

SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (SPDAT v3)

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Contents

Foreword5

SPDAT Design5

Family SPDAT6

SPDAT Client Disclosure.....6

Timing of SPDAT Implementation.....7

Graphing Changes9

Client Assessment9

15 SPDAT Components9

Client Assessment—Total Component Score 10

Approaches to Completing the SPDAT 10

Using the SPDAT in Providing and Helping to Guide Supports 11

Noting Discrepancies..... 11

Components of the SPDAT..... 11

 A. Self Care and Daily Living Skills 12

 B. Social Relationships and Networks..... 12

 C. Meaningful Daily Activity..... 13

 D. Personal Administration and Money Management..... 14

 E. Managing Tenancy..... 16

 F. Physical Health and Wellness 17

 G. Mental Health and Wellness & Cognitive Functioning..... 18

 H. Medication20

 I. Interaction with Emergency Services.....21

 J. Involvement in High Risk and/or Exploitive Situations.....21

 K. Substance Use.....22

 L. Abuse and/or Trauma23

 M. Risk of Personal Harm/Harm to Others24

 N. Legal.....25

 O. History of Homelessness and Housing.....26

Summarizing Scores.....27

SPDAT SUMMARY28

Prioritizing Service Based Upon Score & Guiding Supports30

System Navigation and Support for Clients Can Be Informed Using SPDAT Results.....31

Local Variations in SPDAT Use.....31

Guide to Assist SPDAT Conversation31

Building Consistency Using SPDAT38

Foreword

OrgCode Consulting Inc. is pleased to announce the release of Version 3 of the Service Prioritization Decision Assistance Tool (SPDAT). Since its release in 2010, the SPDAT has been used with over 10,000 unique individuals in over 100 communities across North America and in select locations around the world.

Originally designed as a tool to help prioritize housing services for homeless individuals based upon their acuity, the SPDAT has been successfully adapted to other fields of practice, including: discharge planning from hospitals, work with youth, survivors of domestic violence, health research, planning supports for consumer survivors of psychiatric care systems, and in work supporting people with fetal alcohol spectrum disorders. We are encouraged that so many service providers and communities are expanding the use of this tool, and OrgCode will continue to support the innovative use of the SPDAT to meet local needs.

In preparing SPDAT v3, we have adopted a comprehensive and collaborative approach to changing and improving the SPDAT. Communities that have used the tool for three months or more have provided us with their feedback. OrgCode staff has observed the tool in operation to better understand its implementation in the field. An independent committee composed of service practitioners and academics reviews enhancements to the SPDAT. Furthermore, we continue to test the validity of SPDAT results through the use of control groups. Overall, we consistently see that groups assessed with the SPDAT have better long-term housing and life stability outcomes than those assessed with other tools, or no tools at all.

OrgCode intends to continue working with communities and persons with lived experience to make future versions of the SPDAT even better. We hope all those communities and agencies that choose to use this tool will remain committed to collaborating with us to make those improvements over time.

SPDAT Design

The SPDAT is designed to:

- Help prioritize which clients should receive what type of housing assistance intervention, and assist in determining the intensity of case management services
- Prioritize the sequence of clients receiving those services
- Help prioritize the time and resources of Frontline Workers
- Allow Team Leaders and program supervisors to better match client needs to the strengths of specific Frontline Workers on their team
- 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 and service responses to clients over time

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

The SPDAT is only used with those clients who meet program eligibility criteria. For example, if there is an eligibility criterion that requires prospective clients to be homeless at time of intake to be eligible for Housing First, then the pre-condition must be met before pursuing the application of the SPDAT. For that reason, SPDAT v3 includes an initial screening tool to assess eligibility.

The SPDAT has been influenced by the experience of practitioners in its use, persons with lived experience that have had the SPDAT implemented with them, as well as a number of other excellent tools such as (but not limited to) the Outcome Star, Health of the Nation Outcome Scale, Denver Acuity Scale and the Camberwell Assessment of Needs.

The SPDAT is not intended to replace clinical expertise or clinical assessment tools. The tool complements existing clinical approaches by incorporating a wide array of components that provide both a global and detailed picture of a client's acuity. Certain components of the SPDAT relate to clinical concerns, and it is expected that intake professionals and clinicians will work together to ensure the accurate assessment of these issues. In fact, many organizations and communities have found the SPDAT to be a useful method for bridging the gap between housing, social services and clinical services. This matter is discussed in further detail at the end of this guide.

Family SPDAT

The Family SPDAT (F-SPDAT) was released in Spring 2012 and is designed specifically for working with families. If your organization would like a copy of that tool you can send your request to F-SPDAT@orgcode.com.

SPDAT Client Disclosure

Clients should be informed that you are using the SPDAT. It is best to explain SPDAT as 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 clients that are referred to a case management team as a result of their SPDAT score. At intake or first assessment, it is also prudent to explain to the prospective client that the SPDAT helps to determine the priority with which they will get services and housing. It is important to let the client know that the final determination of a score for any component is a combination of conversation, documentation reviewed, observation and information from other sources. In other words, the outcome is not influenced solely by what they say.

Similar to transparency in case planning, the client should be offered a copy of the Summary Sheet of the SPDAT after it is completed. Whether they may accept or decline, a copy of each SPDAT should be kept in the client's file.

An evaluated best practice from versions one and two of the SPDAT was the use of the SPDAT in the "warm transfer" between intake and the case manager for clients with higher acuity. In the warm transfer, the intake worker, client and case manager (meeting the client for the first time) met together and reviewed each of the 15 components of the SPDAT in detail. Through this process, OrgCode learned:

- clients appreciated understanding the intake worker's assessment and transparency of their reasoning;
- clients appreciated the opportunity to provide commentary on the intake worker's assessment (even though the commentary did not have any further impact on the initial score);
- the receiving case managers appreciated the opportunity to learn more about the clients and ask questions of clarification from the intake worker with the client present;
- the receiving case managers were able to engage in the goal setting process of case planning quicker;
- there was greater continuity between intake and case management. As a result, fewer clients went "missing" between their initial intake and the beginning of the case management services;
- trust between the intake workers and case managers within the community was said to have improved; and,
- clients served through this approach achieved greater housing stability than those who did not.

Timing of SPDAT Implementation

It is recommended that the SPDAT begin at intake after the client has been screened for program eligibility. This can be accomplished at a central intake point for the entire community, at various intake points across community agencies and shelters, or upon specific program intake. 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 across any given service community.

The SPDAT assessment – especially the first assessment done with the client – does not need to be completed in just one client visit. Testing of the tool has demonstrated that there are no discernible differences in assessments conducted over several visits versus those completed in one visit. In the event that a client 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 that 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 client's self-report, keep in mind that the client's 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:

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

For those clients that are receiving supports, the SPDAT should also be used:

- 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

In addition, the SPDAT should be completed any time a client 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 client is in crisis as the episode may misrepresent the overall acuity score. If a client is in crisis, the SPDAT should be completed after the episode has subsided. This may occur in between regularly scheduled applications of the SPDAT.

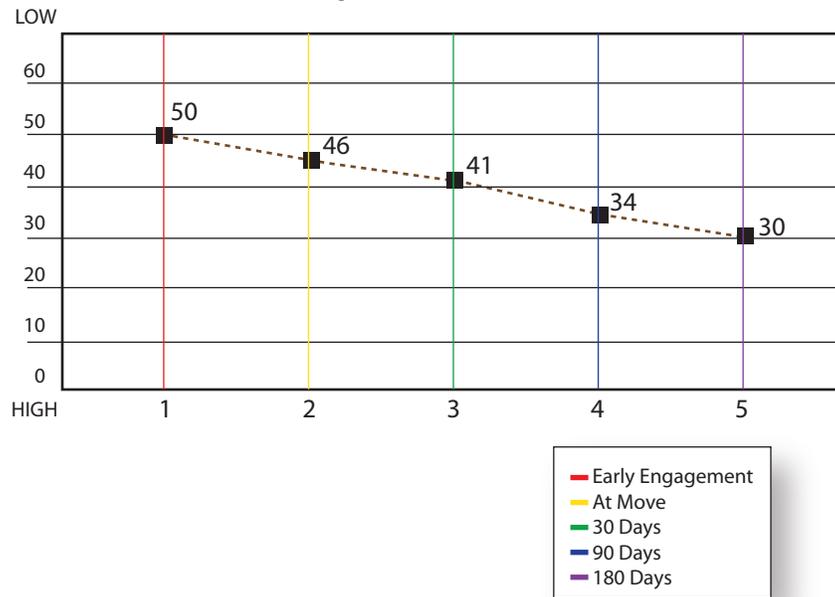
Graphing Changes

Visuals are an important adult learning strategy. Therefore, it is best practice to visually graph the client’s transitions relative to the time intervals noted above. The two examples below illustrate graphing by component or by overall score. The graphs illustrate how the client was assessed during their 5th of 7 applications of the SPDAT—180 days:

Client Assessment 15 SPDAT Components



Client Assessment—Total Component Score



Approaches to Completing the SPDAT

The SPDAT can be completed through observation, conversation, other documentation shared in the intake or case planning process and a client’s self-report. Information can also come from the client’s case plan, information gleaned from home visits and community accompaniment, or existing knowledge from the client’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 clients with complex needs, it may be necessary to have several conversations (sometimes in the form of multiple brief conversations) to gather enough accurate information to complete the tool. If you are uncertain of the accuracy of information received from the client, it is encouraged that you repeat the conversation to get clarity.

A guide is included at the end of this document to assist with communication when a conversational approach is used to gain information for completing the SPDAT. The conversation guide comes from practitioners with direct experience in administering the tool.

Using the SPDAT in Providing and Helping to Guide Supports

For those clients who are provided case management or other supports as a result of their SPDAT score, the SPDAT has proven to have great value in helping to guide case planning and support conversations.

Focusing attention on those areas of the SPDAT where the client has higher acuity has been successful in helping clients work through the Stages of Change (Prochaska & DiClemente). It has also proven to be helpful to case managers and other supports in guiding the conversation in client follow up, as well as in establishing objectives for each follow-up visit. Throughout its use, the SPDAT remains a tool that is client-centered and allows for strength-based approaches to service delivery.

Noting Discrepancies

With many clients you will gather information or observe behavior that may be contradictory to their self-assessment. This can be a positive aspect of case management process when working towards change. Do not shy away from being transparent in your assessment, noting the discrepancies whenever they appear.

Components of the SPDAT

The SPDAT is divided into 15 components (A to O below). Each component has a description that categorizes the scoring relative to each component.

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 specific client 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 client disclosed that resulted in the score.

COMPONENT A

Self-Care and Daily Living Skills

A. Self Care and Daily Living Skills

This component is concerned with the functions of taking care of oneself, meeting daily needs independently, and living autonomously. Behaviours of interest here include 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 individuals who are collectors or hoarders. Crucial to this assessment is the degree to which they are aware that such behaviours are an issue that is negatively impacting their life.

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

If the individual is homeless at the time of assessment the most that they can receive is a 2.

0 =	Takes care of self and meets all daily living needs independently & lives independently.
1 =	Takes care of self and meets all daily living needs by infrequently accessing other community resources as needed.
2 =	Attempts to take care of self and meet all daily living needs, but has a few areas where assistance is sometimes required; may not be living independently (staying in a shelter).
3 =	Not always taking care of self and/or not always aware of what needs to be done to take care of self or daily needs; can require prompts; requires frequent assistance; may excessively acquire belongings (hoard or collect) but is aware that it is an issue.
4 =	Not taking care of self or meeting daily needs; often unaware and almost always needs prompts; requires intensive, frequent assistance; may excessively acquire belongings (hoard or collect) but is not fully aware or is not at all aware that it is an issue.

COMPONENT B

Social Relationships & Networks

B. Social Relationships and Networks

This component is concerned with social relationships and networks. Covered in this component is the client’s engagement with friends and family, and to some degree their interaction and relationships with professionals.

There is no quantifiable measure of how many friends or family members a client should have, or the level of interaction that determines a relationship. More than one relationship involving fairly frequent interaction over several months is encouraged.

In some instances, the capacity of an individual to trust or make an informed decision

about social interaction can be a cause for concern. This is especially true of those clients who have a history of victimization, engagement in dependent relationships, and who are exploited for goods or services.

It is possible for a client to be satisfied with a relationship that is in fact detrimental to their own wellness. These types of situations are captured as a 4 on the scoring scale.

0 =	Has friends and/or family supports as they would like them, and has maintained those relationships for greater than 6 months.
1 =	Has some friends and/or family supports, and/or working on relationships, and/or the relationship is how they would like, but for less than 6 months.
2 =	Engaged in relationships with friends and/or family, occasionally with some difficulties and/or still at the very early stages of relationship development.
3 =	Discussing or is in the early stages of establishing relationships with friends and/or family, but having difficulty maintaining contact or advancing the relationship; or client has relationship with friends or family but it is have some negative consequences on the client's wellness. May be talking to new people, but not at a stage of trusting or liking them yet. Meanwhile, the individual may maintain good relationships with professionals.
4 =	While may have acquaintances or relationships with people out of convenience or necessity – including co-dependent relationships or feelings of need for the relationship based upon past victimization or abuse, no meaningful social relationships and networks with people of their choosing that they like; or client has relationship with friends or family but it is having serious consequences on the client's wellness. While the individual may have relationships with professionals, they are not consistently good.

C. Meaningful Daily Activity

This component is concerned with the ways in which clients spend their days. The activities that a client engages in are informed by their own choices. 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 using substances for large portions of the day and/or spending large portions of the day finding/getting money to pay for substances and/or sleeping or being otherwise incapacitated as a result of their substance use and/or acquiring substances; survival activities (e.g., binning; bottle collecting; sex work); therapy; doctor's appointments and medical treatments; seeking employment; court mandated or ordered activities; and, criminal activities.

One'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 client is engaged in

*COMPONENT C
Meaningful Daily Activity*

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. There is no specific metric for this satisfaction other than a personal feeling 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.

0 =	Has activities related to employment, volunteering, socio-recreation, etc. that provide fulfillment intellectually, socially, physically, emotionally, spiritually, etc., occupying most times of day and most days of the week, and which provide a high degree of personal satisfaction.
1 =	Has some activities related to employment, volunteering, socio-recreation, etc. that provide some fulfillment intellectually, socially, physically, emotionally, spiritually, etc., occupying some times of the day and/or some days of the week, which provide a good degree of personal satisfaction.
2 =	Attempting activities that may provide fulfillment intellectually, socially, physically, emotionally, spiritually, etc. but not occupying most days or most parts of any given day, and not yet providing a good degree of personal satisfaction.
3 =	Discussing or in early stages of attempting activities that may provide fulfillment intellectually, socially, physically, emotionally, spiritually, etc. but not fully committed. At times disengaged from activities, and activities are not yet occupying most days, nor providing personal satisfaction.
4 =	Not engaged in any meaningful daily activities that provide fulfillment intellectually, socially, physically, emotionally, spiritually, etc. Very little to no personal satisfaction.

COMPONENT D

Personal Administration & Money Management

D. Personal Administration and Money Management

This component is concerned with a client’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.

Income sources should be considered formal (for example, employment income; income support through welfare, etc.) as well as informal (for example, proceeds from sex work; “working under the table”; drug sales, etc.).

It is understood that some individuals 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. These individuals are classified as a 2.

0 =	Has an income source and manages all personal finances and benefits independently. Can pay bills and fill out all appropriate paperwork and forms without assistance from others. Has been doing so for 6 months or more.
1 =	Has an income source and manages all personal finances and benefits independently, and can pay bills, and fill out all appropriate paperwork and forms without assistance from others. Has been doing so for less than 6 months.
2 =	Has an income source and manages most personal finances and benefits with a little help from time to time, which may include help paying bills, filling out paperwork and forms or using a voluntary trusteeship program. Also includes those individuals that manage their money well with what they receive but require assistance from the likes of a food bank at the end of the month to make ends meet, as well as those that are on and off income support more than 2 times in any 12 month period.
3 =	Has an income source, but requires frequent assistance to manage personal finance and benefits, which may include the use of a guardian or trustee (which may be voluntary). Likely requires intensive supports to take care of paperwork and forms. Likely requires prompts, reminders and/or assistance paying bills and may not always budget appropriately for all bills. Likely requires intensive assistance budgeting. If a substance user, is likely not involved in accounting for substance use in budgeting. May have significant debt load, including "street debts" and/or gambling debts.
4 =	May or may not have an income. Requires intensive assistance with personal finances and benefits, which may include the use of a guardian or trustee (which may be voluntary). Almost always fails to appropriately fill out forms or complete paperwork. Cannot create or follow a monthly budget. Almost always needs prompts, reminders and/or assistance paying bills and almost always does not have enough income to cover all bills from the previous month (and may not comprehend this, thinking bills are consistently higher than they should be). Most likely not budgeting for substance use, if a substance user. Likely to have significant debt, including "street debts" and/or gambling debts.

COMPONENT E
Managing Tenancy

E. Managing Tenancy

This component is concerned with an individual’s management of their apartment. The primary foci are payment of rent, not disrupting the enjoyment of other tenants, positive relations with the landlord/superintendent and avoiding unit damage.

Any person who is homeless at the time the SPDAT is completed shall be considered a 4.

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

Third party payment of rent is not considered to be assistance in the payment of rent. That is an administrative function of how rent gets paid (not unlike a direct transfer for a mortgage payment), and not necessarily an indication of need for assistance.

0 =	Has taken care of apartment unit for 6 months or more without any external support including such things as payment of rent, following lease agreement and physically maintaining unit in good shape.
1 =	Has taken care of apartment unit for less than 6 months without any external support including such things as payment of rent, following lease agreement and physically maintaining unit in good shape.
2 =	Needs assistance in taking care of the apartment unit up to three times in any three month period or a maximum of once per month, which may include assistance paying rent, managing situations that the landlord has taken exception to, or in physically maintaining the unit in good shape. Has not needed to be re-housed within the past three months.
3 =	Needs assistance in taking care of the unit four to nine times in any three month period or two or more times per month, which may include assistance paying rent, conflict resolution and problem solving and mediation with the landlord, or in physically maintaining the unit in good shape. Has been re-housed as a result of these or similar issues within the past three months or will likely need to be re-housed within the next two months.
4 =	Needs assistance taking care of the unit ten or more times in any three month period or three or more times in any given month, which may include assistance paying rent, conflict resolution and problem solving and mediation with the landlord, or in physically maintaining the unit in good shape. Will need to be re-housed imminently or the re-housing process may be underway. This category also includes all clients that are not yet housed at time of baseline evaluation.

F. Physical Health and Wellness

This component covers physical health and wellness.

There are four considerations related to the client 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 to based upon insufficient health resources in the community); and, how the individual views wellness.

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.

Chronic health issues include, but are not limited to, conditions such as heart disease, cancer, diabetes, and immunological disorders.

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

*COMPONENT F
Physical Health
&
Wellness*

0 =	No physical health issues. Completely well.
1 =	Physical health issues are relatively minor, or in the event of a chronic condition, the individual has considerable knowledge of their health needs and closely follows the treatment protocol. The individual is connected to appropriate professional resources.
2 =	Physical health issues present and while the individual is following treatment protocols, day to day functioning is still impacted.
3 =	Physical health issues present, which may be chronic in nature and/or requires intensive health supports, but the individual is not connected to appropriate professional resources either by choice or because of insufficient community resources. In some limited situations an individual may be connected to supports and following treatment protocols, but the treatment is having very little to no impact on improving day to day living and/or the individual cannot follow all parts of the treatment protocol (e.g., required to rest, but no place to rest 24/7 because of being homeless). The individual may not see the total value of wellness and getting better.
4 =	Serious health issues which are most frequently co-occurring, chronic and complex. In most instances the individual is not connected to appropriate professional resources, or the individual is involved in treatment that is having no impact on the condition and/or the individual cannot implement the treatment protocol; and/or, the individual is palliative.

COMPONENT G
*Mental Health
&
Wellness
&
Cognitive Functioning*

G. Mental Health and Wellness & Cognitive Functioning

This component covers mental health and wellness, as well as cognitive functioning. The intent is not to provide a diagnosis. While there may be many reasons for an individual to have a compromised ability to communicate clearly or engage in socially appropriate behaviour, these may be clues, along with the likes of delusions, hallucinations, incomprehensible dialogue, or 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 are a range of mental health conditions. Consideration should be given to any individual who would fall under Axis I, II or III disorders according to the DSM-IV (Diagnostic and Statistical Manual).

An Axis I disorder covers clinical disorders including major mental disorders and learning disorders. An Axis II disorder covers retardation of mental capacity and personality disorders. An Axis III disorder covers acute medical conditions or physical disabilities such as brain injuries that aggravate existing symptoms or can present symptoms similar to other disorders.

Caution should be exercised in considering whether an individual qualifies as having a 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; whether they have an Axis I or Axis II disorder; 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 the likes of head injuries, learning disabilities (as validated by neuropsychological or psycho-educational 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; compromised executive functioning such as the ability to plan, prioritize, organize or sequence activities.

0 =	No mental health or cognitive functioning issues disclosed, suspected or observed.
1 =	The individual has disclosed that they have a mental health issue or diminished cognitive functioning, and are effectively engaged with professional assistance to manage the issue; or an individual is in a heightened state of recovery, fully aware of their symptoms and wellness and manages their mental health and wellness independently.
2 =	The individual has a disclosed, suspected or possibility of mental health issues and/or cognitive functioning issues based upon that which is observed or heard, but any impact on communication, daily living, social relationships, etc is minimal. Possibly without formal diagnosis. If diagnosed, may not require anything more than infrequent assistance.
3 =	The individual has a significant mental health issue disclosed, suspected or observed, or the individual has significantly diminished cognitive functions, most likely having an impact on communication, daily living, social relationships, etc. The individual may have supports but the mental health and/or cognitive functioning issues still have considerable impact on day-to-day living. Assistance is required, but the client has no consistent, ongoing assistance.
4 =	The individual has a serious and persistent mental health issue disclosed, suspected or observed and/or the individual has major barriers to daily functioning as a result of compromised cognitive functioning; most likely greatly impacting communication, daily living, social relationships, etc., While most often without ongoing assistance, it is possible that the individual does have supports, but their serious and persistent mental health issues or major cognitive functioning issues are still greatly impacting day to day living.

COMPONENT H

Medication

H. Medication

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 a client is using an over the counter medication for a purpose other than intended, it may be considered as part of the component on 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 substance use.

0 =	Does not take any medications, or has demonstrated consistent self-management of medications for greater than 6 months.
1 =	Takes medications and has been self-managing the use of medications for less than 6 months.
2 =	Takes medications but requires some assistance from time to time, including prompts to take the medication, understanding what the medication is for and/or instruction on proper storage or use of the medication.
3 =	The individual takes medications, but may forget to take them regularly or may use them improperly from time to time. If the individual is selling their prescription drugs to others, they keep the majority of the prescription for themselves. Likely requires significant assistance to manage, including regular reminders, schedules or prompts, understanding what the medication is for and/or instruction on proper storage or use of the medication. May also include individuals who have had their prescription changed within the past month and the effects and routine of the new regime are not yet fully worked out, but are not having a debilitating impact on the person's health or daily activities.
4 =	The individual does not use medications as prescribed, which may include frequently failing to take the medication. This includes individuals with a prescription that is never filled (including those who did not fill the prescription because of financial restraints). If the individual is selling their prescription drugs, most or all of the prescription is sold. The individual may also demonstrate a lack of interest or understanding in how and when to take the medication, what it is for, or how it should be stored or used. May also include individuals who have had their prescription changed within the past month and the effects and routine of the new medication are significantly impacting day-to-day living, their health or daily activities.

I. Interaction with Emergency Services

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 client and staff from emergency rooms in hospitals, police officers, ambulance attendants and/or fire-fighters (including in the capacity of providing First Aid/CPR – not solely in their function of fighting fire).

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

0 =	No interaction with emergency rooms, hospital, crisis service, police, ambulance or fire for more than 6 months.
1 =	No interaction with emergency rooms, hospital, crisis service, police, ambulance or fire for less than 6 months.
2 =	One to three interactions with emergency rooms, hospital, crisis service, police, ambulance and/or fire in the last 6 months.
3 =	Four to nine interactions with emergency rooms, hospital, crisis service, police, ambulance and/or fire in the last 6 months.
4 =	Ten or more interactions with emergency rooms, hospital, crisis service, police, ambulance and/or fire in the last 6 months.

J. Involvement in High Risk and/or Exploitive Situations

This component is concerned with a client’s involvement in high risk and/or exploitive situations.

Involvement on the part of the client may have been voluntary or involuntary. It is both what they have done as well as what has been done unto them.

While not an exhaustive list, examples of high risk and exploitive situations include: sex work; injection substance use; slavery; drug mule; unprotected sexual engagement (outside of a monogamous relationship); 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; being in environments prone to violence; engaging in activity solely for the benefit of others without any personal gain or benefit.

*COMPONENT I
Interaction with
Emergency Services*

*COMPONENT J
Involvement in High Risk
and/or
Exploitive Situations*

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 are considered a 4.

People who have been sleeping rough may also be considered to be in a high-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 rough, they may be exposed to higher incidents of violence, sexual assault, and theft.

0 =	Has not been involved in a high risk or exploitive situation for more than 6 months.
1 =	Has not been involved in a high risk or exploitive situation for less than 6 months.
2 =	Has been involved in one to three high risk or exploitive situations in the last 6 months.
3 =	Has been involved in four to nine high risk or exploitive situations in the last 6 months.
4 =	Has been involved in ten or more high risk or exploitive situations in the last 6 months.

COMPONENT K
Substance Use

K. Substance Use

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

Prescription drugs, including methadone treatment, 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 the component on medication.

Information on usage thresholds has been drawn from leading addiction scholars and researchers. It is acknowledged that there can be differences in opinion amongst learned professionals in this field concerning the distinction between substance use and abuse, and in the amounts that can be safely consumed on a daily or weekly basis. "Acceptable consumption thresholds" for alcohol are: 2 drinks per day or 14 total drinks in any one week period for men; 2 drinks per day or 9 total drinks in any one week period for women.

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

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).

0 =	Has not used drugs or alcohol for 12 months or more.
1 =	Does not use drugs. Alcohol consumption does not exceed acceptable consumption thresholds. Substance use has no impact on daily functioning. If practicing abstinence, has achieved at least 14 days of sobriety.
2 =	Up to four incidents of using drugs and/or alcohol in a one month period, that may occasionally include non-palatable alcohol, and/or may occasionally include binge drinking. Any impact that the substance use has on daily functioning is infrequent. If there are health impacts as a result of substance use, the impacts are relatively minor.
3 =	More than four incidents of using drugs and/or alcohol in a one month period, that may include non-palatable alcohol, may include binge drinking, and is likely to exceed daily maximum acceptable consumption thresholds on a regular basis. Impacts of the substance use on daily functioning are frequent, even if the individual does not acknowledge these consequences. Health is likely compromised as a result of alcohol or drugs.
4 =	Use of drugs and/or alcohol is likely daily, frequently including non-palatable alcohol, most often including binge drinking, most often using to the point of complete inebriation (may include passing out). Impacts of the substance use on daily functioning are severe and may be life threatening.

L. Abuse and/or Trauma

This component is concerned with the impact of abuse or trauma experienced by the individual, including inter-generational impacts. Included in this component are individuals who are survivors of abuse or trauma as children. Additionally, traumatic events may be very recent or ongoing, and may be the cause of the current period of homelessness. Note that the experience is not automatically considered to be a traumatic event for all people.

For the purpose of this component institutional abuse is considered a history of abuse or trauma.

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.

*COMPONENT L
Abuse and/or Trauma*

0 =	The individual does not report a past or present experience of abuse and/or trauma.
1 =	The individual has a history of abuse and/or traumatic events, but reports no serious consequences on present functioning and/or ability, or indicates resolution of past abuse through therapeutic means.
2 =	The individual has a history of abuse and/or traumatic events that are impacting present functioning and/or ability. The individual may currently be engaged in therapeutic attempts at recovery, but does not consider self to be recovered.
3 =	The individual has a history of abuse and/or traumatic events that are severely impacting present functioning and/or ability. The individual has not attempted therapeutic recovery.
4 =	The individual is currently experiencing abuse or a traumatic event that is causing the current period of homelessness. No attempt at therapeutic recovery has been made.

COMPONENT M

*Risk of Personal Harm/
Harm to Others*

M. Risk of Personal Harm/Harm to Others

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

Included in this component are both actions and 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 individuals ability to de-escalate.

The indicators that help inform the likelihood or risk 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

0 =	No perceived risk to self or others. No known history of harming self or others. No known threats or making of harmful statements.
1 =	Limited risk to self or others. No history of harming self or others within the past 12 months, though may have limited exposure from the past. No threats or making of harmful statements within the past 6 months.
2 =	Possible risk to self or others. No history of harming self or others within past 12 months, though may have exposure from the past. May have very infrequently made statements concerning potential harm to self or others within the past 6 months, but no action taken. Individual de-escalated after making statements.
3 =	Probable risk to self or others. Episode of attempting or actually harming self or others within past 12 months and likely verbal or written statements threatening harm to self or others within the past 6 months.
4 =	Imminent risk to self or others. Clear, strong threats of harming self or others, without de-escalation. Recent frequent episodes of attempting or actually harming self or others.

N. Legal

This component is concerned with legal issues.

Legal issues pertain to any offences by any order of government or any area of law enforcement to which the person is subject to such things as paying a fine, undertaking community service, or being incarcerated.

Unless it is a single individual involved in such matters, it does not include any involvement in family court or child custody apprehension, as these are dealt with in a separate component.

The time frames references 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).

0 =	No legal issues for 12 months or more.
1 =	At least one legal issue in the past 12 months, but it was discharged or resolved without community service, payment of fine or incarceration. No current legal issues.
2 =	At least one legal issue in the past 12 months and it was resolved through payment of fine or community service. It may also include current legal issues that are unlikely to result in loss of housing or incarceration.
3 =	At least one legal issue in the past 12 months that may result in fines that may put housing at risk and/or periods of incarceration of three months or less that may place housing at risk.
4 =	At least one legal issue in the past 12 months that resulted in fines that place housing at imminent risk and/or periods of incarceration greater than three months.

COMPONENT N

Legal

COMPONENT O
*History of Homelessness
 &
 Housing*

O. History of Homelessness and Housing

This component is concerned with the client’s history of homelessness and housing.

The cumulative duration of homelessness is concerned with the total number of days that a person was homeless 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.

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

This component will not change in later assessments of the SPDAT unless the client reveals new information.

0 =	Cumulative duration of homelessness was less than 7 days over the past four years, which may include being recently re-housed.
1 =	Cumulative duration of homelessness was between 8 and 30 days over the past four years, which may include being recently re-housed.
2 =	Cumulative duration of homelessness was between 30 days and 2 years over the past four years.
3 =	Cumulative duration of homelessness was between 2 years and 5 years over the past decade.
4 =	Cumulative duration of homelessness was greater than 5 years over the past decade.

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 having to reference the complete SPDAT Manual. The most important tool is the Summary Sheet on the next page. The Summary Sheet should be the only documentation visible to the client when using a conversational approach to gaining input for the SPDAT. As previously noted in the section about disclosure, the client should be offered a copy of the Summary Sheet after the application of each SPDAT.

In the event of uncertainty between two possible scores for a component, i.e., if you are uncertain if the client 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:

1. The Comments section should reveal the source of the information that led to the assessment: Self-Report, Observation, Case Notes, Conversation, Other Documentation.
2. The Comments section should be used to note if there was uncertainty and a higher score for the component was used—as noted above.
3. The Comments section can be used to note if any particular circumstances seem to be impacting the assessment score for an individual component.
4. The Comments section can be used to make note of any relevant trends in the component for the client.
5. The Comments section can be used to make any notes that will be helpful for subsequent SPDAT evaluations.

Practitioners should write comments factually. Comments should only be relevant to the context of the SPDAT and mindful of the fact that clients will be offered a copy of the SPDAT Summary Sheet.

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 client. This final score represents the client’s level of acuity out of a total possible rating of 60.

SPDAT SUMMARY

Client: _____

Worker: _____

Date: _____

Component	Assessment (0, 1, 2, 3 or 4)	Comments
A. Self Care and Daily Living Skills		
B. Social Relationships and Networks		
C. Meaningful Daily Activity		
D. Personal Administration and Money Management		
E. Managing Tenancy		
F. Physical Health and Wellness		
G. Mental Health and Wellness		

Component	Assessment (0, 1, 2, 3 or 4)	Comments
H. Medication		
I. Interaction with Emergency Services		
J. Involvement in High Risk and/or Exploitive Situations		
K. Substance Use		
L. Abuse and/or Trauma		
M. Risk of Personal Harm/ Harm to Others		
N. Legal		
O. History of Homelessness and Housing		
TOTAL		

Prioritizing Service Based Upon Score & Guiding Supports

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

Scoring Range	Intervention	Comments
0-19	Housing Help Supports	Generally high functioning individuals with shorter periods of homelessness. Needs are not as complex in most of the SPDAT categories. Are most likely to solve their own homelessness, perhaps with very brief financial assistance, shallow subsidy, access to apartment listings and the like.
20-39	Rapid Re-housing	With some supports, though not as intensive as Housing First, the individuals can access and maintain housing. The focus of the supports will more likely be on a smaller number of SPDAT components. Support services do not last as long as Housing First supports.
40-60	Housing First	These are individuals with more complex needs who are likely to benefit from case management supports either through Intensive Case Management or Assertive Community Treatment. Scores in the SPDAT are likely to be higher (3s and 4s) in many of the components.

Within each category, those clients scoring closer to the top of the threshold are the first priority. For example, if two clients have undergone an intake and one scores a 53 and the other a 49, and there is only one opening on a caseload, the individual with the highest score is served first.

For those clients who receive a Rapid Re-housing or Housing First service, it is expected that the overall SPDAT score is likely to decline over time during the period when a client 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 “graduation” from program supports, leading to decreased and then terminated service supports.

If a client is in crisis at the time of an SPDAT measurement, it may misrepresent overall acuity. To provide greater accuracy in the overall measurement, it is recommended that an additional SPDAT evaluation be taken once the crisis is resolved.

Regardless of the scoring and priority sequencing system outlined above, circumstances may that require additional information be considered in establishing the priority of clients to be served. This decision rests with the Team Leader and/or Senior Managers/Central Administrators within the community. It is incumbent upon these decision makers to justify exceptions in service delivery, acknowledging that there can be many reasons for an exception based upon local circumstances at any point in time. Known as the “notwithstanding” clause of SPDAT use, it is important that this approach is used infrequently, in limited circumstances and with sufficient justification.

System Navigation and Support for Clients Can Be Informed Using SPDAT Results

Individual communities as well as cross-agency partnerships can create specific processes to better assist clients relative to their SPDAT score.

For example, a SPDAT score of 52+ that includes higher scores related to mental health and wellness and/or physical health and/or substance use may trigger a referral or secondary assessment by a specialized health, mental health or addiction resource such as an ACT Team or another specialized service team.

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 assigning of a Follow-up Support Worker to a particular client can be rationalized 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 agencies may result in client transfers among Housing First teams to ensure more balance across teams of clients with higher SPDAT scores.

Local Variations in SPDAT Use

Locally, system administrators can develop their own rules pertaining to priorities from scoring, system navigation, integration with a Homeless Management Information System and the use of the notwithstanding clause.

Individual organizations and communities may not adjust the scoring, ranking or descriptions of any of the 15 components.

Guide to Assist SPDAT Conversation

As noted previously, much of the information for completing the SPDAT can be attained through methods other than a specific conversation about the components. For example, a home visit with a client may self-reveal that they are not managing their medications. This information is used for the SPDAT rather than seeking the information again—unless there

was confusion about the client’s intent. Another example might be a client who shares some legal documentation that provides information relative to understanding how to complete the Legal category of the SPDAT. Information may also be obtained for the SPDAT through observation. Home visits are opportunities to assess the components Self Care and Daily Living Skills and/or Managing Tenancy.

The SPDAT is also integrated with information from the support and case planning process. Conversations with clients relative to their goals and activities often provide sufficient information for the assessment of many of the other components. Information obtained through the support and case planning process does not need to be repeated during the SPDAT assessment unless clarification is required.

When a specific conversation about the SPDAT is needed, the following questions can be helpful in guiding and assisting with that conversation. These questions have worked well during implementation of versions one and two of the SPDAT. To improve implementation, we encourage organizations within each community to share the questions that they are using to gain information from clients.

The following table outlines questions that will guide and assist the conversation. These questions are suggestions, and are not mandatory to achieve responses for the SPDAT. The questions are organized by SPDAT components:

Component	Probing Question(s):
A. Self Care and Daily Living Skills	<ul style="list-style-type: none"> • 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?

Component	Probing Question(s):
<p>B. Meaningful Daily Activity</p>	<ul style="list-style-type: none"> • 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?
<p>C. Social Relationships and Networks</p>	<ul style="list-style-type: none"> • Tell me about your friends, family and the other people in your life. • How often do you get together or chat with these people? • When you go to doctors appointments or meet with other professionals like that, what is that like for you? • Are there any people in your life that you feel are just using you? • Have you ever been threatened with an eviction or lost a place because of something that friends or family did in your apartment? • Are there any of your closer friends that you feel or 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 staying there? • Have you ever been concerned about not following your lease agreement because of your friends or family?

Component	Probing Question(s):
D. Mental Health and Wellness & Cognitive Functioning	<ul style="list-style-type: none"> • Have you ever received any help with your mental wellness? • Have you ever had a conversation with a psychiatrist or psychologist? When was that? • Do you feel you are getting all the help you might need with whatever mental health stress you might have in your life? • Have you ever hurt your brain/head? • When you were in school, did you ever have trouble learning or paying attention? Was any reason given to you for that? • Was there ever any special testing done on you when you were in school or as a kid? • Has any doctor ever prescribed you pills for your nerves, anxiety, feeling down or anything like that? • To the best of your knowledge, when your mother was pregnant with you did she do anything that we now know can have lasting effects on the baby? • Have you ever gone to an emergency room or stayed in a hospital because you weren't feeling 100% emotionally?
E. Physical Health and Wellness	<ul style="list-style-type: none"> • How is your health? • Are you getting any help with your health? How often? • Do you feel you are getting all the care you need for your health? • Anything like diabetes, HIV, Hep C or anything like that going on? • Ever had a doctor tell you that you have problems with your 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 full, healthy, happy life?

Component	Probing Question(s):
F. Substance Use	<ul style="list-style-type: none"> • Be straight up - when was the last time you had a drink or used drugs? • Is there anything we should keep in mind related to drugs or alcohol? • [If they disclose use of drugs and/or alcohol] How frequently would you say you use [specific substance] in a week? • In the last little while have you ever drunk so much you passed out? • Ever get into fights when you drink? • Ever have a doctor tell you that your health may be at risk in any way when you drink or use drugs? • Ever fall down and bang your head when drinking or using other drugs? • Have you ever used alcohol or other drugs in a way that may be considered less safe? • Do you ever end up doing things you later regret after you have tied one on? • Do you ever drink the likes of mouthwash or cooking wine or hand sanitizer or anything like that? • When you use drugs, in the last year have you ever had bad stuff that made you feel off?
G. Medication	<ul style="list-style-type: none"> • Do you take any medicines? • [If they do] Were these prescribed by a doctor? To you? • Have you ever sold some or all of your prescription? • Have you ever had a doctor prescribe you a medicine that you didn't have filled at a pharmacy or didn't take? • Were any of your medicines changed in the last month? How did that make you feel? • Do other people ever steal your medicine? • Tell me about how you store your medicine and make sure you take the right medication at the right time each day.

Component	Probing Question(s):
H. Personal Administration and Money Management	<ul style="list-style-type: none"> • How are you with taking care of money? • How are you with paying bills on time and taking care of other financial stuff? • Do you have any street debts? • Do you have any 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?
I. Abuse and/or Trauma	<ul style="list-style-type: none"> • I don't need you to go into any details that you are not comfortable with, but has there been any point in your life where you experience emotional, physical, sexual or psychological abuse? • Are you currently or have you ever receiving professional assistance to address that abuse? • Does the experience of abuse or trauma impact your day to day living in any way? • Does the experience of abuse or trauma impact your ability to hold down a job, maintain housing or engage in meaningful relationships with friends or family? • Have you ever found yourself feeling or acting in a certain way that you think is caused by a history of abuse or trauma? • Is your most recent or any past episodes of homelessness a direct result of experiencing abuse or trauma?
J. Risk of Personal Harm/Harm to Others	<ul style="list-style-type: none"> • Do you have thoughts about hurting yourself or anyone else? • Have you ever acted on these thoughts? • When was the last time? • What was occurring when you had these feelings or took these actions? • Have you ever received professional help – including maybe a stay at hospital – as a result of feeling or attempting to hurt yourself or others?

Component	Probing Question(s):
K. Interaction with Emergency Services	<ul style="list-style-type: none"> • How often do you go to emergency rooms? • How many times have you had the police speak to you over the past six months? • Have you used an ambulance or needed the fire department at any time in the past 6 months? • How many times have you called or visited a crises team or a crisis counsellor in the last 6 months? • How many times have you been admitted to hospital in the last 6 months? How long did you stay?
L. Involvement in High Risk and/or Exploitive Situations	<ul style="list-style-type: none"> • Does anybody force or trick you to do something 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 or having sex without a condom with a casual partner? • Do you ever find yourself in situations that may be considered at a high risk for violence? • Do you ever sleep outside? Tell me about how you dress and prepare for that? Where do you tend to sleep? • Do you have any illnesses that may be passed on to others?
M. Legal	<ul style="list-style-type: none"> • Got any legal stuff going on? • Have you had a lawyer assigned to you by a court? • [If they do] Got any upcoming court dates? Do you think there's a chance you will do time? • Any involvement with family court or child custody matters? • Any outstanding fines? • Have you paid any fines in the last 12 months for anything? • Have you done any community service in the last 12 months? • 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? • Is your housing at risk in any way right now because of legal things?

Component	Probing Question(s):
N. History of Homelessness and Housing	How long have you been homeless? How many times have been homeless in your life 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 or alley way or garage or barn or bus shelter or anything like that? Have you ever spent time sleeping in an abandoned building? Were you ever in hospital or jail for a period of time when you didn’t have a permanent address to go to when you got out?
O. Managing Tenancy	[For individuals who are housed] Do you think that your housing is at risk? How is your relationship with your neighbours? How have you been doing with taking care of your place?

Building Consistency Using 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 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 client 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 and Housing First within a community. Doing otherwise results in an inconsistent approach to prioritizing services and meeting the needs of clients. “Creaming” is unacceptable and counter-productive.

Infusing SPDAT into a standard practice will require the tool to be a part of the initial orientation or on-boarding 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.

