Community Mobilization Sudbury
Mobilisation Communautaire Sudbury
Weweni EnjiNagidwendaagozing

RMT ANNUAL REPORT 2024

Community Mobilization Sudbury
Rapid Mobilization Table Data Report - 2024

Background

Community Mobilization Sudbury (CMS) is a community partnership representing over 40 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.

The Rapid Mobilization Table (RMT)

Representatives from CMS partner agencies meet twice each week at the Rapid Mobilization Table (RMT). The RMT is a focused, 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 Solicitor General 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.

In 2024 we were proud to recognize the 10th anniversary of the Rapid Mobilization Table. To celebrate the 10th anniversary we hosted an in-person event in May, attended by 49 partners, to reflect on the achievements of the past decade and to explore how we can continue to evolve our practices to better serve our community.

In 2024 the Rapid Mobilization Table underwent a program evaluation. It resulted in several action items supporting continuous quality improvement. They included a quarterly RMT report, tracking of systemic issues information, launching monthly in-person meetings and developing a SharePoint Hub as a one-stop resource for RMT partners. All of these initiatives have begun. We would also like to launch a new RMT evaluation protocol, which is currently in development. We are committed to continuous quality improvement of RMT processes to confirm fidelity to the Four Filter Model and to ensure that we remain effective, responsive and evidence informed as we support some of the most vulnerable individuals in our community.

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, 2024 and December 31, 2024. 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) met the criteria of acutely elevated risk, and b) were identified by partners for presentation to the Rapid Mobilization Table.

RMT 2024 Activity Update

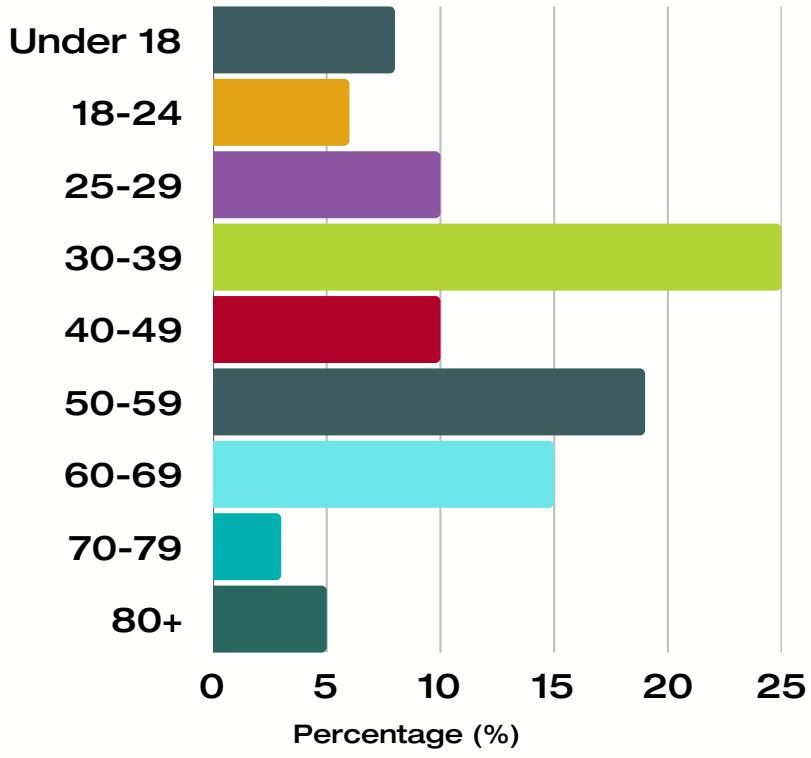
Situations of Acutely Elevated Risk

43
Family

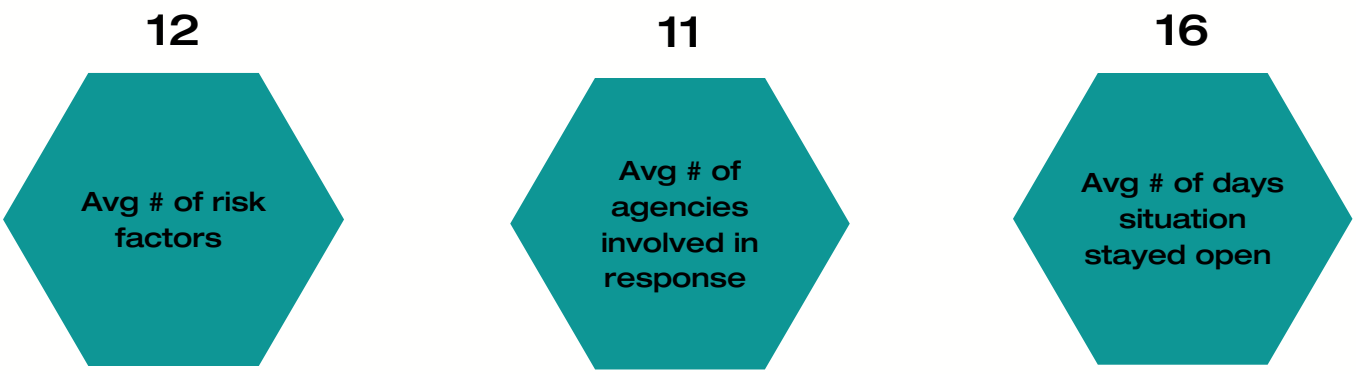
89
Individual

2
Dwelling

1
Neighborhood



RMT Responses



Situations Presented to the Rapid Mobilization Table

A total of 139 situations were presented to the Rapid Mobilization Table between January 1, and December 31, 2024. Of those, 135 (97%) met the CMS threshold of acutely elevated risk and required a multi-agency response (Table 1). The total number of referrals presented continues a slight trend downward over the years (Chart 1).

The trend towards a decline in referrals at RMT is similar to other Situation Tables in the province (as noted at the Ontario Situation Table Community of Practice).
This decline may be related to several potential factors such as improved capacity within partner agencies to identify and address risks and challenges on their own as well as improved collaboration among partner agencies leading to earlier resolution of issues, reducing the need for formal referrals.

Since 2014 partners of RMT have been continually increasing capacity and strengthening relationships to create a unique network of community partners, all with the same goal to support those experiencing high risk of imminent harm. What has been noted is that, because of the strength of their connections, there are instances where partners are able to reach out to each other to help individuals who are at risk, but not yet at acutely elevated risk. Partners work together to mitigate risk before it escalates to the risk threshold thereby avoiding the need to bring forward a formal referral to the Table.

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

Table 1: Situations presented to the Rapid Mobilization Table
January 1, 2024 - December 31, 2024

	n	%
Situation met Acutely Elevated Risk (AER) threshold	135	97%
Situation did not meet Acutely Elevated Risk (AER) threshold	3	2%
Already connected to appropriate personal supports with potential to mitigate risks	1	1%
Total	139	100%

Chart 1: Number of RMT Referrals Meeting AER by Year

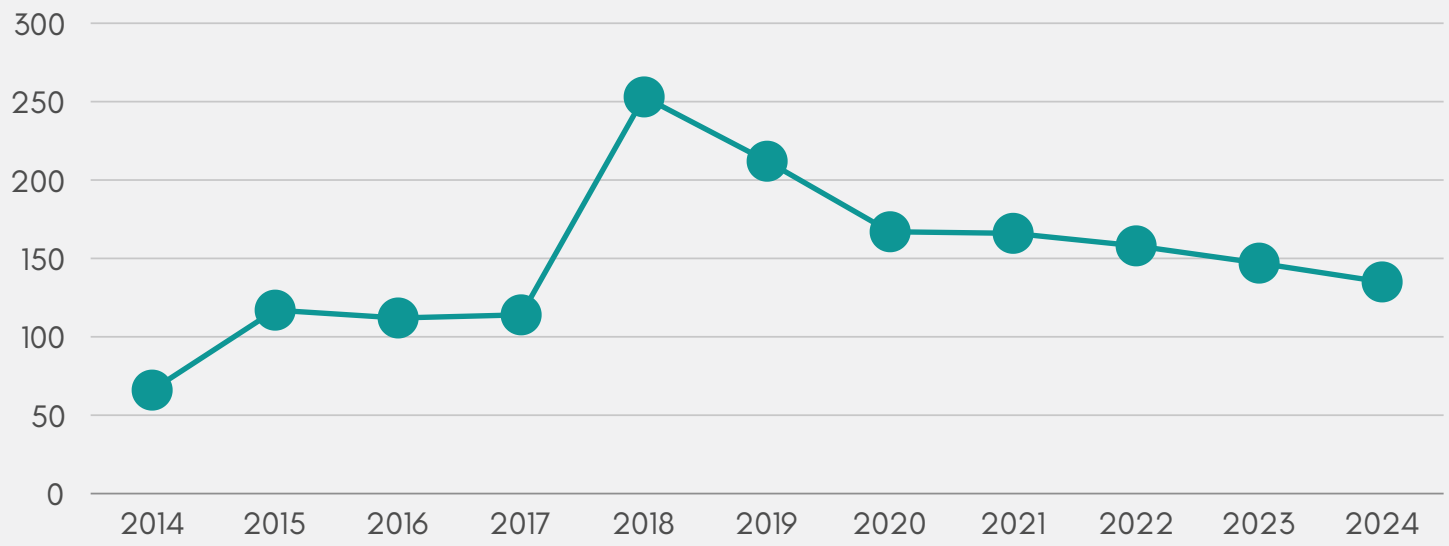
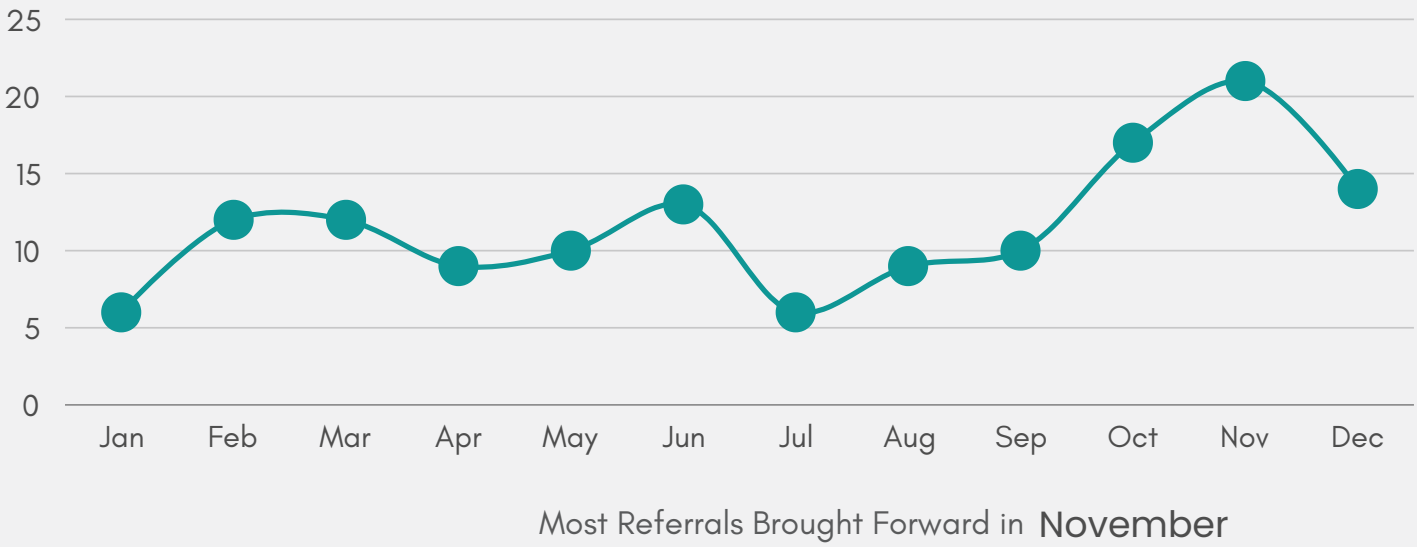


Chart 2: Number of Referrals by Month - 2024



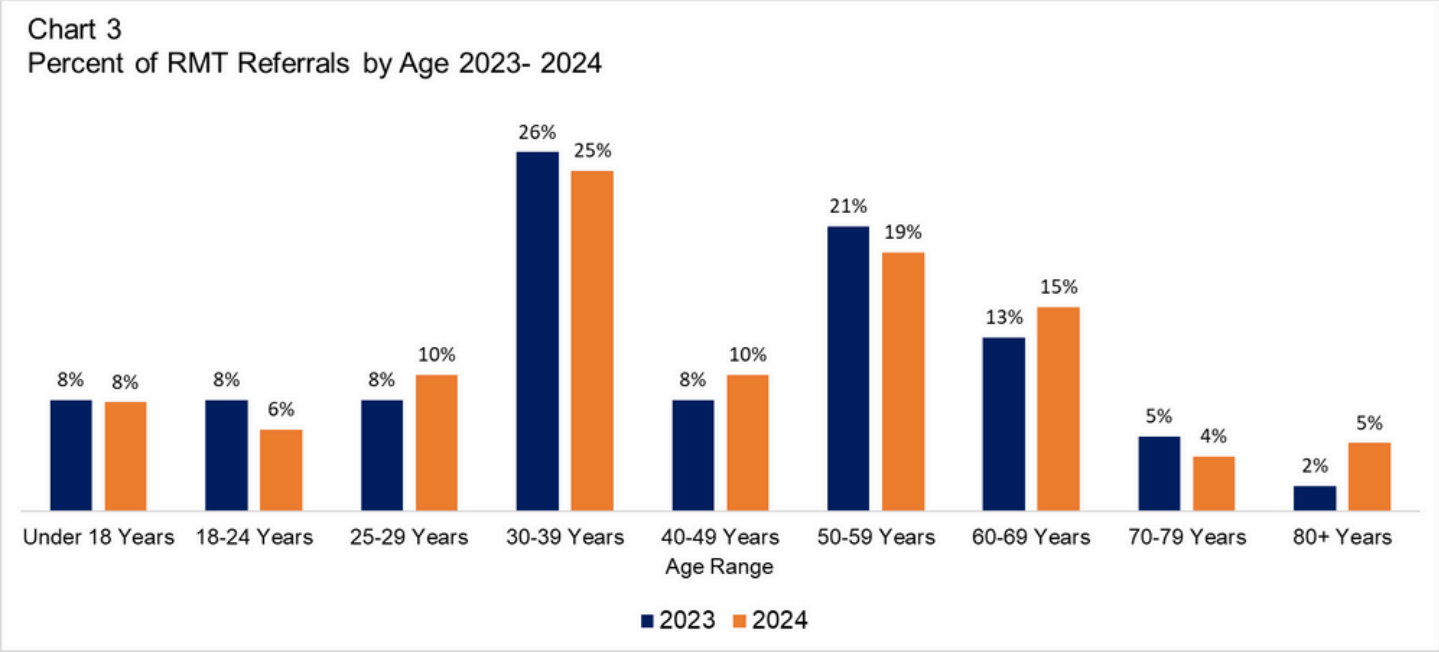
Demographic Breakdown

As in previous years, 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 (66%). This proportion is slightly lower than in 2023 (75%). The number of referrals involving families was higher than in 2023 (25%). Families represented 32% of all presentations meeting the threshold of acutely elevated risk in 2024
Two referrals involved a Dwelling and one involved a Neighbourhood (Table 2).

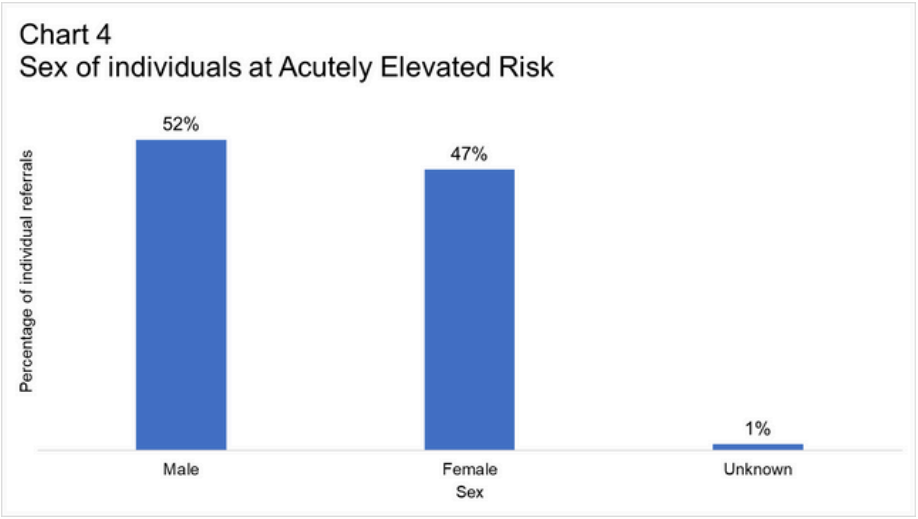
Table 2: Type of situations of Acutely Elevated Risk January 1, 2024 - December 31, 2024		
Types of Situations of Acutely Elevated Risk	n	%
Individual	89	66%
Family	43	32%
Dwelling	2	2%
Neighbourhood	1	1%
Total	135	100%

Presentations Involving Individuals

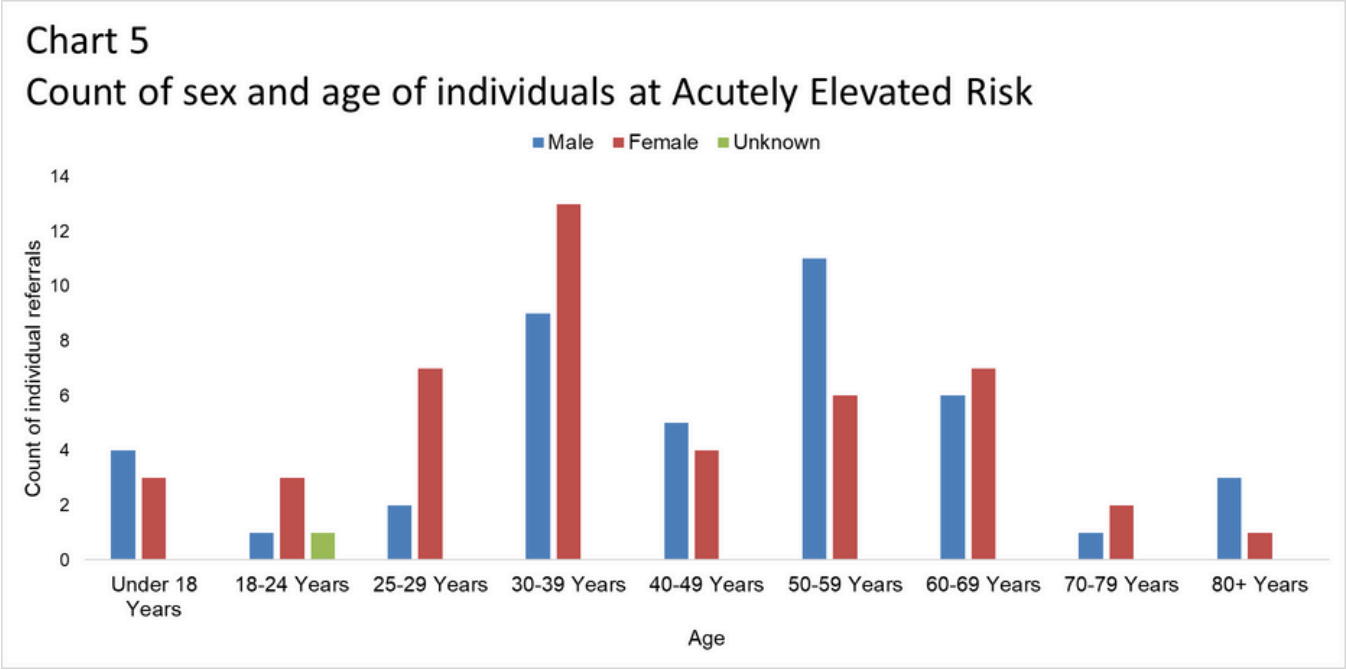
Of the situations that met the threshold of acutely elevated risk, the most frequently identified age group were adults aged 30-39 years (25%) followed by adults aged 50 to 59 years (19%). Youth under the age of 18 represented 8% of presentations. Chart 3 provides additional detail. Please note the percentages have been rounded.



This year there was a slightly larger divide, compared to 2023, between the percentage of individual referrals involving females (47%) and individual referrals involving males (52%) (Chart 4). This is a difference of 5% compared to 2023 where the difference was 2%. CMS recognizes that individuals have diverse gender identities and we strive to use gender-inclusive language when serving individuals and in our written documentation. Please note that the Risk Tracking Database developed by the Ministry of the Solicitor General references Sex as a demographic category rather than gender and individual data is reported as such in this report.

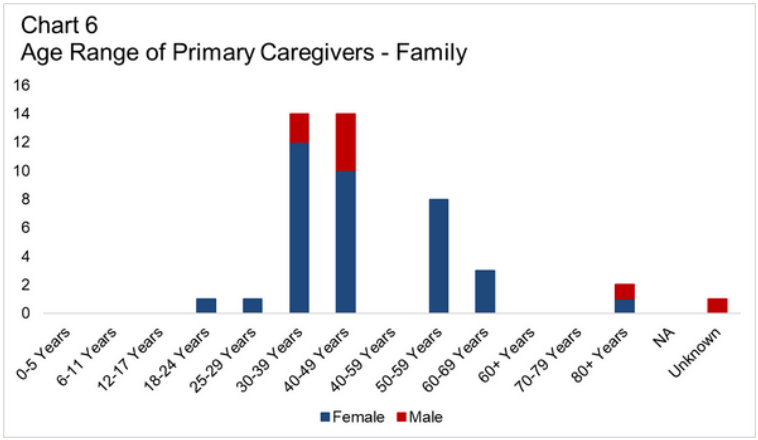


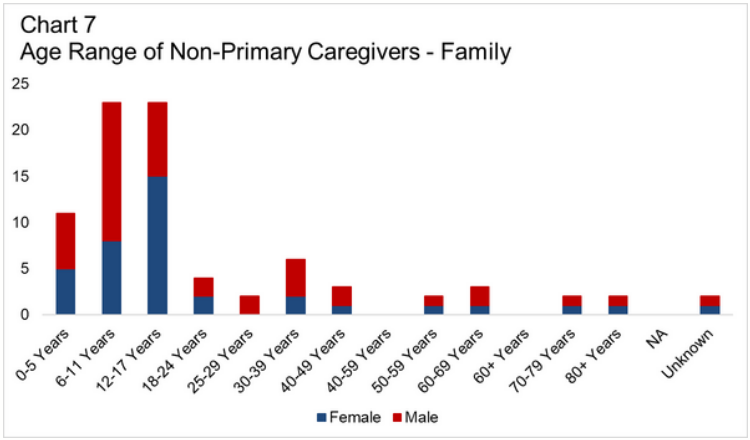
In 2024, females made up a greater percentage of the age group between 18 to 24 years, 25 to 29 years, 30 to 39, 60 to 69 years and 70 to 79 years (Chart 5).



Presentations Involving Families

The number of acutely elevated risk presentations involving families brought forward to RMT in 2024 was 43, slightly higher than the number of presentations in 2023 (37). The most frequent age range of primary caregivers in presentations involving families was 30-39 years and 40-49 years (Chart 6). The most frequent age range of non-primary caregivers was 6-11 years and 12-17 years (Chart 7).





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.

Table 4
Frequency of risk categories in RMT situations of acutely elevated risk 2024

Risk Category	Discussions	Percentage
Mental Health	124	89.21%
Basic Needs	109	78.42%
Physical Health	106	76.26%
Antisocial/Negative Behaviour	94	67.63%
Housing	84	60.43%
Poverty	82	58.99%
Cognitive Functioning	66	47.48%
Physical Violence	64	46.04%
Unemployment	58	41.73%
Drugs	54	38.85%
Criminal Involvement	52	37.41%
Social Environment	51	36.69%
Crime Victimization	49	35.25%
Negative Peers	47	33.81%
Self Harm	39	28.06%
Emotional Violence	38	27.34%
Parenting	37	26.62%
Suicide	30	21.58%
Sexual Violence	27	19.42%
Alcohol	26	18.71%
Threat to Public Health and Safety	19	13.67%
Missing/Runaway	16	11.51%
Missing School	15	10.79%
Supervision	12	8.63%
Elderly Abuse	10	7.19%
Gambling	1	0.72%

The Mental Health risk category has consistently been the most frequently identified risk category at RMT since inception, and this year was no different. Between January 1, 2024 and December 31, 2024. Mental Health was identified in a large portion of situations of acutely elevated risk (89%). Table 4 provides a complete summary of the frequency of the risk categories identified in situations of acutely elevated risk in 2024 at RMT.

Top 5 Risk Categories				
Q1	Q2	Q3	Q4	Total
1. Mental Health 2. Antisocial/Negative Behaviour 3. Basic Needs 4. Physical Health 5. Housing	1. Mental Health 2. Basic Needs 3. Physical Health 4. Housing 5. Poverty	1. Mental Health 2. Basic Needs 3. Physical Health 4. Antisocial/Negative Behaviour 5. Poverty	1. Mental Health 2. Physical Health 3. Basic Needs 4. Antisocial/Negative Behaviour 5. Poverty	**1. Mental Health** **2. Basic Needs** **3. Physical Health** **4. Antisocial/Negative Behaviour** **5. Housing**

Risk Categories Impacting Individuals and Families

Mental Health was the most frequently identified risk category for situations involving both individuals (91%) and families (93%).

Physical Health, Basic Needs, and Antisocial/Negative Behaviour were in the top five risk categories for both individual and family referrals. For individuals Housing rounded out the top five while for families it was poverty.

Tables 5 a-b provides a summary of the top risk categories for the situation types.

Table 5a
Top five frequently identified risk categories impacting individuals (n=89)

	n	%
Mental Health	81	91%
Basic Needs	75	84%
Physical Needs	75	84%
Antisocial/Negative Behaviour	62	70%
Housing	60	67%

Table 5b
Top five frequently identified risk categories impacting families (n=43)

	n	%
Mental Health	40	93%
Basic Needs	33	77%
Physical Health	29	67%
Antisocial/Negative Behaviour	29	67%
Poverty	26	60%

Risk Categories and Sex

Within the top five most frequently identified risk categories in 2024, in presentations involving individuals, the same top five categories are represented for both males and females including Mental Health, Basic Needs, Physical Health, Antisocial/ Negative Behaviour, and Housing (Tables 6 a-b).

Risk Categories by Sex

Male
Table 6a

- 91% Mental Health
- 86% Basic Needs
- 86% Physical Health
- 67% Antisocial/Negative Behaviour
- 67% Housing

Female
Table 6b

- 91% Mental Health
- 83% Basic Needs
- 83% Physical Health
- 72% Antisocial/Negative Behaviour
- 67% Housing

Risk Categories & Age Groups

Summarized below are the most commonly identified risk categories for different age groups presented as individuals (Table 7). Mental Health was ranked as the most identified risk category for most age groups followed by Physical Health and Basic Needs. Please refer to Table 7 for more details.

Table 7
Top most frequently identified risk categories by age group (individual presentations) 2024

Age Range	Risk Category					
0-17 n=7	Mental Health Parenting	86%	Antisocial/Negative Behaviour / Basic Needs / Crime Victimization / Criminal Involvement / Emotional Violence / Social Environment	71%	Drugs / Housing / Missing School / Missing/Runaway / Negative Peers / Physical Violence	57%
18-24 n= 5	Mental Health	100%	Antisocial/Negative Behaviour / Basic Needs / Cognitive Functioning / Housing / Negative Peers / Physical Health / Physical Violence	80%	Criminal Involvement / Emotional Violence / Sexual Violence	60%
25-29 n=9	Housing / Physical Health	100%	Mental Health	89%	Drugs	78%
30-39 n=22	Mental Health / Basic Needs	86%	Housing / Physical Health	82%	Antisocial/Negative Behaviour	77%
40-49 n=9	Mental Health / Physical Health / Basic Needs	100%	Housing	89%	Antisocial/Negative Behaviour / Poverty	78%
50-59 n=17	Mental Health	88%	Basic Needs	82%	Physical Health	77%
60-69 n= 13	Physical Health	100%	Basic Needs / Mental Health / Antisocial/Negative Behaviour	92%	Cognitive Functioning	85%
70-79 n=3	Mental Health / Basic Needs / Physical Health	100%	Cognitive Functioning / Housing / Poverty	67%	Alcohol / Criminal Involvement / Gambling	33%
80+ n=4	Mental Health / Basic Needs / Physical Health	100%	Cognitive Functioning / Elderly Abuse / Housing / Antisocial/Negative Behaviour			50%

Risk Factors

The RTD tracks 105 distinct risk factors grouped within the 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 2024, 1680 risk factors were captured during the 135 RMT discussions that met the threshold of acutely elevated risk. The RTD allows for a maximum collection of 15 risk factors per discussion. The average number of risk factors per discussion in 2024 was 12.

Risk Factors provide a bigger picture of the situation presented. Risk Factors are more specific than their risk category, and therefore when analyzing risk factors and reporting on risk factors, it is important to note that the frequency in which a risk factor occurs may differ from the frequency in which a risk category occurs overall. For example, the Antisocial/Negative Behaviour risk category includes two risk factors whereas the Mental Health risk category contains seven different risk factors. As such, when we add up all those seven risk factor counts under Mental Health, it will show as the higher risk category than Antisocial/Negative Behaviour. It is interesting to note that "Suspected Mental Health Problem" has moved to the 4th most identified risk factor. The top Risk Factor in 2024 was "Person unable to meet own basic needs" followed by "Person exhibiting antisocial / negative behaviour" and "Poverty" (Table 8).

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

Risk Factor	n = 135	%
Basic Needs - person unable to meet own basic needs	91	67
Antisocial/Negative Behaviour - person exhibiting antisocial/negative behaviour	86	64
Poverty - person living in less than adequate financial situation	82	61
Mental Health – suspected mental health problem	73	54
Housing - person doesn't have access to appropriate housing	72	53
Physical Health – general health issue	67	50
Unemployment - person chronically unemployed	52	39
Mental Health – diagnosed mental health problem	47	35
Physical Health – nutritional deficit	46	34
Negative Peers – person associating with negative peers	44	33

Top 5 Identified Risk Factors

- person unable to meet own basic needs — 67%
- person exhibiting antisocial/negative behaviour — 64%
- person living in less than adequate financial situation — 61%
- 54% — suspected mental health problem
- 53% — person doesn't have access to appropriate housing

Study Flags

Study flags are additional considerations that may help to guide RMT responses.

The top two frequently identified study flags were Recent Escalation (72%) and Risk of Losing Housing/Unsafe Living Conditions (57%), these study flags were also the top two most identified study flags in 2023. They were followed by Homelessness, Social Isolation and Transportation Issues. A summary of most frequently identified study flags is shown below.

Top 5 Study Flags

Q1	Q2	Q3	Q4
1. Recent Escalation 2. Risk of Losing Housing/Unsafe Living Conditions 3. Homelessness 4. Child Involved 5. Social Isolation	1. Recent Escalation 2. Risk of Losing Housing/Unsafe Living Conditions 3. Homelessness 4. Social Isolation 5. Methamphetamine Use	1. Recent Escalation 2. Homelessness 3. Risk of Losing Housing/Unsafe Living Conditions 4. Cognitive Disability 5. Transportation Issues	1. Recent Escalation 2. Risk of Losing Housing/Unsafe Living Conditions 3. Homelessness 4. Cognitive Disability 5. Transportation Issues

Most Frequently Identified Study Flags

760 unique study flags

Rapid Mobilization Table Collaborative Responses

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

On average, 11 agencies were engaged per discussion that "Met the Threshold of Acutely Elevated Risk". As in 2023 the Greater Sudbury Police Service presented the highest number of situations to RMT (30%, n=40) and were involved in 128 (95%) responses (either lead or assisting). Other agencies frequently involved in responses include CMHA Sudbury/Manitoulin (94%, n=127), the City of Greater Sudbury Social Services (91%, n=123), Health Sciences North - Mental Health & Addictions - Sudbury (80%, n=108) and Paramedic Services (73%, n=98). In total, in 2024, there was a total of 25 agencies that brought forward a situation to RMT (Table 10).

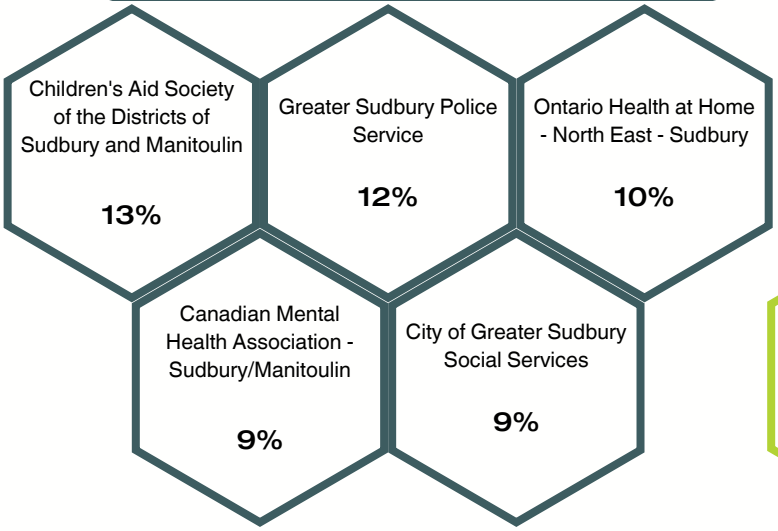
The Children's Aid Society was the most frequently identified lead agency (13%) followed by Greater Sudbury Police Services (12%), Ontario Health at Home (10%), the City of Greater Sudbury Social Services (9%), and CMHA Sudbury/Manitoulin (9%). Please see Table 10 for more details.

Table 10 - Agency Engagement

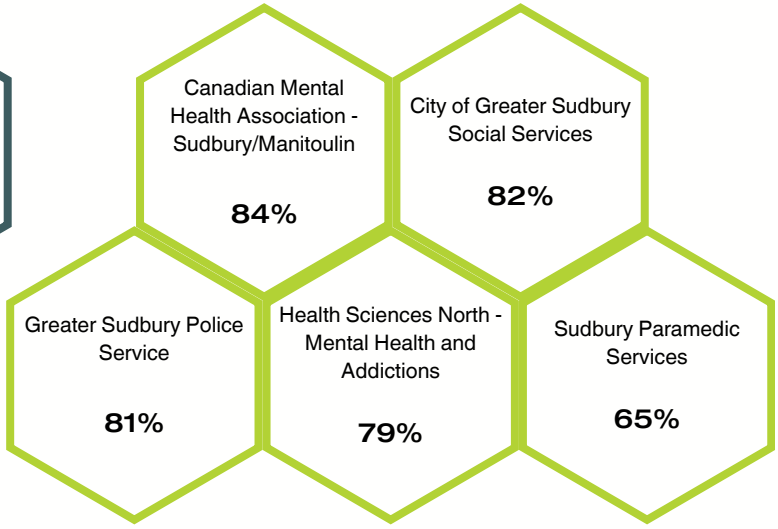
Agency	Originating Agency	Lead Agency	Assisting Agency	Total Discussions
Greater Sudbury Police Service	40	16	110	128
Canadian Mental Health Association - Sudbury/Manitoulin	11	12	114	127
City of Greater Sudbury Social Services	9	12	111	123
Health Sciences North - Mental Health and Addictions - Sudbury	2	2	106	108
Sudbury Paramedic Services	16	10	88	98
Ontario Disability Support Program - Ministry of Children, Community and Social Services - Sudbury	2	2	66	68
Ontario Health atHome - North East - Sudbury	6	14	52	66
Homelessness Network		1	59	60
Monarch Recovery Services	1	2	46	48
Victim Services of Sudbury and Area	1	1	47	48
Children's Aid Society of the Districts of Sudbury and Manitoulin	14	17	29	46
Sudbury Community Service Centre	3	8	34	42
Go-Give Project	5	3	36	40
Sudbury District Nurse Practitioners Clinic	1	2	38	40
Health Sciences North - Safe Beds Program			39	39
Cedar Place Salvation Army Sudbury Women and Family Shelter	1	3	32	35
Office of the Public Guardian and Trustee - Ministry of the Attorney General			35	35
Sudbury Counselling Centre			34	34
Greater Sudbury Housing Corporation	3	2	26	29
Health Sciences North - Inpatient Services			28	28
North East Behavioural Supports Ontario			21	21
Rainbow District School Board	8	4	16	20
Children's Community Network		3	16	19
Safe Harbour House	4	3	16	19
Compass - Sudbury	1	3	15	18
Shkagamik-Kwe Health Centre	1	2	16	18
Canadian Red Cross - Sudbury Branch			17	17
N'Swakamok Native Friendship Centre			15	15
Sudbury Fire Services			15	15
March of Dimes Canada			14	14
Restorative Justice of Sudbury	1		14	14
North East Specialized Geriatric Centre		2	10	12
Northern Youth Services Inc	1	1	11	12
Probation and Parole - Ministry of the Solicitor General - Sudbury			12	12
Elizabeth Fry Society of Sudbury	1	3	6	9
Réseau Access Network	1	1	8	9
Victim Witness Assistance Program - Sudbury			9	9
Ontario Aboriginal Housing Services - Sudbury			8	8
Alzheimer Society of Sudbury-Manitoulin North Bay & Districts			7	7
YMCA of Northeastern Ontario - Employment Services and Immigrant Services			7	7
Kina Gbezhgomi		2	4	6
Conseil scolaire public du Grand Nord de l'Ontario	4	2	3	5
Elder Abuse Prevention Ontario			4	4
John Howard Society of Sudbury			4	4
Canadian Mental Health Association - Greater Sudbury Health Link			3	3
Northern Initiative for Social Action	1	1	2	3
Sudbury Action Centre for Youth			3	3
Conseil scolaire catholique du Nouvel-Ontario			2	2
Metis Nation of Ontario - Sudbury			2	2
Public Health Sudbury & Districts			2	2
Sudbury Catholic Schools			2	2
Developmental Services Ontario - Sudbury			1	1
Genevra House			1	1
Laurentian University	1	1		1
Nogdawindamin Family and Community Services			1	1
Spark Employment Services			1	1

Agency Involvement

Most Frequently Identified Lead Agencies



Most Frequently Identified Assisting Agencies



RMT Responses

Among the 139 situations referred to the RMT in 2024, 88 situations were closed with the reason "Overall Risk Lowered" (63%). This is slightly higher than in 2023 where 61% of situations were closed with the reason "Overall Risk Lowered". There are many strategies built into the Situation Table model that facilitate the lowering of overall risk including: the timeliness of the intervention; a comprehensive assessment of the situation; collaborative decision making; resource mobilization; and targeted interventions. However, there are also many factors that influence outcomes that are out of the control of a Situation Table such as external socioeconomic factors, resource limitations and systemic challenges. Despite these challenges RMT continues to play a vital role in facilitating collaboration, coordination, and proactive risk management efforts within our community. Outcomes of RMT responses are summarized below.

Top Closure Reasons for Situations of Acutely Elevated Risk

59% Connected to Services

10% Informed about services; not yet connected

4% Through no action of the Situation Table

12% Systemic Issue

9% Refused services

	Q1	Q2	Q3	Q4	Total
Number of Closed AER Discussions	29	30	25	51	**135**
Number of Closed Rejected Discussions	1	2	0	1	**4**

Additional outcome categories included: “Situation not deemed to be one of acutely-elevated risk (2%) ”Unable to locate” (2%), “Relocated” (1%); “Already connected to appropriate personal supports with potential to mitigate risk” (1%); and “Connected to personal supports” (1%). 4% of situations were closed as “Overall Risk Lowered – Through no action of the situation table”. In these cases, 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.

In 2024 it took an average of 16 days to close a discussion, equal to the number of days in 2023. The number of days it takes to close a discussion can be influenced by several factors including the complexity of the situation, the number of agencies involved, and the availability of information and resources.

Other factors influencing the amount of time that situations remain open include, trying to locate individuals (unknown incarceration, unknown housing), coordinating participation from other CMS partner agencies, and providing individuals with additional time to engage with appropriate services.

Systemic Issue - Categories

We are introducing a new process to collect information about systemic issues identified through RMT. We have developed a standardized template to record the affected services and a description of the system issue. This information will be reported quarterly to increase understanding of the systemic challenges affecting RMT interventions. This information can be used to identify trends and inform possible solutions at a community level. We have begun to pilot the collection of this information and will begin to formally report on it in the first quarter of 2025.

Services Mobilized

When closing discussions, RMT members identify which services were offered or provided to the individual during the response. 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, Mental Health was the most frequently identified service mobilized (71) followed by Housing (62) and Social Services (55). Social Assistance (38) and Medical Health (37) were the forth and fifth most mobilized services (Table 11).

Table 11
Top 10 most frequently identified services mobilized and type of mobilization

Service \ Mobilization Type	Informed of Service	Connected to Service	Engaged with Service	Refused Services	Total
Mental Health	30	30	11		71
Housing	17	24	21		62
Social Services	17	25	13		55
Social Assistance	11	18	9		38
Medical Health	5	15	17		37
Home Care	7	18	10		35
Food Support	13	12	10		35
Police	8	20	5	1	34
Life Skills	6	13	8		27
Counselling	12	8	5		25

RMT In Action

A referral for an individual male was brought forward to RMT.

This individual had been homeless for an extended period of time wandering the streets of Sudbury. He had no supports in place while struggling with strong addiction issues where he had overdosed on several occasions nearing death.

He was couch surfing when he could or sleeping on the street when he was forced to as he had not accessed any shelters. He was living in poverty with no means of income and struggling with his mental health due to past trauma and the situation he was in at the time.

This individual was brought forward to RMT where numerous community partners collaborated to quickly connect him to supports and resources he needed. He was immediately provided access to temporary housing through the Veteran's Housing Case Management program which is managed by the Homelessness Network and the City.

With support from community partners, he applied for social assistance as a source of income, had the opportunity to access some mental health supports as well as spiritual supports. He was also connected to services for treatment and recovery.

This individual quickly received wraparound supports from several agencies who responded immediately, with the goal of helping him stabilize and work toward greater well-being over time.

This story shows how RMT can make a real difference. It brings together the right people at the right time to respond to urgent needs. When someone is at imminent risk of significant harm, community partners can come together quickly to provide timely, coordinated supports that meets the unique needs of the individual. Because of the Table, this individual was connected to housing, income support, and access to care. It is an example of how community partners, through RMT, are making a difference in our community.

RMT In Action

A family referral was brought forward to RMT.

A couple living in a makeshift camper along a remote riverbank in the winter were referred to RMT due to serious concerns about their safety and well-being. Facing poverty, they were unable to pay rent and had been living in unsafe conditions. The male partner was also suffering from a physical health issue that was going untreated.

Due to the nature of the injuries, lack of alternate accommodations, and with the ongoing support from RMT partners, the couple was placed temporarily in a hotel room through the City that day, giving them a safe and stable place to receive services.

Paramedic services continued providing care and followed up with them while they were temporarily lodged. After a short while, they discovered that the male individual's untreated injury had become significantly infected. He was taken to the hospital immediately, where doctors determined that part of his leg needed to be amputated to prevent the infection from spreading further.

Thanks to the quick, coordinated response from multiple partners through RMT, both individuals continue to be supported and a potentially fatal health crisis was avoided.

This example highlights how RMT brings community partners together to rapidly respond to situations of acutely elevated risk. By acting fast and working as a team, RMT made sure these individuals got the support they needed, right when they needed it most.

Appendix A – 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:

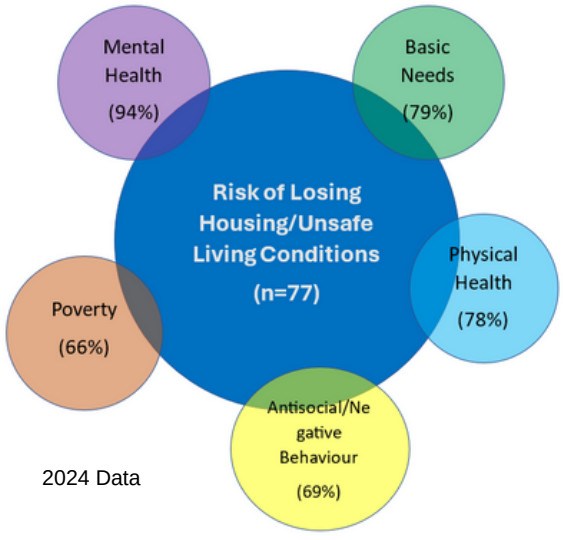
1. The CMS Rapid Mobilization Table has demonstrated itself to be an effective and valued mechanism for mitigating situations of elevated risk – an essential component of the province's proposed Community Safety and Well-being planning framework.
2. Community Mobilization Sudbury is the founder and administrative 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. From May 2014 to December 2024 there has been 16,967 risk factors reported by RMT.

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).



2024 Data

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 mental health, physical health, basic needs, antisocial / negative behaviour, 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.