

APPENDIX 1. DOMICILIARY HOSTEL PROGRAM SURVEY**Table of Contents**

Survey Sections
1. Demographics
2. Physical and mental health status
3. Health conditions
4. Disabilities
5. Quality of life
6. Mental health diagnoses
7. Health care utilization
8. Access / Quality of care
9. Substance use
10. Community activities
11. Social supports
12. Personal choice
13. Use of support services
14. Housing
15. Housing Quality
16. Legal involvement
17. Employment
18. Interviewer's Observations

DOMICILIARY HOSTEL PROGRAM SURVEY

Please print legibly in either black or blue pen.

Very Important Survey Number	Date of Survey (dd/mm/yyyy)	Interviewer ID										
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Survey Site <input style="width: 90%;" type="text"/>		INTERVIEW										
Site Code <table border="1" style="width: 60px; height: 20px;"> <tr> <td style="width:20%;"></td> <td style="width:20%;"></td> <td style="width:20%;"></td> </tr> </table>					Start Time _____ : _____ Finish Time _____ : _____							
There are 18 sections to the survey and a total of 24 pages .		Total Time _____ Minutes										

Section 1: Demographics
In this section, I would like to ask you some basic personal information.

1.1 What language do you **prefer to communicate in?**
 1 English 2 French 3 Other – Specify _____

1.2 What is your name? (Please print)

 FIRST NAME MIDDLE NAME LAST NAME

1.3 What is your date of birth: Month: ____ Day: ____ Year: _____

1.4 What is your age: ____ years

1.5 Your gender is ...: Female Male Transgendered

1.6 Do you have an ODSP/OW ID Number?
 No
 Yes, not here
 Yes, in possession → Number: _____
 Refused

1.7 Do you have you have an Ontario Health Card?
 No
 Yes, not here
 Yes, in possession → Number: _____
 Refused

Section 1: Demographics...Cont'd

- 1.8 Are you a ...
- 1 Canadian Citizen
 - 2 Landed Immigrant
 - 3 Other-Specify: _____

- 1.9 How long have you been living in Ontario?
- _____ Months
_____ Years
- 96 Whole life
 - 99 Never
 - 97 Don't know
 - 98 Refused

- 1.10 To which racial or cultural group do you belong? **(Read categories and mark one only).**
- 1 White, Caucasian
 - 2 Black, African-Canadian
 - 3 First Nations/Aboriginal (e.g., Cree, Mi'kmak, Ojibway, Métis, Inuit)
 - 4 East Asian (Chinese, Japanese, Korean, Taiwanese, Mongolian, Pacific Islander, etc.)
 - 5 South Asian (Bangladeshi, East Indian, Pakistani, Sri Lankan, etc.)
 - 6 Southeast Asian (Cambodian, Filipino, Vietnamese, etc.)
 - 7 West Asian (Afghan, Arab, Iranian, Iraqi, Turkish, etc.)
 - 8 Hispanic, Latin American
 - 9 Other – Specify _____

- 1.11 How much school have you finished? **(Read categories and mark box for the highest level completed or degree received).**
- If currently enrolled, mark the level of previous grade attended or highest degree received.**
- 1 Grade 1- 4
 - 2 Grade 5 - 8
 - 3 Some high school, NO DIPLOMA
 - 4 HIGH SCHOOL GRADUATE – high school DIPLOMA
 - 5 G.E.D.
 - 6 Some college/university, but no degree
 - 7 College/university graduate
 - 8 Graduate/professional studies
 - 9 Other – Specify _____
 - 97 Don't know
 - 98 Refused

- 1.12 What is your marital status? Are you...? **(Read categories in bold and mark only one).**
- 1 **Single (never married)**
 - 2 **Divorced/separated**
 - 3 **Widowed**
 - 4 **Married, including common-law**
 - 97 Don't know
 - 98 Refused

- 1.13 How long have you been living in this domiciliary hostel?
- ___ Weeks ___ Months ___ Years Don't know Refused

1.14 What kind of place were you living in before moving to this domiciliary hostel, the place where you're living now?
Prompts: Own house, apartment, temporary stay with friends and/or relatives, homeless shelter, homeless, rooming house, domiciliary hostel, boarding home, group home, foster home, medical hospital, psychiatric hospital, substance abuse treatment facility, halfway house, nursing home, motel or hotel, jail or prison.

1.15 How long did you live at ____ (response from 1.14)?
 ___ Weeks ___ Months ___ Years Don't know Refused

1.16 Why did you move from ____ (response from 1.14) to this domiciliary hostel? (Record verbatim)

Section 2: Physical and mental health status (SF-12)

These next questions are about your health status now and your current daily activities. Please try to answer every question as accurately as you can. (Refer to Scale 2.1)

2.1 In general, would you say your health is... Excellent Fair
 Very good Poor
 Good Don't know

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Refer to Scale 2.2-2.3)

2.2 ...moderate activities such as moving a table. Does your health now limit you a lot, limit you a little, or not limit you at all? (If participant says s/he does not do activity, probe: Is that because of your health?)
 Yes, limited a lot Yes, limited a little No, not limited at all

2.3 ...climbing several flights of stairs. Does your health now limit you a lot, limit you a little, or not limit you at all? (If participant says s/he does not do activity, probe: Is that because of your health?)
 Yes, limited a lot Yes, limited a little No, not limited at all

The following questions that I will ask you are about your physical health and your daily activities during the past 4 weeks.

2.4 During the past 4 weeks, have you accomplished less than you would like as a result of your physical health?
 Yes No

- 2.5 During the **past 4 weeks**, were you limited in the kind of work or other regular daily activities you do as a result of your physical health?
- Yes No

*The following questions that I ask you are about your emotions and your daily activities during the **past 4 weeks**.*

- 2.6 During the **past 4 weeks**, have you accomplished less than you would like as a result of any emotional problems, such as feeling depressed or anxious?
- Yes No

- 2.7 During the **past 4 weeks**, did you not do work or other regular daily activities as carefully as usual as a result of any emotional problems, such as feeling depressed or anxious?
- Yes No

*The next questions are also about your physical and emotional health during the **past 4 weeks**. (Refer to Scale 2.8)*

- 2.8 During the **past 4 weeks**, how much did pain interfere with your normal work, including both outside and inside the home? Did it interfere...
- Not at all Slightly Moderately Quite a bit Extremely

*The next questions are about how you feel and how things have been with you during the **past 4 weeks**. As I read each statement, please give me the answer that comes closest to the way you have been feeling: Is it all of the time, most of the time, a good bit of the time, some of the time, a little of the time, or none of the time? (Refer to Scale 2.9-2.11)*

- 2.9 How much of the time during the **past 4 weeks**...have you felt calm and peaceful?
- All of the time Most of the time A good bit of the time Some of the time A little of the time None of the time

- 2.10 How much of the time during the **past 4 weeks**...did you have a lot of energy?
- All of the time Most of the time A good bit of the time Some of the time A little of the time None of the time

- 2.11 How much of the time during the **past 4 weeks**...have you felt down?
- All of the time Most of the time A good bit of the time Some of the time A little of the time None of the time

- 2.12 During the **past 4 weeks**, how much of the time has your physical health or emotional problems interfered with your social activities like visiting with friends or relatives?
- (Refer to Scale 2.12)*

All of the time Most of the time Some of the time A little of the time None of the time

Section 3: Health Conditions

I'm going to ask you some questions about health conditions that you may have.

Do you have... (Read list of conditions and mark one box on each line).

	Condition	Yes	No	Don't Know	Refused
1.	High blood pressure or hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have you had a heart attack?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Congestive heart failure (CHF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Heart disease (other than angina, heart attack, or CHF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Chronic Bronchitis or emphysema (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Stomach or intestinal ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Hepatitis – specify type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Cirrhosis (damaged liver from alcohol, drugs, infection, or other causes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	HIV infection or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Have you had any sexually transmitted disease (like Chlamydia or gonorrhea) in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Anemia (low blood, low iron)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Cancer – specify type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	Have you had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.	Arthritis, rheumatism, joint problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.	Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.	Skin disease (like eczema or psoriasis, skin sores or ulcers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. Any other health conditions?

Section 4: Disabilities

Now I am going to ask you about any disabilities you may have

4.1 Has a doctor or health professional ever told you that you have...

	Yes	No	Refused	Don't know
a. Developmental disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Attention Deficit Disorder (ADD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Fetal Alcohol Effects (FAE) or Fetal Alcohol Syndrome (FAS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Head Injury or Acquired Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Other learning disability: (specify)				

4.2 Do you have ...

	Yes	No	Refused	Don't know
a. Visual impairment (other than needing glasses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Amputation (specify: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Any other disability: (specify)				

4.3

	Yes	No	Refused	Don't know
a. When you were in school, were you in Special Education classes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. When you were in school, did you repeat any grades? If yes: c. Which grades did you repeat? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Are you involved in programs or services with the Association for Community Living?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you have a Support Worker who helps you access the services that you need?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4.4

Do you use any of the following assistive devices?

	Yes	No
a. Cane	<input type="checkbox"/>	<input type="checkbox"/>
b. Walker	<input type="checkbox"/>	<input type="checkbox"/>
c. Wheelchair (not motorized)	<input type="checkbox"/>	<input type="checkbox"/>
d. Motorized wheelchair or scooter	<input type="checkbox"/>	<input type="checkbox"/>
e. Prosthetic limbs	<input type="checkbox"/>	<input type="checkbox"/>
f. Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>

Section 5: Quality of life

EQ-5D & VAS

5.1 Please let me know which of the statements I read to you best describes your own health state **today**. I will mark the statement that you choose. (**Refer to Scale 5.1A-5.1E and check one only in each group**)

A. Let's first look at mobility

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

B. Now let's look at self-care

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

C. Next, let's go to usual activities (e.g. going for a walk)

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

D. Okay, now tell me about your pain/discomfort

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

E. Finally, let's look at anxiety/depression

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

To help people say how good or bad their state of health is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your state of health is today.

**Your own
state of health
today**

Best
imaginable
state of health

100

90

80

70

60

50

40

30

20

10

0

Worst
imaginable
state of health

Section 6: Mental health diagnoses

6.1 Have you ever been diagnosed with any of the following mental health problems by a health professional?

	Yes	No	Don't Know	Refused
A. Bipolar Disorder or Manic-Depressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Depression or Major Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Generalized Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Manic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Obsessive-Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Phobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Post Traumatic Stress Disorder (PTSD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Psychosis, other than Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Substance Abuse or Dependence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 7: Health care utilization

Now I am going to ask you some questions about your health care.

- 7.1** Is there a particular person or place that you usually go to when you are sick or need advice about health?
- 1 Yes → **Skip to 7.3**
 0 No
 97 Don't know
 98 Refused

- 7.2** What is the main reason you do not have a particular person or place that you usually go to when you are sick?
(Based on participant's response, mark one box only)
- Seldom or never get sick
 - Don't use doctors / treat myself
 - Recently moved to the area
 - Don't know where to go for care
 - Have had bad experiences with doctors/health care in the past
 - No doctors in the area accepting new patients
 - Have no transportation
 - Wait for an appointment is too long
 - Clinic hours are inconvenient
 - Usual source of health care in the area is no longer available
 - Other – Specify:

 - Don't know
 - Refused

7.3 Do you have a family doctor?	Yes <input type="checkbox"/>	No <input type="checkbox"/> (If no, skip to 7.6)
---	---------------------------------	---

7.4 Does your family doctor usually come to see you where you live (here at the Domiciliary Hostel)?	<input type="checkbox"/>	<input type="checkbox"/>
---	--------------------------	--------------------------

7.5 Do you usually go to see your family doctor at his/her office?	<input type="checkbox"/>	<input type="checkbox"/>
---	--------------------------	--------------------------

7.6 Do you have a psychiatrist who you see regularly?	<input type="checkbox"/>	<input type="checkbox"/>
--	--------------------------	--------------------------

7.7a. When you go for health care, does anyone else go with you?

- Yes
- No
- Don't know
- Refused

} **Skip to 7.8**

b. Who usually goes with you?

c. Does this person work here at the Domiciliary Hostel? Yes No

7.8a. Are you taking any medications that are prescribed by a doctor?

- Yes
- No
- Don't know
- Refused

} **Skip to 7.9**

b. Is there anyone who helps you with taking your prescribed medications?

- Yes
- No
- Don't know
- Refused

} **Skip to 7.9**

c. Who usually helps you?

d. Does this person work here at the Domiciliary Hostel? Yes No

In the past 12 months , have you received health care from ...			b. If "Yes" — How many times in the past 12 months?
	Yes	No	
7.9	<input type="checkbox"/>	<input type="checkbox"/>	
7.10	<input type="checkbox"/>	<input type="checkbox"/>	
7.11	<input type="checkbox"/>	<input type="checkbox"/>	
7.12	<input type="checkbox"/>	<input type="checkbox"/>	
7.13	<input type="checkbox"/>	<input type="checkbox"/>	

Section 9: Substance use

- 9.1** Have you ever used alcohol or drugs in the last 3 years? Yes — **Proceed to “Now I’m going to ...**
 No — **Skip to Section 10**
 Don’t know – **Proceed to “Now I’m going to ...”**
 No — **Skip to Section 10**

Now I’m going to ask you some questions about how alcohol and drug use may have affected your life. If the question describes something that has never happened to you, simply answer Never.

GAIN (Refer to Scale 9.2A-Q) 9.2 When was the <u>LAST</u> time that	Past month	Past 2-6 months	Past 7-12 months	1+Years	Never
A. you tried to hide that you were using alcohol or drugs?	3	2	2	1	0
B. your family, partner, friends, co-workers, or people you live with complained about your alcohol or drug use?	3	2	2	1	0
C. you used alcohol or drugs weekly?	3	2	2	1	0
D. your alcohol or drug use caused you to feel depressed, nervous, suspicious, uninterested in things, reduced your sexual drive?	3	2	2	1	0
E. your alcohol or drug use caused you to have numbness, tingling, shakes, blackouts, hepatitis, TB, sexually transmitted disease or any other health problems?	3	2	2	1	0
F. you kept using alcohol or drugs even though you knew it was keeping you from meeting your responsibilities at work, school or home?	3	2	2	1	0
G. you used alcohol and drugs where it made the situation unsafe or dangerous for you, such as when you were driving a car, using a machine, or where you might have been forced into sex or hurt?	3	2	2	1	0
H. your alcohol or drug use caused you to have repeated problems with the law?	3	2	2	1	0
I. you kept using alcohol or drugs even after you knew it could get you into fights or other kinds of legal trouble?	3	2	2	1	0
J. you needed more alcohol or drugs to get the same high or found that the same amount did not get you as high as it used to?	3	2	2	1	0
K. you had withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or drugs to stop being sick or avoid withdrawal problems?	3	2	2	1	0
L. you used alcohol or drugs in larger amounts, more often or for a	3	2	2	1	0

GAIN (Refer to Scale 9.2A-Q) 9.2 When was the <u>LAST</u> time that	Past month	Past 2-6 months	Past 7-12 months	1+Years	Never
longer time than you meant to?					
M. you were unable to cut down or stop using alcohol or drugs?	3	2	2	1	0
N. you spent a lot of time either getting alcohol and drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?	3	2	2	1	0
O. your use of alcohol and drugs caused you to give up, reduce or have problems at important activities at work, school, home or social events?	3	2	2	1	0
P. you kept using alcohol or drugs even after you knew it was causing or adding to medical, psychological, or emotional problems you were having?	3	2	2	1	0
Q. How old were you when you first got drunk or used any drugs?	_____ Yrs old				

Section 10: Community activities

10.1 I am going to ask you how often you have been involved in different kinds of community activities during the **past 12 months** (If response for 1.13 is < 12 months, then obtain responses only for the number of months participant has resided in this domiciliary hostel). Please give me the word that best describes how frequently you have participated in the following community activities (Refer to Scale 10.1A-M)

	NEVER	RARELY	SOME TIMES	OFTEN	VERY OFTEN	If response is "SOMETIMES," "OFTEN," or "VERY OFTEN": Do you do this activity...		
						With help from Dom Hostel staff	With help from someone else	Without any help
A. gone to a shopping centre or large shopping area.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. attended a movie, concert or play.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. gone to a sports event.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Participated in outdoor or indoor sports activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Visited a park or museum.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Gone to a restaurant, bar, or coffee shop.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Gone to a community centre.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Gone to a church or place of worship.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Gone for a walk.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Participated in work (paid or volunteer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Gone to a library	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Gone to a barber shop or beauty salon.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Gone to a support group or drop in centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 11: Social supports

CMHEI Social Support Scale

I'm going to read you some statements about your relationships with others. For each, please tell me whether you strongly agree, agree, disagree, or strongly disagree.

(Refer to Scale 11.1-11.8)

	Strongly Agree	Agree	Disagree	Strongly Disagree
11.1 If something went wrong, no one would help me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.2 I have family and friends who help me feel safe, secure, and happy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.3 There is someone I trust whom I could turn to for advice if I were having problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.4 There is no one I feel comfortable talking about problems with.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.5 I lack a feeling of intimacy with another person.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.6 There are other people I can count on in an emergency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.7 I provide support to my friends and/or my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.8 I have a lot of serious disagreements and arguments with my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Now, I'm going to ask you some questions about the people you are close to.

11.9 Are there any people with whom you feel at ease and can talk to about personal issues?

- Yes
- No
- No Answer
- Don't Know
- Refused

} **Skip to 12.1**

11.10 Among these people, how many are:
(Check all that apply and record # next to each response)

- family members, _ _
- friends, _ _
- spiritual leaders, _ _
- care providers, _ _
- boyfriend, girlfriend, or partner, _ _
- domiciliary hostel workers, _ _
- other _ _

11.11 During the past month, how often have you been in contact with close friends?
(Refer to Scale 11.11&11.13)

- Not at all → **Skip to 11.13**
- Once or twice
- Once a week
- Several times a week
- No answer
- Don't Know
- Refused

Skip to 11.13

11.12 Of the close friends whom you have been in contact with during the past month, do...

- They all live here in the same building as you
- They all live elsewhere
- Some of them live here and some of them live elsewhere

11.13 During the past month, how often have you been in contact with anyone in your family (including spouse/partner)? **(Refer to Scale 11.11&11.13)**

- Not at all
- Once or twice
- Once a week
- Several times a week
- No answer
- Don't Know
- Refused

Section 12: Personal Choice

The next few questions are about your life here.

	Yes	No	Refused	Don't know
12.1 Do you have a choice about when you wake up and go to bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.2 Do you have a choice about when you eat your meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.3 Do you have a choice about how you spend your money?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.4 Do your benefits or social assistance cheques go directly to the people who operate this hostel?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.5 Does this place hold regular house meetings where you can voice your concerns, feelings, and opinions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.6 Do you have the ability to disagree with the staff who work here?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.7 If you had a complaint or problem about this place, is there someone who works here who you could register your complaint with?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.8 If you had a complaint or problem about this place, is there someone outside of here who you could register your complaint with?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 14: Housing

14.1 Have you **EVER** been homeless?

- Yes
- No
- Don't know
- Refused

} **Skip to 14.3**

14.2 How long ago was the last time you were homeless?

__ __ months ago OR __ __ years ago Don't know Refused

Current Living Situation

14.3 Why are you living here? (Record verbatim)

14.4 Who referred you to this place? _____

Don't know Refused

14.5a. Do you feel that living here has had any effect on your health?

- Yes → **b.** Has the effect on your health been positive, negative, or both?
 - Positive Negative Both Positive and Negative
- No
- Don't know
- Refused

14.6 Are there things that you like about living here?

- No
- Yes → Specify: _____
- Don't know
- Refused

14.7 Are there things that you don't like about living here?

- No
- Yes → Specify: _____
- Don't know
- Refused

14.8 Would prefer to stay here, or move somewhere else?

- Stay → Skip to 14.11
 - Move somewhere else
 - Don't know
 - Refused
- Skip to 14.9a

14.9a. Do you have plans to move out within the next **6 months**?

- No → b. Why are you not planning to move out? _____
- Yes → c. What type of housing would you like to move to? _____

14.10a. Are you having any difficulties finding a different place to live?

- No
- Yes → b. What kind of difficulties are you having? _____

14.11 Do you feel that you are living in a clean environment right now?

- Yes
- No
- Don't know
- Refused

Section 15: Housing Quality

15.1 Please read the following to participants (Now I'd like to ask you some questions about the place where you live NOW.) Please use the following scale to respond to the questions. (Refer to Scale 15.1a-f)

	VERY BAD	BAD	SOMEWHAT BAD	NEITHER GOOD NOR BAD	SOMEWHAT GOOD	GOOD	VERY GOOD
a. How would you rate this place in terms of comfort?	1	2	3	4	5	6	7
b. How would you rate this place in terms of safety?	1	2	3	4	5	6	7
c. How would you rate this place in terms of spaciousness*?	1	2	3	4	5	6	7
d. How would you rate this place in terms of privacy**?	1	2	3	4	5	6	7
e. How would rate this place in terms of friendliness***?	1	2	3	4	5	6	7
f. How would you rate this place in terms of overall quality?	1	2	3	4	5	6	7

***Spaciousness:** Feeling like you have enough space to live comfortably.

****Privacy:** Feeling like you have your own space where you will not be disturbed by other people.

*****Friendliness:** Feeling like you are in a pleasant and welcoming atmosphere and you are comfortable in these surroundings.

Section 16: Legal involvement

- 16.1** In the past 12 months, have you been arrested?
 Yes → If yes, how many times were you arrested? _____
 No
 Don't Know
 Refused
- 16.2** In the past 12 months, have you spent any nights in prison or jail?
 Yes → If yes, how many nights have you spent in prison or jail? _____
 No
 Don't Know
 Refused
- 16.3a** In the past 12 months, have you been on parole or probation?
 Yes → If yes, go to 16.3.b
 No
 Don't Know
 Refused
- }

Skip to 17.1a
- 16.3b** Is living in a domiciliary hostel a requirement of your parole or probation?
 Yes No Don't Know Refused

Section 17: Employment

- 17.1a.** Are you currently working in a paid position?
 Yes No
- If YES,
- b.** How many hours per week? _____ hours
- c.** What kind of work are you doing? _____
- If NO,
- d.** When was the last time you worked in paid position? ____ days ago ____ weeks ago ____ years ago
- e.** What kind of work did you do the last time you had a paid position? _____
- 17.2a.** Are you currently working in a volunteer position?
 Yes No
- If YES,
- b.** How many hours per week? _____ hours
- c.** What kind of volunteer work are you doing? _____

Section 18: Closing and Interviewer's Observations

Thank you very much for your help with this study.

PLEASE REMEMBER TO:

- OBTAIN PARTICIPANT'S SIGNATURE AND PROVIDE REIMBURSEMENT
- START, FINISH, AND TOTAL TIME ON PAGE 2.

INTERVIEWER'S OBSERVATIONS

18.1 Did you observe any of the following?

	Not at all	Slight extent	Modest extent	Moderately	Large extent
A) responding to voices, noises, others can't hear, or to other private experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) responding to or seeing things other can't see	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) suspicion/persecution or other delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) having pressured speech/euphoria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E) seriously agitated or aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F) extremely slowed down/stuporous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G) extremely depressed/sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H) so withdrawn, in own world, or frightened that He/she answered questions only with difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I) unusually bizarre in behavior or appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J) extremely unusual thinking about past/current experiences (NOT situational or cultural)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K) extremely apathetic/flat in affect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L) extremely inappropriate in affect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M) with incoherent, confused speech (NOT situational or cultural)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18.2 Was the participant interested and co-operative?

- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> Not at all interested or cooperative | <input type="checkbox"/> Not very interested or cooperative | <input type="checkbox"/> Reasonably interested and cooperative | <input type="checkbox"/> Very interested and cooperative | <input type="checkbox"/> Extremely interested and cooperative |
|---|---|--|--|---|

18.3 How much difficulty did the participant have answering the questions?

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> Extreme difficulty | <input type="checkbox"/> More than average difficulty | <input type="checkbox"/> Average difficulty | <input type="checkbox"/> Less than average difficulty | <input type="checkbox"/> No difficulty at all |
|---|---|---|---|---|

18.4 INTERVIEWER'S COMMENTS, NOTES, AND REMARKS ABOUT THE PARTICIPANT'S BEHAVIOUR
