Special Series: Coordinated Entry & Domestic/Sexual Violence

Assessing Vulnerability, Prioritizing Risk:

The Limitations of the VI-SPDAT for Survivors of Domestic & Sexual Violence

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July, 2020

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The federal Domestic Violence and Housing Technical Assistance Consortium (the Consortium) is an innovative, collaborative approach to providing training, technical assistance, and resource development at the critical intersection of domestic and sexual violence, homelessness, and housing.

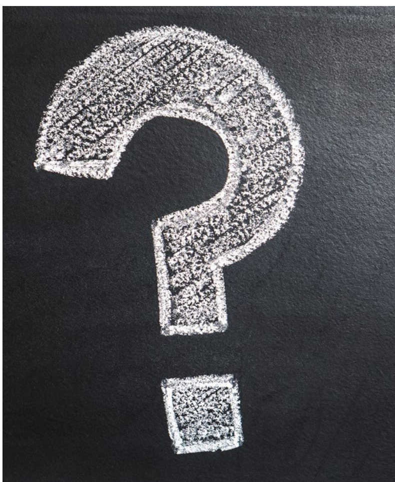
Funded and supported by an unprecedented partnership between the U.S. Department of Health and Human Services, Department of Justice, and Department of Housing and Urban Development, this multi-year Consortium brings together national, state, and local organizations with deep expertise on housing, domestic and sexual violence in order to collaboratively build and strengthen technical assistance to both housing/homelessness providers and domestic/sexual violence service providers. The Consortium aims to improve policies, identify promising practices, and strengthen collaborations necessary to improve housing options for survivors of domestic and sexual violence and their children in order to enhance safety, stability, and well-being.

This publication was made possible by Grant Number 90EV0451 to the National Resource Center on Domestic Violence from the Administration on Children, Youth and Families, Family and Youth Services Bureau, U.S. Department of Health and Human Services. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services.

Individual and structural drivers of homelessness

Homelessness is a persistent public health problem in the United States. **In 2018, approximately 553,000 people experienced homelessness on a given night.**[1] Despite efforts at the federal, state, and local levels to address this problem, the need for housing far outweighs the supply. Continuums of Care (CoC), which are local or regional planning bodies, implement coordinated entry systems to increase community capacity for crisis response, facilitate collaboration across agencies serving individuals and families at risk of homelessness, and allow for the prioritization of scarce housing resources for those at greatest risk for chronic homelessness.[2] Central to this process is a standardized assessment of risk across points of entry into the system that intends to promote equity in access to resources. However, how do we determine who is at greatest risk?

Homelessness has numerous structural drivers including poverty, high unemployment, institutional racism, and limited access to affordable housing.[3,4,5] Researchers have also focused on individual-level risk factors associated with this outcome, including mental illness and substance use.[6,7] Importantly, this work was done primarily with samples of men and veterans, excluding the potential for unique risk factors among non-veteran women, youth, and families. However, a growing body of literature has documented associations between intimate partner violence (IPV), sexual violence (SV), and housing instability among women.8 In addition to survivors becoming homeless due to fleeing abusers, many also have additional risk factors related to abuse, including histories of credit or rental problems (e.g. moving multiple times to avoid their perpetrators), lost time from work, ongoing harassment, limited financial resources to pay rent on their own, and housing discrimination. [8,9]



What is the VI-SPDAT?

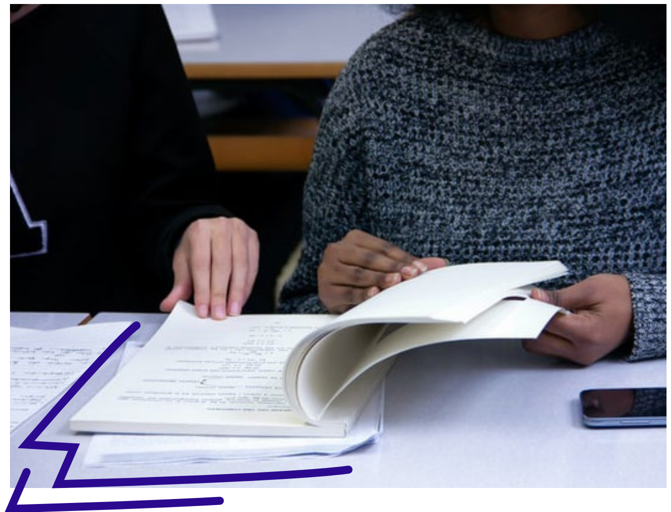
The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) is one of the most commonly used standardized assessment tools used to fulfill the HEARTH Act requirement to develop a mechanism to coordinate housing responses for those at highest risk for chronic homelessness. It is an interview-style assessment tool comprising items across multiple domains: history of housing and homelessness, risks, socialization and daily functions, wellness, and family. The tool generates a score that results in clients being prioritized for permanent supportive housing, rapid rehousing, or transitional housing options.

The Vulnerability Index (VI), was developed by Community Solutions based on the work of Boston's Healthcare for the Homeless program to assess an individual's risk for mortality,[10] which informed decisions about prioritizing scarce housing resources.[3,11] Factors associated with heightened risk included multiple hospitalizations or emergency room visits, being 60 years or older, cirrhosis of the liver, end-stage renal disease, history of frostbite or hypothermia, HIV, and co-occurring mental health and substance use disorders.[10, 12] The Service Prioritization Decision Assistance Tool (SPDAT) was subsequently developed by OrgCode Consulting, Inc., as a more in-depth assessment tool to further consider socioeconomic and psychosocial risk factors related to homelessness. These tools were combined to create the VI-SPDAT, which has been implemented with coordinated entry systems across the United States with the ultimate goal of moving individuals and families into safe, permanent, and sustainable housing.

What does the evidence say?

To date, only one published study has examined the reliability and validity of the VI-SPDAT to assess whether it is performing as desired. Brown and colleagues (2018) analyzed data from a Midwestern CoC's Homeless Management Information System (HMIS) database including 1,495 single adults experiencing homelessness between April 2014 and April 2016.[13] They found that the tool had poor test-retest reliability, with most participants scoring higher on subsequent administrations, and poor inter-rater reliability, which suggested there was variation in scoring across interviewers and sites. Theoretically, a coordinated assessment tool would remove provider bias that could shape access to resources. However, research has documented the ways that variability in community priorities, funding, and federal mandates influences prioritization, even when a common tool is used.[14] These structural influences may be compounded by individual providers advocating differently for clients or receiving inadequate training to implement the VI-SPDAT. For example, a recent study of data from Oregon, Virginia, and Washington found that Black, Indigenous, and people of color were 32% less likely than their White counterparts to receive a high prioritization score, despite their overrepresentation in the Coordinated Entry System.[15] This is an example of the potential for coordinated entry assessment to exacerbate racial inequities in homelessness. Specific to survivors, the most problematic domain in the VI-SPDAT was the 'socialization and daily functions' domain, which includes a question about whether an individual or family's homelessness was "caused by a relationship that broke down, an unhealthy or abusive relationship, or

because family or friends caused [them] to become evicted."[13] These findings suggest that the VI-SPDAT does not adequately assess "vulnerability," especially for survivors of IPV or SV, whose experiences are not fully reflected in this tool.[13] Indeed, the VI-SPDAT does not specifically address unique risk factors for homelessness experienced by survivors (e.g. the need for multiple moves, lost time from work),[8] which may limit the utility of the VI-SPDAT for survivors. Finally, this study found that the type of housing that clients obtained predicted subsequent homelessness, not their VI-SPDAT score, which complicates the current focus on and strategies for assessing risk.

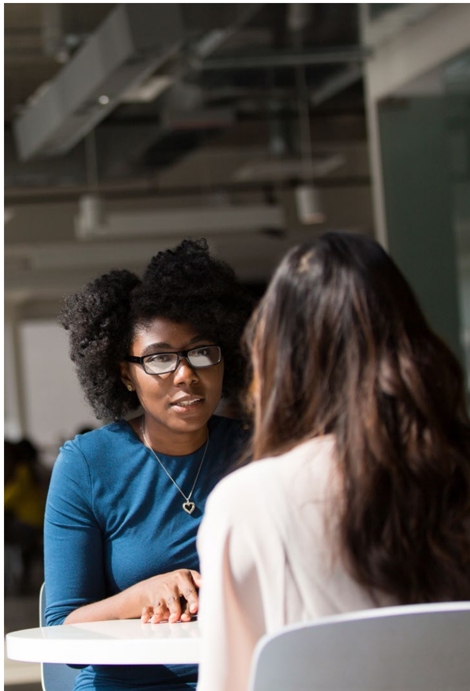


Qualitative research provides some context regarding providers' experience with the VI-SPDAT. A study of 24 primarily Midwestern housing professionals found that the tool's questions about "risky behavior" caused discomfort for clients and the potential for social desirability bias.[16] They further described clients being confused by questions, including items that assess IPV. For example, one provider shared, "They've clearly [said] yes, they've been a victim of domestic violence. But when you ask them in the VI-SPDAT – has anyone hurt you, or forced you to do things you didn't want to do, they say no. Then you can ask a clarifying question. You can say, 'okay well earlier you mentioned domestic violence, does that mean that's not affecting your right now, or can you just clarify that for me?' Or you can ask them the question again and remind you of an earlier answer. And they can either say, "Oh, yeah yeah yeah, I wasn't sure if that's what you were talking about or not (pp 37)." Other providers felt that the cross-sectional nature of the VI-SPDAT meant that survivors were given a higher score that was reflective of their current situation, but not necessarily their long-term vulnerability.[16]

This qualitative work further addresses the need for attention to how the VI-SPDAT is implemented in practice. Providers felt that the interviewer's rapport with the client shaped their assessment of risks and vulnerabilities, corroborating Brown's study of reliability and validity,[10] and recommended additional training on implementing the tool. Developing trauma-informed implementation strategies may be needed to effectively work with survivors who may be re-traumatized by such an assessment, beyond simply training with the goal of consistent delivery. Finally, providers recommended including strengths-based questions to better help clients identify supports they had available to them.

What other tools are used to assess risk and prioritize survivors for housing?

Some communities have added companion assessment tools to identify IPV survivors in conjunction with their VI-SPDAT score. The Danger Assessment is an example of such tools, initially developed in 1986 for health and social service providers to initiate safety planning and promote survivor empowerment by identifying risk for intimate partner homicide [17,18] Evidence suggests the tool demonstrates moderate predictive validity (i.e. moderately predicts future harm), with stronger sensitivity among survivors experiencing greater IPV severity (operationalized primarily as physical IPV).[19] However, it was not designed to inform decisions about housing. One study of 278 survivors in the Portland, Oregon area with housing instability as a primary concern found that increased scores on the Danger Assessment were associated with elevated odds of being absent from work and increased use of hospitals or emergency medicine, which are risk factors for housing instability.[20] However, this tool does not capture other risk factors unique to IPV survivors, such as histories of frequent moves to avoid perpetrators or limited financial resources because of economic abuse. Thus, tools designed to assess IPV lethality may not be adequate to inform the allocation of housing resources (for more information on this, see the paper in this series about the problems of using the Danger Assessment as a housing assessment).



A recent study introduced the SASH (Survivors Achieving Stable Housing) tool, an evidence-informed tool to guide the allocation of housing vouchers for IPV survivors.[21] It comprised a self-referral form, taking 30-45 minutes to complete, and a referral to be completed by a domestic and sexual violence advocate. The SASH tool's development came, in part, from concerns that the VI-SPDAT did not adequately capture survivors needs and barriers, resulting in a misalignment between their needs and available interventions.[21] Despite more comprehensively capturing the lived experiences of survivors, the tool is lengthy with housing outcomes reliant on domestic violence advocates, which could potentially introduce bias. Moreover, further research is needed to understand how the SASH tool could be woven into siloed homelessness and violence advocacy systems, where survivors would be competing for scarce resources[22]

How do we move forward?

Housing needs of IPV and SV survivors are complex and variable, warranting assessment tools that are trauma-informed and developed via collaboration between domestic/sexual violence and housing experts. Specifically, domestic and sexual violence experts are well-positioned to guide the collection of information that more accurately reflects the experiences of survivors and their vulnerability to housing instability and homelessness. For example, best practices in violence assessment include using behaviorally-specific items to determine IPV and SV history, rather than words like "unhealthy" or "abusive" that currently appear in the VI-SPDAT. Moreover, tools could incorporate additional risks for housing instability and homelessness that survivors experience such as economic abuse or long-term patterns of physical or sexual IPV, rather than discrete events. The efficacy of these trauma-informed tools would be strengthened by addressing implementation concerns, including the variable influence of interviewer rapport with clients and individual provider attitudes about how IPV and SV shape a client's immediate and long-term housing needs. Finally, there are significant gaps in research and practice regarding how prioritization decisions are made, especially in communities without dedicated resources for survivors of IPV and SV, and how such decisions predict long-term success in housing stability.

Endnotes

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