Self Sufficiency Matrix 2013

Manual

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Manual and description of the Self Sufficiency Matrix 2013

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Content

Preface

How is the client doing? Is this intervention appropriate for this client? What are the effects of the intervention on the client? Care workers, policy makers and researchers in the care and welfare field are increasingly confronted with these questions. In public health care we are confronted with complex, socio-economic and psychosocial problems, a close cooperation between institutions and services from diverse fields and dynamic target populations with varying needs. Answering these questions is therefore not an easy task. Therefore, the Public Health Service Amsterdam, in cooperation with the city of Rotterdam, developed a measurement tool to provide insight in the level of functioning of client in public health care: the Self Sufficiency Matrix (SSM).

Since the publication of the first version in 2010, a increasing number of municipalities, institutions and organisation have shown an interest in the application and implementation of the SSM. Apparently, the SSM meets the need for reliable, complete and comparable information in public health care that remained largely unfulfilled so far.

Recent development concerning the responsibility of municipalities in organising and managing care for a socially vulnerable population with an increasing diversity, combined with a growing need for accountability for costs in the entire field of health care, have resulted in a even quicker growth of this need for information. Many professionals, policy makers and researchers that have applied the SSM in their work in the past two years have shared their experiences with and have suggested improvement concerning user-friendliness and unequivocality of the SSM. In addition, last year we studied the reliability and validity of the SSM that resulted in mostly encouraging results, but also in some recommendations for improvement. Both the feedback of users and the results of this study have lead to the publication of a new version of the SSM and a completely revised manual that is currently in front of you.

With gratitude to all uses and interested parties in the Netherlands, the SSM 2013 has become clearer, and easier to use. This new manual is more accessible, more complete and provides the reader with extensive information about the background, the use and the possibilities of the SSM 2013. On behalf of the SSM-team we hope you enjoy working with the SSM 2013. I hope you will experience the SSM as a useful and applicable tool in your daily work.

Paul van der Velpen

Director PHS Amsterdam
7 February 2013

What is self sufficiency?

You can be considered self sufficient when you have reached an acceptable level of functioning on the domains that you, and all other Dutch citizens, encounter in daily life.
Self sufficiency is not only sufficiency on one's own. To reach or retain an acceptable level of functioning, you can, or must, make use of the skills, expertise and possibilities of others. These others can be family or fiends, but also professional care workers who can assist in reaching and attaining acceptable levels of functioning.

Self sufficiency is asking for the help of others when you need that to retain or regain an acceptable level of functioning. The questions for help should not only be put out there, but should be phrased in a way that the other understands how he of she can help you become or remain self sufficient. On top of that, support needs to be asked for in time. If you wait until someone else notices your problems and asks help for you, you are not self sufficient.

Self sufficiency in therefore generally defined as:
Realising an acceptable level of functioning on the important domains of daily life by yourself. If necessary, organising the appropriate support when a relapse in your level of functioning is about to occur or is already occurring, that you cannot prevent or fix yourself.

What do I measure with the SSM?

With the SSM, you measure how self sufficient someone is. All information about the functioning of a person is expressed in the SSM in an assessment about the level of self sufficiency of that person at that current moment in time.

The level of self sufficiency is an *outcome*.
The level of self sufficiency in terms of a score on the SSM is the result, the consequence of many factors and processes that have led to this level of self sufficiency at this time. With the SSM you only consider the outcome and leave the causes out of consideration as much as possible. There are two reasons for this. The first is that causes are not always observable and hard to map (for instance personality, culture, motivation). The second is that the way in which these factors interact with each other and with the outcome can be very complex. So, the self sufficiency is assessed without statement about the ways in which it came about.

The level of self sufficiency reflects *a moment in time*.
With the SSM you assess the current level of self sufficiency, i.e. you take a picture of someone's functioning. In general, information older than 30 days can be left out of consideration.

Like the exclusion of historic information, it is also important to not include future predictions in your assessment on the SSM. You observe the functioning at this moment, and expect that this will probably lead to a different level of functioning, but you cannot be certain. Your expectations about what probably will happen will differ from that of other assessors. Besides, all kinds of factors will also influence what will probably happen. Only what you observe is the input for your assessment of the current level of self sufficiency. Only what happens now, is important.

What are the levels of self sufficiency of the SSM?

The SSM is divided into five levels of self sufficiency. The lowest level on the scale reflects minimal self sufficiency, the highest level maximal self sufficiency. The levels are marked with a score; a number between 1 and 5; and with a short description: ‘acute problems’, ‘not self sufficient’, ‘barely self sufficient’, ‘adequately self sufficient’, ‘completely self sufficient’.

In figure below, you can see what the levels mean in terms of self sufficiency. The clarify the classification in five levels, it is also presented for two concepts closely related to self sufficiency, namely need for care and need for support.

	Acute	Not	Barely	Adequately	Completely
Self sufficient	The situation is untenable. Acute problems.	Client is not self sufficient. Situation will deteriorate if there is no intervention.	Limited self sufficiency. Situation is stable, but barely adequate.	The client is adequately self sufficient.	Self sufficiency is above-average.
Care	The client needs (more) care immediately.	Major care need the client cannot provide for him/herself.	Client has a care need that is partially provided for.	Any care need is provided for.	The client does not have a care need.
Support	Additional intensive support is acutely necessary.	Additional support is needed.	Support could be improved.	Support is adequate.	Support is not needed.

The levels of self sufficiency on one domain are *mutually exclusive*.
When scoring the SSM you can only choose one of the five levels per domain. One can not be ‘barely self sufficient’ and ‘adequately self sufficient’ at once on one domain, or have ‘acute problems in self sufficiency’ on a domain and at the same time be ‘not self sufficient’ on the same domain. One functions on one level or the other.

The levels of self sufficiency are ordinal categories. This means that being ‘adequately self sufficient’ on a domain is better than ‘not self sufficient’ and worse than ‘adequately self sufficient’ on that domain.
But it also means that one cannot score, for example, 2½ (‘almost barely self sufficient’). The level of self sufficiency is either the lower or the higher level. The SSM has no space in between the five levels of self sufficiency.

What are the domains of the SSM?

The SSM has **11 domains**:

Finances, day-time activities, housing, domestic relations, mental health, physical health, addiction, activities of daily life, social network, community participation, judiciary.

Selection by *experts in the field* of public health care.
The domains in the SSM are selected from a set of domains that were included in the American versions. Health and social care professionals, researchers and policy makers from the public health care sector selected these eleven domains because they are relevant for *the whole of the Netherlands* and because they are relevant *for every adult*. All domains of the SSM can be assessed for every adult in the Netherlands.

The names of the domains are *carefully chosen*.
In designing the first version of the SSM, professionals from divergent disciplines were asked a) which names of the domains would be a good reflection of the underlying construct (self sufficiency in relation to the domain); b) relate to the language and terms used in daily practice; and c) have meaning to a broad group of care and support givers and professionals with diverse backgrounds, disciplines and levels of education.

Based on the responses of the participants of SSM-training sessions and presentations, experiences of professionals working with the SSM and research into the characteristics of the SSM, a number of domain names is adjusted and refined so that the domain names of the SSM 2013 better cover the construct, better reflect the language used in daily practice and have meaning to a broader and more diverse group of care givers and other professionals.

Additional domains for specific groups are being developed by the SSM-team.
The domains of the SSM are applicable to every adult. In specific situations, like when an adult is responsible for the care and upbringing of children, or for other groups of adults, like the elderly, one wants to assess the self sufficiency on more or even other domains. The SSM-team, that consists of experts of the Public Health Service (PHS) Amsterdam and the city of Rotterdam, develops additional domains for specific groups, on request and based on questions from the field. Reliable, applicable and meaningful additional domains are developed based on scientific research.

What are the indicators of in a cell of the SSM?

For every level on every domain of the SSM indicators are chosen that characterise the specific levels of self sufficiency on the specific domain. The indicators represent important aspects and characteristics of the domain and are a reflection of the level of self sufficiency on this aspect of the domain.

The indicators provide tools for the assessment and guidance for the collection of information.
Based on these indicators, you can provide a reliable assessment of the levels of self sufficiency. You compare the situation of a client in regards to the aspect covered in the indicator, with the situation as described in the cells of the SSM and decide in which cell they match. After that, you compare the situation of the client with the next indicator in the same cell of the SSM. If the situation of the client confers with the *majority* of the indicators in the cell of the SSM you can asses the level of self sufficiency on that domain on that level. The fact that these are indicators, means that not for every client the situation always exactly matches all the indicators for the level of self sufficiency on the domain. You can interpret the indicators as criteria that generally match the situation of a person with the same level of self sufficiency.

How do I score clients with the SSM?

The SSM is an *assessment instrument*.
As a professional caregiver you provide an assessment of the self sufficiency of the client and this assessment is expressed in a score on the SSM. The domains and indicators of the SSM tell you *what information* you need to reach an assessment, but *no how* you collect this information.

The information you need for an assessment can come from three sources: *the client, the colleague, the administrative records*. In theory each of these sources can provide sufficient information for a reliable assessment. In practice the score is generally based on information provided by the client, only supplemented with information from colleagues and administrative records.

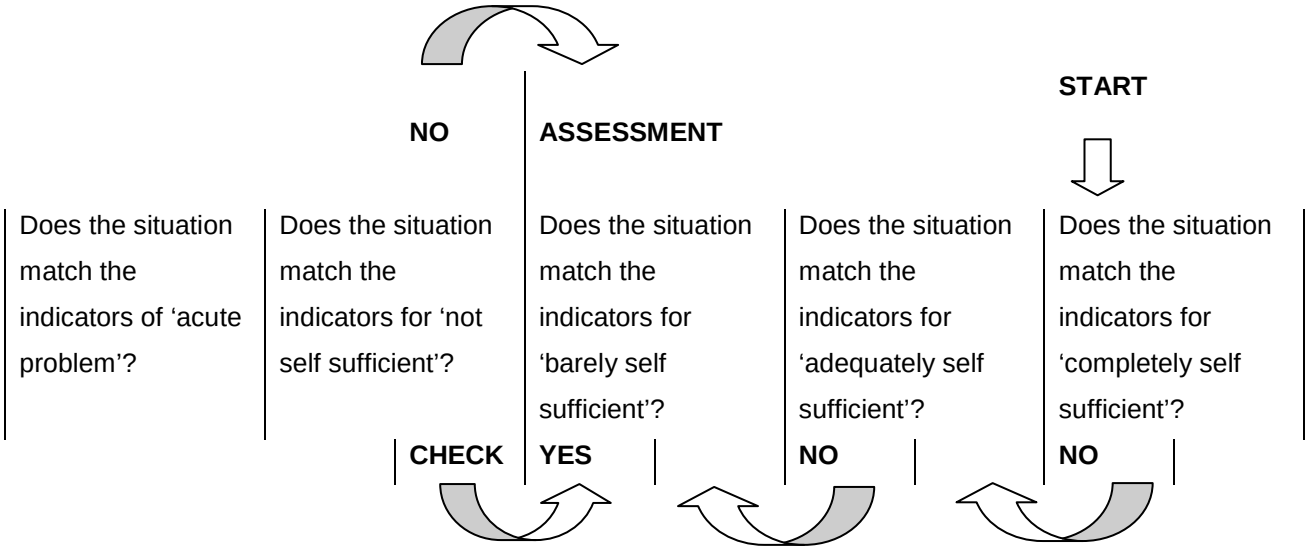
The first and most important source of information is *the client himself or herself*. The situation and the level of functioning of the client on the eleven domains can be topics of the interview at intake, progress, evaluation or exit. You can use the SSM as a 'topic list' during the conversation and complete the scores (directly) after the conversation, or complete the SSM during the conversation.

The second source of information are *your colleagues* within your own organisation and professionals from other organisations that have recently been in contact with the client. If colleagues have also spoken to the client or have had a different form of interaction with the client (made a house call, or ran into the client on the street, for instance) you can also use their information to reach an assessment of the level of self sufficiency of the client. The same holds for professionals from other organisation who have recently been in contact with the client. They might have supplementary information relevant for the assessment of the client on the SSM.

The third source of information that you can use to formulate a score on the SSM are *administrative systems*. Recent reports in the registration system, case registry, client files or other administrative systems that you can access, can be informative in scoring client on the SSM.

When scoring the SSM you start with *the highest level of self sufficiency*.
On every domain you asses, the first step is to decide whether a client complies with (most of) the indicators for 'completely self-sufficient'. If this is not the case, you check the indicators in the cell 'adequately self sufficient' and asses whether the indicators in this level adequately reflect the client level of self sufficiency. If this is not the case, you check the indicators one level below, and so on, until you reach the cell that best reflects the level of self sufficiency; i.e. the situation of the client matches (the majority of) the indicators in the cell. Subsequently you check whether the indicators in the cell one level below are not an adequate reflection of the observed self sufficiency (check) and come to an assessment.

Below you find a schematic reflection of the way you reach an assessment on a domain.



What do I take into consideration when explaining the score?

When explaining and assessing the SSM-scores you have to take several factors into consideration. Clients do not have a level of self sufficiency on the so-called *weighting factors*. Therefore the weighting factors are not included in the SSM, but they do play a role in the evaluation and interpretation of an SSM-score. These weighting factors are: having *health insurance*, the extent to which *cognition is limited*, command of the Dutch *language* and whether a person *cares for children*.

Information on the weighting factors is considered in relation to the self sufficiency of the client. Having health insurance for instance, provides the client with the opportunity to organise health care and pose questions for instance to (formal) care providers to be or become (more) self sufficient on (mainly) the domains of mental health, physical health and addiction of the SSM.

Command of the Dutch language can be divided into speaking, reading, writing and understanding. A limited ability to read Dutch poses very different barriers to the self sufficiency than a limited ability to understand Dutch. Therefore we recommend to specify command of the Dutch language as much as possible.
If specified information about command of the Dutch language is impossible to collect, some information (limited ability in language command yes/no) is off course better than no information at all. The same goes for the other weighting factors.

If and how the *cognitive ability* influences the self sufficiency is not always easy to assess. In some cases you suspect something is off, based on how the client responds or behaves, but you cannot be sure the cognitive ability is limited. Because the possibility for further investigation is not always directly available, the standard score form of the SSM also includes the option: ‘further examination’.

Both command of the Dutch language and the cognitive ability do not necessarily play a role in the self sufficiency of a client. Clients that have a limited command of the Dutch language or have cognitive limitations can be very self sufficient if they ask for help timely and adequately when needed.

Responsibility for children is a weight factor that is taken into consideration at almost every domain. A lower self sufficiency of a client who is responsible for a young child is, in general, more severe than the same level of self sufficiency of a client who is only responsible for him or herself. ‘Being homeless is serious, but being homeless with a baby is worse.’ Information about the clients’ responsibility for children is often overlooked or not registered. Therefore, we included it in the standard score form with the SSM. On this form you can distinguish between young children (0 up to 12 years) and older children (13 up to 18 years).

Which clients can I asses with the SSM?

All adults can be assessed with the SSM.
All domains of the SSM can be completed for all persons in the Netherlands from the ages of 18 until the age of retirement. For this group (‘adults’) all domains are always applicable. In addition, on all domains of the SSM you can expect or strive for at least adequate self sufficiency (score 4): you can expect every adult to realize an acceptable level by himself, and organise the adequate support for the obstacles or problems they encounter.

Minors (under the age of 18) and *elderly* (over the age of retirement) can also be assessed with the SSM.
But for these groups you should take the following into account:
At the assessment of the elderly you should take into account that for this age group no obligation to work or school applies. Day time activities in the SSM is a (trajectory towards) paid work and/or education. Those over the age of retirement are, by definition, no longer obliged to work or attend an education that allows them to perform paid work. Therefore, the domain day time activities has less relevance for the elderly.

A minor is largely dependent on an adult that is legally responsible for him of her. The adult should organize support on behalf of the minor so that the minor can attain or maintain an acceptable level of functioning. One should consider whether it is relevant and meaningful to assess the level of self sufficiency of the minor when it is in reality an indirect measure for the self sufficiency of the adult who is responsible.
Assessing minors with the SSM is possible, but the legally determined care-relation with an adult has consequences for the interpretation of the assessment.

Apart from the conceptual and domain specific considerations in assessing the SSM for minors and the elderly, you should consider the possibility that other age-specific aspects of self sufficiency, not included in the SSM, can be relevant to gain a complete picture of the self sufficiency of these groups. For instance, for the elderly ‘mobility’ might be an important aspect that needs more attention than only considering it as an part of other domains. Additional information like that should be assessed and registered in addition to the SSM. If and what aspects are relevant for a complete assessment of the self sufficiency in other age groups than adults has not been investigated so far.

Of course there are exceptions and you might know someone who is completely self sufficient at 17, or a late developer who still completely relies on his parents at the age of 23, or a 70-year old man who still enjoys a fulltime job at the company he started working with at age 18. There will always be exceptions, but in general the SSM is developed to be completely and reliably filled out for adults between the age of 18 and the age of retirement.

How can I use the score of the SSM?

What you can do with the SSM-score depends on how you use the SSM. Below you'll find an (incomplete) overview of the possible uses that result from the different ways you can apply the SSM.

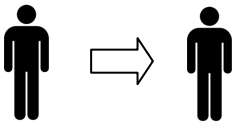
One score for one client.

You can use this score to plan treatment, or clarify the need for support. *John is not self sufficient in the domain of finances, he might benefit from debt management assistance.*

eral clients at one moment.

cores to compare clients among each other and allocate them to different (scarce)

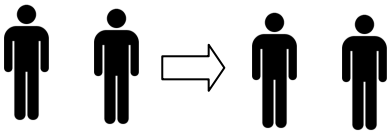
i *is less self sufficient in the domain of finances than Peter: there is only one opening for debt control assistance: I allocate John to that spot.*



SSM scores for one client at several moments in time.

You can use the scores to show the development or progression of the client over time to adjust treatment.

John has become more self sufficient in the domain of Finances: he can possibly handle his debts by himself.



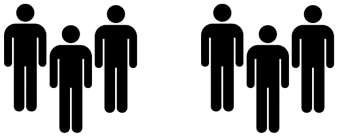
SSM scores for several clients at several moments in time.

You can use the scores to compare the development of clients over time with each other and adjust treatment. *The self sufficiency of John in the domain of finances has improved more than that of Peter even though they both have debt control assistance: possibly Peter will benefit more from another, or a more intensive support method in spending his income.*

SSM scores for all individuals that belong to one client group at one moment in time.

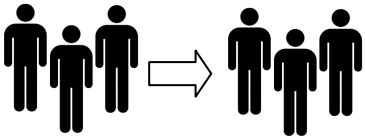
You can use the score to provide insight into the characteristics of the group and create a profile of the target population for a type of treatment. Based on the profile you can then determine whether an individual client belongs to the target population of that type of treatment based on this SSM score and you can determine how many treatment spots are necessary based on the number of clients that fit the profile.

All clients that enter public shelters score, apart from a 2 (not self sufficient) or lower on housing, and a 3 (barely self sufficient) or lower on finances, a 3 or lower on at least two out of the three domains Mental Health, Physical Health, or Addiction. John is not self sufficient in the domain of Physical Health and Addiction. John belongs to the target population of the public shelters. In the coverage area of the public shelters are approximately a 1000 persons that fit the profile of the target population of the shelters, the public shelters currently have 500 beds; possibly more shelters beds should be created.



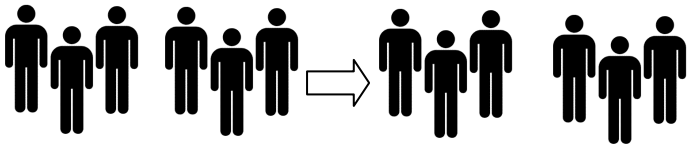
SSM scores for all individuals that can be divided into several unique client populations at one moment in time.

You can use the scores to compare the characteristics and the profile of one group with the other to adjust policies and manage the acquisition of the number of shelter beds. *The group that scores both a 2 or lower in the domain of Housing and Finances and a 2 or lower in the domain of Addiction is considerably larger in the Central area than in the North area, besides, not being self sufficient in regards to housing and finances in the North area occurs more often in combination with a 1 (acute problem) in Daytime activities. It is to be recommended to realise more shelter beds in combination with addiction treatment in the Central area, and in the North area pay more attention to daytime Activities in the shelters.*



SSM scores for all individuals that belong to one client group at several moments in time.

You can use the scores to determine the development of the group that does or does not follow a certain type of treatment, to adjust treatment to the development of the group. *At intake, the target population of the public shelters score 2 or less on housing and finances. Three months later, the groups score 3 on these domains but the self sufficiency in the domain of Mental Health and Addiction remain problematic. A recommendation could be that after Housing and Finances are stabilised, treatment should be include more focus on Mental Health and Addiction.*



SSM scores for all individuals that can be divided into more client groups at several moments in time.

You can use the scores to compare the development of the different groups with each other to determine the effectivity of treatment. *The groups that enter the public shelters is, at intake, comparable to the group on the waiting list for the shelters. After three months the group that has entered the public shelters scores considerably higher than the group on the waiting list on the domains of Housing, Finances, Mental Health, Addiction and Social network. Treatment in the public shelters is effective in improving self sufficiency on these domains.*

Apart from these eight possible uses of the SSM assessment, you can perhaps think of other uses. Take into consideration that for every type of use specific demands should be met in the use of the SSM and possibly additional information is required. For instance, to use the SSM to show progress in clients, you should know if the SSM is sensitive to change of a client in the group you treat ('if the client improves in functioning, does that translate into a higher score on the SSM?') A number of these demands and conditions for applications have already been investigated, but for a number this still needs to be done. If you have questions or ideas about applying or using the scores of the SSM you can contact us at zrm@ggd.amsterdam.nl.

How does the SSM define domains and concepts?

Below you'll find a short explanation of every domain in the SSM, a clarification of the concepts included in the domain and some points of attention that are relevant in the assessment.

Finances

Self sufficiency with regards to finances covers three aspects of income and expenditure: 1) *The level of income in relation to the expenditure*. Does the client have enough income to meet the basic needs, or is the money spend on other things thereby not leaving enough to meet the basic needs and/or building up debts. 2) *The source of income*. Does the income come mainly from welfare/benefits or from paid work. 3) *The management and dynamics of (possible) debts.* Does the person have debts, and if so, do they increase or decrease. Who manages the debts, does the person do this by himself of are debts managed by a third party.

Points of attention

- Person with welfare benefits score a maximum of 3 (barely self sufficient) on this domain.

Concepts

Income = legal periodic flow of money from government sources or other sources (wages, internship remuneration, health insurance act, or own enterprise)

Debts = amount of money due for received products or services of the government (for instance tax department, justice, municipality) or private institutions/persons (for instance housing corporation, power company, bank, mail order service or dealer)

Inappropriate spending = spend such a large part of the income on secondary needs (for instance drugs, gambling, luxury goods) that insufficient income is left for the basic needs.

Basic needs = essential needs for human existence. Mainly: (enough and healthy) food, (safe and stable) housing, and (functional and clean) clothing.

Benefits = income paid on the basis of the criteria for social security. Particularly, unemployment benefits, income support, old-age pensions, and benefits for young disabled people.

Income management / budget control = money flows (income and/or expenditure) are controlled or regulated by institutions or organisations appointed to that effect.

Day-time activities

Self sufficiency in regards to day-time activities concerns having a job and/or attending a trajectory that leads to work (activation, reintegration, or attending an education). If a person has no daytime activities, he of she can cause nuisance, simply because the person has no daily structure and can get bored, hang around, provoke fights etc. The main concern is whether a person has organised a certain form (low-threshold, high-threshold, temporary or steady job) of daytime activities for him or herself. Attending an education for performing qualified work (entry level qualification) or a higher education is also a form of daytime activities.

Points of attention

- Persons without day-time activities score a maximum of 2 (not self sufficient) on this domain.

Concepts

Nuisance = bother or damage in the neighbourhood or public space.

Low-threshold day-time activities = also called 'preparation for employment". A form of day-time activities with an emphasis on developing basic employee skills, such as arriving on time, accepting instructions, motivation and discipline.

High threshold day-time activities = also called "introduction to work". A form of day-time activities with an emphasis on contacts with employers on the basis of suitable and available vacancies, developing job application skills, gaining work experience through trials, placement and support.

Temporary work = paid work that is set to end within a short period (in general less than 3 months). Including seasonal labour and short-running projects.

Entry-level qualification = a diploma that allows you to do trained work. (Equivalents of) a secondary school diploma or a two-year tertiary vocational training are entry-level qualifications, but secondary vocational training is not.

Housing

Self sufficiency in regards to housing concerns the stability and quality of the housing situation of a person. The central question is whether or not the person has a safe, sufficient house, where he or she can stay for a longer period of time. Quality of housing is defined as housing that is safe (consider humidity, air quality, gas and water supply etc) and sufficient (consider living space in relation to household size, heating, lighting, housing effects, like a bed, table, chairs etc.). Stability concerns the expected duration of stay in the current housing, meaning how long the person can still stay in the current house. Autonomy concerning housing applies to the independence of others to organize safe and stable housing, consider aspects like financing, maintenance/ repairs, or acquisition/replacement of housing effects.

Points of attention

- Residing in detention or a care institution is safe, sufficient and possibly stable, but not autonomous housing.

Concepts

Homeless = having no fixed abode (sleep rough or in make shift accommodation).

Night shelter = institution that offers a place to sleep for a night.

Housing that is not suited for permanent habitation = accommodation is unsafe or unstable or not intended for (permanent) habitation (for instance a recreational house, barn, garage, a basement box).

Safe housing = accommodation where physical and mental health are not endangered by characteristics/aspects of the accommodation itself.

Stable housing = accommodation that is available 24 hours a day for at least 90 days.

Marginally adequate housing = accommodation is stable and safe in the short term, but only has essential provisions (electricity, water, gas, bed, table, chair).

Non-autonomous housing = fully dependent on others to provide for safe and stable housing. Every aspect of housing, such as financing, furniture, and maintenance, is organised by third parties.

(Rental) contract with clauses = The housing agreement (rental agreement) contains clauses or conditions regarding behaviour or financing of the person in respect of housing. The contract may be in the name of a care or other institution.
Partially autonomous housing = dependent on others for a number, but not all aspects of a safe and stable housing.

Domestic relations

Self sufficiency in regards to domestic relations concerns the questions whether or not a person maintains good relations with the persons he shares a household with. Do members of the household support the person in his growth and development or do members of the household have a negative influence on the functioning of the person. The other way around is also included: does the person support the members of the household in their growth and development or does the person have a negative influence on the functioning of one or more of the other household members. You assess the quality of all the relations of the person with the other members of the household. The domain concerns, among others, the signalling of domestic violence, abuse and neglect. It is important to consider both verbal and non-verbal signals. If abuse or neglect are not present, a domestic environment can be threatening because of negative repressing interpersonal relations that impede a person in his or her growth and development.

Points of attention

- Persons that live alone, share their household with no one else, always score a 4 (adequate self sufficiency) on this domain.
- Persons living in a ward or institution, or who share their household (common bathroom, kitchen and living room) with a great number of other persons (like in student housing) have many domestic relations that should, at least, not negatively influence the functioning of a persons to attain a high score on this domain.

Concepts

Domestic violence = the physical, mental or sexual violation of the personal integrity by someone from the domestic circle. Domestic violence threatens health as well as safety.
Child abuse = every form of a threatening or violent interaction of a physical, psychological or sexual nature towards a minor, actively or passively imposed by the parents or other persons with whom the minor has a relationship of dependence or lack of freedom, which causes or threatens to cause serious damage in the form of physical or psychological injury.
Neglect = There is no care/attention for physical (e.g. hygiene, food) and/or psychological needs (e.g. attention, support) from one or several members of the household.
Potential abuse or neglect = although there is no domestic violence, child abuse or child neglect, there are risk factors for possible domestic violence, child abuse or child neglect. These risks may be personal factors (e.g. strong jealousy or feelings of hatred, undesirable dependent relationships between members of the Household) or environmental factors (e.g. serious financial situation, social isolation of the household).
Negative behaviour = behaviour that has a negative effect on the person's own functioning, the functioning of others, or the physical environment.
Relational problems = difficulties/limitations in respect of the relations between members of the household.
Consistently open communication = constructive exchange of ideas between members of the household whereby the household members listen and are heard.

Mental health

Self sufficiency in regards to mental health concerns the absence or presence of psychopathology and, if present, the way the person deals with this. The central question is whether a person suffers from symptoms of mental disorders (e.g. depressive, bipolar, psychotic disorders, schizophrenia, (post-traumatic) stress disorders or personality disorders). When a person is dealing with psychopathology, the question is how he deals with the treatment of the disorder: is the person in treatment, does the person attend treatment (treatment compliance)? What influence does the disorders have on the daily functioning of the person?

Points of attention

- Persons suffering from mental health problems who are not in treatment score a maximum of 2 (not self sufficient) on this domain.
- Mental health problems are pathological. Feeling down about the recent death of loved one is not a mental health problem, but a predictable reaction with a clear reason (stressor). The same goes for stress caused by, for instance, serious financial problems or an uncertain housing situation. However, if the cause ceases to exist or the mental health status (feeling down or stressed) remains for a longer period of time without the cause changing, it becomes a mental health problem.

Concepts

Suicidal ideation = plans, thoughts and desires of suicide. Actively thinking of and considering suicide or a suicide attempt to reduce or solve your
problems

Mental health problems = disorders of the mind; whether or not diagnosed as mental illness

Problems with functioning = interference with performing tasks or undertaking actions as a result of psychological problems

Symptoms = expressions of psychological problems that can be observed

Minor symptoms = expressions of psychological problems that may cause some and/or mild functioning problems. Minor symptoms may point to a 'minor' psychological problem or a psychological problem that is developing or in remission.

Treatment compliance = extent to which the person complies with the prescribed therapy.

Minimal symptoms = expressions of unimportant psychological problems or normal reactions to situations/stressors (for example some tension regarding an uncertain future).

Physical health

Self sufficiency in regards to the domain physical health concerns the absence or presence of a physical disorder and, if present, the way the person deals with this. Physical disorders may include injuries (e.g. due to an accident), short-term illnesses (e.g. flu), and chronic illnesses (e.g. diabetes). Some questions that could be asked to assess self-sufficiency regarding physical health could be: 'Does the person care for his wounds (from a band-aid to first aid)?' and 'Does he take his medication as prescribed (including repeat prescriptions, check-ups by treating physician, treatment compliance)'.

Points of attention

- A critical situation is an acute problem but does not have to be life-threatening: a stroke is a critical situation, but so is a broken arm or a wound that is not taken care of with visible symptoms of severe inflammation and the first signs of blood poisoning.
- A person with a chronic or severe disorder that should be treatment but is not, scores a maximum of 2 (not self sufficient) on this domain.
- Persons with a chronic disorders like diabetes or COPD, score a maximum of 4 (adequately self sufficient).

Concepts

Critical situation = physical condition is life threatening or of such a nature that a lack of intervention will lead to serious and long-term health problems

Chronic/progressive medical disorders = physical disorders with a slow, dragging progress and/or an increasingly worsening progress.

Physical health problems = disorders in respect of physical wellbeing. Physical structures and/or processes do not function optimally.

Restriction of activities = no full freedom in carrying out activities (due to physical health problem)

Mobility = the ability to move yourself and/or parts of your body

Addiction

Self sufficiency in regards to the domain addiction concerns the drug and alcohol consumption of a person and the influence this has on his or her daily functioning. The (DSM-IV) criteria for addiction are (in summary) 1. Tolerance, 2. Withdrawal symptoms, 3. Large amounts – long period of time, 4. 'Craving', 5. Dedicate a lot of time to obtaining/use/recovery, 6. Give up important social/professional activities, 7. Continued use despite knowledge of negative physical or psychological consequences. An important question regarding this domain is whether and how many problems a person suffers in social, work-related or physical activities as a result of alcohol/drugs consumption (in other words 'Is the person able to control his substance use?'). When a person is receiving treatment for his addiction, the treatment compliance is taken into account when assessing this domain.

Points of attention

- Every use of alcohol or tobacco (nicotine) is substance use, so also a glass of beer or wine at diner, and smoking cigarettes or cigars. Caffeine (coffee/thee) is not included in substance use (but can be abused). This classification is chosen based on the addictive potential and (social) detrimental effects of these substances.
- Substance abuse as mentioned in level 5 of this domain mainly concerns abuse of prescribed medication for a physical or mental health problem. A client with health problems who uses the medication according to the prescription can score a 5 (completely self sufficient) on this domain.

Concepts

Severe substance abuse = a pattern of inappropriate use of a substance that causes significant restrictions or suffering, as demonstrated by repeated use, which results in not succeeding to fulfil important obligations; repeated use in situations where it is physically dangerous; repeatedly coming into contact with the judiciary in connection with the substance; continued use despite problems on social domain.
Institutional admission/hospitalisation = admittance to an institution or hospital.
Preoccupation with use/obtaining = continued preoccupation with use of or obtaining the substance.
Symptoms of Withdrawal = a substance-specific syndrome as a result of stopping (or reducing) the use of the substance following considerable and long-term use.
Withdrawal avoidance behaviour = actions carried out to avoid or postpone the syndrome (for example avoiding situations where you cannot use, using substitute substances).
Essential life activities = actions and behaviour of existential importance to (continued) life (for example eating, drinking, sleeping).
Problems related to use = mental, social or physical problems that arose as a direct result of drugs use.

Activities of daily life

Self sufficiency in regards to activities of daily life concerns the degree to which a person provides for himself in performing Activities of Daily Living (ADL) or has organised others to perform these activities. This ranges from basic activities of self-care (eating, washing, dressing, going to the toilet) to more complex activities such as organising the household and caring for others (children or other persons for whom the person has been made responsible). During the assessment of this domain, self-care activities are distinguished from more complex ADL activities, and therefore it is important that both aspects of the ADL are discussed.

Points of attention

- Opening and sorting the mail is also a complex activity.
- Self care concerns the question of how well and clean a person takes care of himself.
- Complex tasks concern how well and clean a person takes care of his direct environment.

Concepts

Self care = those aspects of ADL activities that concern your own body and mind. These aspects include the activity of feeding yourself, keeping yourself clean (wash) and dressing yourself.
Complex activities = ADL activities that require some planning and organisation. This includes for example: shopping, cleaning (washing up, vacuuming, etc.), and the care for (young) children.
Basic tasks = elementary or life-essential needs, particularly (healthy) eating/drinking, safe housing and clothing (*see also domain finances*).

Social network

Self sufficiency in regards to social network concerns the number and the quality of relationships with friends, family and acquaintances (not members of in the household). An important question within this domain is whether the person is able to gather enough and the right people around him who can support him in his growth and development. The quality of the social network is important, because a person can

have a very extensive network that simply consists of people who he, when needed, cannot rely on and/or who have a negative influence on the behaviour of the person (so-called 'toxic friends', for example a drugs network or friends who are criminally active). The social network can also comprise relatives who are not part of the household (for example uncles, aunts, grandfathers and grandmothers who do not live with the person in the same household). As the person may not think immediately of this part of the social network, explicit questions should be asked about the existence and the quality of the relationship with relatives.

Points of attention

- A toxic circle of friends has the addition "if present" on every level of self sufficiency. This means that there does not have to be a toxic circle of friends, but if there is, you should assess whether the person also has other social contacts or only a toxic friends.
- The lack of ability/resources to help, as mentioned in level 2 of this domain, can be caused by for instance large (physical) distance, financial restraints or the inabilities of the members of the social network.

Concepts

Necessary support = the help/support/reinforcement a person needs to keep going and/or to function in his environment.
Toxic friends = individuals or groups who, in their contact with a person, have a negative or destructive influence on the functioning of a person (e.g. 'drugs friends', criminal gangs, 'lover boys' etc.)
Serious social isolation = a lack of human contact that is experienced as worrisome and sad by society (social norm) and the person him of herself.
Active and passive withdrawal from social relationships = stable, meaningful contacts are not developed/maintained as a result of the (sub)conscious actions of the person (e.g. aggressive or distant behaviour, lack of physical care, etc.) or lack of actions by a person (e.g. hesitant attitude, not turning up for appointments, etc.).
Supportive relationships = contacts that have a positive/helpful/stimulating influence on the functioning of a person.
Healthy social network = enough support in (a number of) stable, supportive relationships to fulfil the needs of a person in respect of receiving (and giving) support.

Community participation

Self sufficiency in regards to community participation concerns the extent to which a person is able to participate in structured community activities and organisations. It concerns the actual participation of the person and the presence of promoting or impeding external factors (e.g. transport, time, childcare etc). Participation in any form of organised activity, such as a sports club, an association, social club, committee, church, support or advice groups is seen as community participation. A visit to a cafe, a coffee shop or other places of entertainment are not included in community participation

Points of attention

- Score 1 (acute problem) on this domain is the only score in the entire SSM in which you state that the domain itself (community participation) is not applicable because the situation of a person does not allow participation (the person is merely surviving).

Concepts

Crisis situation / survival mode = condition in which the physical and/or mental integrity of a person is under threat and the person has to make an enormous effort to provide for his own basic needs.

Isolated from the community = functioning outside or on the margins of society. No participation in social activities, no membership of a community (group, club, organisation).

Social skills = ability to be/continue to be part of a community and/or take part in social activities

Barely participates in community = community activities are not noteworthy, attempts to take part in a community flounder in an early stage of contact due to limited social skills of the person and/or strongly impeding environmental factors (e.g. money, transport, time).

Some community participation = participation in one or two, but not many community activities, but being impeded in this from time to time by environmental factors. Participation is largely unilateral (beneficial for the person, but not directly for the community).

Actively participating in community = closely and regularly involved with (organising) social activities and communities. Taking on (core) tasks within those communities. Both the person and the community benefit from participation.

Judiciary

Self sufficiency in the domain of judiciary concerns whether or not the person is in contact with the police or the judiciary now or has been in the recent past. If the person currently has cases pending with the judiciary, this could interfere with any care, housing or daytime activities. Having a criminal record could influence access to work. In many cases, the judicial matters will have to be closed before any other trajectories can start. Police contacts concern all apprehensions by the police for a violation or offense. Judicial cases are in general cases regarding the criminal justice system: 1 = client receives penalty. The client has to appear before a judge. Especially the current insecurity about the near future creates an acute problem. 2 = client is currently being punished. Client is in detention, has community service, extramural detention (electronic surveillance), but also transactions by the public prosecutor (for instance for driving without a license or using a false identity). 3= client has no punishment (left) if he abides with the court ordered conditions. 4 = client has served his time, but can experience some detrimental consequences (for instance because he cannot receive a statement of good behaviour for a job). 5 = client has not received punishment (for a long time). Client has never committed an offense, or it was such a long time ago that it is no longer included in his criminal record, or the person is legally not prosecuted for committing an offense. There are no barriers for a statement of good behaviour, when required.

Points of attention

- On the domain judiciary, unlike most other domains, incidents that occurred in the not so recent past are taken into account in the assessment. This is related to the fact that judiciary contacts have possible long term consequences.
- Persons with a criminal record score a maximum of 4 (adequately self sufficient) on this domain.
- Most minor traffic offenses, for instance fines for using public transport without a ticket, cycling without light, speeding (to a certain limit) are not included in the criminal justice system but are handled administratively. Apprehension by the police is considered a police contact, but when the fine is paid, it is not a judicial case.

- In general one can say that an offense/crime is only a judicial case if the prosecutor handles it.

Concepts

Contact with the police/judiciary = coming into contact with the police and/or the judiciary in connection with an offence or crime

Outstanding warrants = cases regarding offences and/or crimes the police and/or judiciary still have to deal with or still need to rule on.

Pending cases = cases regarding offences and/or crimes for which the person is currently receiving the punishment (e.g. community service, reporting duty, probation period)

Conditional punishment = a conditional punishment means that there is a verdict but it is not executed yet under the conditions set by the judge. Conditions can be, apart from the general condition that no new crime can be committed, restrictions in freedom (ban from a certain location, ban on drinking alcohol, or commandment to report) or influencing behaviour (like following a training).

Conditional release = a convicted person who has a sentence or detention of over a year, is released early after two third of this sentence is served. Conditions can be, apart from the general condition that now new crime can be committed, restrictions in freedom (ban from a certain location, ban on drinking alcohol, or commandment to report) or influencing behaviour (like following a training).

Criminal record = a record of the breaches of the law for which someone has been convicted. If a person needed to appear for a criminal offence and was convicted by the judge, this is recorded on the criminal record. A criminal record for criminal offences expires after 5 years and for crimes after 30 years.