VULNERABILITY ASSESSMENT TOOL

FOR DETERMINING ELIGIBILITY & ALLOCATING SERVICES & HOUSING FOR ADULTS EXPERIENCING HOMELESSNESS

Training Manual for Conducting Assessment Interviews

CANADIAN VERSION - EXCERPT

Canadian Observatory on Homelessness

homelesshub.ca

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The original VAT manual was developed by the Downtown Emergency Service Center (DESC) in Seattle, Washington. The Canadian version was developed in 2016 by the COH. The COH would like to thank the VAT Training Sub-Committee for their contributions to the Canadianization of DESC's manual:

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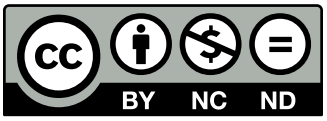

PREFATORY NOTE FROM THE CANADIAN OBSERVATORY ON HOMELESSNESS:

INTEGRATING THE VAT INTO CANADIAN HOUSING FIRST APPROACHES

The original DESC Vulnerability Assessment Tool (VAT) was developed in 2003 by staff at the Downtown Emergency Service Center (DESC) in Seattle, Washington. DESC is an organization that provides a range of services to people experiencing homelessness, including an emergency shelter, permanent supportive housing and mental health and substance abuse treatment programs.

In 2015, a task force convened by the Canadian Observatory on Homelessness and the Mental Health Commission of Canada analyzed 15 different assessment tools and concluded that the VAT was the best screening tool available for use in prioritizing clients for Housing First programs (Aubry, Bell, Ecker, & Goering, 2015).

BRINGING THE VAT INTO THE CANADIAN CONTEXT

Employment and Social Development Canada (ESDC) has incorporated the VAT into the Homeless Individuals and Families Information System (HIFIS), offering Canadian service providers free software for recording VAT results and generating reports.

The VAT and its training manual have been lightly revised to reflect the Canadian context. All changes have been reviewed and approved by DESC. The most substantive revision to the Vulnerability Assessment Tool itself is the incorporation of the Canadian definition of homelessness, which includes couch-surfing and other forms of provisional accommodation, and the replacement of the United States (U.S.) Department of Housing and Urban Development (HUD) definition of chronic homelessness with the Canadian Homelessness Partnering Strategy (HPS) definition for chronic and episodic homelessness.

A Checklist 6, What You Should Have in Place before You Use the VAT, is provided below. This checklist summarizes the best practices for using a standardized assessment tool with individual clients and as part of a coordinated system in a community.

WHAT THE VAT DOES & DOES NOT DO

The VAT, as with other prioritization tools, was created out of necessity because of a scarcity of shelter, housing, appropriate supports and other resources. While the VAT can play a key role in a coordinated systems approach to ending homelessness, it cannot help to solve the fundamental problem of scarcity unless it is accompanied by significant investments. The VAT can play its strongest role when it is used not only to assess individuals, but to generate information about the gaps in the system and to develop a platform for advocacy and action. This approach includes ensuring that all individuals who complete a VAT must be supported to find housing and access resources, even if they are not prioritized for the primary resource being made available. (For further information, see Appendix 12: Ethical Use of the VAT 34 and Appendix 13: Best Practices In Making Referrals & Following Up After the Interview 38 in the VAT Training Manual.)

WHAT THE VAT DOES

The Vulnerability Assessment Tool (VAT) is a structured way of measuring a person's vulnerability to continued instability. The VAT is designed for use with adults experiencing homelessness. Service providers use the VAT to identify individuals who would benefit most from high-impact interventions such as supportive housing or ongoing community-based intensive case management services. Vulnerability is assessed across 10 domains:

- Survival Skills
- Basic Needs
- Indicated Mortality Risks
- Medical Risks
- Organization/Orientation
- Mental Health
- Substance Use
- Communication
- Social Behaviours
- Homelessness

The VAT can also help to inform systems change. Analyzing the range of VAT scores helps reveal the spectrum of vulnerability within the community, and this data may be shared with funders to support calls for needed resources such as supportive housing units, rent supplements, caseworkers, Assertiveness Community Treatment (ACT) Teams, etc. The data can

also provide information on which services people are requesting, and reveal gaps in the service system.

The VAT can play a key role in a coordinated systems approach to ending homelessness. In particular, the VAT can provide a consistent and fair way to identify people who would most benefit from high-impact interventions, such as supportive housing and ongoing multi-disciplinary case management. This is critically important, since chronically and episodically homeless single adults frequently slip through the cracks in the service system.

Finally, using a standardized assessment tool like the VAT allows communities to share a common language and system for coordinating services.

WHAT THE VAT DOES NOT DO

Identify Individual Housing Preferences

Consumer choice is a key element of a Housing First approach. While a VAT assessment can identify people who would benefit from supportive housing, you will also need to ask another set of questions specific to the types of housing you are able to offer.

Studies have shown that long-term housing stability is affected by a person's ability to define their preferences and make choices about where they want to live and who they want to live with. Housing stability is not just about affordability and support levels; it's about quality of life and engagement with community. People need to be able to make housing choices based on neighbourhood, size of unit, sense of safety and security, amenities (e.g., laundry on site, garden plot, private kitchen, etc.), the presence or absence of specific rules (e.g., whether drinking or substance use is permitted; overnight guests are permitted; smoking indoors is permitted; pets are welcomed; etc.); proximity to services and resources (e.g., public transit; friends, family or street family; library; drop-in; school; workplace; health care centre; park, etc.). In some cases, an individual may weigh the factors of location, safety, connection with community and proximity to services and resources, and may ultimately prefer to live in a tent city or a micro-house village rather than in one of the housing units they are offered.

End Homelessness

The key function of the VAT is to provide a consistent and fair way to identify people who would most benefit from high-impact interventions such as supportive housing and ongoing multi-disciplinary case management. This is critically important, since chronically and episodically homeless single adults frequently slip

through the cracks in the service system. While the VAT can play a key role in a coordinated systems approach to ending homelessness, it must be used in conjunction with other initiatives such as:

- **Building housing and effecting system changes**. For communities using the VAT to implement a coordinated assessment system, it is important to ensure that these are integrated with a broader set of investments in system change. The VAT and other prioritization tools were created out of necessity because of a scarcity of housing, appropriate supports and other resources. Ending homelessness will not come about through improvements in prioritization methods; it will come about through increasing the stock of truly affordable (30% of income) public and private sector housing options, ensuring that all members of the community have an income that allows them to stably sustain their housing while meeting their other needs, investing in person-centred services that are flexible enough to meet individual needs with a minimum of red tape, and providing space and opportunities for people with lived experience of homelessness to build community, support each other and define for themselves what healing and a good quality of life look like. While the VAT does not build housing or create resources, it can help to develop a platform for advocacy and action by providing statistics on the depth of need in the community.
- **Developing specialized strategies for diverse experiences of homelessness**. It is also important to strategize and fund timely interventions for other groups who are experiencing homelessness. For example, for families and youth who become homeless, it is critical to provide supports to help them re-enter housing as soon as possible before a pattern of chronic and episodic homelessness develops. It is also important to invest in prevention; for example, discharge planning for individuals exiting hospitals, correctional facilities, the child welfare system and other institutions. Homelessness among Aboriginal Peoples, survivors of domestic violence, survivors of sex trafficking, individuals who are transgender or identify as part of the LGBTQ2 community, veterans, newcomers and other specific population groups also requires specialized strategies and supports.

For further information on these types of planning, see the Canadian Housing First Toolkit for a step-by-step guide, Housing First in Canada for community- and population-specific case studies, and the Homeless Hub and the Community Workspace on Homelessness for a wide range of research publications and practical tools (Gaetz, Gulliver, & Richter, 2014; Gaetz, Scott, & Gulliver, 2013; Polvere et al., 2014).

CHECKLIST: WHAT YOU SHOULD HAVE IN PLACE BEFORE YOU USE THE VAT

The analysis that ranked the VAT first out of 15 assessment tools used criteria established by the U.S. Department of Housing and Urban Development (HUD), identifying "that tools should be valid, reliable, inclusive, person-centered, user-friendly, strengths-based, have a Housing First orientation, sensitive to lived experience, and transparent" (Aubry et al., 2015; see also U.S. Department of Housing and Urban Development, 2014). Many of these criteria extend beyond the particular qualities of one coordinated assessment tool and speak to the broader context in which the tool is implemented. A tool may be person-centred or strengths-based on paper, but whether it will actually meet these criteria depends on the individuals, organizations and communities administering it.

The checklist below provides some best practices for ensuring that the implementation of a coordinated assessment tool like the VAT is both effective and ethical.

CHECKLIST FOR IMPLEMENTING COORDINATED ASSESSMENT

People with lived experience of homelessness are engaged in helping to design and implement the interview and follow-up processes. The assessment tool is piloted and both interviewers and interviewees are asked for their feedback on how to improve the experience.

Partnerships have been established with other service providers. Decisions have been made about what information will be shared, how it will be shared, when it will be shared, and which staff will be responsible for supporting continued communications and coordination of services.

Outreach teams are in place to ensure that highly vulnerable people who typically avoid agencies are being invited to participate. It is important to hire people with lived experience of homelessness to help with outreach.

A **communications plan** is in place. Outreach and other direct service staff talk to people on the street and in shelters about what is happening with the coordinated assessment process. Messaging is consistent around the rationale for taking this approach.

The staff members selected to be assessors are **friendly and skilled at building rapport**. They have experience working directly with individuals experiencing homelessness, but are not responsible for meeting individuals' basic needs (i.e., controlling access to beds, food, washrooms, etc.). This is important to protect individuals' sense that they are being treated fairly and that staff treatment has not changed based on disclosures made during the assessment. When selecting assessors, take power dynamics into consideration.

Assessors have received **training** in how to conduct interviews, score the assessment, store the data, and follow up with clients.

Assessors have received training in the **trauma-informed approach to delivering services** along with training in Aboriginal cultural awareness, anti-racism/anti-oppression, transgender and LGBTQ2 awareness, and mental health first aid.

The community has a **resource ready to offer those who are prioritized** (e.g., supportive housing; a rent supplement; ongoing intensive case management; or another type of resource).

If the resource being offered is housing, there is a diverse range of options available. A secondary questionnaire is in place to ask individuals for their preferences and needs regarding type of housing, location/neighbourhood, number of bedrooms, accessibility needs, shared/single accommodations, amenities, rules, pets/no pets, smoking/non-smoking, etc.

Each organization conducting assessments has **something to offer individuals who are on the waiting list or who do NOT meet prioritization criteria** (e.g., staff from the organization or a partner agency follow up with each individual to help them find housing through other channels, identify who can assist the individual to access the things they said they needed during the interview, and connect with peer-run services and supports.) It is a good idea to recruit workers with lived experience of street homelessness for these roles.

Each organization conducting assessments has a **private room** where clients can share their stories with the interviewer without being overheard by other clients or staff.

Well-defined privacy protocols are in place for obtaining informed client consent, collecting clients' information, storing it, and defining access to it.

Each organization has **evaluation and supervision** protocols in place. Assessments should be reviewed by supervisors on a regular basis to ensure consistency and quality. Feedback on the tool is gathered on a regular basis and is used to inform improvements in the way the tool is administered and coordinated with other services and supports. Feedback is gathered from interviewers and interviewees (including both those who were prioritized and those who did not meet prioritization criteria).

CONTENTS

This document provides an excerpt from the Canadian version of DESC's Vulnerability Assessment Tool manual. Access to the full manual is available to individuals and organizations who participate in the training. For more information, please visit www.homelesshub.ca/VAT

INTRODUCTION

The Vulnerability Assessment Tool (VAT), developed at the Downtown Emergency Service Center (DESC) in Seattle, Washington, provides a structured way of measuring an individual's vulnerability to continued instability. By rating an individual's level of functioning or severity of condition across 10 domains, a comprehensive assessment of vulnerability can be reached and then compared with vulnerability assessments of other people experiencing homelessness. The assessment process entails a structured interview followed by completion of the rating scales.

The tool is designed for use by service workers accustomed to interacting directly with individuals experiencing homelessness, and training is required to ensure reliable application of the tool.

BACKGROUND & DEVELOPMENT OF THE TOOL

The original VAT was developed in 2003 by DESC staff. DESC provides a range of services to people experiencing homelessness, including an emergency shelter, permanent supportive housing and mental health and substance abuse treatment programs.

2003: VAT USED TO PRIORITIZE ACCESS TO DESC PROGRAMS

DESC was founded with a particular focus on the most vulnerable adults experiencing homelessness. Various DESC programs have long given priority for services to those adults with greater presenting needs. Decisions about assignment of shelter beds, enrollment in mental health programs and access to DESC's permanent supportive housing units have been guided by the idea that when resources are in short supply, they should be reserved for individuals likely to be at relatively greater risk without the services. Initially, priority distinctions were based on basic characteristics. For example, individuals with mental illness were automatically prioritized for shelter beds. Similarly, individuals with mobility or sensory impairments were prioritized for beds, as were women and men over age 60. This simple process worked well for DESC's programs until the number of individuals in the priority groups substantially surpassed the available service slots (shelter beds, etc.). At that point, additional assessment was needed to identify the individuals of greatest need within a population already designated as our highest priority.

The VAT was developed by a group of staff familiar with the needs and characteristics of the chronic homeless population served in DESC's shelter, housing, mental health and substance abuse programs. Following the example of the Problems Severity Summary instrument, the DESC VAT was designed as a set of scales, each rating an individual's level of functioning or other characteristics for a specific domain. The domains were identified as the areas most germane to determining an individual's vulnerability. By looking at each area and assigning a score, an assessor would have a structured way of determining an objective overall rating of vulnerability for any given individual. The first use of the tool was in DESC's shelter program as a way to determine which individuals already identified as a DESC priority

would get the limited beds available. A small group of DESC staff was selected to conduct assessments using the tool, and procedures were created for assessing new shelter clients and assigning beds based on vulnerability assessment scores. Assessor feedback about the tool led to some refinements about how assessments were conducted, but the rating instrument remained unchanged for more than 6 years.

Over this time, DESC found the tool useful in helping to distinguish among the individuals most needing shelter. This allowed beds to be assigned to those who were most at risk of being victimized or injured, of hurting themselves, of coming to harm simply because they could not take care of their basic needs or of not being able to make progress without substantial support.

2005: VAT USED TO PRIORITIZE ACCESS TO DESC PERMANENT SUPPORTIVE HOUSING

DESC operates permanent supportive housing programs targeted to the highest-need, most vulnerable adults experiencing homelessness. As with DESC's shelter programs, the many permanent housing programs have limited capacity and cannot house nearly all the individuals in need. Since the late 1990s, DESC has attempted to place into these housing units the individuals experiencing homelessness with the greatest needs. Aiming to ensure that each vacancy was filled by the most vulnerable individual, housing staff would try to collect information from sources knowledgeable about the individuals referred for housing.

This typically involved conversations with case managers, outreach workers, shelter workers and others, to get a sense of whose needs were relatively greatest. While this process resulted in very high-needs individuals accessing DESC's housing, it was cumbersome and somewhat subjective. As the use of the VAT became established in DESC's shelter, it became apparent the tool could serve the same purpose in DESC's supportive housing to determine who to place first in the next available housing unit. In 2005, this became DESC's regular practice for selecting who will occupy its housing.

2005: VAT USED TO PRIORITIZE ACCESS TO DESC PERMANENT SUPPORTIVE HOUSING

Over time, the existence of DESC's VAT became more widely known among homeless service providers locally and beyond. DESC received many requests for copies of the tool, and was informed of other providers using it for their own programs.

As the tool began to show promise as an instrument that might be used more widely, DESC decided to evaluate the tool's reliability and validity. In 2008, funding was acquired to allow DESC to hire a third-party research centre to conduct the evaluation. Around this time, a different instrument focusing on vulnerability also began to experience more widespread use. Developed by Common Ground in New York City, the Vulnerability Index distinguished among individuals experiencing homelessness based on the presence of certain conditions found to be associated with an increased mortality risk. This tool was developed based on research conducted by Dr. Jim O'Connell in Boston.

In comparison with the Common Ground tool, the DESC tool was relatively limited in its attention to health conditions, so before evaluating its own tool, DESC reviewed its elements with several experts outside DESC. Key informants included physicians from Seattle & King County Public Health, physicians from a major local health clinic for people experiencing homelessness, and substance abuse treatment experts. DESC also consulted with Dr. O'Connell to help them understand his research findings.

These discussions with outside experts resulted in three modifications to the DESC VAT:

- The scale related to health conditions was enhanced to have a greater emphasis on the range of likely health problems, combined with how the individual is following up with care.
- A scale related to mortality risk was added. This scale largely follows the Common Ground Vulnerability Index, although some of the listed conditions were changed to reflect mortality risks among individuals experiencing homelessness in Seattle.
- A second scale relating to substance use was added to better capture relapse vulnerability among people in addiction recovery.

2009: VAT EVALUATED AS VALID AND RELIABLE

The modified version of the DESC VAT was put into use in 2009, and then evaluated by researchers from the Washington Institute for Mental Health Research and Training, affiliated with the University of Washington.

The results, reported in March 2010, were very promising, showing the tool had strong properties of reliability and validity (Ginzler & Monroe-DeVita, 2010). Recommendations from the evaluation were to enhance the training manual and interview script, and to merge the substance use scales into a single item. These recommendations were followed, resulting in the current scale of 10 items and the accompanying training manual and interview script. The full psychometric analysis is available in the 'Research' section of the DESC website.

2009: VAT EVALUATED AS VALID AND RELIABLE

In March 2015, the Mental Health Commission of Canada and the Canadian Observatory on Homelessness launched a work group to evaluate the assessment tools used in communities across North America to prioritize people for housing programs and Housing First initiatives. Fifteen assessment tools were rated according to criteria established by the U.S. Department of Housing and Urban Development (HUD), identifying "that tools should be valid, reliable, inclusive, person-centered, user-friendly, strengths-based, have a Housing First orientation, sensitive to lived experience, and transparent" (Aubry et al., 2015; see also U.S. Department of Housing and Urban Development, 2014).

The report concluded that DESC's VAT was the best assessment tool currently available in the field for helping communities to prioritize housing services to individuals who are experiencing homelessness. Please visit the Homeless Hub website for the Screening for Housing First full report, table of screening tools and webinar presentation slides.

BROADER SYSTEMS ISSUES & LIMITATIONS

Policy priorities around access to services and housing for individuals experiencing homelessness vary widely. Prioritization criteria may be influenced by date of request (first come, first served), length of homelessness (long-term shelter stayers), presence of certain conditions (e.g., HIV), high utilization of expensive crisis services, or other factors. While these approaches may have reasonable rationales behind them, the result is that some highly fragile individuals who are reluctant to enroll in formal care programs are unlikely to be prioritized for housing unless their level of vulnerability is taken into account. DESC's VAT provides a way to identify those individuals with the greatest overall needs.

While there is often a high correlation between some factors (such as long-term homelessness and high crisis service utilization) and high vulnerability, individuals assessed as highly vulnerable are not necessarily also high utilizers of other services. Likewise, high utilizers of crisis services are not necessarily highly vulnerable. If a policy priority is to house high systems utilizers who have the greatest needs, the VAT allows for the second part of that equation to be determined so that resources are allocated to individuals who need them the most.

The DESC VAT allows providers to do two things:

- **Develop an objective sense of an individual's vulnerability to continued instability.**
- **Distinguish among the many adults experiencing homelessness in the community who have also had a vulnerability assessment. Assessment scores can then be used in the allocation of resources.**

The VAT can also help to inform systems change. Analyzing the range of VAT scores helps reveal the spectrum of vulnerability within the community, and this data may be used to advocate with funders for additional resources. In those communities where there are few supportive housing options available, the VAT has been used to provide objective data to advocate for those individuals experiencing homelessness. The data can also provide information on which services people are requesting and reveal gaps in the service system.

While an assessment score offers a view of an individual's relative overall set of needs, it does not define the level or type of support an individual needs. Additional research may reveal whether assessment scores can be used to determine the best type of housing for an individual, but until that happens, the amount of support, supervision, medical care, etc., that any given individual needs will have to be determined separately from the vulnerability assessment process.

Because this type of research has not yet been conducted, avoid using assessment scores for purposes other than determining relative overall need. An individual with a higher score is deemed to be more vulnerable to continued instability, but that does not necessarily mean they require a more intensive level of services or supervision than someone with a lower score. Assessment scores alone should not be used to determine that an individual's needs are beyond the scope of a particular service or housing program.

Please see the Prefatory Note 1 at the beginning of this manual for further discussion on integrating the VAT into Canadian Housing First approaches.

USING THE DESC VULNERABILITY ASSESSMENT TOOL

Agencies that intend to use the Vulnerability Assessment Tool (VAT) described in this manual agree to do the following:

- Receive training by certified VAT trainers in the proper implementation of the VAT.
- Follow DESC's instructions for implementing the tool, including having the necessary minimum number of assessors.
- Credit DESC in your use of the tool.
- Provide feedback and/or de-identified data to DESC to assist with tool improvements.

APPENDICES

APPENDIX 1: DESC VULNERABILITY ASSESSMENT TOOL

SURVIVAL SKILLS

Vulnerability, safety, dependency on others, ability to manoeuvre independently in safe manner, judgement.

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 behaviour.	Has some survival skills; is occasionally taken advantage of (e.g., friends only present on paydays); needs some assistance in recognizing unsafe behaviours 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 money to someone for an errand and individual never returned or short-changed them).	Spends most of their time alone and lacks street smarts; possessions often stolen; may be 'befriended' by predators; lacks social protection; presents with fearful, childlike or helpless demeanour; has marked difficulty understanding unsafe behaviours; is or was recently a domestic violence survivor; may trade sex for money or drugs.	Easily draws predators; vulnerable to exploitation; has been victimized regularly (e.g., physical assault, robbery, sexual assault); no insight regarding dangerous behaviour (e.g., solicitation of sex/drugs); clear disregard for individual safety (e.g., walks into traffic).
1	2	3	4	5

BASIC NEEDS

Ability to obtain/maintain food, clothing, hygiene, income, 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, etc.; takes care of hygiene; adequate self-care.	Some trouble staying on top of basic needs, but usually can take care of self (e.g., hygiene/ clothing are usually clean/ good).	Occasional attention to hygiene; has some openness to discussing issues; generally poor hygiene, but able to meet needs with assistance (e.g., prompting from support staff); may not be spending money on basic needs.	Doesn't wash regularly; uninterested in receiving referrals or other help, but will access services in emergency situations; low insight regarding needs; is not spending money on basic needs and has limited insight about it.	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

INDICATED MORTALITY RISKS

Mortality Risks:

1. Three or more hospitalizations in 12 months;
2. Three or more emergency department visits in previous 3 months (for medical reasons);
3. Aged 60 or older; 4. Cirrhosis of the liver;
5. Renal disease;
6. Diabetes;
7. Heart disease;
8. Tri-morbidity – co-occurring psychiatric issue, substance abuse and (any) 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

MEDICAL RISKS

Medical conditions that impact individual'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/ ARE BEING MANAGED	CHRONIC MEDICAL CONDITION(S) THAT IS/ ARE 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 issue or skin infection, but takes medications; follows up with medical provider; doesn't appear ill currently.	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 medications more often than not; significant visual or hearing impairment; has not been in hospital for overnight stay in last 3 months. OR Over 60 years old without reported conditions but does not access care even for routine checkups.	Poorly managed chronic medical condition due to individual's inability/ unwillingness/lack of access to medical care. Examples may be: diabetes or hypertension; needs home oxygen; liver failure; kidney failure requiring dialysis; sleep apnea requiring C-PAP; HIV not adequately treated; severe arthritis affecting several joints; pregnancy; frequent asthma flares; recurrent skin infections; cancer. Symptoms with no known explanation: swelling, untreated open wounds, shortness of breath, chest pains, or unexplained weight loss, chronic cough, incontinent of urine or stool. Not taking medications as prescribed or frequently loses them; can't name doctor or last time seen; hospitalized overnight in last 3 months; illiterate or does not speak English or French.	Untreated chronic medical condition; terminal illness that is worsening; missing limb(s) with significant mobility or life activity issues; obvious physical problem that is not being cared for (e.g., large sores or severe swelling); uncontrolled diabetes; refuses to seek care; breathing appears difficult with activity; more than one extended hospitalization in past year for serious medical condition.
1	2	3	4	5

ORGANIZATION/ORIENTATION

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

NO IMPAIRMENT	MILD IMPAIRMENT	MODERATE IMPAIRMENT	HIGH IMPAIRMENT	SEVERE IMPAIRMENT
Good attention span; 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; occasional confusion with regard to orientation; moderate memory or developmental disability problems.	Disorganized or disoriented; poor awareness of surroundings; memory impaired, making simple follow-through difficult; severe dementia.	Highly confused; disorientation in reference to time, place or individual; evidence of serious developmental disability, dementia or other organic brain disorder; too many belongings to manage; memory fully (or almost fully) absent/ impaired.
1	2	3	4	5

MENTAL HEALTH

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

NO MH ISSUES	MILD MH ISSUES	MODERATE MH ISSUES	HIGH MH ISSUES	SEVERE MH NEEDS
Reports no MH issues; doesn't present with any symptoms.	Reports feeling down about situation, circumstances (e.g. situational depression).	Reports having MH issues; reports having service connection already in place or soon to be; may be taking prescribed medications; does not present as highly symptomatic.	Tenuous service engagement; possibly not taking medications that are needed for MH; not interested in services due to mental illness/ low insight or presents with fairly significant symptoms; describes history of suicide attempts AND recent attempts.	No connection to services (but clearly needed) or extreme symptoms that impair functioning (e.g., talking to self, distracted, severe delusions/ paranoia, fearful/phobic, extremely depressed or manic mood); no insight regarding mental illness.
1	2	3	4	5

SUBSTANCE USE

Issues related to substance use, services, spectrum of substance use, and 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 use, having no negative impact on level of functioning.	Sporadic use of substances not obviously affecting level of functioning; is aware of substance use; is still able to meet basic needs most of the time.	90 to180 days into addiction recovery; co-occurring disorder without 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.	In first 90 days of chemical dependency treatment or addiction recovery; still enmeshed in alcohol- or 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.	Active addiction with little or no interest in chemical dependency treatment involvement. Obvious deterioration in functioning (e.g., mental health) due to substance use; severe symptoms of both substance use and 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

COMMUNICATION

Ability to communicate with others.

NO COMMUNICATION BARRIER	MILD COMMUNICATION BARRIER	MODERATE COMMUNICATION BARRIER	HIGH-LEVEL COMMUNICATION BARRIER	SEVERE COMMUNICATION BARRIER
No language barriers; able to communicate clearly with staff about needs; responds appropriately to questions.	Has occasional trouble communicating needs; language barrier may be an issue.	Very limited English or French, making it difficult to understand what individual is communicating.	Physical impairment making communication very difficult (e.g., hearing impairment and unable to use sign language); doesn't speak English or French at all; simple communication is hard to understand.	Significant difficulty communicating with others (e.g., not able or willing to speak either verbally or through sign language, or uses fragmented speech); likely unable to understand basic communication altogether.
1	2	3	4	5

SOCIAL BEHAVIOURS

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

NO PROBLEM ADVOCATING FOR SELF AND/OR PRESENTS WITH PREDATORY BEHAVIOURS	MILDLY PROBLEMATIC SOCIAL BEHAVIOURS	MODERATELY PROBLEMATIC SOCIAL BEHAVIOURS	HIGHLY PROBLEMATIC SOCIAL BEHAVIOURS	SEVERELY PROBLEMATIC SOCIAL BEHAVIOURS
Capable of appropriate self- advocacy and social interaction in nearly all instances. OR Reports a history of predatory behaviour; is observed to be targeting vulnerable individuals to 'befriend;' uses intimidation to get needs met (e.g., threatening and menacing to staff/individuals).	Mostly "gets along" in general; if staff need to approach, individual can tolerate input and respond with minimal problems; may need repeated approaches about same issue even though it seems they 'get 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 behaviour and consequences; has few social contacts; negative behaviour often interferes with others in surrounding; often yells, screams or talks to self. May describe occasional or semi-regular bars from services for disruptive behaviours. Possible frequent jail time.	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 individuals; has significantly impaired ability to deal with stress; has no apparent social network. May be consistently barred from services. Likely large amount of jail time.
1	2	3	4	5

HOMELESSNESS (REVISED FOR CANADIAN CONTEXT)*

Length of time homeless

NEWLY HOMELESS	MODERATE HISTORY OF HOMELESSNESS	CHRONICALLY OR EPISODICALLY HOMELESS (NATIONAL HOMELESSNESS PARTNERING STRATEGY DEFINITION)
Has been homeless less than 3 months and has experienced no other episodes of homelessness within the last 5 years. May be new to the area (e.g., moved here looking for work or only here for the season).	Has been homeless for 3 to 6 months in the past 12 months. OR Has experienced 2 episodes of homelessness in the past 12 months. OR Has experienced less than 1 month of homelessness out of the past 12 months, but has experienced other episodes of homelessness in the past 5 years. Few prospects for housing at present. May have no options for housing due to history; ability to participate in process, etc. May be living in transitional housing; couch-surfing or living in overcrowded/'doubled up' conditions in someone else's home; living day-to-day or week-to-week in motels or hostels; or living in another type of provisional accommodation.	Is experiencing chronic or episodic homelessness: ■ Chronic homelessness. Has been homeless for 6 months or more in the past year (i.e., has spent more than 180 cumulative nights in a shelter or place not fit for human habitation). ■ Episodic homelessness. Has experienced three or more episodes of homelessness in the past year (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 place not fit for human habitation). These definitions also include individuals exiting institutions (e.g., child welfare system, mental health facilities, hospitals, and correctional institutions) who have a history of chronic and episodic homelessness and cannot identify a fixed address upon their release.
1	2	3

** For information on the changes, please see Appendix 11: 'Canadianizing' the VAT 29. For the original DESC Homelessness domain, please see Appendix 10: Homelessness Domain (Original DESC Version)*

APPENDIX 10: HOMELESSNESS DOMAIN (ORIGINAL DESC VERSION)

HOMELESSNESS

Length of time homeless

NEWLY HOMELESS	MODERATE HISTORY 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

APPENDIX 11: 'CANADIANIZING' THE VAT

The VAT Working Group convened by the Canadian Observatory on Homelessness and the Mental Health Commission of Canada has made a few changes to adapt the Vulnerability Assessment Tool (VAT) and Interview Script to the Canadian context. All changes were reviewed and approved by DESC prior to publication.

THE VULNERABILITY ASSESSMENT TOOL

The Homeless domain (see Homelessness (Revised for Canadian Context)* 27) in the original DESC version is defined according to the United States Department of Housing and Urban Development (HUD) funding program priorities; these priorities are defined slightly differently in Canada. As a result, the Homelessness domain has been revised to reflect the Canadian context. If your organization would prefer to use the original version, please see Appendix 10: Homelessness Domain (Original DESC Version).

Canadian Definitions of 'Chronic' and 'Episodic' Homelessness (HPS)

To meet the criteria of a 3, the Homelessness domain's highest score, the individual must now meet the Canadian Homelessness Partnering Strategy (HPS) definitions of chronic and episodic homelessness (Employment and Social Development Canada, 2016a). Both the U.S. HUD definition and the Canadian HPS definition focus on people living in emergency shelters and sleeping rough. One key difference is that HPS focuses on the last 12 months to set priorities for interventions. Another important difference is that HPS counts stays in institutions (e.g., correctional facilities, hospitals, etc.) as part of a person's experience of homelessness, if they have history of chronic/ episodic homelessness and do not have a fixed address to go to upon release.

Changing the VAT Homeless domain's score of 3 to reflect the HPS definition simplifies the assessment process for Canadian service providers, who may need to report to HPS on interventions provided to that specific subset of individuals. Other organizations who may not have programs tied to HPS funding may also want to identify individuals who meet the nationally recognized definition for chronic and episodic homelessness. This will allow organizations using the VAT to directly compare data with the results of the national Point-in-Time Count and other national data collection initiatives and publications.

Canadian Definition of Homelessness (COH)

The scores of 1 and 2 have been changed to reflect the Canadian definition of homelessness, developed by the Canadian Observatory on Homelessness in collaboration with people with lived experience, service providers, researchers and other stakeholders (Canadian Observatory on Homelessness [formerly the Canadian Homelessness Research Network], 2012).

The U.S. HUD definition of homelessness excludes transitional housing, interim housing, couch-surfing, day-to-day or week-to-week motel stays, institutional stays (hospitals, correctional facilities, etc.) and other forms of provisional accommodation. The COH definition provides a typology of homelessness that includes 1) unsheltered, 2) emergency sheltered, 3) provisionally accommodated and 4) at risk of homelessness. The original Homelessness domain in the VAT covers 1) unsheltered and 2) emergency sheltered types of homelessness. The revised Canadian version includes 3) provisional accommodations. However, the VAT is not designed to provide accurate assessments of individuals who are currently housed, however precariously (see the section on Eligibility in this manual). As a result, 4) individuals at risk of homelessness are not included in the rating criteria in the Homelessness domain in either the original or the revised version.

The Canadian Homelessness Partnering Strategy (HPS) identifies individuals who have been experiencing chronic and episodic homelessness within the last 12 months as the first priority group to receive housing and other interventions. The next set of priority groups HPS identifies includes “individuals who have been homeless (in a shelter or living on the street) for 3 to 5 months over a year; individuals who experienced two or more episodes of homelessness over a year; [and] individuals currently in transitional housing.” These are all represented in the revised Homelessness domain VAT score of 2.

Anticipated Impact on Scoring

The impact that the changes to the Homelessness domain will have on the VAT prioritization process is expected to be minimal. The Homelessness domain is scored on a three-point scale, so there is less room for variation than in the five-point scales for the other domains. An individual's VAT score could vary by no more than one point between the Canadian version and the U.S. version.

EXAMPLES	U.S. VAT SCORE	CANADIAN VAT SCORE
An individual who has been homeless for fewer than 6 months out of the last 12, but who has been cycling in and out of shelters for the last 3 years.	3	2
An individual who has been sleeping in their car for a year and a half.	3	3
An individual who has been sleeping outside for the last 8 months, but experienced no other episodes of homelessness in the preceding 4 years.	2	3
An individual who has been couch-surfing for a year.	1	2
An individual who has been living in transitional housing for 5 months.	1	2
An individual who may be known to landlords and face exclusion from the rental market due to a history of arson, drug-trafficking, assaults or significant property damage.	3	2
An individual leaving a hospital or correctional facility who has a history of chronic and episodic homelessness and cannot identify a fixed address upon their release.	**2 or 3** (depending on the # of episodes of homelessness in the past 3 years)	3

THE VULNERABILITY ASSESSMENT TOOL INTERVIEW SCRIPT

The interview script contains three sections: A) questions about the client's contact information, B) questions about the client's age, gender, military service, immigration status, etc. and C) questions corresponding to the 10 domains of client vulnerability.

Section A: Contact Information

Minor stylistic changes; no substantive changes.

Section B: Demographics

Substantive changes have been made to this section to better reflect common Canadian data collection requirements. For example, a question about Aboriginal heritage has been added. DESC's original demographic questions have been replaced with the Canadian Point-In-Time (PIT) Count survey's core demographic questions (Employment and Social Development Canada, 2016b). These have been supplemented with two additional questions on gender identity and sexual orientation recommended by the Canadian Observatory on Homelessness (COH) in the Point-in-Time Count Toolkit (Canadian Observatory on Homelessness, 2016).

Aside from the question about age, the demographic questions in Section B are not taken into account during the scoring of the Vulnerability Assessment. As a result, the changes to this section will not have any impact on the VAT prioritization process.

Section C: Vulnerability Assessment Questions

Minimal changes have been made to the Vulnerability Assessment questions. Certain questions have been rephrased to better reflect Canadian terminology.

NOTES ON MAKING CHANGES TO THE VAT

Please note that no changes may be made to the Appendix 1: DESC Vulnerability Assessment Tool 19 or to Section C in the Interview Script. If there are any aspects of the VAT that are not suiting the needs of your community or organization, please email the Downtown Emergency Service Center (DESC) at info@desc.org to consult.

Section A: Contact Information and Section B: Demographic Information in the Interview Script collect information for administrative purposes that may vary from program to program and do not affect an individual's VAT score. For these two sections, your organization may make changes without seeking DESC's approval.

APPENDIX 12: ETHICAL USE OF THE VAT

Any coordinated assessment tool is only as good as the processes in place to support its administration. Using the VAT in an ethical way means Minimizing Harms 34 and Maximizing Benefits 36 to the individuals who participate. Specific strategies for Minimizing Harms and Maximizing Benefits to individuals who participate in Vulnerability Assessments are provided below. This section draws and expands on HUD's Effective and Ethical Criteria for Assessment Processes and the recommendations in COH and MHCC's Screening for Housing First (Aubry et al., 2015; U.S. Department of Housing and Urban Development, 2014).

MINIMIZING HARMS

Protect interviewee privacy.

The Vulnerability Assessment Tool, like all assessment tools, asks a set of personal questions. It is essential to put processes in place to protect interviewee privacy. This includes but is not limited to:

- Conducting the interview in a private room or confidential setting where the conversation will not be overheard by others.
- Storing data securely (e.g., paper files are locked away and digital files are password-protected, and the number of staff who can access these is limited).
- Obtaining informed consent for sharing information, both internally with other staff and externally with other service providers.
- Training staff to share the information with each other or with other service providers only 1) if the client has signed an informed consent permitting this sharing and 2) if the reason for sharing is to help the client access a service or resource the client has identified wanting to access.

Take a trauma-informed approach.

Staff assessors should be trained to take a trauma-informed approach. In the context of administering the VAT, assessors should be equipped to recognize when a person may be feeling anxious or distressed in responding to questions. Assessors should be clear that interviewees do not need to answer any question they do not feel comfortable answering. At the end of each section, assessors should also offer the opportunity for Taking A Break. If the interview is not progressing coherently, or if the individual is clearly in crisis, it may be a good idea to reschedule the interview for a later time (see Stopping An Interview). Managers should support assessors in taking a person-centred approach, reassuring them that it is more important to respond to the needs of the individual in the moment than it is to fill quota requirements for the number of assessments completed.

If, at the end of the assessment, the interviewee is clearly upset or showing signs of distress about the information they have just disclosed, the assessor should take the time to connect with them and help them feel safe and calm again. It is a good practice to have caseworkers available who can speak with the individual for a longer period of time following the interview if needed. (See Appendix 13: Best Practices In Making Referrals & Following Up After the Interview 38.)

Ensure all parties understand that participation in the VAT interview and any offered resources is optional.

When inviting an individual to participate in the VAT, it is important to make it clear to them that participation is optional, and if they choose not to participate, it will not negatively affect their access to other services your agency may provide. Similarly, if the individual receives a high VAT score and is prioritized for the service you are offering (e.g., housing, rent case management, etc.), it is still their choice whether to accept that service.

It is equally important to make this clear to the staff, managers, funders and community partners who are working with you to administer the VAT. Staff may inadvertently place pressure on individuals to participate in the VAT because they feel strongly that the individual would be prioritized for a housing placement and this would be the best option for the individual. In other instances, staff assessors may feel pressure from managers, funders or community partners to complete a certain number of VATs per week or per month. It is critical that all parties be clear that while participating in the VAT can provide significant benefits to an individual, only that individual can decide what is best for them.

It is service providers' responsibility to offer options and share information, but the individual should feel they are making their own decision without feeling pressured in one direction.

Acknowledge and work to address power dynamics.

Be aware of power dynamics when selecting staff to serve as assessors and deciding the time and location of assessments. Is the staff person someone who controls access to basic resources (e.g., food, beds, washrooms, etc.)? If so, there is a strong risk the individual will feel their access to these resources could be affected by the information they provide about their drug use, history of interactions with the correctional system, negative interactions with romantic partners or others, etc.

MAXIMIZING BENEFITS

Ensure all individuals benefit from participation.

Interviewees who do **not** meet prioritization criteria should also receive some benefit from their participation in the Vulnerability Assessment. For example, a staff person from the organization administering the VAT or another worker from a partner agency should connect with the interviewee soon after the VAT to follow up 1) about the person's score and what it means and 2) to assist the person to connect with available local resources and services to help them meet the needs and goals they identified. For further details, please see Appendix 13: Best Practices In Making Referrals & Following Up After the Interview 38.)

Use the VAT to inform system change.

The VAT can be a powerful tool to help inform systems change in your community. It can help to reveal what the spectrum of vulnerability looks like among people experiencing homelessness. It can help to provide insights into what kinds of services people are looking for and where the gaps are. If the waiting list is growing and no new resources are coming online, this raw data can be shared with funders to clarify the scale and scope of what is needed to truly effect change.

It is important to build data analysis into your budget, ensuring that individuals within the staff team are trained to aggregate the data and communicate the emerging trends. Not only can prioritization tools like the VAT help to allocate scarce resources, they can also help to confront the overall problem of the scarcity itself.

Gather feedback and improve processes.

Regularly gather feedback on how the assessment tool is working. This should include efforts to answer the overall question proposed in Screening for Housing First: "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?" (Aubry et al., 2015, p. 3) VAT interviewees, both those who have been prioritized and those who did not meet prioritization criteria, should play a key role in evaluating this question and proposing improvements for how the VAT is administered.

APPENDIX 13: BEST PRACTICES IN MAKING REFERRALS & FOLLOWING UP AFTER THE INTERVIEW

MAKING REFERRALS

The Appendix 2: DESC VAT Interview Script asks a number of questions of individuals that are about immediate and longer-term service needs. For example, the VAT asks if the individual knows where to go for basic needs like food, showers and laundry (Q9, Q11); if they feel scared or unsafe (Q6); if they would be interested in working with addictions professionals, mental health professionals and financial trustees (Q14, Q15, Q17, Q8); and if there are specific services they are looking for or specific goals they would like support with (Q1, Q17, Q18).

While these questions are important to assess an individual's vulnerability and produce an accurate score, it is important that the organization administering the VAT also ensures that the individual receives support for any immediate service needs or safety issues they disclose. (See Appendix 12: Ethical Use of the VAT 34.)

Hold referrals to the end of the interview.

Timing is important. Referrals should **not** be offered while the interview is in progress – this changes the nature and focus of the conversation and adds more time. It is also important for the assessor to be clear that their role during the interview is not to provide direct service as a case worker or housing worker, but simply to conduct an assessment. (See Interviewer Dos & Don'ts for more information.)

We recommend that the assessor take a moment at the end of the interview to connect the individual with some of the key services they mentioned. You may want to have a piece of paper or a brochure ready to offer with some commonly requested resources listed (e.g., nearby food banks, drop-in centres, health centres, housing help centres, employment centres, etc.) along with anti-poverty groups, peer mentor services, and peer-run support groups.

Address safety concerns.

If the individual mentions immediate safety concerns during the interview, you should follow your organization's normal protocol. Where safety issues are concerned, it may be more appropriate to assist the individual to make a direct connection (a 'warm transfer') rather than simply provide a referral. Depending on the nature of the safety concern, you may want to see if there is a bed available at a domestic violence shelter, make an appointment with a trauma counsellor or connect the individual with another specialized service. In some cases, it may also be appropriate to call 911 or involve other agencies. Talk to the individual about how they would like to proceed, what supports they would need in order to feel safer, and what strategies they could use to keep themselves safe.

Have staff from your organization or from a partner agency available for more in-depth conversations.

With the exception of safety concerns (discussed above), the conversation the assessor has with the individual following the interview should be kept fairly brief. Again, the assessment should not turn into a casework conversation. For examples of how to phrase referrals following the interview, please see Keep the Focus on the Individual at the end of the Interviewer Dos and Don'ts section.

In many cases, an individual may want to have a longer conversation and receive additional support. An individual may also be feeling vulnerable about some of the information they have shared. It is a good idea to have staff from your organization or from a partner agency available to have more in-depth conversations as needed. It is also a good idea for the worker providing the follow-up and additional supports to have lived experience of street homelessness. More broadly, peer-run services and groups should be part of the follow-up strategy and included in your community's coordinated approach to delivering services following the VAT prioritization process.

A sample conversation at the end of the VAT interview may look like this:

"During our conversation, there were a few things you mentioned that I would like to follow up on right away:

- *You mentioned that you would find trustee services helpful. I can give you a number to call and a pamphlet here that explains more about that.*
- *You also mentioned that you have been looking for mental health services. There is a psychiatrist who comes to the [X] shelter across the street twice a week and a trauma counsellor who works at the [X] crisis centre downtown; I can give you more information if you are interested.*
- *You also mentioned that you are having trouble getting your laundry done. Did you know that [X] drop-in centre has a laundry machine in the basement and people are welcome to sign up to use it for free any time between nine and five on weekdays?"*

"I am happy to write this down for you. If there is anything else you need help with immediately, please connect with [Name] at the front desk and [Name] will be able to help you find the things you are looking for."

FOLLOWING UP

Your organization should have a process in place for following up with the individual after the assessment. The assessor may or may not be the person who follows up with the individual. It may be a member of your staff or it may be someone from a partner agency or a staff member with the funder. Whatever the process, it is important to communicate it to the individual following their interview. Let them know:

- When the individual can expect to hear the results of their assessment.
- Who will be following up (agency, name, role, etc.).
- How the worker will follow up (e.g., phone, email, in person, by appointment, via an agency or other worker that the individual has given permission for the worker to contact – e.g., an outreach worker, caseworker, housing worker, etc.).
- Who the individual can talk to if they have not heard back or if they have questions, and the contact information for that worker or agency.

For example, the assessor may say something like this:

> *"We are now going to review your responses to assess your level of priority for [the resource]. You will hear from us in [X] days. At that time, we will let you know whether or not we are able to offer you [X], whether you have a spot on the waiting list, or whether you are not a match for this service. If you would like to follow up with us, you can call me at [phone number] or stop by the front desk here and ask for me, [Name], or [Another Staff Name], and we will be happy to give you an update."*

Follow-up should happen within a defined and brief period of time. The person doing the follow-up lets the individual know whether they have been prioritized to receive the resource. If the individual has been prioritized, the worker lets them know what the next steps are. If the individual has not been prioritized, the worker talks with them about their options for finding housing, accessing case management services, or connecting with other services or resources the individual may need. Workers with lived experience of street homelessness should be recruited and hired to provide the follow-up and assist individuals with navigating the system. Individuals who score high in the VAT are often individuals who avoid services. Someone who has 'been there' has the skills to establish the trust and rapport needed. These individuals also have a deep knowledge of the barriers people face and strategies for overcoming those barriers in creative ways.

APPENDIX 14: REFERENCES

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