

	<h2 style="margin: 0;">Doing Time: Baseline Interview</h2> <p style="font-size: small; margin: 10px 0;">During this first interview, I would like to ask you some questions about your health, based on the 9 topic areas that women in prison told us were important to their health. I will also ask you to answer questions that are part of a standardized World Health Organization Questionnaire that you may complete yourself on a paper form or I can read them to you. Your data will be entered into the computer but with only a study number attached to it, not your name. Do you mind if I record your verbal answers to the first set of questions on a digital recorder?</p>
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Institution: <input type="checkbox"/> ACCW <input type="checkbox"/> Other _____ Legal Status: <input type="checkbox"/> Remanded <input type="checkbox"/> Sentenced <input type="checkbox"/> Other _____	How long were you inside prison this time? _____
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DATE OF ARREST (this time): <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: x-small; margin-top: 5px;"> Day Month Year </div>	RELEASE DATE: <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> <div style="border-top: 1px solid black; width: 20px; height: 10px; margin: 0 5px;"></div> </div> <div style="display: flex; justify-content: space-around; font-size: x-small; margin-top: 5px;"> Day Month Year </div>
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1. ACCESS TO INDIVIDUALIZED PRIMARY HEALTH CARE

1. Have you thought about finding a family doctor? Yes No

2. Do you have some specific plans for accessing a family doctor? Yes No

If so – what are they?

2. ACCESS TO HEALTH EDUCATION

1. Do you have some plans to learn more about your health or health care? Yes No

If so – what are they?

HEALTH CONDITIONS: <input type="checkbox"/> Diabetes <input type="checkbox"/> Hepatitis C <input type="checkbox"/> MRSA infection <input type="checkbox"/> Cervical dysplasia <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Obesity <input type="checkbox"/> Endocarditis <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Personality disorder <input type="checkbox"/> High blood pressure <input type="checkbox"/> Other _____	DID YOU RECEIVE TREATMENT FOR ANY OF THESE CONDITIONS IN PRISON? <input type="checkbox"/> Diabetes <input type="checkbox"/> Hepatitis C <input type="checkbox"/> MRSA infection <input type="checkbox"/> Cervical dysplasia <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Obesity <input type="checkbox"/> Endocarditis <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Eating disorder <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Personality disorder <input type="checkbox"/> High blood pressure <input type="checkbox"/> Other _____	DID YOU LEARN NEW INFORMATION ABOUT ANY OF THE HEALTH CONDITIONS YOU HAVE WHILE YOU WERE IN PRISON? <input type="checkbox"/> Diabetes <input type="checkbox"/> Hepatitis C <input type="checkbox"/> MRSA infection <input type="checkbox"/> Cervical dysplasia <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Obesity <input type="checkbox"/> Endocarditis <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Eating disorder <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Personality disorder <input type="checkbox"/> High blood pressure <input type="checkbox"/> Other _____	WERE YOU TAKING MEDICATIONS IN PRISON? List: _____ _____ _____ _____ _____ _____ WHICH MEDS DO YOU PLAN TO CONTINUE TO TAKE? List: _____ _____ _____ _____
CURRENT METHADONE TREATMENT: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Past <input type="checkbox"/> < 6 months <input type="checkbox"/> < 1 year <input type="checkbox"/> 1-3 years <input type="checkbox"/> > 3 year			

3. MORE EXERCISE AND BETTER NUTRITION

a. What kinds of exercise would you like to do? _____

How often? _____

How much time spent in each session? _____

B. Would you like to learn more about nutrition? Yes No
If so how do you plan to learn more?

4. DENTITION AND ORAL HEALTHa. Do you have some plans to access dental care? Yes No
If so – what are they?

5. ACCESS TO SAFE AND STABLE HOUSING**LIVING SITUATION ON ADMISSION:**

- Owns house/apartment
 Rents
 Lives with family (no rent)
 Lives with friends(no rent)
 Hotel/boarding house
 Institution (tx centre, hospital)
 Homeless
 In custody
 Other
- _____

CITY OF RESIDENCE PRIOR TO ARREST:

CITY OF RESIDENCE WHERE YOU PLAN TO LIVE NOW

PLANNED LIVING ARRANGMENTS AT PRESENT

- Owns house/apartment
 Rents
 Lives with family (no rent)
 Lives with friends(no rent)
 Hotel/boarding house
 Institution (tx centre, hospital)
 Homeless
 In custody
 Other

6. JOB SKILLS, TRAINING AND RELEVANT EMPLOYMENT**EDUCATION:**

- Less than high school
 High school or equivalent
 Trades certificate/diploma
 Some college/university
 Completed college/university

EMPLOYMENT at the time of arrest:

- Yes No
- Full-time
 Part-time
 Seasonal/unsteady

- Social Assistance (Welfare)
 Unemployment Insurance
 Disability
 Criminal activity only income
 No means of support
 Other _____

CURRENT FINANCIAL RESOURCES

7. PEER AND COMMUNITY SUPPORT

a. What kinds of peer and community support do you hope to connect with?

b. How do you plan to connect with these sources of support?

8. ABILITY TO CONTRIBUTE TO SOCIETY

a. Describe a time in your life when you were doing something that was meaningful to you.

b. What does being a "productive member of society" look like to you today?

c. How would you like to get involved in activities that make you feel like you are being productive in society?

9. RELATIONSHIPS WITH CHILDREN, FAMILIES AND OTHERS

a. What are your hopes for your relationship with your family over the next year?

b. What are your hopes for your relationships with your children over the next year?

c. What are your hopes for your relationships with your partner over the next year?

d. What role do you think your friends will have in your return to the community?

OTHER DEMOGRAPHIC QUESTIONS**BIRTHDATE:**

AGE TODAY:
_____ years

Day	Month	Year							

ABORIGINAL STATUS

- Non-aboriginal
 Aboriginal

If aboriginal

- Status
 Non-status

Band _____

MARITAL STATUS AT ADMISSION:

- Single
 Married/Common-law
 Current girlfriend/boyfriend
 Separated/Divorced
 Widowed

CHILDREN:

- Yes No
_____ years
_____ years
_____ years
_____ years
_____ years

REASON FOR INCARCERATION: (Check all relevant)

- Assault
 Other offence against persons
 Break & Enter
 Other offence against property
 Drug offence
 Sexual offence
 Driving offence
 Breach/Parole violation/Escape
 Other

SECURITY LEVEL upon release.

- Min. Med. Max

FIRST LANGUAGE

The following questions come from a World Health Organization Quality of Life Questionnaire. They ask how you feel about your quality of life, health, or other areas of your life. You may take this paper yourself and tick the boxes or I can read out each question to you, along with the response options. **Please choose the answer that appears most appropriate.** If you are unsure about which response to give to a question, the first response you think of is often the best one.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your **life in the last four weeks**.

		Very poor	Poor	Neither poor nor good	Good	Very Good
1.	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2.	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the last four weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3.	To what extent do you feel that physical pain prevents you from doing what you need to do?	5	4	3	2	1
4.	How much do you need any medical treatment to function in your daily life?	5	4	3	2	1
5.	How much do you enjoy life?	1	2	3	4	5
6.	To what extent do you feel your life to be meaningful	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
7.	How well are you able to concentrate?	1	2	3	4	5
8.	How safe do you feel in your daily life?	1	2	3	4	5
9.	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about how completely you experience or were able to do certain things in the last four weeks

		Not at all	A little	Moderately	Mostly	Completely
10.	Do you have enough energy for everyday life?	1	2	3	4	5
11.	Are you able to accept your bodily appearance?	1	2	3	4	5
12.	Have you enough money to meet your needs?	1	2	3	4	5
13.	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14.	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
15.	How well are you able to get around?	1	2	3	4	5

Participant ID: _____

Interview Date: _____

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
		Use #3 for any of the questions in this section that are not applicable to you in thinking about the last four weeks.				
16.	How satisfied are you with your sleep	1	2	3	4	5
17.	How satisfied are you with your ability to perform your daily living activities	1	2	3	4	5
18.	How satisfied are you with your capacity for work?	1	2	3	4	5
19.	How satisfied are you with yourself?	1	2	3	4	5
20.	How satisfied are you with your personal relationships?	1	2	3	4	5
21.	How satisfied are you with your sex life?	1	2	3	4	5
22.	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23.	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24.	How satisfied are you with your access to health services	1	2	3	4	5
25.	How satisfied are your with your transport?	1	2	3	4	5

The following question refers to how often you have felt or experienced certain things in the last four weeks.

		Never	Seldom	Quite often	Very often	Always
26.	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	5	4	3	2	1

Do you have any comments about this interview?
