

SAMPLE COPY OF THE PECUNIA Resource Use Measurement (PECUNIA RUM) Instrument

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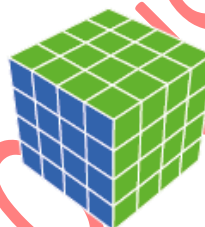
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PECUNIA



Resource Use Measurement (RUM) Instrument



The PECUNIA project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 779292. Further information about the project and this questionnaire can be found at <https://www.pecunia-project.eu/>

INTRODUCTION

In this questionnaire we are trying to find out about the various impacts of your health or wellbeing including different types of **service use, medication, informal help, education, work and private expenses**.

Please read the instructions provided for each question carefully. Questions that can be skipped are clearly indicated. If you have difficulty answering any of the questions, please provide the best answer you can.

Only consider service use and impacts related to your own health or wellbeing.

Responses will be kept confidential and used for research purposes only.

Thank you in advance for helping by completing this questionnaire!



RESIDENTIAL CARE

In this section, we ask you about **your current usual place of accommodation** and the **overnight stays** you have had away from your usual place of accommodation in the **past 3 months**.

| | |
|--------------------------|--|
| A1 | What is your current usual place of accommodation? <i>Please tick only one answer. If you are unsure, please tick 'Other' and provide details.</i> |
| <input type="checkbox"/> | Own home (e.g. owned or rented flat or house) |
| <input type="checkbox"/> | Someone else's home (e.g. parents' or friend's home) |
| <input type="checkbox"/> | Dormitory (e.g. boarding school, university residence) |
| <input type="checkbox"/> | Paid temporary accommodation (e.g. hotel) |
| <input type="checkbox"/> | Emergency shelter (e.g. temporary/short-term shelter for homeless) |
| <input type="checkbox"/> | Sheltered housing (e.g. longer-term housing with assistance, supported housing) |
| <input type="checkbox"/> | Nursing home (e.g. residential care home with nursing staff) |
| <input type="checkbox"/> | Other long-term residential care home |
| <input type="checkbox"/> | Therapeutic community home (e.g. temporary group residence for therapeutic purposes) |
| <input type="checkbox"/> | Place of detention (e.g. prison) |
| <input type="checkbox"/> | On the street |
| <input type="checkbox"/> | Other, please specify: _____ |

A2 Have you stayed overnight away from your current usual place of accommodation in the past 3 months?

Please tick all answers that apply and indicate the number of nights that you spent in each place. If you are unsure, please tick 'Other' and provide details.

| | | |
|--------------------------------|--|--------------|
| <input type="checkbox"/> | Someone else's home (e.g. parents' or friend's home) | _____ nights |
| <input type="checkbox"/> | Dormitory (e.g. boarding school, university residence) | _____ nights |
| <input type="checkbox"/> | Paid temporary accommodation (e.g. hotel) | _____ nights |
| <input type="checkbox"/> | Emergency shelter (e.g. short-term shelter for homeless) | _____ nights |
| <input type="checkbox"/> | Sheltered housing (e.g. long-term housing with assistance, support) | _____ nights |
| <input type="checkbox"/> | Nursing home (e.g. residential care home with nursing staff) | _____ nights |
| <input type="checkbox"/> | Other long-term residential care home | _____ nights |
| <input type="checkbox"/> | Therapeutic community home (e.g. temporary group residence for therapeutic purposes) | _____ nights |
| Hospital | | |
| <u>In-patient admission 1:</u> | | |
| <input type="checkbox"/> | Type of hospital department (e.g. oncology, surgery, psychiatry): _____ | _____ nights |
| | Reason for admission (if known): _____ | |
| <u>In-patient admission 2:</u> | | |
| <input type="checkbox"/> | Type of hospital department (e.g. oncology, surgery, psychiatry): _____ | _____ nights |
| | Reason for admission (if known): _____ | |
| <u>In-patient admission 3:</u> | | |
| <input type="checkbox"/> | Type of hospital department (e.g. oncology, surgery, psychiatry): _____ | _____ nights |
| | Reason for admission (if known): _____ | |
| <input type="checkbox"/> | Residential palliative/terminal care (e.g. hospice) | _____ nights |
| <input type="checkbox"/> | Place of detention (e.g. jail) | _____ nights |
| <input type="checkbox"/> | On the street | _____ nights |
| <input type="checkbox"/> | Other, please specify: _____ | _____ nights |

NON-RESIDENTIAL HEALTH AND SOCIAL CARE

In this section, we ask you about any **non-residential health and social care services** you have used regarding your health or wellbeing in the **past 3 months**. These services do not involve any overnight stay and may be planned (non-emergency) or unplanned (emergency).

| | | |
|--------------------------|--|------------|
| B1 | Have you used any non-residential, <u>non-emergency</u> health or social care services in the past 3 months? | |
| | <i>These services include, for example, attending a day hospital or day care centre, routine check-up appointments, scheduled consultations (in person, over the phone or online), help from a social worker, participating in a support group, or receiving a special transport ride.</i> | |
| <input type="checkbox"/> | Yes | |
| <input type="checkbox"/> | No Please go to question B2 | |
| <input type="checkbox"/> | I don't know/I would rather not say Please go to question B2 | |
| B1.1 | How many times have you used any of the following non-emergency day care services in the past 3 months? | |
| | <i>Please tick all answers that apply and indicate the number of days you used a given service for. If you are unsure, please tick 'Other' and provide details.</i> | |
| <input type="checkbox"/> | Medical day care (e.g. day-patient in hospital, day hospital) | _____ days |
| <input type="checkbox"/> | Non-medical day care (e.g. day care centre, social clubs) | _____ days |
| <input type="checkbox"/> | Other, please specify: _____ | _____ days |

B1.2 How many times have you used any of the following other non-emergency health or social care services in the past 3 months?

Please tick all answers that apply and indicate the number of times you have used a given service. If you are unsure, please tick 'Other' and provide details.

| | Face-to-face contacts | Online or telephone contacts |
|--|-----------------------|------------------------------|
| <input type="checkbox"/> Primary medical care (e.g. general practitioner) | ___ times | ___ times |
| <input type="checkbox"/> Nursing care (e.g. practice nurse, mental health nurse, community nurse) | ___ times | ___ times |
| <input type="checkbox"/> Dental care (e.g. dentist, orthodontist) | ___ times | ___ times |
| <input type="checkbox"/> Specialist medical care (e.g. gynaecologist, orthopaedist, psychiatrist) Please specify: _____ | ___ times | ___ times |
| <input type="checkbox"/> Care by other health care professional (e.g. physiotherapist, psychologist, dietician) Please specify: _____ | ___ times | ___ times |
| <input type="checkbox"/> Alternative health care (e.g. acupuncturist, homeopath, osteopath) Please specify: _____ | ___ times | ___ times |
| <input type="checkbox"/> Imaging services (e.g. X-ray, CT, MRI) Please specify: _____ | ___ times | ___ times |
| <input type="checkbox"/> Laboratory services (e.g. blood test, genetic test) Please specify: _____ | ___ times | ___ times |
| <input type="checkbox"/> Mobile palliative/terminal care (e.g. at home) | ___ times | ___ times |
| <input type="checkbox"/> Social care (e.g. social worker, case manager, home help) Please specify: _____ | ___ times | ___ times |
| <input type="checkbox"/> Other, please specify: _____ | ___ times | ___ times |

| | | |
|---|-----------------------|------------------------------|
| B1.3 How many times have you participated in any support or self-help group in the past 3 months? Please tick if applies and indicate the number of times you have participated. If you are unsure, please tick 'Other' and provide details. | | |
| | Face-to-face contacts | Online or telephone contacts |
| <input type="checkbox"/> Support or self-help group | ___ times | ___ times |
| <input type="checkbox"/> Other, please specify: _____ | ___ times | ___ times |
| B1.4 How many times have you contacted a helpline (phone or online) regarding your health or wellbeing in the past 3 months? Please tick all answers that apply and indicate the number of contacts you had with a given service. If you are unsure, please tick 'Other' and provide details. | | |
| <input type="checkbox"/> For information (e.g. call to 111) | ___ times | |
| <input type="checkbox"/> For support (e.g. related to mental health or domestic violence) | ___ times | |
| <input type="checkbox"/> Other, please specify: _____ | ___ times | |

| | | |
|--|-----------------------|------------------------------|
| B2 Have you used any non-residential, emergency health or social care services in the past 3 months? These services include, for example, an emergency ambulance call or visit, a visit to an Accident and Emergency (A&E) department, or contacting a crisis centre or helpline. | | |
| <input type="checkbox"/> Yes | | |
| <input type="checkbox"/> No Please go to question B3 | | |
| <input type="checkbox"/> I don't know/I would rather not say Please go to question B3 | | |
| B2.1 How many times have you used any of the following emergency health or social care services in the past 3 months? Please tick all answers that apply and indicate the number of contacts you had with a given service. If you are unsure, please tick 'Other' and provide details. | | |
| | Face-to-face contacts | Online or telephone contacts |
| <input type="checkbox"/> Emergency ambulance service | ___ times | ___ times |
| <input type="checkbox"/> Emergency medical service | ___ times | ___ times |
| <input type="checkbox"/> Accident and Emergency (A&E) department | ___ times | ___ times |
| <input type="checkbox"/> Fire brigade | ___ times | ___ times |
| <input type="checkbox"/> Crisis centre | ___ times | ___ times |
| <input type="checkbox"/> Crisis care team | ___ times | ___ times |
| <input type="checkbox"/> Other, please specify (e.g. mountain rescue): _____ | ___ times | ___ times |

| | | |
|--------------------------|--|-------------|
| B3 | Have you used any vocational services in the past 3 months? | |
| <input type="checkbox"/> | Yes | |
| <input type="checkbox"/> | No <i>Please go to the next section</i> | |
| <input type="checkbox"/> | I don't know/I would rather not say <i>Please go to the next section</i> | |
| B3.1 | How many days have you used any of the following vocational services in the past 3 months? <i>Please tick all answers that apply and indicate the number of days you used a given service. If you are unsure, please tick 'Other' and provide details.</i> | |
| <input type="checkbox"/> | Vocational training (training for a specific type of job that provides a qualification to work in a specific profession, e.g. as an electrical technician) | _____ days |
| <input type="checkbox"/> | Sheltered workshop (place of work specially designed to provide a safe environment for people with (mental) disability, unpaid or very low paid) | _____ days |
| <input type="checkbox"/> | Integration workplace (place of work promoting the integration and inclusion of people with (mental) disability into a work environment, low paid) | _____ days |
| <input type="checkbox"/> | Supported employment programmes (supporting people with some (mental) disability to secure and retain paid employment, normally paid) | _____ days |
| <input type="checkbox"/> | Other, please specify: _____ | _____ days |
| B4 | Have you received any special transport to attend a planned appointment with health or social care services or vocational services in the past 3 months? <i>These transports could include for instance a ride with a non-emergency ambulance.</i> | |
| <input type="checkbox"/> | Yes | |
| <input type="checkbox"/> | No <i>Please go to the next section</i> | |
| <input type="checkbox"/> | I don't know/I would rather not say <i>Please go to the next section</i> | |
| B4.1 | How many times have you received special transport to attend a planned appointment with health or social care services or vocational services in the past 3 months? <i>Please tick all answers that apply and indicate the number of times you used a given service. If you are unsure, please tick 'Other' and provide details.</i> | |
| <input type="checkbox"/> | Non-emergency ambulance ride | _____ times |
| <input type="checkbox"/> | Special transport service (e.g. for special needs) | _____ times |
| <input type="checkbox"/> | Other, please specify: _____ | _____ times |

PRESCRIPTION MEDICATION

In this section, we ask you about any **prescribed medication** you have taken regarding your health or wellbeing in the **past 3 months**. This could include tablets, capsules, liquids or injections.

| C1 Have you used any prescribed medication in the past 3 months? | | | | | | | |
|--|---|-------|---|--|---|-------|---|
| <input type="checkbox"/> Yes | | | | | | | |
| <input type="checkbox"/> No <i>Please go to the next section</i> | | | | | | | |
| <input type="checkbox"/> I don't know/I would rather not say <i>Please go to the next section</i> | | | | | | | |
| C1.1 Please list below any prescribed medications you have taken in the past 3 months. <i>If you have taken the same medication at different doses for different periods, please list each dose and the corresponding period (if known) in a separate row. In case the provided space is not enough, you can add further information later in section 'Final remarks'.</i> | | | | | | | |
| Medication name | Medication type | Dose | Unit | How often have you taken the given medication? | For how long have you taken the given medication in the past 3 months? | | |
| <i>Example: Zoloft</i> | <input checked="" type="checkbox"/> tablet/capsule <input type="checkbox"/> cream <input type="checkbox"/> liquid <input type="checkbox"/> injection <input type="checkbox"/> other | 50 | <input checked="" type="checkbox"/> mg <input type="checkbox"/> g <input type="checkbox"/> ml <input type="checkbox"/> other | 2 times | <input checked="" type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> as needed <input type="checkbox"/> other: _____ | 12 | <input checked="" type="checkbox"/> day(s) <input type="checkbox"/> week(s) <input type="checkbox"/> month(s) |
| 1 | <input type="checkbox"/> tablet/capsule <input type="checkbox"/> cream <input type="checkbox"/> liquid <input type="checkbox"/> injection <input type="checkbox"/> other | _____ | <input type="checkbox"/> mg <input type="checkbox"/> g <input type="checkbox"/> ml <input type="checkbox"/> other | _____ times | <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> as needed <input type="checkbox"/> other: _____ | _____ | <input type="checkbox"/> day(s) <input type="checkbox"/> week(s) <input type="checkbox"/> month(s) |
| 2 | <input type="checkbox"/> tablet/capsule <input type="checkbox"/> cream <input type="checkbox"/> liquid <input type="checkbox"/> injection <input type="checkbox"/> other | _____ | <input type="checkbox"/> mg <input type="checkbox"/> g <input type="checkbox"/> ml <input type="checkbox"/> other | _____ times | <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> as needed <input type="checkbox"/> other: _____ | _____ | <input type="checkbox"/> day(s) <input type="checkbox"/> week(s) <input type="checkbox"/> month(s) |
| 3 | <input type="checkbox"/> tablet/capsule <input type="checkbox"/> cream <input type="checkbox"/> liquid <input type="checkbox"/> injection <input type="checkbox"/> other | _____ | <input type="checkbox"/> mg <input type="checkbox"/> g <input type="checkbox"/> ml <input type="checkbox"/> other | _____ times | <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> as needed <input type="checkbox"/> other: _____ | _____ | <input type="checkbox"/> day(s) <input type="checkbox"/> week(s) <input type="checkbox"/> month(s) |
| 4 | <input type="checkbox"/> tablet/capsule <input type="checkbox"/> cream <input type="checkbox"/> liquid <input type="checkbox"/> injection <input type="checkbox"/> other | _____ | <input type="checkbox"/> mg <input type="checkbox"/> g <input type="checkbox"/> ml <input type="checkbox"/> other | _____ times | <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> as needed <input type="checkbox"/> other: _____ | _____ | <input type="checkbox"/> day(s) <input type="checkbox"/> week(s) <input type="checkbox"/> month(s) |
| 5 | <input type="checkbox"/> tablet/capsule <input type="checkbox"/> cream <input type="checkbox"/> liquid <input type="checkbox"/> injection <input type="checkbox"/> other | _____ | <input type="checkbox"/> mg <input type="checkbox"/> g <input type="checkbox"/> ml <input type="checkbox"/> other | _____ times | <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> as needed <input type="checkbox"/> other: _____ | _____ | <input type="checkbox"/> day(s) <input type="checkbox"/> week(s) <input type="checkbox"/> month(s) |
| 6 | <input type="checkbox"/> tablet/capsule <input type="checkbox"/> cream <input type="checkbox"/> liquid <input type="checkbox"/> injection <input type="checkbox"/> other | _____ | <input type="checkbox"/> mg <input type="checkbox"/> g <input type="checkbox"/> ml <input type="checkbox"/> other | _____ times | <input type="checkbox"/> per day <input type="checkbox"/> per week <input type="checkbox"/> per month <input type="checkbox"/> as needed <input type="checkbox"/> other: _____ | _____ | <input type="checkbox"/> day(s) <input type="checkbox"/> week(s) <input type="checkbox"/> month(s) |

INFORMAL HELP

In this section, we ask you about any **informal help** (unpaid) you received from your family, friends, and/or neighbours because of your health or wellbeing in addition to the usual in the **past 3 months**.

Such additional informal help can include, for example, helping with food preparation, eating and drinking, washing, bathing, dressing, medication, mobility around the house, mobility outside the house, housekeeping, shopping, or looking after someone (e.g. your child) instead of you.

D1 On average, how many hours of additional informal help have you received weekly because of your health or wellbeing in the past 3 months?

If none, please enter 0.

☐ _____ hours per week *Please go to the next section*

☐ I don't know/I would rather not say *Please go to the next section*

EDUCATION

In this section, we ask you about your **education**, any difficulties you have faced in completing your education (e.g. missing school or repeating a year), and your use of any education support services (e.g. tutoring or remedial teaching) regarding your health or wellbeing in the **past 3 months**.

| | |
|--------------------------|---|
| E1 | What is the highest level of education you have completed? |
| | <i>For example:</i> |
| <input type="checkbox"/> | Early childhood education or lower |
| <input type="checkbox"/> | Primary education |
| <input type="checkbox"/> | Lower secondary education |
| <input type="checkbox"/> | Upper secondary education |
| <input type="checkbox"/> | Post-secondary or short-cycle tertiary education |
| <input type="checkbox"/> | Tertiary education |
| <input type="checkbox"/> | Other, please specify: _____ |

| | |
|--------------------------|---|
| E2 | Have you been a student in the past 3 months? |
| | <i>Being a student means that you are enrolled in an educational facility (either full-time or part-time) and receive education on a regular basis. Special education addresses students' individual needs (e.g. learning/physical/developmental disabilities).</i> |
| <input type="checkbox"/> | Yes, in a special education day school |
| <input type="checkbox"/> | Yes, in a day school |
| <input type="checkbox"/> | Yes, in a special education boarding school |
| <input type="checkbox"/> | Yes, in a boarding school |
| <input type="checkbox"/> | Yes, in a higher education school (e.g. university, college, vocational school) |
| <input type="checkbox"/> | No <i>Please go to the next section</i> |
| <input type="checkbox"/> | I don't know/I would rather not say <i>Please go to the next section</i> |
| <input type="checkbox"/> | Other, please specify: _____ |

| | |
|--------------------------|---|
| E3 | Have you had problems with completing your education because of your health or wellbeing in the past 3 months? |
| | <i>Please tick all answers that apply.</i> |
| <input type="checkbox"/> | Yes, I had to stop my education |
| <input type="checkbox"/> | Yes, I had a study delay (e.g. I had to repeat a year) |
| <input type="checkbox"/> | Yes, I had to change to a lower education level |
| <input type="checkbox"/> | No |
| <input type="checkbox"/> | I don't know/I would rather not say |
| <input type="checkbox"/> | Other, please specify: _____ |

| | |
|--------------------------|--|
| E4 | Have you missed any days of education because of your health or wellbeing in the past 3 months? <i>Please only consider the days when you were not able to participate in classes.</i> |
| <input type="checkbox"/> | Yes, I have missed _____ school days |
| <input type="checkbox"/> | No |
| <input type="checkbox"/> | I don't know/I would rather not say |

| | |
|--------------------------|--|
| E5 | Have there been days when you were bothered by health or wellbeing problems at school in the past 3 months? |
| <input type="checkbox"/> | Yes, for _____ days |
| <input type="checkbox"/> | No |
| <input type="checkbox"/> | I don't know/I would rather not say |

| | |
|--------------------------|--|
| E6 | Have you used education support services because of your health or wellbeing in the past 3 months? <i>This includes any additional educational support you have received, for example, tutoring, additional lessons.</i> |
| <input type="checkbox"/> | Yes |
| <input type="checkbox"/> | No <i>Please go to question E7</i> |
| <input type="checkbox"/> | I don't know/I would rather not say <i>Please go to question E7</i> |

| | |
|--------------------------|---|
| E6.1 | On average, how much education support services did you use weekly in the past 3 months? |
| | Number of hours per week |
| <input type="checkbox"/> | Education support at your place of study _____ hours |
| <input type="checkbox"/> | Education support in a private setting (e.g. private tutoring) _____ hours |
| <input type="checkbox"/> | Other, please specify: _____ hours |

| | |
|--------------------------|--|
| E7 | Have you received any special transport to attend education in the past 3 months? <i>Please consider any special transport service you needed for your educational appointments. These transports could include for instance a ride with an arranged taxi service.</i> |
| <input type="checkbox"/> | Yes |
| <input type="checkbox"/> | No <i>Please go to the next section</i> |
| <input type="checkbox"/> | I don't know/I would rather not say <i>Please go to the next section</i> |

| | |
|--------------------------|---|
| E7.1 | How many times have you received special transport to attend education in the past 3 months? <i>Please tick all answers that apply and indicate the number of times you used a given service. If you are unsure, please tick 'Other' and provide details.</i> |
| <input type="checkbox"/> | Special transport service (e.g. for special needs) _____ times |
| <input type="checkbox"/> | Other, please specify: _____ times |

WORK

In this section, we ask you about your **work, paid and unpaid**, and any difficulties you might have faced with your work performance regarding your health or wellbeing in the **past 3 months**. Unpaid work includes, for example, household tasks, childcare, or voluntary work.

| | |
|--------------------------|--|
| F1 | Have you been doing any paid work in the past 3 months? |
| <input type="checkbox"/> | Yes, as a full-time employee |
| <input type="checkbox"/> | Yes, as a part-time employee |
| <input type="checkbox"/> | Yes, as a self-employed person |
| <input type="checkbox"/> | Yes, other, please specify: _____ |
| <input type="checkbox"/> | No, I was on long-term sick leave <i>Please go to question F5</i> |
| <input type="checkbox"/> | No, I was on long-term leave for other reasons (e.g. maternity leave, study leave) <i>Please go to question F5</i> |
| <input type="checkbox"/> | No, I do not do paid work (e.g. student, retired, homemaker, volunteer) <i>Please go to question F5</i> |
| <input type="checkbox"/> | No, I am unemployed <i>Please go to question F5</i> |
| <input type="checkbox"/> | No, other, please specify: _____ <i>Please go to question F5</i> |
| <input type="checkbox"/> | I don't know/I would rather not say <i>Please go to question F5</i> |

| | |
|-----------|--|
| F2 | On average, how many hours of paid work do you usually do a week? |
| | <i>Please indicate the average hours per day worked (between 1-24 hours) and the number of days you usually work per week (between 1-7 days) separately.</i> |
| | I work _____ hours per day, _____ days per week. |

| | |
|--------------------------|--|
| F3 | Have you missed any paid work because of your health or wellbeing in the past 3 months? |
| <input type="checkbox"/> | No |
| <input type="checkbox"/> | Yes, I have missed _____ work days in the past 3 months. |

| | |
|--------------------------|--|
| F4 | Have you had any days when you worked but your work performance was negatively affected because of your health or wellbeing in the past 3 months? |
| | <i>If yes, please also indicate by how much your work performance was on a 0-100% scale (0%= I was not able to work at all, 100%= I could work as usual).</i> |
| <input type="checkbox"/> | No |
| <input type="checkbox"/> | Yes, I have had _____ work days when my performance was negatively affected. On these days, my work performance has been _____% of the usual. |

F5 On average, how many hours of unpaid work (e.g. household tasks, childcare, or voluntary work) do you usually do a day?

If none, please enter 0.

I usually do unpaid work for _____ hours a day.

F6 Have you had any days when you were not able to do your unpaid work because of your health or wellbeing in the past 3 months?

☐ No

☐ Yes, I was not able to do my unpaid work for _____ days in the past 3 months.

SAFETY AND JUSTICE SYSTEM

In this section, we ask you about your contacts with the safety and justice system (e.g. police, lawyers) in the **past 3 months**. These contacts might have occurred due to litigations you have been involved in, incidents or crimes that have affected you as a victim, and/or any crimes that you have committed.

G1 Have you had any contact with the police in the past 3 months?

Please only consider a face-to-face contact either at a police station or somewhere. Emergency phone calls (e.g. 112 or 999) are excluded.

- ☐ Yes, number of contacts: _____
- ☐ No
- ☐ I don't know/I would rather not say

G2 Have you used legal services (e.g. contact with a lawyer) in the past 3 months?

This could be a face-to-face meeting, an online consultation or a phone call with someone working in legal services.

- ☐ Yes, number of times: _____
- ☐ No
- ☐ I don't know/I would rather not say

G3 Have you been to court in the past 3 months?

Please note that this could be in any role (e.g. victim, witness or defendant).

- ☐ Yes, _____ time(s) for civil law (e.g. for a divorce)
- ☐ Yes, _____ time(s) for criminal law
- ☐ No
- ☐ I don't know/I would rather not say

G4 Have you been confined anywhere involuntarily (e.g. in a prison, police station or secure psychiatric hospital) in the past 3 months?

This means that you were not free to leave.

- ☐ Yes
- ☐ No *Please go to question G5*
- ☐ I don't know/I would rather not say *Please go to question G5*

G4.1 How many nights were you confined involuntarily in the past 3 months?

- | | Number of nights |
|--|------------------|
| <input type="checkbox"/> Police station/place of detention (e.g. prison) | _____ nights |
| <input type="checkbox"/> Secure hospital/secure psychiatric institution | _____ nights |
| <input type="checkbox"/> Other, please specify: _____ | _____ nights |

G4.2 How many hours did you spend in confinement on days where you were only confined for part of the day (i.e. did not spend the night there)?
Please note that we are only asking about times when you were confined and then released on the same day.

| | Number of hours |
|--|-----------------|
| <input type="checkbox"/> Police station/place of detention (e.g. prison) | _____ hours |
| <input type="checkbox"/> Other, please specify: _____ | _____ hours |

G5 Have you been a victim of or involved in theft in the past 3 months?

- ☐ Yes
- ☐ No Please go to question G6
- ☐ I don't know/I would rather not say Please go to question G6

G5.1 How often did the following happen related to theft in the past 3 months?

| | Number of times | I was involved as... |
|--|-----------------|---|
| <input type="checkbox"/> Stealing without violence (e.g. theft, pickpocketing) | _____ times | <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Both <input type="checkbox"/> I would rather not say |
| <input type="checkbox"/> Stealing with violence (e.g. robbery) | _____ times | <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Both <input type="checkbox"/> I would rather not say |

G6 Have you been affected by property damage (vandalism) in the past 3 months?

- ☐ Yes
- ☐ No Please go to question G7
- ☐ I don't know/I would rather not say Please go to question G7

| G6.1 How often have you been affected by the following acts of property damage in the past 3 months? | | |
|---|-----------------|---|
| | Number of times | I was involved as... |
| <input type="checkbox"/> Damage to a car (e.g. it was scraped with a key or the windows were smashed) | _____ times | <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Both <input type="checkbox"/> I would rather not say |
| <input type="checkbox"/> Minor damage to a home (e.g. graffiti) | _____ times | <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Both <input type="checkbox"/> I would rather not say |
| <input type="checkbox"/> Major damage to a home (e.g. it was burned down) | _____ times | <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Both <input type="checkbox"/> I would rather not say |
| <input type="checkbox"/> Other, please specify: _____ | _____ times | <input type="checkbox"/> Victim <input type="checkbox"/> Perpetrator <input type="checkbox"/> Both <input type="checkbox"/> I would rather not say |

| | |
|--|-------------|
| G7 Have you received any special transport for your legal appointments (e.g. court session) in the past 3 months? <i>Please consider any special transport service you needed for your legal appointments (e.g. court sessions). These transports could include for instance a ride in a police car.</i> | |
| <input type="checkbox"/> Yes | |
| <input type="checkbox"/> No <i>Please go to the next section</i> | |
| <input type="checkbox"/> I don't know/I would rather not say <i>Please go to the next section</i> | |
| G7.1 How many times have you received special transport for your legal appointments (e.g. court sessions) in the past 3 months? <i>Please tick all answers that apply and indicate the number of times you used a given service. If you are unsure, please tick 'Other' and provide details.</i> | |
| <input type="checkbox"/> Ride in a police car | _____ times |
| <input type="checkbox"/> Inmate transport | _____ times |
| <input type="checkbox"/> Other, please specify: _____ | _____ times |

PRIVATE EXPENSES

In this section, we ask you about private expenses you and your family have incurred regarding your health or wellbeing in the **past 3 months**. These could include paying for private health insurance, health and social care out-of-pocket payments, paying for help with something you were not able to do on your own, such as cleaning or personal care, buying something (e.g. a wheelchair or walking frame), or modifying your home to help with mobility.

H1 How was your health and social care paid for in the past 3 months?

Please tick all answers that apply. If you are unsure, please tick 'Other' and provide details.

- ☐ Public or national health service (e.g. UK NHS)
- ☐ Public or social health insurance
- ☐ Private health insurance
- ☐ Paid out-of-pocket
- ☐ Other, please specify: _____
- ☐ I don't know/I would rather not say

H2 In total, how much have you and/or your family spent privately regarding your health or wellbeing in the past 3 months?

Please estimate total expenses for the following goods and services in the past 3 months. Consider only private expenses where you/your family have not been and will not be reimbursed. Please tick all answers that apply and indicate the expenses for these as relevant.

| | | Total private expenses |
|--------------------------|-------------------------------------|------------------------|
| <input type="checkbox"/> | Private health insurance | _____ £ (GBP) |
| <input type="checkbox"/> | Residential care services | _____ £ (GBP) |
| <input type="checkbox"/> | Non-residential care services | _____ £ (GBP) |
| <input type="checkbox"/> | Prescription medication | _____ £ (GBP) |
| <input type="checkbox"/> | Education support services | _____ £ (GBP) |
| <input type="checkbox"/> | Safety and justice system services | _____ £ (GBP) |
| <input type="checkbox"/> | I don't know/I would rather not say | |

| H3 Have you and/or your family incurred any other private expenses regarding your health or wellbeing in the past 3 months? <i>Please estimate total expenses for the following goods and services in the past 3 months. Consider only private expenses for which you/your family have not been and will not be reimbursed. Please tick all answers that apply and indicate expenses for these as relevant.</i> | |
|---|---------------|
| Total private expenses | |
| <input type="checkbox"/> Cleaning or housekeeping assistance | _____ £ (GBP) |
| <input type="checkbox"/> Paid childcare while you are attending appointments or temporarily away | _____ £ (GBP) |
| <input type="checkbox"/> Complementary approaches to healthcare such as (online) self-help, diet and nutrition, expressive therapies (e.g. dance, drama, music or poetry therapy), stress reduction and relaxation techniques (gym, yoga, mindfulness meditation) | _____ £ (GBP) |
| <input type="checkbox"/> Holistic healing activities from someone other than a qualified healthcare professional, such as Ayurveda treatment, ceremonies, chanting | _____ £ (GBP) |
| <input type="checkbox"/> Durable goods such as wheelchairs, rollators or walkers, bathroom accessories (e.g. non-slip mat, bathing chairs, shower handrails), nightlights, emergency alarms, adjustable beds, special telephones | _____ £ (GBP) |
| <input type="checkbox"/> Non-durable goods (intended to be used for a short period of time), such as (disposable) swabs, dressing material | _____ £ (GBP) |
| <input type="checkbox"/> Refurbishment of your home | _____ £ (GBP) |
| <input type="checkbox"/> Change of your residence/living arrangements or change to your type of accommodation (e.g. moving from an independent house in the community to an institutional care setting) | _____ £ (GBP) |
| <input type="checkbox"/> Cancellation or postponement of your holiday | _____ £ (GBP) |
| <input type="checkbox"/> Informal carer's hotel costs when they accompany you when you travel, or the cost of respite care when those normally assisting you are away or otherwise unavailable | _____ £ (GBP) |
| <input type="checkbox"/> Over-the-counter medication | _____ £ (GBP) |
| <input type="checkbox"/> Therapeutic pets (e.g. guide dog) | _____ £ (GBP) |
| <input type="checkbox"/> Transport <i>Please consider only transport that concerns activities not listed before in the questionnaire</i> | _____ £ (GBP) |
| <input type="checkbox"/> I don't know/I would rather not say: | |

FINAL REMARKS

I1 You have reached the final section of the questionnaire. Please tell us how easy it has been for you to complete.

1 --- 2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10
Very easy Very difficult

I2 If you have any comments regarding completing this questionnaire, please share them with us below.

Thank you for helping by completing this questionnaire!