

# Housing First Scotland

## Pathfinder Programme Outcomes Follow-Up Questionnaire

To be used at 6, 12, 18 and 24 months post recruitment to the programme

**Unique tracker ID**

- Confirmation that service user has provided written consent for this data to be shared with the evaluation team

**Date of survey completion**

**Tenancy start date** (if applicable)

**Survey time-point**

i.e. time since recruited to (began receiving support from) Housing First:

- 6 months  
 12 months  
 18 months  
 24 months

## Achievements

1. Thinking back over the past six months, what would you consider to be your greatest achievement?

## Housing and Neighbourhood

2. Where are you currently living? *(select one)*

- Own social rented tenancy (provided by council or housing association)
- Own private rented tenancy
- Night shelter / winter shelter
- Hostel
- Refuge
- B&B
- Other temporary accommodation (e.g. temporary furnished flat)
- Friend or family's house on informal and temporary basis (sofa surfing)
- In a tent, caravan or car
- Squat
- Supported housing
- On transport (e.g. bus)
- Prison
- Hospital, detox or rehab
- Sleeping rough
- Don't know
- Prefer not to say
- Other (please specify): \_\_\_\_\_

**3. Where you currently live, do you have: (select one)**

- your own tenancy, and you moved in less than 6 months ago?  
(please go to question 4)
- your own tenancy, and you moved in 6 or more months ago?  
(please go to question 5)
- I don't have a social or PRS tenancy  
(please go to question 5)

**4. Which if any of the following accommodation situations have you stayed in since moving into your own Housing First tenancy? Please select all that apply and specify how many nights approximately**

Accommodation Situation	Number of Nights
<input type="checkbox"/> Sleeping rough	
<input type="checkbox"/> Night shelter / winter shelter	
<input type="checkbox"/> Hostel	
<input type="checkbox"/> Refuge	
<input type="checkbox"/> B&B	
<input type="checkbox"/> Other temporary accommodation (e.g. temporary furnished flat)	
<input type="checkbox"/> Staying with friends or family on informal and temporary basis because you had no home of your own (sofa surfing)	
<input type="checkbox"/> In a tent, caravan or car	
<input type="checkbox"/> Squat	
<input type="checkbox"/> Supported housing	
<input type="checkbox"/> On transport (e.g. bus)	
<input type="checkbox"/> Prison	
<input type="checkbox"/> Hospital	
<input type="checkbox"/> Detox or rehab	
<input type="checkbox"/> Other	

**5. Which if any of the following accommodation situations have you stayed in during the past six months? Please select all that apply and specify how many nights approximately**

Accommodation Situation	Number of Nights
<input type="checkbox"/> Sleeping rough	
<input type="checkbox"/> Night shelter / winter shelter	
<input type="checkbox"/> Hostel	
<input type="checkbox"/> Refuge	
<input type="checkbox"/> B&B	
<input type="checkbox"/> Other temporary accommodation (e.g. temporary furnished flat)	
<input type="checkbox"/> Staying with friends or family on informal and temporary basis because you had no home of your own (sofa surfing)	
<input type="checkbox"/> In a tent, caravan or car	
<input type="checkbox"/> Squat	
<input type="checkbox"/> Supported housing	
<input type="checkbox"/> On transport (e.g. bus)	
<input type="checkbox"/> Prison	
<input type="checkbox"/> Hospital	
<input type="checkbox"/> Detox or rehab	
<input type="checkbox"/> Other	

## 6. How satisfied are you with these aspects of your accommodation?

	Very Satisfied	Fairly Satisfied	Neither Satisfied nor Dissatisfied	Slightly Dissatisfied	Very Dissatisfied	Don't Know	Prefer Not to Say
The amount of choice you had over the place you live	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How close you live to family and friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How close you live to shopping, public transport, post office etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much control you have over who can come into your place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How long you will be able to live in your place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The safety in your neighbourhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The amount of privacy you have	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How affordable your place is	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The conditions / state of repair of your place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The safety and security of the building	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Health and Wellbeing

**7. Which if any of these health problems or disabilities have you had in the past six months?**  
(select all that apply)

- Chest/breathing problems, asthma, bronchitis
- Heart/high blood pressure or blood circulation problems
- Stomach/liver/kidneys or digestive problems
- Diabetes
- Alcohol problem
- Drug problem
- Blood borne virus (BBV) e.g. Hep B, Hep C or HIV
- Epilepsy
- Migraine or frequent headaches
- Problems or disability connected with: arms, legs, hands, feet back, or neck (including arthritis and rheumatism)
- Difficulty in seeing (other than needing glasses to read normal size print)
- Difficulty in hearing
- Skin conditions/allergies
- Cancer
- Stroke
- Other health problems \_\_\_\_\_

**8. Do you have any of the following conditions?** (select all that apply)

- Anxiety
- Depression
- Psychosis or schizophrenia
- Bipolar disorder
- Eating disorder
- Post-traumatic disorder
- Autism
- Learning disability
- Acquired brain injury
- Other
- Don't know
- Prefer not to say

**9. How is your physical health in general? (select one)**

- Excellent
- Very good
- Good
- Fair
- Poor
- Very poor
- Don't know
- Prefer not to say

**10. Compared to six months ago, how would you rate your physical health now? (select one)**

- Much better now than six months ago
- Slightly better now than six months ago
- About the same now as six months ago
- Slightly worse now than six months ago
- Much worse now than six months ago
- Don't know
- Prefer not to say

**11. How would you describe your mental health? (select one)**

- Excellent
- Very good
- Good
- Fair
- Poor
- Very poor
- Don't know
- Prefer not to say

**12. Compared to six months ago, how would you rate your mental health now? (select one)**

- Much better now than six months ago
- Slightly better now than six months ago
- About the same now as six months ago
- Slightly worse now than six months ago
- Much worse now than six months ago
- Don't know
- Prefer not to say

**13. Below are some statements about your feelings and thoughts.**

*Please choose the option which best describes your experience over the past two weeks.*

I've been...	None of the time	Rarely	Some of the time	Often	All of the time
feeling optimistic about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
feeling useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
feeling relaxed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dealing with problems well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
thinking clearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
feeling close to other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
able to make up my own mind about things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**14. Thinking about the last week, please rate yourself on each of the following statements:**

I have...	All of the Time	Most of the Time	A Fair Amount of the Time	A Little of the Time	None of the Time	Don't Know	Prefer Not to Say
been taking care of my mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
been taking care of my physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
been eating a good diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
slept well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
had a good daily routine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## Substance use

### 15. How often do you have a drink containing alcohol?

- Never (skip to question 19)
- monthly or less
- 2-4 times a month
- 2-3 times a week
- 4 or more times a week
- Prefer not to say

### Alcohol unit reference

One unit of alcohol



Half pint of "regular" beer, lager or cider



Half a small glass of wine



1 single measure of spirits



1 small glass of sherry



1 single measure of aperitifs

Drinks more than a single unit



2  
Pint of "regular" beer, lager or cider



3  
Pint of "strong" or "premium" beer, lager or cider



1.5  
Alcopop or a 275ml bottle of regular lager



2  
440ml can of "regular" lager or cider



4  
440ml can of "super strength" lager



3  
250ml glass of wine (12%)



9  
75cl Bottle of wine (12%)

### 16. How many units of alcohol do you drink on a typical day when you are drinking?

- 0 to 2
- 3 to 4
- 5 to 6
- 7 to 9
- 10 or more

### 17. How often do you have 6 or more units if female, or 8 or more if male, on a single occasion?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

**18. Do you consider yourself to be dependent on alcohol?**

- No, not dependent
- Yes, slightly dependent
- Yes, moderately dependent
- Yes, very dependent
- Don't know
- Prefer not to say

**19. How often, if at all, have you used any of the following in the past three months (✓)**

	Never	Once or twice	Monthly	Weekly	Daily or almost daily	Don't know	Prefer not to say
<b>Cannabis</b> <i>(marijuana, skunk, hash, weed)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Powder cocaine</b> <i>(coke, gear, Charlie)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Crack cocaine</b> <i>(rock)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Methamphetamine</b> <i>(crystal meth, glass)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Stimulants</b> <i>(speed, whizz, ecstasy, MDMA)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Heroin/opiates, codeine, methadone, subutex</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hallucinogens</b> <i>(LSD, acid, mushrooms, ketamine)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>New psychoactive substances</b> <i>(etizolam, spice, mamba, NOX etc.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Misuse of prescription drugs</b> <i>(diazepam, temazepam Valium, sleepers, pregabalin, gabapentin)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Solvents, butane</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. Do you consider yourself to be dependent on illegal drugs or misused prescription medication? (select one)

- No, not dependent
- Yes, slightly dependent
- Yes, moderately dependent
- Yes, very dependent
- Don't know
- Prefer not to say

21. In the past six months did you take drugs prescribed for you for:

	Yes	No	Don't Know	Prefer not to say
Alcohol misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A mental health need	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Social relationships and community integration

22. Please indicate whether you agree or disagree with the following statements:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Don't know	Prefer not to say
I am content with my friendships and relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have enough people I feel comfortable asking for help at any time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My friendships and relationships are as satisfying as I would want them to be	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know most of the people who live near me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I interact with the people who live near me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel at home where I live	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel like I belong where I live	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel safe where I live	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that I am accepted where I live	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23. On a scale of 1 -7 where 1 is 'terrible' and 7 'delighted', how do you feel about... (circle one number for each)

- a. The way you spend your time?  
(terrible) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | (delighted)
- b. The amount of time you spend with other people?  
(terrible) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | (delighted)
- c. The way things are in general between you and your family?  
(terrible) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | (delighted)
- d. The things you do with other people?  
(terrible) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | (delighted)
- e. The people you see socially?  
(terrible) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | (delighted)

## Economic status, financial wellbeing and activity

24. What are your current sources of income? (select all that apply)

- Benefits
- Paid work
- Begging
- Selling Big Issue
- Money from family or friends
- Sex work
- Other
- None
- Don't know
- Prefer not to say

25. Which if any of the following benefits do you currently receive? (select all that apply)

- Universal Credit (UC)
- Income Support
- Jobseekers Allowance (JSA)
- Employment and Support Allowance (ESA)
- Personal Independence Payment (PIP)
- Disability Living Allowance (DLA)
- Pension
- Tax credits
- Other

**26. How well would you say you were coping financially these days? Are you... (select one)**

- Doing well financially?
- Doing alright?
- Just about getting by?
- Finding it quite difficult?
- Finding it very difficult?
- Don't know
- Prefer not to say

**27. Are you currently involved in: (select all that apply)**

- Education or training?  
If so, how many hours per week? \_\_\_\_\_
- Voluntary work?  
If so, how many hours per week? \_\_\_\_\_
- Paid work?  
If so, how many hours per week? \_\_\_\_\_

## Experience of crime/ASB

**28. In the past six months, did any of these things happen to you? (select all that apply)**

- belongings were robbed off you (directly).  
If so, how many times? \_\_\_\_\_
- belongings were stolen (when they weren't on you at the time).  
If so, how many times? \_\_\_\_\_
- property or belongings were damaged deliberately.  
If so, how many times? \_\_\_\_\_
- sexually assaulted.  
If so, how many times? \_\_\_\_\_
- physically assaulted.  
If so, how many times? \_\_\_\_\_
- threatened with violence.  
If so, how many times? \_\_\_\_\_

**29. In the past six months, did any of these things happen to you: (select all that apply)**

- receive a caution from the police?  
If so, how many times? \_\_\_\_\_
- get arrested?  
If so, how many times? \_\_\_\_\_
- attend a court appearance?  
If so, how many times? \_\_\_\_\_
- convicted of a crime?  
If so, how many times? \_\_\_\_\_
- required to wear a tag?  
If so, for how many weeks? \_\_\_\_\_
- held in police custody?  
If so how many nights? \_\_\_\_\_
- held in prison?  
If so how many nights? \_\_\_\_\_
- receive a warning letter about nuisance or anti-social behaviour?  
If so, how many times? \_\_\_\_\_
- given a 'ticket' (conditional offer of fixed penalty) for begging or drinking in the street?  
If so, how many times? \_\_\_\_\_

## Service use

### 30. In the past six months how many times did you:

- Visit a GP surgery?  
If so, how many times? \_\_\_\_\_
- Visit A&E (Accident and Emergency)?  
If so, how many times? \_\_\_\_\_
- Have an ambulance called to assist you?  
If so, how many times? \_\_\_\_\_
- Attend a hospital appointment for a physical health problem?  
If so, how many times? \_\_\_\_\_
- Stay in hospital for a physical health need?  
If so, how many days? \_\_\_\_\_
- Attend a GP or nurse walk-in service (including within day centres, hostels or other services)?  
If so, how many times? \_\_\_\_\_
- Attend a mental health service appointment (including therapists but not advice or help from a GP)?  
If so, how many times? \_\_\_\_\_
- Stay in hospital for a mental health need?  
If so, how many nights? \_\_\_\_\_
- Attend residential drug treatment services?  
If so, how many nights? \_\_\_\_\_
- Attend community-based drug treatment services (e.g. NA)?  
If so, how many times? \_\_\_\_\_
- Attend residential alcohol treatment services?  
If so, how many nights? \_\_\_\_\_
- Attend community-based alcohol treatment services (e.g. AA)?  
If so, how many times? \_\_\_\_\_



## Goals

**31. To what extent have you achieved your own goals in the past six months? (*select one*)**

- fully achieved
- partly achieved
- not achieved
- don't know
- prefer not to say

**32. Finally, what are your goals for the next six months?**

**Thank you very much for taking the time to complete this survey**