Screening for *Housing First*

The Homelessness Partnering Secretariat (HPS) has developed several directives to assist communities with the shift to a Housing First framework. The first directive states that chronically and episodically homeless individuals should be prioritized to receive Housing First services[1]. Therefore, it is imperative that communities are equipped with the necessary information and skills so as to facilitate the screening and prioritization of homeless individuals into Housing First services.

THE SCREENING PROCESS CAN SERVE SEVERAL PURPOSES. The process allows for initial engagement to be made with homeless individuals in the community. Once contact has been made, homeless service providers can begin to determine if individuals meet program eligibility requirements. From there, a system of prioritization can be developed in order to place individuals with the highest needs into Housing First services quickly. The focus of this review is on the screening process which is just one phase of the assessment road map.

THE SCREENING PROCESS MAY DIFFER DEPENDING UPON THE NEEDS AND COMPOSITION OF A COMMUNITY'S HOMELESS POPULATION, BUT THE SCALE SHOULD BE AS BRIEF AS POSSIBLE. Moreover, certain domains should be assessed. These are:

- HOUSING STATUS: *Is the person homeless? Chronically? Episodically?*
- VULNERABILITY STATUS: *What is their level of vulnerability (physical health, mental health, substance use)? Is the person at risk of harm to him/herself or others?*
- SERVICE USE: *Is the individual a high service user?*
- SEVERITY OF NEED: *What is the individual's severity of need (low, moderate, high)?*
- FURTHER ASSESSMENT: *Does the individual require further assessment or assistance?*

1. Chronic homelessness refers to, "individuals, often with disabling conditions (e.g. chronic physical or mental illness, substance abuse problems), who are currently homeless and have been homeless for six months or more in the past year (i.e., have spent more than 180 cumulative nights in a shelter or place not fit for human habitation)" (HPS, 2014). Episodic homelessness refers to, "individuals, often with disabling conditions, who are currently homeless and have experienced three or more episodes of homelessness in the past year (of note, episodes are defined as periods when a person would be in a shelter or place not fit for human habitation, and after at least 30 days, would be back in the shelter or inhabitable location)" (HPS, 2014).

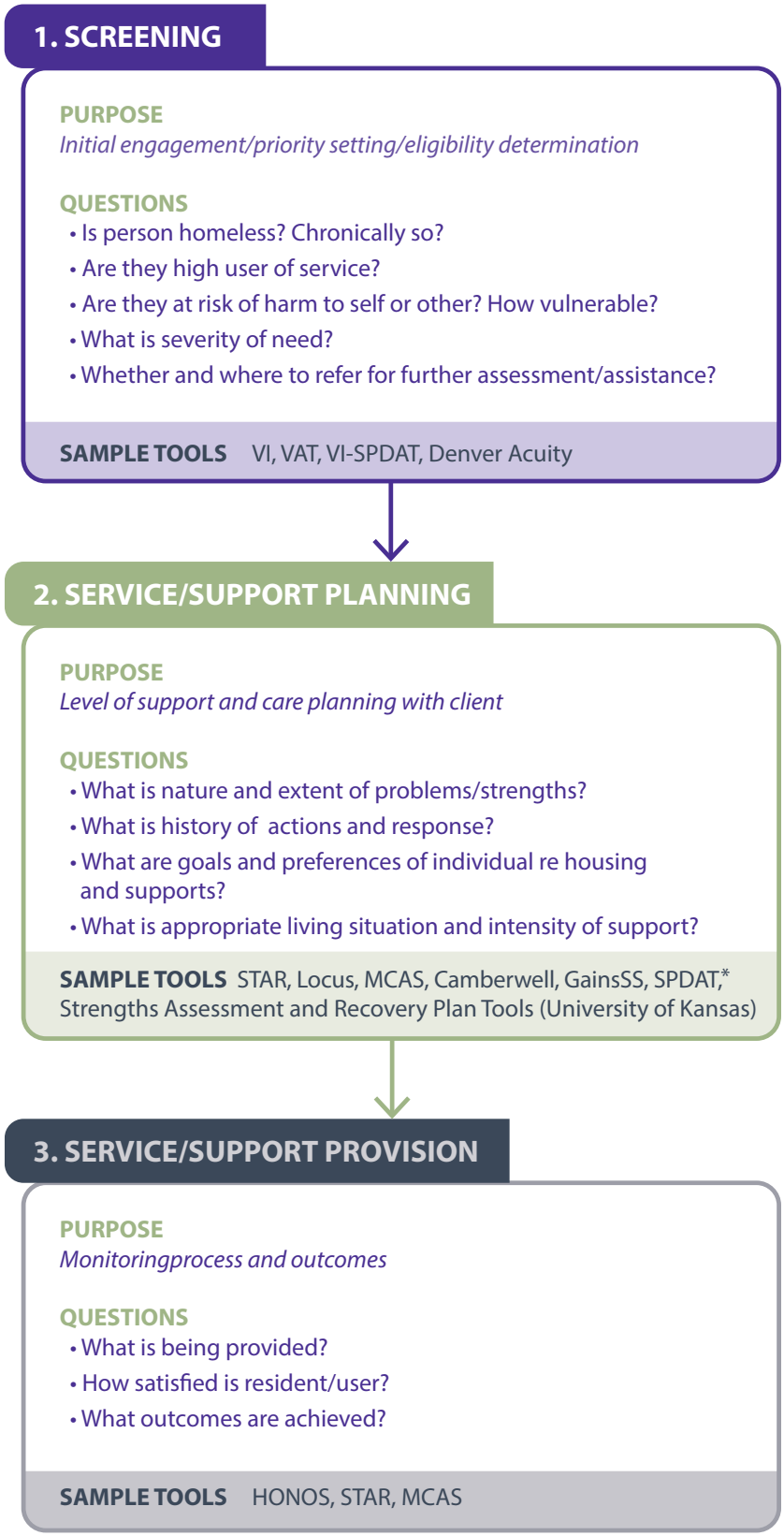
COH Canadian Observatory on Homelessness the homeless hub

Mental Health Commission of Canada | Commission de la santé mentale du Canada

Prepared by Dr. Tim Aubry, University of Ottawa; Meaghan Bell, Calgary Homeless Foundation; John Ecker, University of Ottawa; Dr. Paula Goering, University of Toronto

FIGURE 1

ASSESSMENT ROADMAP



*This tool is described by OrgCode as a multi-purpose tool that can also be used for functions 1 and 3.

As the homeless service sector is generally unaware of the wide range of screening options available beyond the VI-SPDAT, a Housing First Assessment Taskforce was created by the Canadian Observatory on Homelessness to provide recommendations of other suitable screening tools for communities to use. The Taskforce included researchers with extensive experience with measures relevant to those who experience mental health problems and illnesses, service providers, and program managers. (SEE APPENDIX A FOR MEMBERSHIP.)

THE FIRST STEP FOR THE TASKFORCE WAS CONDUCTING A SCAN OF EXISTING PRACTICES AND SCREENING TOOLS USED IN THE HOMELESSNESS SECTOR. These tools were rated based upon criteria developed by the Department of Housing and Urban Development (HUD) in the United States. The criteria states that **tools should be valid, reliable, inclusive, person-centered, user-friendly, strengths-based, have a Housing First orientation, sensitive to lived experiences, and transparent.** The tools were also assessed on training requirements and locations of use.

A TOTAL OF 17 TOOLS WERE LOCATED IN THE SEARCH AND EACH WAS ASSESSED USING THE HUD CRITERIA.[2] The strengths and weaknesses of the tools were discussed among the Taskforce members during monthly meetings. Once the most promising tools were identified, key informant interviews were conducted with the developers and current users of the tools. This process enabled the Taskforce to uncover the specifics of each tool and develop a comprehensive understanding of their use and scope.

Based upon this process, the Taskforce concluded that the Vulnerability Assessment Tool (SEE APPENDIX B FOR A COPY OF THE RATING SCALE) was the best brief screening tool available that can assist with prioritization[3] of clients for Housing First programs. The Tool was developed by the Downtown Emergency Service Centre in Seattle, Washington. It involves a structured interview to assess a homeless individual on 10 domains: survival skills, basic needs, indicated mortality risks, medical risks, organization/orientation, mental health, substance use, communication, social behaviours, and homelessness. Scores are rated on a five-point scale, with higher scores indicating a greater vulnerability. The Tool has been evaluated by external reviewers and has demonstrated good reliability and validity. The Tool is also easy to use, relatively short, and maintains a person-centered focus.

IT IS IMPORTANT TO RECOGNIZE THAT THE VULNERABILITY ASSESSMENT TOOL IS JUST ONE PHASE OF THE SCREENING AND PRIORITIZATION PROCESS. The Tool will help communities to develop a pool of the most vulnerable among their homeless populations. The results of the Tool should be used in conjunction with several other means, including: client interview information, case conferences, information from referral sources if available, recognition of any contextual factors, and an individual's housing and service preferences. As well, the Tool was created for one phase of the assessment process (SEE APPENDIX C FOR THE ASSESSMENT ROADMAP).

Service/support planning and provision would require complementary measures designed for those purposes. Note that the Tool was developed for the single adult population. Additional questions or adaptations might be necessary for families, youth and Aboriginal populations and these changes could affect the reliability and validity of the scoring.

2. A copy of the review document can be accessed by contacting Tim Aubry at taubry@uottawa.ca.
3. The information from the VAT tool overlaps with what is often found in level of care assessments but there is not at present a standardized method of translating scores into a level of care assignment. Communities who want to use if for this purpose will need to develop their own mapping to service intensity.

AS COMMUNITIES PREPARE TO UNDERTAKE THE TASK OF IMPLEMENTING A STANDARDIZED TOOL TO ASSESS PRIORITY/ELIGIBILITY FOR HOUSING FIRST PROGRAMS THEY SHOULD:

- ENGAGE IN A PROCESS OF SYSTEM MAPPING TO ENSURE THERE IS A SHARED UNDERSTANDING OF AVAILABLE PROGRAMS AND THEIR TARGET POPULATIONS, SERVICE SYSTEM CAPACITY AND GAPS, AND ITS ALIGNMENT WITH COMMUNITY PRIORITIES. For example – are their programs that are only serving women fleeing violence, veterans, etc. and are these characteristics captured in the assessment process so they can inform service placement? It is critical that communities have a shared, collective understanding of their homeless population and the services available to them in order to ensure accurate placements.

- BE OPEN TO ADAPTATIONS IN HOW YOU USE ASSESSMENT TOOLS TO MEET YOUR LOCAL NEEDS! Keep in mind that assessment tools supplement all of the other information you are collecting through contacts with clients and other service providers. What is it that your community needs to know about the client being assessed to ensure there is a robust, useful, and reliable process for prioritizing placements and determining the most appropriate placement? Remember that the goal of a standardized assessment tool is to contribute to the needed information and facilitate the processes that ensure the best program match. Do you have the information necessary to do this?

- DEVELOPING PROCESSES FOR GATHERING FEEDBACK ON THE USE OF THE SELECTED ASSESSMENT TOOL WILL HELP COMMUNITIES ASSESS ITS USEFULNESS IN DETERMINING CLIENT PLACEMENTS, IDENTIFYING ADAPTATIONS THAT MAY BE NEEDED AND INFORMING FUTURE PLANNING (I.E. ANY GAPS IN THE SYSTEM). When developing this feedback process, communities should ensure they are collecting the necessary information for coordinating access and assessments to answer the question, "Does our tool, and our processes/practices improve our ability to prioritize clients, make appropriate referrals based on assessed needs within the parameters of program eligibility requirements, and ultimately improve outcomes for clients in Housing First programs?"

- STANDARDIZING ASSESSMENTS WILL IMPACT HOW THE SYSTEM FUNCTIONS AND NEEDS TO BE VALUE-ADDED. It is critical to develop community buy-in and this will necessitate multiple and ongoing efforts to facilitate collaboration and solicit feedback (this will also inform the first previous three points!) A useful mechanism for facilitating collaboration and soliciting feedback are placement committees which bring together service providers to review assessments and discuss appropriate program placements. Placement committees allow for ongoing dialogue and sharing of information above and beyond the assessment tool (e.g. previous experiences with a particular client around what worked really well) through dialogue taking into consideration all of the information about a client and not relying solely or narrowly on a number or score provided by a standardized assessment. Placement committees also allow for the continued autonomy of agencies as active participants in the decision-making process of who they ultimately intake into their program.

APPENDIX A

TASKFORCE MEMBERS

DR. TIM AUBRY (University of Ottawa)

MEAGHAN BELL (Calgary Homeless Foundation)

JOHN ECKER (University of Ottawa)

DR. STEPHEN GAETZ (Canadian Observatory on Homelessness, York University)

DR. PAULA GOERING (Centre for Addiction and Mental Health)

CATHARINE HUME (Mental Health Commission of Canada)

STASHA HUNTINGFORD (University of Calgary)

CAROLINE JOHNSON (Centre for Northern Families)

ALLYSON MARSOLAIS (Canadian Observatory on Homelessness, York University)

DR. GEOFFREY NELSON (Wilfrid Laurier University)

BRUCE PEARCE (End Homelessness St. John's)

LAURAL RAINE (City of Toronto, Shelter, Support and Housing Administration)

DR. SAM TSEMBERIS (Pathways to Housing)

DR. ALINA TURNER (Turner Research & Strategy)

APPENDIX B

VULNERABILITY ASSESSMENT TOOL

VULNERABILITY ASSESSMENT TOOL

Client Name_____**Staff Name**_____

Survival Skills

Vulnerability, safety, dependency on others, ability to maneuver independently in safe manner, judgment

No evidence of vulnerability	Evidence of mild vulnerability	Evidence of moderate vulnerability	Evidence of high vulnerability	Evidence of severe vulnerability
Strong survival skills; capable of networking and self advocacy; knows where to go and how to get there; needs no prompting regarding safe behavior	Has some survival skills; is occasionally taken advantage of (e.g. friends only present on paydays); needs some assistance in recognizing unsafe behaviors and willing to talk about them.	Is frequently in dangerous situations; dependent on detrimental social network; communicates some fears about people or situations; reports being taken advantage of (e.g. gave $ to someone for an errand and person never returned or short changed)	Is a loner and lacks "street smarts"; possessions often stolen; may be "befriended" by predators; lacks social protection; presents with fearful, childlike or helpless demeanor; has marked difficulty understanding unsafe behaviors; is or was recently a DV victim; may trade sex for money or drugs	Easily draws predators; vulnerable to exploitation; has been victimized regularly (e.g. physical assault, robbed, sexual assault); often opts for the street to shelters; no insight regarding dangerous behavior (e.g. solicitation of sex/drugs); clear disregard for personal safety (e.g. walks into traffic)
1	**2**	**3**	**4**	**5**

Comments or observations about survival skills:

Basic Needs

Ability to obtain/maintain food, clothing, hygiene, etc.

No Trouble Meeting Needs	Mild Difficulty Meeting Needs	Moderate Difficulty Meeting Needs	High Difficulty Meeting Needs	Severe Difficulty Meeting Needs
Generally able to use services to get food, clothing, takes care of hygiene, etc.	Some trouble staying on top of basic needs, but usually can do for self (e.g. hygiene/clothing are usually clear/good)	Occasional attention to hygiene; has some openness to discussing issues; generally poor hygiene, but able to meet needs with assistance (e.g. prompting and I&R (Information and Referral)	Doesn't wash regularly; uninterested in I&R or help, but will access services in emergent situations; low insight re. needs	Unable to access food on own; very poor hygiene/clothing (e.g. clothes very soiled, body very dirty, goes through garbage & eats rotten food) resistant to offers of help on things; no insight
1	**2**	**3**	**4**	**5**

Comments or observations about basic needs:

Client Name_____Staff Name_____

Indicated Mortality Risks

Mortality Risks: 1. More than three hospitalizations in 12 months; 2. More than three ER visits in previous three months; 3. Aged 60 or older; 4. Cirrhosis of the liver; 5. Renal disease; 6. Diabetes; 7. Heart disease; 8. Tri-morbidity, co-occurring psychiatric, substance abuse and chronic medical condition.

Has none of the 8 identified risk factors	Has 1 of the identified risk factors	Has 2 of the identified risk factors	Has 3 of the identified risk factors	Has 4+ of the identified risk factors
1	**2**	**3**	**4**	**5**

Comments or observations about indicated mortality risks:

Medical Risks

Medical conditions that impact person's ability to function.

No Impairment	**Minor or temporary health problem(s)**	**Stable significant medical or physical issue(s), or chronic medical condition(s) that is being managed**	**Chronic medical condition(s) that is not well-managed or *significant* physical impairment(s)**	**Totally neglectful of physical health, extremely impaired by condition, serious health condition(s)**
No health complaints; appears well; would likely access medical care if needed	Cast or splint but able to take care of daily activities; recovering from minor surgery and doing well with self-care; acute medical problem such as a respiratory or skin infection but takes medications; follows up with medical provider	Chronic but stable medical problems such as diabetes, emphysema, high blood pressure, heart disease, seizure disorder, Hepatitis C or B, HIV disease; cancer in remission; has clinic or doctor and takes meds more often than not; smaller or larger stature/size making person vulnerable; sight or hearing impaired; has not been in hospital for overnight stay in last 3 months; OR over 60 years old w/o reported conditions but does not access care even for routine checkups	Poorly managed diabetes or hyper-tension, undergoing treatment for Hep C; needs home oxygen; liver failure; kidney failure requiring dialysis, sleep apnea requiring C-PAP; HIV disease not adequately treated; dementia; severe arthritis affecting several joints, pregnancy, frequent asthma flares, recurrent skin infections, cancer. Symptoms without known explanation: swelling, untreated open wounds, shortness of breath, recurrent chest pain, unexplained weight loss, chronic cough, cognitive impairment, incontinent of urine or stool. Not taking meds as prescribed or frequently loses them; can't name doctor or last time seen; hospitalized in last 3 months; illiterate or non-English speaking.	Untreated AIDS, terminal illness that is worsening; missing limb(s) with significant mobility or life activity issues; obvious physical problem that is not being cared for such as large sores or severe swelling. Blind, deaf and/or mute, severe dementia, uncontrolled diabetes, refuses to seek care; breathing appears difficult with activity; can't name or doesn't seek regular medical care; more than one hospitalization in past year.
1	**2**	**3**	**4**	**5**

Comments or observations about medical risks:

Client Name_____**Staff Name**_____

Organization/Orientation

Thinking, developmental disability, memory, awareness, cognitive abilities – how these present and affect functioning.

No impairment	Mild impairment	Moderate impairment	High impairment	Severe impairment
Good attention span; adequate self care; able to keep track of appointments	Occasional difficulty in staying organized; may require minimal prompting re: appointments; possible evidence of mild developmental disability; dementia or other organic brain disorder; some mild memory problems	Appearance is sometimes disorganized; has a significant amount of belongings making mobility challenging; occasional confusion w/ regard to orientation; moderate memory or developmental disability problems	Disorganized or disoriented; poor awareness of surroundings; memory impaired making simple follow-through difficult	Highly confused; disorientation in reference to time, place or person; evidence of serious developmental disability, dementia or other organic brain disorder; too many belongings to manage; memory fully or almost or absent / impaired
1	**2**	**3**	**4**	**5**

Comments or observations about organization/orientation:

Mental Health

Issues related to mental health status, MH services, spectrum of MH symptoms & how these impair functioning.

No MH issues	Mild MH Issues	Moderate MH issues	High MH issues	Severe MH needs
	Reports feeling down about situation, circumstances; (e.g. situation depression)	Reports having MH issues, but does not talk about them; reports having service connection already in place; may be taking prescribed medications	Tenuous service engagement; possibly not taking medications that are needed for MH; not interested in services due to mental illness / low insight	No connection to services (but clearly needed), extreme symptoms that impair functioning (e.g. talking to self, distracted, severe delusions/ paranoia, fearful/phobic, extreme depressed or manic mood); no insight regarding Mental Illness
1	**2**	**3**	**4**	**5**

Comments or observations about mental health:

Client Name_____Staff Name_____

Substance Use

Issues related to substance use, services, spectrum of substance use & how use impairs functioning

No or Non-Problematic Substance Use	Mild Substance Use	Moderate Substance Use	High Substance Use	Severe Substance Use
No substance use or strictly social – having no negative impact on level of functioning.	Sporadic use of substances not obviously affecting level of functioning; is aware of substance use, still able to meet basic needs most of the time	Ninety (90)-180 days into addiction recovery; COD w/o any follow-up care; relapse risk still present. OR Substance use affecting ability to follow through on basic needs; has some support available for substance use issues but may not be actively involved; some trouble making progress in goals (e.g. could be a binge user.)	In first 90 days of CD treatment or addiction recovery; still enmeshed in alcohol/drug using social group; high relapse potential. OR Use obviously impacting ability to gain/maintain functioning in many areas, (e.g. clear difficulty following through with appointments, self-care, interactions with others, basic needs); not interested in support for substance use issues but this may be due to low insight or other reasons (e.g. mental illness)	Active addiction with little or no interest in CD treatment involvement. Obvious deterioration in functioning (e.g. MH, due to Sub Use); severe symptoms of both substance use & mental illness; low or no insight into substance use issues; clear cognitive damage due to substances; no engagement with substance use support services (and clearly needed)
1	**2**	**3**	**4**	**5**

Comments or observations about substance use OR observed suspected signs of using drugs/alcohol:

Communication

Ability to communicate with others, when asked questions, initiating conversations.

No communication barrier	Mild communication barrier	Moderate communication barrier	High level communication barrier	Severe communication barrier
Has strong and organized abilities; no language barriers; able to communicate clearly with staff about needs	Has occasional trouble communicating needs; language barrier may be an issue; occasionally reacts inappropriately when stressed	Poor attention span; withdrawn but will interact with staff/service providers when approached; pressured speech; very limited English	Physical impairment making communication very difficult (e.g. hearing impaired & unable to use ASL); unwilling/unable to communicate w/ staff (e.g. shy, poor or no eye contact); doesn't speak English at all	Significant difficulty communicating with others (e.g. mute, fragmented speech); draws attention to self (e.g. angry talk to self/others); refuses to talk to staff when approached; may leave to avoid talking to provider
1	**2**	**3**	**4**	**5**

Comments or observations about communication:

Client Name_____**Staff Name**_____

Social Behaviors

Ability to tolerate people & conversations, ability to advocate for self, cooperation, etc.

Predatory behaviors, and/or no problems advocating for self	**Mildly problematic social behaviors**	**Moderately problematic social behaviors**	**Highly problematic social behaviors**	**Severely problematic social behaviors**
Has a hx of predatory behavior; is observed to be targeting vulnerable clients to "befriend"; uses intimidation to get needs met (e.g. threatening and menacing to staff/clients); more than adequately advocates for own needs, if not overly so	Mostly "gets along" in general; if staff need to approach person, s/he can tolerate input & respond with minimal problems; may need repeated approaches about same issue even though it seems s/he "gets it"	Has some difficulty coping with stress; sometimes has angry outbursts when in contact with staff/others; some non-cooperation problems at times	Often has difficulty engaging positively with others; withdrawn and isolated; has minimal insight regarding behavior and consequences; has few social contacts; negative behavior often interferes with others in surrounding; often yells, screams or talks to self	Responds in angry, profane, obscene or menacing verbal ways; may come across as intimidating and off-putting to providers; may provoke verbal and physical attacks from other clients; has significantly impaired ability to deal with stress; has no apparent social network
1	**2**	**3**	**4**	**5**

Comments or observations about social behaviors:

Homelessness

Length of Time Homeless

Newly Homeless	**Moderate hx of homelessness**	**Chronically homeless**
Has been homeless less than 1 month; new to the area (e.g. moved here looking for work or only here for the season)	Has been homeless for 1-12 months; few prospects for housing at present	Has been homeless for 1 year + or has had at least 4 episodes of homelessness within the last 3 years; may have no options for housing due to history; ability to participate in process, etc.
1	**2**	**3**

Comments or observations about homelessness:

APPENDIX C

As the purpose of this review was to conduct a scan of existing practices and screening tools used in the homelessness sector, some tools that serve other functions were not included. One such tool, which is widely used within the homelessness sector, is the Service Prioritization Decision Assistance Tool (SPDAT). This tool was created by OrgCode Consulting, co-creators of the VI-SPDAT. The SPDAT is a multi-purpose tool which is designed to:

1. Help prioritize which clients should receive what type of housing assistance intervention, and assist in determining the intensity of case management services;
2. Prioritize the sequence of clients receiving those services;
3. Help prioritize the time and resources of Frontline Workers;
4. Allow Team Leaders and program supervisors to better match client needs to the strengths of specific Frontline Workers on their team;
5. Assist Team Leaders and program supervisors to support Frontline Workers and establish service priorities across their team;
6. Provide assistance with case planning and encourage reflection on the prioritization of different elements within a case plan;
7. Track the depth of need and service responses to clients over time.

Since the goal of the taskforce was to focus exclusively on screening tools, we included the VI-SPDAT specifically designed for that function in our review. The multi-purpose nature of the SPDAT extended beyond the terms of our search so it was excluded.

APPENDIX D

REFERENCES FOR SUPPORTING LITERATURE

Barker, S., Barron, N., McFarland, B.H., & Bigelow, D.A. (1994). A community ability scale for chronically mentally ill consumers: Part I. Reliability and validity. *Community Mental Health Journal*, 30 (4), 363-383.

Bassani, D.G., Dewa, C.S., Krupa, T., Aubry, T., Gehrs, M., Goering, P.N., & Streiner, D.L. (2009). Factor structure of the Multnomah Community Ability Scale – longitudinal analysis. *Psychiatry Research*, 167, 178-189.

Cronley, C., Petrovich, J., Spence-Almaguer, E., & Preble, K. (2013). Do official hospitalizations predict medical vulnerability among the homeless?: A postdictive validity study of the Vulnerability Index. *Journal of Health Care for the Poor and Underserved*, 24 (2), 469-486.

OrgCode Consulting Inc. & Community Solutions. (2015). SPDAT brief: Changes in the VI-SPDAT v2.0.

Sherman, P.S. & Carey, C.S. (1998). Intensity and duration of intensive case management services. *Psychiatric Services*, 49, 1585-1589.

The Washington Institute for Mental Health Research and Training. (2010). DESC's Vulnerability Assessment Tool for individuals coping with chronic homelessness: A psychometric analysis. Report prepared for the Downtown Emergency Service Centre.

Tutty, L.M., Bradshaw, C., Hewson, J., MacLaurin, B., Waegemakers Schiff, J., & Worthington, C. (2012). On the brink? A pilot study of the Homelessness Assets and Risk Tool (HART) to identify those at risk of becoming homeless. Report prepared for the Calgary Homeless Foundation.