Vision: ***Collaborative, caring innovation for community safety and well-being***

Mission: ***Shared leadership and intervention for improved community safety and well-being through timely and responsive partnership mobilization***

Values ***Integrity ~ Compassion ~ Creativity ~ Humility ~ Honesty ~ Respect ~ Change***

1.0 Background

The Oxford Situation Table began forming in May 2014 with the support of local Police Services and the member agencies of the Oxford Health Link. It emerged from a community discussion regarding the Ministry of Health and Long Term Care's initiative through Local Health Integration Networks to support the development of regional health links to better coordinate health services to address 'the top 5%'; those most frequently using health care, often via the emergency department. In the meantime, the Ministry of Corrections and Community Safety had been embarking on supporting regional community mobilization efforts to mitigate risk and avoid over use of costly emergency services in situations where a mobilized, multi-disciplinary, proactive approach would be a better solution for individuals and families. As a result, the small group turned to look at the evidence-based concept of a Situation Table.

A Situation Table is a forum and framework for highly structured collaboration among human service providers such as first responders, health trustees, government institutions and community-based agencies. Based on the Community Mobilization Prince Albert Model, and supported by the Community Safety and Well-Being Tools provided by the Ontario Association of Chiefs of Police Ontario Working Group, it mobilizes existing resources to help citizens/families rapidly reduce acutely elevated risk.

Acutely elevated risk exists when a number of complex factors are identified that, if left unattended, would likely result in serious harm or lead to the situation worsening to the point where a more formal and intrusive intervention is required. This could include incidents such as apprehension of children, criminal charges, frequent use of emergency medical care, or prolonged medical or psychiatric inpatient hospital stays. Before any situation is discussed at a situation table, it must be determined that the situation involves such risk factors that extend beyond the scope or normal business practices of any one agency. In situation table discussions, any situation must also cross multiple sectors in order to meet the threshold for further discussion as a complex situation in need of a coordinated response.

The situation table is a clearly defined process for determining if an individual and/or family are at acutely elevated risk and if multi-agency intervention is required. The process is designed to balance a citizen's right to privacy with the value or necessity of addressing the elevated risk to reduce harm. Each meeting begins with a focused review of situations that have been auctioned by the situation table at a previous meeting. This process ensures that the correct de-identified information has been recorded and confirms that the intervention successfully reduced the acutely elevated risk in order to close the situation. A second round of discussion involves the identification of any new situations that may potentially require intervention. The intervention is a rapid mobilization of community service providers that are able to address the multiple risk factors by 'thinking outside the box' and working together.

At each stage of a situation table discussion, if it is determined that multi-agency intervention is not required, the situation is then handled by the appropriate organizations internally as per their normal practice and procedures. The situation table is not a case management or planning table. All case management and case planning remains with the individual agencies involved in any intervention. The situation table does not track or monitor cases on an ongoing basis and maintains no authority over short-term interventions or follow-up services. Discussions are deemed closed at the situation table when the acutely elevated risk has been reduced and the individual and/or family have been connected to relevant community resources to alleviate risk. All case planning and case management is conducted by those agencies involved and is not within the mandate of the situation table (Jerome, et al., 2013).

This report represents the analysis of data collected during the first six months of the Oxford Situation Table project from November 18, 2014 – May 18, 2015. Meeting each Tuesday morning, situation table participants represent multiple community agencies across Oxford County, a population of 106,000 citizens across a large geographical area. This evaluation framework is based on the reporting process done in both Prince Albert, Saskatchewan and the work in North Bay, Ontario. There are approximately 15 other Ontario communities engaged in a similar process.

2.0 Methods

As per the Community Safety & Wellbeing toolkit, data was entered into a Microsoft Excel database at the Oxford Situation Table meetings predominately by the co-chair of the situation table who is a member of the Woodstock Police Services. The data was reviewed monthly by this co-chair to ensure it was accurate, and revised as needed with clarification sought from participants as needed. The database included variables derived from the Prince Albert model which includes 104 risk factors and 26 risk categories as well as select demographic variables. These variables are identical to those used in other areas of the province which will eventually be uploaded to a provincial database through the Ministry of Community Safety and Corrections to allow for cross consultation to explore regional trends and issues.

In addition, an evaluation of the situation table participants' experience working together on this new project was also conducted. This evaluation was to capture the participant experience both at the table, and at times where they were involved in rapid mobilization interventions. It was also adapted to determine the relationship amongst providers at the onset of the project and throughout. This evaluation was carried out weekly to create a baseline and track progress throughout the project.

All Situation Table participants completed a final comprehensive evaluation.

Individuals and families who were connected to service through the Situation Table were invited to participate in an evaluation.

3.0 Results

3.1 Number of situations

Table 1 shows the number of referred situations to Oxford County Situation Table between November 18, 2014 and May 18, 2015. Seven (7) of these referrals did not meet the threshold for acutely elevated risk and were rejected, while forty-four (44) of the situations presented were approved.

Table 1: Frequency and outcome of situations referred

Referrals (n=51)	**#**	**%**
Approved	44	86
Rejected	7	14
Total referred	51	100
Approved (n=44)		
Concluded	34	77
Remain open	4	9
Reopened	6	14

3.2 Duration of service & individuals helped

The majority of individuals presented to the situation table were cooperative and connected to services (74%); however, 8% of individuals were informed about services and 13% refused services. Unfortunately, 2% of individuals relocated before they could be informed or connected to services and 3% of individuals deceased before they could be informed or connected to services (See Figure 2).

The average number of days between the date a situation was opened and the date it was concluded was 1-12 days. In total there were 51 situations brought forward involving 62 individuals. Of these, 44 situations were approved and 43 people were helped (connected to or informed of services).

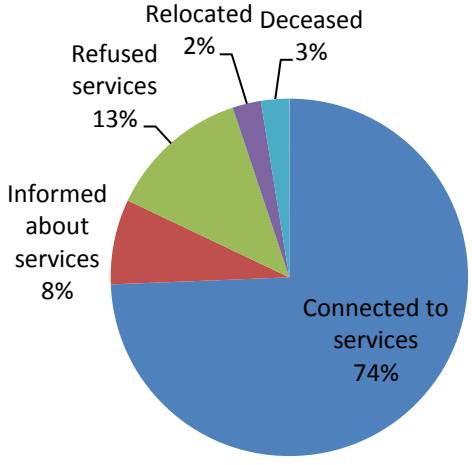


Figure 2: Situation Conclusion

3.3 Demographics

Gender & Age

Out of the 62 people referred through 44 situations (individuals, families or dwellings) 54% were female, compared to 46% males. See Figure 3.

The majority of individuals in presented situations of acutely elevated risk were youth aged 16-17 (19.4%). This is followed by youth aged 12-15 (17.8%) and older adults aged 60 or more (16.1%). See Figure 4. It is interesting to note that since the end of the pilot project in May, there has been a significant increase noted in older adults.

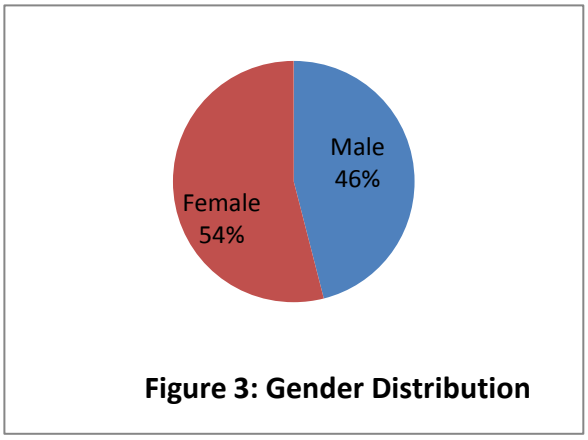


Figure 3: Gender Distribution

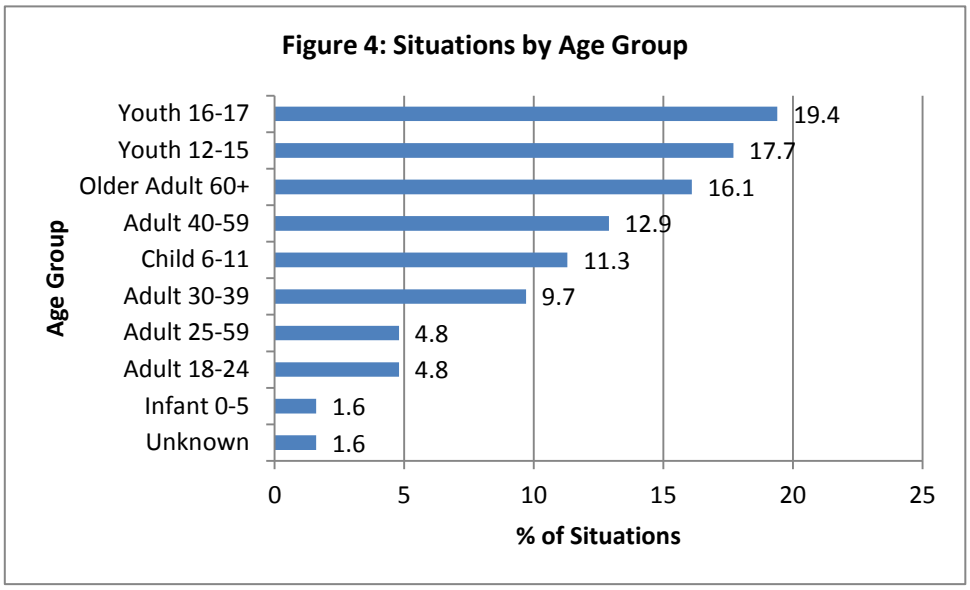
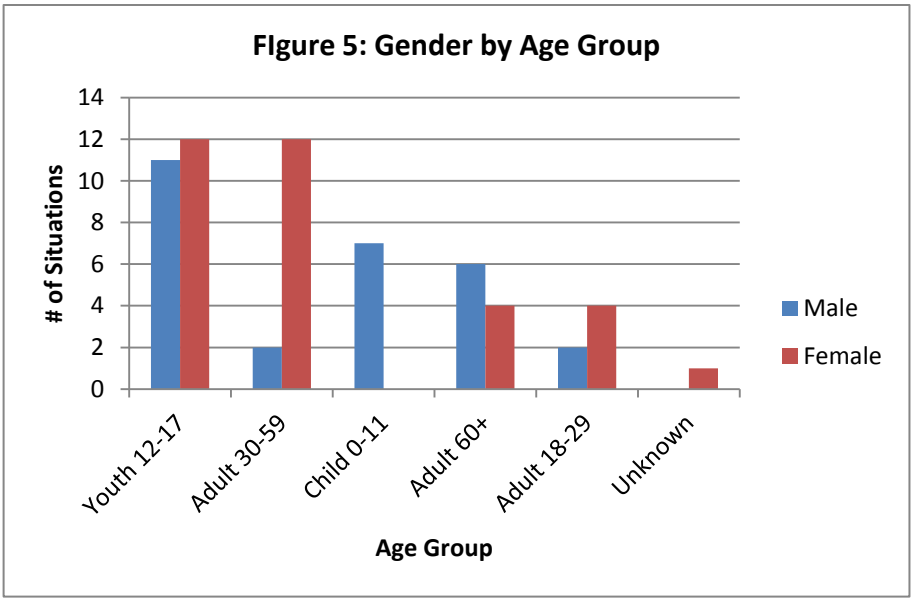


Figure 5 shows gender distribution within each age group. As stated above, youth aged 12-17 had the greatest number of situations, with a fairly equal distribution of males and females. Adults aged 30-59 had a significantly higher proportion of females than males within that age group.



Type of Situation

The majority of situations of acutely elevated risk involved an individual person at 67%. This is compared to 19% of situations that involved families and 12% that involved dwellings and 2% that focused on the environment or neighbourhood. See Figure 6.

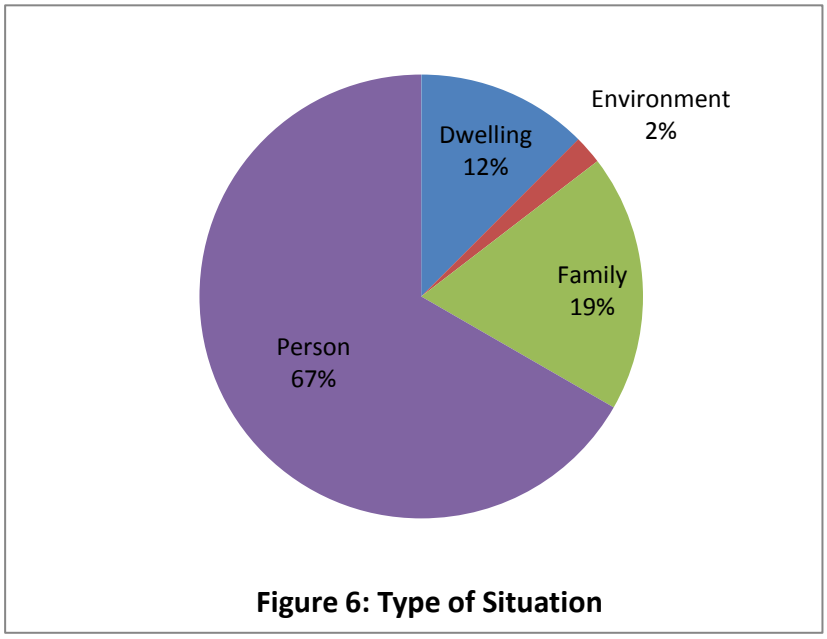


Figure 6: Type of Situation

3.4 Risk categories

Figure 7 shows the frequency of situations per category. The highest frequencies were mental health related situations (61%), followed by situations involving criminality (45%).

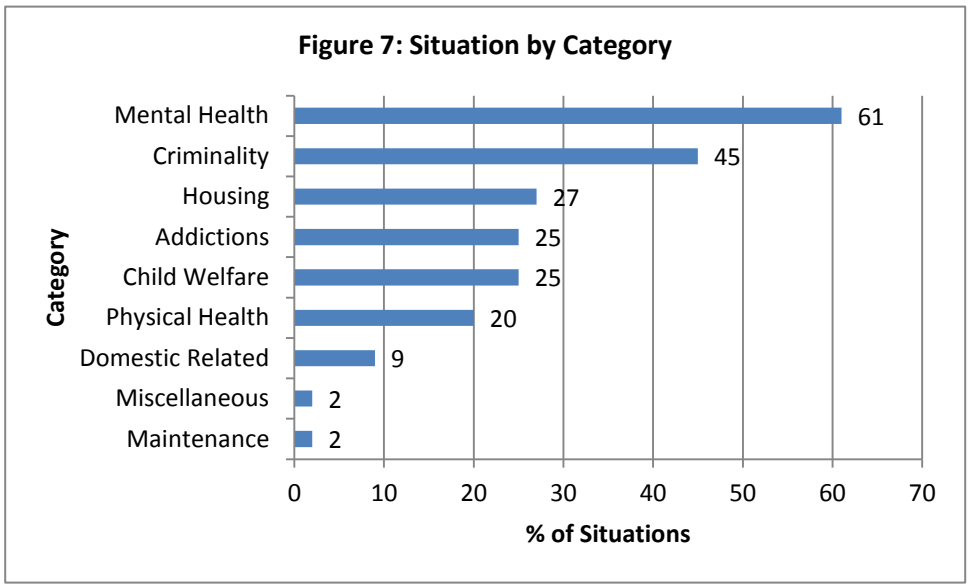


Figure 8 shows risk categories separated by age group. As mentioned earlier, mental health was reported most frequently at the Oxford Situation Table. Figure 9 shows that youth aged 12-17 report the highest number of mental health situations out of every age group. This is also true for criminality, child welfare and addictions categories.

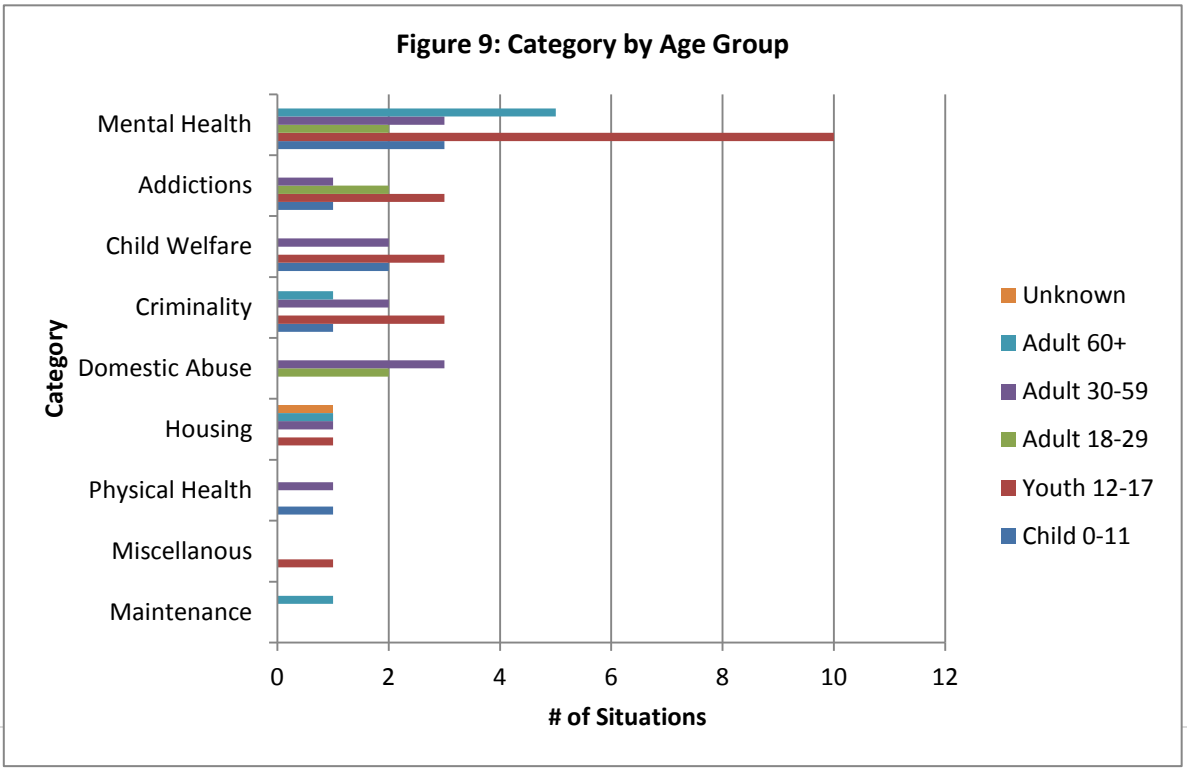
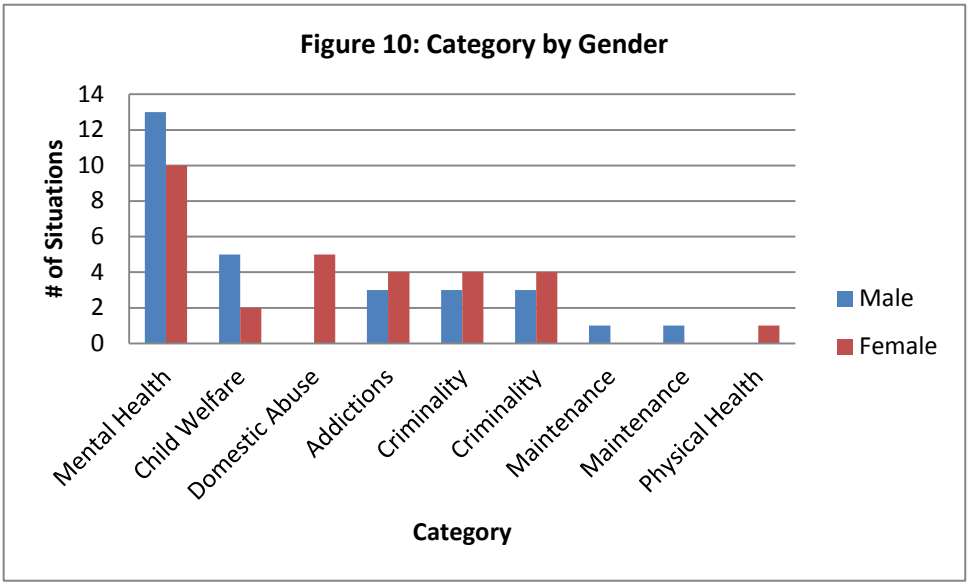


Figure 10 shows risk categories distributed by gender. Males experienced more situations in the categories of child welfare, maintenance, mental health and miscellaneous. Females experienced more situations in the categories of addictions, criminality domestic abuse and physical health. Males and females experienced an equal number of housing related situations.



3.5 Risk identification

Table 11 shows the top ten risk factors presenting at the Oxford Situation Table. Out of 69 risk factors seen at the Oxford Situation Table during the six month pilot, suspected mental health ranked highest (23.2%), followed by individuals exhibiting antisocial or negative behaviour (20.3%) and diagnosed mental health (18.8%).

Table 11: Top 10 risk factors

Risk Factor	#	%
Mental Health - suspected	16	23.2
Antisocial/negative behaviour – exhibiting	14	20.3
Mental health – diagnosed	13	18.8
Supervision –not properly supervised	11	15.9
Housing –doesn't have access	11	15.9
Criminal involvement - assault	10	15.5
Suicide –current suicide risk	9	13.0
Antisocial/negative behaviour – within home	9	13.0
Self-Harm – engaged in self-harm	9	13.0
Threat to public health and safety	9	13.0

3.6 Agencies

Table 12 summarizes the frequency with which agencies presented situations to the Oxford Situation Table between November 2014 and May 2015. The Oxford OPP introduced the most situations (n=25, 56.8%), followed by Woodstock Police Services (n=7, 15.9%).

Table 12: Frequency of originating agencies presenting situations

Originating Agency	#	%
OPP Oxford	25	56.8
Woodstock Police Services	7	15.9
Children's Aid Society Oxford	4	9.1
CMHA Oxford	2	4.6
Domestic Abuse Services Oxford	2	4.6
Ingersoll NPLC	2	4.6
Addiction Services of Thames Valley	1	2.3
Probation Services	1	2.3

Table 13 summarizes the frequency with which lead agencies responded to each situation. Children's Aid Society Oxford took the lead in responding to the most situations (n=8, 20.5%), followed by Addiction Services of Thames Valley (n=6, 15.4%) and CMHA Oxford (n=6, 15.4%).

Table 13: Frequency of lead agencies responsible for situations

Lead Agency	#	%
Children's Aid Society Oxford	8	20.5
CMHA Oxford	6	15.4
Addiction Services of Thames Valley	6	15.4
Oxford OPP	4	10.3
Oxford-Elgin Child and Youth Centre	3	7.7
Community Care Access Centre	3	7.7
Domestic Abuse Services Oxford	2	5.1
Ingersoll NPLC	2	5.1
Woodstock & Area CHC	2	5.1
Probation Services	1	2.6
Thames Valley District School Board	1	2.6
Woodstock General Hospital	1	2.6

Table 14 summarizes the frequency of assisting agencies recruited for a rapid mobilization intervention for each identified situation. CMHA Oxford assisted on the greatest number of situation (n=17, 43.6%), followed by Oxford OPP (n=16, 41.0%) and Woodstock General Hospital (n=16, 41.0%). The average number of assisting agencies per situation was 4.5.

Table 14: Frequency of assisting agencies recruited for situations

Assisting Agency	#	%
CMHA Oxford	17	43.6
OPP Oxford	16	41.0
Woodstock General Hospital	16	41.0
Oxford-Elgin Child and Youth Centre	16	41.0
Children's Aid Society Oxford	15	38.5
Thames Valley District School Board	12	30.8
Woodstock & Area CHC	12	30.8
Addiction Services of Thames Valley	11	28.2
Domestic Abuse Services Oxford	10	25.6
Oxford County – Ontario Works	8	20.5
Community Care Access Centre	7	17.9
Victim Assistance Services of Oxford County	6	15.4
Woodstock Police Service	5	12.8
Probation Services	5	12.8
CMH-Mental Health (Hospital)	4	10.3
Oxford EMS	4	10.3
Ingersoll NPLC	2	5.1
Oxford County - Housing	2	5.1
CMH-ER (Hospital)	1	2.6
Developmental Services Ontario	1	2.6
Alzheimer's Society	1	2.6
London Catholic District School Board	1	2.6
Oxford County – Public Health	1	2.6
RSA	1	2.6
Woodstock Fire Department	1	2.6

It can be argued that when an agency or organization shows intervention involvement in only one or a few situations that they are not a valued resource or that use of time becomes an issue. In the experience of the Oxford Situation Table this is not the case. The discussion, expertise and experience of each representative is critical in ensuring process, intervention and recognition of situations brought forward.

4.0 Study Limitations

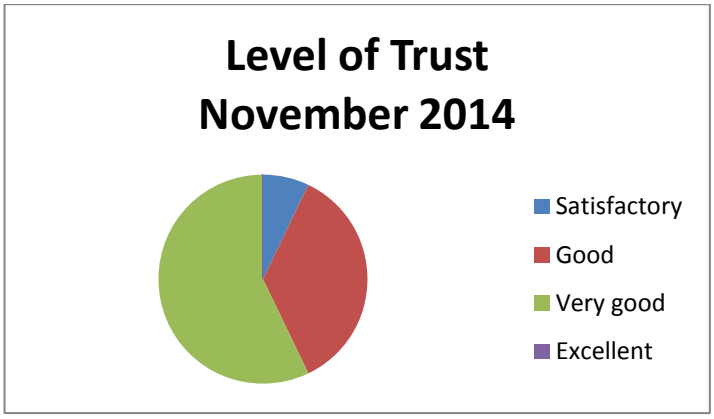
The Oxford Situation Table has much strength and has been supported and guided by the Ontario Working Group through the Ontario Association of Chiefs of Police and the other project leads facilitating similar situation tables in other regions. However, recognizing that it is a new initiative which has only been in existence for six months is essential when reviewing the preliminary data. In addition, the only model available for data collection designed for situation tables emerging in Ontario are based on an Excel database which was occasionally challenging to work with, requiring frequent review and revisions. The database was, at times, difficult for the individual entering data to manage by nature of its

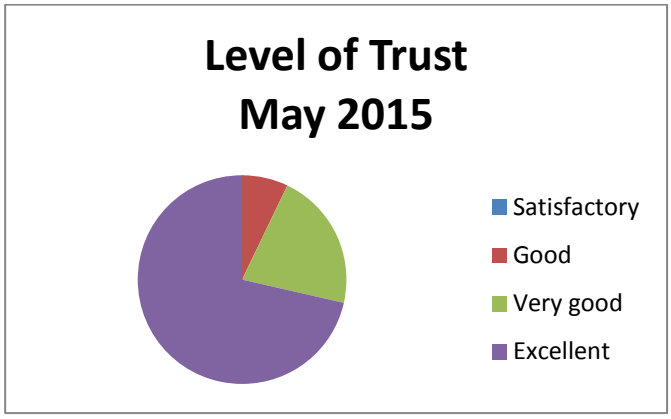
design and frequently halted discussions to clarify details of risk. It is therefore possible that some risk factors were inadvertently overlooked due to the large number of possible variables.

Recall bias should also be considered in relation to participants' recollection of situations that required re-opening. As maintaining privacy and confidentiality is a key priority, de-identified data is collected during the meetings. If a situation requires re-opening, participants' recollection of the situation could be impacted given the lack of identifiable information. Recall bias may have also occurred during the data cleaning process when blank cells required review and revision prior to data analysis being conducted.

It should also be noted that as a new process, the police were the service/agency primarily bringing forward situations for presentation. As the project has progressed and the agency participants become more comfortable and knowledgeable with the process, it is appropriate to assume that there would be an increase of referrals from these other agencies. At the onset of the process, there was limited trust between agencies which was also a limitation. However, this was evaluated weekly to determine changes to fostering increased trust and communication amongst agency providers. See Table 15 below. Further reflections from situation table participants representing agency providers can be reviewed in Appendix A.

Table 15: Participant level of trust among professionals





5.0 Discussion Points

As mentioned early in this report, the first discussion regarding the concept of a situation table in Oxford County took place in May 2014. This discussion was facilitated by the Ingersoll Nurse Practitioner-Led Clinic and involved the United Way of Oxford, Oxford Social Planning Council, Canadian Mental Health, Woodstock & Area Community Health Centre, OPP, Woodstock Police Service, and Public Health. Our focus was on each agency's passion to collaborate, and the fact that often times there is agency frustration around the pivotal point of mobilizing efforts into actions. It was decided at that time that a Situation Table was appropriate based on police identifying a steady increase in calls for service in areas of domestic violence, mental health and social disorder.

This was echoed by the local health providers and Health Links Chairs (CMHA and Public Health) where there was a need for support in the community to mitigate risk early and avoid hospital wait times and admissions for high users. In addition, recent efforts to better coordinate and increase addiction treatment in Oxford has identified key areas where there are a significant number of people in Oxford accessing treatment for substance use.

A project steering committee was formed to include CMHA Oxford and Public Health who are the current chairs of the Oxford Health Link, the OPP and Woodstock Police to represent both provincial and municipal police serving Oxford County, and the Ingersoll Nurse Practitioner-Led Clinic as the project lead agency representative. Moving forward into the first year, the steering committee will also include Woodstock General Hospital Mental Health.

The second phase of development, not to be overlooked, involved orientation and education of potential key partners. Invitations went to emergency response and crisis response services requesting representation from both leadership and front-line level to ensure a 'top down and bottom up' approach to informing agencies. With the support of the United Way of Oxford and a minimal grant through the Proceeds of Crime (total amount of monetary funds used in development and implementation in one year was under $2,000.00), experts were brought from communities already engaged in risk mitigation projects to provide background and address questions from the community. It was at this point that our Oxford Situation Table began to form as member agencies were identified and asked to send passionate individuals committed to their work and who were willing to bring their expertise, innovation and collaborative spirit to work beyond common agency practice. These individuals were brought together in October and November to become further educated on the process and engaged in activities to foster trust and change concepts.

The first situations were heard by this dynamic group of 14 people on November 18, 2014 and they participated in 26 meetings where they heard 51 (44 were accepted; 7 were declined) situations of acutely elevated risk. When we begin to review the anecdotal outcomes from participants and those whom the situation table were involved in supporting we begin to see the significant change happening in our community.

When we talk about change there are three specific and significant changes that can be clearly identified when we consider the data shared in this report regarding the outcomes of the Oxford Situation Table to date. First, it is clear that there have been extensive changes in the way our services are growing with regard to how we work together both at a leadership and front-line level. This includes, but is not limited to, increased trust and understanding of services that we provide, as well as services that we do not provide. It has helped us establish actual relationships that extend past email and telephone to have meaningful face to face open, honest and respectful discussions about how to help clients 'today', and also talk about systemic issues we encounter and how we can improve to be better together in order to best help clients who cross our various sectors.

Second, we know from our various ministry data that the top 5% of users of emergency services such as police, EMS, fire and emergency health care take up 66% of our provincial dollars. These users are our most complex clients and/or patients whose complexities and risk factors cross multiple social determinants of health. By working together at the situation table to mitigate that risk we have clearly shown that there is opportunity to avoid or decrease the use of emergency response and work collaboratively toward significant cost savings which will allow us to divert these savings to other areas of concern in our community. Take, for example, the fact that the average cost for the Woodstock Police to respond to a mental health call is 357.12 which is a conservative estimate based on an average call time of 4 hrs and

usually involving dispatch, a 2 officer response, crisis mental health services as needed, time at WGH and/or trying to track down other resources/supports and the paperwork to follow. Several individuals who were brought forward to the situation table in the pilot period had anywhere from 167 to 378 incidents of mental health responses by police that would require the above intervention and therefore, cost per police officer. If we use the *lower number* at 167 and the individual cost of 357.12 per officer, that individual requiring service has cost approximately 59,639.04 not including the cost of medical services provided in the hospital emergency department or the cost of additional community crisis team response services. By using data provided from the situation table we will have the opportunity now to review these cost savings with more depth and efficiency and divert these savings to other needed services within our own sectors.

And finally, while all human service sectors get excited about saving money and improving services in a time where cut backs are the norm for all sectors, for those participants at the situation table, and many of the individuals who were supported through collaborative, rapid mobilization interventions, the change that has the most impact on our community involved saving lives, extending lives to ensure dignity at end of life, supporting wellness and creating a safer community. The Canadian Index of Well-being – a long established marker for Canadian health and wellbeing identifies that while Ontario has made great strides in the area of 'safer and more caring communities' (+15.4%), there is still room for improvement. Our situation table has seen how this improvement can happen.

Sharing some of our many situations will illustrate this.

#1

The situation: A young man in his mid 20's was brought forward to the situation table due to escalating involvement with police including suicidal threats, substance use and substance use related crime such as theft, suspected mental health and possible homelessness. The police had the individual in custody and were concerned about where he would go and what would happen upon his release.

The response: The addiction worker actually went to meet this individual in cells, letting him know that the police and community were worried about him and that she was willing to meet with him that afternoon if he was inclined. The individual attended the appointment offered later that afternoon and met with the worker that same day with the at 3:10 on that Friday afternoon.

The client explained that he had been arrested at a multi-service centre where he had been trying to access services. He was now in Woodstock and had no phone and no way of getting back to the south part of the County where he was from. He also explained that once he got back to his home town, he would be homeless. The worker supported the individual in contacting his sister who had been driving all night looking for him. They came in and met with the addiction worker, community health outreach worker, and the young man.

The outcome: A plan was created with this young man to have sisters take their brother back to their home town and support him in a hotel for the weekend until he could access more permanent supportive housing.

The young man was provided strategies and options to deal with his substance use withdrawal. He stated that most of the resources and counselling are offered at his local multi-service centre and he was fearful of returning based on his recent arrest. The community health outreach worker assured him that she would be there to meet him and make the

reconnection a smooth ones so he can continue to access counselling for his addiction issues and work further with the community health outreach worker to secure supportive housing and other community supports. All of this transpired late on a Friday afternoon for this young man. The worker involve told us that he was genuinely thankful and that he told her that the police officer that picked him up and offered services 'changed his life'.

2

The situation: An elderly adult male reported that his roommate had died. Upon attending the call at this trailer, police and the coroner determined that the roommate had been deceased for 5 days. It was unclear how mentally cognizant the husband was based on his response to his wife's death. The trailer was in deplorable conditions with numerous animals and animal feces, stacked dishes and old food, soiled bedding, and no fresh food in the home. The gentleman did not appear to be in good health. In addition, it was found that he did not have a telephone and in recent months the trailer park owner had stopped allowing him use of the his own phone due to hygiene issues. The man had no transportation and taxis had stopped agreeing to pick him up due to significant hygiene related odour.

The response: The police brought this situation to the table where it was quickly agreed that it met the threshold for acutely elevated risk. A team was determined including police, EMS, WACHC nurse and CMHA who attended that afternoon to talk with the elderly gentleman. With a kind and creative team approach from the team, the individual agreed to go to hospital.

The outcome: Based on serious health concerns and mental health assessment the elderly man was admitted to hospital for care. In the meantime, the team attempted to work with public health and fire department to determine an appropriate course of action to clean up the man's home. The family contacted and involved in the situation to support ongoing care and connection to services.

The rest of the story: This is a great example of how systemic issues can be identified. This man remained in hospital for many months for no other reason that his family did not follow up on any clean up of his home or pay for a capacity assessment and because of humanitarian reasons, the hospital was hesitant to discharge him. This is not necessarily a good use of resources or a good quality of life for the individual. While his imminent risk of harm was reduced, the system needs to review coordinated discharge planning that supports quality of life and community resources. The outcome of the situation has motivated us to better look at ER diversion opportunities and coordinated care plans that include health care and community support once individuals are connected to service.

#3

The situation: A 72 year old female had contact with the police based on a concerned neighbour call that she had become isolated and they had not seen her out for some time. Police checked on the individual late one evening and she appeared at the door with a towel around her head but no visible signs of physical distress, her home had a 'horrific' smell, and she was very resistant to any help. Mental health crisis was contacted and advised that, for reasons presented by police that the situation might be best to involve CMHA to possibly present at the situation table.

The response: CMHA brought the situation forward the next day but did not need to wait to present at situation formally. Due to the established trust and reliable partnerships, CMHA, OPP and EMS established a plan to visit this

woman that afternoon. They attended that afternoon and found the woman living in deplorable conditions as she was unable to make it to her bathroom and had been defecating and urinating in buckets, she had been unable to manage cleaning her home for many months, and even preparing meals had been difficult. The woman had a towel around her head and it was discovered that the smell in the home was not the feces or urine, but more so bacteria seeping out of an open head wound which the woman had been covering with a towel and a tuque. This feisty aged woman had family in a city approx. 5 hours away but had not been in touch for some time. After a 45 minute visit with the individual, the team was able to support her in self determination to leave her home voluntarily and seek medical assistance. Her comment...'well, no one has cared in so many years, but if you think I should...'

The outcome: The individual was transported and supported with compassion to the hospital where it was found that her wound was a malignancy that had gone unattended for so long it was extending externally. She was admitted, treated, and follow-up cancer treatment was also provided. Team members contacted her family who were happy to reconnect, neighbours visited. And the team coordinated home clean up so that return home to recover with the appropriate supports would be possible. The woman was able to return to a clean and healthy independent living situation with both professional and personal supports in place to recover.

The rest of the story: Eight months following the intervention this spirited member of our community died of a stroke. The team involved from the situation table, some of whom may never have met one another past a professional phone call, shared the news in the following way. Below are some parts of the message.

"I have some sad news to share that I learned late yesterday. Our beloved <<>> died on Sunday. She died of a stroke and they found another tumour in her head. They operated and unfortunately she didn't come out of the recovery. My understanding from speaking with her neighbours that she had become much closer to those who were now coming to her home, often giving hugs and high fives. They believe that she would have died alone long ago without the intervention and this gave her a few more happy months."

"The care, support and compassion shown by all of you who intervened meant that this individual passed with love and care, dignity and people around her who cared."

These are just 3 examples of 44 similar stories.

Conclusion

Future plans will include accessing the provincial web-based data collection system when it becomes available to support a more efficient and user-friendly database. The goal of the steering committee is to engage in closer examination of agencies' performance indicators to determine the extent that the identification of elevated risk has resulted in improved community safety and well-being. This will include indicators such as police calls for service, hospital emergency room visits, hospital discharges where situations return to the situation table shortly after, school truancy rates, and/or mental health crisis referrals or calls. The participant members of the situation table will be utilizing a systemic challenges identification form to document these challenges to be submitted to the steering committee and filtered to the agencies and systems where change can be considered and may be most likely to happen. Despite demonstrating tremendous progress, particularly in bridging gaps between agencies that can best provide coordinated care to complex individuals

and families, there are many areas identified for improvement and enhancement toward greater successes in the future. The participants and many agencies involved have already committed to continuing with the Oxford Situation Table to be part of these successes.

To those who have taken part and have been, and continue to be, willing to 'think outside the box', the steering committee and those involved in the development of the Oxford Situation Table are sincerely grateful.

APPENDIX A: Oxford Situation Table Participant Reflections

1. **Participant recommendations to continue to improve effective communication and collaboration between Oxford Situation Table partner agencies:**

- Develop a web-based message board to allow partners to ask questions and easily find resources
- Strong leaders and consistent representation at the table to keep people engaged and communication flowing
- Members are open to, and investing in, optimizing communication and collaboration
- More consistency among having representation from every agency present at every meeting
- Find a place in the process to celebrate successes; although the pilot is over
- Continuing to check in and build relationships and trust among those at the table is key, specifically through training about the actual intervention techniques, logistics, follow-up
- It is important we have difficult conversations about gaps in services that we've observed based on the situation table experience e.g. how do we support discharge plan as a community better, how do we follow up with people to avoid their return to the situation table
- Actively working on identifying gaps and finding ways to reduce them as a community
- Celebrate! Celebrate! Celebrate! Our community is doing incredible things...together!
- Capitalize on opportunities to partner together will help the Oxford County situation table promote and foster stronger working connections
- At the current time, I have not experienced a situation where communication and collaboration was lacking once the situation table was up and running. Everyone seemed very open and eager to share information. The legal issues surrounding the privacy of individuals was a stumbling block on a small scale at the start, however after repeated assurances it is not a problem if done right, that issue disappeared
- The communication and collaboration between the agencies was excellent. The group was very well led, and all agencies came to each meeting ready to assist as needed in interventions. Sitting on at this table has been very enlightening and positive
- To continue to present cases at the Situation Table and to trust the process of working together.
- The current level of communication and collaboration is already very good. Perhaps a semi-annual breakfast meeting or informal social gathering would encourage even more trust and understanding.
- By continuing the good work that is being done at this table! It is imperative that the information/process be filtered down throughout participating agencies so there are no barriers to interventions/collaborations.

2. **Overall participant experiences:**

"I was very guarded at the beginning of the Connectivity pilot. Sharing information without client consent, at times, runs counter to client directed care and college ethics. The training provided and leadership of founding members was invaluable to support sharing of information within the parameters of the elevated, imminent risk. I have definitely come to appreciate the efficacy of The Table and believe that collaborative and ethical sharing of client information facilitates access to care in a timely matter."

"The Table has bolstered community partnerships and trusting relationships between agencies. I have been able to access peer support and service education above and beyond the cases discussed at The Table."

"In 36 years of policing, I have never seen such incredible change or amazing things happen."

"There has been a marked reduction of calls for service. Although a formal quantitative analyses has not been internally conducted thus far, some 25 plus situation were brought forward by the OPP. Those situations had individuals attached that averaged some 40 plus calls for service by police each over the reporting system life span. One individual had been involved with the police over 327 times over a course of 8 years. Many of the individuals had 5 plus calls for service in 2015. Proper interventions reduced these calls for service to virtually zero. Not in all cases, but in the majority of cases, once the intervention was undertaken and the individual was properly connected to services, the police calls ceased."

"Sam, this is the best day of my career!"

"This experience has allowed me to grow and expand my learning to many other areas of my work with the community. I have discovered that a broader understanding of the success of collaboration and the sharing of ideas, resources and skill sets can be used for other community initiatives. It has been quite helpful to draw on some of learning opportunities that I have gathered from our collaboration. Even a group with different goals and outcomes, such as Food Security, can not only benefit from successful partnerships but actually requires it for sustainability."

"It is the best part of my entire week. I feel like I am actually making a difference!"

"I had no I idea your agency did that!"

"The overall building of trust between the partners cannot be overstated. All the partners at the table work in unison with a common goal to assist those in our community who are at acutely elevated risk."

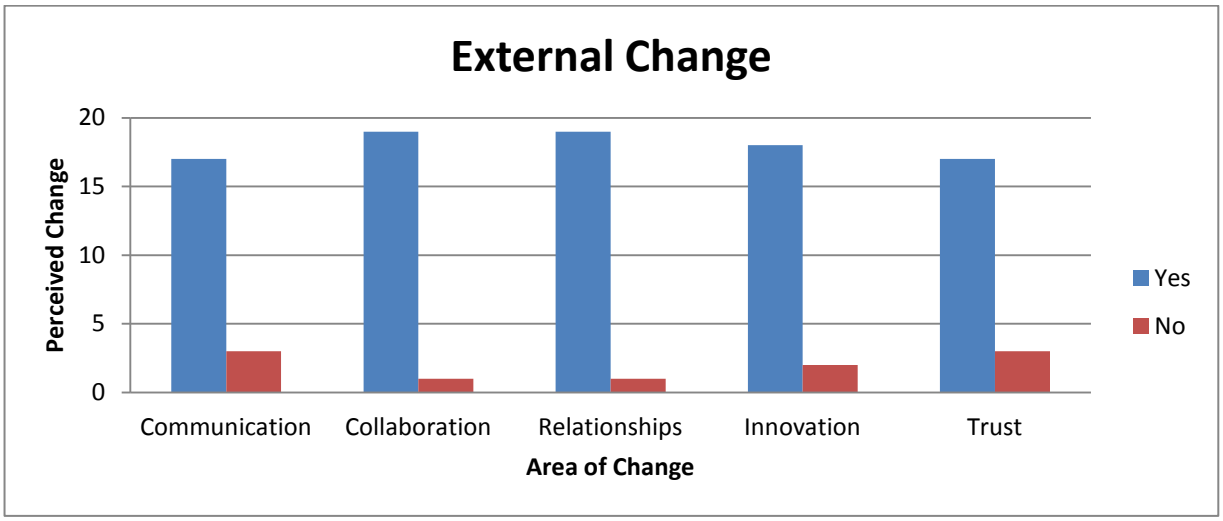
"I believe The Table has fostered relationships and trust between community service agencies. When service providers have the opportunity to talk and teach each other about services and limits to services offered it is more likely that clients will have access to the most appropriate resources and fit."

"We've had a 'coming together' of a large group of people who may not otherwise have met and /or have worked together in such a manner. Although many members of the group are service orientated, there are many other different roles in the various agencies and I believe all will have gained a better understanding of the other organizations. This will undoubtedly be reflected in overall service to the community."

"I believe this group will grow to be perceived within the community as reliable, trustworthy and competent due to the timeliness, the coordination and the comprehensiveness of the responses as well as a reduction in what may have otherwise been an overlap in services."

Change Agents

Participant perceived ***improvements between their organization and other Oxford Situation Table partner agencies*** as a result of their involvement in the pilot project.



Participants ***perceived improvements within your own organization*** as a result of interactions resulting from the Oxford Situation Table pilot project.