A Survey of Domiciliary Hostel Program Tenants in Ontario

Final Report

Dr. Stephen Hwang, Shirley Chiu, and Emma Wilkins
From the Centre for Research on Inner City Health,
The Keenan Research Centre in the
Li Ka Shing Knowledge Institute of
St. Michael's Hospital
30 Bond St.
Toronto, Ontario M5B 1W8

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EXECUTIVE SUMMARY

Background Information on Domiciliary Hostels

Ontario's Domiciliary Hostel Program is a residential care program first developed in the 1970s to meet the housing needs of impoverished, frail seniors. The program has evolved over time and now provides permanent housing with limited supports to a heterogeneous group of vulnerable adults who have very modest financial resources. Domiciliary Hostel Program tenants include persons with mental illness, physical disabilities, developmental disabilities, and the frail elderly.

Until now, very little reliable data has been available on the individuals served by the Domiciliary Hostel Program, the circumstances that bring people into the program, and the circumstances in which they live. The goal of this project is to support policy work and service planning by providing reliable information about the characteristics and service needs of tenants in the Domiciliary Hostel Program in Ontario. The specific objectives of this research project were 1) to describe the characteristics of Domiciliary Hostel Program tenants; 2) to describe Domiciliary Hostel Program tenants' use of community supports and services, use of health care, and participation in community life; and 3) to describe the housing pathways of Domiciliary Hostel Program tenants. Data were collected through face-to-face interviews with a representative sample of Domiciliary Hostel Program tenants. Supplemental information on study participants was obtained through linkages with provincial databases.

Data Collection and Demographic Characteristics of Study Participants

Approximately 4,700 individuals reside in Domiciliary Hostel Programs across Ontario. This study surveyed individuals within 8 Consolidated Municipal Service Managers (CMSMs): Windsor, Essex County, Waterloo, Hamilton, York Region, Ottawa, Prescott-Russell, and Cornwall, which account for about 4,000 program beds (about 85% of all beds in Ontario). Between January and May of 2008, a total of 258 participants (response rate of 71%) were enrolled at 54 Domiciliary Hostels. Study participants had the following characteristics: 59% were male, 77% were under the age of 65 years, 90% were white, 50% were single/never married, 54% did not graduate from high school, 96% were not currently working in any paid position, 90% spoke English as their primary language, 98% were Canadian citizens, and 88% were residents of Ontario for 20 years or more. Tenants under 65 years tended to be male (65%), meanwhile, tenants 65 years and older tended to be female (63%).

Physical Health Conditions and Developmental Disabilities

The majority of participants (89%) reported having at least one physical health condition. The most commonly reported physical health conditions were arthritis/rheumatism/joint problems, difficulty walking, high blood pressure, diabetes, asthma, chronic bronchitis/emphysema, epilepsy/seizures, anemia, heart attack, and skin disease, and stroke. A diagnosis of developmental disabilities (developmental disability and/or fetal alcohol effects/fetal alcohol syndrome (FAE/FAS)) was reported

by 21% of participants, and 30% of participants reported being diagnosed with developmental, learning or other disabilities[1].

Mental Health Issues and Substance Use

Domiciliary Hostel tenants had a very high prevalence of mental health issues: 73% of the participants reported being diagnosed with at least one mental health issue (excluding substance abuse/dependence) and 52% reported being diagnosed with at least one of the following serious mental health issues: schizophrenia, psychosis other than schizophrenia, bipolar affective disorder (manic-depressive illness), and manic disorder. The majority of study participants (64%) reported no use of alcohol or drugs in the last 3 years. Based on the Global Appraisal of Individual Needs (GAIN) instrument, 8% of the participants were classified as having a moderate level of substance dependence in the last 1 year, and 5% were classified as having a high level of substance dependence. A total of 23% of the participants had used alcohol and/or drugs in the last 3 years, but were classified as having no/low level of substance dependence.

Developmental Disabilities, Mental Health Issues, and Substance Abuse/Dependence

A total of 19% of the participants had self-reported both developmental disabilities and at least one diagnosed mental health issue, excluding substance abuse/dependence. Meanwhile, a total of 17% of the participants had self-reported both a diagnosed mental health issue and substance abuse/dependence.

Physical and Mental Health Status and Quality of Life

Based on the Short Form Health Survey (SF-12), Domiciliary Hostel tenants tended to have poorer physical health status and mental health status than the U.S. general population. These differences were however not extremely large, as the mean scores of hostel tenants were within 1 standard deviation of the population mean. Compared to the Canadian population, hostel tenants were substantially more likely to report experiencing problems with mobility, usual activities, self-care, pain/discomfort, and anxiety/depression (as measured by the Euroqol Health Sates-5D (EQ-5D)). Meanwhile, their self-rated health-related quality of life was also poorer (11 points lower) than that of the Canadian population.

Health Care

Most participants (87%) reported they had a usual source of health care, which was in most cases a family doctor. It was more common for the participant to go see his or her family doctor at the doctor's office (64%) than for the family doctor to come to see

[1] The proportion who reported developmental difficulties was examined in two ways: 1) developmental disabilities only, and 2) developmental disabilities, learning or other disabilities (developmental disability, attention deficit disorder, dyslexia, FAE/FAS, and cerebral palsy).

the participant at the Domiciliary Hostel (38%). A total of 40% of participants had a psychiatrist whom they saw regularly. Overall satisfaction with the way health care services had been provided during the last 12 months was high, with 81% of participants reporting that they were very satisfied or somewhat satisfied. A total of 41% of participants reported that they were accompanied during health care visits. Among these participants, the person accompanying them was most commonly the Domiciliary Hostel staff or operator (37%) or a family member or friend (35%). The vast majority (97%) of participants were taking prescribed medications, of which 79% of these participants reported receiving help taking their medications. The person assisting them with their medications was most often the Domiciliary Hostel staff or operator (64%) or a nurse working at the Domiciliary Hostel (32%).

Support Services, Community Life, and Social Supports

A total of 43% of participants reported they had a support worker who helped them access services, and the same percentage reported using some type of community services/supports in the past 12 months or during the period they had resided in the Domiciliary Hostel (if less than 12 months). The most commonly used services/supports included mental health programs, drop-in services, religious services, addiction services, and activities offered on-site or off-site, such as arts and crafts, movies, bingo, social outings, and recreational activities like bowling, exercising, and dancing. Of all the types of community services/supports used by the participants, one-third of the services/supports were provided at the Domiciliary Hostel. The services/supports most often provided at the Domiciliary Hostel were activities, religious services, Assertive Community Treatment, mental health programs, and city social services.

Participants' level of involvement in community activities in the last 12 months or for the duration they had resided in the Domiciliary Hostel (if less than 12 months) was generally low. The only activities that more than half of participants reported engaging in sometimes, often, or very often were going for a walk (77%), going to a restaurant, bar, or coffee shop (62%), and going to a shopping centre or large shopping area (59%). Barriers to involvement or participation in community activities were not assessed as part of this study. Perceived support, however, was relatively high, with 80% of participants reporting that there was at least one person with whom they felt at ease and could talk to about personal issues. Among these participants, the most common persons identified included friends (75%), family (72%) and Domiciliary Hostel staff or operator (68%).

Housing

Participants tended to be long-term Domiciliary Hostel tenants, with the average duration of tenancy at the current Domiciliary Hostel being 5.1 years. Tenants were most likely to have moved into their current residence from their own house or family's house (28%), an apartment (28%), or another Domiciliary Hostel (17%). The most common reasons that participants cited for moving into their current Domiciliary Hostel were mental health issues, a change in family situation, the desire to move to a better

residence, their physical health conditions, the need for assistance with daily living/dispensing of medications, and their previous residence was no longer available. A total of 35% of participants had been homeless one or more times in their life. However, this experience was usually not recent, with the last episode of homelessness occurring an average of about 10 years ago.

Participants reported a relatively high level of perceived housing quality at their current Domiciliary Hostel. The average quality score was 33.8, where 6 represents the worst possible score and 42 represents the best possible score. A total of 87% of tenants reported that they liked at least some aspects about living at the hostel, and 48% disliked at least some aspects about the hostel. When asked about their preferences, 63% of participants stated they would prefer to stay at their current Domiciliary Hostel, whereas 33% would prefer to move elsewhere. Among the tenants who indicated they preferred to move elsewhere or were unsure, 56% reported they planned to move within the next 6 months.

Comparison of the Health of Participants by Age

Individuals younger than age 65 years (non-seniors) were significantly different from those who were age 65 years and over (seniors). Non-seniors were more likely to have developmental disabilities, developmental, learning or other disabilities, head injury/acquired head injury, mental health issues (excluding substance abuse/dependence), serious mental health issues, self-reported substance abuse/dependence in their lifetime, and to have used alcohol or drugs in the last 3 years.

Health, Use of Community Services/Supports, and Involvement in Community Activities of Participants: Subgroup Comparisons

The interviews indicated that Domiciliary Hostels serve individuals with diverse characteristics and service needs. Groups were compared based on age (non-seniors versus seniors), facility size (smaller versus larger facilities), duration of tenancy in the current Domiciliary Hostel (short-term versus long-term tenants), serious mental health issues (presence versus absence), developmental disabilities (presence versus absence), and developmental, learning or other disabilities (presence versus absence). It was found that non-seniors tended to have better physical health status. Seniors, long-term tenants, and tenants without serious mental health issues, developmental disabilities or developmental, learning or other disabilities tended to have better mental health status.

Overall, community integration was low among hostel tenants, although non-seniors, tenants in smaller facilities, long-term tenants, and tenants with serious mental health issues, developmental disabilities or developmental, learning or other disabilities were better integrated than their counterparts. Non-seniors, tenants in smaller facilities, short-term tenants, and those with serious mental health issues, developmental disabilities or developmental, learning or other disabilities were more likely to have used community services/supports in the past 12 months or for the duration they had

resided in the Domiciliary Hostel (if less than 12 months). In addition, non-seniors, tenants in larger facilities, long-term tenants, and those with serious mental health issues, developmental disabilities or developmental, learning or other disabilities tended to have a support worker. Meanwhile, tenants residing in smaller sites, short-term tenants, tenants without serious mental health issues, and tenants with developmental disabilities or developmental, learning or other disabilities tended to be younger than their counterparts.

Data linkage with the Provincial Database

A substantial proportion of Domiciliary Hostel tenants received financial assistance from the Ontario Disability Support Program (ODSP) or Ontario Works (OW). An ODSP/OW identifier was obtained for 191 (74%) of participants. Linkage with the Ministry of Community and Social Services and Ministry of Health and Long-Term Care databases was successful for 178 individuals (69% of all participants and 93% of those for whom a number was obtained). Among these participants, most were receiving ODSP benefits (94%), a very small proportion were receiving OW benefits (3%), and 3% had received ODSP/OW benefits but were no longer receiving them. The mean number of moves between January 1, 2003 and May 31, 2008 was 2.6. Meanwhile, 30% had 0 moves, 35% had 1-4 moves, and 20% had 5 or more moves between this period.

For the 178 participants whose social assistance data could be accessed, the International Statistical Classification of Diseases and Related Health Problems (ICD-9) codes revealed that the most common primary and secondary diagnoses were schizophrenia (41%), developmental delay/mental retardation (15%), personality disorders (12%), neurotic disorders (12%), affective psychoses (8%), and epilepsy (4%). The self-reported presence of certain conditions was compared to ODSP disability determination files to determine the concordance between these two data sources. For the 178 participants for whom data linkage was accomplished, the disability determination file confirmed the diagnosis of schizophrenia or psychosis in 67% of the individuals who self-reported these diagnoses. In comparison, the corresponding figures were only 22% for individuals who self-reported a diagnosis of developmental disabilities, 20% for individuals who self-reported a diagnosis of bipolar/manic, and 25% for individuals who self-reported any other mental health diagnosis.

These relatively low figures for the correlation of self-reported developmental disabilities, bipolar/manic, and other mental health diagnoses with ODSP disability diagnoses may be due to a number of factors. First, an individual may accurately self-report that they have a specific condition (e.g., developmental disability), but they may have qualified for disability on the basis of a different condition (e.g., epilepsy). Second, the disability determination file contains only the individual's primary and secondary diagnoses; thus, for an individual with three or more conditions, the disability file will fail to confirm at least some of these diagnoses. Third, individuals may report a condition that is in a different category than the diagnosis assigned by the disability determination process (e.g., an individual may self-report bipolar disorder

but have been assigned the ICD-9 code for major depression). Fourth, the individual may have "no disability" listed as their primary ICD-9 code, for the reasons given above. Finally, individuals may self-report conditions (e.g. depression) that have not been formally confirmed by a health care provider. Overall, these findings emphasize the fact that a formal diagnostic interview or a careful review of medical records, not correlation to the disability determination file, would be a preferable method of confirming self-reported diagnoses of developmental disabilities or mental health diagnoses.

Strengths and Limitations of the Study

This study has a number of major strengths. It provides reliable and detailed information on Domiciliary Hostel tenants that was obtained through face-to-face interviews with a random sample of tenants and through linkages with disability databases. The level of cooperation from Domiciliary Hostel operators was very high, and 71% of eligible tenants agreed to participate in the study. Rigorous research methods were used to ensure the highest possible standards of data quality and analysis. Certain limitations of this study should be kept in mind. In particular, this study did not sample tenants in 17 CMSMs that account for 15% of Domiciliary Hostel beds in Ontario, and the results of this study may not be generalizable to these jurisdictions. In addition, 13% of individuals approached for possible participation in this study were deemed ineligible, primarily due to an inability to converse appropriately. These individuals may therefore represent a subgroup of Domiciliary Hostel tenants who have higher levels of disability and illness than those who were recruited in the study. As a result, our findings may underestimate the levels of illness or disability among Domiciliary Hostel tenants overall.

Implications and Conclusions

In summary, this study provides reliable and valuable information on the characteristics of Domiciliary Hostel tenants in Ontario. Since the inception of the Domiciliary Hostel Program more than three decades ago, this program has clearly evolved from housing frail seniors to housing a diverse group of vulnerable adults, including individuals with mental and physical illness, developmental disabilities, as well as the elderly. While it is beyond the scope of this report to make specific policy or program recommendations, it is hoped that the information in this report will be useful in supporting future policy and program planning.

HISTORY ON DOMICILIARY HOSTELS*

In the late 1950s, municipalities began to provide financial support for impoverished adults living in unregulated lodging or boarding homes. In the early 1970s, the province of Ontario began to develop more formalized policies to help provide adults who would be otherwise homeless with shelter and basic needs in lieu of direct financial assistance. After proclamation of the *Nursing Homes Act (1972)*, municipalities began to access provincial funding to provide longer-term accommodation to those persons who did not meet the requirements of the new Act (e.g. to those who required assistance with activities of daily living but who did not require regular nursing care). The name 'Domiciliary Hostel' emerged as a term used to describe a range of housing operations that received funding to provide board and lodging and some support for activities of daily living on a per-bed basis. Domiciliary Hostels were initially created as a municipal response to meet the housing needs of impoverished frail/elderly adults. Over the years the program has evolved to become permanent housing for vulnerable adults with a wide range of special service needs, such as persons with mental illness, physical and/or developmental disabilities and/or frail elderly.

Prior to 1998, the province cost-shared the Domiciliary Hostel Program with municipalities (80% provincial/20% municipal). As of January 1998, under the Local Services Realignment process, the Domiciliary Hostel Program was identified as being entirely a municipal responsibility. This decision was reversed following the recommendations of the Provincial Task Force on Homelessness. In June 1998, the province made a commitment to review the Domiciliary Hostel Program and agreed to again cost-share the program with municipalities (80% provincial/20% municipal).

The province currently has very limited reliable information about tenants in Domiciliary Hostels, the circumstances that bring people to the hostels, and the circumstances in which they live. One provincial-level investigation, carried out in 1999, sought to develop a profile of the Domiciliary Hostel Program.[i] Research methods included a survey of operators, site visits and a literature review. Although this study suggests that Domiciliary Hostel tenants have service needs related to mental illness, physical disability, developmental disability and substance abuse, the findings are limited by the study's reliance on second-hand information concerning tenant characteristics and needs. To support policy work and service planning, both the Ontario Ministry of Community and Social Services (MCSS) and the Ontario Ministry of Health and Long-term Care (MOHLTC) require descriptive information about Domiciliary Hostel tenants and their service needs.

*Note: The History on Domiciliary Hostels section was prepared by MCSS.

STUDY OBJECTIVES

The goal of this project was to support policy work and service planning by providing reliable information about the characteristics and service needs of tenants in the Domiciliary Hostel Program in Ontario. This information was obtained through face-to-face interviews with a representative sample of Domiciliary Hostel Program tenants and linkages with provincial databases to obtain supplemental information on these tenants.

The specific objectives of this research project were:

1. To describe the characteristics of Domiciliary Hostel Program tenants in terms of:
   - Demographics
   - Income and Education
   - Prevalence of mental illness, substance abuse, and other vulnerabilities
   - Physical and Mental Health status
   - Participation in community life.

2. To describe Domiciliary Hostel Program tenants' current use of supports and services with respect to:
   - Participation in community life;
   - Mental health and addiction services;
   - Social services; and
   - Health care

3. To describe the life paths of Domiciliary Hostel Program tenants by characterizing:

   - Reasons that led to their entry into the current Domiciliary Hostel
   - Satisfaction with their current housing
   - Preferences for future housing.

METHODS

Research Team and Project Advisory Committee

This study was commissioned through a Request for Proposals issued by the Ontario Mental Health Foundation (OMHF), Ontario MOHLC, and Ontario MCSS. The study was jointly funded by MOHLTC and MCSS. The research team, led by Dr. Stephen Hwang, a research scientist at the Centre for Research on Inner City Health (CRICH), St. Michael's Hospital, Toronto, and his research team at CRICH were commissioned to conduct this study. Dr. Hwang leads a team with extensive experience in working with vulnerable populations and is internationally recognized for his work on homelessness and health.

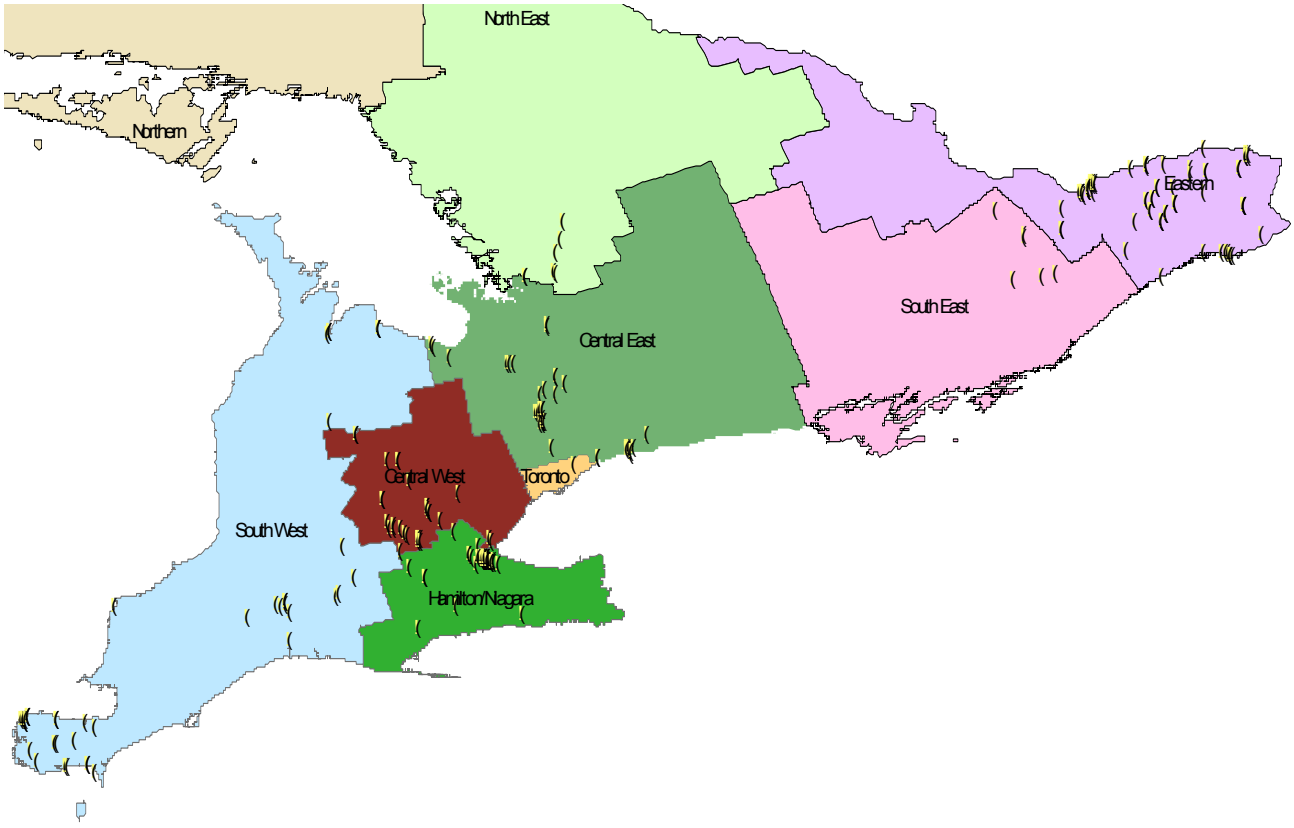
The Project Advisory Committee (PAC) consisted of representatives from MCSS, MOHLTC, Consolidated Municipal Service Managers (CMSMs) and District Social Service Administration Boards (DSSABs), Ontario Homes for Special Needs

Association (OHSNA), Habitat Services, and the tenants' association. Throughout the course of the project, the PAC convened periodically to discuss and provide feedback to the research team concerning the survey instrument, methods and process, deliverables, and knowledge transfer.

Sampling Methods – Selection of CMSMs

There are 25 CMSMs in the province of Ontario that house approximately 4,700 Domiciliary Hostel funded tenants. Individuals were surveyed in 8 CMSMs which account for about 4,000 program beds (about 85% of all beds in the province) **(Figure 1)**. The remaining 17 CMSMs account for only about 700 Domiciliary Hostel Program beds (about 15% of all beds in the province). This selective sampling strategy was adopted to reduce the logistical difficulties and high costs that would have resulted from recruiting participants in all CMSMs. **Table 1** shows the distribution of Domiciliary Hostel Program beds in the 8 CMSMs that were selected for the survey, as well as the 5 Local Health Integration Networks (LHINs) corresponding to these CMSMs. Note that the terms "Domiciliary Hostel" and "hostel" are used interchangeably throughout this report.

Figure 1. Domiciliary Hostel Distribution in Ontario.



Source: Community Services Branch, 2007 Information Policy & Integration Unit, Policy Research & Analysis Branch – MCSS.

Table 1. Distribution of Domiciliary Hostel Program beds in CMSMs selected for Survey.

LHIN	REGION	CMSM	No. of Beds*
1 – Erie St. Clair	South West	Windsor	355
		Essex County	242
3 – Waterloo Wellington	Central West	Waterloo	341
4 – Hamilton Niagara Haldimand Brant	Hamilton/Niagara	Hamilton	1045
8 – Central	Central East	York Region	404
11 – Champlain	Eastern	Ottawa	848
		Prescott-Russell	461
		Cornwall	265
All		All	4,024

*Data on number of beds provided by Ontario MCSS in December 2007.

Sampling Methods – Sample Size

For this descriptive study, the total sample size of 250 participants was selected based on multiple considerations, including face validity, desired confidence intervals around key variables, and resource and time constraints.

Confidence intervals for key variables can be determined for this sample size. For example, if the prevalence of mental illness among participants is estimated to be in the range of 50-75%, a sample size of 250 provides a 95% confidence interval of ±6%. The 95% confidence interval is the "margin of error" for the estimate, 19 times out of 20.

Note that this calculation assumes zero correlation among multiple individuals sampled at a single Domiciliary Hostel (i.e., individuals at a single hostel are presumed to have the same degree of variability as individuals across all hostels in that CMSM). Since some degree of correlation is expected (i.e., individuals who share similar characteristics may tend to cluster at specific hostels), the effective sample size may be somewhat reduced, and the actual 95% confidence intervals may be slightly wider than those shown.

Sampling Methods – Selection of Domiciliary Hostels

MCSS provided a database of all Domiciliary Hostel Program facilities and the capacity of each facility. The survey sample was stratified by CMSM. After consultation with the PAC, it was decided that sampling from a total of 50 Domiciliary Hostels would succeed in capturing variability within the system, while remaining within the time and resource constraints for the study. As a result, the study sought to enrol 5 individuals at each of approximately 50 Domiciliary Hostels, for a total sample of 250 participants.

The number of individuals recruited in each CMSM was proportionate to the number of Domiciliary Hostel beds in that CMSM. For example, the Windsor CMSM had 355 Domiciliary Hostel beds, which represented 9% of the total of 4,024 beds across the 8 CMSMs in the study. Thus, approximately 9% of study participants were recruited in the Windsor CMSM.

Within each CMSM, the probability of a specific Domiciliary Hostel being selected as a study site was proportionate to the number of Domiciliary Hostel funded beds it contained. Thus, larger Domiciliary Hostels had a higher probability of being selected than smaller Domiciliary Hostels. Note that the study sought to recruit 5 individuals at each selected site, regardless of the size of the site. In cases where a selected site had fewer than 5 Domiciliary Hostel funded beds, an additional site in that CMSM was randomly selected to ensure proportionate representation of the CMSM in the overall sample.

MOHLTC and MCSS sent an introductory letter to all Domiciliary Hostels within the 8 CMSMs informing them of the study. Each CMSM then sent letters of notification to the Domiciliary Hostels that had been selected for participation in the study. The research team then telephoned the operators of these sites to obtain permission to recruit participants at their facility. At least 4 attempts were made to contact each operator. In the event of a refusal, an alternate site within the same CMSM was selected.

Sampling Methods – Selection of Domiciliary Hostel Tenants

Upon arriving at a site, the research team and Domiciliary Hostel staff worked together to locate 5 eligible and willing study participants. Random selection of individuals at each site was accomplished using a list of random numbers. Most sites had a mix of privately-funded and Domiciliary Hostel MCSS per-diem program-funded tenants, but only Domiciliary Hostel MCSS per-diem program-funded tenants were eligible for selection. Throughout the selection process, measures were taken to ensure the confidentiality of all tenants at each site.

After potential participants were randomly selected, those individuals who were present at the site during the recruitment visit were approached to determine their eligibility and interest in participating in the study. Bilingual research team members approached and interviewed individuals whose preferred language was French. Potential participants were given a brief description of the study. This description included the purpose of the study, nature and time length of the survey, and reimbursement amount. Potential participants were deemed ineligible if they had severely impaired mental capacity or were unable to participate in the informed consent process. If the selected tenant was not present at the time of recruitment (e.g., due to a doctor's appointment or participation in a day program), another tenant was randomly selected.

Survey Instrument

The survey instrument was designed to be administered using pen-and-paper and constructed in English by the research team in consultation with the PAC. Items were drawn based upon the research team's large experience of conducting similar surveys with homeless and vulnerably housed individuals. Whenever possible, items were obtained from previously validated instruments. The survey instrument was pilot tested with 12 participants at Habitat Services in Toronto[2] and revised to improve flow and ease of administration, and reduce burden on the participants. Approval for the minor modifications was provided by PAC and OMHF.

The survey and consent form were translated to French by a professional translation service after careful review of different companies offering translation service. The back-translation was carried out independent of the translation service by two CRICH bilingual Research Assistants. The survey was administered in English or French, according to each participant's language preference. **Table 2** outlines the domains for the questionnaire and the data sources from which the questions were obtained. The full questionnaire is displayed in Appendix 1.

Table 2. Questionnaire Domains and Data Sources.

Domains	**Source**
1. Demographics	• Adapted from National Survey of Homeless Assistance Providers and Clients (NSHAPC); Statistics Canada; Census Canada; and other additions
2. Physical and mental health status	• Short Form Health Survey (SF-12)
3. Heath conditions	• Adapted from NSHAPC; and Street Health Survey 1992
4. Disabilities	• Research team and Project Advisory Committee (PAC)
5. Quality of life	• Euroqol Health Sates-5D (EQ-5D) and Visual Analog Scale (VAS)
6. Mental health diagnoses	• MCSS database; adapted from DSM-IV

[2] There are no Domiciliary Hostels in Toronto. Pilot tests were conducted at two Habitat Services sites in Toronto as it provided the research team with the opportunity to interview a group comparable to Domiciliary Hostel residents. Habitat Services provides housing to tenants with serious mental health conditions in the private sector board and care settings.

7. Health care utilization	• Adapted from Behavioral Risk Factor Surveillance System (BRFSS) 2000; Street Health Survey 1992; NSHAPC; and other additions
8. Access / Quality of care	• Canadian Community Health Survey (CCHS), Cycle 1.1; Commonwealth Fund Survey; adapted from Street Health Survey 1992; and other additions
9. Substance use	• Global Appraisal of Individual Needs (GAIN) – Substance Abuse and Dependence Scale
10. Community activities	• Ottawa Panel Study
11. Social supports	• Community Mental Health Evaluation Initiative (CMHEI) Social Support Scale
12. Personal choice	• Research team and PAC
13. Use of support services	• Ottawa Panel Study
14. Housing	• Research team and PAC
15. Housing Quality	• Toro's Housing Quality Instrument
16. Legal involvement	• Evangel Hall Study and other additions
17. Employment	• Research team and PAC
18. Interviewer's Observations	• Research team

Data Analysis

Interview data was entered and analyzed using SPSS 16.0. Descriptive statistical analyses were obtained for categorical, ordinal, and continuous variables. Crosstabulations were conducted to determine possible associations such as between physical and mental health status, community services/supports, and community activities, and major variables, including: age, facility size, duration of tenancy in current Domiciliary Hostel, serious mental health issues, developmental disabilities, and developmental, learning or other disabilities. Crosstabulations were also used to confirm selected self-reported conditions with provincial data on disability diagnoses. Meanwhile, correlation coefficients were obtained to determine the association between physical and mental health status and perceived housing quality.

Ethical Issues

This study was reviewed and approved by the St. Michael's Hospital Research Ethics Board.

In terms of risk and benefits, the main potential risk to participants was breach of confidentiality. The study posed no physical risks to participants. Potential psychological risks were considered unlikely and limited to possible psychological distress related to answering questions about sensitive topics such as substance abuse and mental illness. Participants were given the option to not answer specific questions if they so wished. The only direct benefit to study participants was a payment of $20. Given the time required to complete the survey and the lack of significant risk to participants, this payment was not felt to represent an undue influence on the informed consent process.

All study participants gave written informed consent to participate in the study. Interviewers spoke with each potential participant to explain the objectives of the study, what participation would entail, the kinds of questions that would be asked, the nature of planned data linkages to assess their use of health and social services, and the risks and benefits of the study. All individuals were informed that participation in the research study was completely voluntary, that they could change their mind about participating at any time, and that their decision regarding participation would not affect their housing or access to services. Potential participants were given a copy of the written consent form that fully described the study and provided contact information if they had any questions at a later date. If the interviewer was uncertain about the individual's capacity to provide informed consent, the interviewer assessed their capacity using a series of questions approved by the St. Michael's Hospital Research Ethics Board.

To ensure protection of confidentiality, interviewers were trained in the absolute necessity of confidentiality with respect to interviewing procedures and the handling of all data collected. Surveys took place in locations at each facility that were as private as possible. Each participant's name and other identifying information (such as date of birth and health card number) were recorded on a numbered form that was physically separate from the questionnaire data. Completed paper survey forms are stored in a locked file cabinet located at CRICH, access to which is restricted to authorized research personnel. Electronic survey data are stored on a secure server at St. Michael's Hospital and on encrypted data storage devices. Only authorized research personnel have access to these data.

The location and identity of Domiciliary Hostel Program facilities that were selected for the study are confidential. The results presented in this report are in aggregate form only; no individual-level or facility-level data are disclosed.

RESULTS

Domiciliary Hostel Recruitment

Between January and May of 2008, a total of 54 Domiciliary Hostels were recruited from Windsor, Essex County, Waterloo, Hamilton, York Region, Ottawa, Prescott-Russell, and Cornwall. This total of 54 sites includes 3 sites that were added to the

sample to compensate for other Domiciliary Hostels that participated in the study but had too few tenants to permit the recruitment of 5 individuals. The total of 54 sites also includes 2 sites that served as replacements for the 2 Domiciliary Hostels that were initially selected but declined to participate in the study. **Table 3** shows a breakdown of recruitment by CMSM.

Table 3. Recruitment by Region.

CMSM	No. of sites recruited	No. of participants recruited
Windsor	5	25
Essex County	4	17
Waterloo	4	20
Hamilton-Wentworth	14	65
York Region	6	26
Ottawa	11	55
Prescott-Russell	6	30
Cornwall	4	20
Totals	**54**	**258**

Of the 54 Domiciliary Hostels enrolled in the study, 33 sites reported having received letters of introduction from the MOHLTC and MCSS, 12 sites reported that they did not receive any letters, and 10 were unsure. Even though 22 of the selected hostels were unaware of the study when contacted by the research team, the site recruitment process was not hindered, as the majority of operators were willing to participate in the study after being provided with a description over the telephone.

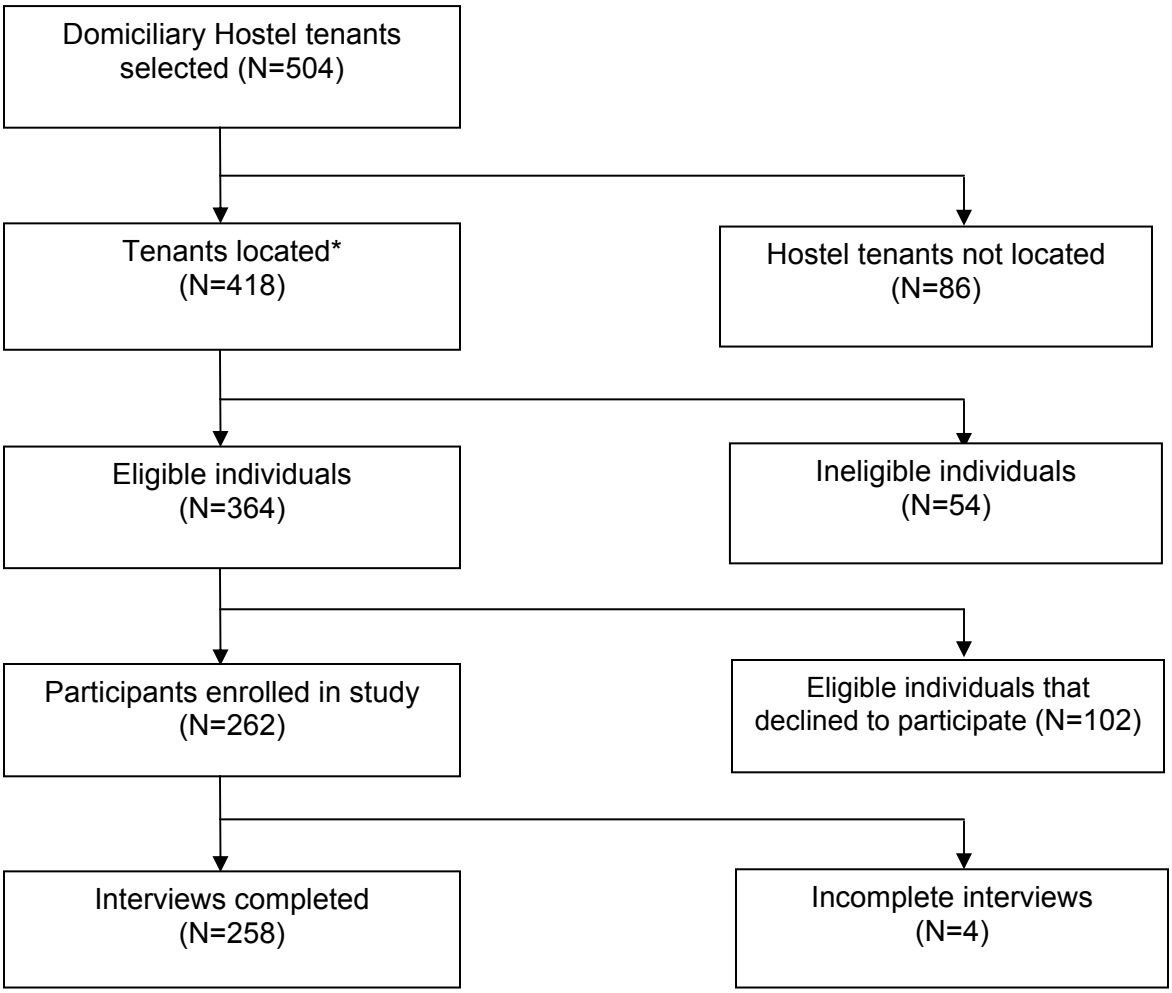
Telephoning site operators provoked a variety of responses. Some operators were cautious when contacted while others were actively interested in contributing to and being kept informed of the study results. Apprehension in some site operators was most often due to their presumption that the research team lacked an understanding of the severity of the mental health issues experienced by Domiciliary Hostel tenants. A concern for tenants' confidentiality was also a source of concerns. At all but 2 sites, a detailed description of the participant recruitment and interview process and a review of the research team's experience and training succeeded in providing reassurance to site operators and thus, enrolment of their Domiciliary Hostel in the study. A number of operators expressed keen interest in having their tenants interviewed and noted that having the research team interview tenants would bring change for the better at their facility and others within the same region.

Recruitment of Study Participants

After recruitment across 54 Domiciliary Hostels, 504 individuals were selected and an effort was made to find them. Of these individuals, 418 were actually located*. Only 364 of these individuals were eligible to participate in the study. Of the eligible individuals, 262 expressed interest in participating in the study and were able to give

written informed consent. Four of these individuals were unable to complete the interview process, and a total of 258 individuals successfully completed the survey. Thus, the study enrolled 258 of 418 (62%) of all tenants who were located, and 258 of 364 (71%) of the individuals who were located and eligible to participate in the study. Recruitment rates were comparable from region to region **(Figure 2 and Table 4)**.

Figure 2. Flow chart of Participant Recruitment.



*Tenants were present at the Domiciliary Hostel on the days the interviews were being conducted.

Table 4. Participant Response Rates by CMSM.

CMSM	N (%)† Located	N (%)* Eligible	N (%)* Enrolled and Completed
Windsor	36 (92)	32 (89)	25 (69)
Essex County	29 (88)	25 (86)	17 (59)
Waterloo	31 (82)	26 (84)	20 (65)
Hamilton-Wentworth	105 (80)	93 (89)	65 (63)
York	46 (85)	40 (87)	26 (59)
Ottawa	99 (81)	88 (89)	55 (57)
Prescott-Russell	44 (88)	36 (82)	30 (68)
Cornwall	28 (78)	24 (86)	20 (75)
Totals	**418 (83)**	**364 (87)**	**258 (62)**

† Percent of those individuals originally selected
* Percent of those individuals actually located

Of the ineligible candidates (N=54), the majority were deemed so due to their inability to engage in conversation appropriately (N=45). A more precise reason could not be determined as proper assessment of these individuals would have required consent. The remaining ineligible individuals were excluded due to language barriers (N=5), inability to participate based on physical illness (N=2), or hearing impairment (N=2). The original study protocol indicated that the research team would attempt to interview individuals who were hearing impaired, but these 2 individuals were excluded by hostel staff and could not be further assessed by the research team.

At the majority of sites, hostel staff members were willing to work with the research team to select and locate potential participants for the study. In some cases, the research team was not able to directly approach selected individuals, as the hostel staff/operator insisted that they approach the individual first and determine their ability and willingness to participate in the study. The reasons most often cited by the hostel staff/operator for tenants' ineligibility or refusal were the tenant's mental health, impaired cognitive status, or disinterest. Occasionally, the research team was allowed to make contact with individuals that hostel staff had initially suggested were ineligible, and the research team found these individuals to be capable of completing the interview based on the flexibility and patience of the interviewers.

There were 102 individuals who declined to participate in the study. Of those, the most common reasons cited were lack of interest in and/or discomfort with taking part in the study (N=88). Almost half of the refusing participants (N=50) expressed their preference to not participate in the study directly to the site staff, without having any contact with the research team. This occurred because either the staff had spoken to tenants in advance and determined their interest in participating in the study, or they had spoken to them privately after they had been selected by the research team on the day of the interviews. In both cases, the staff requested that the research team not approach these tenants.

Four individuals agreed to participate in the study but were unable to complete the interview process. The reasons for their inability to complete the survey were lethargy and sickness, diminished attention span, lack of comfort, and/or lack of interest.

Response to the Interview Process from Study Participants

The overall response from participants to the interview process was positive. Many participants were initially hesitant based on concerns that the interview would be like a test, that they would not be able to answer the questions well enough, or that they would not feel comfortable with the interviewer. However, upon completion of the interview, most participants were much more relaxed and happy to have had someone to converse with.

The survey instrument took between 25 - 144 minutes to administer. The mean was 59 minutes, and the median was 55 minutes. One of the main difficulties for study participants was the duration of the interview. For many, focusing on the survey for one hour strained their attention and concentration. The process was both physically and mentally demanding, especially for the elderly participants. In some cases, multiple breaks and persistent encouragement was required to complete the interview.

Descriptive Statistics

Demographic Characteristics

As shown in **Table 5**, study participants were 59% male and 41% female. The mean age of the sample was 55 years, with 77% of participants being under the age of 65 years. Participants tended to be white (90%), single/never married (50%), and to not have completed high school (54%). The vast majority of participants were Canadian citizens (98%), and most (88%) had resided in Ontario for 20 years or more. English was the preferred communication language for 90% and French for 10%.

An overwhelming 96% of the participants were not currently working in a paid position, and 9% had never worked in their life. In their previous employment, participants tended to have engaged in low-skill jobs. The 6 most common types of previous work were general labour (e.g., cleaning, gardening, moving) (14%), machine operator/factory worker (13%), sales and services (e.g., housekeeping, janitor, hairdressing) (10%), occupations in the food and beverage services (9%), construction trades and landscaping (7%), and administrative or clerical occupations (7%). Among participants currently employed (4%), the mean number of hours worked per week was 8.5 hours, and the jobs were predominantly low-skill jobs. Current involvement in volunteer work was reported by 12% of the participants, and the mean number of volunteer hours per week was 7.8 hours. The most common types of volunteer work were cleaning and maintenance, helping at the Domiciliary Hostel, helping organizations/community centres, landscaping, and socializing with/escorting people.

A total of 198 (77%) participants indicated that they had an Ontario Disability Support Program (ODSP) or Ontario Works (OW) number. Although participants were not directly asked to name any of their other income sources, 33 participants who indicated they were not receiving ODSP or OW volunteered the information that they were recipients of a pension or other benefits. Of these individuals, 19 stated they were recipients of the Old Age Security (OAS) program, 11 were recipients of the Canada Pension Plan (CPP), and 3 were recipients of other programs, including Military Pension, Workplace Safety and Insurance Board (WSIB) and other insurance.

Concerning legal involvement, 8% of the participants had been arrested in the past 12 months. Among those who had any arrests, the mean number of arrests was 2. In the past 12 months, 5% of the participants had spent at least 1 night in jail. Among those who had spent any time in jail, the mean number of nights in jail was 19.4 nights. A total of 7% of the participants had been on parole or probation in the past 12 months, and 4% were currently living in a Domiciliary Hostel as a requirement of their parole or probation. Tenants who reported being diagnosed with any mental health issues (excluding substance abuse/dependence) were twice as likely to have been arrested in the past 12 months compared to those who did not report being diagnosed with any mental health issues (10% vs. 5%).

Table 5. Demographic Characteristics of Study Participants. Data are given as number (%), unless otherwise specified.

Characteristics	All participants (N=258)
Age, years, mean (SD)	55 (14.9)
Age	
< 29 years	13 (5)
30-39 years	22 (9)
40-49 years	47 (18)
50-59 years	89 (35)
60-69 years	47 (18)
70-79 years	23 (9)
≥80 years	17 (7)
Senior Status	
No (<65 years)	199 (77)
Yes (≥65 years)	59 (23)
Sex	
Male	151 (59)
Female	107 (41)
Length of stay in Ontario, years, mean (SD)	45.5 (20.2)
Length of stay in Ontario	
<10 years	10 (4)
10-19 years	21 (8)
20-29 years	30 (12)
30-39 years	31 (12)
40-49 years	38 (15)
50-59 years	64 (25)
60-69 years	30 (12)

70-79 years	17 (7)
≥80 years	12 (5)
Don't know	5 (2)
Language	
English	232 (90)
French	25 (10)
Other	1 (0)
Race/ethnicity	
White	233 (90)
Black	6 (2)
First Nations	8 (3)
Asian	4 (2)
Hispanic/Latin American	2 (1)
Other race/ethnicity	5 (2)
Citizenship Status	
Canadian Citizen	253 (98)
Landed immigrant	5 (2)
Marital status	
Single/never married	129 (50)
Divorced/separated	75 (29)
Married, including common law	24 (9)
Widowed	30 (12)
Education	
< Grade 4	12 (5)
Grade 5-8	42 (16)
Some high school, no diploma	85 (33)
High school or equiv.	53 (21)
Some college/university, but no degree	34 (13)
College/University graduate	20 (8)
Graduate/professional studies	3 (1)
Other	5 (2)
Don't know	4 (2)
Employment	
Not currently working in a paid position	248 (96)
# of years since participant last worked[3], mean (SD)	14.1 (11.7)
Previous type of work[4]	
Never worked	23 (9)
General labour (eg. cleaning, gardening, moving)	35 (14)
Machine operator/Factory worker	32 (13)
Sales and services (eg. housekeeping, janitor, hairdressing)	25 (10)
Chef and cook, occupations in the food and beverage services	23 (9)
Construction trades, landscaping, greenhouse worker	18 (7)
Administrative or clerical occupations	18 (7)
Trades (eg. mechanic, machinist, electrician, carpenter)	14 (6)
Retail (eg. sales clerk, cashier)	10 (4)
Occupations in protective services (security and police work)	8 (3)
Transport (people, food, and products)	6 (2)

Note: SD = standard deviation

[3] N=201. Excludes individuals currently working and individuals who have never worked.

[4] N=248. Excludes individuals currently working.

Childcare and home support workers	5 (2)
Nurses	5 (2)
Occupations in arts and culture	4 (2)
Assistant in health or education	3 (1)
Business, finance, law (professional/consultant)	3 (1)
Real estate sales	2 (1)
Teachers	1 (0)
Don't know	5 (2)
Missing	8 (3)
Currently working in a paid position	10 (4)
Number of hours working per week[5], mean (SD)	8.5 (6.1)
Type of work	
Nursing	1(0)
Administrative work at a hospital	1(0)
Teaching music	1(0)
Painting/Contracting	1(0)
Babysitting	1(0)
Washing dishes, arranging flowers	1(0)
Delivering papers	1(0)
General labour	1(0)
Looking after people	1(0)
Arranging chairs	1(0)
Volunteer work	
Currently involved in volunteer work	31 (12)
# of volunteer hours per week[6], mean (SD)	7.8 (7.9)
Type of volunteer work	
Cleaning/janitorial/maintenance	6 (2)
Helping at the Domiciliary Hostel	6 (2)
Helping organizations/community centres	4 (2)
Landscaping or watering flowers	4 (2)
Socializing with/escorting people	4 (2)
Helping friends/hairdresser/sponsored events	3 (1)
Clerical/library	2 (1)
Hospitality help	1 (0)
Don't know	1 (0)
Ontario Disability Support Program (ODSP) or Ontario Works (OW)	
Indicated had an ODSP or OW number	198 (77)
Legal involvement	
Been arrested in the past 12 months	21 (8)
# of times arrested in the past 12 months[7], mean (SD)	2 (2.3)
Spent any nights in jail in the past 12 months	12 (5)
# of nights spent in jail in the past 12 months[8], mean (SD)	19.4 (44.4)
Have been on parole or probation in the past 12 months	17 (7)
Living in a Domiciliary Hostel is a requirement of participant's parole or probation	10 (4)

[5] N=10. Among those currently working in a paid position.
[6] N=31. Among those currently involved in volunteer work.
[7] N=21. Among those with any arrests in the past 12 months.
[8] N=12. Among those who spent any nights in jail in the past 12 months.

i. Physical Health Conditions and Physical Disabilities

Participants were asked whether they had any of 21 physical health conditions, which were classified into 10 systems or categories: cardiovascular, respiratory, endocrine, gastrointestinal/liver, infectious, hematologic, neurological, musculoskeletal, skin, and other health conditions. An overwhelming 89% of the participants reported having at least one physical health condition. The 5 most common categories reported by participants were cardiovascular, respiratory, endocrine, neurological, and musculoskeletal. The most commonly reported physical health conditions were arthritis/rheumatism/joint problems (45%), difficulty walking (45%), high blood pressure (34%), diabetes (25%), asthma (20%), chronic bronchitis/emphysema (19%), epilepsy/seizures (16%), anemia (14%), heart attack (14%), skin disease (13%), and stroke (12%) **(Table 6)**.

In terms of impairments and other disabilities, 19% reported a visual impairment, 18% reported a hearing impairment, 2% had an amputation, and 4% had other physical disabilities. The use of assistive devices was quite high among the participants with 20% using a walker, 18% a cane, 5% a wheelchair, 5% a hearing aid, and 4% a motorized wheelchair or scooter.

ii. Developmental Disabilities, Learning Disabilities, and Head Injury

Participants were questioned whether they were diagnosed with any developmental disabilities, which included developmental disability or fetal alcohol effects/fetal alcohol syndrome (FAE/FAS). A total of 21% participants reported having any developmental disabilities **(Table 6)**.[9] Meanwhile, 30% of the participants reported being diagnosed with any of the following developmental, learning or other disabilities: developmental disability, attention deficit disorder (ADD), dyslexia, FAE/FAS, and cerebral palsy. The prevalence of a history suggestive of possible developmental or learning disabilities was relatively high, with 33% reporting they attended special education classes, 39% who had repeated grades in school, 10% who were currently involved with the Association for Community Living, and 8% who indicated they had "other" types of learning disabilities. Meanwhile, 15% had suffered a head injury/acquired head injury.

iii. Diagnosed Mental Health Issues and Substance Use

Participants were asked if they were diagnosed with any of the following 11 mental health issues: generalized anxiety disorder, panic disorder, phobia, obsessive-compulsive disorder, post-traumatic stress disorder, depression/major depression, bipolar affective disorder/manic-depressive illness, manic disorder, schizophrenia, psychosis other than schizophrenia, personality disorder. The prevalence of any mental health issue was very high at 73% **(Table 6)**. A total of 28% of the participants reported one mental health issue, 14% reported two mental health issues, and 30%

[9] FAE/FAS is considered a type of developmental disability under the definition utilized by MCSS and the Developmental Services Branch. Throughout the rest of this report, the term "developmental disabilities" refers to the self-reported presence of a developmental disability and/or FAE/FAS.

reported 3 or more mental health issues. The 6 most common mental health issues were depression/major depression (41%), schizophrenia (37%), generalized anxiety disorder (24%), bipolar disorder/manic-depressive (21%), panic disorder (15%), and personality disorder (15%). We defined a group of 4 "serious mental health issues", consisting of schizophrenia, psychosis other than schizophrenia, bipolar affective disorder (manic-depressive illness), and manic disorder, which tend to be persistent and disabling. The prevalence of a serious mental health issue was 52%. The vast majority of participants with serious mental health issues (95%) had a psychiatrist who they saw regularly and/or a family doctor.

A diagnosis of substance abuse/dependence over their lifetime was reported by 19% of the participants. The majority of study participants (64%) reported no use of any alcohol or drugs in the last 3 years. Meanwhile, 92 (36%) participants reported that they had used alcohol or drugs at least once in the last 3 years. It is important to note that this study did not attempt to differentiate among the use of alcohol only, the use of drugs only, and the use of both alcohol and drugs.

The Global Appraisal of Individual Needs (GAIN) is an instrument designed to help clinicians and researchers make diagnostic impressions about participants based on the American Psychiatric Association's (APA) Diagnostic and Statistics Manual of Mental Disorders criteria (DSM-IV-TR, 2000). The GAIN was administered to participants who reported any use of alcohol and/or drugs in the last 3 years.[ii] One of the 8 core sections of the GAIN focuses on substance use, and this section contains 17 questions related to how alcohol and drug use may have affected the participant's life. According to the GAIN, "substance dependence" is defined as when "the individual's body has been physiologically changed… [and] the individual is losing control of his/her own body and behaviors and responsibilities.… [Dependence suggests] the need for treatment and the high likelihood of relapse in response to physiological conditions (e.g., withdrawal, cravings) and environmental cues (e.g., classical conditioning or situations that trigger cravings".[ii]

The GAIN substance dependence score for the past year was calculated for the 36% of participants who had used any alcohol and/or drugs in the past 3 years. Individuals were classified as having no/low dependence, moderate dependence, or high dependence on the basis of their GAIN score. It is important to note that the "no/low dependence" category includes individuals who used minimal amounts of substances (e.g., alcohol) and had no evidence of substance dependence, as well as individuals with relatively mild substance dependence. Among all study participants, 23% were classified as having no/low substance dependence in the past year, 8% were classified as having moderate substance dependence, and 5% were classified as having as high substance dependence.

iv. Developmental Disabilities, Mental Health Issues, and Substance Abuse/Dependence

A total of 19% of the participants had self-reported both developmental disabilities and at least one diagnosed mental health issue, excluding substance abuse/dependence.

Meanwhile, 17% of the participants had self-reported both a diagnosed mental health issue and substance abuse/dependence.

v. SF-12 Physical and Mental Component Subscale scores

The SF-12 is a validated health status instrument used to generate Physical Component subscale (PCS) and Mental Component subscale (MCS) scores.[iii] The instrument consists of 12 items which measure physical functioning, role limitations due to physical health conditions, bodily pain, general health, vitality (energy/fatigue), social functioning, role limitations due to emotional problems and psychological distress and psychological well being. The scores range continuously from 0 (worst) to 100 (best), standardized to a mean of 50 and standard deviation of 10 in the U.S. general population.[iv,10] Domiciliary Hostel tenants tended to have poorer physical health status (PCS score: 45.5) and poorer mental health status (MCS score: 42.5) than the U.S. general population. These differences were not extremely large, as the mean scores of hostel tenants were within 1 standard deviation of the population mean.

iv. Quality of life

The EQ-5D is a standardized health related quality of life measure which consists of two parts. The first part measures health state or functional limitations and contains the five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression.[v] Each dimension has three possible levels which include "no problems", "some problems" and "extreme problems", and participants were asked to select one level reflecting their "own health state today" for each of the five dimensions. Compared to the Canadian population,[vi] Domiciliary Hostel tenants were substantially more likely to report experiencing at least some problems (some problems or extreme problems) for all five dimensions: pain/discomfort (38% vs. 57%), anxiety/depression (30% vs. 48%), mobility (16% vs. 46%), usual activities (14% vs. 40%), and self-care (2% vs. 27%) **(Table 7)**.[11] A single EQ-5D summary index was also calculated by applying a formula that attaches weights to each of the levels in each of the dimensions. The possible EQ-5D index scores range from 0.0 (death) to 1.0 (perfect health). The scoring algorithm was derived based on the valuation of EQ-5D health states from general U.S. population samples[vii]. The mean EQ-5D summary index score among participants was 0.74 **(Table 6)**.

The second part consists of the EQ Visual Analog score (VAS), which generates a global self-rating of health-related quality of life on the day of the interview. A value of 0 represents the worst imaginable state and 100 the best imaginable state.[v] The

[10] Normalized data on the general Canadian population are not available.
[11] Normalized data on the general U.S population are not available. In order to derive normalized data for Canada, the demographic characteristics were standardized based on a European population structure enabling EuroQoL Group, the developers of this instrument, to compare results among 15 countries.

mean EQ-VAS score among the participants was 68.9, which is 11 points lower than the mean EQ-VAS score derived for the Canadian population (80.4)[11] **(Table 6)**.

Table 6. Health Conditions and Status, Quality of Life, and Substance Use. Data are given as numbers (%), unless otherwise specified.

	All participants (N=258)
Physical Health Conditions	
Any Physical Health Condition[12]	229 (89)
Cardiovascular	
High blood pressure	88 (34)
Angina	21 (8)
Heart attack	37 (14)
Congestive heart failure	11 (4)
Heart disease	25 (10)
Respiratory	
Asthma	52 (20)
Chronic Bronchitis/emphysema	48 (19)
Endocrine	
Diabetes	64 (25)
Gastrointestinal/Liver	
Stomach/Intestinal ulcers	21 (8)
Hepatitis	19 (7)
Hepatitis B	4 (1)
Hepatitis C	14 (5)
Cirrhosis	11 (4)
Infectious Diseases	
HIV infection/AIDS	4 (2)
Sexually transmitted diseases (STD)	3 (1)
Hematologic	
Anemia	37 (14)
Cancers	11 (4)
Brain	1 (0)
Breast	3 (1)
Hodgkins Disease	1 (0)
Intestinal	1 (0)
Lung	2 (1)
Oral	1 (0)
Prostate	1 (0)
Skin	1 (0)
Neurological	
Stroke	30 (12)
Epilepsy/Seizures	40 (16)
Musculo-skeletal	
Arthritis/rheumatism/joint problems	116 (45)

[12] Responded 'Yes' to any of the following: High blood pressure, Angina, Heart attack, Congestive heart failure, Heart disease, Asthma, Chronic Bronchitis/emphysema, Diabetes, Stomach/Intestinal ulcers, Hepatitis, Cirrhosis, HIV infection/AIDS, STD, Anemia, Cancer, Stroke, Epilepsy/Seizures, Arthritis/rheumatism/joint problems, Difficulty walking, Skin Disease, or Other Health Conditions.

Difficulty walking	117 (45)
Skin disease	33 (13)
Other health conditions[13]	81 (31)
Impairments and other Physical Disabilities	
Visual impairment (other than needing glasses)	49 (19)
Hearing impairment	46 (18)
Amputation	4 (2)
Other physical disability	9 (4)
Use of assistive Devices	
Walker	50 (20)
Cane	46 (18)
Wheelchair	14 (5)
Hearing aid	13 (5)
Motorized wheelchair/Scooter	9 (4)
Prosthetic limbs	1 (0)
Any Developmental, Learning or Other Disabilities	78 (30)
Developmental Disabilities[14]	55 (21)
Developmental Disability	49 (19)
Fetal Alcohol Effects (FAE)/Fetal Alcohol Syndrome (FAS)	9 (3)
Attention Deficit Disorder (ADD)	29 (11)
Dyslexia	11 (4)
Cerebral Palsy	7 (3)
Indicators of Possible Developmental or Learning Disabilities	
Attended Special Education classes	86 (33)
Repeated grades in school	100 (39)
Currently involved with the Association for Community Living	25 (10)
Other Learning Disability	21 (8)
Head Injury/Acquired Head Injury	39 (15)
Diagnosed Mental Health Issues (self-report)	
Have at least one Diagnosed Mental Health Issue (excluding Substance Abuse/Dependence)[15]	187 (73)
Have at least one Diagnosed Serious Mental Health Issue[16]	135 (52)
Anxiety Disorder	
Generalized Anxiety Disorder	62 (24)
Panic Disorder	39 (15)
Phobia	25 (10)
Obsessive-Compulsive Disorder	23 (9)
Post Traumatic Stress Disorder (PTSD)	21 (8)
Mood Disorders	
Depression/Major Depression	106 (41)
Bipolar Disorder/Manic-Depressive	54 (21)
Manic Disorder	22 (9)

[13] Included a wide variety of conditions such as Alzheimers, bad back, kidney problems, low blood pressure and sleep apnea.
[14] Responded 'Yes' to Developmental Disability and/or FAE/FAS.
[15] Responded 'Yes' to any of the following: Generalized Anxiety Disorder, Panic Disorder, Phobia, Obsessive-Compulsive Disorder, PTSD, Depression/Major Depression, Bipolar Disorder/Manic-Depressive, Manic Disorder, Schizophrenia, Psychosis other than Schizophrenia, or Personality Disorder.
[16] Responded 'Yes' to any of the following: Bipolar Disorder/Manic-Depressive, Manic Disorder, Schizophrenia, or Psychosis other than Schizophrenia.

Schizophrenia	94 (37)
Psychosis, other than Schizophrenia	17 (7)
Personality Disorder	38 (15)
Substance Abuse/Dependence (over lifetime)	49 (19)
Self-reported both Developmental Disabilities and at least one Diagnosed Mental Health Issue, excluding Substance Abuse/Dependence)	50 (19)
Substance (Alcohol and Drugs) Use and Problems	
Ever used alcohol or drugs in the last 3 years	92 (36)
Past year Substance Dependence Index (GAIN)	
No substance use	166 (64)
No/Low	58 (23)
Moderate	21 (8)
High	13 (5)
Self-Reported both a Diagnosed Mental Health Issue and Substance Abuse/Dependence	43 (17)
SF-12 Physical Component subscale, mean (SD)	45.5 (12.7)
SF-12 Mental Component subscale, mean (SD)	42.5 (9.5)
Quality of life	
EQ-5D Summary Index	0.74 (0.22)
EQ-Visual Analogue Scale (VAS) score, mean (SD)	68.9 (21.9)

Table 7. Comparison of Quality of Life (EQ-5D) Dimensions between the Canadian Population and Study Participants.

	Canadian population	All participants (N=258)		
Quality of Life (EQ-5D) dimensions	**With at least some problems* (%)**	**With at least some problems* (%)**	**With some problems (%)**	**With extreme problems (%)**
Pain/discomfort	38	57	45	11
Anxiety/depression	30	48	39	9
Mobility	16	46	45	1
Usual activities	14	40	34	6
Self-care	2	27	24	3

*Some problems + extreme problems

Health Care

The majority of the Domiciliary Hostel participants had a usual source of health care (87%) **(Table 8)**. This finding is comparable to the Canadian Community Health Survey (CCHS) 2007 data, where 85% of Canadians 12 years or older had a regular medical doctor.[viii] Among the 32 (12%) of participants who reported not having a usual source of health care, the two most common reasons were "seldom/never get sick" (N=10), and "don't use doctors/treat myself" (N=6). A total of 86% of the participants reported having a family doctor. Most (64%) of these individuals usually saw their family doctor at the doctor's office, and 38% usually had their family doctor visit them at the Domiciliary Hostel. A relatively large proportion of participants (40%) reported

they had a psychiatrist who they saw regularly. During the past 12 months, 62% of the participants had sought health care from a doctor's office, outpatient clinic, walk-in clinic or community health centre, 38% at a hospital emergency room, and 28% had been admitted to a hospital (excluding overnight emergency room stays). The mean number of visits to a doctor's office, outpatient clinic, walk-in clinic or community health centre was 7.5.

In the past 12 months, 96% of the participants had sought some type of health care. Their overall satisfaction with the way health care was provided during this period was high, with 81% expressing they were "very" or "somewhat satisfied". Participants' level of confidence that he/she could obtain good health care when needed was also high, with 88% indicating "very" or "somewhat confident".

A special diet for health reasons were followed by 76 (30%) of the participants, and the majority was able to obtain foods they are supposed to eat, always (N=35, 46% of those following a special diet) or often (N=12, 16% of those following a special diet). Among the 26 participants who were sometimes/rarely/never able to obtain foods they were supposed to eat, the majority were female (69%), under 65 years old (85%), residents of larger facilities (54%), and had resided in the current Domiciliary Hostel for >1 year (65%). These 26 participants had substantially lower physical health status (mean SF-12 PCS score: 37.3 vs. 45.5), health state (mean EQ-5D summary index: 0.60 vs. 0.74), self-rated health-related quality of life (51.7 vs. 68.9), and relatively similar mental health status (mean SF-12 MCS score: 41.4 vs. 42.5) compared to the total sample enrolled in the study.

Table 8. Health Care. Data are given as numbers (%), unless otherwise specified.

	All participants (N=258)
Usual source of health care	
Have a usual source of health care	
Yes	225 (87)
No	32 (12)
Don't know	1 (0)
Main reason do not have a usual source of health care[17]	
Seldom/Never get sick	10 (30)
Don't use doctors/Treat myself	6 (18)
Don't know where to go	2 (6)
No transportation	3 (9)
Have had bad experiences with doctors/Health care in the past	2 (6)
Other	8 (24)
Don't know/Refused	2 (6)
Family doctor	
Have a family doctor	222 (86)
Family doctor usually comes to see participant at Domiciliary Hostel[18]	85 (38)

[17] N= 33. Excluding those have a usual source of health care.
[18] N=222. Among those who have a family doctor.

Usually goes to see family doctor at doctor's office[18]	142 (64)
Psychiatrist	
Have a psychiatrist who is seen regularly	102 (40)
Health care in the past 12 months	
Received health care from a doctor's office, outpatient clinic, walk-in clinic, or community health centre	159 (62)
No. of visits in the past 12 months, mean (SD)	7.5 (10.4)
Received health care from a hospital emergency room	98 (38)
No. of visits in the past 12 months, mean (SD)	2.2 (1.5)
Received health care from a hospital (not including overnight emergency room stays)	72 (28)
No. of hospital admissions in the past 12 months, mean (SD)	2.0 (1.9)
Satisfaction and confidence	
Overall satisfaction with the way health care services have been provided to participant during the last 12 months	
Very satisfied	149 (58)
Somewhat satisfied	59 (23)
Neither satisfied nor dissatisfied	11 (4)
Somewhat dissatisfied	16 (6)
Very dissatisfied	12 (5)
Did not use health care services in the last 12 months	10 (4)
Confident that can easily obtain good health care when needed	
Very confident	149 (58)
Somewhat confident	77 (30)
Not too confident	24 (9)
Not confident at all	4 (2)
Don't know	3 (1)
Special diet and foods	
Follows a special diet for health reasons	
Yes	76 (30)
No	179 (70)
Don't know/Refused	3 (1)
How often able to obtain the foods supposed to eat[19]	
Always	35 (46)
Often	12 (16)
Sometimes	22 (29)
Rarely	2 (3)
Never	2 (3)
Missing	3 (4)

Support Services

A total of 41% of participants were accompanied during health visits. Among these participants, the most common accompanying persons identified included the Domiciliary Hostel staff/operator (37%), family/friends (35%), and professionals (19%) **(Table 9)**. An overwhelming 97% of the study participants took prescribed medications, of which 79% of these participants reported receiving help taking their

[19] N= 76. Among those who follow a special diet for health reasons.

medications. The two most common persons providing assistance were Domiciliary Hostel staff/operator (64%), and nurses working at the Domiciliary Hostel (32%).

A total of 43% of participants indicated they had a support worker who helped with accessing service. The term 'support worker' was not defined for tenants and therefore tenants may have included individuals such as Domiciliary Hostel staff who provided assistance in accessing services. Forty-three per cent of the tenants reported using some type of community services/supports in the past 12 months or during the period they had resided in the Domiciliary Hostel (if less than 12 months). Some participants used multiple services/supports. **Table 10** displays the 5 most commonly reported services and supports: mental health programs (14%), drop-in services (7%), religious services (6%), addiction services (5%), and activities offered on-site or off-site, such as arts and crafts, movies, bingo, social outings, and recreational activities such as bowling, exercising, and dancing (5%).

Of all the community services/supports participants reported they had used, 33% (54/162) were provided on-site at the Domiciliary Hostel. The most common services/supports provided on-site were: activities (57%), religious services (44%), other services/supports (38%), Assertive Community Treatment (33%), mental health programs (22%), and city social services[20] (20%) **(Table 10).**

Table 9. Support Services. All data are given as numbers (%).

	All participants (N = 258)
Accompaniment during health care visits	
Participant accompanied during health care visits	
No	150 (58)
Yes	105 (41)
Don't know	2 (1)
Person accompanying participant[21]	
Domiciliary Hostel staff/operator	39 (37)
Family/Friend	37 (35)
Professional	20 (19)
Other/Can't tell	9 (9)
Don't know	2 (2)
Missing	1 (1)
Prescribed medications	
Takes prescribed medications	249 (97)
Receives help taking medications[22]	
Yes	197 (79)
No	51 (20)

[20] 'City social services' was one of the various examples provided to the participants, and therefore participants did not elaborate further on the types of city social services.
[21] N=105. Excludes individuals not accompanied during health care visits.
[22] N=249. Among those taking prescribed medications.

Refused	1 (0)
Person assisting with medications[23]	
Domiciliary Hostel staff/operator	126 (64)
Nurse working at the Domiciliary Hostel	64 (32)
Other Professional	2 (1)
Family/Friend	1 (0)
Other/Can't tell	4 (2)
Has a support worker that helps with access to services	111 (43)
Community services and supports	
Used community services/supports in the past 12 months or during the period they had resided in the Domiciliary Hostel (if less than 12 months)	112 (43)

Table 10. Types of Community Services/Supports used by Participants[24].
All data are given as numbers (%).

Types of community services/supports	Used community services/supports (N=258)	Services/supports provided at the Domiciliary Hostel
Mental Health Programs	36 (14)	8 (22)
Drop-in Services	19 (7)	3 (16)
Religious Services	16 (6)	7 (44)
Activities	14 (5)	8 (57)
Addiction Services	13 (5)	0 (0)
City Social Services[20]	10 (4)	2 (20)
Services/Supports offered by the Domiciliary Hostel operator	9 (3)	9 (100)
Assertive Community Treatment	6 (2)	2 (33)
Other	39 (15)	15 (38)

Community Life

The Community Activities scale contains 13 questions, which measure the frequency with which individuals participate in activities such as visiting a shopping centre, a community centre, a place of worship, or participating in outdoor/indoor activities, or paid or volunteer work in the past 12 months or during the duration they had resided in the Domiciliary Hostel (if less than 12 months). Responses were scored on a scale from 0 (never) to 4 (very often) and missing responses were assigned a value of '0'. [25] To obtain an overall score, scores from each question were summed. The score ranged from 0 to 52, with higher scores reflecting greater integration in the community. Overall, participants demonstrated very low involvement in activities, with a mean score of 12.7 **(Table 11)**. The only activities that more than half of all participants reported engaging in sometimes, often, or very often were going for a walk (77%), going to a restaurant, bar, or coffee shop (62%), and going to a shopping centre or large shopping area (59%). Furthermore, more than three-quarters of the participants

[23] N=197. Among those receiving help taking medications.
[24] Some participants provided multiple responses.
[25] Fifteen missing responses were assigned a value of '0'.

had never or rarely attended a movie/concert/play, sports event, community centre, library, support group/drop-in centre, or participated in outdoor/indoor activities or paid/volunteer work. Barriers to involvement or participation in these activities were not assessed as part of this study.

Participants who indicated they had been involved in each of the community activities 'sometimes', 'often' or 'very often' in the past 12 months or during the duration they had resided in the Domiciliary Hostel (if less than 12 months) were asked if they did the activity with help from Domiciliary Hostel staff, someone else, or without any help. **Table 11** displays that the most common activities for which Domiciliary Hostel staff provided assistance included: visiting a shopping centre/large shopping area (N=28), restaurant/bar/coffee shop (N=21), participating in outdoor/indoor activities (N=18), visiting a barber/beauty salon (N=14), and a movie/concert/play (N=11).

Table 11. Community Activities. Data are given as numbers (%), unless otherwise specified.

	All participants (N=258)	**Activities that are done with help from Domiciliary Hostel staff[26] N**
Community Activities		
Community Activities Score, mean (SD)	12.7 (7.3)	--
Involvement in community activities in the past 12 months or during the duration they had resided in the Domiciliary Hostel (if less than 12 months)		
Gone to a shopping centre/large shopping area		
Never/Rarely	106 (41)	--
Sometimes/Often/Very Often	152 (59)	28
Attended a movie/concert/play		
Never/Rarely	220 (85)	--
Sometimes/Often/Very Often	38 (14)	11
Gone to a sports event		
Never/Rarely	240 (93)	--
Sometimes/Often/Very Often	16 (6)	5
Participated in outdoor/indoor activities		
Never/Rarely	202 (78)	--
Sometimes/Often/Very Often	55 (21)	18
Visited a park/museum		
Never/Rarely	182 (71)	--
Sometimes/Often/Very Often	75 (29)	11
Gone to a restaurant/bar/coffee shop		
Never/Rarely	98 (38)	--
Sometimes/Often/Very Often	159 (62)	21
Gone to a community centre		

[26] Asked only of participants who responded 'sometimes', 'often' or 'very often'. Includes individuals who received help from Domiciliary Hostel staff exclusively or in combination with other individuals.

Never/Rarely	220 (85)	--
Sometimes/Often/Very Often	36 (14)	4
Gone to church/place of worship		
Never/Rarely	187 (72)	--
Sometimes/Often/Very Often	71 (28)	4
Gone for a walk		
Never/Rarely	59 (23)	--
Sometimes/Often/Very Often	198 (77)	8
Participated in work (paid/unpaid)		
Never/Rarely	195 (76)	--
Sometimes/Often/Very Often	62 (24)	8
Gone to a library		
Never/Rarely	210 (81)	--
Sometimes/Often/Very Often	47 (18)	5
Gone to a barber/beauty salon		
Never/Rarely	168 (65)	--
Sometimes/Often/Very Often	88 (34)	14
Gone to a support group/drop-in centre		
Never/Rarely	219 (85)	--
Sometimes/Often/Very Often	35 (14)	5

Personal Choice and Social Supports

The majority of participants felt that they were provided with choices while living at their Domiciliary Hostel. More than three-quarters of the participants felt they had a choice related to finances (how to spend their money), and bedtimes, and felt able to register complaints about the hostel with hostel staff, and disagree with the hostel staff **(Table 12)**. Issues with which participants had the least amount of choice included registering complaints about the hostel with someone other than hostel staff, holding of regular house meetings where tenants could voice their concerns and feelings, and meal times.

The Community Mental Health Evaluation Initiative (CMHEI) Social Support Scale contains eight questions pertaining to help, safety, security and happiness, trust receiving advice, comfort talking about problems, intimacy, reliance during emergencies, providing support to friends and/or family, and disagreements with family. Participants were asked to respond to each question on a scale from 0 (strongly agree) to 4 (strongly disagree). The overall score was calculated by adding scores from each question. If missing responses were present for 1-4 questions, a value of 1.5 was assumed for unanswered questions. When missing responses were present for more than 4 questions, the score was identified as missing.[27] Overall scores could range from 0 to 24, with higher scores reflecting greater perceived support. Participants had a mean CMHEI Social Support score of 16.1. For seven of the eight questions, 75% of the participants indicated they had someone they could count on, trust, or feel comfortable with. The dimension where the weakest support was apparent was the feeling of intimacy with another person, with only 42% agreeing or strongly agreeing.

[27] Sixteen responses were assigned a value of '1.5', and 1 score was identified as missing.

Most participants (80%) had people with whom they could feel at ease with and talk to. These participants identified multiple individuals, and the responses included friends (75%), family (72%), Domiciliary Hostel staff/operator (68%), caregivers (48%), spiritual leaders (28%), boyfriend/girlfriend/partner (25%), and other (3%). During the past month, 77% of the participants had been in contact with close friends at least once or twice, of which all lived in the same building for 25%, all lived elsewhere for 33%, and some lived in the same building and some lived elsewhere for 43%. During the past month, 75% of the participants had been in contact with family members at least once, and 24% had not been in touch at all.

Table 12. Personal Choice and Social Supports. Data are given as numbers (%), unless otherwise specified.

	All participants (N=258)
Personal choice	
Have a choice about how to spend own money	204 (79)
Have a choice about waking up and going to bed	202 (78)
There is someone who works at the Domiciliary Hostel with whom complaints or problems about the hostel can be registered with	201 (78)
Have a choice on whether benefits or social assistance cheques go directly to the Domiciliary Hostel operator	196(76)
Has ability to disagree with staff who work at the Domiciliary Hostel	196 (76)
There is someone outside the Domiciliary Hostel with whom complaints or problems about the hostel can be registered with	144 (56)
Regular house meetings are held at the Domiciliary Hostel so that concerns, feelings and opinions can be voiced	120 (47)
Have a choice about when to eat meals	57 (22)
Social supports	
CMHEI Social Support Score, mean (SD)	16.1 (4.0)
"If something went wrong, no one would help me"	
Strongly Agree/Agree	56 (22)
Disagree/Strongly Disagree	202 (78)
"I have family and friends who help me feel safe, secure, and happy	
Strongly Agree/Agree	199 (77)
Disagree/Strongly Disagree	56 (22)
"There is someone I trust whom I could turn for advice if I were having problems"	
Strongly Agree/Agree	215 (84)
Disagree/Strongly Disagree	41 (16)
"There is no one I feel comfortable talking about problems with"	
Strongly Agree/Agree	70 (27)
Disagree/Strongly Disagree	184 (72)
"I lack a feeling of intimacy with another person"	
Strongly Agree/Agree	108 (42)
Disagree/Strongly Disagree	144 (56)
"There are other people I can count on in a emergency"	

Strongly Agree/Agree	230 (89)
Disagree/Strongly Disagree	26 (10)
"I provide support to my friends and/or my family"	
Strongly Agree/Agree	201 (78)
Disagree/Strongly Disagree	55 (22)
"I have a lot of serious disagreements and arguments with my family"	
Strongly Agree/Agree	56 (22)
Disagree/Strongly Disagree	199 (77)
Has people with whom participant feels at ease and can talk to about personal issues	
Yes	207 (80)
No	50 (19)
Don't know	1 (0)
Person participant feels at ease and can talk to about personal issues[28]	
Friends	155 (75)
Family	149 (72)
Domiciliary Hostel staff/operator	141 (68)
Care providers	100 (48)
Spiritual leaders	58 (28)
Boyfriend/Girlfriend/Partner	52 (25)
Other	7 (3)
Been in contact with close friends during the past month[28]	
Not at all	44 (21)
Once or twice	52 (25)
Once a week	36 (17)
Several times a week	72 (35)
Don't know/Refused	3 (1)
Of the close friends whom participant has been in contact with during the past month,[29]	
Some live in the same building and some live elsewhere	68 (43)
All live elsewhere	52 (33)
All live in the same building	40 (25)
During the past month, how often participant has been in contact with anyone in his/her family[28]	
Not at all	49 (24)
Once or twice	52 (25)
Once a week	52 (25)
Several times a week	52 (25)
Don't know/Refused	2 (1

Housing

Participants tended to be stably housed. Most participants had been tenants in the current Domiciliary Hostel for at least 1 year (69%) and the average duration of tenancy was 5.1 years. The average length of stay at participants' previous residence

[28] N=207. Excludes individuals reporting they do not have a person they feel at ease and can talk to about personal issues.
[29] N=160. Excludes individuals reporting no contact with their close friends during the past month.

was 7.9 years **(Table 13)**. The most common types of residences that participants had lived in just prior to their current Domiciliary Hostel were their own/family house (28%), an apartment (28%), and another Domiciliary Hostel (17%). A total of 35% of the participants had ever been homeless in their lifetime. Among these individuals the mean number of years since they had been homeless was 10.2 years, and the range was 2 months - 50 years. Referral to their current Domiciliary Hostel came primarily through a social/case/shelter worker or other community agency (25%), friend/family (22%), doctor/other health provider/ACT/social worker at hospital (15%), hospital (12%), or previous/current Domiciliary Hostel operator/staff (11%).

A total of 46% of participants felt that living at the current hostel had no effect on their health, whereas 37% felt it had a positive effect, 7% felt it had a negative effect, and 9% felt it had both a positive and a negative effect. Most participants (87%) liked aspects about living at the hostel. The main positive aspects included the food, tenants, friendly staff, activities offered, friendly people, atmosphere/environment, freedom, and human contact. In contrast, 48% of participants disliked aspects about the hostel. The common aspects included the tenants, food or size of portion, lack of freedom, lack of discipline, conflict among tenants and harassment, uncaring and unfriendly staff, noisy/crowded/living in groups, and the structured environment/rules.

Toro's Housing Quality Scale measures 6 dimensions of housing quality: comfort, safety, spaciousness, privacy, friendliness, and overall quality. Responses were scored on a 7-point scale ranging from 1 (very bad) to 7 (very good), including a middle option of 4 (neither good nor bad). The overall score was calculated by adding scores from each question. When missing responses were present for 1-3 questions, a value of 4 was assumed. [30] Overall scores range from 6 to 42, with higher scores signifying higher level of perceived housing quality. Participants had a relatively high Housing Quality score with a mean of 33.8. On a normalized scale of 0 (worst) to 100 (best), this would represent a score of 77. The means for the six dimensions ranged from 5.1 to 5.8, where 5 represents "somewhat good".

Table 13. Housing. Data are given as numbers (%), unless otherwise specified.

	All participants (N=258)
Duration of tenancy in current Domiciliary Hostel, years, mean (SD)	5.1 (5.9)
≤ 1 year	69 (27)
> 1 year and ≤ 2 years	40 (16)
> 2 years and ≤ 3 years	33 (13)
> 3 years and ≤ 4 years	16 (6)
> 4 years and ≤ 5 years	11 (4)
> 5 years and ≤ 6 years	9 (3)
> 6 years and ≤ 7 years	13 (5)
> 7 year and ≤ 8 years	8 (3)
> 8 year and ≤ 9 years	2 (0)
≥ 9 years and ≤ 10 years	8 (3)

[30] Seven missing responses were assigned a value of '4'.

≥ 10 years	40 (16)
Don't know	9 (4)
Length of stay at previous residence, years, mean (SD)	7.9 (11.1)
Previous residence type	
Own/Family house	73 (28)
Apartment	71 (28)
Another Domiciliary Hostel	45 (17)
Rooming/Boarding house	17 (7)
Psychiatric hospital	12 (5)
Homeless	10 (4)
Group/Foster home	8 (3)
Temporary stay with family/friends	7 (3)
Nursing Retirement home	6 (2)
Medical hospital	6 (2)
Motel/Hotel	1 (0)
Other/Don't know	2 (1)
Ever been homelessness	90 (35)
# of years ago participant was homeless, mean (SD)	10.2 (10.6)
Person who referred participant to this Domiciliary Hostel	
Social/Case/Shelter Worker or other community agency not associated with the hospital	64 (25)
Friend/Family	57 (22)
Doctor/Other Health Provider/ACT/Social worker at hospital	39 (15)
Hospital	31 (12)
Previous/Current Domiciliary Hostel operator/staff	28 (11)
Myself/Nobody	16 (6)
Other/Unknown/Refused	23 (9)
Feels that living at current Domiciliary Hostel had has an effect on his/her health	
No effect	119 (46)
Positive effect	96 (37)
Both Positive and Negative effect	22 (9)
Negative effect	18 (7)
Don't know/Missing	3 (1)
Likes things about living at this Domiciliary Hostel	225 (87)
Things participants likes about living at this Domiciliary Hostel[31]	
Food/meals	63 (28)
Tenants (eg. good people, friends)	42 (19)
Friendly staff	40 (18)
Activities/recreation offered	32 (14)
Friendly people	29 (13)
Atmosphere/environment	28 (12)
Freedom	24 (11)
Human contact	20 (9)
Everything	20 (9)
Location	12 (5)
Assistance with daily living	11 (5)
Privacy	11 (5)

[31] N=225. Excludes individuals who did not like things about living at current Domiciliary Hostel, Don't know and Missing. Some participants provided multiple responses.

Structured environment (eg. set meal or sleep times)	10 (4)
Room amenities/layout	10 (4)
Having shelter	10 (4)
Support/advice from staff	9 (4)
Cleanliness	9 (4)
Quiet	8 (4)
Going for walks/exercise	7 (3)
Dispensing of medications	6 (3)
Nurses	4 (2)
Security/safety	3 (1)
Domiciliary Hostel layout	3 (1)
Accessibility (ie. no stairs are good)	3 (1)
Smoking allowed	3 (1)
Women only environment	2 (1)
Affordability	1 (0)
Dislikes things about living at this Domiciliary Hostel	123 (48)
Things participants dislikes about living at this Domiciliary Hostel[32]	
Tenants	29 (24)
Food or size of portion	27 (22)
Lack of freedom	17 (14)
Lack of discipline/conflict among tenants/harassment	15 (12)
Staff (eg. uncaring, unfriendly)	14 (11)
Noisy/Crowded/Living in groups	12 (10)
Lack of privacy	11 (9)
Structured environment/rules and operation of hostel	9 (7)
Lack of activities/Boring environment	6 (5)
Feeling of isolation and loneliness	6 (2)
Control of finances	4 (3)
Demographics (too young)	4 (3)
Lack of quality health care	3 (2)
Controlled dispensing of medications	3 (2)
Physical environment (eg. lighting, temperature)	3 (2)
Location	2 (2)
Domiciliary Hostel layout	2 (2)
Cleanliness	2 (2)
Culture (ie. lack of multiculturalism, lack of interest in pets)	2 (2)
Lack of security/safety	1 (1)
Room layout	1 (1)
Don't know/Refused	3 (2)
Prefer to stay or move somewhere else	
Stay	163 (63)
Move somewhere else	85 (33)
Don't know	9 (4)
Refused	1 (0)
Plan to move out within the next 6 months[33]	
Yes	53 (56)
No	41 (43)

[32] N=123. Among those who disliked things about living at the current Domiciliary Hostel. Some participants provided multiple responses.
[33] N=95. Among those who responded would prefer to move elsewhere, Don't know or Refused.

Refused	1 (1)
Reason for not moving[34]	
Need support/Health services	12 (29)
Effort required to secure residence/lack of resources	7 (17)
Unappealing/Lack of alternative accommodation	6 (15)
Current accommodation is satisfactory	3 (7)
Depends on family/partner	3 (7)
Not allowed to move[35]	2 (5)
Lack of accessibility	1 (2)
Legal requirement	1 (2)
Undecided/Don't know	2 (5)
Missing	2 (5)
Perceived Housing Quality	
Toro's Housing Quality Score, mean (SD)	33.8 (6.5)
Rating of Domiciliary Hostel in terms of[36]:	
Comfort, mean (SD)	5.8 (1.4)
Safety, mean (SD)	5.8 (1.3)
Spaciousness, mean (SD)	5.5 (1.5)
Privacy, mean (SD)	5.1 (1.9)
Friendliness, mean (SD)	5.8 (1.4)
Overall quality, mean (SD)	5.8 (1.2)

Table 14 displays the self-reported reasons why participants moved from their previous residence. The most common responses were mental health issues (18%), change in family situation (16%), current residence is better than the previous (16%), physical health conditions (14%), assistance with daily living/dispensing of medications (12%), and their previous residence was no longer available (11%). Among the 45 participants who had moved from another Domiciliary Hostel, common reasons were that the current residence is better than the previous (29%), concerns about personal safety (20%), previous residence no longer available (16%), food complaints (9%), problems with physical environment (7%), problems with tenants (7%), and problems with staff/operator (7%).

[34] N=41. Among those who do not plan to move within the next 6 months.
[35] Reasons included staff indicated participant cannot move out on their own or if participant moved out they couldn't move back in.
[36] Scored on a seven-point scale ranging from 1 (very bad) to 7 (very good), and with a middle option of 4 (neither good nor bad).

Table 14. Participants' Self-Reported Reasons for Moving from Previous Residence. All data are given as numbers (%).

	All participants (N=258)	Participants moving from another Domiciliary Hostel (N=45)[37]
Mental health issues	47 (18)	1 (2)
Change in family situation/death in family/ domestic instability	42 (16)	0 (0)
Current residence is better than previous	41 (16)	13 (29)
Physical health conditions	36 (14)	0 (0)
Assistance with daily living/proper dispensing of medication	30 (12)	0 (0)
Previous residence closed/burnt down or no longer available	29 (11)	7 (16)
Concerns about personal safety (eg. safety, theft)	12 (5)	9 (20)
Financial reasons/Lost employment	9 (4)	0 (0)
Substance abuse problems	7 (3)	0 (0)
Legal/Government requirement	7 (3)	0 (0)
Evicted/kicked out	6 (2)	3 (7)
Loneliness	6 (2)	0 (0)
Better location/Near family	4 (2)	1 (2)
Food complaints at Domiciliary Hostel	4 (2)	4 (9)
Problems with physical environment (eg. cleanliness, accessibility)	3 (1)	3 (7)
Problems with other tenants	3 (1)	3 (7)
Problems with Domiciliary Hostel staff/operator	3 (1)	3 (7)
Other	11 (4)	2 (4)
Don't know	6 (2)	3 (7)

When participants were asked about their plans for staying or moving elsewhere, 163 (63%) responded they would prefer to stay at the current hostel, whereas 85 (33%) stated they would prefer to move elsewhere **(Table 15)**. Among the tenants who indicated they preferred to move elsewhere or were unsure, 56% (N=53) stated that they planned to move within the next 6 months. Of these individuals, the three most common types of housing desired were an apartment, own/family house, and another Domiciliary Hostel **(Table 15)**. Difficulties finding a place were experienced by 19 participants, with the most common reasons being lack of finances/employment (N=8), lack of resources/information (N=4), and not being allowed to move[38] (N=3).

[37] Percentages do not sum to 100% due to multiple responses provided by some participants.
[38] The reasons provided by the 3 participants who responded they were "not allowed" to move included: staff indicated they could not move, or that if they moved out they could not move back in.

Table 15. Type of Housing and Difficulties Experienced among those with Plans to Move. All data are given as numbers (%).

	Participants with plans to move (N=53)
Type of housing he/she would like to move to[39]	
Apartment	23 (43)
Own/Family house	9 (17)
Another Domiciliary Hostel	6 (11)
Any type of independent housing	5 (9)
Long-term care/brain facility	2 (4)
Retirement home	2 (4)
Rooming/Boarding home	2 (4)
Group home	1 (2)
Supportive housing	1 (2)
Church-based residence	1 (2)
Don't know	1 (2)
Have experienced difficulties finding a place to live[39]	19 (36)
Types of difficulties experienced	
Lack of finances/employment	8 (15)
Lack of resources/information	4 (8)
Not allowed to move	3 (6)
Lack of/restrictive alternative accommodation	1 (2)
On Waiting list	1 (2)
Emotional attachment to current tenants	1 (2)
Effort required to secure residence	1 (2)

Cross Tabulations

Comparison of Physical and Mental Health Issues, and Developmental, Learning or Other Disabilities, and Housing, Personal Choice and Social Supports by Age

The prevalence of physical and mental health issues, and development and learning disabilities were compared by age. Participants were classified as non-seniors (<65 years) or seniors (≥65 years). A total of 199 (77%) participants were non-seniors, and 59 (23%) were seniors. Approximately two-thirds of non-seniors were male (65%) and approximately two-thirds of seniors were female (63%). Seniors tended to have a higher prevalence of physical health conditions, such as cardiovascular related conditions, chronic bronchitis/emphysema, cirrhosis, anemia, stroke, arthritis/rheumatism/joint problems, and difficulty walking **(Table 16)**. Meanwhile, non-seniors tended to have a higher prevalence of asthma, diabetes, hepatitis, epilepsy, infectious diseases, epilepsy/seizures, skin diseases, and other health conditions. The prevalence rate of stomach/intestinal ulcers and cancer were comparable among both groups.

[39] N=53. Among those who plan to move within the next 6 months.

Compared to seniors, non-seniors tended to have a higher prevalence of developmental disabilities (9% vs. 25%), developmental, learning or other disabilities (10% vs. 36%), head injury/acquired head injury (3% vs. 19%), at least one mental health issue (excluding substance abuse/dependence) (36% vs. 83%), at least one serious mental health issue (Bipolar Disorder/Manic-Depressive, Manic Disorder, Schizophrenia, or Psychosis other than Schizophrenia) (17% vs. 63%), self-reported substance abuse/dependence (7% vs. 23%), and the use of alcohol or drugs in the last 3 years (19% vs. 41%).

The three most common types of residences that non-seniors and seniors had lived in prior to moving to their current Domiciliary Hostel included their own/family house (28% vs. 29%), apartment (26% vs. 34%), and another Domiciliary Hostel (18% vs. 17%) **(Table 16)**. Non-seniors were more likely to report being provided with choices while living at their Domiciliary Hostel for 6 of the 8 issues. The only two issues for which seniors indicated greater personal choice included the holding of regular house meetings where residents could voice their concerns and feelings, and registering complaints about the hostel with someone outside of the hostel. Non-seniors and seniors had very similar mean CMHEI Social Support scores (16.0 vs. 16.4), although non-seniors were more likely to report having people with whom they could feel at ease with and talk to about personal issues (82% vs. 75%)

Table 16. Comparison of Physical and Mental Health Issues, Developmental, Learning or Other Disabilities, and Housing, Personal Choice and Social Supports by Age. Data are given as numbers (%), unless otherwise specified.

	Non-seniors (<65 years) (N=199)	**Seniors (≥65 years) (N=59)**
Sex		
Male	129 (65)	22 (37)
Female	70 (35)	37 (63)
Physical Health Conditions		
Cardiovascular		
High blood pressure	66 (33)	22 (37)
Angina	11 (6)	10 (17)
Heart attack	23 (12)	14 (24)
Congestive heart failure	6 (3)	5 (9)
Heart disease (other than angina, heart attack, or CHF)	18 (9)	7 (12)
Respiratory		
Asthma	43 (22)	9 (16)
Chronic Bronchitis/emphysema	34 (17)	14 (24)
Endocrine		
Diabetes	52 (26)	12 (20)
Gastrointestinal/Liver		
Stomach/Intestinal ulcers	16 (8)	5 (9)
Hepatitis	18 (9)	1 (2)
Hepatitis B	4 (2)	1 (2)
Hepatitis C	14 (7)	0 (0)

Cirrhosis	7 (4)	4 (7)
Infectious Diseases		
HIV infection/AIDS	4 (2)	0 (0)
Sexually transmitted diseases	3 (2)	0 (0)
Hematologic		
Anemia	27 (14)	10 (17)
Cancers	9 (5)	2 (4)
Brain	1 (1)	0 (0)
Breast	2 (2)	1 (2)
Hodgkins Disease	1 (1)	0 (0)
Intestinal	0 (0)	1 (2)
Lung	2 (1)	0 (0)
Oral	1 (1)	0 (0)
Prostate	1 (1)	0 (0)
Skin	1 (0)	0 (0)
Neurological		
Stroke	15 (8)	15 (25)
Epilepsy/Seizures	36 (18)	4 (7)
Musculo-skeletal		
Arthritis/rheumatism/joint problems	83 (42)	33 (56)
Difficulty walking	75 (38)	42 (71)
Skin disease	27 (14)	6 (10)
Other health conditions	68 (34)	13 (22)
Any Developmental, Learning or Other Disabilities	72 (36)	6 (10)
Developmental Disabilities	50 (25)	5 (9)
Developmental Disability	45 (23)	4 (7)
FAE/FAS	8 (4)	1 (2)
ADD	27 (14)	2 (3)
Dyslexia	11 (6)	0 (0)
Cerebral Palsy	7 (4)	0 (0)
Indicators of Possible Developmental or Learning Disabilities		
Attended Special Education classes	79 (40)	7 (12)
Repeated grades in school	84 (42)	16 (27)
Currently involved with the Association for Community Living	24 (12)	1 (2)
Other Learning Disability	20 (10)	1 (2)
Head Injury		
Head Injury/Acquired Head Injury	37 (19)	2 (3)
Diagnosed Mental Health Issues (self-report)		
Have at least one Diagnosed Mental Health Issue (excluding Substance Abuse/Dependence)	166 (83)	21 (36)
Have at least one Diagnosed Serious Mental Health Issue	125 (63)	10 (17)
Anxiety Disorder		
Generalized Anxiety Disorder	57 (29)	5 (9)
Panic Disorder	38 (19)	1 (2)
Phobia	25 (13)	0 (0)
Obsessive-Compulsive Disorder	22 (11)	1 (2)
Post Traumatic Stress Disorder (PTSD)	19 (10)	2 (3)
Mood Disorders		
Depression or Major Depression	92 (46)	14 (24)
Bipolar Disorder or Manic-Depressive	50 (25)	4 (7)

Manic Disorder	20 (10)	2 (3)
Schizophrenia	88 (44)	6 (10)
Psychosis, other than Schizophrenia	17 (9)	0 (0)
Personality Disorder	37 (19)	1 (2)
Substance Abuse/Dependence (over lifetime)	45 (23)	4 (7)
Substance (Alcohol and Drugs) Use and Problems		
Ever used alcohol or drugs in the last 3 years	81 (41)	11 (19)
Past year Substance Dependence Index (GAIN)		
No past year dependence	118 (59)	48 (82)
No/Low	49 (25)	9 (15)
Moderate	19 (10)	2 (3)
High	13 (7)	0 (0)
Previous Residence Type		
Own/Family house	56 (28)	17 (29)
Apartment	51 (26)	20 (34)
Another Domiciliary Hostel	35 (18)	10 (17)
Rooming/Boarding house	16 (8)	1 (2)
Psychiatric hospital	11 (6)	1 (2)
Homeless	10 (5)	0 (0)
Group/Foster home	7 (4)	1 (2)
Temporary stay with family/friends	3 (2)	4 (7)
Nursing Retirement home	4 (2)	2 (3)
Medical hospital	5 (3)	1 (2)
Motel/Hotel	0 (0)	1 (2)
Other/Don't know	1 (1)	1 (2)
Personal choice		
Have a choice about how to spend own money	165 (83)	39 (66)
Have a choice about waking up and going to bed	161 (81)	41 (70)
There is someone who works at the Domiciliary Hostel with whom complaints or problems about the hostel can be registered with	157 (79)	44 (75)
Have a choice on whether benefits or social assistance cheques go directly to the Domiciliary Hostel operator	157 (79)	39 (66)
Has ability to disagree with staff who work at the Domiciliary Hostel	154 (77)	42 (71)
There is someone outside the Domiciliary Hostel with whom complaints or problems about the hostel can be registered with	109 (55)	35 (59)
Regular house meetings are held at the Domiciliary Hostel so that concerns, feelings and opinions can be voiced	92 (46)	28 (48)
Have a choice about when to eat meals	46 (23)	11 (19)
Social supports		
CMHEI Social Support Score, mean (SD)	16.0 (4.1)	16.4 (3.7)
Has people with whom participant feels at ease and can talk to about personal issues	163 (82)	44 (75)

Comparison of the Health, Use of Community Services/Supports, and Involvement in Community Activities of Participants by:

i. Age

Non-seniors had higher physical health status (mean SF-12 PCS score: 43.3 vs. 39.5), but lower mental health status (mean SF-12 MCS score: 44.6 vs. 48.5) compared to seniors **(Table 17)**. Health state (mean EQ-5D summary index: 0.75 vs. 0.71) and self-rated health-related quality of life (mean EQ-VAS score: 69.5 vs. 66.9) was slightly better among non-seniors than among seniors. Non-seniors were more likely to take prescribed medications (99% vs. 90%). Seniors were less likely than non-seniors to report being accompanied during health care visits (30% vs. 41%), but more likely to usually have a family doctor come see them at the Domiciliary Hostel (52% vs. 34%).

Non-seniors were more likely than seniors to have a support worker help access services (46% vs. 32%) and to use any community services/supports (48% vs. 27%) especially mental health programs (17% vs. 5%), drop-in services (9% vs. 2%), and addiction services (7% vs. 0%). There were no differences between the two groups on whether certain services were provided at the Domiciliary Hostel. As measured by the mean Community Actitivities score, integration in the community was greater among non-seniors (13.8) compared to seniors (9.0).

Table 17. Health, Community Services/Supports, and Community Activities by Age. Data are given as numbers (%), unless otherwise specified.

	Non-seniors (<65 years) (N=199)	**Seniors (≥65 years) (N=59)**
SF-12 Physical Component subscale, mean (SD)	43.3 (9.4)	39.5 (9.3)
SF-12 Mental Component subscale, mean (SD)	44.6 (12.7)	48.5 (12.7)
Quality of life		
EQ-5D Summary Index, mean (SD)	0.75 (0.22)	0.71 (0.24)
EQ-Visual Analogue Scale (VAS) score, mean (SD)	69.5 (21.9)	66.9 (21.7)
Accompaniment during health care visits		
Participant accompanied during health care visits	82 (41)	23 (30)
Person works at the Domiciliary Hostel	39 (20)	6 (10)
Prescribed medications		
Takes prescribed medications	196 (99)	53 (90)
Person works at the Domiciliary Hostel	155 (78)	38 (64)
Community services/supports		
Has a support worker who helps with accessing services	92 (46)	19 (32)
Used any community services/supports in the past 12 months or during the period they had resided in the Domiciliary Hostel (if less than 12 months)	96 (48)	16 (27)
Types of community services/supports[40]		

[40] Some participants provided multiple responses.

Mental Health Programs	33 (17)	3 (5)
Drop-in Services	18 (9)	1 (2)
Religious Services	12 (6)	4 (7)
Activities	10 (5)	4 (7)
Addiction Services	13 (7)	0 (0)
City Social Services	9 (5)	1 (2)
Services/Supports offered by the Domiciliary Hostel operator	7 (4)	2 (3)
Assertive Community Treatment	6 (3)	0 (0)
Other	32 (16)	7 (12)
Community Activities		
Community Activities Score, mean (SD)	13.8 (7.1)	9.0 (6.9)
Gone to a shopping centre/large shopping area		
Never/Rarely	74 (37)	32 (54)
Sometimes/Often/Very Often	125 (63)	27 (46)
Attended a movie/concert/play		
Never/Rarely	165 (83)	55 (93)
Sometimes/Often/Very Often	34 (17)	4 (7)
Gone to a sports event		
Never/Rarely	185 (93)	55 (93)
Sometimes/Often/Very Often	13 (7)	3 (5)
Participated in outdoor/indoor activities		
Never/Rarely	154 (77)	48 (81)
Sometimes/Often/Very Often	45 (23)	10 (17)
Visited a park/museum		
Never/Rarely	134 (67)	48 (81)
Sometimes/Often/Very Often	64 (32)	11 (19)
Gone to a restaurant/bar/coffee shop		
Never/Rarely	69 (35)	29 (49)
Sometimes/Often/Very Often	130 (65)	29 (49)
Gone to a community centre		
Never/Rarely	164 (82)	56 (95)
Sometimes/Often/Very Often	33 (17)	3 (5)
Gone to church/place of worship		
Never/Rarely	141 (71)	46 (78)
Sometimes/Often/Very Often	58 (29)	13 (22)
Gone for a walk		
Never/Rarely	32 (16)	27 (46)
Sometimes/Often/Very Often	167 (84)	31 (53)
Participated in work (paid/unpaid)		
Never/Rarely	144 (72)	51 (87)
Sometimes/Often/Very Often	55 (28)	7 (12)
Gone to a library		
Never/Rarely	157 (79)	53 (90)
Sometimes/Often/Very Often	42 (21)	5 (9)
Gone to a barber/beauty salon		
Never/Rarely	129 (65)	39 (66)
Sometimes/Often/Very Often	68 (34)	20 (34)
Gone to a support group/drop-in centre		
Never/Rarely	162 (81)	57 (97)
Sometimes/Often/Very Often	33 (17)	2 (3)

ii. Facility Size

Surveys were conducted at 54 Domiciliary Hostels. The total number of beds at these hostels ranged from 4-130, and the median number of beds was 35 beds.[41] Facilities were categorized as smaller (<35 beds) and larger (>35 beds), with 126 (49%) smaller facilities and 132 (51%) larger facilities **(Table 18)**. Participants residing in smaller facilities tended to be younger (mean age: 49.6 years vs. 60.2 years), had better health state (mean EQ-5D summary index: 0.79 vs. 0.69), and had similar physical health status (mean SF-12 PCS score: 43.5 vs. 41.4) and mental health status (mean SF-12 MCS score: 46.4 vs. 44.6) compared to those in larger sites.

Participants at smaller sites were less likely than those at larger sites to be accompanied during health care visits (38% vs. 43%) and to have a support worker help access services (41% vs. 46%), but more likely to be taking prescribed medications (99% vs. 94%) and to have a Domiciliary Hostel staff assist with medications (79% vs. 71%). The use of community services/support (53% vs. 34%), especially mental health programs (18% vs. 10%), and addiction services (10% vs. 1%), and integration in the community (mean Community Activities score: 14.4 vs. 11.0) was higher among participants in smaller rather than larger sites. There were no differences between the two groups on whether particular services were provided at the Domiciliary Hostel.

Table 18: Health, Community Services/Supports, and Community Activities by Facility Size. Data are given as numbers (%), unless otherwise specified.

	Participants living in smaller facilities[42] (N=126)	**Participants living in larger facilities (N=132)**
Age, years, mean (SD)	49.6 (12.6)	60.2 (15.1)
SF-12 Physical Component subscale, mean (SD)	43.5 (9.2)	41.4 (9.6)
SF-12 Mental Component subscale, mean (SD)	46.4 (12.5)	44.6 (13.0)
Quality of life		
EQ-5D Summary Index, mean (SD)	0.79 (0.20)	0.69 (0.23)
EQ-Visual Analogue Scale (VAS) score, mean (SD)	68.0 (23.6)	69.7 (20.1)
Accompaniment during health care visits		
Participant accompanied during health care visits	48 (38)	57 (43)
Person works at the Domiciliary hostel	20 (16)	25 (19)
Prescribed medications		
Takes prescribed medications	125 (99)	124 (94)
Person works at the Domiciliary Hostel	99 (79)	94 (71)
Community services/supports		

[41] The number of beds at each facility includes both Domiciliary Hostel Program-funded beds and all other beds. Total number of beds in each facility was used (rather than the number of Domiciliary Hostel beds) because this measure was felt to be more likely to be correlated with the types and extent of services/supports offered.

[42] Facilities include Domiciliary Hostel and non-Domiciliary Hostel beds. Median for 54 hostels visited for study=35 beds. Smaller beds categorized as <35 beds and Larger beds categorized as >35 beds).

Has a support worker who helps with accessing services	51 (41)	60 (46)
Used any community services/supports in the past 12 months or during the period they had resided in the Domiciliary Hostel (if less than 12 months)	67 (53)	45 (34)
Types of community services/supports used[43]		
Mental Health Programs	23 (18)	13 (10)
Drop-in Services	10 (8)	9 (7)
Religious Services	5 (4)	11 (8)
Activities	9 (7)	5 (4)
Addiction Services	12 (10)	1 (1)
City Social Services	3 (2)	7 (5)
Services/Supports offered by the Domiciliary Hostel operator	4 (3)	5 (4)
Assertive Community Treatment	4 (3)	2 (2)
Other	25 (14)	14 (18)
Community Activities		
Community Activities Score, mean (SD)	14.4 (7.1)	11.0 (7.2)
Gone to a shopping centre/large shopping area		
Never/Rarely	46 (37)	60 (46)
Sometimes/Often/Very Often	80 (64)	72 (55)
Attended a movie/concert/play		
Never/Rarely	104 (83)	116 (88)
Sometimes/Often/Very Often	22 (18)	16 (12)
Gone to a sports event		
Never/Rarely	119 (94)	121 (92)
Sometimes/Often/Very Often	6 (5)	10 (8)
Participated in outdoor/indoor activities		
Never/Rarely	98 (78)	104 (79)
Sometimes/Often/Very Often	28 (22)	27 (21)
Visited a park/museum		
Never/Rarely	79 (63)	103 (78)
Sometimes/Often/Very Often	46 (37)	29 (22)
Gone to a restaurant/bar/coffee shop		
Never/Rarely	35 (28)	63 (48)
Sometimes/Often/Very Often	91 (72)	68 (52)
Gone to a community centre		
Never/Rarely	105 (83)	115 (87)
Sometimes/Often/Very Often	21 (17)	15 (11)
Gone to church/place of worship		
Never/Rarely	88 (70)	99 (75)
Sometimes/Often/Very Often	38 (30)	33 (25)
Gone for a walk		
Never/Rarely	18 (14)	41 (31)
Sometimes/Often/Very Often	108 (86)	90 (68)
Participated in work (paid/unpaid)		
Never/Rarely	92 (73)	103 (78)
Sometimes/Often/Very Often	34 (27)	28 (21)
Gone to a library		

[43] Some participants provided multiple responses.

Never/Rarely	95 (75)	115 (87)
Sometimes/Often/Very Often	31 (25)	16 (12)
Gone to a barber/beauty salon		
Never/Rarely	76 (60)	92 (70)
Sometimes/Often/Very Often	48 (38)	40 (30)
Gone to a support group/drop-in centre		
Never/Rarely	99 (79)	120 (91)
Sometimes/Often/Very Often	24 (19)	11 (8)

iii. Duration of Tenancy in Current Domiciliary Hostel

Duration of tenancy in the current Domiciliary Hostel was obtained for 249 of the 258 participants, of which 69 (27%) participants were categorized as short-term tenants (≤1 year) and 180 (70%) as long-term tenants (>1 year) **(Table 19)**. Long-term tenants tended to be older (mean years: 56.3 years vs. 51.0 years), had better mental health status (mean SF-12 MCS score: 46.6 vs. 43.0) and self-rated health-related quality of life (mean EQ-VAS score: 70.8 vs. 62.3), and slightly better health state (mean EQ-5D summary index: 0.75 vs. 0.70) compared to short-term tenants. The physical health status among long-term and short-term tenants was comparable (mean SF-12 PCS score: 42.5 vs. 41.7).

Long-term tenants were slighly more likely than short-term tenants to have a support worker (44 vs. 41%), take prescribed medication (98% vs. 94%), have a Domiciliary Hostel staff assist with medications (77% vs. 74%) and accompany them during health visits (19% vs. 12%), and to be better integrated into community (mean Community Activities score: 11.6 vs. 13.4). Long-term tenants were less likely than short-term tenants to be accompanied during health visits (37% vs. 46%), and to use community services/supports (37% vs. 61%), especially mental health programs (12% vs. 17%) and other services/supports (12% vs. 26%). There were however no differences between the two groups on whether certain services were provided at the Domiciliary Hostel.

Table 19. Health, Community Services/Supports, and Community Activities by Duration of Tenancy in Current Domiciliary Hostel. Data are given as numbers (%), unless otherwise specified.

	Short-term tenants (≤1 year) (N=69)	**Long-term tenants (>1 year) (N=180)**
Age, years, mean (SD)	51.0 (15.5)	56.3 (14.7)
SF-12 Physical Component subscale, mean (SD)	41.7 (9.6)	42.5 (9.5)
SF-12 Mental Component subscale, mean (SD)	43.0 (12.8)	46.6 (12.6)
Quality of life		
EQ-5D Summary Index, mean (SD)	0.70 (0.23)	0.75 (0.22)
EQ-Visual Analogue Scale (VAS) score, mean (SD)	62.3 (22.4)	70.8 (21.0)
Accompaniment during health care visits		
Participant accompanied during health care visits	32 (46)	67 (37)
Person works at the Domiciliary Hostel	8 (12)	34 (19)

Prescribed medications		
Takes prescribed medications	65 (94)	177 (98)
Person works at the Domiciliary Hostel	51 (74)	138 (77)
Community services/supports		
Has a support worker who helps with accessing services	28 (41)	80 (44)
Used any community services/supports in the past 12 months or during the period they had resided in the Domiciliary Hostel (if less than 12 months)	42 (61)	67 (37)
Types of community services/supports used[44]		
Mental Health Programs	12 (17)	22 (12)
Drop-in Services	5 (7)	13 (7)
Religious Services	3 (4)	13 (7)
Activities	3 (4)	11 (6)
Addiction Services	5 (7)	8 (4)
City Social Services	4 (6)	6 (3)
Services/Supports offered by the Domiciliary Hostel operator	3 (4)	6 (3)
Assertive Community Treatment	3 (4)	3 (2)
Other	18 (26)	21 (12)
Community Activities		
Community Activities Score, mean (SD)	11.6 (7.0)	13.4 (7.4)
Gone to a shopping centre/large shopping area		
Never/Rarely	33 (48)	66 (37)
Sometimes/Often/Very Often	36 (52)	114 (63)
Attended a movie/concert/play		
Never/Rarely	63 (91)	149 (83)
Sometimes/Often/Very Often	6 (9)	31 (17)
Gone to a sports event		
Never/Rarely	67 (97)	164 (91)
Sometimes/Often/Very Often	2 (3)	14 (8)
Participated in outdoor/indoor activities		
Never/Rarely	59 (86)	134 (74)
Sometimes/Often/Very Often	10 (15)	45 (25)
Visited a park/museum		
Never/Rarely	53 (77)	123 (68)
Sometimes/Often/Very Often	16 (23)	56 (31)
Gone to a restaurant/bar/coffee shop		
Never/Rarely	30 (44)	62 (34)
Sometimes/Often/Very Often	38 (55)	118 (66)
Gone to a community centre		
Never/Rarely	62 (90)	150 (83)
Sometimes/Often/Very Often	7 (10)	28 (16)
Gone to church/place of worship		
Never/Rarely	47 (68)	131 (73)
Sometimes/Often/Very Often	22 (32)	49 (27)
Gone for a walk		
Never/Rarely	16 (23)	40 (22)
Sometimes/Often/Very Often	53 (77)	139 (77)
Participated in work (paid/unpaid)		

[44] Some participants provided multiple responses.

Never/Rarely	57 (83)	130 (72)
Sometimes/Often/Very Often	12 (17)	49 (27)
Gone to a library		
Never/Rarely	55 (80)	147 (82)
Sometimes/Often/Very Often	14 (20)	32 (18)
Gone to a barber/beauty salon		
Never/Rarely	49 (71)	111 (62)
Sometimes/Often/Very Often	19 (28)	69 (38)
Gone to a support group/drop-in centre		
Never/Rarely	57 (83)	154 (86)
Sometimes/Often/Very Often	12 (17)	22 (12)

iv. Serious Mental Health Issues

A total of 135 (52%) participants reported being diagnosed with any serious mental health issue, namely Bipolar Disorder or Manic-Depressive, Manic Disorder, Schizophrenia, or Psychosis, other than Schizophrenia **(Table 20)**. Participants with serious mental health issues tended to be older (mean years: 60.9 years vs. 49.7 years), have lower mental health status (mean SF-12 MCS score: 43.0 vs. 48.2), and have similar physical health status (mean SF-12 PCS score: 43.4 vs. 41.4) and self-rated health-related quality of life (mean EQ-VAS score: 69.3 vs. 68.6) than those without serious mental health issues.[45] Health state was similar for both groups.

Tenants with serious mental health issues were slightly more likely than their counterparts to take prescribed medications (98% vs. 95%), and to have a Domiciliary Hostel staff accompany them during health visits (19% vs. 15%) and to assist with their medications (81% vs. 68%). These individuals were however less likely to be accompanied during health visits (36% vs. 46%). Tenants with serious mental health issues were more likely to have a support worker (48% vs. 37%), use any community services/supports (51% vs. 35%), especially mental health services (17% vs. 11%) and drop-in services (12% vs. 2%), and be integrated into the community (mean Community Activities score: 13.6 vs. 11.7) compared to those without serious mental health issues. However, there were no differences between the two groups on whether certain services were provided at the Domiciliary Hostel.

[45] Participants without serious mental health conditions include those with no serious or less serious mental health conditions.

Table 20. Health, Community Services/Supports, and Community Activities by Serious Mental Health Issues. Data are given as numbers (%), unless otherwise specified.

	Participants with serious mental health issues[46] (N=135)	Participants without serious mental health issues (N=123)
Age, years, mean (SD)	60.9 (15.7)	49.7 (11.8)
SF-12 Physical Component subscale, mean (SD)	43.4 (9.3)	41.4 (9.5)
SF-12 Mental Component subscale, mean (SD)	43.0 (12.7)	48.2 (12.3)
Quality of life		
EQ-5D Summary Index, mean (SD)	0.74 (0.22)	0.73 (0.23)
EQ-Visual Analogue Scale (VAS) score, mean (SD)	68.6 (21.7)	69.3 (22.1)
Accompaniment during health care visits		
Participant accompanied during health care visits	49 (36)	56 (46)
Person works at the Domiciliary Hostel	26 (19)	19 (15)
Prescribed medications		
Takes prescribed medications	132 (98)	117 (95)
Person works at the Domiciliary Hostel	109 (81)	84 (68)
Community services/supports		
Has a support worker who helps with accessing services	65 (48)	46 (37)
Used any community services/supports in the past 12 months or during the period they had resided in the Domiciliary Hostel (if less than 12 months)	69 (51)	43 (35)
Types of community services/supports used[47]		
Mental Health Programs	23 (17)	13 (11)
Drop-in Services	16 (12)	3 (2)
Religious Services	9 (7)	7 (6)
Activities	8 (6)	6 (5)
Addiction Services	9 (7)	4 (3)
City Social Services	6 (4)	4 (3)
Services/Supports offered by the Domiciliary Hostel operator	5 (4)	4 (3)
Assertive Community Treatment	5 (4)	1 (1)
Other	21 (16)	18 (15)
Community Activities		
Community Activities Score, mean (SD)	13.6 (7.3)	11.7 (7.2)
Gone to a shopping centre/large shopping area		
Never/Rarely	48 (36)	58 (47)
Sometimes/Often/Very Often	87 (64)	65 (53)
Attended a movie/concert/play		
Never/Rarely	113 (84)	107 (87)
Sometimes/Often/Very Often	22 (16)	16 (13)

[46] Responded 'Yes' to any of the following: Bipolar Disorder or Manic-Depressive, Manic Disorder, Schizophrenia or Psychosis, other than Schizophrenia.
[47] Some participants provided multiple responses.

Gone to a sports event		
Never/Rarely	124 (92)	116 (94)
Sometimes/Often/Very Often	10 (7)	6 (5)
Participated in outdoor/indoor activities		
Never/Rarely	103 (76)	99 (81)
Sometimes/Often/Very Often	32 (24)	23 (19)
Visited a park/museum		
Never/Rarely	88 (65)	94 (76)
Sometimes/Often/Very Often	46 (34)	29 (24)
Gone to a restaurant/bar/coffee shop		
Never/Rarely	51 (38)	47 (38)
Sometimes/Often/Very Often	84 (62)	75 (61)
Gone to a community centre		
Never/Rarely	110 (82)	110 (89)
Sometimes/Often/Very Often	23 (17)	13 (11)
Gone to church/place of worship		
Never/Rarely	100 (74)	87 (71)
Sometimes/Often/Very Often	35 (26)	36 (29)
Gone for a walk		
Never/Rarely	27 (20)	32 (26)
Sometimes/Often/Very Often	108 (80)	90 (73)
Participated in work (paid/unpaid)		
Never/Rarely	100 (74)	95 (77)
Sometimes/Often/Very Often	35 (26)	27 (22)
Gone to a library		
Never/Rarely	106 (79)	104 (85)
Sometimes/Often/Very Often	29 (22)	18 (15)
Gone to a barber/beauty salon		
Never/Rarely	86 (64)	82 (67)
Sometimes/Often/Very Often	48 (36)	40 (33)
Gone to a support group/drop-in centre		
Never/Rarely	109 (81)	110 (89)
Sometimes/Often/Very Often	23 (17)	12 (10)

v. Developmental Disabilities

A total of 55 (21%) participants reported being diagnosed with developmental disabilities, and 191 (74%) reported not being diagnosed with any developmental disabilities **(Table 21)**. Twelve participants (5%) indicated they did not know whether they had been diagnosed with developmental disabilities and were therefore excluded from this subgroup comparison. Participants with developmental disabilities tended to be younger (mean years: 50.0 years vs. 56.7 years), have slightly lower self-rated health-related quality of life (mean EQ-VAS score: 66.6 vs. 69.9), and considerably lower mental health status (mean SF-12 MCS score: 40.2 vs. 46.8) and health state (mean EQ-5D summary index: 0.68 vs. 0.75) than participants without developmental disabilities. The physical health status was similar between tenants with and without developmental disabilities (mean SF-12 PCS score: 41.1 vs. 42.7). Participants with developmental disabilities were also more likely to be accompanied during health visits (47% vs. 38%), and to have a Domiciliary Hostel staff accompany them to health visits (26% vs. 15%) and assist with medications (80% vs. 72%).

Participants with developmental disabilities were slightly more likely to have a support worker help with accessing services (46% vs. 42%) and to be integrated into the community (mean Community Activities score: 14.4 vs. 12.2) compared to those without developmental disabilities. Tenants with developmental disabilities were also more likely to report using community services/supports (55% vs. 39%), namely mental health programs (22% vs. 12%), drop-in services (13% vs. 6%), religious services (9% vs. 5%), and addiction services (9% vs. 3%). These tenants were also twice as likely to report being provided with mental health services and being engaged in activities at the Domiciliary Hostel than tenants without developmental disabilities.

Table 21. Health, Community Services/Supports, and Community Activities by Developmental Disabilities. Data are given as numbers (%), unless otherwise specified.

	Participants with developmental disabilities[48] (N=55)	**Participants without developmental disabilities (N=191)**
Age, years, mean (SD)	50.0 (12.8)	56.7 (15.2)
SF-12 Physical Component subscale, mean (SD)	41.1 (9.0)	42.7 (9.7)
SF-12 Mental Component subscale, mean (SD)	40.2 (12.2)	46.8 (12.8)
Quality of life		
EQ-5D Summary Index, mean (SD)	0.68 (0.20)	0.75 (0.23)
EQ-Visual Analogue Scale (VAS) score, mean (SD)	66.6 (23.6)	69.9 (21.3)
Accompaniment during health care visits		
Participant accompanied during health care visits	26 (47)	73 (38)
Person works at the Domiciliary Hostel	14 (26)	29 (15)
Prescribed medications		
Takes prescribed medications	54 (98)	183 (96)
Person works at the Domiciliary Hostel	137 (72)	44 (80)
Community services/supports		
Has a support worker who helps with accessing services	25 (46)	81 (42)
Used any community services/supports in the past 12 months or during the period they had resided in the Domiciliary Hostel (if less than 12 months)	30 (55)	74 (39)
Types of community services/supports used[49]		
Mental Health Programs	12 (22)	22 (12)
Drop-in Services	7 (13)	12 (6)

[48] Responded 'Yes' to any of the following: Developmental disability or FAE/FAS.
[49] Some participants provided multiple responses.

Religious Services	5 (9)	9 (5)
Activities	4 (7)	10 (5)
Addiction Services	5 (9)	6 (3)
City Social Services	2 (4)	8 (4)
Services/Supports offered by the Domiciliary Hostel operator	3 (6)	4 (2)
Assertive Community Treatment	0 (0)	5 (3)
Other	9 (16)	26 (14)
Community Activities		
Community Activities Score, mean (SD)	14.4 (7.0)	12.2 (7.4)
Gone to a shopping centre/large shopping area		
Never/Rarely	17 (31)	84 (44)
Sometimes/Often/Very Often	38 (69)	107 (56)
Attended a movie/concert/play		
Never/Rarely	43 (78)	165 (86)
Sometimes/Often/Very Often	12 (22)	26 (14)
Gone to a sports event		
Never/Rarely	53 (96)	178 (93)
Sometimes/Often/Very Often	2 (4)	13 (7)
Participated in outdoor/indoor activities		
Never/Rarely	44 (80)	150 (79)
Sometimes/Often/Very Often	11 (20)	40 (21)
Visited a park/museum		
Never/Rarely	42 (76)	133 (70)
Sometimes/Often/Very Often	13 (24)	57 (30)
Gone to a restaurant/bar/coffee shop		
Never/Rarely	16 (29)	76 (40)
Sometimes/Often/Very Often	39 (71)	114 (60)
Gone to a community centre		
Never/Rarely	43 (78)	165 (86)
Sometimes/Often/Very Often	11 (20)	25 (13)
Gone to church/place of worship		
Never/Rarely	40 (73)	137 (72)
Sometimes/Often/Very Often	15 (27)	54 (28)
Gone for a walk		
Never/Rarely	9 (16)	48 (25)
Sometimes/Often/Very Often	46 (84)	142 (74)
Participated in work (paid/unpaid)		
Never/Rarely	37 (67)	150 (79)
Sometimes/Often/Very Often	18 (33)	40 (21)
Gone to a library		
Never/Rarely	45 (82)	154 (81)
Sometimes/Often/Very Often	10 (18)	36 (19)
Gone to a barber/beauty salon		
Never/Rarely	31 (57)	127 (67)
Sometimes/Often/Very Often	23 (42)	63 (33)
Gone to a support group/drop-in centre		
Never/Rarely	43 (78)	170 (89)
Sometimes/Often/Very Often	11 (20)	20 (11)

vi. Developmental, Learning or Other Disabilities

A total of 78 (30%) participants reported having at least one developmental, learning or other disabilities, and 165 (64%) reported not having any developmental, learning or other disabilities **(Table 21)**. Fifteen participants (6%) did not know if they had any of these disabilities and were therefore excluded from this subgroup comparison. Participants with developmental, learning or other disabilities tended to be younger (mean age: 49.0 years vs. 57.9 years), have slightly lower self-rated health-related quality of life (mean EQ-VAS score: 68.0 vs. 70.0), considerably lower mental health status (mean SF-12 MCS score: 41.9 vs. 47.0) and health state (mean EQ-5D summary index: 0.69 vs. 0.76), and similar physical health status (mean SF-12 PCS score: 41.5 vs. 42.8) compared to participants without developmental, learning or other disabilities. Tenants with developmental, learning or other disabilities were also more likely to be accompanied during health visits (46% vs. 37%), and to have a Domiciliary Hostel staff accompany them to health visits (21% vs. 16%) and assist with medications (80% vs. 70%).

Participants with developmental, learning or other disabilities were slightly more likely to have a support worker (46% vs. 41%), take prescribed medications (99% vs. 95%), and to be physically integrated into the community (mean Community Activities score: 14.0 vs. 12.2) in contrast to their counterparts. Tenants with developmental, learning or other disabilities were more likely to report using community services/supports (50% vs. 38%), particularly mental health programs (18% vs. 11%), addiction services (8% vs. 3%), and other programs (18% vs. 12%) than their counterparts. There were however no differences between the two groups on whether certain services were provided at the Domiciliary Hostel.

Table 22. Health, Community Services/Supports, and Community Activities by Developmental, Learning or Other Disabilities. Data are given as numbers (%), unless otherwise specified.

	Participants with developmental, learning or other disabilities[50] (N=78)	**Participants without developmental, learning or other disabilities (N=165)**
Age, years, mean (SD)	49.0 (12.9)	57.9 (15.0)
SF-12 Physical Component subscale, mean (SD)	41.5 (9.0)	42.8 (9.7)
SF-12 Mental Component subscale, mean (SD)	41.9 (12.7)	47.0 (12.7)
Quality of life		
EQ-5D Summary Index, mean (SD)	0.69 (0.20)	0.76 (0.23)
EQ-Visual Analogue Scale (VAS) score, mean (SD)	70.0 (21.1)	68.0 (23.4)

[50] Responded 'Yes' to any of the following: Developmental disability, ADD, Dyslexia, FAE/FAS or Cerebral Palsy.

Accompaniment during health care visits		
Participant accompanied during health care visits	36 (46)	61 (37)
Person works at the Domiciliary Hostel	16 (21)	27 (16)
Prescribed medications		
Takes prescribed medications	77 (99)	157 (95)
Person works at the Domiciliary Hostel	62 (80)	116 (70)
Community services/supports		
Has a support worker who helps with accessing services	36 (46)	68 (41)
Used any community services/supports in the past 12 months or during the period they had resided in the Domiciliary Hostel (if less than 12 months)	39 (50)	62 (38)
Types of community services/supports used[51]		
Mental Health Programs	14 (18)	18 (11)
Drop-in Services	7 (9)	12 (7)
Religious Services	5 (6)	9 (6)
Activities	4 (5)	10 (6)
Addiction Services	6 (8)	5 (3)
City Social Services	3 (4)	7 (4)
Services/Supports offered by the Domiciliary Hostel operator	3 (4)	4 (2)
Assertive Community Treatment	1 (1)	4 (2)
Other	14 (18)	20 (12)
Community Activities		
Community Activities Score, mean (SD)	14.0 (6.9)	12.2 (7.5)
Gone to a shopping centre/large shopping area		
Never/Rarely	26 (33)	74 (45)
Sometimes/Often/Very Often	52 (67)	91 (55)
Attended a movie/concert/play		
Never/Rarely	60 (77)	145 (88)
Sometimes/Often/Very Often	18 (23)	20 (12)
Gone to a sports event		
Never/Rarely	75 (96)	153 (93)
Sometimes/Often/Very Often	3 (4)	12 (7)
Participated in outdoor/indoor activities		
Never/Rarely	65 (83)	127 (77)
Sometimes/Often/Very Often	13 (17)	37 (22)
Visited a park/museum		
Never/Rarely	53 (68)	119 (72)
Sometimes/Often/Very Often	25 (32)	45 (27)
Gone to a restaurant/bar/coffee shop		
Never/Rarely	25 (32)	66 (40)
Sometimes/Often/Very Often	53 (68)	98 (59)
Gone to a community centre		

[51] Some participants provided multiple responses.

Never/Rarely	65 (83)	140 (85)
Sometimes/Often/Very Often	12 (15)	24 (15)
Gone to church/place of worship		
Never/Rarely	59 (76)	116 (70)
Sometimes/Often/Very Often	19 (24)	49 (30)
Gone for a walk		
Never/Rarely	14 (18)	42 (26)
Sometimes/Often/Very Often	64 (82)	122 (74)
Participated in work (paid/unpaid)		
Never/Rarely	54 (69)	130 (79)
Sometimes/Often/Very Often	24 (31)	34 (21)
Gone to a library		
Never/Rarely	63 (81)	133 (81)
Sometimes/Often/Very Often	15 (19)	31 (19)
Gone to a barber/beauty salon		
Never/Rarely	47 (60)	108 (66)
Sometimes/Often/Very Often	30 (39)	56 (34)
Gone to a support group/drop-in centre		
Never/Rarely	65 (83)	145 (88)
Sometimes/Often/Very Often	12 (15)	19 (12)

Association between Physical and Mental Health Status and Perceived Housing Quality

Pearson Correlation coefficients were obtained in order to determine the association between physical and mental health status and perceived housing quality. Pearson Correlation coefficients range from -1.0 to +1.0, with a correlation of +1 reflecting a strong positive relationship between two variables and a correlation of -1 reflecting a strong negative or inverse relationship. Physical health status was measured using SF-12 Physical Component subscale scores, mental health status using SF-12 Mental Health Component subscale scores, and perceived housing quality using Toro's Housing Quality scores. **Table 23** shows that there were only weak associations between perceived housing quality and physical health status (0.18) and mental health status (0.12). These findings indicate that participants who had better physical health or better mental health were more likely to report better perceived housing quality at their current Domiciliary Hostel; however, this association was not particularly strong.

Table 23. Pearson Correlation Coefficients displaying the Association between Physical and Mental Health Status and Perceived Housing Quality

	Perceived Housing Quality* Pearson Correlation coefficient
Physical Health Status[+]	0.18
Mental Health Status[#]	0.12

*Measured using Toro's Housing Quality Scores
[+]Measured using the SF-12 Physical Component subscale scores
[#]Measured using the SF-12 Mental Component subscale scores

Data linkage with the Provincial Database

Personnel from the MCSS Policy Research and Analysis Branch (PRAB) assisted with retrieval, technical advice, and analysis of information from provincial (MCSS and MOHLTC) databases pertaining to study participants who provided informed consent for such information to be shared with the research team. A total of 198 participants (77%) indicated they had an ODSP/OW number, and the research team was able to obtain an ODSP/OW number for 191 participants (74% of all participants, and 96% of those believed to have such a number). Successful linkage with the provincial ODSP disability determination file was made for 178 participants for whom ODSP/OW numbers were obtained (69% of all participants, and 93% of those for whom a number was obtained).[52] Among these participants, 167 (94%) of the participants were on ODSP, 6 (3%) were on OW, 2 (1%) had ODSP benefits that had been terminated, and 3 (2%) had OW benefits that had been terminated.

In the group of 178 participants for whom data linkage was accomplished, the majority were non-seniors (98%). The mean number of residential moves[53] during the 5 year, 5 month period between January 1, 2003 and May 31, 2008 was 2.6 **(Table 24)**. During this period, 30% had no moves, 35% had 1-4 moves, and 20% had 5 or more moves. Seniors tended to be more stably housed than non-seniors, (mean number of residential moves during this period: 0.3 vs. 2.7). Meanwhile, a total 42% of the 178 participants had a trustee.

Table 24. Data from the MCSS and MOHLTC database. Data are given as numbers (%), unless otherwise specified.

	Participants for whom successful linkage with MCSS and MOHLTC databases were made (N=178)
# of moves between Jan. 1, 2003-May 31, 2008, mean (SD)	2.6 (3.3)
# of moves between Jan. 1, 2003-May 31, 2008	
0	53 (30)
1	36 (20)
2	23 (13)
3	23 (13)
4	8 (4)
5 or more	35 (20)
Has a trustee	74 (42)

[52] Three individuals did not provide consent to the linkage of information, and 10 individuals provided numbers for which a linkage could not be made.
[53] Only moves to a different street address were counted (i.e., moves within a single building were excluded).

The International Statistical Classification of Diseases and Related Health Problems (ICD-9) is published by the World Health Organization and provides codes to classify essentially all known diseases. **Table 25** displays the primary and secondary ICD-9 diagnostic codes and descriptions obtained from the disability determination files for the 178 participants for whom data linkage was accomplished. The six most common ICD-9 primary and secondary diagnoses included schizophrenia (N=73, 41%), developmental delay/mental retardation (N=27, 15%), personality disorders (N=22, 12%), neurotic disorders (N=21, 12%), affective psychoses (N=15, 8%), and epilepsy (N=8, 5%). For 9 individuals, "No Disability" was identified as their primary ICD-9 code. This anomaly may be explained by two possible scenarios: (1) the individual has been determined to be disabled because he/she meets Canada Pension Plan Disability (CPP-D) criteria for disability and therefore does not require independent assessment for the Ontario Disability Support Program (ODSP), in which case no ICD-9 code is recorded by ODSP; or (2) the individual receiving ODSP is the non-disabled spouse of a disabled recipient.

The self-reported presence of certain conditions was compared to ODSP disability determination files to determine the concordance between these two data sources. These comparisons were conducted for the 178 participants for whom data linkage was accomplished. As can be seen in **Table 26,** the disability determination file confirmed the diagnosis of schizophrenia or psychosis in 67% of the individuals who self-reported these diagnoses. In comparison, the corresponding figures were only 22% for individuals who self-reported a diagnosis of developmental disabilities, 20% for individuals who self-reported a diagnosis of bipolar/manic, and 25% for individuals who self-reported any other mental health diagnosis **(Table 26)**.

These relatively low figures for the correlation of self-reported developmental disabilities, bipolar/manic, and other mental health diagnoses with ODSP disability diagnoses may be due to a number of factors. First, an individual may accurately self-report that they have a specific condition (e.g., developmental disability), but they may have qualified for disability on the basis of a different condition (e.g., epilepsy). Second, the disability determination file contains only the individual's primary and secondary diagnoses; thus, for an individual with three or more conditions, the disability file will fail to confirm at least some of these diagnoses. Third, individuals may report a condition that is in a different category than the diagnosis assigned by the disability determination process (e.g., an individual may self-report bipolar disorder, but the disability determination process may have assigned the diagnosis of major depression). Fourth, the individual may have "no disability" listed as their primary ICD-9 code, for the reasons given above. Finally, individuals may self-report conditions (e.g. depression) that have not been formally confirmed by a health care provider. Overall, these findings emphasize the fact that a formal diagnostic interview or a careful review of medical records, not correlation to the disability determination file, would be a preferable method of confirming self-reported diagnoses of developmental disabilities or mental health diagnoses.

Table 25. Primary and Secondary ICD-9 Diagnoses for Disabilities among Participants (N=178).

ICD-9 Code	ICD-9 Description	N(%)
--	No Disability	9 (5)
44	Other HTLV-III/LAV conditions	1 (0.6)
70	Viral hepatitis	1 (0.6)
250	Diabetes mellitus	2 (1)
278	Obesity and other hyperalimentation	3 (2)
294	Other organic psychotic conditions (chronic)	1 (0.6)
295	Schizophrenic psychoses	73 (41)
296	Affective psychoses	15 (8)
297	Paranoid states	3 (2)
298	Other nonorganic psychoses	3 (2)
300	Neurotic disorders	21 (12)
301	Personality disorders	22 (12)
303	Alcohol dependence syndrome	3 (2)
304	Drug dependence	1 (0.6)
305	Nondependent abuse of drugs	1 (0.6)
307	Special symptoms or syndromes not elsewhere classified	2 (1)
311	Depressive disorder not elsewhere classified	4 (2)
314	Hyperkinetic syndrome of childhood	2 (1)
315-319	Development delays/Mental retardation	27 (15)
315	Specific delays in development	4 (2)
317	Mild mental retardation	11 (6)
318	Other specified mental retardation	2 (1)
319	Unspecified mental retardation	10 (6)
333	Other extrapyramidal disease and abnormal movement disorders	1 (0.6)
334	Spinocerebellar disease	1 (0.6)
335	Anterior horn cell disease	1 (0.6)
345	Epilepsy	8 (4)
348	Other conditions of brain	2 (1)
369	Blindness and low vision	2 (1)
401	Essential hypertension	2 (1)
413	Angina pectoris	1 (0.6)
414	Other forms of chronic ischemic heart disease	1 (0.6)
443	Other peripheral vascular disease	1 (0.6)
493	Asthma	1 (0.6)
496	Chronic airways obstruction, not elsewhere classified	1 (0.6)
592	Calculus of kidney and ureter	1 (0.6)
696	Psoriasis and similar disorders	1 (0.6)
722	Intervertebral disc disorders	1 (0.6)
729	Other disorders of soft tissues	1 (0.6)
758	Chromosomal anomalies	1 (0.6)
783	Symptoms concerning nutrition, metabolism, and development	1 (0.6)
820	Fracture of neck of femur	1 (0.6)
852	Subarachnoid subdural and extradural hemorrhage following injury	1 (0.6)
907	Late effects of injuries to the nervous system	1 (0.6)
959	Injury, other and unspecified	1 (0.6)

Table 26: Correlation of Selected Self-Reported Conditions with ODSP Disability Diagnosis Data

Self-Reported Condition	ODSP disability diagnosis (ICD-9 codes)	Number of individuals with self-reported condition	Number of individuals with self-reported condition that correlated with ODSP disability diagnosis	% of individuals with self-reported condition that correlated with ODSP disability diagnosis
Developmental Disabilities (including Fetal Alcohol Effects, Fetal Alcohol Syndrome)	315-319	46	10	22
Schizophrenia/Psychosis	294, 295, 297, 298	87	58	67
Bipolar/Manic Disorder	296	49	10	20
Any Other Mental Health Diagnosis (including Generalized Anxiety Disorder, Panic Disorder, Personality Disorder, Phobia, Obsessive-Compulsive Disorder, PTSD, Depression, Major Depression)	300, 301, 311	111	28	25

SUMMARY OF MAJOR FINDINGS

Demographic Characteristics of Study Participants

A total of 258 participants (response rate of 71%) were enrolled in the study at 54 Domiciliary Hostels across 8 CMSMs in Ontario. The majority of study participants were male (59%), aged under 65 years (77%), white (90%), single/never married (50%), Canadian citizens (98%), residents of Ontario for 20 years or more (88%), not a high school graduate (54%), currently unemployed (96%), engaged in low-skills jobs at their previous or current place of employment, not currently involved in volunteer activities (88%), and had English as their preferred communication language (90%). Tenants aged 65 years and over tended to be female (63%) and tenants younger than 65 years tended to be male (65%). In the past 12 months, 7% of the participants had been on parole or probation, and 4% were currently living in a Domiciliary Hostel as a requirement of their parole or probation.

Physical Health Conditions and Developmental Disabilities

As measured by the SF-12 Physical Component Subscale score, Domiciliary Hostel tenants tended to have poorer physical health status (4.5 points lower) than the U.S. general population. An overwhelming 89% of the participants reported having at least

one physical health condition. The most commonly reported physical health conditions were arthritis/rheumatism/joint problems (45%), difficulty walking (45%), high blood pressure (34%), diabetes (25%), asthma (20%), chronic bronchitis/emphysema (19%), epilepsy/seizures (16%), anemia (14%), heart attack (14%), and skin disease (13%) and stroke (12%). Moreover, 19% reported a visual impairment, 18% a hearing impairment, and 15% a head injury/acquired head injury. Twenty-one per cent of the participants reported they had been diagnosed with developmental disabilities and 30% reported they had been diagnosed with developmental, learning or other disabilities.

Mental Health Issues and Substance Use

Compared to the U.S general population, Domiciliary Hostel tenants had poorer mental health status (7.5 points lower) as measured by the SF-12 Mental Component Subscale score. Nearly three-quarters (73%) of the sample reported being diagnosed with a mental health issue, excluding substance abuse/dependence, and more than half (52%) of the sample reported being diagnosed with a serious mental health issue. The 6 most common mental health issues included depression/major depression (41%), schizophrenia (37%), generalized anxiety disorder (24%), bipolar disorder/manic-depressive (21%), panic disorder (15%), and personality disorder (15%). About one-third (36%) of the participants reported using alcohol or drugs in the last 3 years and 19% reported a history of substance abuse/dependence. Based on the GAIN past-year substance dependence index, 8% were classified as having moderate dependence and 5% as high dependence.

Developmental Disabilities, Mental Health Issues, and Substance Abuse/Dependence

A total of 19% of the participants had both self-reported developmental disabilities and at least one diagnosed mental health issue, excluding substance abuse/dependence. Meanwhile, a total of 17% of the participants had both self-reported a diagnosed mental health issue and substance abuse/dependence.

Quality of Life

Participants' health state as measured using the EuroQol-5D (EQ-5D) index score was 0.74, on a scale that ranges from 0.0 (death) to 1.0 (perfect health). For all five EQ-5D dimensions measured (pain/discomfort, anxiety/depression, mobility, usual activities, and self-care), Domiciliary Hostel tenants were substantially more likely to report experiencing some problems compared to the Canadian population. Meanwhile, tenants' self-rated health-related quality of life was 68.9, which is 11 points lower than that of the Canadian population.

Health Care

The majority of the participants had a usual source of health care (87%) and a family doctor (86%). Approximately two-thirds of the participants (64%) usually saw their family doctor at the doctor's office and 38% usually had a family doctor visit at the

Domiciliary Hostel. Use of health care in the past 12 months was common among hostel tenants where 62% had received health care from a doctor's office, outpatient clinic, walk-in clinic or community health centre, 38% at a hospital emergency room, and 28% at a hospital. Meanwhile, 40% had a psychiatrist who they saw regularly.

Participants were overall satisfied with the way health care was provided during the 12 months with 81% expressing they were "very" or "somewhat satisfied" and 88% indicating that he/she was "very" or "somewhat confident that he/she could obtain good health care when needed. A special diet for health reasons were followed by 30% and the majority were able to obtain the foods they needed. Domiciliary Hostel staff/operator were the most common persons assisting tenants with their medications (64%) and accompanying them during health visits (37%).

Support Services, Community Life, and Social Supports

Forty-three per cent of the participants had a support worker who helped with accessing services, and the same percentage reported using some type of community services/supports in the past 12 months or for the duration they had resided in the Domiciliary Hostel (if less than 12 months). The most commonly used services/supports included mental health programs (14%), drop-in services (7%), religious services (6%), activities offered on-site or off-site such as arts and crafts, bingo, bowling and movies (5%), and addiction services (5%). Of the services/supports used by participants, one-third was provided at the Domiciliary Hostel. The most common supports/services provided at the Domiciliary Hostel, included activities (57%), religious activities (44%), other services/supports (38%), and Assertive Community Treatment (33%), mental health programs (22%), and city social services (20%).

Participants demonstrated very low involvement in activities in the last 12 months or during the duration they had resided in the Domiciliary Hostel (if less than 12 months) where on a scale from 0 (low) to 52 (high), their mean Community Activities scale score was 12.7. The most common activities Domiciliary Hostel staff assisted participants with included participating in outdoor/indoor activities (33%), visiting a sports event (31%), a movie/concert/play (29%), a shopping centre (18%), a barber/beauty salon (16%), and a park/museum (15%). Perceived support was relatively high where on a scale of 0 (low) to 24 (high), the mean CMHEI Social Support score was 16.1. The majority of the participants (80%) indicated they had people with whom they could feel at ease with and talk to. The most common individuals identified were friends (75%), family (72%), and the Domiciliary Hostel staff/operator (68%). During the past month, 77% of the participants had been in contact with close friends at least once or twice and 75% with family at least once or twice.

Housing

The average length of stay in the current Domiciliary Hostel for participants was 5.1 years, and 7.9 years at their previous residence. Slightly more than one-third (35%) of

the sample had been homeless one or more times in their life and the average number of years ago they were homeless was 10.2 years. The majority of participants felt that living at the current hostel had no effect on his/her health (46%) and 37% felt it had a positive effect. Most participants (87%) liked aspects about living at the hostel and the main reasons included the food, tenants, friendly staff, activities offered, friendly people, atmosphere/environment, freedom, human contact, and everything. Forty-eight of the participants disliked things about the hostel and the common aspects included the tenants, food or size of portion, lack of freedom, lack of discipline/conflict among tenants and harassment, uncaring and unfriendly staff, noisy/crowded/living in groups, and the structured environment/rules. Participants had a relatively high level of perceived housing quality with a mean Toro Housing Quality score of 33.8.

Participants' previous residence mainly consisted of their own/family house (28%), an apartment (28%), and another Domiciliary Hostel (17%). The most common reasons tenants provided for moving from their previous residence to the Domiciliary Hostel included mental health issues (18%), change in family situation (16%), current residence is better than the previous (16%), physical health conditions (14%), assistance with daily living/dispensing of medications (12%), and previous residence was no longer available (11%). Among the 45 participants who had moved from another Domiciliary Hostel, some reasons were: current residence is better than the previous (29%), concerns about personal safety (20%), previous residence was no longer available (16%), food complaints (9%), problems with physical environment (7%), problems with tenants (7%), and problems with staff (7%). Nearly two-thirds of participants (63%) responded they would prefer to stay at the current hostel and 33% who would prefer to move elsewhere. Among the tenants who indicated they preferred to move elsewhere or were unsure, 56% stated they planned to move within the next 6 months. The three most common types of housing desired by these tenants were an apartment, own/family house, and another Domiciliary Hostel.

Health, Use of Community Services/Supports, and Involvement in Community Activities of Participants: Subgroup Comparisons

Comparisons of various subgroups of participants revealed the following trends. Tenants residing in smaller sites, short-term tenants, and tenants without any serious mental health issues, developmental disabilities, or developmental, learning or other disabilities tended to be younger than their counterparts. Non-seniors tended to have higher physical health status, be more integrated in the community, have a support worker, be accompanied during health care visits, take prescribed medications, have a Domiciliary Hostel staff accompany them to health care visits and assist with medications, and use community services/supports, especially mental health programs, drop-in services, and addiction services. Non-seniors were also more likely to have developmental disabilities, developmental, learning or other disabilities, head injury/acquired head injury, mental health issues (excluding substance abuse/dependence), serious mental health issues, self-reported substance abuse/dependence, and to use of alcohol or drugs in the last 3 years. Seniors

however had a higher mental health status and slightly higher self-rated health-related quality of life.

Participants in smaller sites had better health state and were more likely to be taking prescribed medications. They were also more likley to have a Domiciliary Hostel staff assist with medications, be better integrated in the community, and to use community services/support, especially mental health programs and addiction services. Meanwhile, participants in larger sites were more likely to be accompanied during health care visits and have a support worker help access services.

Long-term tenants had better mental health status and self-rated health-related quality of life, and slightly better health state than short-term tenants. Meanwhile, physical health status was similar among both groups. Long-term tenants were slighly more likely to be better integrated into community, have a support worker, take prescribed medication, and have a Domiciliary Hostel staff assist with medications and accompany them during health visits. Meanwhile, short-term tenants were more likely to be accompanied during health visits, and to use community services/supports, especially mental health programs and other services/supports.

Participants with any serious mental health issues tended to have lower mental health status, but similar physical health status compared to those without serious mental health issues. Participants with serious mental health issues were more likely to have a support worker, take prescribed medications, and have a Domiciliary Hostel staff accompany during health visits and assist with their medications. These tenants were also more likely to use any community services/supports, especially mental health services and drop-in services, and to be better integrated into the community.

Tenants with developmental disabilities as well as tenants with developmental, learning or other disabilities tended to have slightly lower self-rated health-related quality of life, considerably lower mental health status and health state, and similar physical health status compared to their counterparts. These tenants were also more likely to use community services/supports, be accompanied during health visits, and have Domiciliary Hostel staff accompany them during health visits and assist with medications. They were also slightly more likely to have a support worker and to be better integrated into the community.

When comparing groups based on age, facility size, duration of tenancy in their current Domiciliary Hostel, serious mental health issues, and developmental, learning or other disability, no differences were found on whether any of the groups were more likely to receive particular community services/supports at their Domiciliary Hostel. Participants with developmental disabilities were however twice as likely to report being provided with mental health services and being involved in activities at the Domiciliary Hostel than those without developmental disabilities.

Data linkage with the Provincial Database

Linkage with the disability databases for 178 participants showed that the most common primary and secondary ICD-9 diagnoses were schizophrenia (41%), developmental delay/mental retardation (15%), personality disorders (12%), neurotic disorders (12%), affective psychoses (8%), and epilepsy (4%). The self-reported presence of certain conditions was compared to ODSP disability determination files to determine the concordance between these two data sources. In the 178 participants for whom data linkage was accomplished, the disability determination file confirmed the diagnosis of schizophrenia or psychosis in 67% of the individuals who self-reported these diagnoses. In comparison, the corresponding figures were only 22% for individuals who self-reported a diagnosis of developmental disabilities, 20% for individuals who self-reported a diagnosis of bipolar/manic, and 25% for individuals who self-reported any other mental health diagnosis.

These relatively low figures for the correlation of self-reported developmental disabilities, bipolar/manic, and other mental health diagnoses with ODSP disability diagnoses may be due to a number of factors. First, an individual may accurately self-report that they have a specific condition (e.g., developmental disability), but they may have qualified for disability on the basis of a different condition (e.g., epilepsy). Second, the disability determination file contains only the individual's primary and secondary diagnoses; thus, for an individual with three or more conditions, the disability file will fail to confirm at least some of these diagnoses. Third, individuals may report a condition that is in a different category than the diagnosis assigned by the disability determination process (e.g., an individual may self-report bipolar disorder but have been assigned the ICD-9 code for major depression). Fourth, the individual may have "no disability" listed as their primary ICD-9 code, for the reasons given above. Finally, individuals may self-report conditions (e.g. depression) that have not been formally confirmed by a health care provider. Overall, these findings emphasize the fact that a formal diagnostic interview or a careful review of medical records, not correlation to the disability determination file, would be a preferable method of confirming self-reported diagnoses of developmental disabilities or mental health diagnoses.

Among the 178 participants, 30% had 0 moves, 35% had 1-4 moves, and 20% had 5 or more moves between January 1, 2003 and May 31, 2008.

DISCUSSION

Strengths of the Study

This study remedies the shortcomings and limitations of available data on Domiciliary Hostel tenants. It builds on the sparse information available from a 1999 report on Domiciliary Hostel tenants,[i] which collected data on tenants' characteristics and needs entirely by proxy, using a 1-page "Resident Information Form" that was completed on the behalf of each tenant by hostel operators. In contrast, data for this study were collected using face-to-face interviews with a representative sample of Domiciliary

Hostel Program tenants and linkages with existing government databases to obtain supplemental information on these tenants.

This study provides reliable, detailed, and relevant data on Domiciliary Hostel tenants, including their demographic characteristics, physical and mental health, prevalence of developmental and learning disabilities, health care, use of community services and supports, participation in community life, social supports, circumstances that bring them to the hostels, circumstances in which they live, and their preferences for future housing. In order to collect this magnitude and level of data, it was important that all components of the questionnaire be administered. For many participants the length of the survey was very challenging, but the flexibility, patience, and persistent encouragement of our research team led to the successful completion of 258 interviews and only 4 incomplete interviews.

We successfully received permission to conduct this study at 95% (54 out of 56) of randomly selected Domiciliary Hostels. The response rate achieved among hostel tenants was also high, with 71% of eligible individuals agreeing to participate in the survey. This rate is comparable with our experience with a survey of 1,200 homeless shelter residents in Toronto, where 73% of eligible individuals agreed to participate in the survey.

Limitations of the Study

This study has certain limitations. First, the study was powered to provide reliable estimates of the characteristics of Domiciliary Hostel tenants in Ontario as a whole. The study's sample size therefore does not provide adequate power to compare the characteristics of individuals in different LHINs or CMSMs. In other words, the number of participants surveyed in each CMSM was too small to allow for meaningful comparisons between CMSMs.

Second, sampling took place in only 8 of the 25 CMSMs that have Domiciliary Hostel Programs. The 17 CMSMs that were not sampled account for 15% of all Domiciliary Hostel Program beds in Ontario. It is unknown if the characteristics of Domiciliary Hostel tenants in the sampled CMSMs differ significantly from those in the non-sampled CMSMs. As a result, our findings may not be generalizable to the 15% of Domiciliary Hostel tenants living in the 17 non-sampled CMSMs.

Third, 54 out of 418 (13%) individuals approached for possible participation in the study were deemed ineligible, primarily due to an inability to converse appropriately. The inability to converse appropriately is likely to have been related to severe mental illness and/or cognitive impairment. These individuals may therefore represent a subgroup of Domiciliary Hostel tenants who have higher levels of disability and illness than those who were recruited in the study, causing our findings to somewhat underestimate the level of illness in the Domiciliary Hostel Program overall.

Fourth, 102 out of 364 (28%) of eligible individuals declined to participate in the study. The characteristics of these individuals may have differed from those enrolled in the

study. However, there is no evidence to suggest that those who declined to participate in the study were likely to be systematically healthier or sicker than those who did participate.

Implications and Conclusions

Since the inception of the Domiciliary Hostel Program more than three decades ago, this program has clearly evolved over time from housing frail seniors to a diverse group of vulnerable adults, including individuals with mental and physical illness, developmental disabilities, and the elderly. These tenants have a very high prevalence of mental health issues. The prevalence of substance dependence is much lower than the prevalence of mental health issues.

Domiciliary Hostel staff assist tenants in a number of ways, including helping them take their prescribed medications, accompanying them for health visits, and providing social support. Nonetheless, these individuals tend to use relatively few community services and to have low levels of involvement in community activities. Tenants of Domiciliary Hostels generally perceive the quality of their housing to be quite good, and 63% express a preference to stay at their current residence.

While it is beyond the scope of this report to make specific policy or program recommendations, it is hoped that the information from this report will be useful in supporting future policy and program planning.

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