	<b>Total number of visits?</b>
Hospital out-patient clinic (doctor visits, scans, etc.)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Visits <input type="text"/> <input type="text"/>
Hospital accident and emergency (A&E) department	Yes <input type="checkbox"/> No <input type="checkbox"/>	Visits <input type="text"/> <input type="text"/>

11. What is your current employment or training situation?

<b>Activity during the day</b>	<b>Tick one category that best describes your situation now</b>
a) In an apprenticeship (e.g to be a plumber, hair-dresser, etc.) , government supported training	<input type="checkbox"/>
b) Employed Full Time	<input type="checkbox"/>
c) Employed Part Time	<input type="checkbox"/>
d) Self-employed	<input type="checkbox"/>
e) Employed but on sick leave	<input type="checkbox"/>
f) Unpaid employment (e.g. voluntary job)	<input type="checkbox"/>
g) Unemployed	<input type="checkbox"/>

**12. Ethnicity**

<b>Please circle the one that applies to you</b>		
White British	White Other European	Mixed / multiple ethnic group
Asian /Asian British	Black / Black British	Other ethnic group – Please specify .....

**Please put your completed questionnaire in the envelope provided and give it to the researcher.**

**Thank you for your time**

1 This study is funded by the National Institute for Health Research (NIHR)

  
***National Institute for  
Health Research***