Greater Moncton Homelessness Steering Committee Le Comité directeur des sans-abri du Grand Moncton

**A Common Intake and Assessment Process to Better Serve the Homeless**

**in the Greater Moncton Area**

Final Report

**Presented to the Greater Moncton Homelessness Steering Committee**

**March 2016**

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**Acronyms**

CE: Community Entity

DPA: Data Provision Agreement

ESDC: Employment and Social Development Canada

HIFIS: Homeless Individuals and Families Information System (Government of Canada software system)

HMIS: Homeless Management Information System

HPS: Homelessness Partnering Strategy (Canada)

HUD: U.S. Department of Housing and Urban Development

NHIS: National Homelessness Information System (Government of Canada initiative which uses HIFIS)

RR: Rapid Re-housing

SPDAT: Service Prioritization Decision Assistance Tool

VI-SPDAT: Vulnerability Index - Service Prioritization Decision Assistance Tool

VAT: Vulnerability Assessment Tool

**Introduction**

The Greater Moncton Homelessness Steering Committee (GMHSC) has made common intake and assessment a priority of the *Greater Moncton’s 5-year Community Plan to end homelessness 2014 – 2019*.

Common intake and assessment (also called coordinated intake and assessment) is a standardized and shared process for entry into the homeless-serving system, which is comprised of all the agencies serving the homeless population in a given geographic area. As a first step in working towards common intake and assessment, the GMHSC has chosen to focus on community agencies that are providing housing.

According to the National Alliance to End Homelessness (US), in addition to eliminating the need for clients to repeatedly re-tell their often traumatic stories, the benefits of adopting a common intake and assessment process include:

* *Helping people move through the system faster (by reducing the amount of time people spend moving from program to program before finding the right match);*
* *Reducing new entries into homelessness (by consistently offering prevention and diversion resources upfront, reducing the number of people entering the system unnecessarily); and*
* *Improving data collection and quality and providing accurate information on what kind of assistance consumers need.* (National Alliance to End Homelessness, cited in Gaetz, 2014).

As was wisely put by Jaime Rogers and Tracy Flaherty-Willmott, there is a significant shift that adopting a common intake and assessment process requires:

***Current System: “Should we accept this household into our program?”***

*•Program-Centered*

*•Unique forms and assessment processes to each organization or small subgroup of programs*

*•Uneven knowledge about available housing and service interventions in the area.*

***Future System: “What housing /service assistance is best for each household and quickly ends their homelessness permanently?”***

*•Client-Centered*

*•Standard forms and assessment processes used by every program for every client*

*•Coordinated referral process across the area*

*•Accessible information about available housing and service interventions in the area*

(Rogers, J., & T. Flaherty-Willmott, 2013)

This report, produced by Sarah LeBlanc Consulting for the GMHSC, will outline findings and conclusions from a literature review and from consultations with GMHSC members and homelessness coordinating agencies in other cities on the topic of common intake and assessment. It will also highlight work completed by the GMHSC’s Committee mandated to pursue the project of common intake and assessment. Finally, taking into account all of the findings, it will present recommendations on common intake and assessment models for the Greater Moncton Area.

**Methodology**

The methodology employed to arrive at the recommendations presented in this report was as follows:

A literature review focussing on best practices regarding common intake and assessment processes was conducted. Following this, the majority of members of community organisations of the GMHSC were interviewed during approximately 1-hour semi-directed conversations. Exchanges with homelessness coordinating agencies of the cities of Fredericton (NB), Saint-John (NB), Waterloo (ON), London (ON) and Lethbridge (AB) also took place in order to gain insight from their ventures into common intake and assessment. It is worth noting that this is a relatively new process everywhere in Canada.

From the GMHSC, a smaller committee was also formed to discuss the concrete implementation of this process in Moncton. The committee, which has met four times thus far, will continue its work after the submission of this report.

These steps were taken in order to arrive at the best possible recommendations for a model of common intake and assessment that provide a solution for Moncton. Each part of the process is further detailed within this report.

**A Brief Literature Review**

**What is a common intake and assessment process for housing clients?**

Common intake and assessment, also called coordinated intake and assessment, is a process whereby several organizations serving populations affected by homelessness come together by using the same intake and assessment tools and practices, make common decisions about placement of clients and share information about clients in order for the homeless-serving system to provide the best match for services for each individual or family. Different models exist and some of them will be discussed here.

**ON THE OTHER HAND…**

*“Uncoordinated intake systems cause problems for providers and consumers. Families with housing crises may end up going to multiple agencies that cannot serve them before they get to the one most appropriate for their needs. Each agency may have separate and duplicative intake forms or requirements, slowing down families’ receipt of assistance, and each interaction with an agency opens up a need for data entry into a Homeless Management Information System (HMIS) or a similar system. Extra staff, time, and money are spent doing intake and assessment, taking time away from other, more housing-focused, tasks such as case management, housing location, and landlord negotiation.”*

- National Alliance to End Homelessness, 2011.

**Process features**

Different models and many possibilities exist in choosing and implementing a common intake and assessment process. Here are the main features of such a process and the best practices associated with each.

**Intake and Assessment tools**

Developed by OrgCode Consulting, the SPDAT, which stands for Service Prioritization Decision Assistance Tool, and VI-SPDAT software are the most widely used intake and assessment tools in Canada. SPDAT is a comprehensive assessment tool used to determine acuity and level of care based on questions around: mental health & wellness and cognitive functioning, physical health & wellness, medication, substance use, experience of abuse and/or trauma, risk of harm to self or others, involvement in higher risk and/or exploitative situations, interaction with emergency services, legal involvement, managing tenancy, personal administration & money management, social relationships & networks, self-care & daily living skills, meaningful daily activities, history of housing & homelessness. The VI-SPDAT (Vulnerability Index SPDAT) is a much shorter intake and assessment tool based on the “full” SPDAT.

SPDAT is widely used and appreciated in Canada. However, it is difficult to access independent research conducted on it. OrgCode, the makers of SPDAT, have extensively tested and refined SPDAT over the years. Without questioning the validity of their findings, the basis and the parameters of their studies and testing are hard to identify in their own literature. However, it is stated:

*After three months roll out of Version 2 of the SPDAT, SPDAT using clients had a 92% housing stability rate compared to 74% of non-SPDAT users. After a full year of Version 2, SPDAT using clients had an 88% housing stability rate compared to 63% of non-SPDAT users.*

*Across six communities that had good pre- and post- community data, the results of the SPDAT are also illuminating. Across these communities – both rural and urban – the average recidivism rate prior to implementing the tool was 14.02%, which has been reduced to 9.12% since the tool was put into place. Clients exiting into permanent housing averaged 57% across these communities prior to implementing the tool, and has increased to 78%. Also, clients achieving case plan goals has increased 150% across these communities since the tool was introduced.* (OrgCode Consulting,2013)

**Centralized or Decentralized Intake and Assessment**

There are two ways clients can receive access in a common intake and assessment process: either through centralized intake and assessment in one location, or through a decentralized coordinated intake and assessment, where all participating agencies can perform intake and assessment using the same tool and sharing data. In decentralized intake and assessment there is thus “no-wrong-door”.

Centralized intake allows for highly specialized staff to be in charge of intake and even diversion and other referral services. Its advantages are: ease of administration, guaranteed consistency in intake and assessment and quality of intake and assessment. It is recommended for small geographic areas or where public transit is easily accessible.

Decentralized intake allows every participating agency to perform intake and assessment, but they must use the same intake and assessment tools and share data and coordinate referrals, if possible. Its main advantage is ease of access for clients and is recommended for larger geographic areas and/or areas with poor public transit.

In all cases:

*Getting providers to buy in to the idea of releasing control over the intake process may be difficult at first; however, it is necessary for a coordinated entry system to be successful. (…) Providers should prepare staff for changes to their intake process and eliminate “side doors,” access points to services that exist outside of the centralized system. This means programs will have to learn to reject requests for admission for a client from individuals or organizations with which they may have a personal relationship….* (National Alliance to End Homelessness, 2011)

**Decision-Making**

In a common intake and assessment process decisions around referrals and placements are made in a coordinated way. Since this is the case, it entails a high level of collaboration among participating agencies. If positive relationships are not already established, relationship-building becomes a necessary first step for the organizations undertaking this endeavour together.

*Committee*

The use of committees is a common way to allow for collective decision-making in a common intake and assessment system. Within the committee, different types of decision-making are possible. Whether in a centralized or decentralized access model, this committee, typically comprised of representatives from all participating agencies as well as the intake and assessment specialist(s), will discuss placement and referral of clients that have gone through intake that week. There exists a wide spectrum of mandates or levels of authority a committee can be given. For example, all placement/referral decisions can follow consensus or majority-rule, where the committee is the final decision-making authority. In this case, a participating organization does not have the right to refuse to provide services if that is the committee’s decision. Another model follows the same procedure but grants a veto to the concerned organization. A third option is to simply have discussions in committee but leave all powers to the receiving-organisations.

The general idea is that the more power that is granted to the committee, the better the referrals are likely to be. However, what is most important is the need for these decision-making procedures to be discussed, negotiated and agreed upon through signed agreements by the participating organizations.

**Privacy**

Concerns for clients' privacy when sharing data and information can be addressed by having the appropriate consent release forms. This must also be collectively discussed. Information and data sharing parameters must be formalized through signed agreements between the participating organisations.

**Conditions for Success**

* It is important to take the time to discuss and design a model that fits local needs and realities. There is no one-size-fits-all approach.
* The keys to success will be (i) determining through discussion what works for you, (ii) trying it, and (iii) having a process in place to evaluate it and allow for changes.
* Taking the time to establish relationships of collaboration and sign written agreements. Clarity and agreement regarding roles, responsibilities and authority are crucial.

**EVALUATION**

*“Evaluation of a coordinated intake system can be accomplished in several ways. Recently housed consumers can be given brief questionnaires to gather information about their experience with the system. Responses should be analyzed based on when the consumer first made contact with the homeless assistance system and when they were placed into permanent housing. Communities will want to see if, since the implementation of a coordinated entry model, the time from system entry to permanent housing has gotten shorter and involved fewer interactions with different agencies. These surveys can also ask consumers how they accessed services; if they did not access them through the intake center, the community will know that some side doors in the community still exist.”*

- National Alliance to End Homelessness, 2011.

**Summary Findings of Consultations**

The majority of community organisations who are members of the GMHSC were interviewed during approximately 1-hour semi-directed conversations held in December 2015 and January 2016. They were asked about their current practices, needs and challenges regarding intake and assessment and their views on and interest in common intake and assessment. They were also asked about conditions for success for implementing a common intake and assessment process.

**Organizations surveyed:**

* SIDA-AIDS Moncton
* Atlantic People’s Housing (AVIDE)
* Blankets for Moncton
* Crossroads for Women/Carrefour pour femmes
* Harvest House
* John Howard Society of Southeastern NB
* Maison Cannell House
* Maison Nazareth House
* Youth Impact Jeunesse
* Pregnancy Resource Centre
* Re-Connect Street Intervention Program
* Salvus Clinic
* Greenfield House (Salvation Army)
* YWCA Moncton
* United Way of Greater Moncton

**Interview findings**

* **The great majority view common intake and assessment as a positive and even a necessary step forward for Moncton.**

**The following views were generally espoused by all organizations:**

* Willingness to work together;
* Already a high level of collaboration and cross-referrals between organisations;
* Interest in and willingness to increase collaboration and communication between organisations;
* Priority is serving clientele as best as possible;
* Experience or perception of good or great relationship between organizations providing housing;
* Need for better understanding of what services are provided by other organisations;
* Concern about confidentiality of clients within a common intake and assessment system.

**Other relevant findings:**

* **Mixed views on how/whether the concern over confidentiality of clients can be addressed.**
  + Many think it is simply a question of having the appropriate information release form, while others state it is a deeper ethical issue.
* **Judgement of clientele by other organisations is a recurring concern.**
* **There are many different perceptions and understandings of common intake and assessment processes among organisations interviewed.**
* **Beginning to adopt SPDAT in Moncton: 2 agencies have reported using it for a short time:**
  + YWCA for 6 months (VI-SPDAT and SPDAT); John Howard for 1 year (VI-SPDAT).
* **There is not yet a consensus around whether the intake and assessment should be centralized or decentralized.**
  + Concerns around centralized intake:
    - accessibility of clients (by foot, immediate access, etc.)
    - clients and specific clienteles feeling comfortable
  + Concerns around decentralized intake:
    - unrealistic to implement within Moncton context.

**Committee Work**

The GMHSC’s Committee on Common Intake and Assessment has met on February 4th, February 26th, March 16th and March 29th of 2016.

* **Participating organisations:**
  + Harvest House
  + House of Nazareth
  + John Howard
  + Reconnect + SUN Network
  + Salvus Clinic
  + SIDA-AIDS Moncton
  + United Way
  + YWCA

**The committee identified the following target population for common intake and assessment:**

* Homeless\* population of the Greater Moncton Area.
  + \* We follow the Canadian Observatory on Homelessness’ definition of homelessness: “Homelessness describes the situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. (…) Homelessness describes a range of housing and shelter circumstances, with people being without any shelter at one end, and being insecurely housed at the other.” It includes those who are 1) Unsheltered, 2) Emergency Sheltered, 3) Provisionally Accommodated, and 4) At Risk of Homelessness (the full definition can be viewed here: **[http://www.homelesshub.ca/sites/default/files/COHhomelessdefinition-1pager.pdf](http://www.homelesshub.ca/sites/default/files/COHhomelessdefinition-1pager.pdf" \t "_parent)).**

**The committee identified the following goals for common intake and assessment for the Greater Moncton Area:**

* Create an efficient process that eliminates intake and assessment duplication and is respectful of clients;
* Promote placement of clients in appropriate programs, by sharing information;
* Prevent clients from having to re-tell story;
* Have more information on clients in order to better assist them and identify what other services a client uses;
* Avoid clients “shopping around” for services, thus duplicating staff efforts and creating a loss of efficiencies;
* Being able to find clients and clients’ next of kin;
* Promote client and agency success;
* Measure client and agency success and identify gaps in services;
* Share data (helps build the case for support). Use data to create averages, estimates of cost of service, etc.;
* Promote a collective impact approach and a systems approach.

**In other cities**

**Fredericton, New Brunswick**

**Population: 94,268 (Fredericton's Census Agglomeration, 2011)[[1]](#footnote-1)**

**Based on an interview with Faith McFarland, Community Action Group on Homelessness**

* Community Action Group on Homelessness (CAGH) is currently exploring how to do common intake and assessment.
* Service Coordination Working Group, comprised of frontline workers, is coming up with strategy to incrementally implement common intake and assessment.
* Think they will eventually use SPDAT in a decentralized intake and assessment process.
* 3 organisations currently use SPDAT: Community Health Clinic, Capital Region Mental Health and Addictions, John Howard Society.
  + Looking at the possibility of using Salesforce to share data in the future.
* Will use VI-SPDAT – as part of Point in Time count on Feb. 21-22. Around 40 people will be trained to administer VI-SPDAT.

**Saint John, New Brunswick**

**Population: 70,063 (2011)[[2]](#footnote-2)**

**Based on correspondence with Jenny O’Connell, Community Development Coordinator, Human Development Council**

* Currently no formal mechanism for referrals or collaboration (at the ground level, collaboration happens through the Community Council on Homelessness).
* Working group recently looked at each agency’s existing intake forms, as well as the Calgary Homeless Foundation's intake forms and created a draft of a common intake form.
* The draft form is currently being reorganized so that the workflow is in line with HIFIS 4. Looking into shared server space as a community.

**London, Ontario**

**Population: 506,400 (2015)[[3]](#footnote-3)**

**Based on an interview with Jan Richardson, Manager, Homeless prevention, City of London**

London started the process of discussing coordinated intake and assessment 1.5 to 2 years ago. This is closely tied to the goals they have identified in their community plan. They have designed a model focusing on centralized intake for their 3 emergency shelters. It is not in operation yet but will be very soon. One of their priorities will be diversion from shelters.

They will be using a centralized intake location and also have the capacity to meet people in their location. Shelters will not be used as a centralized intake location because they want to focus on

diversion from shelters. In their opinion, decentralized coordinated intake has failed, and that’s why they chose a centralized approach.

They will use VI-SPDAT and are looking into HIFIS as an HMIS and data-sharing system. They have considered the VAT (an alternative to SPDAT), but they do not think it is a great option, since it has not been tested on the same level as SPDAT. SPDAT is also better in their opinion because it is embedded into HIFIS and is a proven tool.

The City of London now has four people working on homelessness. Provincial funding is funnelled through the cities. They also have the London Homelessness Coalition, which includes about 15 homeless-serving organizations.

**Waterloo, Ontario**

**Population: 568,500[[4]](#footnote-4)**

**Based on an interview with Lynn Macaulay, Initiatives Coordinator, Waterloo Homelessness and Housing Umbrella Group**

The region of Waterloo currently has co-ordinated access and intake for: (1) families who want to access shelter services, (2) supportive housing (where subsidized housing and supports are offered together), and (3) access to roughly 10 000 units of subsidized housing. These three streams are coordinated by different organisations. They use VI-SPDAT. They do not yet have co-ordinated access for singles/couples requiring access to shelters but hope to have it in place in the next 12-24 months.

Data sharing happens in a variety of ways at the moment, but they are preparing to implement HIFIS 4. They have had HIFIS in the community for many years, but HIFIS 4 will enable data-sharing. They have been using VI-SPDAT for a couple of years and find it is a very effective tool for determining levels of acuity and for understanding people’s vulnerabilities.

The implementation of coordinated intake was completed in stages. The first pilot project in one of the six Waterloo communities was launched in 2013, and they have been changing the way they deliver services continuously over the past three years.

They used to front-load a lot of services in shelters, so it attracted a lot of people – now they have changed strategies because want to divert clients from shelters as much as possible. Through their use of coordinated intake, they have reduced the use of shelters by families, which is defined as least one parent and one child, by 48%. At this point, shelters do not participate in the coordinated intake system; however, they all use VI-SPDAT. They also want to move towards having the shelters participate in coordinated intake.

The Waterloo Homelessness and Housing Umbrella Group is the network of all agencies working on homelessness. There is a staff person employed part-time who is responsible for advocacy, education and capacity-building. However, municipalities have their own staff members that do the planning and lead the change to coordinated intake and assessment.

**Lethbridge, Alberta**

**Population: 94,804 (2015)[[5]](#footnote-5)**

**Based on an interview with Wally Czech, Housing First Specialist, City of Lethbridge**

The central intake system used by the City of Lethbridge is designed around Housing First clients, but it is also meant to be for anyone who has a housing issue. Implemented in 2012, the system services approximately 1000 people per year.

They believe centralized intake is better than decentralized intake due to the tendency for groups to become territorial and for the increased likelihood of complications arising from improper coordination between group.

Lethbridge has two centralized intakes: one for youth and one for adults. The city also has mobile intakes performed by the same team. (Domestic violence shelters do their own assessments). The intakes proceed as follows:

1. quick pre-screening to determine Housing First eligibility;

2. if not Housing First, still refer to appropriate service. Try for warm transfer;

3. refer Housing First clients.

The city also has a rapid re-housing program that focuses on getting people out of shelters, preventing evictions and providing follow-up (for up to 6 months). Diversion programs work with shelters to get exit strategies within 7-10 days for new arrivals. Shelters also operate as a centralized intake system.

Lethbridge is moving away from using SPDAT for centralized intake. The city has found SPDAT limiting when assessing youth population: some people score lower than they should. Working with the provincial government, Mr. Czech has created an assessment tool for youth that may eventually be accessible for any agency in Canada.

Lethbridge is now using VAT (Vulnerability Assessment Tool) instead of SPDAT for adults because it is believed that VAT allows for more subjectivity in scoring. The VAT was created by DESC in Seattle. They still use SPDAT in case management. For data management, they use the Efforts to Outcomes HMIS to handle all referrals.

Shelters are directly funded by the province in Alberta and cities are also funded to address homelessness. One person employed full-time oversees the centralized intake system, and members of the different agencies meet bi-weekly for case consultations.

**Recommendations**

Based on the findings outlined in this report, the following are the recommended components for a successful implementation of a common intake and assessment process in the Greater Moncton Area.

**1. Increased collaboration**

* Sharing and networking events for frontline workers who are performing intake and assessment.
* Service Guide containing descriptions of programs and services offered by all homeless-serving agencies in the Greater Moncton Area.
  + Goal: To provide better referrals.

**2. SPDAT and Data Sharing**

* Recommend adopting SPDAT and VI-SPDAT to any organisation that thinks it may be useful.
* Especially recommended for organisations that provide housing and do not yet have a comprehensive and electronic assessment process.
  + Some exceptions: women fleeing violence.
* Data Sharing.

**3. Committee**

* Have a committee comprised of representatives from all participating organisations and intake/assessment specialists.
* Frequency of meetings depends on role given to committee.

**4. Intake and Assessment: Decentralized or Centralized**

* **Decentralized**: Based on preferences expressed, limited resources and because the Greater Moncton Area is sprawled, a decentralized common intake and assessment process is an appropriate option.
* **Centralized**: A centralized intake and assessment process is also worth giving serious consideration because it ensures high-quality intakes/assessment and referrals. This process also has the potential to improve diversion. It requires a dedicated staff-person and proper space. The human resources investment required to make centralized intake operational can potentially be recuperated through staff time saved in every participating agency. The fact that many agencies are already located in proximity to one another may also lessen the advantages of a decentralized system.

**5. Accessibility concerns: women, language, others.**

* It may be worth looking into whether gender and language concerns over access to services can be addressed in part through the adoption of a common intake and assessment process. Indeed, it seems fewer women are accessing some services offered to the homeless population in the Greater Moncton Area. Furthermore, a coordinated or centralized intake could address language concerns by having dedicated bilingual or multilingual staff.

The most important decision to be made in implementing a common intake and assessment process for the Greater Moncton Area is deciding whether such a process is to be centralized or decentralized. Here are models of both options:

Referral Committee

Organisation B

Intake/Assessment using VI-SPDAT

Organisation C

Intake/Assessment using VI-SPDAT

Organisation D

Intake/Assessment using VI-SPDAT

Organisation A

Intake/Assessment using VI-SPDAT

Referrals

Referrals

Cases

Cases

Cases

Cases

Referrals

Referrals

**OPTION 1**

**Organisational Model – Decentralized Intake/**

**Assessment**

Referral Committee

Organisation B

Organisation C

Organisation D

Centralized Intake/Assessment using VI-SPDAT (Hosted by Organisation A)

Referrals

Cases

Referrals

Referrals

**OPTION 2**

**Organisational Model – Centralized Intake/Assessment**

Organisation A

Referrals

**Draft Pilot Project Implementation Plan**

The following is a draft of a common intake and assessment pilot project implementation plan that highlights the most important actions to be taken. Smaller and other actions should be added as seen fit. The timeline should be filled out by the Common Intake and Assessment Committee in collaboration with the GMHSC Coordinator.

|  |  |  |
| --- | --- | --- |
| **Action** | **Resources needed** | **Timeline** |
| Continued meetings of the Common Intake and Assessment Committee | * Organiser * Participants |  |
| Look into accessibility concerns: women, language, others | * Leader |  |
| Evaluation | * Evaluation plan with timeline * Evaluation Lead | The Plan should be created before beginning implementation. |
| Sharing and networking event for frontline workers who are performing intake and assessment | * Organiser * Participants |  |
| Service Guide containing descriptions of programs and services offered by all homeless-serving agencies in the Greater Moncton Area. Goal: To provide better referrals. | * Dedicated staff for this project (perhaps a Summer student-employee given that grants exist from the federal and provincial governments for Summer student-employees). |  |
| SPDAT Training | * 1-day training from OrgCode Consulting (2500$ + hst + travel, so budget 3500$) * Participants |  |
| Adopt SPDAT and/or VI-SPDAT. Especially recommended for organisations that provide housing and do not yet have a comprehensive and electronic assessment process  (Some exceptions: women fleeing violence). | * Leader * Technical support |  |
| Discussions and negotiations regarding data and information sharing and use, resulting in signed agreements and new release forms for clients | * Leader |  |
| Share data (through platforms such as HIFIS 4,which includes SPDAT, or Salesforce) | * Signed agreements on data and information sharing between participating organisations * HIFIS 4 is free and Salesforce is free for a group of up to 10 charities * Technical support to implement this in participating orgs |  |
| Discussions and negotiations regarding committee mandates, members, decision-making powers that result in a signed agreement | * Leader |  |
| Have a committee comprised of representatives from all participating organisations to discuss cases, referrals and placement  (Frequency of meetings depends on role given to committee). | * Signed agreement on committee mandate and decision-making powers * Leader * Logistics organiser |  |

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