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

Rapid Mobilization Table Data Analysis Update: February, 2015

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Rapid Mobilization Table Data Analysis
Update: February, 2015

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Background

Community Mobilization Sudbury (CMS) is a community partnership representing key sectors in the human services system such as health, children's services, policing, education, mental health and addictions, 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 clear definition of acutely elevated risk is a critical component of the CMS model.

Acutely elevated risk *refers to a situation affecting an individual, family, group or place where circumstances indicate a high probability of the risk of imminent and significant harm to self or others (e.g. offending or being victimized, lapsing on a treatment plan, experiencing an acute physical or mental health crisis, situations which may be detrimental to the well-being of children/youth). The acute nature of these situations is an indicator that circumstances, cutting across multiple human service disciplines, have accumulated to the point where a crisis is imminent or new circumstances have contributed to severely increased threats of harm to self or others.*

The Community Mobilization Sudbury model is based upon a well-established, evidence-informed, and evaluated model that originated in Scotland and has since been successfully replicated in Prince Albert, Saskatchewan. In Ontario, similar models are currently operating in Toronto, North Bay and Cambridge. Others are being developed in communities across the province. CMS is *not* a service delivery mechanism, but rather a way of utilizing and mobilizing existing systems and resources in a coordinated and collaborative way.

It is recognized that the CMS model is an investment of resources "upstream" in the coordinated prevention of negative outcomes, rather than a "downstream" response to harmful incidents once they have occurred. Community Mobilization Sudbury discussions and collaborations result in coordinated interventions to reduce acutely elevated risk. 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 primary goals:

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

The Rapid Mobilization Table (RMT)

Representatives from partner agencies meet twice a week at the *Rapid Mobilization Table* (RMT). The RMT is a focussed, disciplined discussion where participants collaboratively identify situations of acutely elevated risk. 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 requirements are maintained throughout RMT discussions, a "four filter" approach has been developed. 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. For additional details regarding the RMT process for identifying and responding to acutely elevated risk, refer to the CMS document, *Definitions and procedures guiding Rapid Mobilization Table meetings and discussions*.

Partners

We are very thankful for our funders and partner agencies. Without their expertise and commitment, Community Mobilization Sudbury would not be possible.

CMS partners are:

Behavioural Supports Ontario	NOAH's Space
Canadian Mental Health Association	North East Community Care Access Centre
Centre de santé communautaire du Grand Sudbury	North East Local Health Integration Network
Children's Aid Society of the Districts of Sudbury & Manitoulin	N'Swakamok Native Friendship Centre
City of Greater Sudbury	Rainbow District School Board
Conseil scolaire catholique du Nouvel-Ontario	Shkagamik-Kwe Health Centre
Conseil scolaire public du Grand Nord de l'Ontario	Sudbury Counselling Centre
Greater Sudbury Emergency Services	Sudbury Action Centre for Youth
Greater Sudbury Police Service	Sudbury Catholic District School Board
Health Sciences North	Sudbury Community Service Centre
Monarch Recovery Services	

Rapid Mobilization Table data analysis

At each Rapid Mobilization Table (RMT) meeting, the decision support specialist captures de-identified information of situations presented. Variables collected include demographics, risk factors, agencies involved in response, actions taken as part of the response and how the situations are closed. The following section provides an analysis of data captured during Rapid Mobilization Table meetings between May 6 and December 31, 2014. Due to the small sample size, it is important that readers interpret the data with caution. 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.

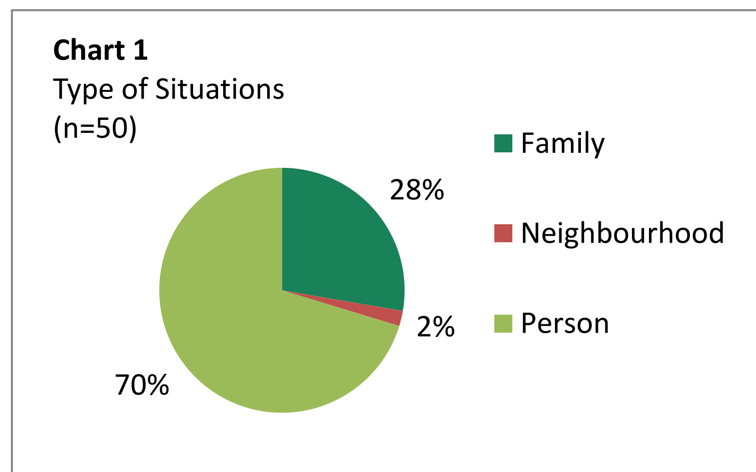
Situations presented to the RMT

A total of 66 situations were presented at RMT between May 6 and December 31, 2014. Of those, 50 (76%) met the threshold of acutely elevated risk (see Table 1). Three of those 50 situations were resolved without further RMT response, as it was determined through information sharing that the individuals/families were either already connected to services/supports or were in care/custody. Forty-seven situations of acutely elevated risk required a multi-agency response. Within these 47 situations, 1 individual was presented three times and 5 individuals were presented on two separate occasions due to re-occurring acutely elevated risk.

Table 1
Situations presented to the Rapid Mobilization Table between May and December, 2014
(n=66)

	n	%
Situation met the threshold of acutely elevated risk	50	76%
Situation was resolved through information sharing	3	5%
Situation required multi-agency response	47	71%
Situation did not meet threshold of acutely elevated risk	16	24%

The majority (70%, n=35) of situations of acutely elevated risk presented at the RMT involved individuals at risk. This is compared to 28% (n=14) of situations that involved families at risk and 2% (n=1) that focused on a neighbourhood at acutely elevated risk of harm. See Chart 1.



Originating agencies

Table 2 summarizes the frequency with which partner agencies presented situations of acutely elevated risk to the RMT between May and December, 2014. Greater Sudbury Police Service introduced the most situations (50%, n=25).

Table 2
Frequency of situations presented by RMT participating agencies.
(n=50)

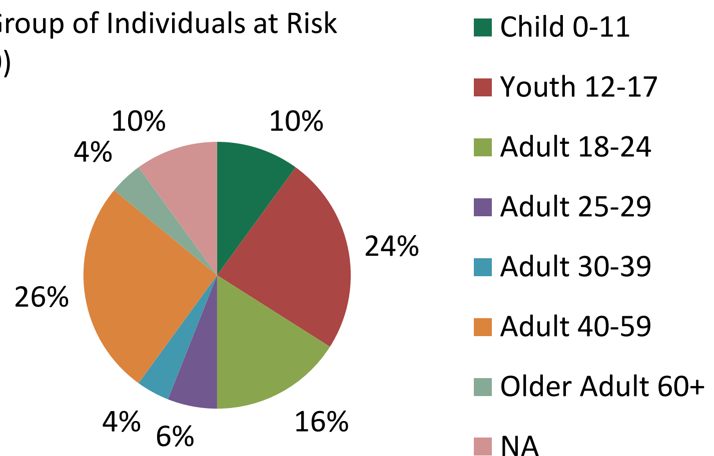
	n	%
Greater Sudbury Police Service	25	50%
City of Greater Sudbury Emergency Services	6	12%
Health Sciences North Crisis Intervention	5	10%
Rainbow District School Board	5	10%
Children's Aid Society Sudbury/Manitoulin	4	8%
Sudbury & District Health Unit	1	2%
Corner Clinic	1	2%
Monarch Recovery Services	1	2%
Sudbury Action Centre for Youth	1	2%
Sudbury Community Service Centre	1	2%

Demographics

Age

Of the situations that met the threshold of acutely elevated risk, 34% (n=17) involved children/youth under the age of 18. Twenty-six percent (n=13) were adults between the ages of 18 and 39 and 30% (n=15) were adults over the age of 40, (see Chart 2 for a complete breakdown of represented age groups).

Chart 2
Age Group of Individuals at Risk
(n=50)

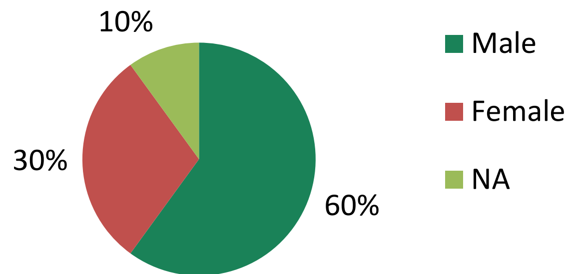


Note: NA refers to an identified neighbourhood or family that did not have a specific age group at risk.

Gender

Three out of five situations of acutely elevated risk (60%) involved a male individual, compared to 30% of situations that involved a female individual, (see Chart 3). Five situations (10%) focused on either a family or neighbourhood. These are categorized as 'NA' for gender.

Chart 3
Gender of Individuals at Risk
(n=50)



Note: NA refers to an identified neighbourhood or family that did not have a specific gender group at risk.

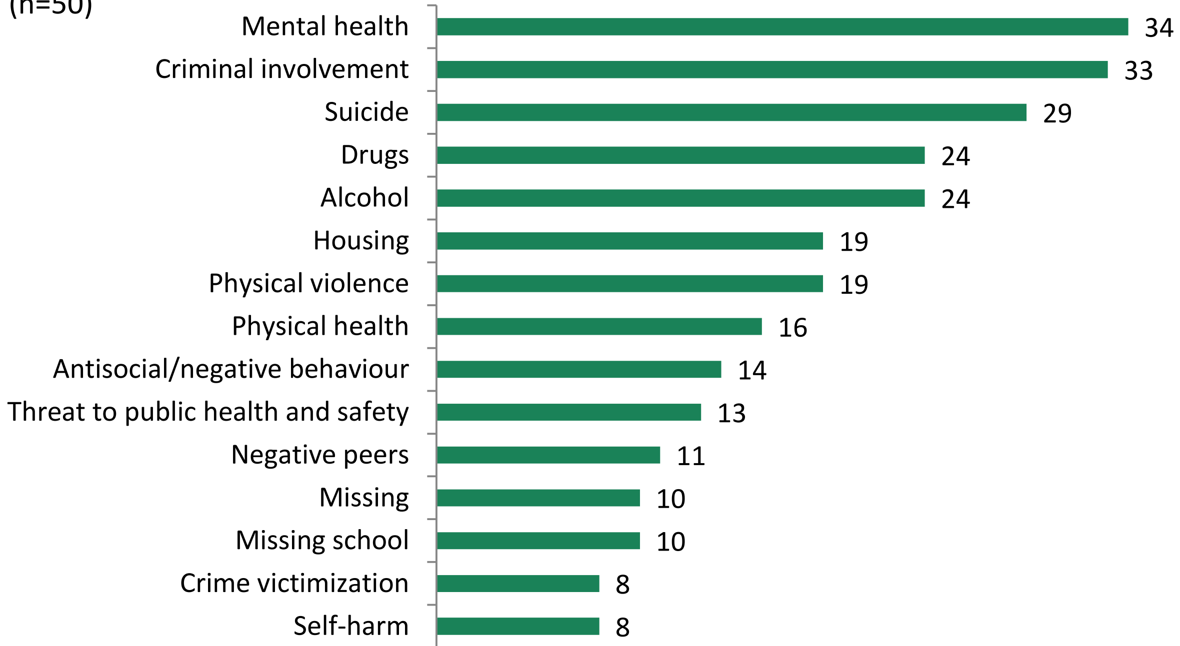
Risk factors contributing to acutely elevated risk

Categories of risk

There are 26 broad categories of risk captured from RMT situations of acutely elevated risk. Each includes multiple distinct risk factors. For example, under the category of *criminal involvement*, risk factors include:

- Arson
- Assault
- Drug trafficking
- Possession of weapons
- Possession of drugs
- Break and enter
- Damage to property
- Homicide
- Robbery
- Sexual assault
- Theft
- Threat
- Other

Mental health was the top risk category identified in more than two-thirds (68%, n=34) of situations of acutely elevated risk. Other frequently identified risk categories include: criminal involvement (66%, n=33), suicide-previous or current (58%, n=29), drugs (48%, n=24) and alcohol (48%, n=24). See Chart 4 for a breakdown of the top 15 risk categories



Risk categories by age group

There is great variance in the risk categories presented by age groups. For children/youth under 18, drugs and suicide were identified in the most situations (65%), compared to criminal involvement and mental health among adults aged 18-39 (77%) and mental health among adults over the age of 40 (93%). See Table 3 for a summary of the most frequently identified risk categories by age group.

Table 3
Most frequently identified risk categories by age group (T indicates a 'tie' between multiple risk factors)

#	Children/Youth Under 18 (n=17)	#	Adults 18-39 (n=13)	#	Adults 40+ (n=15)
T1	Drugs; Suicide (65%)	**T1**	Criminal involvement; Mental health (77%)	**1**	Mental health (93%)
2	Criminal involvement (59%)	**2**	Suicide (69%)	**T2**	Housing; Physical health (73%)
T3	Physician violence; Missing school (53%)	**3**	Alcohol (62%)	**3**	Criminal involvement (60%)
4	Mental health (47%)	**T4**	Drugs; Threat to public health and safety (54%)	**T4**	Alcohol; Suicide (53%)
T5	Antisocial/negative behaviour; Missing (35%)	**5**	Housing (46%)	**5**	Antisocial/negative behaviour (40%)

Risk categories by gender

The most frequently identified risk categories also vary by gender. Whereas criminal involvement and mental health (70% each) were the top risk categories for situations of acutely elevated risk for males, mental health and suicide were the top risk categories for females, each identified in 73% of situations, (see Table 4).[1]

Table 4
Most frequently identified risk categories by gender

#	Male (n=30)	#	Female (n=15)
T1	Criminal involvement; Mental health (70%)	**T1**	Mental health; Suicide (73%)
2	Suicide (57%)	**T2**	Drugs; Criminal involvement (53%)
T3	Alcohol; Drugs (47%)	**T3**	Alcohol; Antisocial/negative behaviour; Drugs (47%)
4	Housing (43%)	**4**	Physical violence (40%)
5	Physical violence (37%)	**T5**	Housing; Physical health; Self-harm; Missing school (33%)

Risk Factors

The CMS database tracks 104 distinct risk factors that fall under the 26 risk categories, (e.g. criminal involvement, mental health, alcohol). A total of 352 instances of these risk factors were identified as part of RMT situation presentations. An average of 7 risk factors were identified for each situation of

[1] These situations represent those classified as individuals at risk (n=35) in addition to 10 situations of families at risk which involved an individual as the primary source of risk within the family.

acutely elevated risk (minimum of 2, maximum of 14). The most frequently captured risk factor was a diagnosed mental health problem which was identified in 19 situations of acutely elevated risk. Criminal involvement – assault and not having access to appropriate housing were also frequently identified risk factors—identified in 16 situations each. See Chart 5 for a summary of the top 20 most frequently identified risk factors presented at the RMT.

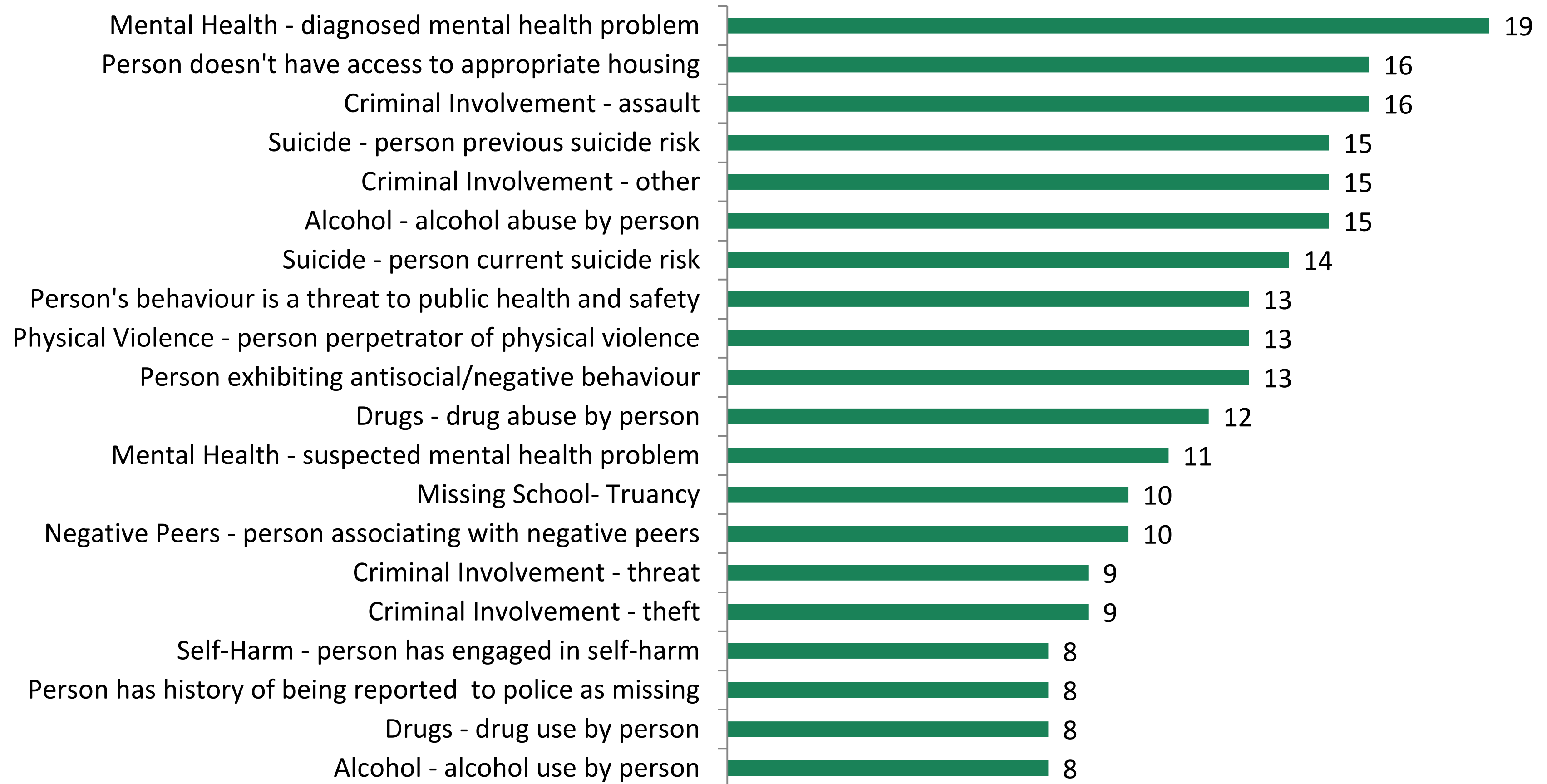


Chart 5
Top 20 risk factors identified in situations of acutely elevated risk
(n=50)
Mental Health - diagnosed mental health problem
19
Person doesn't have access to appropriate housing
16
Criminal Involvement - assault
16
Suicide - person previous suicide risk
15
Criminal Involvement - other
15
Alcohol - alcohol abuse by person
15
Suicide - person current suicide risk
14
Person's behaviour is a threat to public health and safety
13
Physical Violence - person perpetrator of physical violence
13
Person exhibiting antisocial/negative behaviour
13
Drugs - drug abuse by person
12
Mental Health - suspected mental health problem
11
Missing School- Truancy
10
Negative Peers - person associating with negative peers
10
Criminal Involvement - threat
9
Criminal Involvement - theft
9
Self-Harm - person has engaged in self-harm
8
Person has history of being reported to police as missing
8
Drugs - drug use by person
8
Alcohol - alcohol use by person
8

Rapid Mobilization Table Collaborative Responses

Lead and assisting agencies are identified as participants in each RMT response based on their mandate and capacity to respond to the risk factors present. The lead agency is responsible for coordinating the response and reporting back at the next RMT meeting. Assisting agencies may or may not be active in the response. However, they do contribute to the planning of the response based on their prior involvement or the perspective that they bring to understanding the situation. An average of 6 agencies participated in each collaborative response to acutely elevated risk.

Lead agencies

Greater Sudbury Police Service was the most frequently identified lead in more than one-third of RMT responses (34%, n=16). Other lead agencies are identified in Table 5.

Table 5
Frequency of agencies identified to lead RMT responses to acutely elevated risk (n=47)

	n	%
Greater Sudbury Police Service	16	34%
Children's Aid Society Sudbury/Manitoulin	10	21%
Health Sciences North Crisis Intervention	5	11%
Rainbow District School Board	3	6%
Canadian Mental Health Association	2	4%
Monarch Recovery Services	2	4%
N'Swakamok Native Friendship Centre	2	4%
Behavioural Supports Ontario	1	2%
City of Greater Sudbury Emergency Medical Services	1	2%
Corner Clinic	1	2%
NOAH's Space	1	2%
Sudbury Action Centre for Youth	1	2%
Sudbury Community Service Centre	1	2%
Sudbury & District Health Unit	1	2%

Assisting agencies

Table 6 identifies the frequency with which RMT partners participated as assisting agencies in RMT responses.

Table 6
Frequency of agencies identified to assist with RMT responses to acutely elevated risk (n=47)

	n	%
Health Sciences North Crisis Intervention[2]	37	79%
Canadian Mental Health Association	27	57%
Greater Sudbury Police Service	22	47%
Monarch Recovery Services	17	36%
Children's Aid Society Sudbury/Manitoulin	14	30%
Rainbow District School Board	11	23%
NOAH's Space	10	21%
N'Swakamok Native Friendship Centre	9	19%
City of Greater Sudbury Emergency Services	7	15%
Sudbury Counselling Centre	6	13%
City of Greater Sudbury Social Services	5	11%
Sudbury & District Health Unit	5	11%
Corner Clinic	3	6%
Sudbury Community Service Centre	3	6%
Shkagamik-Kwe Health Centre	2	4%
Sudbury Action Centre for Youth	2	4%
Behavioural Supports Ontario	1	2%

Non-RMT assisting agencies

When lead and assisting agencies are identified, the RMT also indicates if other non-RMT agencies may be required as part of the response. Responders share de-identified information with these agencies in order to gain information and perspective on the type of supports that may be provided to the individuals/families at risk. Referrals may be made back to non-RMT agencies as part of responses. Below is a summary of non-RMT partners that were identified and connected with as part of responses to acutely elevated risk.

- Child and Family Centre (n=12)
- North East Community Care Access Centre (n=6) (became a CMS partner on January 6, 2015)
- Sudbury Community Services Centre (n=4), (became a CMS partner on July 24, 2014)
- Youth Probation (n=5)

[2] HSN Crisis Intervention has been frequently identified as an assisting responder with the understanding that they will be available should there be need for immediate mental health support or assessment.

- Behavioural Supports Ontario (n=2), (became a CMS partner on July 22, 2014)
- Children's Community Network (n=2)
- Corner Clinic (n=2), (became a RMT participant on July 15, 2014)
- Sudbury Counselling Centre (n=2), (became a CMS partner on June 19, 2014)
- Individual's Primary Care Provider (n=2)

Special considerations that help guide responses

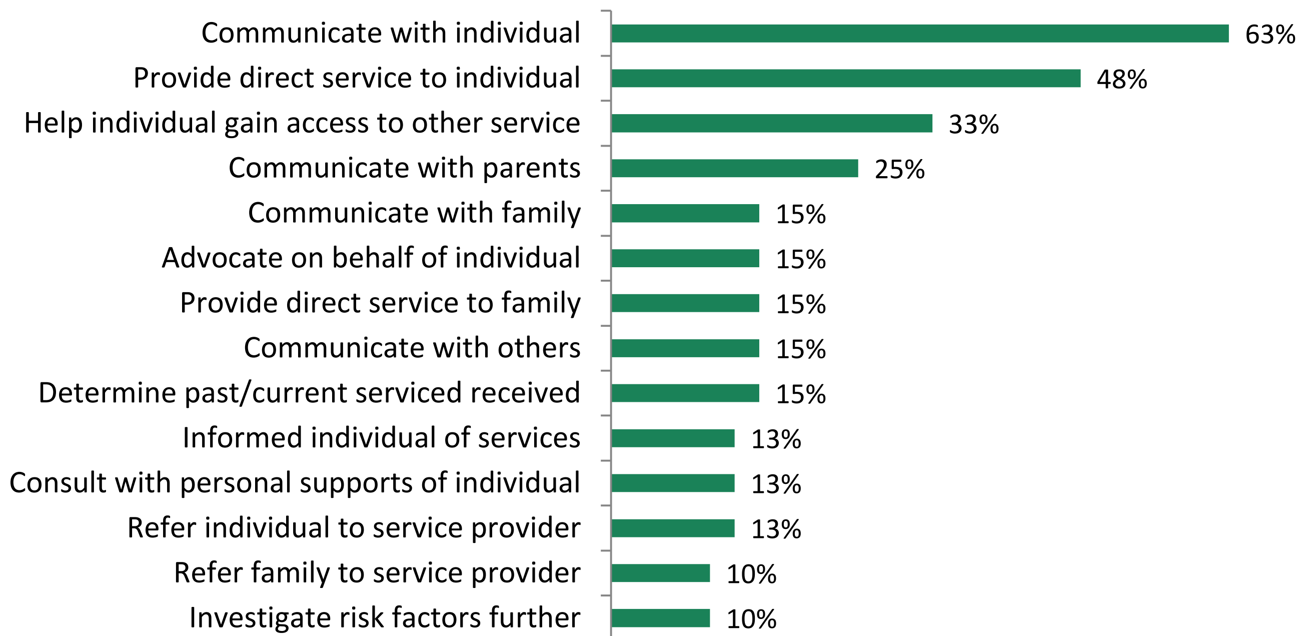
As part of the de-identified information gathered in the program database, CMS tracks special considerations that may help to guide RMT responses. Of situations of acutely elevated risk that required multi-agency response:

- 47% of situations involved children
- 32% of situations involved an individual that identifies as First Nations/Aboriginal
- 26% of situations involved an individual with a cognitive disability
- 21% of situations were identified as a Youth Criminal Justice Act Conference
- 21% of situations involved domestic violence in the household
- 15% of situations involved an individual who was homeless

Actions taken in response to situations of acutely elevated risk

On June 3, 2014, RMT started tracking specific actions taken by agencies as part of RMT responses. Within 40 responses (between June 3 and December 31, 2014), a total of 137 actions were taken with an average of 3 actions per response.

Chart 6 provides a summary of most frequent actions taken by RMT partners in response to situations of acutely elevated risk.



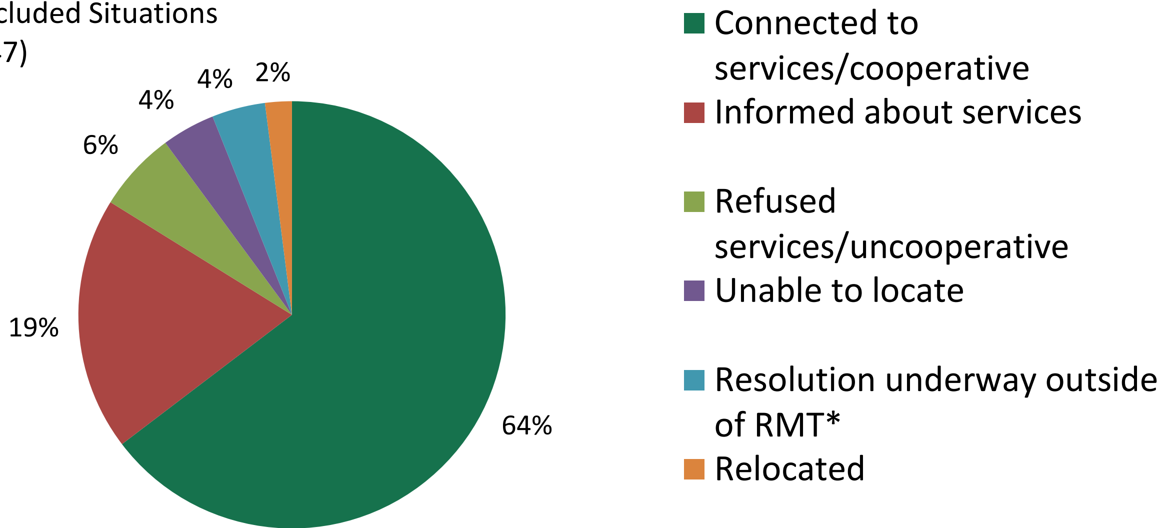
Situation resolution

All 47 situations of acutely elevated risk which required a multi-agency response were concluded as of December 31, 2014 with a total of 69 individuals helped through agency interventions. On average, situations remained open for 6 days (minimum of 2 days, maximum of 16 days). Factors influencing the amount of time that situations remained open include:

- Trying to locate individuals (unknown incarceration, unknown housing)
- Finding ways to connect with individual when coordinating other agencies not at RMT
- Individuals who have a long history of being at risk, and have challenging relationships with many service providers.

The majority of situations have been closed as *"connected to services/cooperative"* (64%), or *"informed of services"* (19%). Six percent (n=3) were closed as *"refused services/uncooperative"*. Of note, mental health and cognitive disability were identified as concurrent risk factors for all three of these individuals.

Two situations required a long-term resolution to address and mitigate risks. See Chart 7 for a summary of how RMT situations were concluded.



*Two situations required longer term soluations. For example, a neighbourhood was brought forward and it was decided that the intervention would need a long-term collaborations in order to mitigate risks.

Examples of successful or innovative responses

The CMS mission is, "Innovative connections for community well-being". Taking an "outside of the box" approach to identifying and responding to situations of risk is at the heart of what we do. The following de-identified stories illustrate several successes shared by RMT participants.

#1: A youth was presented to the RMT as suicidal and a recent witness to a traumatic event. Several additional risk factors were impacting the youth's level of risk including frequent criminal involvement. The youth was hospitalized at the time of presentation, to be discharged on the day of presentation. RMT partners communicated with the youth's physician. It was determined that the youth should remain in hospital until more stable. RMT responders met with the youth and their psychiatrist to develop safety and treatment plans prior to hospital discharge. The youth continues to improve on a daily basis. Prior to RMT involvement, police had 16 interactions with the youth over an 8 month period. There have been no police interactions with the youth in the past 5 months.

#2: A young adult was presented to RMT as currently missing, believed to be suicidal, with a history of physical violence and homicidal ideation. The individual had a common-law partner and new baby. Immediately following the RMT meeting, RMT partners were able to locate the individual and bring them to HSN Crisis for assessment. The individual was voluntarily admitted for psychiatric treatment at the hospital. RMT partners completed safety plans with the common-law partner and the family was connected to appropriate counselling services.

#3 CAS was informed by a child welfare agency in another province that one of their families had relocated back to Sudbury. One of the children had been receiving counselling services and was thought to pose a risk to self and others. Following presentation at RMT, GSPS was able to locate the family. RMT partners reached out to the family and were able to connect them to appropriate local services and supports.

#4: An individual was presented to RMT as having a diagnosed mental illness, unable to meet basic needs and currently living out of their vehicle. They had made previous suicide attempts and were believed to be a current suicide risk due to seasonal triggers. By the following meeting (2 days later), RMT partners had been able to connect the individual to housing and assist with additional supports.

System/Service Gaps and Barriers

Beyond the identification of immediate risk factors, RMT discussions also provide CMS partners with an opportunity to identify broader issues impacting the safety and well-being of the community. System gaps, barriers to accessing services, and policies that impact service provision are captured as part of RMT field notes. The following table captures some of the more common issues identified by RMT participants.[3]

[3] It is important to acknowledge that these notes are anecdotal, based on the reported experiences and perceptions of RMT participants and individuals served. Other factors, external to the CMS/RMT process, may be influencing these identified issues and gaps on an ongoing basis.

Table 7
Issues identified during RMT discussions

Housing/Shelter	• Limited emergency shelter options are available for individuals ○ with limited mobility; ○ who are under the influence of alcohol or other substances.[4]
Residential addiction support services	• Perceived need exists to establish or expand ○ A residential Managed Alcohol/Harm Reduction Program ○ Addiction supportive housing ○ A formalized support program for males who are on wait lists to receive residential addiction treatment.[5]
Individuals with dual diagnoses or concurrent disorders	• There is a perceived need for ○ more coordinated, “wrap-around” services for individuals with mental illness and developmental disability. ○ more options that integrate community/supportive living and mental health support.
Waitlists	• Long waitlists for service impact multiple sectors and providers.
Developmental disability supports	• The cost of capacity/cognitive assessments is a barrier for certain individuals to obtain cognitive and developmental disability supports. • There are few structured supports in place for youth requiring developmental services that are transitioning from CAS to adult care.
Differences in values and processes across sectors	• Most notably, justice and human service agencies are frequently required to reconcile differences in the processes, requirements and expectations of their sectors.
Other identified issues	• The ‘working poor’ experience barriers to accessing services that are sometimes more readily available to those on social assistance. • The need for a fixed address restricts certain agencies from providing service to those who are homeless or transient.

[4] Since the identification of this need, an accessible emergency shelter has been established. It is accessible to those under the influence of alcohol and other substances.
[5] A support program is currently in the development stages to try and meet this need. Currently, the men’s recovery program provides pre and post support to men entering treatment programs in other communities.

Summary note

The Community Mobilization Sudbury partnership continues to demonstrate early progress towards its program goals. Individuals and families at high risk of harm have been connected to timely supports. These supports have been provided by a diverse team of CMS partners and community stakeholders, demonstrating the complexity of issues impacting individuals and families at risk. Partners are working together in increasingly collaborative ways — building relationships and trust as they work within a new model of service provision. Lastly, CMS data has influenced the planning and development of several emerging community initiatives. These include the development of a local Managed Alcohol/Harm Reduction Program, the proposed Greater Sudbury Health Link and cross-sectoral Community Safety and Well-being plans. A formal evaluation of CMS processes and preliminary impacts is underway. A full report of that evaluation will be available in the spring of 2015.

Appendix A

List of risk factors collected within Rapid Mobilization Table data.

RISK CATEGORY	RISK FACTORS	DESCRIPTION
Alcohol	alcohol use by person	known to consume alcohol; no major harm caused
	alcohol abuse by person	known to excessively consume alcohol; causing self-harm
	alcohol abuse in home	living at a residence where alcohol has been consumed excessively and often
	harm caused by alcohol abuse in home	has suffered mental, physical or emotional harm or neglect due to alcohol abuse in the home
	history of alcohol abuse in home	excessive consumption of alcohol in the home has been a problem in the past
Antisocial/Negative Behavior	person exhibiting antisocial/negative behavior	is engaged in behaviour that lacks consideration of others, which leads to damages to other individuals or the community (i.e: partying; public urination; rude, obnoxious or disruptive behaviour)
	antisocial/negative behavior within home	resides where there is a lack of consideration for others, resulting in damage to other individuals or the community (i.e: partying; public urination; rude, obnoxious or disruptive behaviour)
Basic Needs	person being neglected by others	basic physical, nutritional or other needs are not being met by others they depend upon
	person neglecting others' basic needs	has failed to meet the physical, nutritional or other needs of others under their care
	person unable to meet own basic needs	cannot independently meet their own physical, nutritional or other 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

Crime Victimization	damage to property	has been reported to police to be a victim of someone damaging their property
	arson	has been reported to police to be the victim of arson
	theft	has been reported to police to be the victim of theft (someone stole from them)
	break and enter	has been reported to police to be the victim of break and enter (someone broke into their premises)
	robbery	has been reported to police to be the victim of robbery (someone threatened/used violence against them to get something from them)
	assault	has been reported to police to be the victim of assault (i.e: hitting, stabbing, kicking)
	sexual assault	has been reported to police to be the victim of sexual assault (i.e: touching, rape)
	threat	has been reported to police to be the victim of someone uttering threats to them
	other	has been reported to police to be the victim of other crimes not mentioned above
Criminal Involvement	damage to property	has been suspected, charged, arrested or convicted for damage to property
	arson	has been suspected, charged, arrested or convicted for arson
	theft	has been suspected, charged, arrested or convicted for theft
	break and enter	has been suspected, charged, arrested or convicted for break and enter
	robbery	has been suspected, charged, arrested or convicted for robbery (which is theft with violence or threat of violence)
	assault	has been suspected, charged, arrested or convicted of assault
	sexual assault	has been suspected, charged, arrested or convicted for sexual assault
	threat	has been suspected, charged, arrested or convicted for uttering threats
	homicide	has been suspected, charged, arrested or convicted for the unlawful death of a person
	animal cruelty	has been suspected, charged, arrested or convicted for animal cruelty
	drug trafficking	has been suspected, charged, arrested or convicted for drug trafficking
	possession of weapons	has been suspected, charged, arrested or convicted for possession of weapons
	possession of drugs	has been suspected, charged, arrested or convicted for possession of drugs
	other	has been suspected, charged, arrested or convicted for other crimes

Drugs	drug use by person	known to use illegal drugs (or misuse prescription drugs); no major harm caused
	drug abuse by person	known to excessively use illegal/prescription drugs; causing self harm
	drug abuse in home	living at a residence where illegal (or misused prescription drugs) have been consumed excessively and often
	harm caused by drug abuse in home	has suffered mental, physical or emotional harm or neglect due to drug abuse in the home
	history of drug abuse in home	excessive consumption of drugs in the home has been a problem in the past
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
	person perpetrator of elderly abuse	has knowingly or unknowingly caused intentional or unintentional harm upon others because of physical, mental or situational vulnerabilities associated with the aging process
Emotional Violence	person victim of emotional violence	has been emotionally harmed by others who have controlled their behaviour, name-called, yelled, belittled, bullied or intentionally ignored them, etc.
	person perpetrator of emotional violence	has emotionally harmed others by controlling their behaviour, name-calling, yelling, belittling, bullying, intentionally ignoring them, etc.
	emotional violence in the home	resides with a person who exhibits controlling behaviour, name-calling, yelling, belittling, bullying, intentional ignoring, etc.
	person affected by emotional violence	has been affected by others falling victim to controlling behaviour, name-calling, yelling, belittling, bullying, intentional ignoring, etc. (i.e: witnessing; having knowledge of)
Gambling	chronic gambling by person	regular and/or excessive gambling; no harm caused
	chronic gambling causes harm to self	regular and/or excessive gambling; resulting in self-harm
	chronic gambling causes harm to others	regular and/or excessive gambling that causes harm to others
	person affected by the gambling of others	is negatively affected by the gambling of others

Gangs	gang association	social circle involves known or suspected gang members, but is not a gang member
	gang member	is known to be a member of a gang
	threatened by gang	has received a statement of intention to be injured or have pain inflicted by gang members
	victimized by gang	has been attacked, injured, assaulted or harmed by a gang in the past
Housing	person does not have access to appropriate housing	is living in inappropriate housing conditions or none at all (i.e: condemned building, street)
	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)
	unsafe living conditions	housing is not safe to live in or is infested (i.e. hoarding, bed bugs)
Mental Health	diagnosed mental health problem	has a professionally diagnosed mental health problem
	suspected mental health problem	suspected of having a mental health problem (no diagnosis)
	self-reported mental health problem	has reported to others to have a mental health problem(s)
	witnessed traumatic event	has witnessed an event that has caused them emotional or physical trauma
	mental health problem in the home	residing in a residence where there are mental health problems
	grief	experiencing deep sorrow, sadness or distress caused by loss
	not following prescribed treatment	not following treatment prescribed by a mental health professional; resulting in risk to self or others
Missing School	Truancy	has unexcused absences from school without parental knowledge
	Chronic Absenteeism	has unexcused absences from school with parental knowledge, that exceed the commonly acceptable norm for school absenteeism

Missing/Runaway	runaway with parents' knowledge of whereabouts	has run away from home with guardian's knowledge but guardian is indifferent
	runaway without parents' knowledge of whereabouts	has runaway and guardian has no knowledge of whereabouts
	person reported to police as missing	has been reported to the police and entered in the Canadian Police Information Centre (CPIC) as a missing person
	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
Negative Peers	person associating with negative peers	is associating with people who negatively affect their thoughts, actions or decisions
	person serving as a negative peer to others	is having a negative impact on the thoughts, actions or decisions of others
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
	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
	parent-child conflict	ongoing disagreement and argument between guardian and child that affects the functionality of their relationship and communication between the two parties

Physical Health	pregnant	pregnant
	physical disability	suffers from a physical impairment
	terminal illness	suffers from a disease that cannot be cured and that will soon result in death
	chronic disease	suffers from a disease that requires continuous treatment over a long period of time
	nutrition deficit	suffers from insufficient nutrition, causing harm to their health
	general health issue	has a general health issue which requires attention by a medical health professional
	not following prescribed treatment	not following treatment prescribed by a health professional; resulting in risk
Physical Violence	person victim of physical violence	has experienced physical violence from another person (i.e: hitting, pushing)
	person perpetrator of physical violence	has instigated or caused physical violence to another person (i.e: hitting, pushing)
	physical violence in the home	lives with threatened or real physical violence in the home (i.e: between others)
	person affected by physical violence	has been affected by others falling victim to physical violence (i.e: witnessing; having knowledge of)
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
	person threatens self-harm	has stated that they intend to cause non-suicidal injury to their own body
Sexual Violence	person victim of sexual violence	has been the victim of sexual harassment, humiliation, exploitation, touching, or forced sexual acts
	person perpetrator of sexual violence	has been the perpetrator of sexual harassment, humiliation, exploitation, touching, or forced sexual acts
	sexual violence in the home	resides in a home where sexual harassment, humiliation, exploitation, touching, or forced sexual acts occur
	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)

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
	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
Suicide	person current suicide risk	currently at-risk to take their own life
	person previous suicide risk	has in the past, been at-risk to take their own life
	affected by suicide	has experienced loss due to suicide
Supervision	person not properly supervised	has not been provided with adequate supervision
	person not providing proper supervision	has failed to provide adequate supervision to a dependent 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 a danger to the health and safety of the community (i.e: unsafe property, intentionally spreading disease, putting others at risk)
Unemployment	person temporarily unemployed	without paid work for the time being
	person chronically unemployed	persistently without paid work
	caregivers temporarily unemployed	caregivers are without paid work for the time being
	caregivers chronically unemployed	caregivers are persistently without paid work