Service Prioritization Decision Assistance Tool (SPDAT)

SINGLE ADULTS SPDAT WORKBOOK

VERSION 5.0

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Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) was released to the public in 2010. Since its release, the SPDAT and accompanying products like the VI-SPDAT, have become the most used triage and assessment tools in homelessness services in the world. This fifth release of the SPDAT line of products brings with it subtle changes, clarification in wording and scoring, and provision of a better user experience for assessors and program participants alike.

VI-SPDAT Series

The **Vulnerability Index – Service Prioritization Decision Assistance Tool** (VI-SPDAT) was developed as a pre-screening tool for busy environments such as drop-in centers and communities that may not have the resources to conduct a full SPDAT assessment for every person as the first phase of assessment. It was made in collaboration with Community Solutions, creators of the Vulnerability Index for street outreach engagement, as a brief survey that can be conducted to quickly determine whether a person has high, moderate, or low acuity. The use of this survey can help prioritize which participants should be given a full SPDAT assessment first. As this is an initial prescreen, OrgCode has provided a number of guidance tools and training videos to assist in the implementation of this tool. Care should be taken to identify where, when, why and with whom this prescreen survey is introduced to promote a trauma informed and harm reducing approach. A webinar is available to assist in optimizing the benefits while decreasing any of the inherent challenges related to any self-reporting surveys. This webinar can be accessed ***here***.

Current versions available:

- VI-SPDAT Version 3.0 for Single Adults
- VI-SPDAT Version 3.0 for Families
- VI-SPDAT Version 2.0 for Transition Aged Youth (24 years and younger)
- VI-SPDAT Version 1.0 for Families led by Transition Aged Youth
- VI-SPDAT Version 1.0 for Prevention/Re-Housing for Single Adults
- VI-SPDAT Version 1.0 for Prevention/Re-Housing for Families
- VI-SPDAT Version 1.0 for Justice Discharge

All versions are available online at www.orgcode.com

SPDAT Series

The **Service Prioritization Decision Assistance Tool (SPDAT)** was developed as an assessment tool for frontline workers to assist in the development of service interventions and support plans dedicated to housing stability. SPDAT assessments tend to serve two paramount goals within a community's system of care. The SPDAT is used by frontline staff that work with program participants who are currently homeless to inform decisions on appropriate service interventions and to assist with prioritization and program matching decisions for finite supportive housing resources locally. As a case management tool, the SPDAT is used within housing focused programs to help

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guide support service to the household once in housing. The SPDAT provides an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those self-reports with evidence. As a result, these tools may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Current versions available:

- SPDAT Version 5.0 for Single Adults
- F-SPDAT Version 3.0 for Families
- Y-SPDAT Version 2.0 for Transition Aged Youth

SPDAT Training Series

To use any products within the SPDAT assessment series, training by OrgCode Consulting, Inc. or an OrgCode certified trainer is required. The full-day in-person SPDAT training provides you the opportunity to bring together as many community partners and practitioners as you want to be trained for one fee.

The training gives you the workbook, case studies, application to current practice, a history of the research, evidence-informed practices, various contributors, guidance on the expected service orientation for practitioners, a review of each component of the tool, conversation guidance with prospective participants and more!

More information about SPDAT training is available online at

http://www.orgcode.com

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Terms and Conditions Governing the Use of the SPDAT

SPDAT products have been developed by OrgCode Consulting, Inc. with extensive feedback from key community partners including people with lived experience. Training is required for the administration and interpretation of the SPDAT assessment. Use of the SPDAT products without authorized training is strictly prohibited.

By using this tool, you accept and agree to be bound by the terms of this expectation.

No sharing, reproduction, use or duplication of the information herein is permitted without the express written consent of OrgCode Consulting, Inc.

Ownership

The Service Prioritization Decision Assistance Tool ("SPDAT") and accompanying documentation is owned by OrgCode Consulting, Inc. This includes all versions of the SPDAT for various population groups, as well as all versions of the VI-SPDAT for various population groups.

Training

Although the SPDAT products are publicly available to communities, training by OrgCode Consulting, Inc., or a third-party trainer, authorized by OrgCode, must be successfully completed and there is a fee for that SPDAT Training. After meeting the training requirements to administer and interpret the SPDAT Series, practitioners are permitted to implement the SPDAT in their work.

Restrictions on Use

You may not use the SPDAT prior to successfully completing training on its use, provided by OrgCode Consulting, Inc. or a third-party trainer authorized by OrgCode. You may not share the SPDAT with other individuals not trained on its use. You may not train others on the use of the SPDAT, unless specifically authorized by OrgCode Consulting, Inc.

Restrictions on Alterations

OrgCode Consulting, Inc. is the owner of the SPDAT line of products. You may not modify the SPDAT or create any derivative work of the SPDAT or its accompanying documentation, without the express written consent of OrgCode Consulting, Inc. Derivative works include but are not limited to translations.

Disclaimer

Although OrgCode is the owner of the Service Prioritization Decision Assistance Tool intellectual property, the management and staff of OrgCode Consulting, Inc. (OrgCode) cannot control the way in which the SPDAT products will be used, applied or integrated into related processes by communities, agency management or frontline workers. OrgCode assumes no legal responsibility or liability for the use of the SPDAT, decisions that are made or services that are received in conjunction with the SPDAT or VI-SPDAT suite of tools.

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PART 1: ABOUT THE TOOL

SPDAT Design

The SPDAT is designed to:

- *Help* prioritize which participants should receive what type of housing assistance intervention and assist in determining the intensity of case management services.
- *Assist* in the prioritization sequence of participants receiving those services.
- *Allow* Team Leaders and program supervisors to better match participant needs to the strengths of specific Frontline Workers on their team.
- *Help* prioritize the time and resources of Frontline Workers.
- *Support assessment* of needs at initial engagement, as well as inform long-term service planning.
- *Assist* Team Leaders and program supervisors to support Frontline Workers and establish service priorities across their team.
- *Provide assistance* with case planning and encourage reflection on the prioritization of different elements within a case plan.
- *Track* the depth of need as well as the intensity, frequency and duration of service responses over time with a goal of increasing housing stability (thereby decreasing acuity)

The SPDAT is **NOT** designed to:

- Provide a diagnosis.
- Assess current risk or be a predictive index for future risk.
- Take the place of other valid and reliable instruments used in clinical research and care.
- Make decisions – including decisions related to the Coordinated Entry/Access prioritization process. It is recommended that communities incorporate much more than just one variable, such as score, in the determination of participant prioritization. It is a decision *assistance* tool.

SPDAT Disclosure

The program participant should be informed that you are using SPDAT. It is best to explain that the SPDAT is a tool to help guide them to the right services, as well as assist with the case planning process and track changes over time (for those people that are referred to a case management team). As part of the intake or Coordinated Entry/Access process, it is also prudent to explain to the prospective participant that the SPDAT is one variable that helps to determine referrals and the priority with which they will get services and housing, but may be accompanied by other information used in the community to determine final priority sequence. It is important to let the participant know that the final determination of a score for any component is a combination of conversation, documentation review, observation, and information from other sources that, with consent, will be gathered. In other words, the outcome is not influenced solely by what they say.

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Similar to transparency in case planning, the person that completes the SPDAT should be offered a copy of the Summary Sheet of the SPDAT after it is completed, which they may accept or decline. A copy of each SPDAT should be kept in the participant's file or as part of their electronic record.

Timing of SPDAT Implementation

Consideration should be made depending on whether the SPDAT Assessment is being used at entry as part of a Coordinated Entry System/Access, with housing-based case management, or both. Many communities have adopted a phased assessment approach within their coordinated entry workflow. This approach progressively engages participants and gathers only the information necessary to direct persons through phases of the homeless response system beginning with prevention and diversion resources, shelter intake, initial assessment of housing barriers, service needs, and then conducting comprehensive assessment with the SPDAT tool—phasing in increased engagement, staffing and resources as participants are unable to rapidly resolve their housing crisis. In this example, the initial SPDAT score may be used as one factor in housing prioritization lists.

As a case management tool, it is recommended that the SPDAT begin after the person has been screened for program eligibility to determine a baseline acuity score. Naturally, this score will change the more you learn about the realities and strengths of the household over time. Although any single organization will benefit from using the SPDAT, the value of the tool and the results it provides are improved as more organizations align in its use.

The SPDAT assessment – especially the first assessment completed with a new household, does not need to be completed in just one engagement. Testing of the tool has demonstrated no discernible differences in those assessments conducted over several visits versus those completed in one visit. In the event that a program participant wishes to take additional time to consider their participation in a program, or in the event that the person conducting an assessment with the individual thinks it would be advantageous to take a break, they are encouraged to do so. Should the accuracy of the information seem suspect to the person conducting the interview based upon the person's self-report, keep in mind that with their consent information can be corroborated from other sources. This type of cross-referencing may be critical for ensuring the best possible assessment that reflects the highest degree of accuracy.

The early application of the tool is a baseline for subsequent SPDAT measurement. The suggested intervals following the baseline SPDAT assessment are as follows:

- Intake/Early in engagement, i.e., early stages of involvement of Housing Worker and prospective participant showing interest in being housed and supported;
- In the "warm transfer" between intake and case managers for those that are being recommended for supports based upon their SPDAT acuity; and
- At or very shortly after (within 2 days of) move in for those that are receiving supports.

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For those that are receiving ongoing support services, the SPDAT should also be updated:

- On or about 30 days
- On or about 90 days
- On or about 180 days
- On or about 270 days
- On or about 365 days

The above schedule provides recommended milestones to update the SPDAT assessment, however, the SPDAT should also be updated any time a person is re-housed or experiences a significant shift in their case plan, either positive or negative. As discussed later, it is not recommended that the SPDAT be completed when a person is in crisis as the episode may misrepresent the overall acuity score.

Graphing Changes

Visuals are an important adult learning strategy. Therefore, it is best practice to visually graph the person's transitions relative to the time intervals noted above. The two examples below illustrate graphing by component or by overall score.

Figure 1 Graphing Changes by Overall Score Over Time

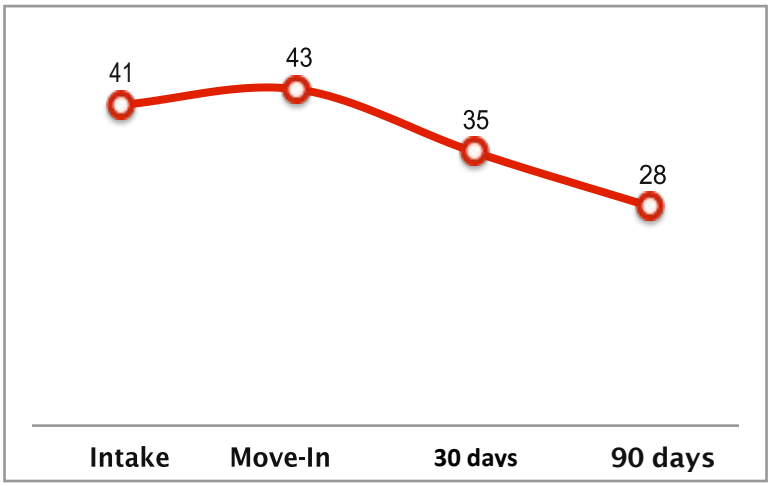

Figure 2 Graphing by Component Over Time

Approaches to Completing the SPDAT

The SPDAT should be completed through observation, conversation, all available documentation, a person's self-report as well as with information shared by other collateral professionals that the participant has given you consent to contact. Information can also come from the person's case plan, information gleaned from home visits and community accompaniment, or existing knowledge from the participant's engagement with your organization. While a conversational approach can be helpful when using the SPDAT, it is not mandatory.

The SPDAT can be completed as part of one conversation in the intake process, or through a series of visits in the early stages of the relationship. For some people with complex needs, it may be necessary to have multiple brief conversations to gather enough accurate information to complete the tool. If you are uncertain of the accuracy of information shared verbally by the person, the worker is encouraged is not only encouraged to summarize and seek clarification during the discussion but also to gather information using multiple methods of gathering insights. It is important to ensure that the SPDAT assessment surpasses self-reporting.

Gathering information to complete the SPDAT

There are four methods used to gather information to complete the SPDAT. Observation, Conversation, gathering supportive Documentation, and talking to Other Professionals.

It's important to think of the SPDAT as a tool for practitioners that can assist with organizing and prioritizing the incredible volume of information that we obtain through service engagements. Think of it less as a physical tool or something you have to 'do' with participants. The information that is needed to complete the SPDAT is likely already available through the intake and engagements occurring in day to day housing focused programming, and if not, the SPDAT can assist with identifying what additional information needs to be gathered to complete or update the assessment for accuracy in scoring.

We recommend becoming intimately familiar with the SPDAT Components and their respective scoring thresholds and ask yourself, how will I go about gathering the information that is needed in order for me to feel confident that I am scoring accurately – do I need to observe, ask more questions, gather additional documents, or talk to another professional, or all of the above?

Information about consumers should never be solicited or shared without participant consent. We must be good stewards of confidential and privileged information.

Observation: What do you see with your eyes?

Observation is a primary way in which we gather information about the people we have the privilege to serve. However, it's important to understand our own lens and biases through which we view the world in order to remain neutral and non-judgmental. It's also important to understand that what we observe about the household may differ than how they see themselves. Navigate these nuances with empathy, compassion and honesty.

Conversation: What do you hear?

Conversing with consumers is a critical part of the service relationship and engagement. It is recommended that practitioners are trained in and utilize their knowledge of Motivational Interviewing and Trauma-Informed practices when soliciting information for the SPDAT. Prompt questions are made available throughout this workbook for suggestions. They are not intended to be a script. They do not need be read verbatim, in any particular order, or used at all if you have other ways to get what you need for an accurate score that reflects the current reality for the consumer.

Documentation: What documentation would be helpful?

Gathering supportive documentation may be useful in completing the SPDAT. Ask the potential service participant for documentation that would be helpful for completing the assessment. This includes such documents related to legal or medical issues, family related or court documents, and anything related to housing or their history of homelessness.

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Other Professionals: What do other professionals have to share?

In addition to observation and conversation, sometimes it is helpful or useful to, with consent, obtain additional information from other professionals with whom your household has been engaged. Examples of this include social workers, school professionals, landlords, other service providers, a primary care physician or psychiatrist, etc.

Using the SPDAT in Providing and Helping to Guide Supports

For those people that receive case management or other housing focused supports as a result of their depth of need (as identified by their SPDAT score), the SPDAT has proven to have great value in helping to guide case planning, service interventions and support conversations. Focusing attention on those life areas incorporated into the SPDAT where the person has higher acuity has been successful in helping people work through the Stages of Change to improved stability. The insights gleaned from the SPDAT assessment have also proven helpful to case managers and other supports in guiding the conversation during engagements, as well as in establishing objectives for each follow-up visit. Throughout its use, the SPDAT remains a tool that is person-centered and allows for strength-based approaches to service delivery.

Noting Discrepancies

With some people you will gather information or observe behavior that may be contradictory to the participant's self-assessment. This can be a positive thing in the case management process in working towards change. Do not shy away from being transparent in your assessment, noting the discrepancies whenever they appear. Respectfully unearth discrepancies when evident, as this is an important component in our professional relationships with participants as we strive to assist them in their journey to improved housing stability.

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Components of the SPDAT

The SPDAT is divided into 15 components or life areas (20 for families using the Family SPDAT). Each component has a description that categorizes the scoring relative to each component. These components are further organized into 4 domains or thematic groups that link components together.

The domains and components within the SPDAT are as follows:

Domain	Components
Wellness	A. Mental Health & Wellness & Cognitive Functioning B. Physical Health & Wellness C. Medication D. Substance Use E. Experience of Abuse and/or Trauma
Risks	F. Risk of Harm to Self or Others G. Involvement in Higher Risk and/or Exploitive Situations H. Interaction with Emergency Services I. Legal Involvement J. Managing Tenancy
Socialization & Daily Functioning	K. Personal Administration & Money Management L. Social Relationships & Networks M. Self-care & Daily Living Skills N. Meaningful Daily Activity
Housing & Homelessness History	O. History of Housing & Homelessness

The scoring begins with "0" that indicates higher functioning/non-issue. Level "4" indicates a more serious issue/situation. While a description is provided for each component complete with definitions, it is useful to include examples in conjunction with each score. Certain scenarios require careful consideration about which score to use when the scenario does not precisely match the descriptions. In these instances, it is important for staff to provide their rationale for the score indicated.

For each component, there is an opportunity to record what you observed or the comments that the individual disclosed that resulted in the score.

PART 2: THE DOMAINS AND COMPONENTS OF THE SPDAT

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Wellness

A. Mental Health & Wellness & Cognitive Functioning

What do I need to know to complete this component?

This component covers mental health and wellness, as well as cognitive functioning. The intent is not to provide a diagnosis but to better understand how these issues may impact daily living and housing stability.

While there may be many reasons for the person to have a compromised ability to communicate clearly or engage in socially appropriate behavior, these may be clues, along with the likes of delusions, hallucinations, incomprehensible dialogue, or an apparent disconnect from reality. A suspected or untrained observation of mental illness or compromised cognitive functioning can be a prompt for further dialogue to have an appropriate professional engage.

There is a range of mental health conditions. Consideration should be given to the program participant who has a diagnosable mental health condition, especially serious and persistent mental illness.

Key points:

➡ Look for the presence of mental health issues or cognitive impairments

➡ Look for the impact of those health issues on daily functioning

➡ Does the individual have a diagnosis of a mental health illness, or do you believe they could be hospitalized for their compromised mental health?

Caution should be exercised in considering whether the individual qualifies as having a serious and persistent mental illness, when they do not disclose or provide documentation related to their serious and persistent mental illness. Some considerations in making this determination would include such things as: whether they have been hospitalized for psychiatric care two or more times in the last two years and whether it is reasonable to believe they would likely be hospitalized for psychiatric care according to a mental health professional.

Included in consideration of compromised cognitive functioning are barriers to daily functioning that result from brain injuries, learning disabilities (as validated by neuropsychological or psychoeducational testing), and/or developmental disorders. In most instances, barriers to daily functioning as a result of compromised cognitive functioning will include one or more of the following: diminished aptitude; issues with memory especially related to visual or verbal acquisition, retrieval, retention and/or recognition; attention issues such as decreased visual or auditory spans of attention; and compromised executive functioning such as the ability to plan, prioritize, organize or sequence activities.

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How do I complete this component?

Observation

- Does the person appear to be having any visual or auditory hallucinations?
- Is the person speaking in an incomprehensible manner?
- Is the person demonstrating severe anxiety and debilitating depression that makes it impossible to complete the activities of daily living?
- Does the person often have trouble with memory or comprehension, more so than would be normal for a person with average cognitive functioning capabilities?
- Does the person exhibit signs of severe paranoia or otherwise act irrationally?

Conversation

- Have you ever received any help with your mental health or has any professional expressed their concern for your mental wellness?
- Do you feel that you are getting all the help they need for your mental health or stress?
- Has a doctor ever prescribed you pills for nerves, anxiety, depression, or anything like that?
- Have you ever gone to an emergency room or stayed in a hospital because you weren't feeling 100% emotionally?
- Do you have trouble learning or paying attention, or have you been tested for learning disabilities?
- Have you ever hurt your brain or head?

Documentation

- Do you have any documents or papers about your mental health or brain injury or your learning needs?
- Do you have any documents from past stays in hospital because of your physical health?

Other Professionals

➡ Remember to obtain informed consent before contacting professionals!

- Are there other professionals we could speak with that have knowledge of your mental health or cognitive functioning? Perhaps a doctor, social worker, or counsellor?

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How do I score this component?

4	**Any** of the following: ☐ Serious and persistent mental illness (declaration of such; or, two or more hospitalizations in a mental health facility or psychiatric ward of a hospital because of a diagnosable mental health condition that is likely serious and persistent) **and** not in a heightened state of recovery currently ☐ Major barriers to performing tasks and functions of daily living or communicating intent because of a brain injury, learning disability, or developmental disability
3	**Any** of the following: ☐ Heightened concerns about state of mental wellness, but without two or more hospitalizations in a mental health facility/ward (or proof thereof), and/or without knowledge of the presence of a diagnosable mental health condition ☐ Diminished ability (reduced achievement) to performing tasks and functions of daily living or communicating intent because of a brain injury, learning disability, or developmental disability
2	While there may be concern for overall mental health or mild impairments to performing tasks and functions of daily living or communicating intent, **all** of the following are true: ☐ No major concerns about the safety or ability of the individual to be housed without intensive supports to assist with mental health or cognitive functioning ☐ No major concerns to the health and safety of others because of mental health or cognitive functioning ability ☐ No compelling reason to have the individual screened by an expert in mental health or cognitive functioning prior to housing to fully understand capacity
1	☐ The individual is in a heightened state of recovery, understands symptoms and strategies for coping with them, **and** is engaged with mental health supports as necessary.
0	☐ No mental health or cognitive functioning issues disclosed, suspected, or observed.

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B. Physical Health & Wellness

What do I need to know to complete this component?

This component covers physical health and wellness. Mental health and wellness is covered in "**A. Mental Health & Wellness & Cognitive Functioning**", and is not included as a consideration in this component.

There are four considerations related to the person in this component: whether they have a physical health issue; the severity of the health issue; whether they are accessing care for that physical health issue (including those who may wish to access care but are unable due to insufficient health resources in the community); and, how the individual views wellness.

Key points:

➡ Look for the presence of physical health issues and access to treatment.

➡ Look for the impact of those health issues on daily functioning

➡ Does the individual have any chronic health problems that would impact their housing?

In this component, minor physical health issues are those that can be treated without overly intensive care or through non-obtrusive, accessible interventions. For example, an individual who breaks their arm and requires a cast, but does not require surgery or extensive physiotherapy, may be considered to have a minor physical health issue. Another example might include an individual with an arthritic knee who routinely uses a mobility-assistance device but has minimal challenges in achieving the activities of daily living.

Chronic health issues include, but are not limited to, conditions such as heart disease, cancer, diabetes, and immunological disorders that are not easily treated and/or healed. These conditions continue to impact daily functioning regardless of treatment provided.

Intensive health support includes the provision of professional wound care, assistance with a colostomy bag, injection medications, and similar medical interventions.

How do I complete this component?

Observation

- Does the person have any professional wound dressings or open wounds?
- Does the person have an oxygen tank, colostomy bag, or other advanced medical apparatus?
- Does the person use a cane, crutches, a walker, or a wheelchair?
- Does the person have any amputated limbs?
- Does the person have any casts, slings, or splints?
- Does the person exhibit other signs of chronic illness, such as difficulty breathing, or a chronic cough?
- Does the person wear a bracelet from a recent hospital admission?

Conversation

- How is your health?
- Are you getting any help with your physical health and wellness? How often?
- Do you have any documented physical disabilities?
- Do you feel you are getting all the care you need for your physical health?
- I don't need any details, but do you have any illnesses like diabetes, HIV, Hep C, or anything like that going on with you?
- Ever had a doctor tell you that you have problems with blood pressure or heart or lungs or anything like that?
- When was the last time you saw a doctor? What was that for?
- Do you have a clinic or doctor that you usually go to?
- Anything going on right now with your health that you think would prevent you from living a healthy life?

Documentation

- Do you have any documents or papers about your health?
- Do you have any documents from past stays in hospital because of your physical health?

Other Professionals

➡ ***Remember to obtain informed consent before contacting professionals!***

- Are there other professionals we could speak with that have knowledge of your physical health? Maybe a doctor or a nurse that can provide other details that would be important to know as assist you?

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How do I score this component?

4	**Any** of the following: ☐ Co-occurring chronic health conditions ☐ Attempting a treatment protocol for a chronic health condition, but the treatment is not improving health ☐ Palliative health condition
3	Presence of a health issue with **any** of the following: ☐ Not connected with professional resources to assist with a serious health issue, by choice ☐ Single chronic or serious health concern but does not connect with professional resources ☐ Unable to follow the treatment plan as a direct result of homeless status ☐ 60 Years of Age or Older **with** one or more consecutive years of homelessness **and** none of the other conditions noted above as scoring a "4"
2	☐ Presence of a relatively minor physical health issue, which is managed and cared for with appropriate professional resources or through informed self-care, ☐ Presence of a physical health issue, for which appropriate treatment protocols are followed, but there is still a moderate impact on their daily living
1	Single chronic or serious health condition, but **all** of the following are true: ☐ Able to manage the health issue and live a relatively active and healthy life ☐ Connected to appropriate health supports ☐ Educated and informed on how to manage the health issue and consistently follow these requirements.
0	☐ No serious or chronic health condition disclosed, observed, or suspected ☐ If any minor health condition, they are managed appropriately

C. Medication

What do I need to know to complete this component?

This component addresses medications that have been prescribed by a professional and that are being used in an amount and for a purpose that is consistent with the prescription.

Over-the-counter medications are not included here. If the person is using an over-the-counter medication for a purpose other than intended, it may be considered as part of "**D. Substance Use**".

Those who take medications that are not prescribed by a medical professional, even if it is for a mental health or physical ailment, should be considered "**D. Substance Use**".

Key points:

➡ Look for prescribed medications and/or unfilled scripts.

➡ Do they follow the directions of the medication that's prescribed to them?

➡ Over-the-counter drugs are not part of this component (see "D. Substance Use")

➡ Prescription medication not in the person's name are not part of this component (see "D. Substance Use")

How do I complete this component?

Observation

- Are there any prescription bottles in their bathroom/among their possessions?
    - Do the bottles have their name on it or someone else's?
    - What are the dates on prescription bottles?
- Do they have a pillbox or any other method to keep their medications organized and stored?
- Do they have visible reminders telling them to take their medication?
- Any scripts (indicating a prescribed but unfilled medication) in their possession?
- If you have completed "**A. Mental Health & Wellness & Cognitive Functioning**" and/or "**B. Physical Health & Wellness**", have you identified the presence of any health issues that may require medication?

Conversation

- Have you recently been prescribed any medications by a health care professional?
- Do you take any medication, prescribed to you by a doctor?
- Have you recently had a doctor prescribe you a medication that wasn't filled or you didn't take?
- Were any of your medications changed in the last month? How did that make you feel?
- Do other people ever steal your medications?
- Do you ever sell or share your medications with other people?
- How do you store your medication and make sure you take the right medication at the right time each day?
- What do you do if you realize you have forgotten to take your medications?

Documentation

- Do you have any papers or documents about the medications you take?

Other Professionals

➡ ***Remember to obtain informed consent before contacting professionals!***

- Have you ever had medications managed by someone else and just given to you at the time(s) to take them? Who were they?
- Has there been anyone involved in helping you understand your medications, like meetings or extended conversation with a pharmacist?

How do I score this component?

4	**Any** of the following: ☐ In the past 30 days, started taking a prescription which **is** having any negative impact on daily living, socialization, or mood ☐ Shares or sells prescription, but **keeps less** than is sold or shared ☐ Regularly misuses medication (e.g. frequently forgets; often takes the wrong dosage; uses some or all of medication to get high) ☐ Has had a medication prescribed in the last 90 days that remains unfilled, for any reason
3	**Any** of the following: ☐ In the past 30 days, started taking a prescription which is **not** having any negative impact on daily living, socialization, or mood ☐ Shares or sells prescription, but **keeps more** than is sold or shared ☐ Requires intensive assistance to manage or take medication (e.g., assistance organizing in a pillbox; working with pharmacist to blister-pack; adapting the living environment to be more conducive to taking medications at the right time for the right purpose, like keeping nighttime medications on the bedside table and morning medications by the coffeemaker) ☐ Medications are stored and/or administered by a third-party
2	**Any** of the following: ☐ Fails to take medication at the appropriate time or appropriate dosage, 1-2 times per week ☐ Self-manages medication except for requiring reminders or assistance for refills ☐ Successfully self-managing medication for 30 or fewer consecutive days
1	☐ Successfully self-managing medication for more than 30, but less than 180, consecutive days
0	**Any** of the following: ☐ No medication prescribed to them ☐ Successfully self-managing medication for 181+ consecutive days

D. Substance Use

What do I need to know to complete this component?

This component covers substance use, which is the use of alcohol (including non-palatable alcohol) and/or other drugs.

Prescription drugs, including methadone treatment and medical marijuana, are not considered in this component unless they are used for a purpose other than for how they were prescribed. Otherwise, they are considered in "**C. Medication**".

"Acceptable consumption thresholds" for alcohol are: 3 drinks per day or 15 total drinks in any one-week period for men; 2 drinks per day or 10 total drinks in any one week period for women.

Non-palatable alcohol includes any substance with an alcohol content that is not intended for consumption. This would include substances such as mouthwash, cooking wine and alcohol based hand-sanitizers.

Key points:

➡ Be familiar with acceptable consumption thresholds

➡ Look for the frequency with which they use drugs or alcohol beyond acceptable consumption thresholds

➡ Look for the consumption of non-palatable alcohol, inhalants, or injection drugs

➡ Look for frequency of using to the point of complete inebriation or blacking out

➡ Consumption thresholds come from Centre for Addiction and Mental Health

Binge drinking is classified as any instance where a male consumes 5 or more drinks or a female consumes 4 or more drinks in a single hour; or when 10 or more drinks are consumed in a single drinking episode (for example, an evening of drinking).

Inhalant use includes getting high on the fumes from the likes of aerosols, solvents, gases, or nitrites.

How do I complete this component?

Observation

- Look for a significant number of empties where the person lives. Ask if the person was collecting them for recycling.
- Look for a visible rigs, cooker, or other works.
- Does the program participant have the shakes, especially in the morning?
- Is the program participant intoxicated in the morning?
- Does the program participant have puncture marks, track marks, inflammation or infection on arms, legs or other visible places on the person where they have been punctured for injection substance use?
- Does the program participant have sores or blisters at the front of the lips, with co-occurring blackening of gums and teeth in one area of the mouth?

Conversation

- When was the last time you used alcohol or other drugs?
- Anything we should keep in mind related to your used of drugs or alcohol?
- How often would you say you use [substance] in a week?
- Ever have a doctor tell you that your health may be at risk because of your drinking or drug use?
- Have you engaged with anyone professionally related to your substance use? Could we speak with them?
- Ever get into fights, fall down and bang your head, do things you regret later, or pass out when drinking or using other drugs?
- Have you ever used alcohol or other drugs in a way that may be considered less than safe?
- Do you ever drink mouthwash or cooking wine or hand sanitizer or anything like that?
- Ever huff or sniff gas, glue, paint, hairspray or anything like that?

Documentation

- Is there a record of the person being in an addiction treatment program?
- Does any documentation cite substance use or lack of sobriety as a reason for the refusal or termination of services or housing (i.e. ineligibility for program or eviction notice)?

Other Professionals

➡ ***Remember to obtain informed consent before contacting professionals!***

- Is there anyone who has assisted you with your substance use in the past like. A doctor, nurse or harm reduction worker?
- Have you ever attended inpatient or outpatient substance use treatment? Is there someone there we should speak with to understand how to assist you better?
- Have you ever been part of a pain management program?

How do I score this component?

4	☐ In a life-threatening health situation as a direct result of substance use, **or**, In the past 30 days, **any** of the following are true... ☐ Substance use is almost daily (21+ times) **and** often to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use 4+ times ☐ Substance use resulting in involuntarily passing out 2+ times
3	☐ Experiencing serious health impacts as a direct result of substance use, though not in a life-threatening position as a result, **or**, In the past 30 days, **any** of the following are true... ☐ Substance use (drugs and/or alcohol) reached the point of complete inebriation 12-20 times ☐ Alcohol use usually exceeded the consumption thresholds (at least 5+ times), but usually not to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use occurred 1-3 times
2	In the past 30 days, **any** of the following are true... ☐ Substance use reached the point of complete inebriation fewer than 12 times ☐ Alcohol use exceeded the consumption thresholds fewer than 5 times
1	☐ In the past 365 days, no alcohol use beyond consumption thresholds, **or**, ☐ If making claims to sobriety, no substance use in the past 30 days
0	☐ In the past 365 days, no substance use

E. Experience of Abuse and/or Trauma

What do I need to know to complete this component?

This component uses self-reports to assess the impact of abusive and traumatic experiences on day to day life, and to assess the state of recovery, if any. The purpose of this component is not to uncover what the traumatic events were/are, and care must be exercised to avoid exploring the traumatization through questioning.

In recognition that not all have access to professional counseling services, therapeutic recovery should be considered broadly. This is particularly pertinent when considering culturally significant healing practices.

Key points:

➡ This section is entirely self-reported. If the individual says they have suffered no abuse, they get a "0". Reports regarding this component may change over time and this will be captured during updates to the SPDAT.

➡ Look for the impact of abuse or trauma on housing stability

How do I complete this component?

There is no expectation that all front-line workers have expertise in addressing and responding to trauma and abuse.

To avoid re-traumatizing the individual, it is recommended that the practitioner ask selected approved questions as written. This section is entirely self-reported; therefore, it is recommended that workers do not probe for details of the trauma/abuse...

Conversation

- Please do not go into any details, but has there been any point in your life where you experienced abuse or trauma?
- IF YES:
- Do you believe that is the reason why you became homeless?
- Does this impact your day to day life?
- Do you believe this is getting in the way of getting out of homelessness?
- Have you ever gone to a counsellor of any kind or received therapy of any kind as a result of this?
- Have you recovered from this (these) experience(s)?

How do I score this component?

4	☐ A reported experience of abuse or trauma, believed to be a direct cause of their homelessness
3	☐ A reported experience of abuse or trauma that is **not** believed to be a direct cause of homelessness, but the abuse or trauma (experienced before, during, or after homelessness) **is** impacting daily functioning and/or ability to get out of homelessness
2	**Any** of the following: ☐ A reported experience of abuse or trauma, but is not believed to impact daily functioning and/or ability to get out of homelessness ☐ Engaged in therapeutic attempts at recovery, but does not consider self to be recovered
1	☐ A reported experience of abuse or trauma, and considers self to be recovered
0	☐ No reported experience of abuse or trauma

Risks

F. Risk of Harm to Self or Others

What do I need to know to complete this component?

This component is concerned with risk of personal harm and/or risk to others.

Included in this component are both actions as well as written or verbal statements. That is, the undertaking of harm as well as the threatening of harm.

There are no guaranteed ways in which someone can predict if another person will act in ways harmful to themselves or others.

The assessment for this component takes into consideration the likelihood of risk which considers a number of indicators, the history of harming oneself or others, the time since the last action or threats, and, the individual's ability to de-escalate.

The indicators that help inform the likelihood of risk may include such things as:

- Severe depression
- Giving away personal possessions
- Expressing plans for a suicide attempt
- Sense of hopelessness
- Access to lethal means such as a weapon or toxic substance
- Previous suicide attempts
- Excessive substance use
- Social withdrawal and isolation
- History of incarceration for violent acts
- Specific threats of violence against specific people
- Strong feelings of being wronged by a specific person or group of people
- Expressing plans for a violent act against another person or group of people.

Key points:

➡ Look for evidence or risk of self-harm or physical violence

➡ Examine risk factors related to violent behavior and/or threats made by the individual towards others

How do I complete this component?

Observations

- Does the person bear scars or burns, especially on their wrists or arms, which could have come from self-harming?
- Does the person own/have access to any weapons, including firearms or knives?
- Is the person quick to anger?
- Has the person ever threatened you with physical harm, or anyone else while you were in their presence?
- Is the person staying outside? Do they have the equipment, supplies and knowledge to take care of themselves while staying outside?

Ask

- Do you have thoughts about hurting yourself or anyone else?

- Have you recently left a situation you felt was abusive or unsafe? How long ago was that?
- Have you been in any fights recently, whether you started it or someone else did?
  - How long ago was that?
  - How often do you get into fights?

Documentation

- Are there any restraining orders or protective orders filed against the person?
- Has the person ever been mandated to attend anger management classes?
- Has the person ever been on suicide watch?

Other Professionals

➡ ***Remember to obtain informed consent before contacting professionals!***

- Domestic/Family/Intimate Partner Violence Professional
- Street Outreach Worker
- Harm Reduction Support Worker

How do I score this component?

4	**Any** of the following: ☐ In the past 90 days, left an abusive situation ☐ In the past 30 days, attempted, threatened, or actually harmed self or others ☐ In the past 30 days, involved in a physical altercation (instigator or participant) ☐ Sleeping outside and not prepared with supplies and knowledge
3	**Any** of the following: ☐ In the past 180 days, left an abusive situation, but no exposure to abuse in the past 90 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 180 days, but not in the past 30 days ☐ In the past 365 days, involved in a physical altercation (instigator or participant), but not in the past 30 days
2	**Any** of the following: ☐ In the past 365 days, left an abusive situation, but no exposure to abuse in the past 181+ days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 365 days, but not in the past 181+ days ☐ 366+ days ago, 4+ involvements in physical altercations
1	☐ 366+ days ago, 1-3 involvements in physical altercations ☐ Sleeping outside and is prepared
0	☐ Reports no instance of harming self, being harmed, or harming others

G. Involvement in Higher Risk and/or Exploitive Situations

What do I need to know to complete this component?

This component is concerned with the person's involvement in higher risk and/or exploitive situations.

Involvement on the part of the person may have been voluntary or involuntary.

While not an exhaustive list, examples of higher risk and exploitive situations include:

- Sex work
- Injection substance use
- Human and/or sex trafficking, forced labor, exploitation, etc.
- Drug Mule
- Unprotected sexual engagement with unknown or multiple partners
- Binge drinking
- Sleeping outside as a result of blacking out
- Being directly or indirectly forced to work
- Being used for any activity against one's will, consent or knowledge
- Being short-changed for work undertaken
- Staying/living in environments prone to violence
- Engaging in activity solely for the benefit of others without any personal gain or benefit.
- Use of non-palatable alcohol or inhalants.

Key points:

➡ Look for instances of:

⇨ Unprotected sex with multiple partners

⇨ Binge drinking

⇨ Sleeping outdoors

⇨ Injection drug use

⇨ Being taken advantage of/ exploited

⇨ Abusive or violent relationships

➡ Count the total number of risky occasions in the past 6 months

This component also includes those individuals leaving an abusive situation given the high risk the abuser presents. As the mental or physical abuse experienced by the victims is a daily occurrence, these victims should receive a score of "4."

People who have been sleeping outside may also be considered to be in a higher risk situation. Without protective clothing and appropriate sleeping gear they run the risk of exposure and temperature related ailments. Depending on where they are sleeping outside, they may be exposed to higher incidents of violence, sexual assault, and theft.

How do I complete this component?

Observations

- Do they have puncture marks, track marks, inflammation or infection on arms, legs or other visible places on the person where they have been punctured for injection substance use (also see "D. Substance Use")?
- Did they report binge drinking in component "D. Substance Use"?
- How many times has this happened in the past 6 months?

- Did they report an abusive/traumatic experience in component "E. Experience of Abuse and/or Trauma" or identify that they recently left an abusive situation in component "F. Risk of Harm to Self or Others"?
- Is the person currently living/sleeping outside without the supplies and knowledge to reduce risk?
- Does the individual own any weapons, including firearms and knives?
- Any reports of regular inhalant use or non-palatable alcohol use in Component "D. Substance Use"?

Ask

- Does anybody force or trick you to do things that you don't want to do?
- Do you ever do stuff that could be considered dangerous like drinking until you pass out outside, or delivering drugs for someone, having sex without a condom with a casual partner, or anything like that?
- Do you have any debts where someone will hurt you if you don't pay them back?
- Do you ever find yourself in situations that may be considered at a high risk for violence?
- Do you ever sleep outside?
    - How do you dress and prepare for that?
    - Where do you tend to sleep?

Other Professionals

➡ ***Remember to obtain informed consent before contacting professionals!***

- Domestic/Family/Intimate Partner Violence Professional
- Street Outreach Worker
- Harm Reduction Support Worker

How do I score this component?

4	**Any** of the following: ☐ In the past 180 days, engaged in 10+ higher risk and/or exploitive events ☐ In the past 90 days, left an abusive situation
3	**Any** of the following: ☐ In the past 180 days, engaged in 4-9 higher risk and/or exploitive events ☐ In the past 180 days, left an abusive situation, but not in the past 90 days
2	**Any** of the following: ☐ In the past 180 days, engaged in 1-3 higher risk and/or exploitive events ☐ 181+ days ago, left an abusive situation and the past abuser is not deceased or incarcerated
1	☐ Any involvement in higher risk and/or exploitive situations occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no involvement in higher risk and/or exploitive events

H. Interaction with Emergency Services

What do I need to know to complete this component?

This component is concerned with interactions with emergency services.

An interaction is not a casual encounter such as striking up a conversation with a police officer on the street, passing by a firefighter battling a blaze, seeing ambulance workers provide care on the street, or taking a friend to the emergency room. The interactions this component is interested in are deliberate and direct interactions between the person and staff from emergency rooms in hospitals, police officers, ambulance attendants and/or firefighters (including in the capacity of providing First Aid/ CPR – not solely in their function of fighting fire).

Also relevant to this component is the person's interaction with crisis services, and their time spent in hospitals for overnight or long-term care.

Key points:

➡ Look for:

- ⇨ Admittance to ER
- ⇨ Hospitalizations
- ⇨ Ambulance rides
- ⇨ Use of crisis services, distress centers, suicide prevention services, sexual assault crisis services, sex worker crisis services, or similar
- ⇨ Interactions with police
- ⇨ Interactions with firefighters

➡ Count the total number of interactions in the past 6 months

How do I complete this component?

Ask

- How often do you go to emergency rooms? How many times have you been to the ER in the last 180 days?
- How many times have you had the police speak to you over the past 180 days?
- Have you used an ambulance or needed the fire department at any time in the past 180 days?
- How many times have you called or visited a crisis team or a crisis counselor in the last 180 days?
- How many times have you been admitted to hospital in the last 180 days?

Other Professionals

➡ ***Remember to obtain informed consent before contacting professionals!***

- Police
- Hospital
- Paramedics

How do I score this component?

4	☐ In the past 180 days, cumulative total of 10+ interactions with emergency services
3	☐ In the past 180 days, cumulative total of 4-9 interactions with emergency services
2	☐ In the past 180 days, cumulative total of 1-3 interactions with emergency services
1	☐ Any interaction with emergency services occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no interaction with emergency services

I. Legal Involvement

What do I need to know to complete this component?

This component is concerned with legal issues.

Legal issues pertain to any offences that result in such things as paying a fine, undertaking community service, or being incarcerated.

The time frames referenced below pertain to the length of time since the most recent court appearance (not the time since the charge which may have occurred quite a bit of time before).

How do I complete this component?

Ask

- Do you have any "legal stuff" going on?
- Have you had a lawyer assigned to you by a court?
- Do you have any upcoming court dates?
- Do you think there's a chance you will do time?
- Any outstanding fines?
- Have you paid any fines or done community service in the last 12 months for anything?
- Is anybody expecting you to do community service for anything right now?
- Did you have any legal stuff in the last year that got dismissed?
- Are your housing at risk in any way right now because of legal issues?

Key points:

➡ Any currently outstanding or recently resolved legal issues?

➡ What is the impact of these legal issues on the person's housing?

Documentation

- Any documentation of arrests, warrants, or court dates?

Other Professionals

➡ ***Remember to obtain informed consent before contacting professionals!***

- Lawyer or Public Defender
- Probation or Parole Officer

How do I score this component?

4	**Any** of the following: ☐ Current outstanding legal issue(s), likely to result in fines of $500+ ☐ Current outstanding legal issue(s), likely to result in incarceration of 3+ months (cumulatively), inclusive of any time held on remand/in detention ☐ Identified as a sexual predator or dangerous offender ☐ If there are conditions of release that, if not met, will likely result in being incarcerated for a period greater than 90 days
3	**Any** of the following: ☐ Current outstanding legal issue(s), likely to result in fines less than $500 ☐ Current outstanding legal issue(s), likely to result in incarceration of less than 90 days (cumulatively), inclusive of any time held in remand/detention ☐ If there are conditions of release that, if not met, will likely result in being incarcerated for a period of 90 days or less
2	**Any** of the following: ☐ In the past 365 days, relatively minor legal issue has occurred and was resolved through community service or payment of fine(s) ☐ Current outstanding relatively minor legal issue that is unlikely to result in incarceration (but may result in community service) or house arrest
1	☐ There are no current legal issues, **and** any legal issues that have historically occurred have been resolved without community service, payment of fine, or incarceration
0	☐ No legal issues within the past 365 days, **and** currently no conditions of release

J. Managing Tenancy

What do I need to know to complete this component?

This component is concerned with a participant's management of their apartment. The primary focus incorporates such issues as payment of rent, not disrupting the enjoyment of other tenants, positive relations with the landlord/superintendent and avoiding unit damage.

Any person that is homeless at the time the SPDAT is completed shall receive a score of "4".

This component is specifically concerned with the retention of housing and the implementation of skills necessary to care for one's apartment and manage their tenancy.

Since direct payments like a third party payment of rent is an administrative function of how rent gets paid and not an indication of need, this practice is not considered to be an example of "required assistance" to maintain tenancy.

Key points:

➡ How often does the person have conflicts or disputes with landlords or neighbors?

➡ How often have they been evicted?

➡ Is there an impending eviction?

How do I complete this component?

Ask

- Are you currently homeless?
- [If the person is housed] Do you have an eviction notice?
- [If the person is housed] Do you think that your housing is at risk?
- How are your relationship with your neighbors?
- How do you normally get along with landlords?
- How have you been doing with taking care of your place?

Documentation

- Warning letter
- Eviction notice

Other Professionals

➡ ***Remember to obtain informed consent before contacting professionals!***

- Landlord
- Tenant Counsel/Residential Board
- Lawyer/Legal Clinic Representatives
- Shelter Workers
- Street Outreach Workers
- Housing Support Worker

info@orgcode.com www.orgcode.com

How do I score this component?

4	**Any** of the following: ☐ Currently homeless ☐ In the next 30 days, will be re-housed or return to homelessness ☐ In the past 365 days, was re-housed 6+ times ☐ In the past 90 days, support worker(s) have been cumulatively involved 10+ times with housing matters outside of regular housing supports
3	**Any** of the following: ☐ In the next 60 days, will be re-housed or return to homelessness, but not in next 30 days ☐ In the past 365 days, was re-housed 3-5 times ☐ In the past 90 days, support worker(s) have been cumulatively involved 4-9 times with housing matters outside of regular housing supports
2	**Any** of the following: ☐ In the past 365 days, was re-housed 2 times ☐ In the past 180 days, was re-housed 1+ times, but not in the past 60 days ☐ Continuously housed for at least 90 days but not more than 180 days ☐ In the past 90 days, support worker(s) have been cumulatively involved 1-3 times with housing matters outside of regular housing supports
1	**Any** of the following: ☐ In the past 365 days, was re-housed 1 time ☐ Continuously housed, with no assistance on housing matters, outside of regular housing supports, for at least 180 days but not more than 365 days
0	☐ Continuously housed, with no assistance on housing matters, outside of regular housing supports, for at least 366 days

Socialization & Daily Functioning

K. Personal Administration & Money Management

What do I need to know to complete this component?

This component is concerned with a person's ability to manage their money and the associated administrative tasks such as paying bills, filling out forms, completing a budget, and submitting necessary paperwork or documentation. These tasks can be performed by the participant or another participant's support team, family or friends.

A person may have multiple sources of income, including formal (for example, employment income; income support through welfare or social assistance, etc.) as well as informal (for example, proceeds from sex work; "working under the table"; drug sales, etc.). All should be considered for this component.

Key points:

➡ Look for all sources of income – formal and informal

➡ Look for debts

➡ Examine ability to manage money and complete administrative tasks

It is understood that some people may only have a small amount of income. It may be that they manage that small amount of income quite well, but still run out of money towards the end of the month in most, if not all, months. This shortfall of funds is not an issue with their ability. It is an issue with the amount of money they receive relative to their other expenses such as housing. Households experiencing such a situation should receive a scored of "2."

How do I complete this component?

Ask

- How are you with taking care of money?
- Do you have a bank account and does this help you manage your money?
- How are you with paying bills on time and taking care of other financial stuff like completing your taxes? Does anyone help you with paying bills?
- Do you have any street debts or drug or gambling debts?
- Is there anybody that thinks you owe them money?
- Do you budget every single month for every single thing you need? Including cigarettes? Booze? Drugs?
- Do you try to pay your rent before paying for anything else?
- Are you behind in any payments like child support or student loans or anything like that?

Documentation

- Bank statements
- Any records of debts, including credit card statements or letters from collections agencies?
- Any records of a trustee or guardian who handles the financials?

Other Professionals

➡ ***Remember to obtain informed consent before contacting professionals!***

- Trustee, guardian or payee
- Income support worker
- Allied professionals
- SOAR Worker or Benefits Specialist

How do I score this component?

4	**Any** of the following: ☐ Cannot create or follow a budget, regardless of supports provided ☐ Does not comprehend financial obligations ☐ Does not have an income (including formal and informal sources) ☐ Substantial real or perceived debts with a payment required of at least $1,000 per month, past due or requiring monthly payments ☐ Not aware of the full amount spent on substances, if they use substances ☐ Compulsive, chronic or chaotic gambling that makes it impossible to meet other financial obligations
3	**Any** of the following: ☐ Requires intensive assistance to create and manage a budget (including any legally mandated guardian/trustee that provides assistance or manages access to money) ☐ Only understands their financial obligations with the assistance of a 3rd party ☐ Not budgeting for substance use or gambling, if they are involved with either activity ☐ Real or perceived debts of $500-$999 per month, past due or requiring monthly payments
2	**Any** of the following: ☐ In the past 365 days, source of income has changed 2+ times ☐ Real or perceived debts of $100 - $499 per month ☐ Budgeting to the best of ability (including formal and informal sources), but still short of money every month for essential needs ☐ Voluntarily receives assistance creating and managing a budget or restricts access to their own money (e.g. voluntary guardian/trusteeship) ☐ Has been self-managing financial resources and taking care of associated administrative tasks for less than 90 days
1	☐ Has been self-managing financial resources and taking care of associated administrative tasks for at least 90 days, but for less than 180 days
0	☐ Has been self-managing financial resources and taking care of associated administrative tasks for at least 180 days

L. Social Relationships & Networks

What do I need to know to complete this component?

This component is concerned with relationships and social networks. Covered in this component is the impact of social relationships for the participant, particularly how it impacts their ability to maintain housing. Explore the participant's engagement with friends, family, and to some degree their interaction and relationships with professionals.

There is no quantifiable measure of how many relationships the person should have, or the level of interaction that determines a relationship.

In some instances, the capacity of the person to trust or make an informed decision about social interaction can be a cause for concern. This is especially true for those who have a history of victimization, engagement in dependent relationships, and who are exploited for goods or services.

Key points:

➡ Look for meaningful social connections

➡ Are any social connections having a negative impact on housing?

Healthy social relationships can be helpful for housing stability and improved quality of life. It is, however, possible for a person to report being satisfied with a relationship that is in fact detrimental to their own wellness and ability to stay housed. These types of situations are captured as a "4" on the scoring scale.

How do I complete this component?

Observations

- Does the individual keep any photographs or memorabilia suggesting important relationships?
- Does the individual have any (visible) tattoos that contain a person's name?
- Do they frequently get calls or texts while you are meeting with them?
- Are their friends frequently around them?

Ask

- Tell me about your friends, extended family or other people in your life.
- How often do you get together or chat with friends?
- When you go to doctor's appointments or meet with other professionals like that, what is that like?
- Are there any people in your life that you feel are just using you?
- Are there any of your closer friends that you feel are always asking you for money, smokes, drugs, food, or anything like that?
- Have you ever had people crash at your place that you did not want to stay there?
- Have you ever been threatened with an eviction or lost a place because of something that friends or family did in your apartment?

- Have you ever been concerned about not following your lease agreement because of friends or family?

Other Professionals

➡ ***Remember to obtain informed consent before contacting professionals!***

- Housing Support Worker
- Other allied professionals providing supports
- Shelter Workers

How do I score this component?

4	**Any** of the following: ☐ In the past 90 days, left an exploitive, abusive, or dependent relationship ☐ Friends, family. or other people are placing security of housing at imminent risk, **or** impacting life, wellness, or safety ☐ No friends or family and demonstrates struggles to engage in socially appropriate ways in public/social service settings (i.e. aggressive behavior, yelling, etc.) ☐ Currently homeless or recently re/housed and would classify most of friends and family as homeless
3	**Any** of the following: ☐ In the past 90-180 days, left an exploitive, abusive, or dependent relationship ☐ Friends, family, or other people are having some negative consequences on wellness or housing stability ☐ No friends or family but demonstrating an ability to engage in socially appropriate ways in public/service settings ☐ Meeting new people with an intention of forming friendships ☐ Reconnecting with previous friends or family members, but having trouble advancing the relationship ☐ Currently homeless or recently housed, and would classify some of friends and family as being housed, while others are homeless
2	**Any** of the following: ☐ More than 180 days ago, left an exploitive, abusive, or dependent relationship and the abuser is not incarcerated or deceased ☐ Developing relationships with new people but not yet fully trusting them ☐ Currently homeless or recently housed, and would classify friends and family as being housed
1	☐ Has been housed for less than 180 days, **and** is engaged with friends or family, who are having no negative consequences on the individual's housing stability
0	☐ Has been housed for at least 180 days, **and** is engaged with friends or family, who are having no negative consequences on the individual's housing stability

M. Self-Care & Daily Living Skills

What do I need to know to complete this component?

This component is concerned with the person's ability to take care of their/his/herself, meeting daily needs independently, and living autonomously. Of interest here includes such things as taking care of one's own personal hygiene, as well as being able to cook, clean, and do laundry.

This component also gives consideration to those people that may be involved in collecting or hoarding. Crucial to this assessment is the degree to which they are aware that such behaviors are negatively impacting their housing stability.

Under the scoring scheme below, lives "independently" refers to the ability to live without permanent on-site supports. It does not include individuals living as couples or with roommates.

Key points:

➡ How is their personal hygiene?

➡ How often does the person use community resources like food banks, shelters, or things like public washrooms?

➡ Look for hoarding or collecting behaviors.

How do I complete this component?

Observations

- Does the person have strong body odor, or ripped or dirty clothing?
- [If housed] Is the person's apartment relatively tidy, with clean dishes and laundry?
- [If housed] Any sign of pests?
- [If housed] What does the inside of their fridge/freezer look like?

Ask

- Do you have any worries about taking care of yourself?
- Do you have any concerns about looking after cooking, cleaning, laundry, or anything like that?
- Do you ever need reminders to do things like shower or clean up?
- If I were to come over to your last apartment, what would it look?
- Do you know how to shop for nutritious food on a budget?
- Do you know how to make low cost meals that can result in leftovers to freeze or save for another day?
- Do you tend to keep all of your clothes clean?
- Have you ever had a problem with mice or other bugs like cockroaches as a result of a dirty apartment?
- When you have had a place where you have made a meal, do you tend to clean up dishes and the like before they get crusty?

Other Professionals

➡ ***Remember to obtain informed consent before contacting professionals!***

- Housing Support Worker
- Other allied professionals providing supports
- Shelter Workers

How do I score this component?

4	**Any** of the following: ☐ Unable and/or unaware of how to care for themselves, their apartment, or their surroundings ☐ Currently homeless and relies upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing) on an almost daily basis ☐ Engaged in hoarding or collecting behavior and is not aware that it is an issue in their life
3	**Any** of the following: ☐ Able and/or aware of some areas of how to care for themselves, their apartment or their surroundings, but misses other areas because of lack of insight ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), 14+ days in any 30-day period ☐ Engaged in hoarding or collecting behavior and is aware that it is an issue in their life
2	**Any** of the following: ☐ Fully able and/or aware of all that is required to take care of themselves, their apartment and their surroundings, but has not yet mastered the skills or time management to fully execute this on a regular basis ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), fewer than 14 days in every 30-day period
1	☐ In the past 365 days, accessed community resources 4 or fewer times, and is fully taking care of all their daily needs
0	☐ For the past 366 days, fully taking care of all their daily needs independently

N. Meaningful Daily Activity

What do I need to know to complete this component?

This component is concerned with the ways in which person spend their days and their involvement in activities that bring them a sense of enjoyment, connection and meaning. These activities should extend beyond those pursuits that are informed solely by the requirements of the case plan. Meaningful daily activities should provide engagement for most, if not all, days of the week.

Examples of activities that are not considered to be meaningful daily activities include:

- Doctor's appointments and medical treatments;
- Seeking employment;
- Court mandated or ordered activities
- Therapy and counseling;
- Criminal activities.
- Substance use, including:
    - Using substances for large portions of the day;
    - Spending large portions of the day finding/getting money to pay for substances;
    - Sleeping or being otherwise incapacitated as a result of their substance use and/or acquiring substances;
- Survival activities, such as:
    - Binning;
    - Bottle collecting;
    - Sex work;

Key points:

➡ How much time every day does the person spend doing things other than "just getting by"?

➡ Do the daily activities provide personal satisfaction?

A person's choice of meaningful daily activity is informed by personal and cultural preferences, as well as financial capacities. Of importance is not only that the person is engaged in meaningful daily activities, but that they also have a sense of fulfillment on some level from the participation in that activity. This usually is equated with intellectual, emotional, social, physical, or spiritual fulfillment.

In addition, the activities and the sense of fulfillment should provide a sense of personal satisfaction to the participating person. There is no specific metric for this satisfaction other than a personal feeling that can be attributed to feelings of self-esteem, contentment, confidence, recovery, etc.

While it is reasonable for an individual to enjoy solitary meaningful daily activities, there is an expectation that some activities will involve interacting with the community outside of their immediate housing situation.

How do I complete this component?

Observations

- Does the individual have a day planner, online calendar, or other tool for organizing their time?
- Do they keep flyers, brochures, or catalogues of activities from locations like community centers, churches, or libraries? If yes: do these materials look like they have ever been referenced?
- Does the individual have any memos reminding themselves to go to events?

Ask

- How do you spend your day?
- How do you spend your free time?
- Does that make you feel happy/fulfilled?
- How many days a week would you say you have things to do that make you feel happy/fulfilled?
- How much time in a week would you say that you are totally bored?
- When you wake up in the morning, do you tend to have an idea of what you plan to do that day?
- How much time in a week would you say you spend doing stuff to fill up the time rather than doing things that you love?
- Are there any things that get in the way of you doing the sorts of activities you would like to be doing?

Documentation

- Calendar
- Appointment reminder cards
- Flyers
- Brochures

How do I score this component?

4	☐ No planned, legal activities described as providing fulfillment or happiness
3	☐ Discussing, exploring, signing up for and/or preparing for new activities or to re-engage with planned, legal activities that used to provide fulfillment or happiness
2	☐ Attempting new or re-engaging with planned, legal activities that used to provide fulfillment or happiness, but uncertain that activities selected are currently providing fulfillment **or** happiness, or the individual is not fully committed to continuing the activities
1	☐ Has planned, legal activities described as providing fulfillment or happiness 1-3 days per week
0	☐ Has planned, legal activities described as providing fulfillment or happiness 4+ days per week

History of Housing & Homelessness

O. History of Housing & Homelessness

What do I need to know to complete this component?

This component is concerned with the person's history of housing and homelessness.

The cumulative duration of homelessness is concerned with the total number of days that a person experienced homelessness within the specified time period. It acknowledges that a person may have been homeless for one or two days, housed, then homeless again. The number of days spent homeless is added up to produce the cumulative total.

Key points:

➡ Look for total time the person has spent homeless

The types of homelessness captured in this section include absolute homelessness (sleeping outside; staying in shelters; living in a car; squatting) as well as relative homelessness (couch surfing; overcrowding). What is most important is the person's own determination of what constituted their homelessness. Prompts may be necessary to assist people in making a determination of when they considered themselves to be housed or homeless.

How do I complete this component?

Ask

- How long have you been homeless?
- How many times have you experienced homelessness other than this most recent time?
- Have you spent any time sleeping on a friend's couch or floor? And if so, during those times did you consider that to be your permanent address?
- Have you ever spent time sleeping in a car, alleyway, garage, barn, bus shelter, or anything like that?
- Have you ever spent time sleeping in an abandoned building?
- Have you ever been in hospital or jail for a period of time when they didn't have a permanent address to go to when they got out?
- Have you ever owned a house in your name?
- Have you ever had a lease in your name?
    - If yes, have you ever been evicted?

Documentation

- HMIS records
- Legal and tenancy records

How do I score this component?

4	☐ Over the past 10 years, cumulative total of 5+ years of homelessness, **OR** ☐ Currently homeless and has neither had a lease in their name nor owned a house in their name
3	☐ Over the past 10 years, cumulative total of 2+ years but fewer than 5 years of homelessness, **OR** ☐ Currently housed after being homeless, never had a lease in their name nor owned a house in their name, **and** has been housed 180 days or less
2	☐ Over the past 4 years, cumulative total of 30+ days but fewer than 2 years of homelessness, **OR** ☐ Currently housed after being homeless, never had a lease in their name nor owned a house in their name, **and** has been housed 181 days or more
1	☐ Over the past 4 years, cumulative total of 7+ days but fewer than 30 days of homelessness, **OR** ☐ Currently housed after being homeless, previously had a lease in their name or owned a house in their name, **and** has been housed 180 days or less
0	☐ Over the past 4 years, cumulative total of 7 or fewer days of homelessness, **OR** ☐ Currently housed after being homeless, previously had a lease in their name or owned a house in their name, **and** has been housed 181 days or more

PART 3: SCORING

Summarizing Scores

It is recommended that Frontline Workers, Team Leaders and Program Supervisors build familiarity with the descriptions of all of the components above. The objective is to achieve competence in applying the SPDAT without using the full SPDAT Workbook. The most important tool is the Summary Sheet (see next page). It is recommended that the Summary Sheet should be the only documentation visible to the program participant when using a conversational approach to obtaining the participant's input for the SPDAT updates. The participant should be offered a copy of the Summary Sheet after the application of each SPDAT.

Both the aggregate and individual component scores have great value for establishing baseline information and tracking longitudinal progress. The aggregate score reflects overall acuity, and individual component scores can be used to focus on a particular area of risk and vulnerability or a demonstration of strength. The individual component scores may go up and down but over time, if these individual scores inform overall service planning and delivery, the aggregate score will decrease thus increasing overall potential towards housing stability and improved wellness.

When in doubt about the best score option, score higher. In the event of uncertainty between two possible scores for a component, i.e., if you are uncertain if the person is a "2" or a "3", the higher score should be used.

The Comments section should be used throughout the Summary Sheet for five fundamental reasons:

- Reveals the source of the information that led to the assessment: Self-Report, Observation, Case Notes, Conversation, Other Documentation.
- Used to note if there was uncertainty and a higher score for the component was used as noted above.
- Identify if any circumstances seem to be impacting the assessment score for an individual component.
- Make note of any relevant trends in the component for the participant.
- Identify any methodological or logistical measures that will be helpful for subsequent SPDAT updates.

Practitioners should write comments factually while remaining mindful that the program participant will be offered a copy of the SPDAT Summary Sheet. Comments should only be relevant to the context of the SPDAT and its impact of housing stability and future case planning goals.

When summarizing the scores, it is important that a score is noted for every component. For example, noting a "0" is appropriate, leaving the component blank with an implied "0" is not appropriate. After there is a value for each component, a total score can be tallied for the participant. This final score represents the person's level of acuity out of a total possible rating of 60 for the SPDAT for Single Adults.

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Scoring Summary Sheet

COMPONENT	SCORE	COMMENTS
MENTAL HEALTH & WELLNESS AND COGNITIVE FUNCTIONING		
PHYSICAL HEALTH & WELLNESS		
MEDICATION		
SUBSTANCE USE		
EXPERIENCE OF ABUSE AND/OR TRAUMA		
RISK OF HARM TO SELF OR OTHERS		
INVOLVEMENT IN HIGHER RISK AND/OR EXPLOITIVE SITUATIONS		
INTERACTION WITH EMERGENCY SERVICES		
LEGAL INVOLVEMENT		
MANAGING TENANCY		
PERSONAL ADMINISTRATION & MONEY MANAGEMENT		

COMPONENT	SCORE	COMMENTS
SOCIAL RELATIONSHIPS & NETWORKS		
SELF-CARE & DAILY LIVING SKILLS		
MEANINGFUL DAILY ACTIVITIY		
HISTORY OF HOUSING & HOMELESSNESS		
TOTAL		

Prioritizing Service Based Upon Acuity Score & Available Supports

The recommended intervention and approach to supports is linked to the level of acuity.

SCORING RANGE	RECOMMENDED INTERVENTION	COMMENTS
0-19	Least intensive service supports	Lower scores generally reveal lower risk households with shorter periods of homelessness. Needs tend to not be as complex in most of the SPDAT components. These households can often solve their own homelessness, perhaps with very brief financial assistance, shallow subsidy, access to housing listings and referral to mainstream supports.
20-34	Moderate and often time-limited supports	Household would likely benefit from moderate intensity support services and time-limited financial assistance to obtain and maintain housing. The focus of the supports will more likely be on a smaller number of SPDAT components. Support services may be short in duration and may include brokering additional services within the community.
35-60	High intensity supports lasting for a longer duration of time and perhaps even permanently	Person has multiple complex needs and are likely to benefit from high intensity case management supports either through Intensive Case Management or Assertive Community Treatment. Scores in many of the SPDAT components are likely to be higher (3's and 4's).

For those people who receive moderate or high intensity service, it is expected that the overall SPDAT score is likely to decline over time during the period when a person is receiving supports even though there may be fluctuations in any of the 15 elements from one review to the next.

Consistently lower scores (which reflects overall life improvements and increased stability) can be used to focus on moving on from program supports, leading to decreased and then terminated support services.

If a person is in crisis at the time of a SPDAT update, it may misrepresent overall acuity. To provide greater accuracy in the assessment of housing and support needs, it is recommended that the SPDAT update not be completed until after the immediate crisis is resolved.

Regardless of the scoring recommendations outlined above, communities are encouraged to consider multiple variables/circumstances in establishing the priority of households to be served with the available housing support programs available locally. The SPDAT is likely an important piece of information -but not the only information- considered in the prioritization process in a community.

Informing System Navigation and Support Using SPDAT Results

Individual communities as well as cross-agency partnerships can create specific processes to better assist households relative to the housing and support needs revealed by their aggregate and single component SPDAT scores.

For example, a SPDAT score of 40+ that includes higher scores related to mental health and wellness and/or physical health and/or substance use may trigger a referral for a secondary clinical assessment by a specialized health, mental health, or addiction resource.

Within individual teams, Team Leaders can use the SPDAT scores in each component to help inform which Follow-up Support Worker may have a skill set or expertise to best assist with a specific circumstance. The assignment of Follow-up Support Workers to particular program participants can be streamlined using SPDAT information.

There may also be instances where SPDAT scores are employed to enhance inter-agency partnership or overall caseload balance throughout the service system. For example, Team Leader and/or Senior Management meetings across an agency may result in transfers among frontline or case management staff to ensure improved distribution of people with higher SPDAT scores across team caseloads.

Local Variations in SPDAT Use

Locally, system administrators can develop their own rules and policies pertaining to the identification of local priority populations, the specific products to be used locally, system navigation and referral processes, or integration within a Homeless Management Information System, etc.

It is important to reiterate however that individual organizations and communities may not adjust the scoring, ranking, or descriptions of any of the components.

Building Consistency in the Use of the SPDAT

The key to effectively and consistently using the SPDAT within a team and throughout a community is training, practice and sharing successes and mistakes.

Throughout a community of Housing Help, Rapid Re-housing, Permanent Supportive Housing and Housing First professionals, there should be a common understanding about each component of the SPDAT. It is common to most assessment tools for practitioners to have different perspectives about the score of a particular component. The sign of successful, consistent application of the SPDAT is when two people who have experience working with the same person in the same situation have SPDAT scores that vary by only a single point.

Staff members and organizations should not deviate from the current definitions or operational instructions for the SPDAT or create their own system. To ensure valid and reliable evaluation of outcomes, definitions and interpretations of information must be consistent within and across all organizations delivering Housing Help, Rapid Re-housing, Permanent Supportive Housing and Housing First within a community. Doing otherwise results in an inconsistent approach to prioritizing services and meeting the needs of participants. “Creaming” is unacceptable and counter-productive.

Infusing SPDAT into a standard practice will require that training on the tool is included as part of the initial orientation or onboarding of any new staff. Shadowing and coaching can be effective approaches for ensuring that new staff members apply the SPDAT consistently with other members of the team.