Community **Mobilization** Sudbury
Mobilisation **Communautaire** Sudbury
Weweni **EnjiNagidwendaagozing**

Rapid Mobilization Table Data Report

January to December 2018

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Community Mobilization Sudbury

Rapid Mobilization Table Data Report – 2018

Background

Community Mobilization Sudbury (CMS) is a community partnership representing over 25 organizations from diverse sectors such as health, children's services, policing, education, mental health and addictions, housing and municipal services. We have come together around a common need and desire to build multi-sectoral and collaborative mechanisms for responding to situations of acutely elevated risk***.*** The CMS threshold of ***acutely elevated risk*** refers to:

> *a situation affecting an individual, family, group or place where there is high probability of imminent and significant harm to self or others, (e.g. offending or being victimized, , experiencing an acute physical or mental health crisis, loss of housing). Circumstances require the support of multiple service providers and have accumulated to the point where a crisis is imminent if appropriate supports are not put in place.*

Community Mobilization Sudbury is *not* a stand-alone program or service, but rather a way of utilizing and mobilizing existing systems and resources in a coordinated and collaborative way. It is based upon a well-established, evidence-informed, and evaluated model that originated in Scotland and has since been replicated in communities across Canada and the United States. In Ontario alone, over 60 similar initiatives are now operating or in development.

The CMS model is an upstream investment of resources in the coordinated prevention of negative outcomes, rather than a response to harmful incidents once they have occurred. Community Mobilization Sudbury collaborations result in coordinated responses and supports. These early interventions have demonstrated their potential to reduce the need for more intensive and "enforcement-based" responses such as hospitalizations, arrests and apprehensions.

Community Mobilization Sudbury has three main goals:

- Individuals and families at high risk of harm are connected to timely and appropriate supports.
- Service providers have greater capacity to respond to situations of acutely elevated risk and prevent negative outcomes for individuals, families and communities.
- CMS partners and resources influence positive change to improve the conditions that influence community safety and well-being.

Community Mobilization Sudbury Partners		
Ministry of the Solicitor General – Adult Probation & Parole	Homelessness Network	Shkagamik-Kwe Health Centre
Behavioural Supports Ontario	John Howard Society of Sudbury	Sudbury Action Centre for Youth
Canadian Mental Health Association-Sudbury/Manitoulin	Ministry of Children, Community and Social Services – Youth Justice Services	Sudbury and Area Victim Services
Children's Aid Society of the Districts of Sudbury and Manitoulin	Ministry of Children, Community and Social Services – ODSP	Sudbury Community Service Centre
City of Greater Sudbury	Monarch Recovery Services	Sudbury Counselling Centre
Conseil scolaire catholique du Nouvel-Ontario	North East Local Health Integration Network – Home & Community Care	Sudbury Catholic District School Board
Conseil scolaire public du Grand Nord de l'Ontario	N'Swakamok Native Friendship Centre	Sudbury District Nurse Practitioners Clinics
Greater Sudbury Paramedic Services	Office of the Public Guardian and Trustee	Sudbury District Restorative Justice
Greater Sudbury Police Services	Rainbow District School Board	
Health Sciences North	Réseau Access Network	

The Rapid Mobilization Table (RMT)

Representatives from CMS partner agencies meet twice each week at the *Rapid Mobilization Table* (RMT). The RMT is a focussed, disciplined discussion where participants collaboratively identify situations involving those who are at high risk of harm. Once a situation is identified, all necessary agency partners participate in a coordinated, joint response – ensuring that those at risk are connected to appropriate, timely, effective and caring supports.

In order to ensure that privacy is maintained appropriately throughout RMT discussions, a “four filter” approach has been developed and endorsed by the Ministry of Community Safety and Correctional Services and the office of Ontario’s Information and Privacy Commissioner. These filters establish the presence of acutely elevated risk, identify relevant risk factors related to the risk, identify the agencies required to mitigate the risk, and guide the coordinated, collaborative response.

Rapid Mobilization Table Data Overview

At each Rapid Mobilization Table (RMT) meeting, de-identified data is captured to reflect the nature of RMT discussions. Variables collected include demographics, risk factors, involved agencies and situation conclusion details. The Ministry of the Solicitor General (formally the Ministry of Community Safety and Correctional Services) created a Risk Tracking Database (RTD) to collect and store this data.

This report provides a detailed outline of RMT data collected between January 1, 2018 and December 31, 2018. The demographics and risk factors presented are not meant to be representative of the full nature and scope of risk in the City of Greater Sudbury. Rather, they represent situations that: a) meet the criteria of acutely elevated risk, and b) were identified by partners for presentation to the Rapid Mobilization Table.

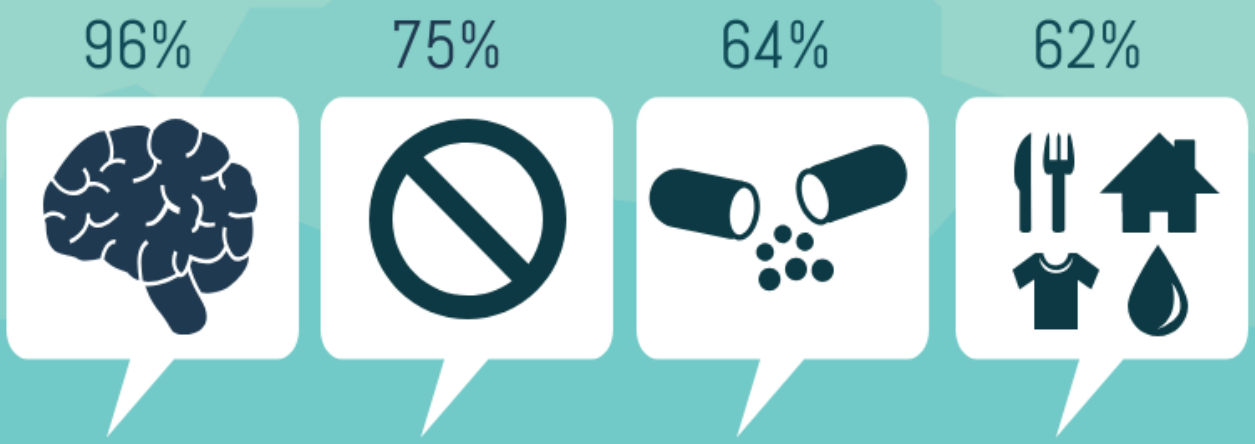
RMT 2018 Activity Update

244 Situations of Acutely Elevated Risk

17 Family

227 Individual

Most Frequently Identified Risks



Mental Health

Antisocial/ Negative behaviour

Drugs

Basic Needs

RMT Responses

10.8	8	10
Avg # of risk factors identified	Avg # of agencies involved in response	Avg # of days situation stayed open

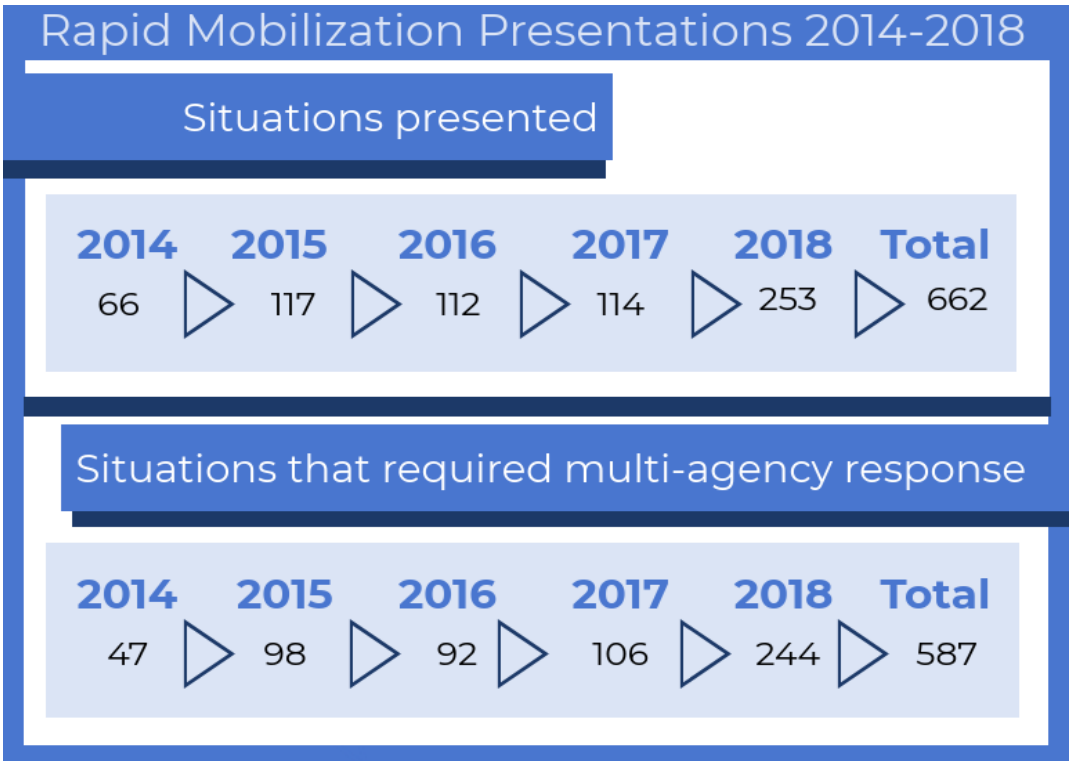
Situations presented to the Rapid Mobilization Table

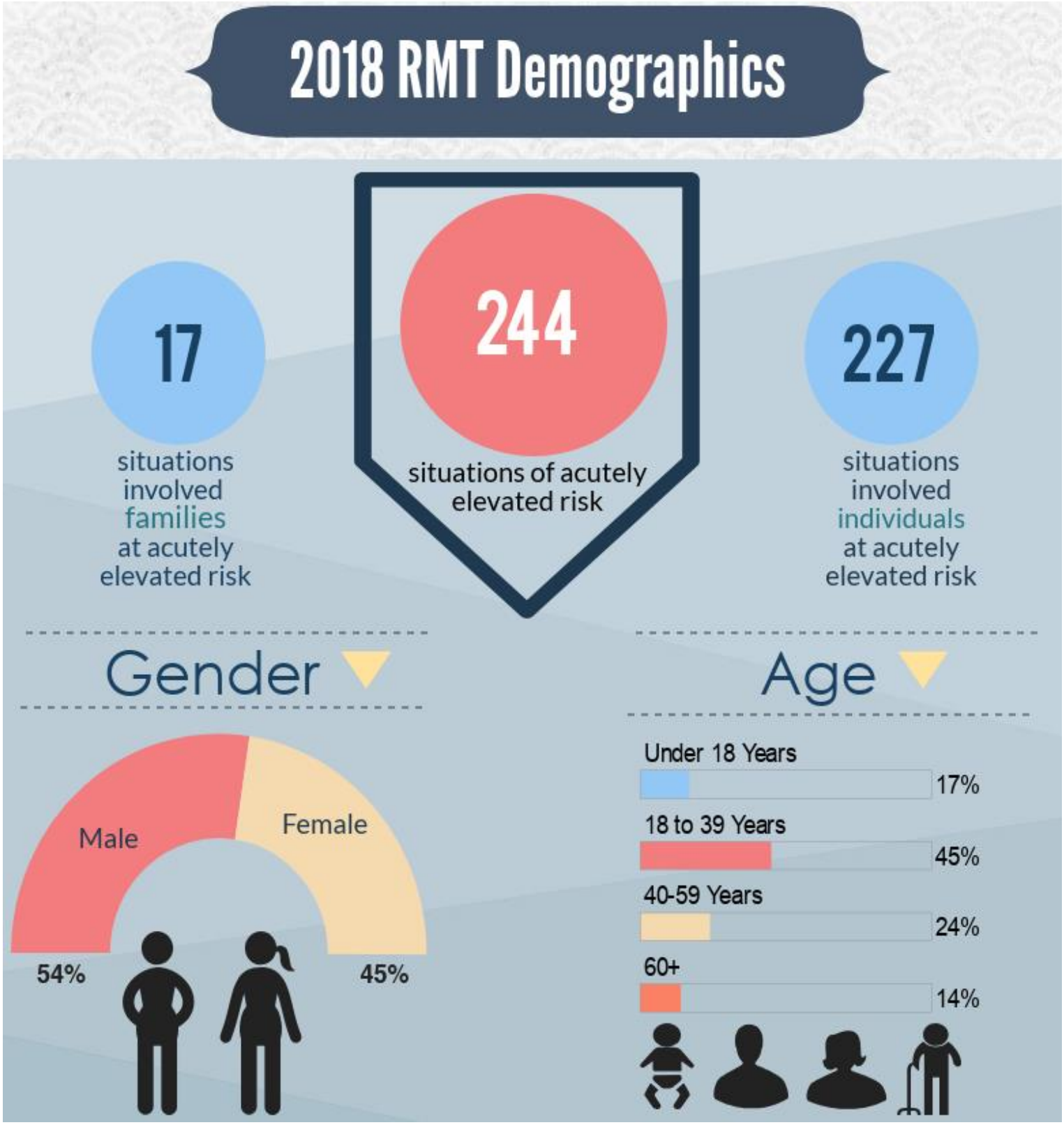
A total of 253 situations were presented to the Rapid Mobilization Table between January 1, and December 31, 2018. This reflects an increase of 122% over the number of referrals received in 2017 and the most referrals received in any given year of RMT activity. Of those, 244 (96%) met the CMS threshold of acutely elevated risk and required a multi-agency response (see Table 1). Again, this is the highest percentage of appropriate referrals received since the launch of the RMT in 2014. This increase is likely due to increased partner understanding of the threshold of risk, familiarity with the RMT process, and the strong, mutual trust that has developed between partner agencies.

Table 1
Situations presented to the Rapid Mobilization Table January 1, 2018 – December 31, 2018

	n	%
Situation met Acutely Elevated Risk (AER) threshold	244	96%
Situation did not meet Acutely Elevated Risk (AER) threshold	9	4%
Total	**253**	**100%**

It is important to note that even those situations that do not meet the CMS threshold of acutely elevated risk (4% in 2018) benefited from presentation to RMT. When situations do not proceed to response, partners are invited to share suggestions regarding next steps and possible follow-up to assist the presenting agency.




2018 RMT Demographics
17
situations involved families at acutely elevated risk
244
situations of acutely elevated risk
227
situations involved individuals at acutely elevated risk
Gender
Male
Female
54%
45%
Age
Under 18 Years
17%
18 to 39 Years
45%
40-59 Years
24%
60+
14%

Demographic Breakdown

The majority of RMT situations that required a multi-agency response, (i.e. met the threshold of acutely elevated risk), involved individuals at high risk of harm (93%). The remaining involved families (7%). No situations involved neighbourhoods, dwellings, or other environments during the 2018 reporting period.

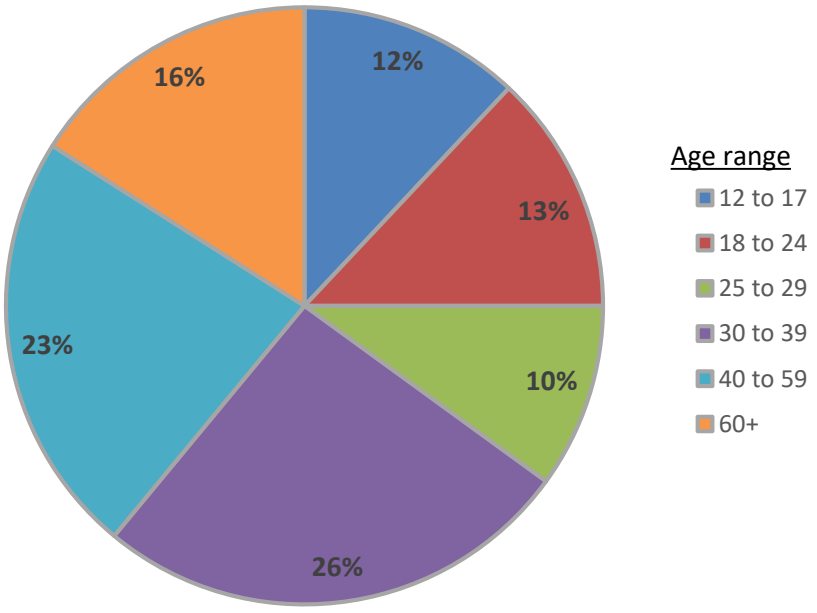
Table 2
Types of situations of acutely elevated risk between January 1, 2018 – December 31, 2018

Types of Situations of Acutely Elevated Risk	n	%
Person	227	93%
Family	17	7%
Total	**244**	**100%**

Presentations involving individuals

Of the situations that met the threshold of acutely elevated risk, the most frequently identified age group were adults aged 30-39 (24%) followed by adults between the ages of 50-59 (21%). Youth aged 12-17 represented 12% of presentations. No individual children under the age of 12 were referred to RMT in 2018.

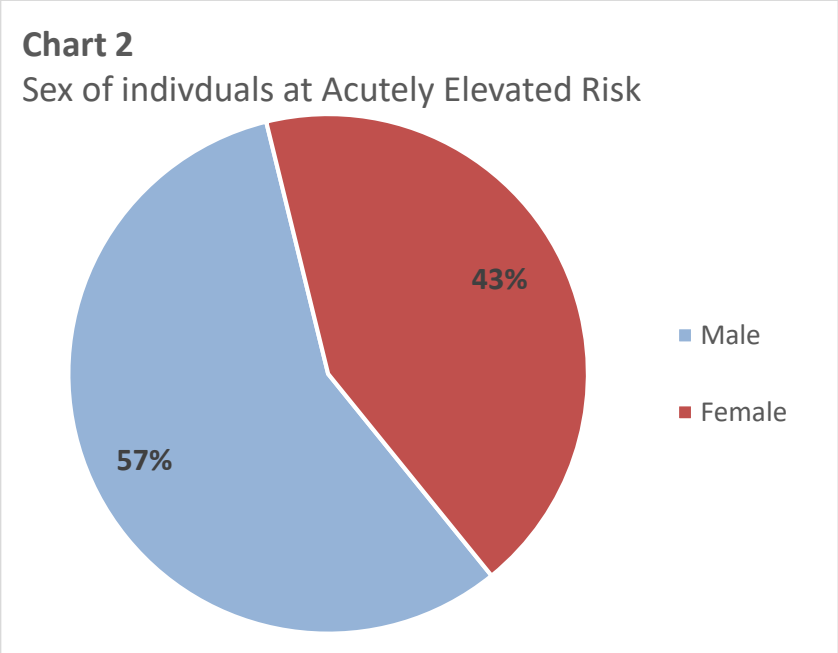
Chart 1
Age range of individuals at Acutely Elevated Risk

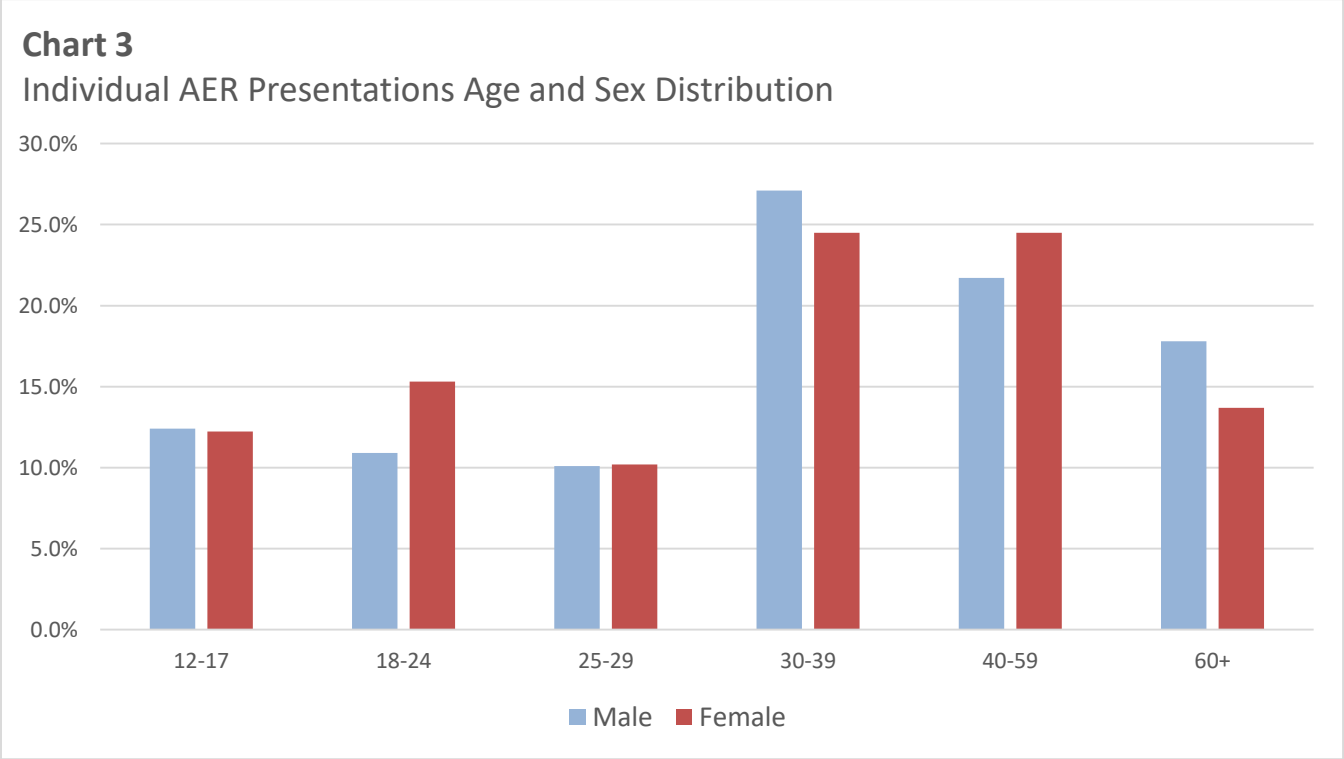


More than half (57%) of individuals presented to RMT were male compared to 43% female individuals.

The most common age range for individual males presented to the table was 30-39 years (27%). Female presentations were most often in the 30-39 age range (24%) as well as the 40-59 age range (24%).

Individuals aged 25-59 were evenly distibuted between sexes, while there were slightly more males presented in the 60+ age range and slightly more females in the 18-24 year cohort (**Chart 3).**



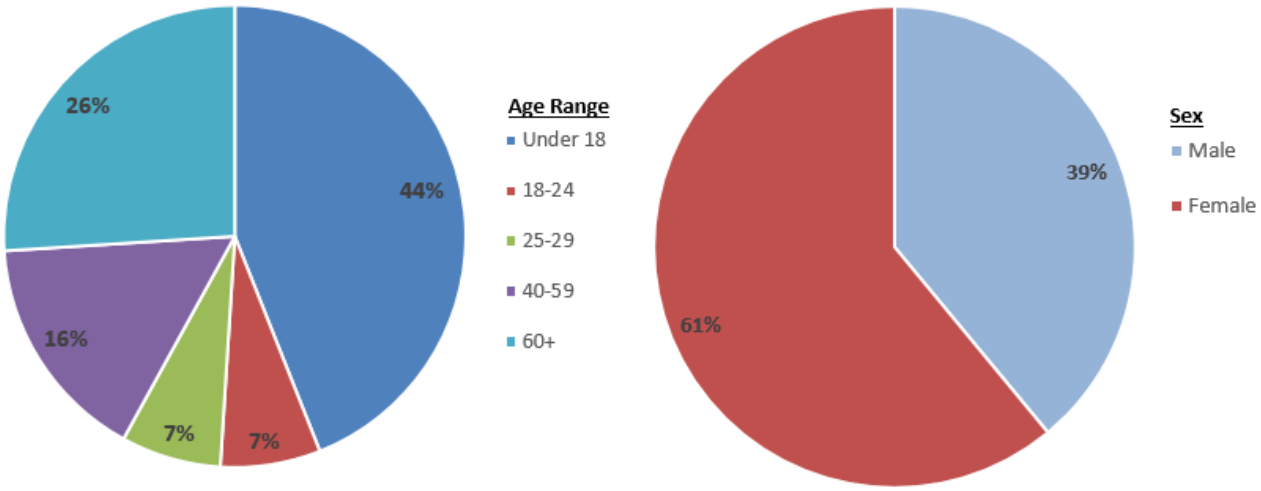


Presentations involving families

Seventeen of the AER presentations brought forward to RMT in 2018 involved families. Family demographics are captured independently on the Risk Tracking Database (RTD). **Chart 4** summarizes the age and sex distributions of this group. In total, 46 affected persons/family members were identified.

Chart 4

Family AER Demographics - Age and Sex distribution



Note regarding data limitations: In one situation, data was captured for the age ranges but gender was unknown. In another family presentation, no individual level demographics identified.

As demonstrated in the chart above, females were more often identified in family presentations than males (61% vs. 39%). This differs from the sex distribution seen in RMT presentations of individuals. Children and youth under 18 years of age were the most frequently identified age group in family presentations – involved in 44% of the 17 situations.

For reporting purposes, the adult age range groupings for family presentations are slightly different from those for individuals. The 25-29 and 30-39 cohorts were combined for family presentations as they represented only 7% of individuals in these presentations.

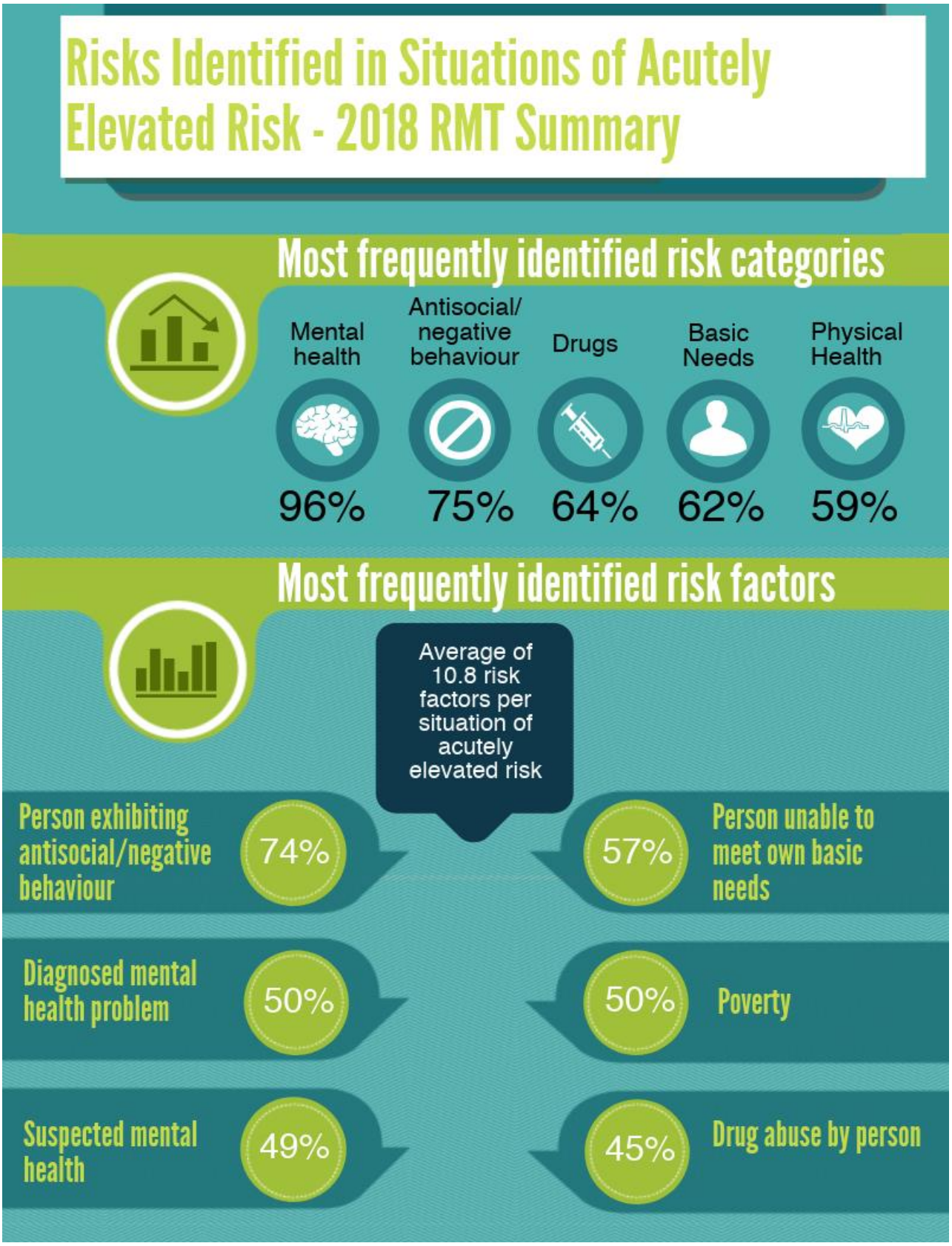
Adults aged 60+ were the second most frequently identified age group in the family presentations (26%), also more than in the individual presentations (16%).

Originating Agencies – All Presentations

As in previous years, the Greater Sudbury Police Service provided the most referrals to the table (44.3%), followed by Health Sciences North Mental Health & Addictions Program (HSN – MHAP) (17.4%), the City of Greater Sudbury Social Services (9.5%) and the Canadian Mental Health Association – Sudbury/Manitoulin branch (8.3%). The following table summarizes the partner referrals to the RMT.

Table 3
Originating agency referrals to RMT (n=253)

Agency	n	%
Greater Sudbury Police Service	112	44%
Health Sciences North – Mental Health & Addictions Program	44	17%
City of Greater Sudbury Social Services	24	10%
Canadian Mental Health Association	21	8%
Sudbury Paramedic Services	14	6%
Children's Aid Society of the Districts of Sudbury/Manitoulin	8	3%
Monarch Recovery Services	5	2%
North East Behavioural Supports Ontario	3	1%
Ontario Disability Support Program – MCCSS	3	1%
Rainbow District School Board	3	1%
Canadian Mental Health Association – Greater Sudbury Health Link	2	0.8%
Conseil scolaire catholique de Nouvel-Ontario	2	0.8%
Greater Sudbury Housing Corporation (non-partner agency)	2	0.8%
Homelessness Network	2	0.8%
Northeast Cancer Centre (non-partner agency)	2	0.8%
Christian Horizons (non-partner agency)	1	0.4%
Conseil scolaire public du Grand Nord de l'Ontario	1	0.4%
Kina Gbezhgomi (non-partner agency)	1	0.4%
Northern Initiative for Social Action (non-partner agency)	1	0.4%
Sudbury Community Service Centre	1	0.4%
Youth Justice Services – MCCSS	1	0.4%


Risks Identified in Situations of Acutely Elevated Risk - 2018 RMT Summary
Most frequently identified risk categories
Mental health
96%
Antisocial/ negative behaviour
75%
Drugs
64%
Basic Needs
62%
Physical Health
59%
Most frequently identified risk factors
Average of 10.8 risk factors per situation of acutely elevated risk
Person exhibiting antisocial/negative behaviour
74%
Person unable to meet own basic needs
57%
Diagnosed mental health problem
50%
Poverty
50%
Suspected mental health
49%
Drug abuse by person
45%

Risk Categories and Factors Contributing to Acutely Elevated Risk

Categories of risk

The Risk Tracking Database (RTD) used by CMS identifies and captures 27 risk categories to facilitate situation presentation, data collection and discussion. A new risk category, *Cognitive Functioning*, was added to the RTD this year, including three new risk factors:

- Cognitive Functioning – Diagnosed Cognitive Impairment/Limitation
- Cognitive Functioning – Suspected Cognitive Impairment/Limitation
- Cognitive Functioning – Self-reported Cognitive Impairment/Limitation

Since its introduction to the Rapid Mobilization Table in early fall, this risk category has been identified in eight situations (3%).

Between January 1 – December 31, 2018, *Mental Health* was the most frequently identified risk category, identified in nearly all situations of acutely elevated risk (96%, n=234). *Antisocial Negative Behaviour* occurred in three-quarters of cases (75%), followed by *Drugs* (64%), *Basic Needs* (62%) and *Physical Health* (59%).

These frequently identified risk categories results are similar to those identified in previous years (2014-2017). *Mental Health* has consistently been the most frequently identified risk category (84% between 2014-2017), often followed by *Antisocial Negative Behaviour* (53%) and *Drugs* (53%). *Basic Needs* and *Physical Health* were the next two most common risk categories in 2018, however in the three-year review, these were outweighed by criminal involvement (52%) and suicide (48%).

Table 4 provides a complete summary of the frequency of the 27 risk categories identified in situations of acutely elevated risk in 2018.

Table 4
Frequency of risk categories in RMT situations of acutely elevated risk 2018

Risk Category	**Total discussions (n) =244**	
	n	**%**
Mental Health	234	96%
Antisocial Negative Behaviour	183	75%
Drugs	155	64%
Basic Needs	151	62%
Physical Health	143	59%
Criminal Involvement	128	53%
Emotional Violence	122	50%
Poverty	122	50%
Alcohol	119	49%
Suicide	110	45%
Physical Violence	106	43%
Unemployment	101	41%
Negative Peers	100	41%
Self-Harm	85	35%
Threat to Public Health and Safety	82	34%
Housing	59	24%
Crime Victimization	57	23%
Parenting	47	19%
Social Environment	38	16%
Missing	37	15%
Missing School	25	10%
Sexual Violence	22	9%
Supervision	12	5%
Elderly Abuse	9	4%
Gangs	9	4%
Cognitive Functioning	8	3%
Gambling	0	0

Risk Categories Impacting Individuals and Families

Mental Health was the most frequently identified risk category for situations involving both individuals (96%) and families (100%). *Antisocial Negative Behaviour*, *Drugs* and *Basic Needs* all featured in the top five most frequently identified risk factors for these groups. *Physical Health* was identified more often for individuals versus *Parenting* which was identified more often in family presentations. A summary of the top ten risk categories for these groups is provided in **Table 5** below.

Table 5
Most frequently identified risk categories impacting individuals and families

Individuals at risk (n=227)			**Families at risk (n=17)**		
	n	**%**		**n**	**%**
Mental Health	217	96%	**Mental Health**	17	100%
Antisocial Negative Behaviour	173	76%	**Parenting**	11	65%
Drugs	145	64%	**Antisocial Negative Behaviour**	10	59%
Basic Needs	142	66%	**Drugs**	10	59%
Physical Health	136	60%	**Basic Needs**	9	53%
Criminal Involvement	120	53%	**Emotional Violence**	9	53%
Emotional Violence	113	50%	**Poverty**	9	53%
Poverty	113	50%	**Criminal Involvement**	8	47%
Alcohol	112	49%	**Negative Peers**	8	47%
Suicide	104	46%	**Physical Violence**	8	47%

Risk Categories & Age Groups

Summarized below are the most commonly identified risk categories for children/youth under 18; adults aged18-39; adults aged 40-59 and adults aged 60+.

Mental Health was the most commonly identified risk category for all of the adult groups (99%, 96%, and 94%). It was the third most commonly identified risk category among children/youth under 18 (82%), following *Antisocial Negative Behaviour* (89%) and *Negative Peers* (86%). *Drugs* was a common risk category amongst those 18 and under (75%), 18-39 (81%) and 40-59 (52%), but was much less common (6%) amongst those aged 60+. **Table 6** summarizes the most frequently identified risk categories ranked for each age group.

Table 6
Most frequently identified risk categories by age group (individual presentations)

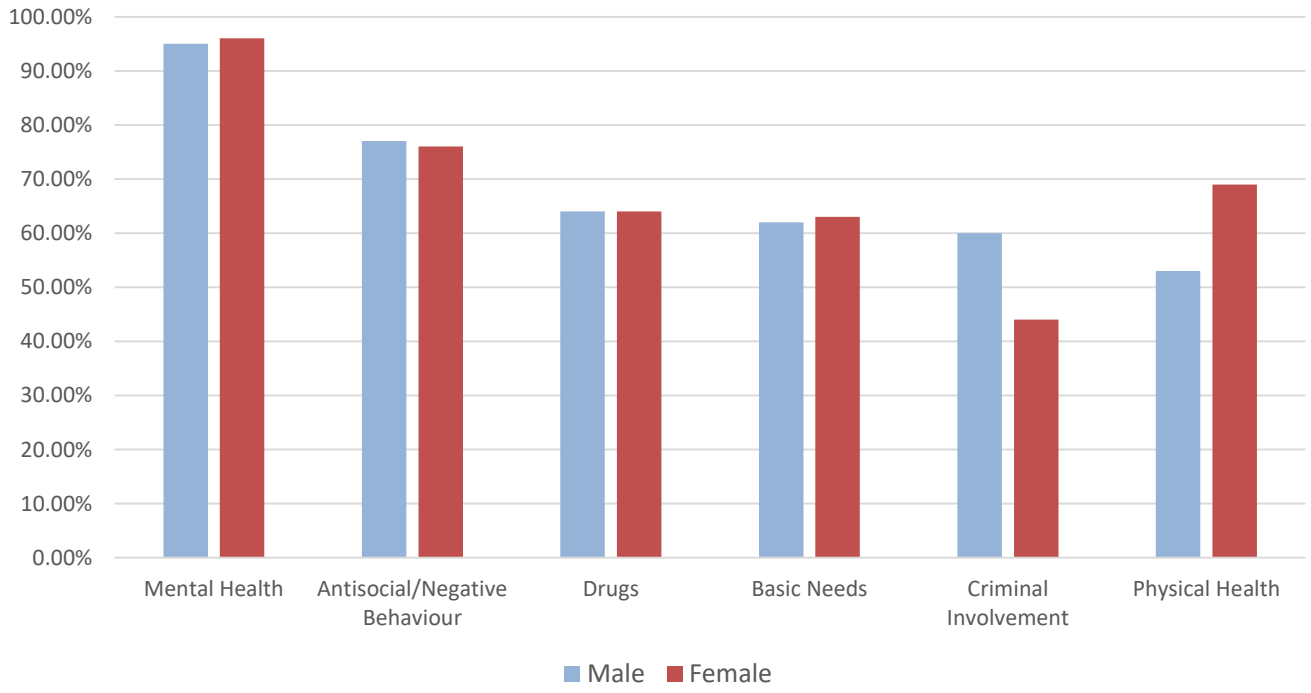
Rank	Under 18 years (n=28)	n (%)	18-39 Years (n=111)	n (%)	40-59 Years (n=52)	n (%)	60+ years (n=36)	n (%)
1	Antisocial Negative Behaviour	**25** (89%)	Mental Health	**110** (99%)	Mental Health	**50** (96%)	Mental Health	**34** (94%)
2	Negative Peers	**24** (86%)	Drugs	90 (81%)	Antisocial Negative Behaviour	**40** (77%)	Basic Needs	**32** (89%)
3	Mental Health	**23** (82%)	Antisocial Negative Behaviour	**89** (80%)	Physical Health	**37** (71%)	Physical Health	**31** (86%)
4	Drugs	**21** (75%)	Basic Needs	**73** (66%)	Unemployment	**33** (63%)	Antisocial Negative Behaviour	**19** (53%)
5	Physical Violence	**21** (75%)	Criminal Involvement	**72** (65%)	Drugs	**32** (62%)	Poverty	**15** (42%)
6	Criminal Involvement	**20** (71%)	Suicide	65 (59%)	Basic Needs	**29** (56%)	Alcohol	**14** (39%)
7	Emotional Violence	**20** (71%)	Poverty	**65** (59%)	Poverty	**29** (56%)	Emotional Violence	**9** (25%)
8	Parenting	**17** (61%)	Physical Health	**62** (56%)	Alcohol	**25** (48%)	Threat to public health and safety	**9** (25%)
9	Missing School	**17** (61%)	Unemployment	**62** (56%)	Emotional Violence	**25** (48%)	Housing	**9** (25%)
10	Missing	**16** (57%)	Alcohol	**60** (54%)	Suicide	**22** (42%)	Elder Abuse	**8** (22%)

Risk Categories & Sex

In general, the most frequently identified risk categories were the same for both males and females, with the exception of *Criminal Involvement,* identified more frequently among males and *Physical Health,* identified more frequently among females (**Chart 5**).

Chart 5

Most frequently identified risk categories by sex



Risk Categories Identified in Situations of Acutely Elevated Risk by Sex and Age - 2018 RMT Summary

Risk categories by sex

Male		Female	
96%	Mental Health	95%	Mental Health
77%	Antisocial/Negative Behaviour	76%	Antisocial/Negative Behaviour
64%	Drugs	69%	Physical Health
62%	Basic Needs	64%	Drugs

Risk categories by age group

Under 18 Years		18 to 39		40 to 59		60+	
Antisocial/Negative Behaviour	89%	Mental health	99%	Mental health	96%	Mental health	94%
Negative Peers	86%	Drugs	81%	Antisocial/Negative Behaviour	77%	Basic Needs	89%
Mental Health	82%	Antisocial/Negative Behaviour	80%	Physical Health	71%	Physical Health	86%

Risk Factors

The RTD tracks 105 distinct risk factors grouped within 27 risk categories. For example, *Antisocial/Negative Behaviour* is a risk category. It includes two risk factors: *antisocial/negative behaviour within the home* and *person exhibiting antisocial/negative behaviour*. Capturing specific risk factors within a risk category provides table members with a clearer understanding of the situation and a more informed assessment of acutely elevated risk.

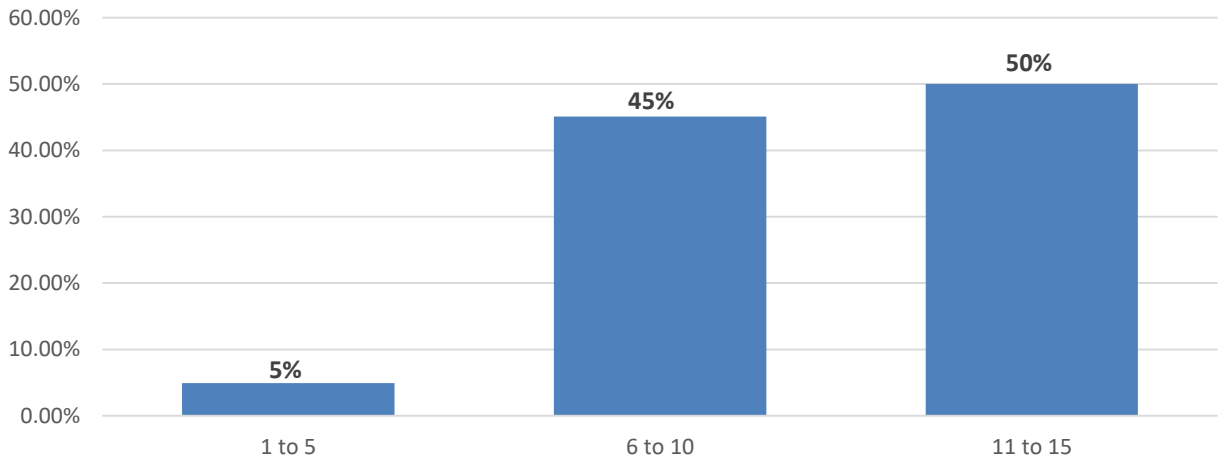
In 2018, 2,629 risk factors were captured during the 244 RMT discussions that met the threshold of acutely elevated risk.

The RTD allows for a maximum collection of 15 risk factors per discussion. This year, every age group except for adults aged 60+ had discussions that included 15 distinct risk factors. The average number of risk factors per discussion was 10.8; this was the same for both males and females.

Half of the 2018 RMT discussions that met the threshold of acutely elevated risk had between 11 and 15 risk factors. Less than 10% had between one and five uniquely identified risk factors (**Chart 6**).

Chart 6

Number of risk factors presented per sitaution of actuely elevated risk - 2018



While the average number of risk factors identified per discussion was similar amongst age groups, children/youth aged 17 and under had the highest average per discussion (12.8). Those aged 60+ had the lowest average of 7.3 risk factors per discussion. See **Table 7** for a full summary.

Table 7
Average risk factors per discussion across age groups

Age Group	Average Risk Factors per discussion
12-17	12.8
18-24	12.5
25-29	11.1
30-39	11.6
40-59	10.1
60+	7.3

Mental Health was the most frequently occurring risk category; this category includes seven individual risk factors.

Two risk factors in this category, *Mental Health – diagnosed mental health problem* and *Mental Health – suspected mental health problem* were two of the most frequently identified risk factors, occurring in about 50% of all AER discussions. *Antisocial/Negative Behaviour – person exhibiting antisocial/negative behaviour* was the most commonly occurring risk factor, identified in 74% of all discussions (**Table 8**).

Table 8
Most frequently identified risk factors in situations of acutely elevated risk

Risk Factor	n = 244	%
Antisocial Negative Behaviour – person exhibiting	180	74%
Basic Needs – person unable to meet own basic needs	138	57%
Mental Health – diagnosed mental health problem	122	50%
Poverty	122	50%
Mental Health – suspected mental health problem	119	49%
Drugs – drug abuse by person	110	45%
Physical Health – general health issue	107	44%
Negative Peers – person associating with negative peers	93	38%
Unemployment – person chronically unemployed	85	35%
Alcohol – alcohol abuse by person	84	34%

Table 9
Most frequently identified risk factors in individual presentations by sex

Rank	Female (n=98)	n (%)	Male (n=129)	n (%)
1	Antisocial/Negative behaviour – person exhibiting antisocial/negative behaviour	**73** (74%)	Antisocial negative behaviour – person exhibiting antisocial/negative behaviour	**98** (76%)
2	Basic Needs – person unable to meet own basic needs	**56** (57%)	Basic Needs – person unable to meet own basic needs	**73** (57%)
3	Mental Health – diagnosed mental Health problem	**48** (49%)	Threat to public health and safety	**69** (53%)
4	Physical Health – general health issue	**48** (49%)	Poverty – person living in less than adequate financial situation	**68** (52%)
5	Drugs – drug abuse by person	**47** (48%)	Mental Health – diagnosed mental health problem	**66** (51%)
6	Mental Health – suspected mental health problem	**47** (48%)	Mental Health – suspected mental health problem	**62** (48%)
7	Poverty – person living in less than adequate financial situation	**45** (46%)	Drugs – drug abuse by person	**58** (45%)
8	Negative Peers – person associating with negative peers	**43** (44%)	Physical Health – general health issue	**54** (42%)
9	Suicide – person previous suicide risk	**38** (39%)	Mental Health – not following prescribed treatment	**50** (39%)
10	Unemployment – person chronically unemployed	**38** (39%)	Physical Violence – person perpetrator of physical violence	**48** (37%)

Table 10
Most frequently identified risk factors in individual presentations by age group

Rank	Under 18 years (n=28)	n (%)	18-39 Years (n=111)	n (%)	40-59 Years (n=52)	n (%)	60+ years (n=36)	n (%)
1	Antisocial negative behaviour – person exhibiting antisocial/negative behaviour	**25** (89%)	Antisocial negative behaviour – person exhibiting antisocial/negative behaviour	**88** (79%)	Antisocial negative behaviour – person exhibiting antisocial/negative behaviour	**39** (75%)	Basic Needs – person unable to meet own basic needs	**29** (81%)
2	Negative Peers – person associating with negative peers	**24** (86%)	Basic Needs – person unable to meet own basic needs	70 (63%)	Mental Health – diagnosed mental health problem	**29** (56%)	Physical Health – general health issue	**24** (67%)
3	Physical Violence – person perpetrator of physical violence	**17** (61%)	Drugs – drug abuse by person	**69** (62%)	Poverty – person living in less than adequate financial situation	**29** (56%)	Mental Health – suspected mental health problem	22 (61%)
4	Missing/Runaway – person has history of being reported to police as missing	**16** (57%)	Poverty – person living in less than adequate financial situation	**65** (59%)	Unemployment - chronic	**28** (54%)	Antisocial negative behaviour – person exhibiting antisocial/negative behaviour	**19** (53%)
5	Missing School – truancy	**16** (57%)	Mental Health – diagnosed mental health problem	**62** (56%)	Physical Health – general health issue	**27** (52%)	Poverty – person living in less than adequate financial situation	**15** (42%)
6	Emotional Violence – person perpetrator of emotional violence	**15** (54%)	Mental Health – suspected mental health problem	52 (47%)	Basic needs – person unable to support own basic needs	**23** (44%)	Physical Health – chronic disease	**14** (39%)
7	Drugs – drug abuse by person	**14** (50%)	Unemployment – person chronically unemployed	**51** (46%)	Mental Health – suspected mental health problem	**23** (44%)	Alcohol – alcohol abuse by person	**12** (33%)
8	Parenting – parent-child conflict	**13** (46%)	Suicide – person previous suicide risk	**50** (45%)	Mental Health – not following prescribed treatment	**21** (40%)	Mental Health – diagnosed mental health problem	**11** (31%)
9	Mental Health – suspected mental health problem	**12** (43%)	Negative Peers – person associating with negative peers	**47** (42%)	Drugs – drug abuse by person	**20** (38%)	Basic Needs – person unwilling to meet own basic needs	**9** (25%)
10	Emotional Violence– person victim of emotional violence	**12** (43%)	Threat to public health and safety	**47** (42%)	Threat to public health and safety	**19** (37%)	Housing – person doesn't have access to appropriate housing	**9** (25%)

Study Flags

Study flags are additional considerations that may help to guide RMT responses. In late 2018, seven new study flags were added to the RTD, bringing the total number of study flags collected to 33. The new study flags added were:

- Custody Issues/Child Welfare
- Gender Issues
- Lack of Supports for Elderly Person(s)
- Methamphetamine Use
- Problematic Opioid Use
- Risk of Radicalization
- Wait List

RMT partner agencies have begun including study flags more frequently in their presentations; in total, 228 (93%) of the AER presentations brought to RMT included study flags. Although the RTD allows for up to 15 study flag entries per discussion, most cases had between one and four entries, and the maximum number identified was 11. This amounted to 504 unique study flags captured in 2018 (**Table 11**).

Table 11
Study Flags identified per discussion

Number of Study Flags per discussion	Percent of discussions with study flags (n=228)
1 to 4	94%
5 to 8	5%
9 to 11	1%

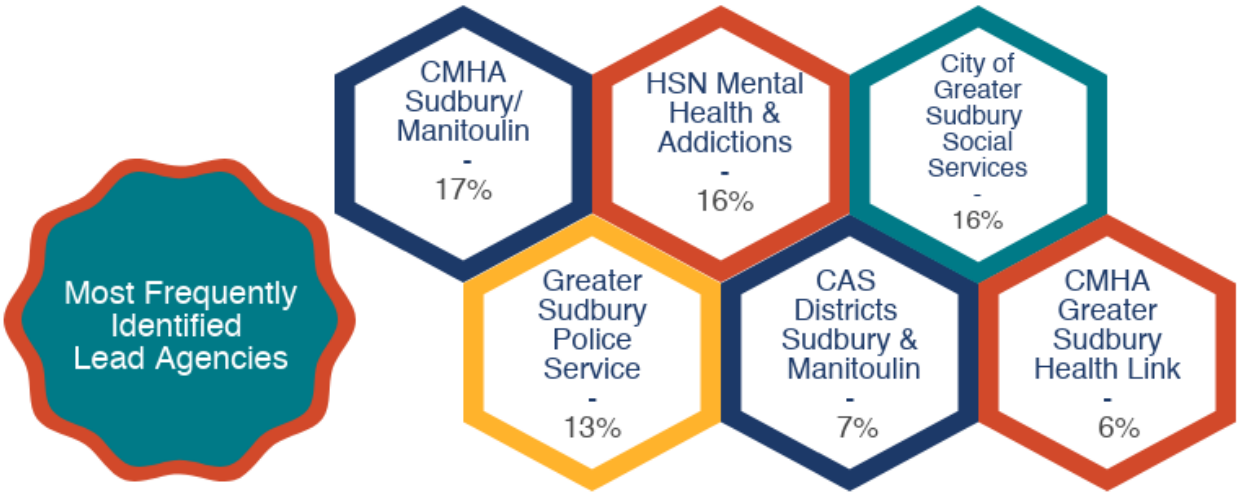
Social Isolation was the most frequently identified study flag; identified in 50% of discussions, followed by *Risk of Losing Housing/Unsafe Living Conditions* (46%). **Table 12** provides a summary of identified study flags.

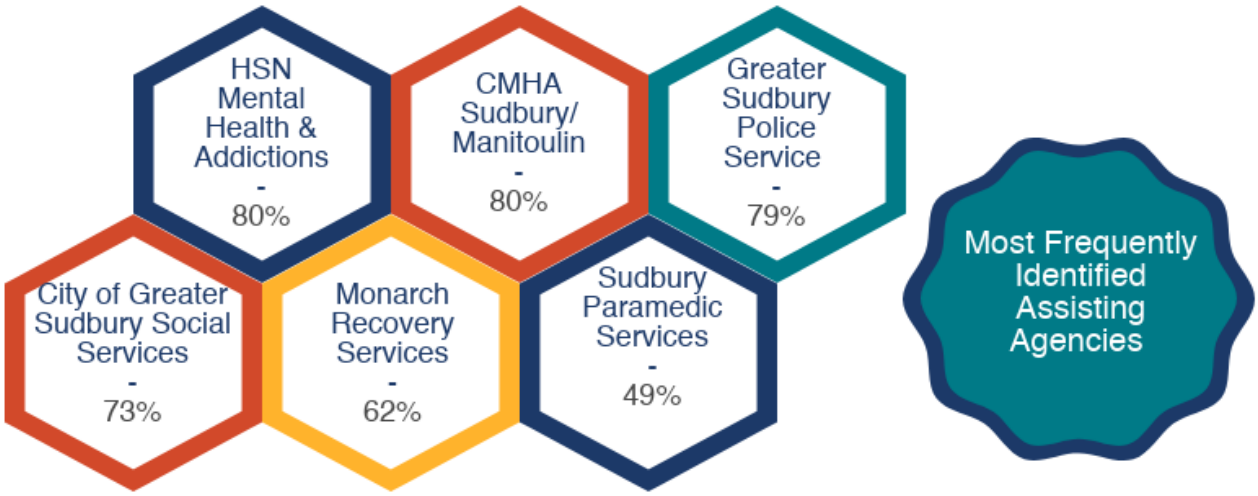
Table 12
Most frequently identified study flags in situations of acutely elevated risk

Study Flag	n = 244	%
Social Isolation	123	50
Risk of Losing Housing/Unsafe Living Conditions	113	46
Homelessness	74	30
Cultural Considerations	41	17
Domestic Violence	21	9
Developmental Disability	15	6.
Recent Escalation	15	6.
Cognitive Disability	11	5
Sex Trade	10	4
Acquired Brain Injury	9	4
Fire Safety	7	3
Homicidal Ideation	6	2

RMT RESPONSES 2018

Agency Involvement





Lead and assisting agencies participate in each RMT response based on their mandate and capacity to respond to the risk factors presented. All responding agencies contribute to the planning of the response based on their prior involvement or the perspective that they bring to understanding the situation. Their active role in the response is determined as part of Filter 3 and 4 planning. The lead agency is responsible for coordinating the response and providing a report back at the next RMT meeting.

Partner agency involvement in RMT situations

An average of eight agencies were involved in responses between January 1 and December 31 of this year. The Greater Sudbury Police Service presented the highest number of situations to RMT (44%, n=112) and were involved in a total 225 (89%) of responses (either lead or assisting). Other agencies frequently involved in responses include Health Sciences North (93%, n=236), CMHA Sudbury/Manitoulin (93%, n=235) and the City of Greater Sudbury Social Services (86%, n=217).

CMHA Sudbury/Manitoulin was the most frequently identified lead agency during responses (17% of all responses), followed by Health Sciences North and the City of Greater Sudbury Social Services (each leading 16% of responses). **Table 13** provides a summary of partner agency involvement in RMT situations.

Table 13
Agency involvement in situations of acutely elevated risk 2018

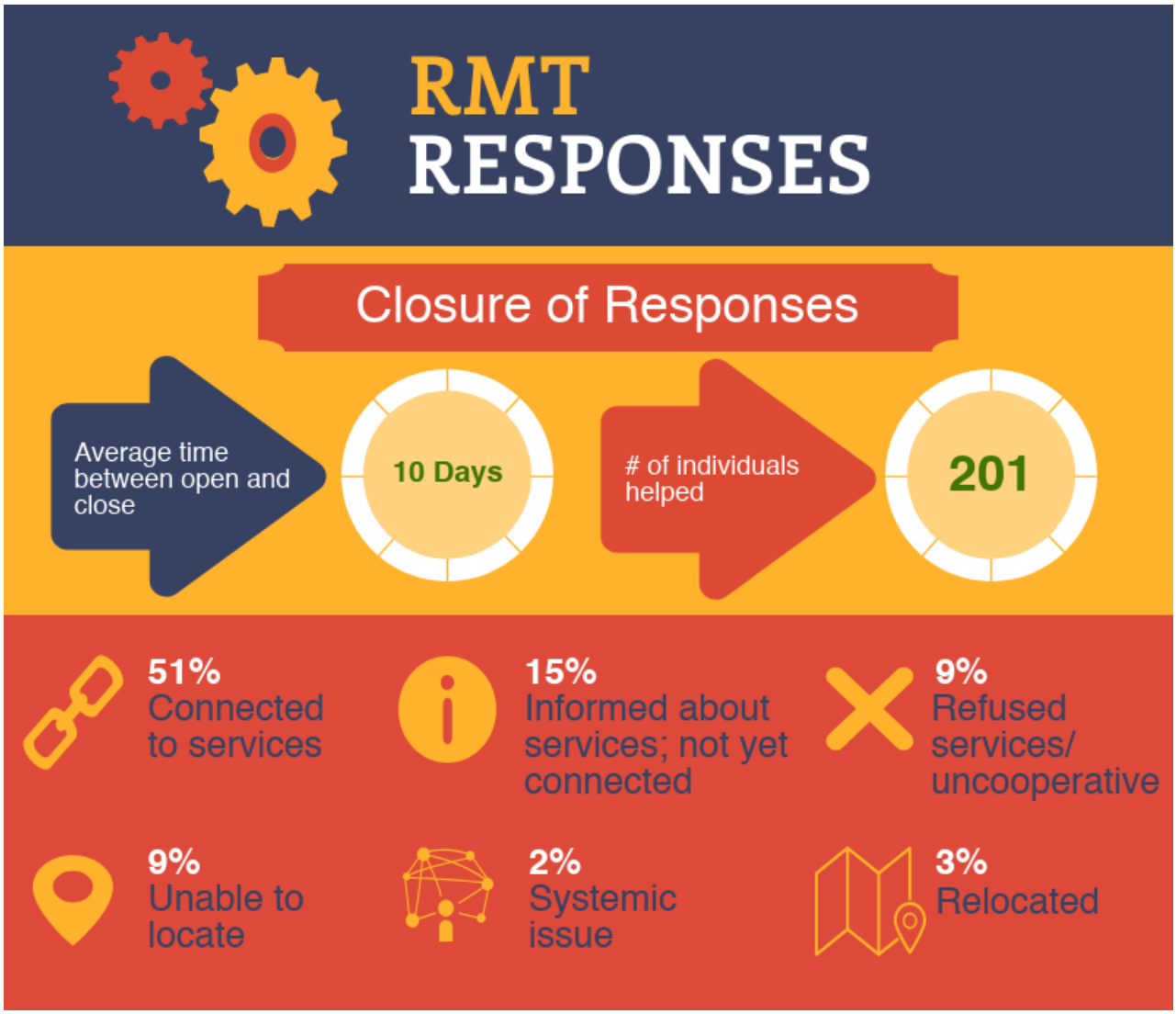
	Originating (n=253)		Lead (n=244)		Assisting (n=244)		Overall Engagement (253 discussions)	
	n	%	n	%	n	%	n	%
Health Sciences North - Mental Health & Addictions	44	17%	40	16%	195	80%	236	93%
Canadian Mental Health Association - Sudbury/Manitoulin	21	8%	41	17%	194	80%	235	93%
Greater Sudbury Police Service	112	44%	31	13%	192	79%	225	89%
City of Greater Sudbury Social Services	24	9%	40	16%	177	73%	217	86%
Monarch Recovery Services	5	2%	13	5%	151	62%	165	65%
Sudbury Paramedic Services	14	6%	3	1.2%	119	49%	124	49%
Homelessness Network	2	0.8%	3	1.2%	96	39%	99	39%
Sudbury Action Centre for Youth	0	0%	4	1.6%	82	34%	86	34%
Ontario Disability Support Program - Ministry of Children, Community and Social Services	3	1.1%	2	0.8%	74	30%	77	30%
Children's Aid Society of the Districts of Sudbury and Manitoulin	8	3%	16	7%	55	23%	71	28%
Sudbury and Area Victim Services	0	0%	2	0.8%	53	22%	55	22%
Réseau Access Network	0	0%	2	0.8%	50	20%	52	21%
North East Local Health Integration Network	0	0%	8	3%	44	18%	52	21%
Shkagamik-Kwe Health Centre	0	0%	2	0.8%	43	18%	45	18%
N'Swakamok Native Friendship Centre	0	0%	2	0.8%	45	18%	47	17%
Canadian Mental Health Association - Greater Sudbury Health Link	2	0.8%	14	6%	29	12%	43	17%
John Howard Society of Sudbury	0	0%	1	0.4%	36	15%	37	15%
Sudbury Counselling Centre	0	0%	0	0%	27	11%	27	11%
Sudbury Community Service Centre	1	0.4%	4	1.6%	26	11%	30	12%
North East Behavioural Supports Ontario	3	1.2%	4	1.6%	22	9%	26	10%
Rainbow District School Board	3	1.2%	2	0.8%	18	7%	21	8%
Public Health Sudbury & Districts	0	0%	0	0%	15	6%	15	6%
Adult Probation and Parole – Ministry of the Solicitor General	0	0%	0	0%	14	6%	14	6%
Youth Justice Services - Ministry of Children, Community and Social Services	1	0.4%	2	0.8%	14	6%	16	6%
March of Dimes Canada	0	0%	0	0%	13	5%	13	5%
Elizabeth Fry Society of Sudbury	0	0%	1	0.4%	12	5%	13	5%
Child and Family Centre	0	0%	0	0%	10	4%	10	4%

Table 13, continued
Agency involvement in situations of acutely elevated risk 2018

	Originating (n=253)		Lead (n=244)		Assisting (n=244)		Overall Engagement (253 discussions)	
Kina Gbezhgomi	1	0.4%	2		7	3%	9	3.6%
TG Innerselves	0	0%	0	0%	6	2%	6	2.4%
Greater Sudbury Housing Corporation	2	0.8%	0	0%	5	2%	5	2%
Northern Initiative for Social Action	1	0.4%	1	0.4%	4	1.6%	5	2%
Conseil scolaire public du Grand Nord de l'Ontario	1	0.4%	0	0%	4	1.6%	5	2%
Sudbury Fire Services	0	0%	0	0%	4	1.6%	4	1.6%
Northeast Cancer Centre	2	0.8%	0	0%	4	1.6%	4	1.6%
Conseil scolaire catholique du Nouvel-Ontario	2	0.8%	1	0.4%	3	1.2%	4	1.6%
Developmental Services Ontario - Sudbury	0	0%	0	0%	4	1.6%	4	1.6%
Sudbury Catholic District School Board	0	0%	0	0%	3	1.2%	3	1.2%
Legal Aid Ontario - Sudbury	0	0%	0	0%	3	1.2%	3	1.2%
Restorative Justice of Sudbury	0	0%	0	0%	2	0.8%	2	0.8%
Nogdawindamin Family and Community Services	0	0%	0	0%	2	0.8%	2	0.8%
Violence Intervention and Prevention Program/VOICES for Women	0	0%	0	0%	1	0.4%	1	0.4%
Genevra House	0	0%	0	0%	1	0.4%	1	0.4%
Independence Centre and Network Sudbury	0	0%	0	0%	1	0.4%	1	0.4%
Laurentian University	0	0%	0	0%	1	0.4%	1	0.4%
Canadian Hearing Society Sudbury	0	0%	0	0%	1	0.4%	1	0.4%
YMCA - Sudbury	0	0%	0	0%	1	0.4%	1	0.4%
Alzheimer Society of Sudbury-Manitoulin North Bay & Districts	0	0%	0	0%	1	0.4%	1	0.4%
Big Brothers Big Sisters of Greater Sudbury	0	0%	0	0%	1	0.4%	1	0.4%
Christian Horizons	1	0.4%	1	0.4%	0	0%	1	0.4%

Situation resolution

Among the 244 situations of acutely elevated risk referred to the RMT in 2018, 201 individuals were identified to have been helped by RMT interventions. On average, situations remained open for 10 days (minimum 2 days, maximum 30 days).



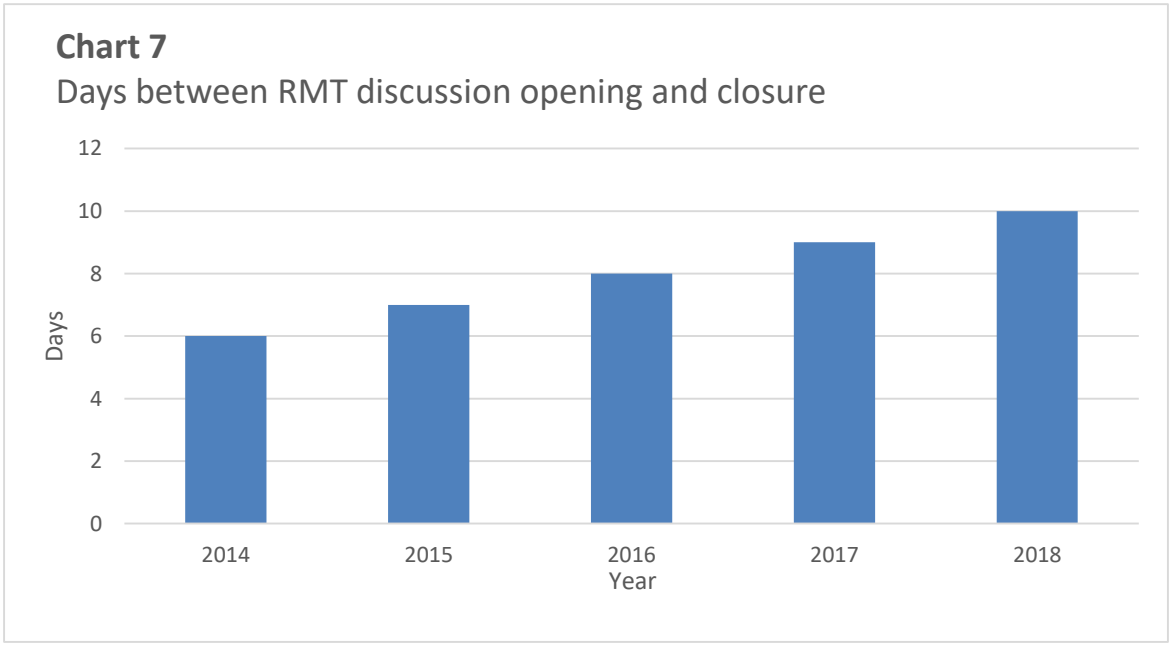
An additional 9% of situations closed as "*Overall Risk Lowered – Through no action of the situation table*". In early filter discussions, the risk factors and situation description met the threshold of Acutely Elevated Risk, however, after further discussion and limited information sharing, it was identified that further response by RMT was not required.

The percentage of discussions concluded with the closure variable "*Risk lowered – Connected to services*" is similar to the result in 2017 (50% in 2017 vs. 51%). There has been a small decrease in the number of situations closed as "*Informed about services; not yet connected*" – 20% in 2017 down to 15% in 2018.

The average number of days between opening a referral to RMT and its closure has been increasing over time (Chart 7).

Factors influencing the amount of time that situations remain open include:

- Trying to locate individuals (unknown incarceration, unknown housing)
- Coordinating participation from other non-CMS partner agencies
- Providing individuals with additional time to engage with appropriate services
- Highly complex histories of being at risk including challenging relationships with many service providers
- Seasonal breaks, conferences and trainings that impact table members' capacity to participate in RMT responses



Services Mobilized

When closing discussions, RMT members have the opportunity to identify which services were offered or provided to the individual during the response. In order to track this, the team has a generalized list of services that correlates with the options captured in the Risk Tracking Database (RTD). Additionally, team members identify the level of service mobilization (i.e. whether the individual or family refused, was informed of, connected to, or engaged with that service because of the RMT intervention).

Of the situations where the team identified services mobilized, the number of services identified ranged from one to eleven, with an average of three services mobilized documented. *Mental Health* was the most frequently identified service mobilized (136 times in 244 discussions), followed by *Housing* (identified 83 times in the 244 discussions) and *Addictions* (77 times in the 244 discussions).

Table 14
Top 10 most frequently identified services mobilized and type of mobilization

Service	Informed	Connected	Engaged	Refused	Total
Mental Health	53	69	11	1	136
Housing	38	36	8	1	83
Addictions	47	24	4	2	77
Social Assistance	14	27	10	5	56
Medical Health	11	31	6	0	48
Counselling	18	24	1	0	43
Social Services	10	22	2	0	34
Harm Reduction	17	13	1	0	31
Victim Support	9	10	4	0	23
Life Skills	13	7	1	1	22

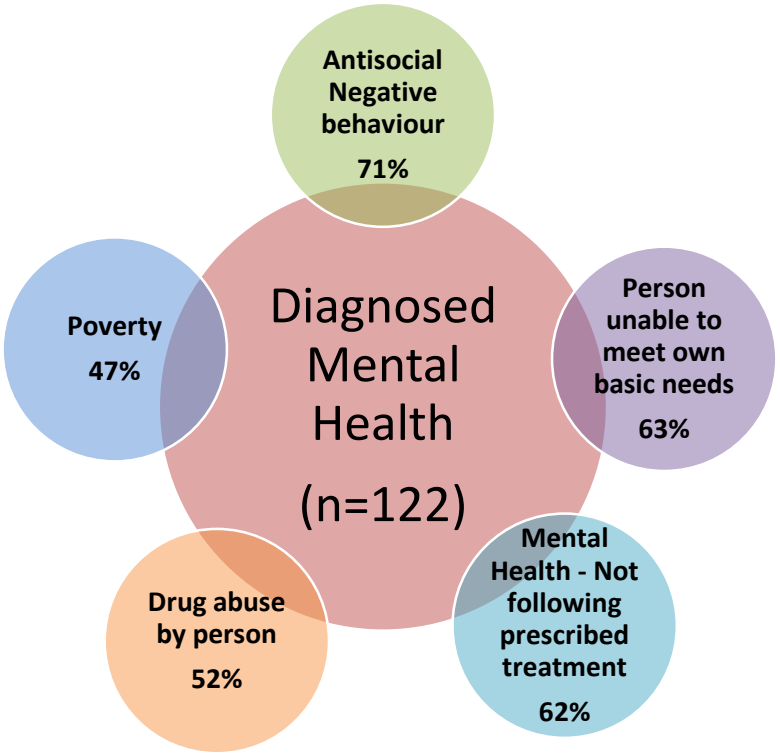
Systemic Issues

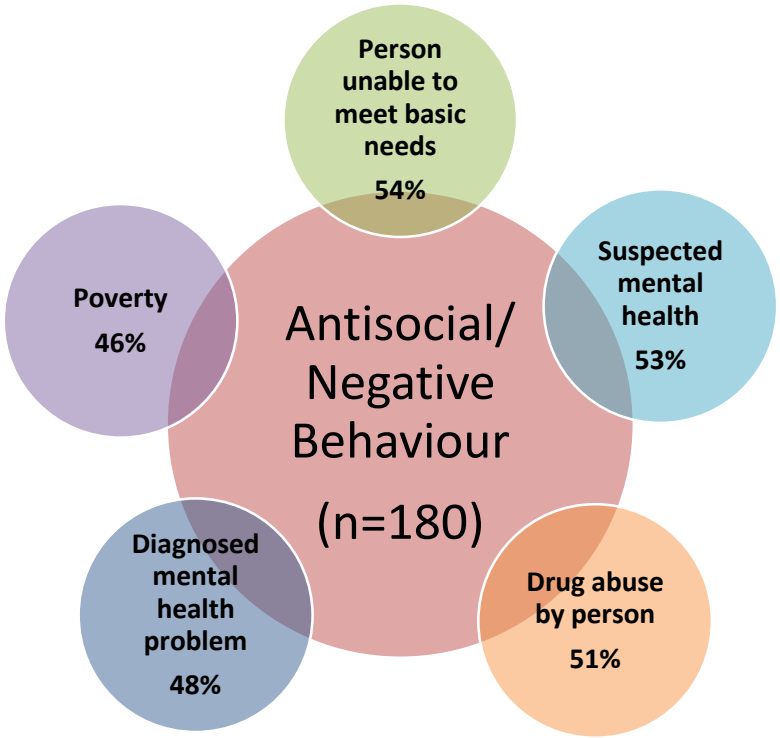
In the fall, the Provincial Situation Table Community of Practice (CoP) introduced a Systemic Issues tracking sheet. This tracking sheet incorporates clear definitions of systemic issues identified by the CoP, and enables situation tables to consistently track systemic issues that arise across the province.

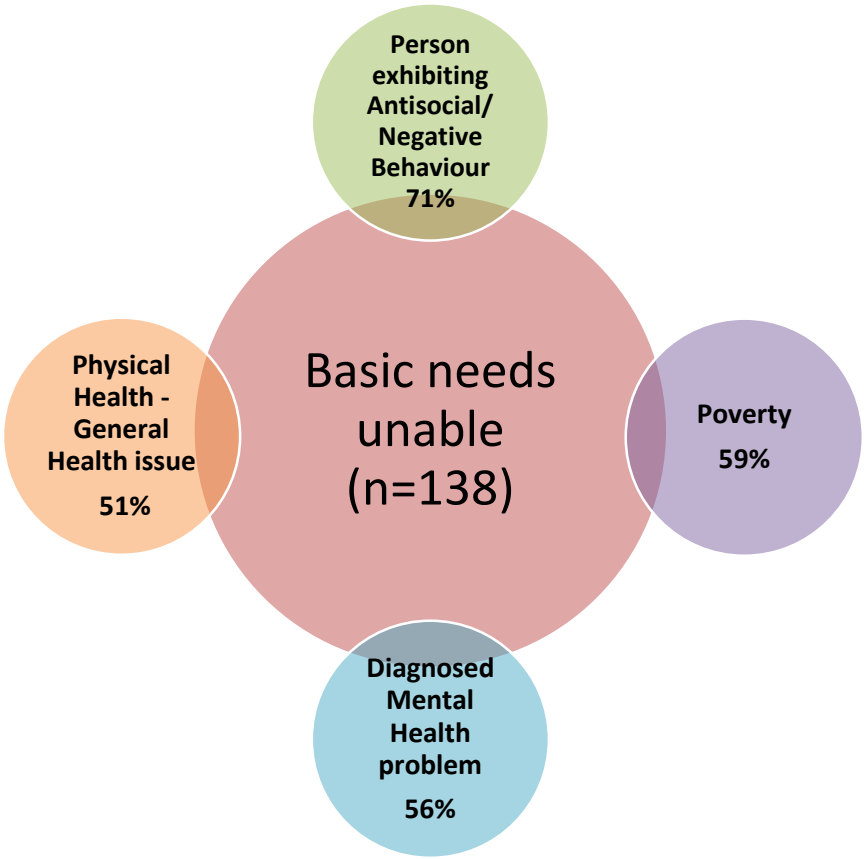
At RMT, 2% of situations (n=4) were closed as “Still AER – Systemic Issue”, most of which were related to the issue ‘Waitlist’, defined as *the length of time before someone is seen for a service in order to mitigate risk.* As collection and tracking of systemic issues is a new RMT practice, this data is not meant to reflect the true scope of systemic issues presented at RMT. Rather, it is meant to illustrate the new potential for future RMT data analysis

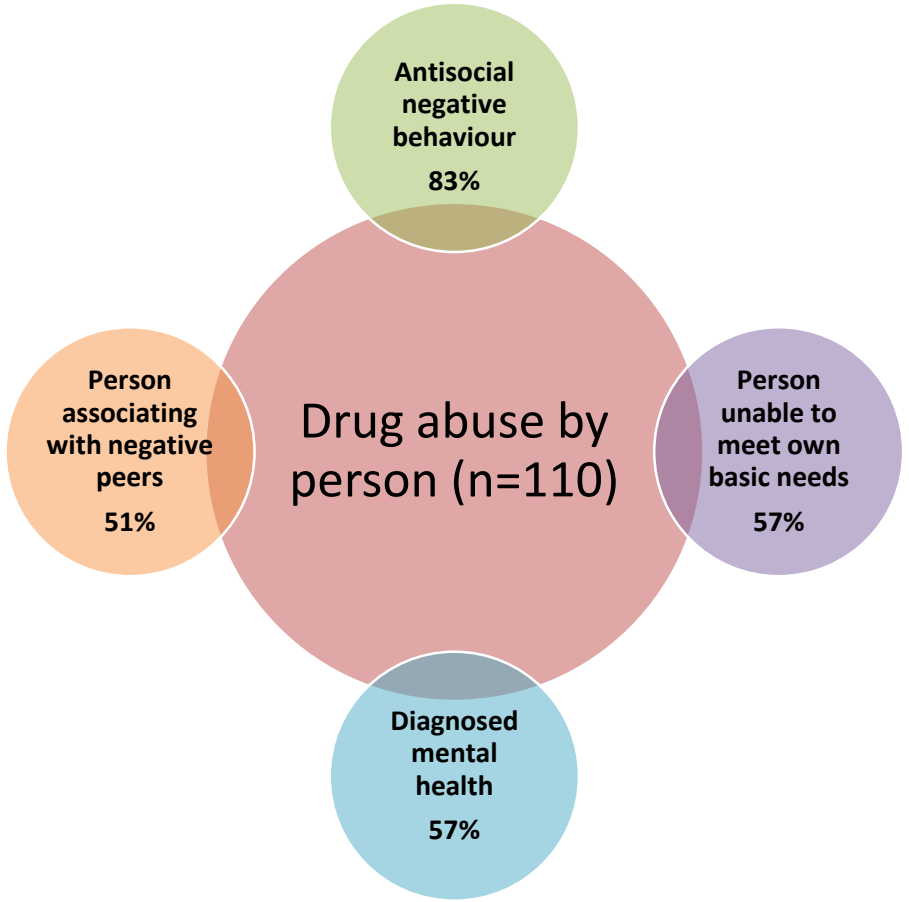
Appendix A – Co-Occurring Risk Factors and Study Flags

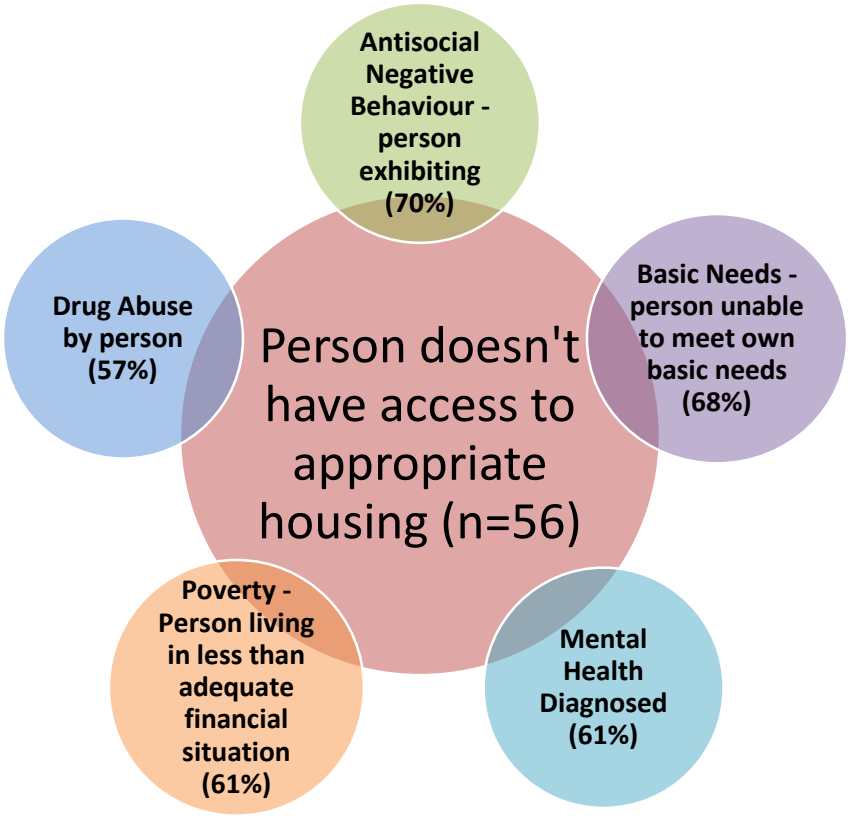
The figures below represent a selection of commonly identified risk factors with most frequently co-occurring risk factors, (e.g. among the 122 RMT situations where *diagnosed mental health* was an identified risk factor, *antisocial negative behaviour* was also identified in 71% of situations, *unable to meet own basic needs* was also identified in 63% of situations…)






Person exhibiting Antisocial/ Negative Behaviour 71%
Physical Health - General Health issue 51%
Basic needs unable (n=138)
Poverty 59%
Diagnosed Mental Health problem 56%


Antisocial negative behaviour 83%
Person associating with negative peers 51%
Drug abuse by person (n=110)
Person unable to meet own basic needs 57%
Diagnosed mental health 57%


Antisocial Negative Behaviour - person exhibiting (70%)
Drug Abuse by person (57%)
Person doesn't have access to appropriate housing (n=56)
Basic Needs - person unable to meet own basic needs (68%)
Poverty - Person living in less than adequate financial situation (61%)
Mental Health Diagnosed (61%)


Person exhibiting antisocial negative behaviour (74%)
Diagnosed Mental Health problem 50%
Person unable to meet own basic needs (73%)
Homelessness (n=74)
Person doesn't have access to appropriate housing (59%)
Poverty (66%)
Drug abuse by person (61%)

Appendix B – Community Mobilization Sudbury and Community Safety & Well-being Planning

In March 2018, Bill 175 – *the Safer Ontario Act* – received Royal Assent. This act reinforces the provincial government's shift to collaborative community safety and well-being planning, giving municipalities a larger role in defining and addressing local needs. *"Municipalities will be mandated to work with police services and local service providers in health care, social services and education to develop community safety and well-being plans that proactively address community safety concerns"* (Ministry of Community Safety & Correctional Services news release, November 2, 2017).

Community Mobilization Sudbury has the potential to make a significant contribution to ongoing, municipally-led community safety and well-being planning initiatives. As examples:

1. The CMS Rapid Mobilization Table has demonstrated itself to be an effective and valued mechanism for mitigating situations of elevated risk – an essential component of the province's proposed Community Safety and Well-being planning framework.
2. Community Mobilization Sudbury is the founder and administrative lead for the provincial *Situation Table Community of Practice*. This group of over 90 members, representing 40+ communities has established multiple mechanisms for sharing promising practices to achieve community safety and well-being. Although currently focused on the operation and advancement of situation tables such as the Rapid Mobilization Table, the membership has begun to discuss their role in informing broader community planning activities.
3. The Community Safety and Well-Being Planning Framework (Booklet 3, v.2) identifies the Risk Tracking Database (RTD) used by situation tables as one tool that can be used by communities to identify, validate and analyze local risks. The CMS Rapid Mobilization Table has data in the RTD dating back to May 2014, and over a five-year period (May 2014-April 2019), has identified 6,406 individual-level risk factors.

The Risk Tracking Database and Community Safety & Well-being Planning

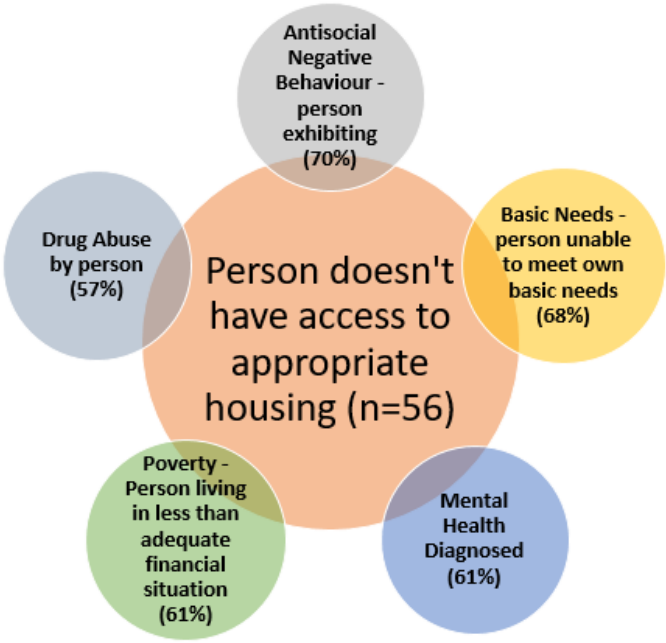
The Ministry of the Solicitor General (formally the Ministry of Community Safety and Correctional Services) developed the Risk Tracking Database (RTD) to provide a standardized means of gathering de-identified information on situations of acutely elevated risk for communities implementing multi-sectoral risk intervention models.

The Ministry worked closely with the Province of Saskatchewan to leverage their existing database, customizing it to suit the needs of Ontario. As a result of this partnership, the data

elements collected in the RTD not only align provincially, but also within other jurisdictions across Canada, allowing for national comparatives.

Community Mobilization Sudbury (CMS) uses the RTD to collect de-identified demographic information, including sex, age range, and discussion type *(i.e. individual, family)* in situations of high risk. Specific risk information for each situation is also collected; the RTD captures 105 risk factors within 27 risk categories (*i.e. Category: alcohol, Risk Factor: alcohol abuse by person*) as well as 33 individual study flags *(i.e. homelessness, child involved*).

The CMS data collected in the RTD is uniquely able to highlight trends in cross-sectoral risk over time, including demographics, risk factors, agency involvement, and conclusions to local situations of risk. This data can be used to inform agency, sector and broader community planning efforts.



Potential service gaps, as well as prevalent, high-priority risks can be identified using CMS data by evaluating co-occurring risk factors. Furthermore, reporting on intersecting risk factors demonstrates the range of multi-sectoral partners needed to plan and design effective programs that truly address the risks and needs in our community.

For example, by understanding that the gap in housing frequently co-occurs with issues related to substance abuse, mental health and poverty, it is clear that planning for housing cannot be carried out without the participation of other health and social service providers.

The data collected by CMS in the RTD is an important contribution to community safety and well-being planning, especially in the context of other community data. While it represents a very specific population at high risk of harm and should not be used in isolation, it is a valuable resource in identifying and validating local, prevalent cross-sectoral risks and can be leveraged, alongside the knowledge, data and experience of community partners. Identifying intersecting risks is a necessary step in eliminating silos and helping community agencies to collaboratively plan and design effective programs.

Appendix C – RMT Success Stories

Individual Male
Risk Factors/Study Flags: Homelessness, Physical Health

During the winter months, the Greater Sudbury Police Service (GSPS) brought the individual to the Off the Street (OTS) emergency shelter. Evicted from his home, he was living outside with his cat; this was the first time he had experienced homelessness. He had sustained injuries due to living outside but had discharged himself from the hospital against medical advice. He was not willing to separate from his beloved cat – his only companion. For that reason, he was not agreeable to seek treatment for his injuries. While at OTS, staff notified him that the Canadian Mental Health Association – Sudbury/Manitoulin (CMHA-S/M) was accepting housing applications the following day. Staff arranged for him to attend the office with his cat.

The following morning, the GSPS presented him to the Rapid Mobilization Table (RMT). RMT agencies participating in response planning included CMHA-S/M, GSPS, Greater Sudbury Paramedic Services, Health Sciences North, and the City of Greater Sudbury Social Services. Unbeknownst to the RMT team, the individual was at CMHA-S/M, seeking housing support and sitting in the lobby with his cat. Upon learning this, the RMT team conducted the response on-site, meeting with him and quickly getting to work finding temporary shelter for his cat. They supported him through the completion of a housing application while Paramedics brought the cat to its temporary home. This helped ease his worries, and he agreed to attend HSN for re-assessment, transported by GSPS and supported by other RMT members.

As a result of the RMT team's response, as well as the CMHA-S/M's residential housing program, he was housed and reunited with his cat within a week. He continues to receive support from CMHA-S/M and is extremely grateful for the assistance he received.

Individual Female, 60+
Risk Factors/Study Flags: Unable to meet own basic needs, Poverty, Physical Health/chronic conditions, Social Isolation

The Canadian Mental Health Association – Sudbury/Manitoulin received a call from an individual concerned about someone they knew. The individual was living without drinking water, did not have access to amenities such a bathroom or working refrigerator, and was spending her days lying in bed. When Rapid Mobilization Table members arrived at the individual's residence, they found the conditions of the home extremely concerning. The individual stated that she would not survive the winter if she continued to live in her current environment. After much discussion, the individual, the team safely transported to Health Sciences North, and supported her through the admission process while also making and

referrals to appropriate community supports. The individual is currently in safe, supported transitional shelter waiting for permanent housing. She expressed her gratitude towards the table:

“The team members did their job and got me in a safer place. I will stay here until I find an apartment. It helped me and I understand why they did it the way they did. Before, I had bad experiences with service providers in the community and I didn’t understand their role. This time, I had a way better experience. Thank you so much!”

Individual Female, 30-39
Risk Factors/Study Flags: Homelessness, Problematic Opioid Use, Social Isolation

The individual was experiencing severe addiction issues and had frequently presented to the emergency department, resulting in several hospitalizations for overdoses—once even requiring resuscitation. She was presented to the Rapid Mobilization Table and during the response, she shared with the members that she was ready to make positive changes in her life and beat her addiction. She expressed gratitude for everyone who came to speak with her. Health Sciences North assisted the individual in obtaining assessments for treatment at a local rehabilitation facility where she successfully completed the program; the Canadian Mental Health Association – Sudbury/Manitoulin (CMHA-S/M) provided court support and on-going case management thereafter. Changes were seen almost instantly in the individual; she obtained stable and secure housing and is working with the local child protection agency towards regaining custody of her child. She attended the Greater Sudbury Police Service and shared her gratitude. Words from Sergeant Valerie Tiplady:

“[Individual] turned herself in today on some outstanding warrants. She has been clean for 30 days. She talked about RMT and how the program helped her. She was well dressed, polite and articulate. She praised the program and the efforts of team members…she recognizes that the hard work continues every day, but she has RMT and a support system in place and is very grateful.”

Individual Male
Risk Factors/Study Flags: Homelessness, Addiction

The individual was living outside in a makeshift tent since the spring of 2018. He was extremely vulnerable, struggling with addiction and living outside without access to a telephone and no other means of accessing supports. The Greater Sudbury Police Service (GSPS) brought him forward to the Rapid Mobilization Table. The Canadian Mental Health Association—Sudbury/Manitoulin (CMHA-S/M) supported the individual through the completion of a Rent Supplement application, which was ultimately successful. GSPS, the City of Greater

Sudbury Social Services (CGS), and CMHA-S/M supported the individual with finding housing; assisting him in making phone calls, and driving and supporting him through apartment viewings. Once the individual had found a unit, CMHA-S/M and CGS were able to help finance the purchase of home goods and coordinate the furniture delivery. The individual has been living in his unit since the end of December 2018; he recently ran into the CGS Ontario Works worker, and became tearful, thanking the worker for the support provided by RMT and the organizations.

Appendix D – Data Dictionary

Ministry of the Solicitor General – Risk Tracking Database Risk Factors

Risk Factor	Definition
Alcohol - alcohol abuse by person	known to excessively consume alcohol; causing self-harm
Alcohol - alcohol abuse in home	living at a residence where alcohol has been consumed excessively and often
Alcohol - alcohol use by person	known to consume alcohol; no major harm caused
Alcohol - harm caused by alcohol abuse in home	has suffered mental, physical or emotional harm or neglect due to alcohol abuse in the home
Alcohol - history of alcohol abuse in home	excessive consumption of alcohol in the home has been a problem in the past
Antisocial/Negative Behaviour - antisocial/negative behaviour within the home	resides where there is a lack of consideration for others, resulting in damage to other individuals or the community i.e. obnoxious, disruptive behaviour
Antisocial/Negative Behaviour - person exhibiting antisocial/negative behaviour	is engaged in behaviour that lacks consideration of others, which leads to damages to other individuals or the community i.e. obnoxious/disruptive behaviour
Basic Needs - person being neglected by others	basic physical, nutritional or medical needs are not being met
Basic Needs - person neglecting others' basic needs	has failed to meet the physical, nutritional or medical needs of others under their care
Basic Needs - person unable to meet own basic needs	cannot independently meet their own physical, nutritional or other needs
Basic Needs - person unwilling to have basic needs met	person is unwilling to meet or receive support in receiving their own basic physical, nutritional or other needs met
Cognitive Functioning - diagnosed cognitive impairment/limitation	has a professionally diagnosed cognitive impairment/limitation
Cognitive Functioning – suspected cognitive impairment/limitation	suspected of having a cognitive impairment/limitation (no diagnosis)
Cognitive Functioning – self-reported cognitive impairment/limitation	has reported to others to have a cognitive impairment/limitation
Crime Victimization - arson	has been reported to police to be the victim of arson
Crime Victimization - assault	has been reported to police to be the victim of assault (i.e. hitting, stabbing, kicking, etc.)
Crime Victimization - break and enter	has been reported to police to be the victim of break and enter (someone broke into their premises)
Crime Victimization - damage to property	has been reported to police to be the victim of someone damaging their property
Crime Victimization - other	has been reported to police to be the victim of other crime not mentioned above
Crime Victimization - robbery	has been reported to police to be the victim of robbery (someone threatened/used violence against them to get something from them)
Crime Victimization - sexual assault	has been reported to police to be the victim of sexual assault (i.e. touching, rape)
Crime Victimization - theft	has been reported to police to be the victim of theft (someone stole from them)
Crime Victimization - threat	has been reported to police to be the victim of someone uttering threats to them
Criminal Involvement - animal cruelty	has been suspected, charged, arrested or convicted of animal cruelty
Criminal Involvement - arson	has been suspected, charged, arrested or convicted of arson

Criminal Involvement - assault	has been suspected, charged, arrested or convicted of assault
Criminal Involvement - break and enter	has been suspected, charged, arrested or convicted of break and enter
Criminal Involvement - damage to property	has been suspected, charged, arrested or convicted of damage to property
Criminal Involvement - drug trafficking	has been suspected, charged, arrested or convicted of drug trafficking
Criminal Involvement - homicide	has been suspected, charged, arrested or convicted of the unlawful death of a person
Criminal Involvement - other	has been suspected, charged, arrested or convicted of other crimes
Criminal Involvement - possession of weapons	has been suspected, charged, arrested or convicted of possession of weapons
Criminal Involvement - robbery	has been suspected, charged, arrested or convicted of robbery (which is theft with violence or threat of violence)
Criminal Involvement - sexual assault	has been suspected, charged, arrested or convicted of sexual assault
Criminal Involvement - theft	has been suspected, charged, arrested or convicted of theft
Criminal Involvement - threat	has been suspected, charged, arrested or convicted of uttering threats
Drugs - drug abuse by person	known to excessively use illegal/prescription drugs; causing self-harm
Drugs - drug abuse in home	living at a residence where illegal (or misused prescription drugs) have been consumed excessively and often
Drugs - drug use by person	known to use illegal drugs (or misuse prescription drugs); no major harm caused
Drugs - harm caused by drug abuse in home	has suffered mental, physical or emotional harm or neglect due to drug abuse in the home
Drugs - history of drug abuse in home	excessive consumption of drugs in the home has been a problem in the past
Elderly Abuse - person perpetrator of elderly abuse	has knowingly or unknowingly caused intentional or unintentional harm upon others because of their physical, mental or situational vulnerabilities associated with the aging process
Elderly Abuse - person victim of elderly abuse	has knowingly or unknowingly suffered from intentional or unintentional harm because of their physical, mental or situational vulnerabilities associated with the aging process
Emotional Violence - emotional violence in the home	resides with a person who exhibits controlling behaviour, name-calling, yelling, belittling, bullying, intentional ignoring, etc.
Emotional Violence - person affected by emotional violence	has been affected by others falling victim to controlling behaviour, name-calling, yelling, belittling, bullying, intentional ignoring, etc.
Emotional Violence - person perpetrator of emotional violence	has emotionally harmed others by controlling their behaviour, name-calling, yelling, belittling, bullying, intentionally ignoring them, etc.
Emotional Violence - person victim of emotional violence	has been emotionally harmed by others who have controlled their behaviour, name-called, yelled, belittled, bullied, intentionally ignored them, etc.
Gambling - chronic gambling by person	regular and/or excessive gambling; no harm caused
Gambling - chronic gambling causes harm to others	regular and/or excessive gambling that causes harm to others
Gambling - chronic gambling causes harm to self	regular and/or excessive gambling; resulting in self-harm
Gambling - person affected by the gambling of others	is negatively affected by the gambling of others
Gangs - gang association	social circle involves known or supported gang members but is not a gang member
Gangs - gang member	is known to be a member of a gang

Gangs - threatened by gang	has received a statement of intention to be injured or have pain inflicted by gang members
Gangs - victimized by gang	has been attacked, injured, assaulted or harmed by a gang in the past
Housing - person doesn't have access to appropriate housing	is living in inappropriate housing conditions or none at all (i.e. condemned building, street)
Housing - person transient but has access to appropriate housing	has access to appropriate housing but is continuously moving around to different housing arrangements (i.e. couch surfing)
Mental Health - diagnosed mental health problem	has a professionally diagnosed mental health problem
Mental Health - grief	experiencing deep sorrow, sadness or distress caused by loss
Mental Health - mental health problem in the home	residing in a residence where there are mental health problems
Mental Health - not following prescribed treatment	not following treatment prescribed by a mental health professional; resulting in risk to self and/or others
Mental Health - self-reported mental health problem	has reported to others to have a mental health problem(s)
Mental Health - suspected mental health problem	suspected of having a mental health problem (no diagnosis)
Mental Health - witnessed traumatic event	has witnessed an event that has caused them emotional or physical trauma
Missing - person has history of being reported to police as missing	has a history of being reported to police as missing and in the past has been entered on CPIC as a missing person
Missing - person reported to police as missing	has been reported to the police and entered in CPIC as a missing person
Missing - runaway with parents' knowledge or whereabouts	has runaway from home with guardian’s knowledge but guardian is indifferent
Missing - runaway without parents' knowledge or whereabouts	has runaway and guardian has no knowledge of whereabouts
Missing School - chronic absenteeism	has unexcused absences from school without parental knowledge, that exceed the commonly acceptable norm for school absenteeism
Missing School - truancy	has unexcused absences from school without parental knowledge
Negative Peers - person associating with negative peers	is associating with people who negatively affect their thoughts, actions or decisions
Negative Peers - person serving as a negative peer to others	is having negative impact on the thoughts, actions or decision of others
Parenting - parent-child conflict	ongoing disagreement and argument between guardian and child that affects the functionality of their relationship and communication between the two parties
Parenting - person not providing proper parenting	is not providing a stable, nurturing home environment that includes positive role models and concern for the total development of the child
Parenting - person not receiving proper parenting	is not receiving a stable, nurturing home environment that includes positive role models and concern for the total development of the child
Physical Health - chronic disease	suffers from a disease that requires continuous treatment over a long period of time
Physical Health - general health issue	has a general health issue which requires attention by a medical health professional
Physical Health - not following prescribed treatment	not following treatment prescribed by a health professional; resulting in risk
Physical Health - nutritional deficit	suffers from insufficient nutrition, causing harm to their health

Physical Health - physical disability	suffers from a physical impairment
Physical Health - pregnant	pregnant
Physical Health - terminal illness	suffers from a disease that cannot be cured and that will soon result in death
Physical Violence - person affected by physical violence	has been affected by others falling victim to physical violence (i.e. witnessing; having knowledge of)
Physical Violence - person perpetrator of physical violence	has instigated or caused physical violence to another person (i.e. hitting, pushing)
Physical Violence - person victim of physical violence	has experienced physical violence from another person (i.e. hitting, pushing)
Physical Violence - physical violence in the home	lives with threatened or real physical violence in the home (i.e. between others)
Poverty - person living in less than adequate financial situation	current financial situation makes meeting the day to day housing, clothing or nutritional needs, significantly difficult
Self-Harm - person has engaged in self-harm	has engaged in the deliberate non-suicidal injuring of their own body
Self-Harm - person threatens self-harm	has stated that they intend to cause non-suicidal injury to their own body
Sexual Violence - person affected by sexual violence	has been affected by others falling victim to sexual harassment, humiliation, exploitation, touching or forced sexual acts (i.e. witnessing; having knowledge of)
Sexual Violence - person perpetrator of sexual violence	has been the perpetrator of sexual harassment, humiliation, exploitation, touching or forced sexual acts
Sexual Violence - person victim of sexual violence	has been the victim of sexual harassment, humiliation, exploitation, touching or forced sexual acts
Sexual Violence - sexual violence in the home	resides in a home where sexual harassment, humiliation, exploitation, touching, or forced sexual acts occur
Social Environment - frequents negative locations	is regularly present at locations known to potentially entice negative behaviour or increase the risks of an individual to be exposed to or directly involved in other social harms
Social Environment - negative neighbourhood	lives in a neighbourhood that has the potential to entice negative behaviour or increase the risks of an individual to be exposed to or directly involved in other social harms
Suicide - affected by suicide	has experienced loss due to suicide
Suicide - person current suicide risk	currently at risk to take their own life
Suicide - person previous suicide risk	has in the past, been at risk to take their own life
Supervision - person not properly supervised	has not been provided with adequate supervision
Supervision - person not providing proper supervision	has failed to provide adequate supervision to a dependant person (i.e. child, elder, disabled)
Threat to Public Health and Safety - person's behaviour is a threat to public health and safety	is currently engaged in behaviour that represents danger to the health and safety of the community (i.e. unsafe property, intentionally spreading disease, putting others at risk)
Unemployment - caregivers chronically unemployed	caregivers are persistently without paid work
Unemployment - caregivers temporarily unemployed	caregivers are without paid work for the time being
Unemployment - person chronically unemployed	persistently without paid work
Unemployment - person temporarily unemployed	without paid work for the time being

Ministry of the Solicitor General – Risk Tracking Database Study Flags

Study Flags	Definition
Acquired Brain Injury	Acquired Brain Injury (ABI) is an injury to the brain, which is not hereditary, congenital, or degenerative. It can be caused by a traumatic blow to the head, severe rotation of the neck or whiplash, or even lack of oxygen.
Child Involved	Child is involved in the discussion brought forward
Cognitive Disability	Dysfunction related to memory, language, orientation, judgement, problem solving etc. Formerly known as organic brain disorders, they include amnestic disorders, Huntington disorder, delirium, dementia, and the formal criteria for mental retardation (this is still a diagnosis in the DSM). Some acquired brain injury can also fit the bill especially as it is seen as declining as one ages. Head trauma or other or declining mental status in the areas first listed due to other physical conditions would be classified as cognitive disorder not otherwise specified.
Custody Issues/Child Welfare	Circumstances related to family separation, custody disputes, or child apprehension
Developmental Disability	An umbrella term used to describe disorders that impair function that typically onset in childhood prior to the completion of development at age 18. These disorders affect the developing nervous system, resulting in impaired intellectual and/or adaptive functioning. Such children have difficulty with adapting to change, understanding covert social cues, managing abstract concepts like money and other needs based issues. Typically, this also affects their ability to understand and regulate emotions and understand their impact on those around them. This does not automatically capture folks with learning disability unless it is also association with one of the conditions below or meets the threshold for pervasive developmental disorder. This definition also include children, youth and adults with Autism Spectrum Disorders, Fetal Alcohol Spectrum Disorders and other genetic metabolic syndromes.
Domestic Violence	Violence or abuse that can happen between people who are related to each other or who have relationships with each other. It includes violence, abuse or intimidation by one person over another which causes fear, or physical and/or psychological harm. It may be a single act, or a series or acts forming a pattern of abuse.
Fire Safety	Residence poses a fire hazard to itself and/or neighbours.
Gaming/Internet Addiction	An excessive, unhealthy amount of playing computer games or being on the internet. Rather than engaging in the real world, an addicted user devotes the majority of his or her time to being on a computer for internet use/gaming. The addicted gamer often isolates him/herself from others and ignores more important responsibilities.
Geographical Isolation	Residing in a remote location with limited access to transportation, services, internet, neighbours, increasing the possibility of victimization or self-harm.
Gender Issues	An individual experiencing difficulties related to gender identity and/or gender expression/presentation. Other risk factors are elevated as a result of gender issues.
Hoarding	A behavioural disorder characterized by the excessive accumulation of material possessions, the character and quantity of which substantially interferes with an individual's normal social functional and vocational roles. The individual cannot or will not willingly part with these possessions and the individual often lacks insight into the safety risks their possessions can cause.
Homelessness	The situation of an individual or family without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it. It is the result of systemic or societal barriers, a lack of affordable and appropriate housing, the individual/household's financial, mental, cognitive, behavioural or physical challenges, and/or racism and discrimination.
Homicidal Ideation	Person has expressed thoughts/ideas about homicide.

Inappropriate Sexual Behaviour/Hyper-Sexuality	Inappropriate dress, actions, etc., for adolescent age group; exhibiting unusual or excessive concern with or indulgence in sexual activity, often being inappropriate.
Lack of Supports for Elderly Person(s)	A lack of family support or incidents or caregiver burnout are leading to escalating risks for elderly person(s) related to health, mental health, housing, basic needs, etc.
Language/Communication Barrier	Sight or hearing difficulties, as well as difficulty accessing services in a client's preferred language
Learning Disability	Refers to a variety of disorders that affect the acquisition, retention, understanding, organization or use of verbal and/or non-verbal information. They range in severity and invariably interfere with the acquisition and use of one or more of the following important skills: oral language, reading, written language and mathematics
Methamphetamine Use	Discussion involving methamphetamine use either by person, friend, or family member. Methamphetamine is a synthetic, highly addictive and illegal stimulant which is part of the amphetamine drug family. On-going methamphetamine use can have devastating effects on the individual, as well as significant costs to the economy through healthcare and criminal justice system involvement, for example.
Problematic Opioid Use	Patterns or types of opioid use that have a higher risk of individual and/or societal impacts. This includes improper use of opioid medicine, taking more than is prescribed, taking it at the wrong time, taking an opioid medicine that was not prescribed to the user, or taking an illegally produced or obtained opioid.
Recent Escalation	Recent increase or change in behaviours and/or circumstances (e.g. number of police calls, ED visits, missing, truancy, physical violence, etc.) which is contributing to the acutely elevated risk of the individual or family.
Recidivism	Chronic tendency towards the repetition of criminal behaviour
Risk of Human Trafficking	The situation includes a risk of being involved in human trafficking. Human trafficking involves the recruitment, transportation, harbouring and/or exercising control, direction or influence over the movements of a person in order to exploit that person, typically through sexual exploitation or forced labour.
Risk of Losing Housing/Unsafe Living Conditions	Person is at risk of being evicted or living conditions are not adequate from a health and safety perspective (e.g. hoarding, pest infestation).
Risk of Radicalization	Individual is exhibiting behaviours that may make them susceptible for recruitment or pose a potential for violence based on a particular ideology (e.g. political, radical, religious, etc.).
Settlement Challenges	Recent immigrants/newcomers/refugees are having difficulty integrating into the community or adjusting to their new living environment.
Sex Trade	Person is involved in the practice of engaging in promiscuous sexual relations or sexual acts in exchange for some type of payment.
Social Isolation	Person does not have access to family or social supports and/or has limited social connections
Social Media	Individual is engaging in negative/risky behaviours through social media or being negatively impacted by social media.
Transportation Issues	Insufficient/non-existent access to personal or public transportation in order to allow individuals to access services or leave an undesirable situation
Trespassing	Illegal entry onto private and/or public property.
Wait list	Service is available but wait list is a barrier to receiving needed supports.