

# SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (SPDAT v2)

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**MARCH 17, 2011**



***Disclaimer***

The management and staff of OrgCode Consulting, Inc. (OrgCode) do not control the way in which the Service Prioritization Decision Assistance Tool (SPDAT) will be used, applied or integrated into related client processes by communities, agency management or frontline workers. OrgCode assumes no legal responsibility or liability for the misuse of the SPDAT, decisions that are made or services that are received in conjunction with the assessment tool.



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## **Foreword**

OrgCode Consulting Inc. is pleased to release Version 2 of the Service Prioritization Decision Assistance Tool (SPDAT). In less than one year, the SPDAT has been introduced to dozens of communities across North America and it has been used with thousands of homeless and formerly homeless persons. In many communities, every service provider involved with housing and homeless services is using the tool. In other communities, individual agencies are piloting the SPDAT.

In Q4 2010, OrgCode asked every community that was using the SPDAT for at least three months to provide feedback on the use of the tool. We are thankful that so many took the opportunity to provide constructive and helpful assistance — we were overwhelmed by the praise for SPDAT and how it has revolutionized service delivery in some communities.

Version 2 includes changes recommended through the feedback survey as well as our own innovations after observing the tool in action. We looked for those elements that were common in the feedback, or repeatedly observed.

In Q1 2011, SPDAT v2 was pretested in several communities to ensure that the new and revised elements of the tool were working, as designed. We are pleased that the SPDAT v2 works consistently well.

It is our intention to continue to work with communities and persons with lived experience to make the SPDAT even better in the future. Our partnership with the communities and agencies who use SPDAT is very important to us at OrgCode and we look forward to continuously improving the tool in support of our partners.

### Intent of the Service Prioritization Decision Assistance Tool

The SPDAT was originally designed to help guide the Frontline Workers and Team Leaders who use an Intensive Case Management (ICM) approach in the delivery of Housing First. While it can still be used in that manner, SPDAT applications have expanded. In addition to Intensive Case Management settings with a focus on housing, the SPDAT is now used in other case management settings including working with people with addictions, people with mental health issues and in correctional settings and work with ex-offenders. SPDAT has also helped communities direct potential clients to Housing First, Rapid Re-housing or even more general Housing Help services. The tool is in use with a variety of sub-populations, as well, including single and two-parent families, recent immigrants and youth.

#### *The SPDAT is designed to:*

- Help prioritize which clients should receive the which type of housing assistance intervention
- Which clients should be next in receiving those services
- Help prioritize time and individual attention 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 in supporting Frontline Workers and establishing service priorities across their team
- Provide assistance with case planning and reflection on priorities of different elements of 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 or future risk
- Take the place of 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 using the SPDAT.

The SPDAT has been influenced by the experience of practitioners in its use, persons with lived experience who have had the SPDAT implemented with them, as well as a number of other excellent tools such as the Outcome Star, Health of the Nation Outcome Scale, Denver Acuity Scale and the Camberwell Assessment of Needs.

## SPDAT Disclosure

Clients should be informed that they are using SPDAT. It is best to explain SPDAT as a tool to help guide them to the right services, 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. 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.

Just like transparency in case planning, the client 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 client's file.

An evaluated best practice from Version 1 of the SPDAT was the use of the SPDAT in the “warm transfer” between intake and the case manager for clients who have higher acuity. In the warm transfer, the intake worker, client and case manager (meeting the client for the first time) all sat down together and reviewed each of the 15 components of the SPDAT in detail. There were many advantages to this process:

- 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 so not as many clients went “missing” between their initial intake and the case management services beginning;
- 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

OrgCode recommends that the SPDAT begins at intake. This can be a central intake point for the entire community; various intake points at community agencies and shelters; or, upon specific program intake. Results are better if there is alignment in the use of the SPDAT across organizations.

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 who are receiving supports, the SPDAT should also be used:*

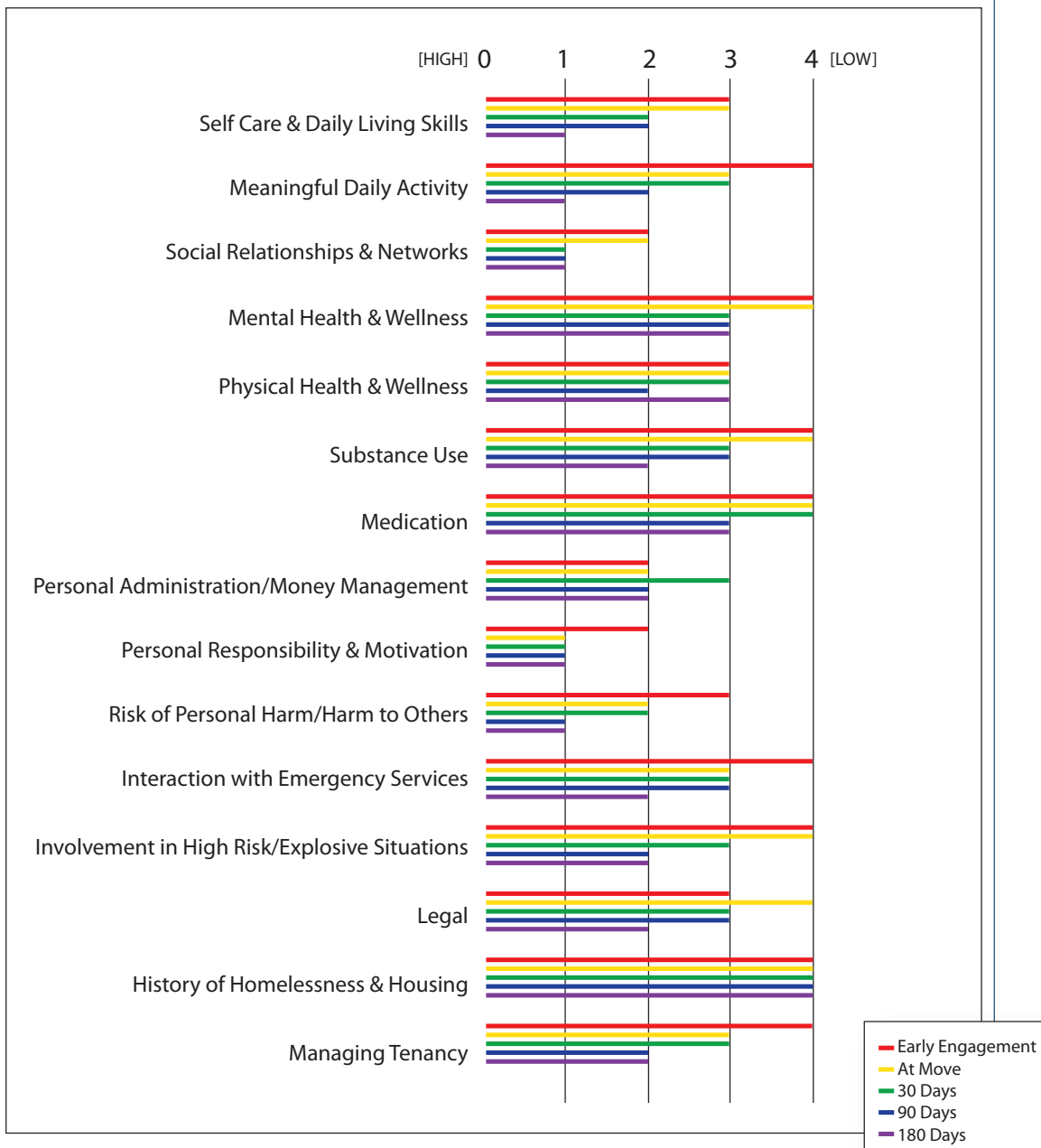
1. On or about 30 days
2. On or about 90 days
3. On or about 180 days
4. On or about 270 days
5. On or about 365 days

In addition, the SPDAT should be completed any time a client is re-housed or experiences a significant shift in their case plan — 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 crisis has subsided. This may occur in between regularly scheduled applications of the SPDAT.

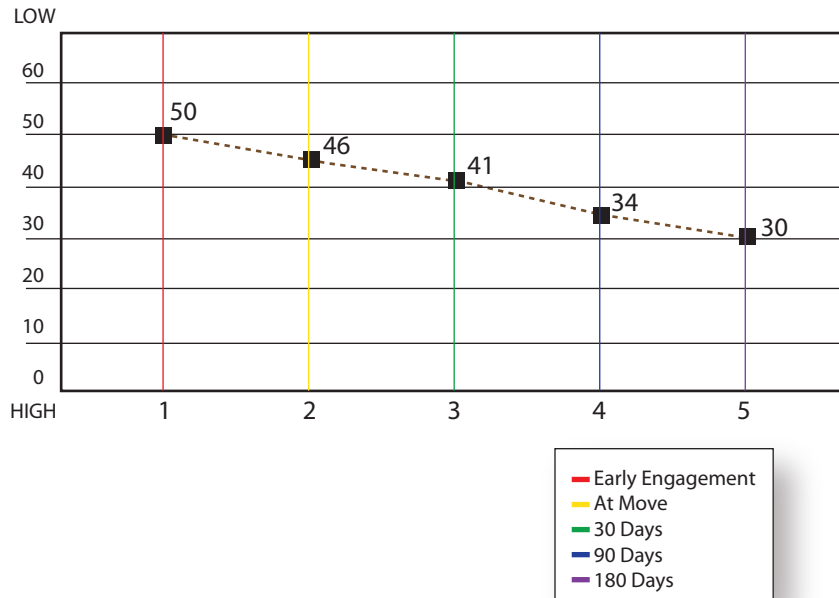
### Graphing Changes

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 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, and 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 — often brief — to gather enough accurate information to complete the tool. If ever you are uncertain with the accuracy of information received from the client, it is encouraged that you repeat the conversation and get clarity.

A conversation guide is included at the end of this document to assist with communication when a conversational approach is used to get information for completing the SPDAT.

## 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 proven to be successful in helping clients work through the Stages of Change. It has proven to be helpful to case managers and other supports in guiding the starting conversation in client follow up, as well as to establish objectives for each follow-up visit. The SPDAT remains a tool that is client centred and allows for strength based approaches to service delivery.

## Components of the SPDAT

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

The scoring begins with "0" and 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 score descriptions. In these instances, it is important for staff to provide their rationale for the score indicated.

There is also 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

*Self-Care and Daily Living Skills*

This component is concerned with functions of taking care of oneself and meeting daily needs, meeting those needs independently & living independently. This includes such things as taking care of personal hygiene, being able to cook, clean, do laundry, and the like. This component also includes excessive acquisition of belongings that impact daily living (hoarding or extreme collecting). The most that excessive acquisition with good or fair insight into their hoarding (are aware that it exists and are aware that it impacts their life) is a 3. Excessive acquisition where the individual has poor insight (thinks it has less of an impact than it does) or are absent of insight (do not acknowledge that it is an issue) is a 4.

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 in taking care of self or meeting daily needs where sometimes assistance is 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 (likely to be an episodic or chronic shelter user; may have experienced long stays in institutional settings during their lifetime); 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 (likely to be a chronic shelter user and/or someone who has experienced long stays in institutional settings during their lifetime); 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

Meaningful Daily Activity

*Meaningful Daily Activity*

This component is concerned with meaningful daily activities - the ways in which clients spend their days. The activities that a client engages in are informed by their own choices. The activities extend beyond those activities that are informed solely by functions of the case plan or other support to achieve goals. 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.

It’s important for clients to be engaged in meaningful daily activities and that clients have a sense of fulfillment from the participation in that activity. This is usually 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 person feeling that can be attributed to feelings of self-esteem, contentment, confidence, recovery, etc.

While it is possible for an individual to enjoy solitary meaningful daily activities, there is an expectation that some of these activities will encourage clients to interact in the community.

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 day and or some days of the week, which provide a good degree of personal satisfaction.
2 =	Trying 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 early stages of trying activities that may provide fulfillment intellectually, socially, physically, emotionally, spiritually, etc. but not fully committed, at times disengaged, and 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.

*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 they have contact with to determine the relationship, though more than one is encouraged.

*COMPONENT C  
Social Relationships  
and  
Networks*

In some instances, the capacity of an individual to trust or make an informed decision about social interaction can be cause for concern. This is especially true of those who have a history of victimization, engagement in dependent relationships, and those that are used for goods or services. There can also be family and friend relationships where the client is satisfied with the relationship, but which is detrimental to the client’s wellness. All of these types of situations are likely captured in 3 or 4 on the scale.

0 =	Has friends and/or family supports as they would like them, 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 less than 6 months.
2 =	Engaged in relationships with friends and/or family, occasionally with some difficulties and/or still at very early stages of relationship development.
3 =	Discussing or early stages of 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 has 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.

**COMPONENT D**  
*Mental Health  
 and  
 Wellness*

*Mental Health and Wellness*

This component covers mental health and wellness.

The intent is not to provide a diagnosis if one does not exist. 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 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. Examples include depression, schizophrenia, phobias, bipolar disorder, anxiety disorders, attention deficit hyperactive disorder, autism and spectrum disorders.

An Axis II disorder covers retardation of mental capacity and personality disorders. Examples include obsessive compulsive personality disorder, antisocial personality disorder, paranoid personality disorder, dependent personality disorders, narcissistic personality disorder, borderline personality disorder and schizoid 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.

As many people are aware, there is discussion of hoarding being included in the DSM-V, and a working group has been studying it's potential inclusion in detail. At the current time, hoarding activities are considered as part of the component on Self Care and Daily Activities and are not considered in this component.

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.

0 =	No mental health issues disclosed, suspected or observed; or the individual is in a heightened state of recovery, fully aware of their symptoms and wellness and manages their mental health and wellness independently.
1 =	Has disclosed that they have a mental health issue, and are effectively engaged with professional assistance to manage the issue; or the individual is in a heightened state of recovery, mostly aware of their symptoms and wellness and manage with minimal supports
2 =	Disclosed, suspected or possibility of mental health 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 be without ongoing assistance or infrequent assistance
3 =	Significant mental health issue disclosed, suspected or observed, most likely having an impact on communication, daily living, social relationships, etc. The individual may have supports by the mental health issues still have considerable impact on day to day living. In other instances the individual may be without ongoing assistance or infrequent assistance
4 =	Serious and persistent mental health issue disclosed, suspected or observed; 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 are still greatly impacting day to day living.

*COMPONENT E  
Physical Health  
and  
Wellness*

*Physical Health and Wellness*

This component covers physical health and wellness. Mental health and wellness is covered in a previous component, and is not included as a consideration in this component.

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 want to 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 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 the likes of heart disease, cancer, diabetes, immunological disorders and the like.

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

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 and closely follows the treatment protocol and any impact on day to day functioning is very minor or non-existent. 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 health issues and/or intensive health supports needed for care, but the individual is not connected to appropriate professional resources either by choice or because they cannot access health resources because of either long waiting lists or lack of availability in the community. If the individual has been provided treatment protocols, 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 well- ness and getting better.
4 =	Co-occurring and most frequently chronic, complex health issues, with the individual most likely not connected to appropriate professional resources; or the individual is involved with treatment but the treatment is having no impact and/ or the individual cannot implement the treatment protocol; and/or, the individual is palliative.

*Substance Use*

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

Prescription drugs including the likes of 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 the thresholds of the amount used come from the Centre for Addiction and Mental Health.

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

*COMPONENT F  
Substance Use*

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 =	Abstinent. Has not used drugs or alcohol for 12 months or more.
1 =	Does not use drugs. Alcohol consumption for men does not consistently exceed 2 drinks per day or 14 total drinks in any one week period; for women does not consistently exceed 2 drinks per day or 9 total drinks in any one week period. Substance use has no impact on daily functioning.
2 =	Up to four incidents of using drugs and/or alcohol to the point of intoxication 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, may include non-palatable alcohol, may include binge drinking, and is likely to exceed daily maximum recommendations on a regular basis. Impacts of the substance use are frequent, even if the individual does not acknowledge the impacts. 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 is highly likely and may be life threatening.

**COMPONENT G**  
*Medication*

*Medication*

This component is concerned with medications prescribed by a professional.

Those who take over the counter medications are not included here. If they are 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 in the component on substance use.

Any individual who does not take any medications is classified as 0.

0 =	Does not take any medications, or consistent self-management of medications for greater than 6 months.
1 =	Takes medications and has been self-managing use of medications for less than 6 months
2 =	Takes medications with 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 =	Takes medications, though may forget or use improperly from time to time. 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 not have debilitating impact on the person's health or daily activities.
4 =	Medications are not used as prescribed, which may include frequently not taking the medication. This includes individuals with a prescription that is never filled (including those who did not fill the prescription because of financial restraints). 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 or significantly impacting day-to-day living, their health or daily activities.

*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, submitting necessary paperwork or documentation, etc.

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 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.

*COMPONENT H  
Personal Administration  
and  
Money Management*

0 =	Has an income source and manages all personal finances and benefits independently, and can pay bills, 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, 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). Most likely cannot appropriately fill out forms or complete paperwork. Most likely cannot create or follow a monthly budget. Most likely 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 I  
Personal Responsibility  
and  
Motivation*

*Personal Responsibility and Motivation*

This component is concerned with personal responsibility and motivation.

Personal responsibility is understood as how one accounts for and accepts their actions.

Motivation is understood as how one assumes responsibility for making change in one's own life.

There will be some instances where an individual cannot take personal responsibility or

struggles with motivation due to considerations outside their control such as cognitive functioning. These are captured on the scale in 4.

0 =	The individual accepts personal responsibility in their life, is motivated to make positive life changes
1 =	Most of the time accepts personal responsibility in their life, is motivated to make positive life changes though may need some assistance thinking about changes to be made or how to make those changes
2 =	Occasionally blames others for life circumstances or events and/or requires more regular prompts and tools to think about making changes or how to make those changes.
3 =	Frequently blames others for life circumstances or events and/or requires frequent prompts and tools to think about making changes or how to make those changes, and is likely pre-contemplative in many (though not all) areas of the individual service plan.
4 =	Persistently blames others for life circumstances or events and/or is pre-contemplative in almost all elements of individual service plan; and/or, is completely unaware of personal responsibility due to compromised cognitive functioning from the likes of brain injury, fetal alcohol spectrum disorder, severe and persistent mental illness.

*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 action 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.

*COMPONENT J  
Risk of Personal Harm/  
Harm to Others*

The indicators that help inform the likelihood 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.

*COMPONENT K  
Interaction with  
Emergency Services*

*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 focuses on are deliberate and direct interactions between the client 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.

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

*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; 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.

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 on the scale.

People who have been sleeping rough may also be considered to be in a high risk situation in specific situations. 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, theft and the like.

*COMPONENT L  
Involvement in High Risk  
or  
Exploitive Situations*

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 M  
Legal

*Legal*

This component is concerned with legal issues.

Legal issues pertain to any municipal, provincial or federal offences to which the person is subject to such things as paying a fine, undertaking community service, or being incarcerated. It also includes any involvement in family court or child custody apprehension.

Legal issues are considered minor most often for municipal or provincial matters. That is to say, if sentenced to incarceration, the individual would most likely spend less than two years in jail.

Legal issues are considered major most often for federal matters, though it can include multiple municipal or provincial matters. Major legal issues are likely to result in incarceration, and that incarceration is likely going to be for two or more years.

As incarceration can have a direct impact on the ability to maintain a tenancy, there is a direct link in this component between the impression of the severity of the legal issue and the likelihood of incarceration, as well as length of incarceration.

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 =	No legal issues for less than 12 months.
2 =	One to three minor legal issues in the last 12 months, though not likely to result in incarceration or impact tenancy.
3 =	Four to nine minor legal issues or occasional major legal issue in the last 12 months, and it is quite probable that the legal issues will result in incarceration and may impact tenancy.
4 =	Ten or more legal issues in the last 12 months, frequently major in nature, that will most likely result in incarceration and will impact tenancy.

*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. All the number of days homeless is added up to get the cumulative total.

The types of homelessness captured in this section include absolute homelessness (sleeping rough; staying in shelters) as well as relative homelessness (couch surfing; overcrowding). What is most important is the client’s own determination of what constituted their homelessness.

This component will not change in later assessments using 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 between 2 years and 5 years over the past decade.
4 =	Cumulative duration of homelessness greater than 5 years over the past decade.

*COMPONENT N  
History of  
Homelessness  
and  
Housing*

COMPONENT O  
Managing Tenancy

*Managing Tenancy*

Any person who is homeless at the time the SPDAT is completed is considered a 4. This component is concerned with an individual’s management of their apartment. The component on self-care and daily activities captures the ability of oneself to take care of oneself and undertake tasks like cleaning their apartment. This component is concerned with the ability 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 payment of rent. That is an administrative function of how rent gets paid — not unlike a direct transfer for a mortgage payment — 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 is likely going to 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 and the re-housing process may be underway. This category also includes all clients that are not yet housed at time of baseline.

## 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 be able to apply the SPDAT without using the full SPDAT Manual. The most important tool is the Summary Sheet (see next page). The Summary Sheet should be the only documentation visible to the client when using a conversational approach to gain input for the SPDAT. As noted previously 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 in the previous paragraph.
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 assessments.

Practitioners should write comments factually. Comments should only be relevant in the context of the SPDAT and with consideration that clients will be offered a copy of the SPDAT Summary Sheet.

When summarizing the scores, it is important that there is a score 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 total score represents the client's score out of 60.

**SPDAT SUMMARY**

Client: \_\_\_\_\_

Worker: \_\_\_\_\_

Date: \_\_\_\_\_

Component	Assessment (0, 1, 2, 3 or 4)	Comments
Self-Care and Daily Living Skills		
Meaningful Daily Activity		
Social Relationships and Networks		
Mental Health and Wellness		
Physical Health and Wellness		
Substance Use		
Medication		
Personal Administration and Money Management		

Component	Assessment (0, 1, 2, 3 or 4)	Comments
Personal Responsibility and Motivation		
Risk of Personal Harm/ Harm to Others		
Interaction with Emergency Services		
Involvement in High Risk and/or Exploitive Situations		
Legal		
History of Homelessness and Housing		
Managing Tenancy		
<b>TOTAL</b>		

**Prioritizing Service Based Upon Score & Guiding Supports**

The recommended intervention and approach to supports is linked to the 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 attention of the supports is more likely going to 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 nearer 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 a 53 is served before the person who scored a 49.

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 review to review.

Consistently lower scores that reflect overall life improvements and increased stability, can be used to focus on “graduation” from program supports, decreased and then terminated service supports.

At times when a client is in crisis at the time of an SPDAT measurement, it may misrepresent overall acuity. It is recommended that an additional SPDAT measurement be taken once the crisis is resolved. This will provide greater accuracy in the overall measurement.

Regardless of the priority sequence and scoring outlined above, there may be instances when particular circumstances may be taken into account 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**

System navigation and support for clients can be informed using SPDAT results. Individual communities or cross-agency partnerships can create specific processes to better assist clients relative to their SPDAT score.

A very high SPDAT score of 52+ with 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 used 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.

### Training on the SPDAT

Only people trained in the correct use and scoring of the SPDAT should use it in practice.

Training can be provided by OrgCode Consulting Inc. representatives either through a webinar series or a 1.5 day workshop. For those individuals and organizations that have been using the SPDAT for some time, refresher training is recommended at least once every two years or when there is significant turnover in the sector. In both instances there are a series of review materials and testing that can be implemented to ensure there is consistent understanding and comprehensive grasp of the content and scoring. This is achieved through written materials and various case studies.

More advanced training on the SPDAT is also available. This training focuses on the following potential topics:

- Using the SPDAT in system administration
- Integrating the SPDAT into improved case management
- Using the SPDAT in research
- Helping Team Leaders support their teams and determine priorities
- Using the SPDAT to structure Assertive Engagement conversations and focus on success in Stages of Change

### Guide to Assist SPDAT Conversation

As noted previously, much of the information for completing the SPDAT can be provided through methods other than a specific conversation about the SPDAT. For example, during a recent home visit 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 be obtained for SPDAT through observation. Home visits are opportunities to inform 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 relative to 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 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 Version 1 of the SPDAT. We encourage organizations within each

community to share the questions they are using to get the info so as to improve implementation.

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

Component	Probing Question(s):
<p>A. Self-Care and Daily Living Skills</p>	<ul style="list-style-type: none"> <li>• Do you have any worries about taking care of yourself?</li> <li>• Do you have any concerns about looking after cooking, cleaning, laundry or anything like that?</li> <li>• Do you ever need reminders to do things like shower or clean up?</li> <li>• If I were to come over to your apartment, what would it look like right now?</li> <li>• Do you currently, or have you ever, acquired and collected a lot of the same type of thing? This might be things you have found when binning or dumpster diving or collecting things like newspapers? (And if they say yes.... What sort of impact has that had on your life?)</li> </ul>
<p>B. Meaningful Daily Activity</p>	<ul style="list-style-type: none"> <li>• How do you spend your day?</li> <li>• How do you spend your free time?</li> <li>• Does that make you feel happy/fulfilled?</li> <li>• How many days a week would you say you have things to do that make you feel happy/fulfilled?</li> </ul>
<p>C. Social Relationships and Networks</p>	<ul style="list-style-type: none"> <li>• Tell me about your friends, family and the other people in your life.</li> <li>• How often do you get together or chat with these people?</li> <li>• Do you trust these people that are your friends or family?</li> <li>• When you go to doctors appointments or meet with other professionals like that, what is that like for you?</li> <li>• Are there any people in your life that you feel are just using you?</li> </ul>

Component	Probing Question(s):
D. Mental Health and Wellness	<ul style="list-style-type: none"> <li>• Have you ever received any help with your mental wellness?</li> <li>• Have you ever had a conversation with a psychiatrist? When was that?</li> <li>• Do you feel you are getting all the help you might need with whatever mental health stress you might have in your life?</li> <li>• Do you ever find that your ability to communicate clearly or function in day to day life or relationships are impacted in any way by your mental health?</li> </ul>
E. Physical Health and Wellness	<ul style="list-style-type: none"> <li>• How is your health?</li> <li>• Are you getting any help with your health? How often?</li> <li>• Do you feel you are getting all the care you need for your health?</li> <li>• For people who are getting help with their physical health - are you able to follow the treatment that your doctor tells you to do like rest or take care of your wounds or that sort of thing?</li> </ul>
F. Substance Use	<ul style="list-style-type: none"> <li>• Be straight up - when was the last time you had a drink or used drugs?</li> <li>• Is there anything we should keep in mind related to drugs or alcohol?</li> <li>• [If they disclose use of drugs and/or alcohol] How frequently would you say you use [specific substance] in a week?</li> <li>• Do you ever get regular drugs from the drug store - over the counter drugs, not the kind you get from the pharmacy - in a different way than how it says to use it? Like taking lots of cough syrup when you don't have a cough?</li> <li>• When you drink, do you ever drink mouthwash like Listerine or cooking wine</li> </ul>
G. Medication	<ul style="list-style-type: none"> <li>• Do you take any medicines?</li> <li>• [If they do] Were these prescribed by a doctor?</li> <li>• [If they do] Do you ever forget to take your medicine?</li> <li>• [If they do] Do you always take your medicine the way the doctor or pharmacist told you to?"</li> <li>• [If they do] Do you ever lose your medicine or ever had it stolen from you so that you couldn't take it?</li> </ul>

Component	Probing Question(s):
H. Personal Administration and Money Management	<ul style="list-style-type: none"> <li>• Be straight up - what are all the places you get money from?</li> <li>• How much steady income do you have monthly? How are you with taking care of money?</li> <li>• How are you with paying bills on time and taking care of other financial stuff?</li> <li>• Do you have any street debts?</li> <li>• Do you have any drug or gambling debts?</li> <li>• Is there anybody that thinks you owe them money?</li> </ul>
I. Personal Responsibility and Motivation	<ul style="list-style-type: none"> <li>• When you look at where you are at now, tell me about how motivated you are to change in the future.</li> <li>• When you think about the things that have happened in your life that led you to being homeless, tell me who is responsible for those things?</li> </ul>
J. Risk of Personal Harm/ Harm to Others	<ul style="list-style-type: none"> <li>• When were the last times that you got in fights?</li> <li>• Do you have thoughts about hurting yourself or anyone else?</li> <li>• Have you ever acted on these thoughts?</li> </ul>
K. Interaction with Emergency Services	<ul style="list-style-type: none"> <li>• How often do you go to emergency rooms?</li> <li>• How many times have you had the police speak to you over the past six months?</li> <li>• Have you used an ambulance or needed the fire department at any time in the past 6 months or so?</li> </ul>
L. Involvement in High Risk and/or Exploitive Situations	<ul style="list-style-type: none"> <li>• Does anybody force or trick you to do something that you don't want to do?</li> <li>• 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?</li> <li>• Do you ever find yourself in situations that may be considered at a high risk for violence?</li> <li>• Do you ever sleep outside? Tell me about how you dress and prepare for that? Where do you tend to sleep?</li> <li>• Have you recently been a victim of abuse?</li> </ul>

Component	Probing Question(s):
M. Legal	<ul style="list-style-type: none"> <li>• Got any legal stuff going on?</li> <li>• Have you had a lawyer assigned to you by a court?</li> <li>• [If they do] Got any upcoming court dates? Do you think there's a chance you will do time?</li> <li>• Any involvement with family court or child custody matters?</li> </ul>
N. History of Homelessness and Housing	<ul style="list-style-type: none"> <li>• How long have you been homeless?</li> <li>• How many times have been homeless in your life other than this most recent time.</li> </ul>
O. Managing Tenancy	<ul style="list-style-type: none"> <li>• [For individuals who are housed] Do you think that your housing is at risk?</li> <li>• How is your relationship with your neighbours?</li> <li>• How have you been doing with taking care of your place?</li> </ul>

**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 and Housing First professionals, there should be a common understanding about each component of the SPDAT. It is common to most assessment tools that there will be different perspectives about the score for 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 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 have to 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 SPDAT to be part of the initial orientation or on-boarding of any new staff. Shadowing and coaching can be effective approaches for ensuring that new staff will apply the SPDAT at a consistent standard relative to other members of the team.



## SPDAT SUMMARY

**Client** \_\_\_\_\_

**Worker** \_\_\_\_\_

**Date** \_\_\_\_\_

Component	Assessment 0, 1, 2, 3 or 4	Comments
1. Self Care and Daily Living Skills		
2. Meaningful Daily Activity		
3. Social Relationships and Net-works		
4. Mental Health and Wellness		
5. Physical Health and Wellness		
6. Substance Use		
7. Medication		

Component	Assessment (0, 1, 2, 3 or 4)	Comments
8. Personal Administration and Money Management		
9. Personal Responsibility and Motivation		
10. Risk of Personal Harm/ Harm to Others		
11. Interaction with Emergency Services		
12. Involvement in High Risk and/or Exploitive Situations		
13. Legal		
14. History of Homelessness and Housing		
15. Managing Tenancy		
<b>TOTAL</b>		