AN EVALUATION OF SITUATION TABLES IN BRITISH COLUMBIA

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The Crime Reduction Research Program

The Crime Reduction Research Program (CRRP) is the joint-research model in British Columbia between academics, the provincial government, and police agencies operated by the Office of Crime Reduction – Gang Outreach. The CRRP is supported and informed by a Crime Reduction Research Working Group that includes representation from the Ministry of Public Safety Solicitor General (represented by Community Safety and Crime Prevention Branch and Police Services Branch), the Combined Forces Special Enforcement Unit of British Columbia, and the Royal Canadian Mounted Police "E" Division.

The CRRP focuses on investing in research that can be applied to support policing operations and informing evidence-based decisions on policies and programs related to public safety in British Columbia. Each year, the CRRP reviews submissions of research proposals in support of this mandate. The CRRP Working Group supports successful proposals by working with researchers to refine the study design as necessary, provide or acquire necessary data for projects, and advise on the validity of data interpretation and the practicality of recommendations.

The CRRP operates a $1M annual funding allocation in the form of grants that are dedicated to support university-led research at Canadian institutions. This project was supported through the 2020/21 CRRP funding allotment.

Executive Summary

Situation Tables (also known as Hubs) have become an increasingly popular means of addressing crime and several co-occurring social problems in communities across Canada. Situation Tables represent a holistic approach to individual and community well-being and safety. They are premised on a model of social service collaboration that aims to identify vulnerable individuals and connect them in a timely fashion with appropriate resources and services. There are currently nine Situation Tables operating across British Columbia, seven of which have been directly supported by the Office of Crime Reduction and Gang Outreach (OCR-GO). Although Situation Tables appear to have a firm theoretical foundation and appear to be a significant improvement over fragmented systems of social service delivery that primarily rely on law enforcement to be service providers across a variety of circumstances for which they are not well suited, there have been no comprehensive assessments of Situation Tables. The goal of the current research is to assess the effectiveness of Situation Tables in British Columbia and to make recommendations, where appropriate, to increase their effectiveness and efficiency.

This project included a literature review focusing on the operation of Situation Tables in Canada and in other countries, paying particular attention to the similarities and differences across jurisdictions. The review also assessed existing evaluations of Situation Tables. This project also examined the volume and nature of all referrals for each Situation Table. Data was provided through OCR-GO for each Situation Table in British Columbia on the volume and nature of referrals, identified risk factors, which agency was the originating agency, which agency took the lead on the file, which agencies provided additional assistance or support, and the outcome of the referral. To better understand the functioning of Situation Tables, the researchers observed the meetings of two Situation Tables. Observing these in action was useful in comparing the operation of the Situation Tables and provided some insight into establishing good practices moving forward. Of note, all observations were conducted by researchers with RCMP security clearances. The researchers also conducted interviews with the Chairs of each operating Situation Table in British Columbia. The interviews were semi-structured, focused on questions related to the structure and mandate of the Situation Table, roles and responsibilities of members, the nature and quantity of cases, the frequency, organization, and structure of meetings, interventions, outcomes, successes, challenges, what works well and what challenges were facing Situation Tables, and next steps. As part of this study, a survey was also designed that could be completed online by all Situation Table members. The survey was made available by a secure link to Survey Monkey where participants could complete the survey. The survey asked questions about one's Situation Table, the participant's role with the Situation Table, the partnership structure, accountability, outcomes, what was working well, and what areas needed improvement.

The data in this section was taken directly from the British Columbia Situation Tables' Risk Tracking Database. The database was provided for analysis by OCR-GO. The earliest case in the database was from November 2015, and the latest case was from February 2021. The database included information on 1,003 referred cases from all Situation Tables in British Columbia. Of the total number of referrals, more than three-quarters (78.6 per cent) of referrals involved individual clients. Moreover, the files involved roughly equal numbers of males (50.4 per cent) and females (48.7 per cent). Of interest, referrals tended to be for older people. Using the age categories in the

Risk Tracking Database, both the modal and median category was for people between the ages of 30 and 39 years old. Most referrals (56.6%) were for people who were 30 years old or older. Supplemental analyses revealed that a higher proportion of younger clients (those under 24 years old) were female, while a higher proportion of older clients (those over 50 years old) were male.

Only a small proportion of referrals were rejected by their respective Situation Table. Of the accepted referrals (n = 884), only 13 or 1.5% of referrals in the database had the status of open. The remaining 98.5% of referrals (n = 871) were closed. Nearly one-third of all accepted referrals (29.1 per cent) were closed within one week. And, while slightly more than one-quarter of referrals (22.5 per cent) were closed between 8 and 14 days, this category was also the median length of time for referrals to stay open. Given that Situation Tables typically met once per week, based on the information in the database, on average, referrals were discussed three times before they were closed. In terms of why a referral was closed, the most common reason was appropriately a reduction in AER (67.8 per cent).

On average, each referral had approximately nine risk factors identified, which demonstrates the complexity of even the "average" Situation Table referral. The range of the number of risk factors per client was from one risk factor to 17 risk factors. The risk factors that were found in a majority of referrals were housing (75.9 per cent), mental health issues (74.6 per cent), drugs addiction or drug issues (71.3 per cent), the lack of basic needs (57.9 per cent), and involvement with crime (50.4 per cent). Males were slightly more likely to have risk factors associated to housing, criminal involvement, and poverty compared to females, while females were more likely to have risk factors associated to drugs and negative peers compared to males. For the entire sample, the most common risk factor for those under the age of 29 years old was drugs. This shifted to housing for those 30 years old and older with the except of those in their 50's. However, when considering the most common risk factor for males and females by age, there were some substantial differences.

Situation Table referrals originated from many different agencies, organizations, and service providers. Most commonly, files originated from the RCMP or other policing agencies (29.3 per cent). The second largest source of referrals (12.3 per cent) was from Housing & Outreach from the Lookout Emergency Aid Society. It is not always the case that the agency or service provider that brought the referral to the Situation Table will also be the lead agency for the intervention team. The greatest proportion of all files (16 per cent) had Housing & Outreach from the Lookout Emergency Aid Society serve as the lead agency. Although almost 30% of referrals originated with the RCMP, the police only assumed the role of lead response agency in fewer than half of these referrals. Many of the same agencies that played a central role in referring clients or taking the lead on files were also heavily involved as assisting agencies.

SITUATION CHAIR INTERVIEWS

Based on the interviews with Chairs, participants felt that critical goals for Situation Tables were to mitigate risk for vulnerable people and families, in part, by identifying individuals who met the threshold for AER and to address the risk factors contributing to AER by developing intervention plans that involved multiple agencies and services. Other identified goals were to break down barriers between agencies and enhance the degree to which agencies and service providers shared

information and communicated with each other to better promote meaningful partnerships that resulted in the delivery of appropriate, timely, and wraparound services to clients. In addition to taking a non-punitive approach to addressing risk factors, Chairs also identified building resiliency in the community as a goal of Situation Tables. While there was not one issue that was common among all Situation Tables, the main reasons for establishing a Situation Table were to develop a more efficient way to address those who were chronically homeless or an increase in street-based populations causing issues in the community, a more effective way to respond to the increasing crime rates, particularly associated with gang activity, the need to address more holistically the growing number of individuals who suffered from mental health-related issues, and to address social chronic offenders or those who frequently came to the attention of the police for behaviours that were typically non-chargeable offences.

All participants indicated that the Chair and members of the Situation Table participated in a two- to four-day training workshop hosted by Global Community Safety as the main element of their training. Some participants indicated that they also participated in some of the online training provided through Sir Wilfred Laurier University and one Chair reported having training conducted by another external consultant. For the most part, Chairs reported that the training they received was beneficial as it resulted in the Chair and Situation Table members being very clear and comfortable about how the four filters and the information sharing protocol worked. There were several themes that Chairs highlighted that could be improved or included in the training of Chairs and Situation Table members. The first main theme had to do with the initial 'door knock' that an agency made with a client. Many Situation Table Chairs reported having some degree of turnover in who attended each meeting, which resulted in challenges in ensuring that those who were attending meetings were properly trained and fully understood the Situation Table model, how the Situation Table worked, and the information sharing protocols used by the Situation Table. Some participants also felt that the training lacked information on how to set up a governance structure, the value of a leadership or steering committee, and how provincial oversight might be a benefit or a hinderance to achieving some of the Situation Table goals, such as greater information sharing, attendance and participation with the Situation Table, or navigating some of the privacy issues that were likely to arise once the Situation Table was dealing with referrals. It was interesting to note that when asked, only about half of the Chairs stated that they felt that all members of their Situation Table had been adequately trained on assessing AER.

Chairs spoke about the need for and value of collaboration, information sharing, and networking in achieving Situation Table goals. Chairs emphasized the importance and value of people getting to know each other and each other's agencies to best address the needs of clients. Chairs reported that Situation Table members worked together to ensure that their partner agencies and frontline workers were aware of the existence of the Situation Table and could either make referrals directly to the Situation Table or work with a Situation Table member to refer clients as needed. Chairs also acknowledged that there was additional collaboration that occurred because of the existence of the Situation Table. Based on the comments made by several Chairs, another benefit of Situation Tables was that it formalized the collaborative process. Some Chairs felt that their Situation Table had resulted in an increase in interagency cooperation, while others felt that this was happening prior to the creation of their Situation Table. All Chairs also indicated that the Situation Table model

improved information sharing and communication between agencies and service providers. Most Chairs also felt that Situation Tables contributed to a greater sense of shared responsibility among partner agencies and service providers for clients. Chairs also spoke about some of the challenges or what was not working well with their Situation Table. A primary issue was related to the turnover in members. Another theme was related to a general sense of disconnect. This manifested in how some members perceived what the outcomes of the Situation Table were supposed to be.

Given that there was a lot of variation in the sizes of the communities and jurisdictions that Situation Tables operated in, it was not surprising that the number of standing members for each Situation Table varied. The main ways that members contributed to Situation Tables were by bringing referrals to the Situation Table for discussion, presenting referrals at Situation Table meetings, which included clarifying or highlighting all AER factors, providing and sharing information, expertise, or input as needed and appropriate on the referrals made by others, and if appropriate, participating in the Four Filter process to contribute to the intervention strategy. It was interesting to note that Chairs focused on two main issues related to the accountability of Situation Table members. The first issue had to do with those members who agreed to participate in an intervention. The second issue was consistent attendance at Situation Table meetings.

As expected, the type of agencies that made referrals to the Situation Table was not equally distributed across Situation Table members. In some communities, most referrals were made by one or two organizations, such as the RCMP. Again, this was typically based on the types of risk factors characterizing a community or jurisdiction, rather than the willingness of members to make referrals to the Situation Table. Chairs spoke of the importance of having representatives at Situation Table meetings that could address the needs of Indigenous peoples as being very important, as well as those who could assist with mental health issues, housing issues, and younger clients. Depending on the Situation Table, some Chairs believed that greater attendance or participation from those engaged in victim services and probation services would also be beneficial.

It was interesting to note that not all Situation Tables had a leadership committee or steering committee to ensure that the Situation Table was operating effectively and appropriately, or to address concerns or challenges that could arise for Chairs or members. For those Situation Tables that did have a leadership committee or steering committee, it appeared that the leadership or steering committee met a few times per year, had someone on the committee from each of the organizations that had a member serving on the Situation Table, had a direct line of communication with the Situation Table Chair, served to promote the work of the Situation Table to others in their professional circles, helped the Chair make the necessary connections to partner agencies, and to address any concerns or decisions made by the Situation Table. As information sharing, collaboration, and having the appropriate agencies and organizations as members of the Situation Table were viewed as critical to the successful operation of a Situation Table, Chairs were asked whether they thought it was a good idea for the provincial government to mandate that certain agencies or service providers must be part of the Situation Table. Chairs were somewhat split on this idea.

When asked what the most common reasons or risk factors were for making a referral to Situation Tables, the three most common issues were mental health, homelessness, and addictions. All Chairs

were asked to assess their Situation Table's effectiveness at detecting acute risk using the Four Filter process on a five-point scale anchored by very ineffective and very effective. All but two Chairs rated their Situation Table as either effective or very effective. A key aspect of being effective at detecting AER is having sufficient contextual information about the subject of the referral. To that end, Chairs were asked how their Situation Tables assessed AER. Critically, Chairs reported that they did not have formal assessment or evaluative tools. An important outcome for Situation Tables is the timely identification of high-risk cases and the acceptance of these types of referrals by the Situation Table. On this issue, all Chairs reported that their Situation Table did a good job of identifying high-risk cases in a timely fashion. The second theme was that success could be measured in the timely identification of AER that more commonly occurred as soon as Situation Table members became more familiar and comfortable with the concept of AER and how to identify it, as members began looking for signs of AER in their clients and addressed it in a collaborative fashion, even outside of the formal structure of a Situation Table meeting. Except for the Situation Table that focuses exclusively on youth, there were no restrictions on the types of referrals that could be made to the Situation Table. On average, Chairs reported that this entire process took between 10 and 20 minutes. In terms of how long the Situation Tables were involved with a typical client, as Situation Tables were not involved in case management, the Situation Table was typically involved with a case for about two weeks.

The most common types of interventions provided by Situation Table members involved mental health, family services, and housing. Chairs spoke about how frontline workers from participating agencies worked with individuals and families to help with education on parenting or life skills, addressing housing needs for those who were chronically underhoused, and providing family therapy or other counselling services, including addictions services. In general, Chairs were rather positive that the intervention plans worked well. Of note, it was felt that if the client was homeless, it was important to secure housing first as this played an important role in connecting the client to other services and was viewed as contributing to the other services being more successful with the client. In sum, obtaining buy-in and establishing trust with the client, ensuring meaningful collaboration among the service providers who volunteered to be part of the intervention team as part of the fourth stage of the Situation Table meeting, clear communication between members and between the intervention team members and the client, accurately identifying what were the client's needs, having a strong lead agency, and timely contact with the client were viewed as necessary aspects of a successful intervention.

Some Chairs believed that some forms of interventions were less successful because there was a disconnect between the level of buy-in the Situation Table received from an agency's leadership. In effect, there were two main themes that several Chairs mentioned in relation to the lack of success of some forms of interventions. The first was related to the length of time the Situation Table was connected to the client and the effect of this on intervention success. The second area of concern, which was shared by many Chairs, was related to the 'door knock' or the initial contact of the lead agency or intervention team with the subject of the referral. While Chairs felt that there was a lot of discussion about how to conduct the 'door knock' during their initial training or during Situation Table meetings, some Chairs believed that the process was not appropriate in all situations and was not always trauma informed. There were several types of interventions that Chairs felt were either

not always available or were not connected to the Situation Table that could better serve clients given the risk profile of those being referred. The first area was housing. Given the increase in the number of clients who were elderly, some Chairs identified a growing need for interventions that were specifically designed to address seniors with significant health issues. Related in part to this issue, some Chairs felt that there was a need for the Situation Table to have greater access to health outreach supports in terms of the number of people on the ground who could engage with those in need.

Chairs believed that Situation Tables had positively affected clients' overall ability to access needed services in a timely fashion. Chairs also believed that the Situation Table served to connect clients to particularly useful or beneficial interventions that the client might otherwise never connect with in the absence of a Situation Table, especially in larger communities. The opinion of Chairs varied on the issue of whether they felt their Situation Table had resulted in a reduced demand for emergency and police services. On the specific issue of information sharing protocols, generally, Chairs did not feel that this was a systemic barrier to the successful operation of their Situation Table.

When asked directly how successful or unsuccessful Chairs felt their Situation Table were, all but one participant indicated that their Situation Table was successful. When asked what was working well and what gave them this feeling of success, Chairs indicated that there was consistent attendance at the weekly Situation Table meetings, collaboration was working well as most members were comfortable connecting with each other during Situation Table meetings and outside of the structure of the Situation Table, there was an increased knowledge among members about what services, programs, and resources were available in the community, how the various agencies supported clients with and without AER, there was an increased sense of trust between members that enabled communication between agencies, and agencies did not see each other as competitors for scarce resources and funding.

There were several commonly identified themes that were recognized as challenges to the successful operation of the Situation Table. It was not uncommon for a small number of agencies from each Situation Table to make most of the referrals or to participate in most of the interventions. Another identified challenge was the disconnect at some Situation Tables between the representatives at the meetings and the decision makers from their respective agencies.

SITUATION TABLE MEMBER SURVEYS

Some of the key words used by Situation Table members about their Situation Table included support, risk, community, services, individuals, and vulnerable. Cumulatively, respondents indicated that the primary goals of Situation Tables were to identify and mitigate instances of elevated risk among people in their communities. To this end, Situation Tables aimed to connect vulnerable individuals to services and agencies in the community that could offer support tailored to their individual needs. Nearly three-quarters of respondents reported receiving training on the Situation Table model. Of those who had received training, most received their training within the first week of joining their Situation Table. The training received by members was almost universally regarded as positive.

Of the members that responded (n = 50), the vast majority (94 per cent) indicated that their Situation Table met, on average, once per week. Critically, only 30% of respondents indicated that they "always" attended these meeting, while another 45% characterized their participation as "often". By far, the most common reason provided for missing Situation Table meetings was scheduling conflicts.

Respondents were asked questions related to the functioning of the Four Filter process in their Situation Table. Approximately three-quarter to four-fifths of respondents indicated that each of the four filters were followed Often or Always. Two-thirds of respondents felt that partners "always" contributed to the Four Filter process, and nearly the same proportion (64 per cent) believed that Situation Table members always shared relevant information. Most respondents (59 per cent) also felt that Situation Table members always provided referral status updates. An area of greater contention was that of bringing forward referrals. Only about one-third (39 per cent) of respondents noted that this form of contribution to the Situation Table was done by members "all of the time", while slightly less respondents (34 per cent) answered "some of the time".

Over 85% of members "strongly agreed" or "agreed" that theirs Situation Table had improved collaboration, increased interagency cooperation, built and improved trust, and had a positive effect on the sharing of both information and expertise, while over 80% felt that their Situation Table had produced an increased sense of shared responsibility. On a personal level, almost 90% of respondents argued that their Situation Table had improved their understanding of AER. In short, from the perspective of respondents, Situation Tables succeeded in fostering a more collaborative environment for addressing clients with AER. The responses regarding accountability were somewhat less positive. While just over 70% agreed with the idea that their Situation Table created an environment of accountability, a significant minority (28 per cent) disagreed. Virtually the same results were found when members were asked whether their Situation Table held the respondent's organization accountable for bringing forward referrals, contributing to discussions, sharing information, volunteering to participate in interventions, and fulfilling their intervention commitments to Situation Table clients. More noticeably, 57% of members disagreed (some strongly) with the notion that their Situation Table made their organizations more accountable than they otherwise would have been if the Situation Table did not exist.

In total, 95% of respondents indicated that their Situation Table was "very" or at least "somewhat" effective in detecting risk and connecting clients to services. A very large proportion of respondents (91 per cent) also considered their Situation Table to be effective at improving overall client access to services and a similar proportion (86 per cent) felt that their Situation Table was effective at mobilizing support for interventions. A notable majority (70 per cent) also maintained that their Situation Table was effective at reducing demand for services.

The most favorably commented-upon aspect of Situation Tables was how they encouraged cooperation and collaboration among agencies. Relatedly, in the view of respondents, the Situation Table model fostered interagency contacts and communication. Taken together, these positive features resulted in clients being better served through a multi-agency approach that focused on reducing AER. The second theme consistently cited by numerous respondents pertained to the Situation Table meetings themselves. Several members specifically pointed to the efforts of the

Chairs of their Situation Table as an integral part of this success, suggesting that the Chairs were adept at holding agencies responsible for participating in meetings and running effective sessions. The most often recurring challenge was in relation to funding and lack of resources. A second area that presented considerable challenges for Situation Tables was related to housing and mental health intervention needs. Respondents from several Situation Tables expressed concern that their Situation Tables were not receiving enough referrals. Although cooperation and collaboration were noted by many respondents as a main positive aspect of Situation Tables, several respondents pointed to "siloing" or a lack of integration as a continuing problem for their Situation Table.

RECOMMENDATIONS

The recommendations presented in this report were focused on how to improve the operation of Situation Tables and to ensure that they operate effectively and efficiently. The areas where detailed recommendations were made included the role of a leadership or steering committee for all Situation Tables, the structure, delivery model, and time frame for training, virtual versus in-person Situation Table meetings, the use of ad-hoc Situation Table meetings, the participation of Situation Table members in delivering interventions, the use and structure of the Risk Tracking Database, the importance of succession planning for Situation Table Chairs and members, expanding and increasing the opportunities for Situation Table, and measures of success.

This review of Situation Tables in British Columbia focused on the perspectives of Situation Table Chairs and a sample of Situation Table members to identify common themes on several substantive issues related to the mandate, structure, and operation of Situation Tables. In reviewing and interpreting the information presented in this report, it is important to keep in mind that Situation Tables are not programs, but rather informal collaborations of organizations, agencies, and service providers. They are designed to mobilize services in situations of AER to reduce risk quickly. Given this, when considering the implementation of a Situation Table and how to define success, it can be challenging to demonstrate some of the key components of the Situation Table model, including the validity of how AER is assessed by individual Situation Tables, the degree of collaboration, cooperation, and information sharing that occurs at Situation Table meetings, and the short- and long-term effects of the intervention strategy. Still, from the perspective of those Chairing and participating in Situation Table meetings, while there are several issues that require the attention of those responsible for improving the operation and functioning of Situation Tables, these people should also focus on opportunities to expand the reach of Situation Tables, increase the membership of Situation Tables through the addition of needed service providers and agencies, and develop intervention strategies to address current and emerging trends in the profile of AER among community members and their families to enhance the lives of clients, as well as contributing to public safety and wellbeing.

Introduction

Situation Tables (also known as Hubs) have become an increasingly popular means of addressing crime and several co-occurring social problems in communities across Canada. Situation Tables represent a holistic approach to individual and community well-being and safety. They are premised on a model of social service collaboration that aims to identify vulnerable individuals and connect them in a timely fashion with appropriate resources and services. There are currently nine Situation Tables operating across British Columbia, seven of which have been directly supported by the Office of Crime Reduction and Gang Outreach (OCR-GO). Although Situation Tables appear to have a firm theoretical foundation and appear to be a significant improvement over fragmented systems of social service delivery that primarily rely on law enforcement to be service providers across a variety of circumstances for which they are not well suited, there have been no comprehensive assessments of Situation Tables. The goal of the current research is to assess the effectiveness of Situation Tables in British Columbia and to make recommendations, where appropriate, to increase their effectiveness and efficiency.

Project Objectives

The main objective of this project was to assess the effectiveness of Situational Tables. Because these initiatives are multifaceted, this evaluation will use a variety of potential metrics of effectiveness. For example, the Surrey Mobilization and Resiliency Table (SMART), the first and most experienced Situation Table in British Columbia, has listed the following as its indicators of success: approved referrals to SMART, cases closed with lowered risk, and SMART interventions completed. These measures are an excellent starting point, and all of them will be included in this evaluation. But, given the mandates of Situation Tables, this project examined a wider range of measures. In part, this project endeavoured to understand the organizational structures of British Columbia's Situation Tables, the partnership structures, the training of members, the volume and nature of referrals, the effects of Situation Tables on information sharing, collaboration, and intervention strategies, and the strengths and challenges facing Situation Tables.

Project Methodology

The objectives of this project were achieved through qualitative and quantitative research methods. The project can be broken down into several key elements.

Canada is not the only country utilizing Situation Tables (or analogous approaches) to address social problems. This project included a literature review focusing on the operation of Situation Tables in Canada and in other countries, paying particular attention to the similarities and differences across jurisdictions. The review also assessed existing evaluations of Situation Tables.

This project also examined the volume and nature of all referrals for each Situation Table. Data was provided through OCR-GO for each Situation Table in British Columbia on the volume and nature of referrals, identified risk factors, which agency was the originating agency, which agency took the

lead on the file, which agencies provided additional assistance or support, and the outcome of the referral.

To better understand the functioning of Situation Tables, the researchers observed the meetings of two Situation Tables. Observing these in action was useful in comparing the operation of the Situation Tables and provided some insight into establishing good practices moving forward. Of note, all observations were conducted by researchers with RCMP security clearances.

The researchers conducted interviews with the Chairs of each operating Situation Table in British Columbia. The interviews were semi-structured, focused on questions related to the structure and mandate of the Situation Table, roles and responsibilities of members, the nature and quantity of cases, the frequency, organization, and structure of meetings, interventions, outcomes, successes, challenges, what works well and what challenges were facing Situation Tables, and next steps. Prior to conducting the interviews, all questions were reviewed and approved by the Police and Security Branch of the Ministry of Public Safety and Solicitor General, British Columbia. All interviews were conducted by the authors of this report. Given the current situation with COVID-19, the interviews were conducted via online video conferencing. The ethics of the research project, including the interview schedule and project methodology, were reviewed by the University of the Fraser Valley's Human Research Ethics Board prior to any data being collected. Participation in the interview was voluntary and those willing to participate were provided with an information sheet prior to the interview that included a detailed overview of the purpose of the interview. Immediately before the interview began, all key points of the information sheet were discussed with participants. Interviews were not recorded using video or audio recording devices and all information provided by participants was transcribed and anonymized prior to analysis. Once the interviews were completed, all the anonymized information was entered into a Microsoft Word document and qualitatively analyzed for common themes. The analyses will focus on themes emerging from the specific content provided by participants during their interviews, in addition to latent content illustrating any underlying themes.

All active Situation Tables participated in this study and at least one chair or co-chair from each Situation Table participated in an interview (n = 11). All interview participants had been with their Situation Table for at least two years, and many had been with the Situation Table since their Situation Table's inception. In terms of how long participants had been serving as Chair at the time of the interview, the range was from six months to the inception of their Situation Table, so participants had a lot of experience with both being Chair and with the functioning of their Situation Table.

As part of this study, a survey was also designed that could be completed online by all Situation Table members. The survey was made available by a secure link to Survey Monkey, where respondents could complete the survey. The survey asked questions about the respondent's Situation Table, their role with the Situation Table, the partnership structure, accountability, outcomes, what was working well, and what areas needed improvement. The survey collected respondents' responses anonymously and no identifying information was recorded or requested other than the Situation Table that the respondent was a member, and which agency the respondent represented. Prior to administering the survey, all questions were reviewed and

approved by the Police and Security Branch of the Ministry of Public Safety and Solicitor General, British Columbia. The survey remained open for 30 days. Once the survey was closed, the survey data was downloaded into the Statistical Package for the Social Sciences (SPSS) for analysis by the authors of this report. In total, 60 respondents completed the online survey.

Literature Review

DEFINITION AND PURPOSE OF SITUATION TABLES

Over the past decade, there has been a change in the way governments, the non-profit sector, private industry, academia, and the philanthropic sector conceptualize the development and implementation of social service delivery (Corley & Teare, 2019). Across Canada, this new direction has encouraged systems to create a range of integrated health and social care practices whereby sectors unite to help solve the complex social issues present in their communities and improve community safety and well-being (CSWB) (Corley & Teare, 2019). The Situation Table, also referred to as the "Hub" model[1], is one such initiative. The Situation Table model is a "multi-sector, collaborative, risk-driven intervention approach to mobilizing multi-sectoral human services for the purposes of rapid risk mitigation focused on the immediate needs of clients [persons, families or communities] experiencing acutely elevated risk [(AER)] of deleterious safety or well-being outcomes" (Corley & Teare, 2019, p. 10). Designed to empower different public sectors, including public safety, health, and social services, Situation Tables allow community partners to: (1) identify individuals who are at risk for experiencing a negative or traumatic event (e.g., victimization, overdose, eviction/inadequate housing, absent parenting, negative peers or environments, criminal involvement, etc.) that could affect their safety and/or well-being (i.e., risk detection), and (2) work collaboratively and rapidly to connect people to immediate and essential supports and services to reduce their composite risks (i.e., share pertinent information and deploy a rapid risk-mitigating intervention) (Corley & Teare, 2019; Government of British Columbia, n.d.; Taylor, 2021).

HOW SITUATION TABLES FUNCTION

Situation Tables have a multi-sectoral and organizational membership of different services, including, but not limited to, police and other justice services, mental health and addictions services, children and youth services, school boards, hospitals, emergency shelters, outreach and harm reduction, and housing (Nilson, 2016a). Bringing members from these different sectors together for weekly meetings, Situation Tables allow organizations to work collaboratively and proactively to identify individuals and families that present with a range of acute risk indicators, and to alleviate the risk(s) prior to the circumstances devolving into crisis or harm situations (Brown & Newberry, 2015; Taylor, 2021). Agency partners bring forth situations to their Situation Table that they believe present particularly risky circumstances requiring immediate intervention. Using some form of a risk tracking database, Situation Table members can capture, share, and analyze information about the nature of the composite risks presented, which, in turn, allows the

[1] The terms Situation Table and Hub will be used interchangeably throughout this report.

Situation Table members to strategize ways to address the immediate risk(s) and determine the need for, and involvement of, each of the respective organizations in the intervention (Brown & Newberry, 2015; Taylor, 2021). Common primary risk factors include victimization, mental health issues, substance use, chronic school absence, absent parenting, and housing problems. Although criminal involvement may be present among the risk factors used to form the basis for a referral to a Situation Table, it is rarely the single or primary indicator of acute risk. Due to the nature of the composite risk factors being more social than criminal, police often play more of an assisting role in Situation Table interventions. In effect, community-agencies are more likely to take the lead role in connecting individuals to the services that can help meet their immediate needs and mitigate the presenting risks (Brown & Newberry, 2015; Taylor, 2021). The goal of Situation Tables is to connect individuals in need of support to the appropriate services within 24 to 48 hours from the time the situation has been presented to the Situation Table (Nilson, 2014). Once the goal of connecting the individual to the appropriate services have been met, and the Situation Table believes the priority presenting risks have been sufficiently mitigated, and/or the client has been connected to appropriate services, the situation is "closed" (i.e., each relevant service provider is now responsible for providing their respective supports) (Brown & Newberry, 2015). In the end, the Situation Tables work to connect individuals to the resources they require to reduce risk for individuals who present numerous risk factors that cross multiple human service sectors (Nilson, 2014). In this way, Situation Tables are not involved in case management or in evaluating the success of any arrangement of interventions. Instead, the role of the Situation Table is limited to connecting the referred individual to services to address the range of risk factors that the individual presented with.

To achieve this goal, a few important notes about the workings and effectiveness of Situation Tables must be mentioned. First, the Situation Tables must meet consistently to ensure the needs of their communities are being addressed in a timely fashion. Situation Table members usually meet one to two days per week (Nilson, 2014). Second, the Situation Tables need to be composed of service representatives who have sufficient authority and influence within their home organizations to be able to create accountabilities in the care planning/decision-making process and mobilize the resources necessary to address the presenting risks (Brown & Newberry, 2015). Third, during the Situation Table discussions, participants from the service providers/agencies must comply with discussion protocols to ensure the privacy of information and safety of individuals are protected (Nilson, 2016a). Finally, the major caveat to the effectiveness of Situation Tables is that the introduction of the situation is time sensitive. There are certain situations that cannot be mitigated by the Situation Table's collaborative, risk-based intervention because they are beyond the Acute Elevated Risk (AER) stage and are already presenting at the "incident", "emergency", "crisis", or "threat" level, such as a child is in immediate danger, or a firearm is found in a school locker (Taylor, 2021). Such instances require an immediate police intervention or some another mandated response (e.g., child protection action) (Taylor, 2021). However, in those circumstances where a case is referred at the appropriate time, Situation Tables are believed to provide many benefits, such as a reduction in long-term demand on emergency and police resources, an increase in vulnerable people's use of services, and the ability to proactively connect people to necessary services (Government of British Columbia, n.d.). Situation Tables also provide a means to identify

where the system is perceived to be failing to meet the needs of those individuals it is intended to serve (Taylor, 2021).

HISTORY OF HUBS

The Canadian Hubs model stemmed from close observations of a collaborative risk-driven intervention initiative adopted in Glasgow, Scotland. In 2015, the Strathclyde Police established the Violence Reduction Unit to target knife crime and young men carrying weapons in public, as well as violent behaviours more generally (Nilson, 2016a). The goal of the unit was to achieve long-term societal and attitudinal changes to curtail risks for crime and violence using a public health approach to violence reduction. Utilizing police services to contain and manage violent behaviours, this initiative added a new component, namely, a collaborative partnership amongst community agencies that allowed for a focus on addressing the root causes of violence (Nilson, 2014; Nilson, 2016a). This initiative worked by having multiple human service providers meet and share information on high-risk individuals, and then engage with those individuals through an intervention. The intervention was designed to create opportunities for ongoing support via case management and access to necessary programs, services, and mentoring to meet the needs of the client. The success of this initiative in reducing gang-related youth violence led to the development of other collaborative risk-driven initiatives to improve community safety and wellness outcomes in Scotland. These public health-oriented approaches created positive health outcomes, including fewer visits by intoxicated individuals to the emergency room, and, in relation to crime and violence, reductions in violent behaviours (Nilson, 2016a).

Other Collaborative-Risk Driven Approaches

The Pulling Levers Focused Deterrence Strategy, also known as Operation Ceasefire, was developed in Boston, Massachusetts. Designed to prevent violence, this initiative involved an intervention team consisting of police officers and professionals from addictions, social services, employment, housing, and other community programs reaching out directly to gang members to inform them that their violence would not be tolerated and that there were supports available to help reduce their risk for violence (Nilson, 2014). This initiative represented a coordinated response; a collective problem-oriented policing tool that involved collaboration with other community-based human service providers (Nilson, 2014). Similar focused deterrence models have been adopted in other American cities, including Indianapolis, Los Angeles, Chicago, and Cincinnati, to address high risk situations and/or those involving violent offenders (Nilson, 2014). The Cincinnati Initiative to Reduce Violence, which was created as a partnership between political leaders and professionals from policing, education, health, street outreach, community activism, and business sectors, was an intervention model that included both legal consequences for violence, as well as opportunities to engage with appropriate supports and community services (Nilson, 2014). Under this model, offenders were approached by the intervention team in face-to-face meetings and told they must cease their violent behaviours. The offenders were also provided with access to supports to assist with exiting their current lifestyle (Nilson, 2014). Evaluations of these types of initiatives suggested that coordinated responses to violent or high-risk individuals that incorporated both criminal

justice professionals and community service providers increased the likelihood that offenders would stop engaging in crime and violent behaviours, including homicides and shootings (e.g., Engel et al., 2010; McGarrell et al., 2006; Papachristos et al., 2007; Tita et al., 2004).

CANADIAN SITUATION TABLES

In 2011, Prince Albert Police Service in Saskatchewan identified a need for change in their approach to community safety (Nilson, 2016a). A group of 25 local professionals, known as "the original gamechangers[2]", launched the original Hub, the Prince Albert Hub[3]. The Hub involved a partnership between the Prince Albert Police Service and community-based organizations that pursued a more coordinated response to manage serious, elevated risk among particularly vulnerable community members. This initiative, which was adapted from the Scotland model, marked the start of a new process of collaboration intended to bring to Canada "immediate and urgently needed service connections to individuals and families facing compound risk factors that, while not yet at the incident or even crisis level, could be readily recognized as heading swiftly and inevitably in that direction" (Taylor, 2021, p. 35). The purpose of the approach was to allow for organizations to immediately and collaboratively respond to and provide short-term opportunities to address emerging problems, risk conditions, and crime-related issues that were identified and brought forward from the frontline operators of any/all participating agencies (Nilson, 2014; Nilson, 2016a)[4].

The Prince Albert model consisted of several key components. The first centred around community readiness. Implementation of a Hub requires a significant level of buy-in, mutual support, and a collective will to do better amongst partners (Nilson, 2016a). Thus, it was imperative that community leaders first considered, among other factors, the level of concern that existed within their community pertaining to acute risk situations, whether there was a champion within the community to lead the initiative, whether the right people could be brought to the table, and whether potential partners had the capacity and resources necessary to participate (Nilson, 2016a). In addition to curating a committed team representing various sectors within the community, the Prince Albert Hub also had an alliance with a specialized team of human service professionals dedicated to tackling the more complicated systemic problems in the community affecting the Hub's clients (Centre of Responsibility or COR). This team supported Hub members by engaging in community outreach, collecting and analyzing data, identifying and developing initiatives to

[2] The group involved representatives from Prince Albert Police Service, Saskatchewan Rivers Public School Division, Prince Albert Catholic School Division, Prince Albert Parkland Health Region, Royal Canadian Mounted Police "F" Division, Saskatchewan Corrections, Saskatchewan Social Services, Prince Albert Fire Department, and Prince Albert Grand Council (Nilson, 2014).

[3] This is also known as the "Community Mobilization Prince Albert" (CMPA).

[4] Designed to create service connections geared toward mitigating elevated risk, the Situation Tables were not geared toward creating comprehensive wraparound long-term care plans.

address systemic issues in the community, and providing opportunities to build capacity to improve the Hub's service delivery (Nilson, 2014).

The second component involved the identification and mitigation of situations of acutely elevated risk. The Prince Albert model defined such situations as being comprised of four conditions: (1) significant interest at stake; (2) probability of harm occurring; (3) severe intensity of harm; and/or (4) multi-disciplinary nature of elevated risk. If one or more of these conditions was not present, the situation would be rejected by the Situation Table and referred to the originating agency or other community services for action (Nilson, 2014).

The third component was the Four Filter Process. When situations were deemed to meet one or more of the conditions for elevated risk, the filter process was utilized to identify priority needs in the community, as well as to protect and promote the privacy interests of the individuals and/or families presenting with AER[5] (Nilson, 2014). The first filter involved the originating agency exhausting all options currently available within their own agency to meet the needs of the client (Nilson, 2016a). The second filter involved the Situation Table considering whether the situation met the criteria outlined for acutely elevated risk (Nilson, 2016a). If AER was present, the third filter involved the Situation Table members sharing basic identifiable information about the client for the purposes of identifying all relevant services and service providers to be included in the intervention[6]. During this stage, only the relevant agencies are permitted to take notes about the information shared (Nilson, 2014). To help direct the discussion and develop the intervention, a lead agency and assisting agencies are identified (Nilson, 2014). The fourth filter encompassed an additional discussion among the agencies deemed appropriate to partake in the intervention, whereby the agency members share additional information about the situation and their plan for the intervention (Nilson, 2016a). The outcome of the Four Filter Process is the development and implementation of the intervention.

The fourth component, which is the key to the Hub model, is the collaborative intervention(s) that occurs during the fourth stage of the Four Filter Process. Within 24 to 48 hours from the date/time the situation was opened, the initial intervention is expected to occur. A multi-sector team of human service providers approach the Hub subject, usually via a door knock, to identify their concerns for risk, and offer immediate connections with appropriate supports and services to initiate the process of risk reduction (Brown & Newberry, 2015; Nilson, 2016a). Following an intervention, the intervention team reports on the results of its attempts to provide services and supports to the client at the next Hub meeting (Nilson, 2014).

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[5] It is important to note that a situation could exit the Hub Table at any time during the Four Filter Process if the Hub members collectively determined that acutely elevated risk was no longer present, and/or the client was connected to appropriate services (Nilson, 2014).

[6] It is important to note that, of those cases that did not receive Situation Table mobilization, the reasons for rejection usually involved the timeliness of the referral, the referral originator had not exhausted all options to address the presenting issue(s), or the individual in question was already connected to appropriate services or supports that had the potential to mitigate the risk(s) (Brown & Newberry, 2015).

The final component of the Hub model involved data collection. The Prince Albert Hub created a Hub Database to capture the information shared during Hub discussions (Nilson, 2017a). This was useful for assisting with the identification of systemic issues, providing support for ongoing Hub discussions, enabling ongoing analysis of Hub processes and outcomes, promoting due diligence, building the capacity for evaluations of the model, and assisting with replications of the Hub model in different communities (Nilson, 2016a). It is important to note that this information mainly focused on keeping track of the risks discussed at the Situation Table and was de-identified to ensure the privacy rights of individuals were not violated by the information sharing process (Nilson, 2014). Information in the database included the originating agency, the age, gender, and type of subject (i.e., individual, family, neighbourhood, etc.), the risks presented, intervention actions, and any systemic issues that were identified (Nilson, 2014; Nilson, 2017a).

Adoption of the Hub Model Across Canada

This informal innovation in collaborative practice has since inspired the development of similar community efforts across Canada (Taylor, 2021). To date, there are over 115 different Situation Table models that have been adopted and implemented in communities across Canada (Corley & Teare, 2019). In Saskatchewan, the Government's development of the Building Partnerships to Reduce Crime initiative created an opportunity for communities to receive additional mentoring and technical support as they began mobilizing initiatives to address AER situations (Nilson, 2016a). Communities that have adopted initiatives like the Prince Albert Hub model include Yorkton, La Ronge, North Battleford, Moose Jaw, Saskatoon, Weyburn/Estevan, Nipawin, Lloydminster, and Swift Current (Nilson, 2014). In Ontario, Hubs have been established in communities, including North Bay, Sudbury, Rexdale, Halton Hills, Cambridge, and North Dumfries, Kitchener, and Guelph. In British Columbia, the first Situation Tables were introduced in Surrey in 2015; the Surrey Mobilization and Resiliency Table (SMART), as well as in Mission; the Mission Active Support Table (MAST). Funded by the Office of Crime Reduction and Gang Outreach (OCR-GO), Situation Tables have now been implemented in several communities across British Columbia. These include Penticton (Penticton Community Active Support Table – CAST), Burnaby (Burnaby Mobilization and Resiliency Table – BMART), Chilliwack (Chilliwack Interagency Response Team – CIRT), Kelowna (Kelowna Outreach and Support Table – KOaST), West Kelowna, Westbank First Nation, and Peachland (Greater Westside Hub), Hope (Hope Situation Table – HOST), Cariboo-Chilcotin region (Cariboo-Chilcotin Acute Response Table – C-CART), and Terrace (Terrace Situation Table).

The Hub model has also been adopted by First Nations communities. The Samson Cree Nation, located in an on-reserve community outside of Edmonton, Alberta, implemented a Hub in 2012. Although the practices of the Hub model appear to align with the needs (e.g., high rates of violence and social problems, such as substance abuse and health problems), as well as the traditions and values of First Nations communities (e.g., holistic and encompassing of individuals within the context of the family, community, and larger society), to date, the Samson Cree Hub remains the only First Nation to have fully applied the Situation Table model over an extended period of time (Nilson, 2016a).

There is also the potential for the Hub model to be adapted and implemented in rural and remote communities (Nilson, 2017b). Hubs can utilize technology, including video communications, to create a virtual Situation Table connecting service providers to one another and to clients (Nilson, 2017b). By removing physical barriers to service access, tech-enabled Hubs may provide a solution to addressing AER situations in rural and remote communities (Nilson, 2017b). This adaptation to the traditional in-person Hub model is currently under development and in the process of being piloted (Nilson, 2017b).

Similarities and Differences Across Canadian Situation Tables

Hubs all appear to be created for similar reasons: (1) realization that current practices in public safety and wellness were unable to adequately address circumstances wherein individuals/families were experiencing elevated risks; and (2) the need to develop mechanisms to proactively address pressing social issues prior to their reaching crisis levels (Nilson, 2014). The Prince Albert Hub was developed as an alternative problem-solving tool to help human service providers address pressing community needs and concerns involving increases in intoxicated persons, missing persons, domestic violence, property crimes and graffiti, poor housing, and gangs (Nilson, 2014). For example, based on the 2014 review of the calls for service completed by the Surrey Royal Canadian Mounted Police (RCMP), it was revealed that the majority of calls for service in Surrey were related to social issues (e.g., poverty, substance abuse, mental health, and homelessness) rather than being of a criminal nature. Recognizing that these types of calls could be better managed by a coordinated community response, SMART was established to address community issues before they required emergency services or police intervention by connecting vulnerable individuals with critical supports available in Surrey (City of Surrey, 2021). Similarly, the Samson Cree Hub was created specifically to address high rates of crime, violence, death, addictions, and community fear in a First Nations community (Nilson, 2016a).

Due to differences in the specific needs of their communities, the individual Hubs appeared to be comprised of a myriad of local service providers. The Kitchener and Cambridge Situation Tables, for instance, were originally comprised of members from a large range of service sectors, including education, police, and justice services, primary health care, community health and hospital services, community mental health and addictions, child protection services, housing and homelessness support services, and sexual assault and victim support services (Brown & Newberry, 2015). The SMART group was made up of professionals from disciplines including law enforcement, corrections, health, social services, income assistance, housing, and education (City of Surrey, 2021). The Samson Cree Hub was formed out of a partnership between agencies in the policing, community wellness, education, probation, corrections, child protection, housing, income support, social services, ambulance, and youth sectors (Nilson, 2016a).

In terms of their functioning, the aim of all Hubs was to initiate and resolve cases as quickly as possible. As indicated above, all Situation Tables aim to develop and execute the initial intervention plan within 24 - 48 hours (City of Surrey, 2021). Moreover, files are intended to be closed within one or two weeks. The SMART Hub and Connectivity Tables, for instance, appear to be able to resolve most of their situations within two to three weeks (Brown & Newberry, 2015; Rezansoff et

al., 2017). In terms of setting up a Hub, most were designed to have members from the partner agencies meet at least once per week to review cases and determine whether individuals or families who have an acutely elevated risk of harm, victimization, or criminality require a rapid multi-agency intervention. Taking a more ad hoc approach; however, the meetings for the Chatham, Ontario Hub, the Fast Intervention Risk-Specific Team, occurred only if a situation was referred to the chairperson and may take place over the phone or in-person (Nilson, 2017b).

Although all Situation Tables in Canada were implemented to reflect the original Prince Albert model, modifications have occurred to ensure the process continued to address the local circumstances. The Samson Cree Hub, for instance, implemented the option of the client to participate in an intervention circle. Planned around the individual or family's needs, the circle would include an Elder (who the individual/family has a relationship with), mobilized a variety of agencies around the individual/family, and occurred at a neutral venue (Nilson, 2016a). In addition to the actual models for intervention, there were expected to be variations in Hub discussion dynamics, risk factors, and outcomes. How cases were referred, as well as who was being served by each Situation Table, was likely to vary based on the nature of the issues presenting in each community. For example, the originating agency for referrals in the Prince Albert Hub tended to be the police who represented just over half of the situations presented to the Hub (Nilson, 2014). In Ontario, most situations referred to the Situation Table were presented by police services (73% in Cambridge and 56% in Kitchener). Similarly, most cases presented at the SMART Table originated from policing agencies (Rezansoff et al., 2017). The police were also the most frequent member organization to respond to situations as either the lead or in an assisting role in the Connectivity Table interventions (Brown & Newberry, 2015). Conversely, in the Prince Albert and Samson Cree Hubs, the police took a less active role in interventions. Social services usually played the lead role in Prince Albert Hub interventions, with the police acting as an assisting agency (Nilson, 2014). The education authority's home liaison usually played a lead role in most of the Samson Cree Hub interventions, and the police were rarely involved in the intervention stage (Nilson, 2016a).

In terms of who was being referred to Situation Tables, it appeared as though youth were the primary clients. Most of the situations referred to the Prince Albert Hub involved female youth between the ages of 12 and 17 years old (Nilson, 2014). Similarly, the Connectivity Tables seemed to be referring youth, who represent approximately one-third of referred cases, as well as adults 18 to 24 years old and 40 to 59 years old. Targeting a slightly older individual, the SMART Hub connected with young adults typically between the ages of 25 and 49 years old. The Samson Cree Hub appeared to be working with families with children who were at risk of becoming involved in gang activity (Nilson, 2014).

Similar to the clientele, the combination of risk factors presenting for each situation also varied. The more common risk factors of the Prince Albert Hub situations included alcohol, criminal involvement, parenting concerns, mental health issues, physical violence, truancy, and drugs (Nilson, 2014). Usually presenting with just over six different risk factors, the individuals being served by the Connectivity Tables typically presented with primary risks related to mental health, criminal involvement, and substance use/abuse (Brown & Newberry, 2015). In comparison to the other Hubs, crime and mental/physical health were less prevalent in SMART situations. Unmet

basic needs, including housing, as well as exposure to negative environments (e.g., abuse) were the most prevalent categories of risk presenting at the SMART Table (Rezansoff et al., 2017).

Identification of risk may also differ across Hub members and Hubs. Although the Prince Albert Hub created a list of risk variables, they lacked a standardized risk assessment process for Situation Tables. Thus, understandings and evaluations of risk may differ from Situation Table to Situation Table (Brown & Newberry, 2015). In terms of identifying risk, the focus was on those factors that existed within the relationship between individuals and the collection of services that have, thus far, been unable to address the individual's issues/needs (Brown & Newberry, 2015). Each agency would identify and evaluate risk as it related to their own sector and bring that information to the Situation Table meeting, where the Situation Table members generated a shared perception of the presenting risk (Nilson, 2014). Although there tended to be a specific language utilized at the Hub meetings pertaining to risk, rather than utilizing a formal risk assessment tool to evaluate the level of risk presenting, Situation Tables appeared to rely on more informal methods, namely the subjectively recorded narrative descriptions made by the Situation Table members (Brown & Newberry, 2015).

Connected to the risk factors, some of the Hubs were taking the model one step further and including discussions about protective factors. The Connectivity Tables were taking a leadership role in moving toward an assets-based approach to community intervention to incorporate protective factors in their database, rather than merely focusing on risk factors (Brown & Newberry, 2015; Newberry & Brown, 2017). Some potentially important protective factor categories that have been identified thus far include financial security and employment, housing and neighbourhood, family supports, education, social support network, pro-social/positive behaviour, and physical/mental health (Newberry & Brown, 2017). The idea behind this expansion was that protective factors might help inform Hubs about individual-, family-, and community-level resiliency, and which assets may be leveraged by interventions (Newberry & Brown, 2017).

The response mobilization process may also vary across Situation Tables. Consistent with the Prince Albert model, the Kitchener Situation Table focused on matching an agency's mandate with the highest priority risk factors. However, the Cambridge Situation Tables' response mobilization process was centred on matching the major presenting needs (e.g., mental health, substance use, criminal involvement) and characteristics (e.g., age) of a situation with Situation Table member expertise and resources (Brown & Newberry, 2015). The focus was on who would have the greatest probability of success in connecting with the individual in need (Brown & Newberry, 2015). The Samson Cree Hub appeared to be using a similar process as they stressed the importance of focusing on the client's needs and risk factors first, while putting the agency mandates second as they created a collaborative solution to help mitigate the client's risks (Nilson, 2016a). In essence, some of the Situation Tables were moving beyond the organizational boundaries created by mandates by taking a more flexible and collaborative approach to their intervention.

THE PROCESSES, EFFECTS, AND OUTCOMES OF SITUATION TABLES

On the surface, the Situation Table model has some appealing features. Compared to the more traditional and siloed approaches to harm reduction, the Situation Table is intuitively superior.

Operating in their own distinct disciplines, service sectors often have different eligibility criteria for service admission, including determinations of risk and levels of risk tolerance (Corley & Teare, 2019). In addition, the information obtained about individual case circumstances has traditionally not been shared between different organizations. This has often resulted in certain individuals receiving incomplete or inappropriate services, and as is often the case for those with the most complex needs, being excluded from receiving certain services entirely (Brown & Newberry, 2015). By sharing information across once separate sectors, police and community agencies can gain a more holistic understanding of the individual circumstances of clients who are at risk of experiencing harmful safety or well-being outcomes (Corley & Teare, 2019). This is believed to fix the diffuse and uncoordinated approach by driving a more coordinated care planning process. Furthermore, as community organizations take a leading role in addressing AER cases, Situation Tables may be more effective in facilitating responses that are less formal and more equitable, supportive, and non-punitive than those traditionally delivered through the criminal justice system (Taylor, 2021). The strong, community-driven uptake of this model across Canada speaks to the perceived opportunity for local-human service professionals to take a proactive harm reduction approach by improving access to help for at-risk clients (Corley & Teare, 2019).

In addition to the intuitive appeal, the Situation Table model has benefited from several evaluations that have assessed the development and application of the model's processes, and some of the initial impacts of service delivery (Corley & Teare, 2019). The impact assessment of the Prince Albert Hub centred on details surrounding the function, structure, outcomes, challenges, and successes of the Hub (Nilson, 2014). Similarly, the Samson Cree evaluation focused on why the model was adapted in the Samson Cree Nation, whether it was consistent with evidence-based practices, how compliant the Samson Cree Nation was with established practices of the model (e.g., referral process, collaborative intervention practices), the impacts of the Hub on clients, agencies, and the police (i.e., lessons learned), and what benefits and challenges were observed. Brown and Newberry's (2015) and Newberry and Brown's (2017) evaluations of the Connectivity Situation Tables[7] in the Waterloo Region of Ontario focused on the processes (e.g., how the Situation Tables were implemented and who was being served) and outcomes (i.e., the benefits for individuals being connected to the supports). Other evaluations of the Hub model have been conducted in Brantford (Babayan et al., 2015), Guelph (Litchmore, 2014), Toronto (Ng & Nerad, 2015), Ottawa (Lansdowne Consulting, 2016), Barrie (Nilson, 2017a), and Surrey (Rezansoff et al., 2017). Most of these evaluations were completed at the local level across multiple dimensions and indicators of health and well-being collected via interviews, focus groups, surveys, direct observation, and/or case studies (Nilson, 2017a). Specifically, evaluations were based on information gathered via feedback from representatives from human service sectors, output data on service/intervention activity, pre-/post-service demand analysis, and a few assessments of client and system impacts (Corley & Teare, 2019; Taylor, 2021).

[7] This includes the Situation Tables adapted and implemented in 2014 in Cambridge and in Kitchener by the Waterloo Regional Police Service (WRPS) in partnership with Langs, and Carizon Family and Community Services, respectively (Brown & Newberry, 2015).

Benefits Associated with Situation Tables

Together, these evaluations have uncovered several benefits associated with the adoption and implementation of Situation Tables in different communities. Situation Tables have provided a mechanism for different service sectors to come together to identify and mitigate risks by creating collaborative interventions that connected individuals, families, and/or communities with appropriate services. In so doing, the Situation Tables were found to create several positives for clients and community service providers. First and foremost, the Situation Tables model was believed to have broken down long-standing institutional siloes (Nilson, 2016a). The collaborative environment helped to build the capacity for Hub agencies to work in a team fashion to create holistic support to clients (Nilson, 2014). By removing barriers to service access in various sectors, Situation Tables have provided an opportunity to connect individuals to appropriate services (Nilson, 2016a). For instance, Brown and Newberry (2015) found that the Connectivity Tables were highly successful in connecting individuals and families in situations of acutely elevated risk with services in just over three-quarters (n = 765) of the cases they addressed and closed. In addition to connecting individuals to services, Situation Tables were believed to increase the speed with which clients were connected to appropriate services (Brown & Newberry, 2015; Nilson, 2016a; Nilson, 2017a). Nilson (2016a) noted that agency members of the Samson Cree Hub believed the Hub helped parents and families access programs sooner and with fewer barriers. Connectivity Table members also expressed satisfaction with the ability of the Table to coordinate and implement responses in a timely manner (Brown & Newberry, 2015). The increase in the effectiveness and efficiency of service delivery to at-risk clients (Lansdowne Consulting, 2016) may be related to another perceived benefit of the Situation Tables Model, that being greater information sharing and cooperation amongst local service providers (Brown & Newberry, 2015; Ng & Nerad, 2015; Nilson, 2016a). By streamlining the service delivery process in acutely elevated risk situations, the Situation Table model enabled service providers to reduce duplication in services, adopt more creative and flexible approaches to address complex community needs, and develop a deeper understanding of their own and other Situation Table agencies' mandates, strengths, and limitations (Nilson, 2014; Nilson, 2016a). By providing the opportunity for agencies to increase their knowledge of, connections to, and rapport with other services in the community, Situation Tables were successful at removing the pressure for different service providers to handle complex issues on their own (Brown & Newberry, 2015; Nilson, 2016a; Nilson, 2017a). In effect, Situation Tables helped individual agencies to create a single plan involving supports and services from multiple sectors that was more tailored to meet the needs of their client(s) (Babayan et al., 2015; Nilson, 2014; Nilson, 2016a). This model increased the options available for responding to situations of acutely elevated risk (Nilson, 2014).

Additional benefits of Situation Tables included their potential to assist with diverting calls away from police and other emergency/crisis services by identifying risks earlier and proactively connecting clients with more appropriate services prior to a crisis occurring (Brown & Newberry, 2015; Nilson, 2014; Nilson, 2016a; Nilson, 2017a. For example, in addition to finding a large decrease in calls for police services associated with both the Connectivity Tables (45% for Cambridge and 47% for Kitchener), Newberry and Brown (2017) also discovered a reduction in the number of emergency department visits for both Cambridge and Kitchener (14% and 69%,

respectively) when comparing hospital records for the year prior to, and one year following intervention for clients who were successfully connected to services through the Connectivity Tables. Reducing the level of risk proactively also meant that the Situation Tables were acting as a preventative tool by reducing future calls for emergency and police services (Newberry & Brown, 2017; Nilson, 2016a; Nilson, 2017a). In addition, Situation Tables may increase service providers' connectivity with vulnerable populations (e.g., homeless or precariously housed individuals, those with mental health needs, and victims of sexual assault or trauma) (Brown & Newberry, 2015). Furthermore, the non-intrusive and voluntary nature of Situation Table interventions removed the adversarial component of service provision and helped to foster a sense of trust in community service providers and the police amongst the individuals being served, to help clients become more aware of their behaviours and how they impact others, to make clients accountable to all service providers, and to increase clients' engagement with services by giving them the power to select the services they want (Brown & Newberry, 2015; Nilson, 2014; Nilson, 2016a; Nilson, 2017a; Rezansoff et al., 2017). Interviews with clients from the SMART Hub suggested that because clients were able to obtain essential advocacy and direct attention from service providers, they were more motivated to make the most of the opportunities presented to them (Rezansoff et al., 2017).

Factors Contributing to Situation Tables' Successes

Factors leading to the successful implementation of Situation Tables include obtaining community buy-in from all service agencies, a willingness to challenge the status quo, having a trusted and engaging coordinator to build the Situation Table's network (i.e., having a strong outreach capacity to access individuals in the community), developing a shared understanding of the Hub's function, purpose and processes among all participating members, having strong communication between partner organizations, creating an equal partnership among Hub members (i.e., contributing equal time and effort to the Situation Table discussions and intervention processes), as well as ensuring confidentiality of information while balancing the need to protect people from harm (Brown & Newberry, 2015; Newberry & Brown, 2017; Nilson, 2014). The development and maintenance of the Situation Table's database, which enables the Situation Table to monitor, evaluate, and improve the Situation Table by identifying patterns and trends in the types of situations and responses mobilized by the Situation Table, and, when possible, having real-time access to each member's home organization's client management database to facilitate mobilizing a response are also important for proper functioning of a Situation Table (Brown & Newberry, 2015; Nilson, 2014; Nilson, 2016a).

Other key ingredients for success include engaging the right types of people, as well as curating strong and committed Situation Table leadership (Brown & Newberry, 2015; Nilson, 2016a). Hubs require having the right types of people running them; individuals need to be able to motivate others to collaborate and support clients (Nilson, 2016a). Brown and Newberry (2015, p. 10) discovered that one of the key indicators of the success of the Situation Tables has been their strategic recruitment and engagement of members who are perceived as "leaders" and "decision-makers" in their home organizations (i.e., those who have the clout and endorsement in their organization to act swiftly and enact the kind of rapid response necessary to mitigate acutely elevated risk). It is crucial to have the endorsement and championing of the Situation Table's

activities at the management or leadership level from each member's organization (i.e., recruitment of agency "doers" to the Situation Table). In terms of establishing leadership, it appears as though it is critical that the Situation Tables create a shared sense of ownership and responsibility for the process across community organizations, have long-standing and strong relationships amongst the lead Situation Table partners, and choose lead partners who have a history of multi-service collaboration, are well-respected in the community, and have experience in and share a service provision philosophy concerning integration of social and health services in community interventions (Brown & Newberry, 2015).

In terms of the delivery of successful Situation Table interventions, there are several actions that must take place. The agencies that can provide services relevant to the presenting risk factors must be actively involved in the intervention (Nilson, 2014). In addition, the intervention must be presented as a voluntary service provision; the Situation Table's intervention team may only offer, not force support (Nilson, 2014). To be most effective, the Situation Table intervention team needs to work with the at-risk individual/family to create a support plan that encompasses a solution that will not only reduce the presenting risks, but also lower the client's overall probability of harm (Nilson, 2014).

Impediments To Situation Table Operations

The evaluations also address some areas where Situation Tables continued to face challenges and/or may be improved. One of the biggest challenges to adopting the Situation Table model stemmed from the ability to transfer an existing model to a new community; all communities have different needs and different players who have different ways of working (Nilson, 2014). In addition, variations in home agency referral processes, differences in conversations about recruitment processes, and distinct information sharing protocols may lead to differences in the levels of risk being brought to Situation Table meetings, as well as the types of information being shared (Brown & Newberry, 2015; Nilson, 2014).

Challenges associated with the structure and functioning of the Hub model appeared to be related primarily to privacy protocols. Some Hub discussions were thwarted by privacy, consent, or legal concerns stemming from Hub members' home organizations (Nilson, 2014; Nilson, 2017a). As a result, some agencies were simply unable to fully partake in the information sharing process (Nilson, 2014). The Four Filter process of the Hub model itself also presented some challenges. The de-identified portions of the Situation Table discussions, such as whether children were involved in the situation, may prevent pertinent pieces of information from being available during discussions, which can negatively affect assessments of acutely elevated risk (Nilson, 2014). In addition, restricting the note-taking capabilities to only those agencies involved in the intervention phase can make it difficult for the other Situation Table members to recall the circumstances of each case during follow-up meetings (Nilson, 2014).

There were also client-based, institutional, and systemic barriers to successful collaboration and intervention. Client barriers included transience, a refusal to engage in the intervention and receive services, and client failure to recognize and be accountable for addressing their risks (Nilson, 2014; Nilson, 2016a). One of the institutional blocks to intervention involved the lack of follow-up mechanisms for ensuring clients had engaged with services (Nilson, 2014). Another barrier

focussed on the voluntary nature of the Hub initiative; there was no mechanism by which Hub members could enforce regulations or policies (Nilson, 2016a). Another institutional barrier involved the participation/attendance of the agency members. Missing and/or changing representatives at the meetings effected the dynamic and structure of the team, as well as their ability to mobilize an appropriate intervention plan (Nilson, 2016a). In addition, the ability for some agencies to set-up and take the lead and/or to assist in interventions may be limited due to the restricted capacities of the most appropriate agency (Brown & Newberry, 2015; Nilson, 2017a). Corrections services, for instance, were unable to engage with clients and build case plans unless they had the legal authority to do so (i.e., they are restricted to working with clients who are already involved with the justice system) (Nilson, 2014). The time commitment required to participate in a Situation Table (at minimum two hours a week for regular meetings) may be a further obstacle for some Situation Table members; this was especially true for members coming from smaller organizations, as they had to balance more commitments within their home organization (Brown & Newberry, 2015).

The larger systemic barriers also hampered the efforts of Situation Tables to mitigate risk and foster long-term positive outcomes (Newberry & Brown, 2017). There appeared to be significant gaps in services presented at some Situation Tables. Brown and Newberry (2015), for instance, discovered that one of the major service delivery gaps in the Waterloo region for both locations involved adult mental health services, including community-level and psychiatric services. In addition to missing services, there may be poor access to services due to long wait lists (e.g., addictions treatment and mental health support coordination), and/or insufficient supports available to meet the needs of clients (e.g., lack of available and affordable housing options) (Newberry & Brown, 2017). Information obtained from SMART Hub clients, for instance, revealed that "needed services [are] often not available, or only available under specific circumstances (e.g., abstinence-based housing without conjoint drug treatment)" (Rezansoff et al., 2017, p. 20). Furthermore, because Hub interventions were designed to provide immediate amelioration of risk in the most acute situations, they did not address long-term solutions for client needs. Thus, many of the resources required by clients to achieve long-term success might not be available via the Hub model (Rezansoff et al., 2017). These challenges associated with accessing local services and resources to mitigate prominent risks might reduce the Situation Table's ability to close situations quickly and/or to prevent a relapse from occurring (Newberry & Brown, 2017).

One final challenge facing Hubs across Canada was sustainability. The ability of the Situation Table initiatives to maintain momentum requires continued support. Not only must Situation Table partners continue to actively engage with the process, but the Situation Tables also need continued monetary backing (Nilson, 2017a). Most Situation Tables were funded through a specific organization, such as the British Columbia Situation Tables, which were monetized by the Office of Crime Reduction and Gang Outreach (OCR-GO) (City of Surrey, 2021), or via finite grants, including the Proceeds of Crime Grant for the Barrie Police Service obtained from the Ontario Ministry of Community Safety and Correctional Services (Nilson, 2017a). As there were differences amongst the Situation Table partner agencies, in terms of their own abilities to contribute to the initiative, it appeared as though monetary support for the initiative was neither permanent nor guaranteed. At

present, it is unclear whether Situation Tables will continue to be funded in the future (Nilson, 2017a).

RECOMMENDATIONS FOR IMPROVING THE HUB MODEL

Collectively, the evaluations suggested that the utility of the Hub model centres on its ability to establish multi-sectoral collaborations to strengthen service delivery for clients requiring urgent care. Some of the more prominent effects of this approach thus far have included quicker access to services (Nilson, 2014), improved cross-sectoral communication and working relationships (Ng & Nerad, 2015), and a self-reported increase in the effectiveness and supportiveness of services by both clients and workers (Babayan et al., 2015; Brown & Newberry, 2015; Lansdowne Consulting Group, 2016; Newberry & Brown, 2017; Nilson, 2016a, 2017). The key information garnered from these evaluations concerning the implementation and approach of these various Hubs/Situation Tables should be used as lessons learned and provide a basis for improving the Hub model (Corley & Teare, 2019).

Based on the findings from the various evaluations, there were several key recommendations for improving the Situation Tables model. The first centres around standardizing the process. Standardizing processes and activities may assist with the functioning of Hubs in all communities. First, in terms of implementing Hubs in new communities, it is important that standardized promising practices are developed, including initial and continual training for Hub members. The Hub discussion process should be mutually understood by all agencies (Nilson, 2014). It is also recommended that Situation Tables standardize their privacy protocols and address outstanding privacy concerns for partnering organizations, including issues surrounding the amount of information necessary for a referral (e.g., presentation of risk factors and historical information) (Brown & Newberry, 2015; Nilson, 2014). While not necessarily the case anymore, because most referrals came from the same source agencies, namely police services and the health sector, it was unclear as to whether agencies that have not served as a referral source were refraining from bringing situations to their respective Situation Table due to privacy concerns (Brown & Newberry, 2015; Nilson, 2017a).

Another facet of the Hub initiative that would benefit from greater standardization, according to the literature, was the process for closing situations. One of the concerns from Hub members was the ambiguity pertaining to what constituted decreased risk. Most cases were closed when a client was connected to a service; however, because there was no follow-up procedure to ensure clients were engaging with services, a mere connection to a service may not have meant the client's risk was being addressed (Nilson, 2014). Instead, it is recommended that the process involved confirming that individuals had received and engaged in services (Nilson, 2014). In addition, to gain a better understanding about lowered risk, it would be beneficial to track individuals who had refused service, and to track specific service actions after a situation had been closed after a specified period of time (Brown & Newberry, 2015).

Although a Hub Database has been developed, the literature stressed that it was important that communities continued to work towards building comprehensive, standardized sets of indicators that correspond to the Situation Table risk categories (e.g., number and types of criminal charges,

number and reasons for emergency room visits, etc.) common Situation Table responses, and ensuring that all outcomes are captured (i.e., short-term as well as longer-term outcomes), including reasons for why a situation was rejected, tasks undertaken by Hub members during an intervention, and services mobilized by the Hub (Brown & Newberry, 2015; Nilson, 2014). This would help to ensure that all important processes and outcomes were consistently captured from all operating Hubs. Building an analytic capacity for Situation Tables to continually work with databases to answer questions about needs, trends, and gaps is crucial for strengthening the structure and format of the Hub model (Brown & Newberry, 2015; Nilson, 2014).

To improve the effectiveness of the Hub model, it was recommended that a follow-up procedure for verifying and tracking client connection to and engagement with services be developed and implemented (Nilson, 2014; Nilson, 2017a). While not the primary function of a Situation Table as currently implemented, it may be important and helpful for clients to feel supported by the Situation Table throughout the process, including following the intervention (Nilson, 2017a). Furthermore, to improve services and attempt to provide further support for participation, Situation Tables need to be able to identify why individuals were not engaging with provided supports; this requires follow-up with contacted clients (Nilson, 2014).

Another recommendation involved generating greater community-buy in and engagement in Situation Tables. There is a pressing need to address service gaps to ensure there are agencies with the relevant resources and tools available to address all elevated risk factors in each situation (Brown & Newberry, 2015; Nilson, 2014; Nilson, 2017a). With large numbers of clients self-identifying as Indigenous, for instance, ensuring Situation Tables provide culturally appropriate services is crucial (Rezansoff et al., 2017). Thus, work should be done towards increasing involvement of more community-based organizations in Situation Tables. In addition to increasing the number of Hub partners, it was also recommended that Situation Tables worked towards creating a system to increase agency attendance and involvement in the Hub process to ensure interventions were able to address the needs of the clients (Nilson, 2014; Nilson, 2016a). Continuity of Hub membership would help ensure the Hub was able to function properly and efficiently by making sure there was consistent information, as well as a shared understanding of the process (Nilson, 2014). A final recommendation that emerged from the literature review involved creating a governance committee. The committee should possess the skills, clout, and connections to provide oversight to Situation Tables in terms of compiling, analyzing, and summarizing data from all Situation Tables for the purposes of strategically pursuing system change, resource allocation, and policy initiatives (Brown & Newberry, 2015).

Situation Table Risk Tracking Database Analyses

The data in this section was taken directly from the British Columbia Situation Tables' Risk Tracking Database. The database was provided for analysis by OCR-GO. The earliest case in the database was from November 2015, and the latest case was from February 2021. The database included information on 1,003 referred cases from all the currently operating Situation Tables in British Columbia, as well as the Situation Table in Chilliwack that suspended operations in 2020.

CLIENT DEMOGRAPHICS AND FILE FEATURES

Table 1 presents information on the number of referrals to Situation Tables by year. In considering the findings presented in Table 1, it is important to keep in mind that the number of Situation Tables was not always the same each year. For example, in 2015 and 2016, the only Situation Table that was in operation in British Columbia was in the City of Surrey. The Mission Situation Table began in 2017, while the advent of Situation Tables in Chilliwack and Penticton by the end of 2018 brought the total number to Situation Tables to four. Five more Situation Tables began accepting referrals in 2019, and one other began in 2020. The number of referrals for 2021 represented only three Situation Tables. This was most likely the result of the COVID-19 pandemic and its effects of the overall operation of Situation Tables.

TABLE 1: NUMBER OF REFERRALS TO SITUATION TABLES BY YEAR (N = 1,003)

	Number of Referrals
2015	15
2016	103
2017	82
2018	125
2019	362
2020	293
2021	23

Although Situation Tables provide assistance to both individuals and families, their activities are more heavily oriented toward the former. Of the total number of referrals, more than three-quarters (78.6 per cent) of referrals involved individual clients. Moreover, the files involved roughly equal numbers of males (50.4 per cent) and females (48.7 per cent). Of interest, referrals tended to be for older people. Using the age categories in the Risk Tracking Database, both the modal and median category was for people between the ages of 30 and 39 years old (see Table 2). Most referrals (56.6%) were for people who were 30 years old or older. Supplemental analyses revealed that a higher proportion of younger clients (those under 24 years old) were female, while a higher proportion of older clients (those over 50 years old) were male.

TABLE 2: AGE OF THE SUBJECTS OF REFERRALS

	% of Total Sample (n = 788)	Males (n = 397)	Females (n = 384)
5 to 15 Years Old	6.6%	5.8%	7.3%
16 to 17 Years Old	5.5%	3.8%	7.0%
18 to 24 Years Old	16.1%	13.4%	19.3%
25 to 29 Years Old	14.1%	12.1%	16.1%
30 to 39 Years Old	23.9%	24.9%	23.2%
40 to 49 Years Old	14.1%	13.6%	15.0%
50 to 59 Years Old	10.4%	13.1%	7.9%
60 Years Old and Older	8.2%	12.8%	3.7%

In terms of the status of a referral, there are three possibilities; 'closed', 'open', or 'rejected'. For the purposes of our analysis, 'rejected' was defined according to the conclusion reasons outlined in the May 2019 Risk-driven Tracking Database – Discussion Conclusion Reasons document provided to the authors of this report by OCR-GO. 'Open' was defined as those referrals that were accepted by the Situation Table at the Filter-Two stage and 'closed' referred to those referrals that were no longer considered 'Open'. Only a small proportion of referrals were rejected by their respective Situation Tables. Specifically, of the 1,003 referrals, 12% were rejected. As discussed throughout this report, the main reasons for rejected a referral were that the originating agency has not exhausted all of their options to address the client prior to bringing the case to the Situation Table, the subject of the referral was already connected to services or personal supports engaged in mitigating risk, a single agency or service provider could address the client's risk alone, or the situation was determined by the Situation Table to not meet the threshold of AER.

Of the accepted referrals (n = 884), only 13 or 1.5% of referrals in the database had the status of open. The remaining 98.5% of referrals (n = 871) were closed. As demonstrated in Table 3, nearly one-third of all accepted referrals (29.1 per cent) were closed within one week. And, while slightly more than one-quarter of referrals (22.5 per cent) were closed between 8 and 14 days, this category was also the median length of time for referrals to stay open. Given the general practice and desire of Chairs to close cases within two weeks, it was somewhat surprising that only 52% of referrals were closed within this time frame. Similarly, it was unexpected that 16.7% of referrals remained opened for longer than one month. Of note, there were 46 referrals in the database that were either missing the start date, close date, or both, which prevented being able to determine how long these cases were open.

TABLE 3: NUMBER OF DAYS REFERRAL REMAINED OPENED (N = 884)

	% of Sample
1 to 7 Days	**29.1%**
8 to 14 Days	**22.5%**
15 to 21 Days	**13.9%**
22 to 31 Days	**12.6%**
More than 31 Days	**16.7%**

The data pertaining to the number of times files were discussed that their Situation Tables tells a similar story to the information on the length of time that referrals remained open. Given that Situation Tables typically met once per week, based on the information in the database, on average, referrals were discussed three times before they were closed. Specifically, 7.5% of referrals were discussed only once, 33.7% were discussed twice, 21.7% were discussed three times, 11.7% were discussed four times, and 17.2% were discussed five or more times. Data was missing for 73 referrals.

In terms of why a referral was closed, as presented in Table 4, the most common reason was appropriately a reduction in AER (67.8 per cent). This was followed by an acknowledgement by the Situation Table that the client was still AER (15.3 per cent), and Other (13.5 per cent). Of note, the

reasons why a referral would be closed while the client was still AER included that the client refused services, the client was informed of services but had yet to be connected to services, or a systemic issue that interfered with the intervention team being able to continue with the client. 'Other' reasons for closing a referral were based on the intervention team members not being able to locate the client or the client having relocated out of the Situation Table's jurisdiction.

TABLE 4: REASONS FOR REFERRAL TO BE CLOSED BY THE SITUATION TABLE (N = 884)

	% of Sample
Overall Risk Lowered	67.8%
Still Acutely Elevated Risk	15.3%
Other	13.5%
Status Not Available	3.5%

The Risk Tracking Database provides information about the presence of one or more risk factors contributing to AER for the subject of the referral. The database tracks a total of 27 broad categories of risk factors[8]. On average, each referral had approximately nine risk factors identified, which demonstrates the complexity of even the "average" Situation Table referral. The range of the number of risk factors per client was from one risk factor to 17 risk factors. The most commonly cited risk factors are presented in Table 5. The risk factors that were found in a majority of referrals were housing (75.9 per cent), mental health issues (74.6 per cent), drugs addiction or drug issues (71.3 per cent), the lack of basic needs (57.9 per cent), and involvement with crime (50.4 per cent). Of note, at least one of housing, mental health, or drug issues was present in 97% of referrals. There were some differences by gender. Males were slightly more likely to have risk factors associated to housing, criminal involvement, and poverty compared to females, while females were more likely to have risk factors associated to drugs and negative peers compared to males (see Table 5).

TABLE 5: RISK FACTORS CONTRIBUTING TO ACUTE ELEVATED RISK IN REFERRALS (N = 948)

	% of Total Referrals	% of Males	% of Females
Housing	75.9%	81.6%	76.6%
Mental Health	74.6%	76.6%	76.6%
Drugs	71.3%	72.5%	82.3%
Basic Needs	57.9%	62.7%	62.2%
Criminal Involvement	50.4%	61.0%	51.6%
Physical Health	46.2%	45.8%	45.6%
Negative Peers	41.7%	42.8%	50.0%
Poverty	39.2%	42.8%	39.1%

[8] The categories of risk factors were: (1) Alcohol; (2) Antisocial/Negative Behaviour; (3) Basic Needs; (4) Cognitive Impairment; (5) Crime Victimization; (6) Criminal Involvement; (7) Drugs; (8) Elderly Abuse; (9) Emotional Violence; (10) Gambling; (11) Gangs; (12) Housing; (13) Mental Health; (14) Missing; (15) Missing School; (16) Negative Peers; (17) Parenting; (18) Physical Health; (19) Physical Violence; (20) Poverty; (21) Self Harm; (22) Sexual Violence; (23) Social Environment; (24) Suicide; (25) Supervision; (26) Threat to Public Health and Safety; and (27) Unemployment.

Each of the risk factor categories was comprised of several more specific risk factors. Using the Surrey Mobilization and Resiliency Table's (SMART) intake form as a model, for example, the Housing risk factor includes two specific items. Of all referrals with housing identified as a risk factor, the breakdown of specific items was: (1) person does not have access to appropriate housing (84.8 per cent) and (2) person transient but has access to appropriate housing (15.2 per cent). The mental health risks category is much more varied and features seven specific items. These items are: (1) suspected mental health problems (41.3 per cent); (2) diagnosed mental health problems (26.8 per cent); (3) grief (8.6 per cent); (4) witnessed traumatic event (8.3 per cent); (5) self-reported mental health problems (5.9 per cent); (6) not following prescribed treatment (5.2 per cent); and (7) mental health problem at home (4.0 per cent). It is also worth noting that one file can include several specific risk factors from the same risk factor category. For instance, as many as four mental health risk factors were identified in a single case. Of the files that cited mental health as a category of risk, 20% included more than one mental health risk factor.

The drugs risk factor category is made up of five specific risk factors. These risk factors are drug abuse by person, drug abuse in home, drug use by person, harm caused by drug abuse in home, and history of drug abuse in home. In the Risk Tracking Database, the drug risk factor category was largely dominated by the two specific risk factors of drug abuse by person (53.2 per cent) and drug use by person (32.6 per cent). The other three specific drug-related risk factors were: (1) drug abuse in the home (8.2 per cent); (2) history of drug abuse in the home (4.2 per cent); and (3) harm caused by drug abuse in the home (1.9 per cent).

Beyond the three most common risk factor categories presented in Table 5, the data suggests that there were a wide range of risks that must be addressed by Situation Tables. For example, 57.9% of all referrals identified basic needs as a risk factor contributing to AER. The specific basic needs risk factors were: (1) person unable to meet own basic needs (73.7 per cent); (2) person unwilling to have basic needs met (13.9 per cent); (3) person being neglected by others (7.3 per cent); and (4) person neglecting others basic needs (5.1 per cent).

The most common issues found in the criminal involvement category were assault (22.1 per cent), theft (21.0 per cent), and uttering threats (8.9 per cent). As will be discussed below, given that nearly one-fifth (19.3 per cent) of referrals identified a crime type as 'other', **the Risk Tracking Database should allow the Situation Table recorder the ability to easily add additional crime types to the database to reduce the non-specific 'other' category**. At the same time, if OCR-GO is going to continue producing yearly reports that aggregates the information from each Situation Table, **it is important that the database is more standardized to ensure that each Situation Table is inputting data in the same way**. It is very important to consider the findings presented in Table 5 because it clearly demonstrates which agencies or service providers are critical to the successful operation of a Situation Table based on the risk factors that clients present with and why agency cooperation and collaboration must be central to Situation Table operations to successful reduce AER in clients.

When considering the most common risk factor category by age, an interesting pattern emerged. For the entire sample, the most common risk factor for those under the age of 29 years old was drugs. This shifted to housing for those 30 years old and older with the except of those in their 50's.

However, when considering the most common risk factor for males and females by age, there were some substantial differences. For young males between the ages of 5 and 15 years old, drugs were the most common risk factor, while mental health was the most common risk factor for females. This switched when considering those between the ages of 16 and 17 years old. While drugs remained the most common risk factor for females between the ages of 25 to 29 years old, for males, the most common risk factors were mental health and housing. The only other difference was for clients in their 50's. Here, the most common risk factor for males was mental health, but the top risk factor for females in this age range was housing (see Table 6)

TABLE 6: RISK FACTORS BY AGE CATEGORY (N = 779)

	Top Risk Factor Total Sample	Top Risk Factor Males	Top Risk Factor Females
5 to 15 years	Drugs	Drugs	Mental Health
16 to 17 years	Drugs	Mental Health	Drugs
18 to 24 years	Drugs	Drugs	Drugs
25 to 29 years	Drugs	Mental Health, Housing	Drugs
30 to 39 years	Housing	Housing	Housing
40 to 49 years	Housing	Housing	Housing
50 to 59 years	Mental Health	Mental Health	Housing
60 and Older	Housing	Housing	Housing

As demonstrated in Table 7, Situation Table referrals originated from many different agencies, organizations, and service providers. The agencies, organizations, and service providers outlined in Table 6 cumulatively accounted for nearly three-quarters (74 per cent) of all file referrals. Most commonly, files originated from the RCMP or other policing agencies (29.3 per cent). The second largest source of referrals (12.3 per cent) was from Housing & Outreach from the Lookout Emergency Aid Society. This was not surprising, given the prevalence of Housing as a risk factor among Situation Table clients. In terms of the youngest clients, various school districts from around the province contributed to bringing referrals to Situation Tables (9.4 per cent). Probation, especially adult probation, was another top organization for bringing referrals to the Situation Table to secure assistance for their clients. First Nations bands or services/agencies that were oriented toward or run by First Nations also played a notable role in bringing referrals to the attention of Situation Tables. Finally, the two most directly relevant provincial Ministries – Children and Family Development and Social Development and Poverty Reduction – along with various other provincial and municipal agencies, accounted for slightly more than 10% of referrals (see Table 7).

TABLE 7: ORIGINATING AGENCY MAKING THE REFERRAL (N = 948)

	% of Referrals
RCMP/Police	29.3%
Housing & Outreach - Lookout Emergency Aid Society	12.3%
School Districts	9.4%
Probation/Community Corrections	8.4%
Ministry of Children and Family Development	4.3%
Ministry of Social Development and Poverty Reduction	3.5%
First Nations Band or Service	3.4%
Other City/Provincial Government	3.4%

It is not always the case that the agency or service provider that brought the referral to the Situation Table will also be the lead agency for the intervention team. Table 8 presents all the agencies that served as the lead agency for intervention in a least 4% of all accepted referrals. The greatest proportion of all files (16 per cent) had Housing & Outreach from the Lookout Emergency Aid Society serve as the lead agency. Although almost 30% of referrals originated with the RCMP, the police only assumed the role of lead response agency in fewer than half of these referrals. This suggests that there were a wider range of risk factors that might bring someone into contact with the police, and that the police might not be the most appropriate lead agency for interventions. Moreover, the fact that police were not always the lead agency resulting from a police referral to the Situation Table, contact with the police is likely only one of several negative outcomes experienced by Situation Table clients. On the other hand, several of the other agencies that featured prominently as lead agencies were also on the list of common originating agencies, but this was not always the case. For example, although it did not play a large role in bringing referrals to Situation Tables, Fraser Health and other regional Health Authorities played the key role of lead agency in a substantial number of files. Mental health agencies, most notably the Canadian Mental Health Association, similarly assumed lead responsibility for over 4% of files.

TABLE 8: LEAD AGENCY FOR INTERVENTIONS (N = 867)

	% of Referrals
Housing & Outreach - Lookout Emergency Aid Society	16.0%
RCMP/Police	12.0%
Fraser Health	9.0%
First Nations Band or Service	6.6%
School District	6.1%
Probation/Community Corrections	5.8%
Mental Health Agency or Association	4.6%
Ministry of Children and Family Development	4.6%
Options Community Services	4.4%

Reviewing the data from the Risk Tracking Database on which agencies most frequently volunteered to assist in delivering interventions provided additional insight into not just

participation of agencies and service providers in the last stage of Four Filter process, but also spoke to the cluster of risk factors that Situation Table members tried to respond to. As demonstrated in Table 9, many of the same agencies that played a central role in referring clients or taking the lead on files were also heavily involved as assisting agencies.

TABLE 9: ASSISTING AGENCIES FOR INTERVENTIONS (N = 867)

	% of Referrals
RCMP/Police	49.5%
Fraser Health	34.4%
Other City/Provincial Government	29.5%
Ministry of Social Development and Poverty Reduction	28.4%
Housing & Outreach - Lookout Emergency Aid Society	21.1%
Probation/Community Corrections	20.3%
Ministry of Children and Family Development	19.8%
Mental Health Agency or Association	19.8%
First Nations Band or Service	19.5%
Interior Health	17.3%

Interview Data with Situation Table Chairs

THE GOALS OF SITUATION TABLES

Participants were asked to outline the main goals of their Situation Table. Given the general mandate and purpose of all Situation Tables, there were several key themes that emerged from the Chairs' responses. Chairs felt that the critical goals for Situation Tables were to mitigate risk for vulnerable people and families, in part, by identifying individuals who met the threshold for AER and to address the risk factors contributing to AER by developing intervention plans that involved multiple agencies and services. In effect, a common goal was to reduce the level of risk among Situation Table clients to the degree that the level of risk was no longer acute. This was achieved by connecting individuals experiencing AER to various services and programs very quickly based on the particular risk factors of the individual. This was achieved by another key goal of Situation Tables; namely facilitating the collaboration between agencies and service providers in the best position to address the client's various needs. To that end, Chairs indicated that a key objective of Situation Tables was to have agencies come together to develop comprehensive strategies to deliver services, programs, and resources as immediately as possible to clients accepted by the Situation Table.

Other identified goal was to break down barriers between agencies and enhance the degree to which agencies and service providers shared information and communicated with each other to better promote meaningful partnerships that resulted in the delivery of appropriate, timely, and wraparound services to clients. In addition to taking a non-punitive approach to addressing risk factors, Chairs also identified building resiliency in the community as a goal of Situation Tables. One Chair defined resiliency as building capacity within individuals to know when, where, and how to get support for themselves. It was felt that Situation Tables could contribute to people becoming

more aware of the types and availability of services in the community, more aware of their own individual risk factors, and how best to address and reduce their risk factors through the partnerships and commitments of those agencies participating in and with Situation Tables. In other words, individuals struggling in the community may not always be aware of all the resources, programs, and services available to them or that they can interact with more than one agency or service provider to address their needs. Given this, one of the goals of Situation Tables was to make the community more aware of the partnerships and collaborations that Situation Table members were involved with and that there was a referral process in their community that individuals in need can access to receive a wider range of integrated assistance. Of note, in addition to supporting at-risk populations, two Chairs also believed that their Situation Tables enhanced the community's ability to support young people more effectively compared to how young people were responded to prior to the development of Situation Tables.

There were several main reasons identified by Chairs for why their community decided to create a Situation Table. Each Chair was asked whether there was a precipitating event or main reason for the creation of their Situation Table. While there was not one issue that was common among all Situation Tables, the main reasons for establishing a Situation Table were to develop a more efficient way to address those who were chronically homeless or an increase in street-based populations causing issues in the community, a more effective way to respond to the increasing crime rates, particularly associated with gang activity, the need to address more holistically the growing number of individuals who suffered from mental health-related issues, and to address social chronic offenders or those who frequently came to the attention of the police for behaviours that were typically non-chargeable offences. More general drivers for the creation of Situation Tables included a need to provide alternatives to individuals who required a much more immediate connection to social service agencies without police intervention and the need for organizations to collaborate more consistently, easily, and with better functioning information sharing protocols that benefited clients rather than having agencies with the same clients working in siloes in which one agency was not aware of the work that another agency was doing with the same client.

THE TRAINING OF SITUATION TABLE CHAIRS AND MEMBERS

As with most programs, a key element for the proper functioning and success of the undertaking is effective training. All but one Chair stated that they received training prior to becoming the Chair of their Situation Table. Of note, that one individual did eventually receive some training, but just not specifically related to the work of the Chair. Moreover, that individual had been a member of the Situation Table and reported being very familiar with the operation and policies of the Situation Table when they became Chair. For the most part, all participants indicated that the Chair and members of the Situation Table participated in a two- to four-day training workshop hosted by Global Community Safety as the main element of their training. Some Chairs indicated that they also participated in some of the online training provided through Sir Wilfred Laurier University and one Chair reported having training conducted by another external consultant.

All Chairs who had the Global Community Safety training reported that this training was done in-person and was classroom-style training. Most Chairs indicated that the training was divided into

two parts: the theoretical and the applied. In terms of the theoretical aspects of the training, Chairs indicated that the workshop consisted of discussing the origins of the Situation Table model, the typical process of a Situation Table, who the various players or participants could be, the important roles that these various players could play, the different kinds of interventions that could be leveraged by a Situation Table, what each of the four filters consisted of, the risk factors that needed to be considered, the importance of confidentiality and privacy, and how a Situation Table could be sustained over time.

The applied aspects of the training involved mock run throughs of simulated and real scenarios to allow Chairs and members opportunities to work through how to present a referral, how to identify and assess AER, how to apply the risk factors associated with AER, and how to progress through each of the four filters. The simulated and real scenarios allowed for Situation Table Chairs and members to discuss and operationalize privacy rules and expectations, learn to communicate with each other, identify what each partner would contribute to different scenarios, and develop and apply the Situation Table's confidentiality oath. Of note, several Chairs reported that considerable time was spent on the Four Filter process and the information sharing protocols that the Situation Table would use. For example, some Chairs indicated that a lot of time was spent on what a referral should look like, how the referral should be brought to the Situation Table, how to maintain privacy when presenting a referral to the entire group, how to disclose or communicate concerns about individuals and families prior to entering the third or fourth filter, and how the Situation Table should track information while maintaining privacy.

For the most part, Chairs reported that the training they received was beneficial as it resulted in the Chair and Situation Table members being very clear and comfortable about how the four filters and the information sharing protocol worked. The training also provided examples and insights into the confidentiality component of the work done through the Situation Table. Several Chairs expressed the value of having training that established the pathways for agencies and organizations to collaborate. Moreover, meeting people face-to-face during the training sessions was seen as very important to the positive functioning of their Situation Table. In effect, the training served to connect agencies and their Situation Table representatives who would be working together each week during the Situation Table meetings. Learning the roles that people had in their home agencies and being able to identify any existing gaps in services as a result of working through real and simulated cases was another benefit of the training workshops. Chairs also generally felt that the training provided a framework and a template for the types of risks that would likely be identified through the Four Filter process. This was achieved, in part, by running through real scenarios. Finally, some Chairs indicated that they were shown videos of cases being presented from other already established Situation Tables or had Chairs from other Situation Tables come to their training sessions to discuss how their Situation Tables worked and how to address some of the more common concerns, such as those involving privacy, confidentiality, and information sharing.

There were several themes that Chairs highlighted that could be improved or included in the training of Chairs and Situation Table members. The first main theme had to do with the initial 'door knock' that an agency made with a client. For the most part, Chairs felt that each 'door knock' was very different, especially when dealing with a client suffering from a mental health issue or

when the client was a youth or young adult. Chairs felt that more information on how to properly and successfully conduct the 'door knock', especially when the police were not involved, would have been beneficial. Another consistent theme was that the training was not geared specifically to the Situation Table taking the training. In other words, several Chairs indicated that the training was primarily based on a mid-sized Situation Table with the same people and agencies consistently participating in Situation Table meetings. These Chairs would have preferred training that specifically reflected an understanding of the community or the agencies that were the members of the Situation Table. For example, one Chair indicated that they had a lot of clients who were homeless, which posed several challenges to the 'door knock' approach taught in the training.

Many Situation Table Chairs reported having some degree of turnover in who attended each meeting, which resulted in challenges in ensuring that those who were attending meetings were properly trained and fully understood the Situation Table model, how the Situation Table worked, and the information sharing protocols used by the Situation Table. So, while it might be seen as a positive that there were a lot of agencies and many people who participated in the Situation Table, having many people that attended occasionally or having different representatives from an agency attend each week created challenges in maintaining the trust, consistency, commitment, and participation required for this model to be successful. As a result, many Chairs felt that the training needed to address this issue and provide strategies to ensure the long-term sustainability of the Situation Table.

As will be discussed in greater detail below, some Chairs also felt that the training lacked information on how to set up a governance structure, the value of a leadership or steering committee, and how provincial oversight might be a benefit or a hinderance to achieving some of the Situation Table goals, such as greater information sharing, attendance and participation with the Situation Table, or navigating some of the privacy issues that were likely to arise once the Situation Table was dealing with referrals. There was also a lack of clarity on the degree to which Situation Tables could or should modify their standard operating procedures to better suit their individual needs, such as meeting on an ad hoc basis for referrals that might need immediate attention, but the Situation Table's next scheduled meeting was several days away.

It was interesting to note that when asked, only about half of the Chairs stated that they felt that all members of their Situation Table had been adequately trained on assessing AER. Of note, this was not necessarily a reflection of the specific training provided by Global Community Safety, but also the result of new people joining the Situation Table after Global Community Safety's training workshops. One concern raised was that there was not a main place that Situation Table Chairs or their members could go for on-going, refresher, or initial training. While some Chairs mentioned that they were aware that Global Community Safety had e-resources that Situation Tables could assess, it was felt that the resources were not clearly laid out. In other words, it was not always easy for Chairs or Situation Table members to access the specific elements that they wanted additional training on. Some Chairs indicated that they had sent or suggested that their members access the training provided by Sir Wilfred Laurier University, but several Chairs indicated that they either provided the necessary training themselves to new members or new members learned how the Situation Table process worked, how to assess AER, and what the elements and distinctions of the Four Filters were by attending and participating in the Situation Table. Several Chairs felt that **it**

would be beneficial if there was quarterly or semi-annual training; however, they recognized that the time commitment and cost of doing so was challenging. They also felt that **a central website or location that Situation Tables could access to provide training to new members, particularly about AER and the identification of risk factors, would be extremely beneficial**.

Again, there was quite a mix of responses when Chairs were asked whether their members took the training provided by Sir Wilfred Laurier University. Some Chairs indicated that all their members had done so, while others reported that none of their members had done so. Some Situation Tables required their members to provide a certificate of completion from Sir Wilfred Laurier University prior to serving as a member of the Situation Table, while other Chairs did not have this requirement. For those Chairs who did use the training provided by Sir Wilfred Laurier University, while it was felt that the training did provide a good idea of what a Situation Tables was and how they operated generally, Chairs felt that the training on AER was lacking and the training was very broad and, therefore, did not necessary apply to the Situation Table's specific circumstances and needs.

THE ACTIVITIES AND STRATEGIES USED BY SITUATION TABLES TO ACHIEVE GOALS

While the Four Filter process will be discussed in greater detail below, Chairs spoke about the need for and value of collaboration, information sharing, and networking in achieving Situation Table goals. Chairs emphasized the importance and value of people getting to know each other and each other's agencies to best address the needs of clients. One Chair indicated that they encouraged different agencies to provide updates on what they had been doing or any new programming or events in which they were involved. The purpose of this was to keep everyone involved in the Situation Table aware of what each agency was doing as a way of fostering collaboration and networking within and beyond the work of the Situation Table. To this end, Chairs indicated that one of the strengths of the Situation Table was that people from different agencies worked together to determine if a client met the threshold of AER and, if so, worked collaboratively to develop strategies to reduce the client's AER. Moreover, it was acknowledged that, to some degree, the Situation Table was only as effective as the number of referrals it received. Given this, Chairs reported that Situation Table members worked together to ensure that their partner agencies and frontline workers were aware of the existence of the Situation Table and partner agencies and frontline workers could either make referrals directly to the Situation Table or work with a Situation Table member to refer clients as needed. Chairs also acknowledged that there was additional collaboration that occurred because of the existence of the Situation Table. Chairs commented that, at times, particularly when the Situation Table meetings occurred in person before the COVID-19 pandemic, Situation Table members would hold sidebar conversations on issues related and not related directly to the Situation Table and its clients. Chairs believed that the increased communication between people that occurred at Situation Table meetings resulted in collaborations that resolved other issues or concerns that did not directly involve the Situation Table's mandate. It was felt that without the existence of the Situation Table, these contacts, conversations, and climate of collaboration would likely not occur, particularly for those working in in larger jurisdictions. In other words, this additional benefit of Situation Tables was seen as less critical in smaller jurisdictions where people were much more likely to already know each other

and be familiar with the mandates, resources, programs, and services of local agencies and service providers.

Based on the comments made by several Chairs, another benefit of Situation Tables was that it formalized the collaborative process. The information sharing protocols that had been put in place as part of the creation of each Situation Table was reported as playing a large role in collaboration and enhancing the range of services and programs provided to clients because the protocols had encouraged and fostered participation amongst agencies that might have had some trust issues or a historical record of not sharing information with other agencies or frontline workers. Chairs also believed that the collaboration fostered by the Situation Tables had increased the timeliness of intervening with clients. In addition to suggesting that the collaboration that had taken place among Situation Table members had also increased beyond the Situation Table itself, some Chairs indicated that the collaboration had served to build and maintain new relationships between members and agencies. It was felt that the result of the increased collaboration among agencies and service providers fostered by the Situation Table was that clients received better and more thorough services than prior to the Situation Table. Another benefit of the collaborative process was that Situation Table members recognized and understood that there were more resources in the community and more funding opportunities than those they had been previously aware of. The collaboration that occurred because of the Situation Table provided members with a much better understanding of where resources could be found in the community, across jurisdictions, and through the provincial and federal governments, and created opportunities to engage more directly with other agencies and service providers. In effect, the Situation Table provided the basis for people to understand where their agency fit in the overall service delivery model to clients and where other agencies, organizations, and service providers fit.

Related to the issue of collaboration was interagency cooperation or the ability to successfully integrate multiple agencies or services to address the diverse needs of clients. Again, some Chairs felt that their Situation Table had resulted in an increase in interagency cooperation, while others felt that this was happening prior to the creation of their Situation Table. While there was a sense that there were still ways to improve interagency cooperation, a general theme was that one outcome of the Situation Table was that agencies were much more proactive in reaching out to others and sharing their concerns about clients, even for those clients who did not meet the requirements of a Situation Table 'door knock'. Another interesting comment was that the Situation Table contributed to giving the community a clearer sense of direction and cohesiveness that contributed to both greater collaboration and interagency cooperation.

A third critical activity within the Situation Table was information and expertise sharing among partner agencies, including increasing communication. While some Chairs suggested that increased information sharing was a bit of a challenge with some agencies, such as the RCMP, all Chairs indicated that the Situation Table model improved information sharing and communication between agencies and service providers. Again, for some communities, this was not a significant challenge prior to the creation of their Situation Table, but, even in these cases, Chairs agreed that the Situation Table enhanced the level of communication and the commitment that agencies and service providers had to information sharing, providing their unique expert insight to discussions of clients, and communicating with a greater degree of openness as partners understood better the

various roles, services, resources, and challenges of participating members. The Chairs also recognized that every agency had to follow their own internal policies but noted that the Situation Table made it much easier for people to discuss a client and how they might contribute to an intervention strategy. In effect, they felt that Situation Tables contributed to breaking down information silos and making people more comfortable reaching out to others from different agencies to assist with clients, regardless of whether those clients were appropriate for or accepted by the Situation Table. It should be stressed that because there might be turnover in the specific agencies who were standing members of the Situation Table or the individuals who represented their agency at Situation Table meetings, communication was critical. To that end, **following up each meeting with an email so that everyone was reminded of who was the lead and supporting agencies involved in an intervention, and using a read-only database for Situation Table members so that everyone was aware of the types of clients, partners, and interventions that took place may be useful ways to maintain communication and engagement**.

Most Chairs also felt that Situation Tables contributed to a greater sense of shared responsibility among partner agencies and service providers for clients. While more than one Chair indicated that the responsibility for bringing referrals or participating in interventions was not always equally distributed among Situation Table members, which, given the issues that a community dealt with would be expected, nearly all Chairs indicated that they felt an increased sense of shared responsibility for addressing AER among members. Some Chairs spoke of an increased sense of trust and respect, and a greater willingness of people to share their opinions and views as the Situation Table gained momentum, frequency, and consistency.

Another theme was consistency, as holding regular Situation Table meetings, keeping the tracking database up to date, and having the same people from the same agencies attend each Situation Table meeting were viewed as critical in keeping members engaged, having a good understanding of the types of risks occurring in the community, and maintaining the value and effectiveness of the Situation Table. Related to this theme was having a good sense of which agencies were involved in which types of interventions so that there was consistency in agency participation, both in terms of attending Situation Table meetings and in participating in all four filters, as appropriate. Given this, **conducting annual internal evaluations that provide general information to Situation Table members about how many files were accepted for intervention, which agencies were making referrals, which agencies were delivering interventions, and which risk factors were most commonly found among clients would be helpful to gauge the performance of the Situation Table and to determine if there are any gaps in service delivery**.

Situation Tables were viewed as working well because they connected people who had a passion and a professional responsibility to assist people with AER. Situation Tables were viewed as effective at breaking down information and service delivery silos and made service providers more aware of what was going on in the community. Chairs felt that Situation Tables made members and their agencies more accountable to identify those with AER and to ensure that appropriate, targeted, timely, and holistic interventions were delivered to those in need by accessing the Situation Table. The collaboration, interagency cooperation, expertise sharing, and a sense of shared responsibility created by Situation Tables were viewed as a more effective method of

identifying AER and addressing client needs than working in agency silos with little communication or a shared strategy across various social service and public safety agencies.

Chairs also spoke about some of the challenges or what was not working well with their Situation Table. A primary issue was related to the turnover in members. This was reflected in two main ways. The first way was in newer member's understanding of the privacy, information sharing protocols, and confidentiality rules of the Situation Table and how these processes worked with a member's home agency's protocols and procedures. Of note, this most commonly manifested in members over-sharing during discussions, rather than not sharing information at all. The second issue was related to newer members not having a good understanding of the role of Situation Tables and not being able to communicate this role internally in their agency to ensure that clients were being appropriately identified and referred to the Situation Table.

Another theme was related to a general sense of disconnect. This manifested in how some members perceived what the outcomes of the Situation Table were supposed to be. In other words, as will be discussed below, Situation Tables are not involved in case management and do not follow up on the longer-term outcomes of clients. Once a client has been connected to the programs or services detailed in the Four Filter process, the Situation Table closes the file. However, it seemed that some members wanted the Situation Table to be more involved in case management or to have a process that followed up with clients after the case had been closed by the Situation Table. The other aspect of disconnect was related to how members interacted with each other during Situation Table meetings. On this issue, some Chairs believed that there was still some work that needed to be done around relationship building and the establishment of trust between Situation Table members and their respective agencies. Related to this concern was that, for some Chairs, there was a disconnect between the members and their agency when it came to empowering Situation Table members to speak on behalf of their agency or to commit their agency to a particular course of action as it related to participating in an intervention. This issue will be discussed in greater detail below. At this point, it is noteworthy that some Chairs were concerned that it did not always appear that those attending the Situation Table meeting were empowered or had the permission to commit their agency to participate in an intervention plan or to work in a collaborative manner. Other shortcomings or ways in which the Situation Table could improve were that not all Situation Table members had access to real-time data during a meeting so they could not contribute to discussions during the third stage of the process; that there was, at times, inconsistent attendance by some agencies; and that some agencies had internal policies, processes, or procedures related to how that agency accepted new clients that did not allow for a member to open a new file on a client accepted at a Situation Table meeting. Finally, as discussed above, although there were the Sir Wilfred Laurier online training tools, a growing concern among some Situation Table Chairs was the lack of training of some members, which was the result of the turnover in who represented an agency at the Situation Table meetings.

THE STRUCTURE OF SITUATION TABLES

As a result of the COVID-19 pandemic, Situation Tables switched from meeting in person to meeting virtually in an online platform, such as Zoom. Still, all Chairs, with one exception, stated that their

Situation Table met once per week. The other Situation Table reported meeting once every two weeks. Given that there was a lot of variation in the sizes of the communities and jurisdictions that Situation Tables operated in, it was not surprising that the number of standing members for each Situation Table varied. Of note, it is our assessment that **the overall number of participating agencies is likely less important than which specific agencies were standing members, how consistently agencies and their representative attended Situation Table meetings, and each member's willingness to make referrals, participate fully in discussions, share their information and expertise, and participate in interventions when appropriate**. As mentioned above, another important element was whom the agency was sending to the Situation Table and that person's commitment and engagement with the Situation Table, as well as their ability to take action or be a decision maker on behalf of their agency.

The main ways that members contributed to Situation Tables were by bringing referrals to the Situation Table for discussion; presenting referrals at Situation Table meetings, which included clarifying or highlighting all AER factors; providing and sharing information, expertise, or input as needed and appropriate on the referrals made by others; and, if appropriate, participating in the Four Filter process to contribute to the intervention strategy. To assist in the general knowledge of all members, discussants also provided updates on programs, policies, partnerships, and strategies that were in place or being developed by their agencies. This served to enhance the awareness of everyone at the Situation Table about the work of each agency and what was occurring in the community. The only issue that some Chairs mentioned about the contributions that members made during Situation Table meetings was in relation to privacy and confidentiality. At times, Chairs felt that there was some over-sharing of information to the whole group when that level of information should have been reserved for only those involved in the fourth stage of the process. Conversely, sometimes Chairs had to remind members that they were able to share information and had to ask specifically if agencies had any information that they would be willing to share, either to the entire group or when the Filter Three process began.

It was interesting to note that Chairs focused on two main issues related to the accountability of Situation Table members. The first issue had to do with those members who agreed to participate in an intervention. Most Chairs reported that there were not many instances of needing to hold Situation Table members accountable for their commitments to conducting a 'door knock' or providing interventions that they agreed to during the meeting. Still, the main way that Chairs held members accountable to their commitments was by asking for an update on all active files and determining why a 'door knock' had yet to occur or why the intervention plan had not been put in place. Some Chairs reported that newer members struggled with setting up the Filter Four conversation, so **Chairs might want to work with newer members to help guide them through the process**. A related challenge involved agencies that could aid at the Filter Four stage but were not volunteering to participate at that stage. Again, **Chairs might need to reach out to those agencies to gain a better understanding of what it is that they could provide and their confidence level in providing that assistance**.

The second issue was consistent attendance at Situation Table meetings. Chairs felt that it was very important for the same representative from standing member agencies to attend each Situation Table meeting. To that end, if some agencies were not regularly attending, Chairs mentioned that

they would reach out to their steering committee or directly to the agency to understand why representatives were not attending, how that could be remedied, and to reinforce the value and importance of regular attendance. Of note, not all Chairs were in favour of making mandatory attendance a condition of being a member of a Situation Table. While all Chairs felt that routine or regular attendance was critical for relationship building, trust, and collaboration, there was a concern that mandatory attendance might result in some agencies deciding to not join or participate with the Situation Table. In effect, **regular attendance should be the expectation** and Chairs should work with their members and their agencies to ensure that consistent attendance was both possible and achieved.

One way to hold Situation Table members accountable for their participation at all stages of the process might be for **each Situation Table to conduct an annual evaluation** and to report the findings of this evaluation to the Situation Table members and, if the Situation Table had a steering committee, to that group as well. The report could detail which agencies or organizations were making referrals, which agencies were attending Situation Table meetings regularly, and which agencies were participating in Filter Four interventions.

One possible concern with Situation Tables could be that members agreed to participate in interventions or made commitments that were not fulfilled. It should be noted that Chairs overwhelmingly reported that they were not faced routinely with situations where a partner agreed to do something at a Situation Table meeting but then their agency backed away from that commitment. In those rare occasions when this had happened, typically the backtracking was the result of the agency simply not having the personnel or resources to participate in the intervention or with the agency not fully understanding the role of the Situation Table. In these cases, having the Chair contact the appropriate person from the partnering agency resolved the issue amicably. Importantly, it should also be noted that Chairs reported that they did not have a say in who the representative from an agency to the Situation Table would be, but some Chairs indicated that they used a variety of strategies to increase the likelihood that the person would be a good fit with the Situation Table. For example, one Chair asked anyone who wanted to join the Situation Table to submit a request that included some information about what the applicant understood about the Situation Table and an assurance of their willingness to commit to the expectations of the Situation Table. The purpose of this process was to ensure that those interested in joining a Situation Table were aware of the level of commitment required. Other Chairs encouraged partnering agencies frontline workers as representatives, as some Chairs believed that frontline workers would be the ones more likely involved in providing the interventions, so it was good that it was these people making the commitment on behalf of their agency to participate in an intervention. In effect, Chairs did not want those who might not be directly involved in the work of the Situation Table to be the representatives of their agency. Moreover, it is important to recognize that, in some communities, potential clients faced many barriers to accessing needed services. Given this, Chairs also highlighted the benefits of having members at the Situation Table who understood and were sensitive to the barriers that many people faced in trying to access services, resources, or programs.

As expected, the type of agencies that made referrals to the Situation Table was not equally distributed across Situation Table members. In some communities, most referrals were made by one or two organizations, such as the RCMP. Again, this was typically based on the types of risk

factors characterizing a community or jurisdiction, rather than the willingness of members to make referrals to the Situation Table. Moreover, none of the Chairs reported a challenge in some organizations referring clients but refusing to participate in interventions for clients referred by other agencies. In addition, Chairs did not report that some organizations were always refusing to participate in the Filter Four stage. Again, there are a number of legitimate reasons why a Situation Table member would not volunteer to participate at the Filter Four stage, such as a lack of resources, personnel, or expertise; however, none of the Chairs indicated that they struggled with having the appropriate members or their agencies participate in interventions. Instead, for some Situation Tables, the challenge was ensuring that the needed agencies were members of the Situation Table or connected to Situation Table members.

Without drawing attention to any specific agencies, organizations, or service providers, Chairs spoke of the importance of having representatives at Situation Table meetings that could address the needs of Indigenous peoples as being very important, as well as those who could assist with mental health issues, housing issues, and younger clients. Depending on the Situation Table, some Chairs believed that greater attendance or participation from those engaged in victim services and probation services would also be beneficial. Of note, the need for these types of agencies to participate with Situation Tables was not meant to suggest that these agencies had refused to engage with their local Situation Tables. Some Chairs indicated that they had so few referrals that it was not practical for some of these agencies to attend regularly. Moreover, Chairs reported being able to reach out to representatives from these types of agencies when needed. Other Chairs stated that they originally had representation from these types of agencies, but the nature of the referrals or the lack of a lot of referrals resulted in some of these agencies choosing to no longer attend the weekly Situation Table meetings. It should also be noted that privacy concerns and the confidentiality policies that some agencies worked under created obstacles for some agencies to be standing members of a Situation Table. For others, there was a need for the Chair or the Situation Table to build or re-build trust to get a particular group, agency, or organization to participate with the Situation Table. Again, it is important to keep in mind that the composition of any Situation Table should be based on the specific needs of each community. As such, **there is not a one-size-fits-all composition or template for how many, and which agencies or organizations should be standing members of the Situation Table**.

It was interesting to note that not all Situation Tables had a leadership committee or steering committee to ensure that the Situation Table was operating effectively and appropriately, or to address concerns or challenges that could arise for Chairs or members. For those Situation Tables that did have a leadership committee or steering committee, it appeared that the leadership or steering committee met a few times per year, had someone on the committee from each of the organizations that had a member serving on the Situation Table, had a direct line of communication with the Situation Table Chair, served to promote the work of the Situation Table to others in their professional circles, aided the Chair in making the necessary connections to partner agencies, and helped to address any concerns or decisions made by the Situation Table. On this last issue, Chairs did not report needing the assistance of their leadership or steering committees, for the most part. Chairs indicated that, rather than bringing an issue to their leadership or steering committee to resolve, they addressed issues, such as attendance or following through with intervention

commitments, directly with their members. The one main issue that appeared to benefit from having a steering committee was when a Chair received a commitment from a senior leader of an agency, but the Situation Table member pushed back claiming that their agency could not do what the leader committed to. Chairs felt that, in these types of cases, it was beneficial that there was a body above the Situation Table that could resolve this 'internal' agency issue.

As information sharing, collaboration, and having the appropriate agencies and organizations as members of the Situation Table were viewed as critical to the successful operation of a Situation Table, Chairs were asked whether they thought it was a good idea for the provincial government to mandate that certain agencies or service providers must be part of the Situation Table. Chairs were somewhat split on this idea. Those in support of this idea believed that if the province required or mandated participation from agencies and service providers, it would remove some of the barriers or reasons provided by some agencies and people for why they could not be a part of the Situation Table, such as privacy concerns related to information sharing. They also felt that mandating agencies to participate with the Situation Table would increase attendance, increase buy-in to the model, and increase agencies participating at the fourth stage of the process. Chairs also felt that for agencies or organizations that had personnel or resource limitations, rather than allocating those limited resources to responding to clients in a siloed or agency-exclusive approach, a requirement to participate with a Situation Table would result in those resources being directed more towards the collaborative or collective work of the Situation Table.

Opposition to the government mandating participation in a Situation Table was based, in part, on a belief that there was little benefit in forcing people to do something that they did not want to do. Several Chairs believed that being forced to do something changed how one performed that task. Chairs believed that Situation Tables worked best when people believed in the philosophy, model, and approach of Situation Tables. Chairs wanted partners who were passionate about their work and the benefits that could be realized through Situation Tables, rather than having a participant who was ordered by their agency or organization to attend the Situation Table because the government mandated participation. Related to that point was a concern that members would interact, collaborate, and share information minimally if they were forced to participate instead of attending meetings because they believed in the values, goals, and work of the Situation Table. Given the views expressed by Chairs, perhaps **the provincial government should participate in establishing a baseline for what a Situation Table's organizational structure should look like, identify the agencies funded through the government so that Chairs have a better idea of who to approach for membership, and outline general expectations that those who are funded by the government should support the work of Situation Tables**.

THE OPERATION OF SITUATION TABLES

The lifeblood of Situation Tables are the referrals that members bring to Situation Table meetings. In general, there were two main ways that discussions were referred to Situation Tables. The first way, which was less common, was for members to reach out to the Situation Table Chair prior to bringing the referral forward to a Situation Table meeting to discuss the referral with the Chair. The purpose of this approach was to ensure that all the necessary information was collected by the

presenter prior to the discussion of the client at the Situation Table and to ensure that the member was comfortable bringing in the referral forward. In these cases, the Chair might go through the paper referral form with the member and assist them in filling it out. This might be done to help the member get more comfortable with ensuring that all appropriate non-identifiers, privacy concerns, and confidentially requirements were used when initially presenting the referral to the group. Some Chairs recognized that there were members who were nervous about making a mistake or disclosing something they should not at the initial stage of the discussion, so conferring and working with the Chair prior to presenting the referral was designed to ensure that all these issues were considered and addressed appropriately. A secondary purpose of this approach was to assess whether the referral would receive buy-in and collaboration from the other members of the Situation Table. If the Chair determined that it was unlikely that the referral would receive the consensus of those at the Situation Table meeting that the client met the criteria for AER, or if the Chair was convinced that there would not be the necessary collaboration offered by members, being aware of the nature of the referral prior to its presentation at a meeting allowed the Chair to assist in resolving the issue outside the structure of the Situation Table or to work with the presenter to ensure that they had all of the necessary information to make a strong referral.

Much more common was for Chairs to open the floor to any new referrals or to do a 'roll-call' of all members present at the Situation Table to ask if anyone had a new referral to make to the group. This process might occur before or after reviewing the status of all active or open referrals from previous Situation Table meetings. Regardless of which approach was used, all Situation Tables Chairs reported that they had a referral or intake form that all agencies filled out and distributed when making referrals. This form had a checklist of the risk factors associated to the client who was the subject of the referral. All the identified risk factors would be presented by the person making the referral and discussed by all members, providing opportunities for members to ask questions. Each risk factor identified by the presenter would be discussed and members would be asked whether they agreed that the risk factors presented were acute, whether the situation met the threshold, and whether a file should be opened by the Situation Table.

During these first two stages of the process, as much as possible, identifying information about the client would not be shared with the group. Once the Situation Table agreed to take the client on as a case, the Chair usually asked the referring agency to provide limited identifiers about the client, such as their name, age, and gender, so that Situation Table members could determine if the client was already on their caseload or in their agency's database, and what additional information each member might have about the client that could be shared with the group. After this information was shared and discussed, a sub-group of members would be put together from those agencies that volunteered to be part of the intervention team. Everyone else would be asked to leave the meeting about that client. The sub-group would meet to discuss what each agency would do to assist the client and it was typically the responsibility of the referring agency or lead agency to follow up with the other agencies to ensure that the intervention plan was carried out in a timely fashion, including the initial 'door knock' or contact with the client. In some Situation Tables, it was also the responsibility of the lead agency to get other agencies that were not standing members of the Situation Table to assist in the intervention plan, where appropriate. Some Chairs reported that their practice involved asking the referring agency to identify other agencies that they believed

would be a good fit for addressing the case and assisting the client. In some cases, Chairs stated that they would ask certain agencies to join the intervention team because the Chair felt that a particular agency had something they could contribute.

Of note, many agencies had 'buddy agencies' that they were assigned. These buddy agencies were not standing members of the Situation Table, but the standing member agency was expected to check in with their buddy agencies prior to the Situation Table meeting to see if they had any updates, issues, or concerns related to an existing intervention that they were involved in or if they had a client that they would like referred to the Situation Table. For the most part, the standing Situation Table member would present any new referrals; however, there were instances where the Chair invited the buddy agency to the meeting because the representative had the required knowledge or insight to present the case more effectively to the Situation Table.

When asked what the most common reasons or risk factors were for making a referral to Situation Tables, the three most common issues, in no particular order, were mental health, homelessness, and addictions. Many Chairs recognised that these issues also commonly contributed to criminal activity. Given this, Chairs argued that it was critically important for all agencies that were responsible for addressing mental health, homelessness, addictions, poverty, and crime to be standing members of the Situation Table, although this was not always the case. For those Situation Tables that had referrals for youth or young adults, in addition to the aforementioned risk factors, some other common reasons why a client was referred to the Situation Table included truancy, the breakup of the family unit, negative peer influences, and victimization.

As identified in the quantitative data section above, there was great variation in the number of cases that were accepted by the different Situation Tables. However, one thing that was consistent was that the overwhelming majority of referrals were accepted by the Situation Tables. There were some common themes related to why a small minority of referrals were not accepted by the Situation Table. The most common themes were that the client was already connected to several of the agencies at the Situation Table, these agencies were already working with the individual, and there already was a case management plan in place. In effect, many Chairs mentioned that there were clients who were already very well connected to agencies and services in the community and were already receiving all necessary services. Other reasons for rejecting a referral were that the lead agency had not yet exhausted all the resources they could provide to the client, so there was no need at the point that the referral was presented to the Situation Table to include additional agencies, or that the client did not meet the threshold of AER. Another reason was that the client had relocated to another jurisdiction. It was interesting to note that one Chair indicated that they had rejected referrals from newer participants of the Situation Table because of a lack of understanding or familiarity with what each agency could provide. In other words, the client was not appropriate for the Situation Table due to the client's needs. This comment spoke to the need for not only training on the role and responsibility of the Situation Table, but **for Chairs to provide more information about the mandate and resources of each participating member agency**. As mentioned above, providing an opportunity for agencies to discuss their mandates, capabilities, programs, and responsibilities during Situation Table meetings, especially when new members joined the Situation Table, is very important so that everyone is aware of what contributions

participating members might be able to make to those referrals that are accepted by the Situation Table.

In addition to having referrals to consider, another key element of Situation Tables is the ability to assess and identify AER. All Chairs were asked to assess their Situation Table's effectiveness at detecting acute risk using the Four Filter process on a five-point scale anchored by very ineffective and very effective. All but two Chairs rated their Situation Table as either effective or very effective. It was interesting to note that some Chairs believed that members had a lot of empathy for their clients and, therefore, might bring referrals for people who were more chronic in their risk factors than being at an AER. Others believed that more education was needed so that members of the Situation Table could do a better job of communicating to their colleagues in their home agency about how the Situation Table worked, and which type of situations were appropriate for the Situation Table to consider. In other words, agency's understanding of which of their clients might be suitable for the Situation Table was integral for the Situation Table to be effective at addressing those with AER in a timely fashion. In effect, Chairs indicated that this lack of general knowledge affected the number and type of referrals being made to the Situation Table. There was also the concern that members might be applying their own judgement about acute risk versus chronic risk and not making an appropriate referral to the Situation Table. In this way, **education with agencies and the community was required not only about the purpose of the Situation Table but also in what AER was, how frontline service providers could identify AER, and how to connect a client who might be experiencing AER to the Situation Table**.

A key aspect of being effective at detecting AER is having sufficient contextual information about the subject of the referral. To that end, Chairs were asked how their Situation Tables assessed AER. Critically, Chairs reported that they did not have formal assessment or evaluative tools. Instead, typically, whomever was the referring agency would discuss their referral and identify the risk factors that they believed characterized their client. Once they were done outlining the referral and the risk factors, in some cases, the Chair would indicate which risk factors they felt were identified by the presenter. This would be followed by a conversation around why the factors identified were considered a risk and whether the culmination of risk factors met the threshold for AER. It was not necessary for there to be unanimity among the Situation Table members. For most Chairs, it was sufficient that there was a consensus among members that the referral met the threshold for AER for the referral to move to the next stage of the process.

It is important to note that there was not a standard number of risk factors that were needed to be established or a set definition of what the threshold for AER was. One Chair stated that their Situation Table considered the identified risk factors against the questions of whether there was a high probability that the individual would harm themselves or others in the very near future; if harm did occur, might the degree of harm be substantial; and whether the effect of the potential harm that the individual might cause to themselves, others, or the community would be concerning to Situation Table members. In effect, for some Situation Tables, the threshold for AER was simply the likelihood that the individual would harm themselves or others within the next 24 to 48 hours. Other Chairs indicated that, at times, their members focused on how long the risk factors had been present rather than the degree or severity of the risk factors. Some Chairs indicated that they would ask the presenter to identify what was different or new to raise the situation from chronic to AER.

Regardless of the process used, all Chairs would then ask each member whether they were in support of the Situation Table accepting the referral.

It was interesting to note that some Chairs felt that the original training they received provided them with the necessary knowledge to accurately assess AER, while others believed that they needed more training, education, and tools to assess AER properly and effectively. For example, many Chairs believed that their Situation Table needed to be retrained on what was the meaning of each risk factor and how individuals could manifest or exhibit each risk factor. Some Chairs also believed that their Situation Table needed refresher training on how to prepare and present referrals to the Situation Table, including identifying all relevant risk factors. Some Chairs also expressed an interest in obtaining more information related to each risk factor, such as how many times particular incidents had occurred, how long the referring agency had been in contact with the individual, and other information that might provide additional context to better assess the risk factors against the criteria of elevated risk. In general, the concern was that the original members of the Situation Table were trained in a three-day workshop, but as new agencies join or the person who represented the agency changed over time, there were not many training options, other than the Sir Wilfred Laurier online training or on-the-job training. Chairs reported being more interested in additional intensive training like what was originally provided when the Situation Table was being established. As a result, some Chairs felt that consistent training on AER was lacking. Given this, and as outlined above, **Situation Tables should give serious consideration to how they train and integrate new members and they should develop and implement a process for consistent, regular training and education for all members**.

An important outcome for Situation Tables is the timely identification of high-risk cases and the acceptance of these types of referrals by the Situation Table. On this issue, all Chairs reported that their Situation Table did a good job of identifying high-risk cases in a timely fashion. Nearly all Situation Table Chairs also believed that their table had been successful in lowering AER. On this point, there were two main themes. The first theme was that the process of reviewing all open referrals at the beginning of each Situation Table meeting for updates and closing those that no longer met the threshold for AER provided Chairs with data that the intervention strategy established through the Four Filter process had been implemented. To this point, the notion of success did not mean the complete absence of one or more risk factors. Instead, success could mean reducing AER to chronic risk or a level of risk that did not put the individual at immediate risk for harming themselves, others, or the community. It could also just mean that the client had been connected to the various programs, resources, or services associated with the intervention plan set out in the Filter Four stage of the process. Moreover, AER can manifest differently for different people. For example, AER is different for a 15-year-old who just became homeless compared to an adult who had been living on the street for the past 10 years. In addition, it is important to remember the purpose of Situation Tables when assessing their contribution to reducing risk. Situation Tables are not case management tables, but a place for agencies to collaborate and share information to build an intervention strategy that agencies will participate in to assist a person in crisis. Given this, several Chairs indicated that one indicator of success was the closing of a client's file, which could be done if the client had been contacted and connected to services or program providers.

The second theme was that success could be measured in the timely identification of AER that more commonly occurred as soon as Situation Table members became more familiar and comfortable with the concept of AER and how to identify it, as members began looking for signs of AER in their clients and addressed it in a collaborative fashion, even outside of the formal structure of a Situation Table meeting. As discussed above, some Chairs indicated that the connections that people made because of participating with a Situation Table created additional opportunities for agencies to work together outside of the Situation Table, which resulted in the timelier identification and intervention of individuals with AER. Still, several Chairs were critical of their Situation Table's ability to know which risk factors had been addressed, which risk factors had been lowered, or whether new risk factors had emerged. In effect, this criticism reflected the concern that Chairs had about the degree to which Situation Tables followed-up on the progress or success of clients. Again, while Situation Tables are not case management tables, some Chairs believed that their Situation Table did not do any consistent tracking or documentation related to AER reduction or if there was a consistent threshold related to risk factors that should be used when closing a file. Again, files were closed either because the client was connected to services, because the client could not be found for approximately two weeks, or because the client had refused services. In other words, a demonstrated reduction in AER was not the only criteria used to close a file because Situation Tables were not case management tables.

Except for the Situation Table that focuses exclusively on youth, there were no restrictions on the types of referrals that could be made to the Situation Table. The only reasons provided by Chairs for why a referral would be excluded from consideration was if it was determined that the individual was already connected to several services, or the lead agency had the ability to address all the needs of their client. Once a referral got to the Filter Four stage, the Chair would assign a case number and identify the lead agencies and all those who agreed to assist in the intervention plan. It was then generally expected that within 24 to 48 hours those involved in that part of the process would have met to discuss the individual, developed an intervention plan, and attempted to contact the individual.

One Chair provided a succinct example of the entire process. In this example, the referral was brought forward by a women's resource agency. In Filter One, the presenter described the client as a woman between 30 and 40 years old, living homeless, pregnant, using substances, and being the victim of at least two assaults. After this basic overview, the Chair would ask if anyone had any clarifying questions. The Chair might then summarize the risk factors and ask members to decide whether the client met the criteria for AER based on these indicators. Once a consensus of members decided that this case met the threshold for AER, the next stage (Filter Two) had the presenter identify the person so that the Situation Table members could search their databases for any relevant information they might have about the individual and their current situation. At this point (Filter Three), the Chair would ask who could be involved in planning and delivering intervention services. Once this was completed, the Chair would record in the database which agency would serve as the lead agency and which other agencies would assist in providing interventions. In Filter Four, that sub-group would then determine the intervention plan and how to deliver the interventions, and then report back to the Situation Table one or two weeks later to assess whether the case needed to stay open or could be closed.

On average, Chairs reported that this entire process took between 10 and 20 minutes. Some Chairs indicated that their process took between 30 and 45 minutes per referral and there were exceptional cases that sometimes took one hour to complete. In terms of how long the Situation Tables were involved with a typical client, as Situation Tables were not involved in case management, the Situation Table was typically involved with a case for about two weeks. Chairs reported that if a client could not be located in the first week, they would keep the file open for another week; however, if the client was still not contacted, the file would be closed as it was unlikely that the client was still at an acute elevated risk. Moreover, once a client was connected to services and AER was reduced, the Situation Table would close the file. Again, this typically occurred within two weeks. Of note, the Situation Table could always reopen a case if the client was located and found to still be at AER. If the case could not be closed because Situation Table members were not able to fulfil their commitments, Chairs were inclined to keep the cases open for another week or so and to apply some pressure on the sub-group to deliver on their intervention plan. When it came to youth, it appeared that the timelines were extended somewhat. Here, Chairs indicated that it might take longer to locate and connect with the youth, and they provided more time to ensure that the youth was connected to and participating with services. The final way that a file was closed was when the client refused services. It should be noted that Chairs felt that only a small proportion of clients refused services once they were approached by the lead agency's representative. Based on the comments by Chairs, the number of clients who refused services ranged from a just a few clients to approximately 25% of clients in some larger jurisdictions.

As demonstrated in the quantitative analysis section above, all Situation Tables maintained a database that contained all the relevant information related to the referral. Once a file was closed, the information remained in the database indefinitely, although one Chair believed that their database was purged every five years, and another believed that their database would be purged every seven years. Of note, the information in the database does not include any identifying information about the client. Rather, it includes the case number, the date the case was opened and closed, what were the risk factors that contributed to an assessment of AER, and which agencies were involved in the intervention plan. While participating agencies might have information about the client in their own record systems and that could be accessed according to their own agency-specific data access protocols, Chairs stated that they reminded members that any notes taken during the Situation Table meeting should be shredded either at the conclusion of the meeting or once the case had been closed. Part of the reason for keeping the information after a case was closed was for yearly reporting to the BC Ministry of Public Safety and Solicitor General. Again, Chairs emphasized that the data that was kept after a file was closed was the basic information presented by the person who made the initial presentation of the referral and did not include any identifying variables.

As expected, the number of cases that were discussed at a typical Situation Table meeting varied based on the Situation Table. While some Situation Tables could go weeks without having a new referral, and some had one new referral to discuss every few weeks, some Situation Table Chairs reported having two or three new referrals each meeting and updates on another two or three cases. In terms of emerging risk factors that were becoming more common in Situation Table discussions, Chairs commonly identified homelessness, mental health, seniors with chronic health

issues that do not meet the criteria for Assisted Living and those with cognitive decline, and issues particular to Indigenous people, such as intergenerational trauma and colonization as risk factors that were increasing in frequency among clients referred to the Situation Table.

SITUATION TABLE INTERVENTIONS

The most common types of interventions provided by Situation Table members involved mental health, family services, and housing. Chairs spoke about how frontline workers from participating agencies worked with individuals and families to help with education on parenting or life skills, addressing housing needs for those who were chronically underhoused, and providing family therapy or other counselling services, including addictions services. In addition, if the client was Indigenous, it was common for First Nations service providers connected to the Situation Table to provide direct services. If the client was a youth, mentorship and connecting the client to a youth worker who could serve as a positive role model and build a relationship with the youth was another common intervention strategy used by Situation Table members. Other intervention strategies tended to focus on connecting youth to other services, such as clinical and culturally sensitive counseling. Regardless of the age or ethnicity of the client, Chairs also indicated that providing emergency funds or income assistance to individuals and their families was another intervention strategy used by participating agencies when deemed appropriate and necessary to reduce AER.

In general, Chairs were rather positive that the intervention plans worked well. In discussing the types of interventions that were considered the most effective and why these interventions worked, there were several main themes. Chairs felt that Situation Tables were very successful at getting a key frontline worker or a team of service providers to connect with the client to meet their everyday needs. While not an exhaustive list and considering that there was not consensus among the responses provided by the Chairs, for many, it was felt that counselling services, social services, poverty reduction, having a mental health worker come to the client rather than the client going to the location of the service provider, and providing support for families were considered successful interventions. Chairs also mentioned that some of the elements that made interventions more likely to succeed included a client who was willing to accept the assistance offered by the intervention team, follow-up from one of the case managers from the lead agency to ensure that the client was connected to the necessary services, ensuring that the client felt that they were being heard, and having someone from the referring agency act as the lead agency because they typically already had a relationship with the client. Of note, Chairs felt that if the client was homeless, it was important to secure housing first as this played an important role in connecting the client to other services and was viewed as contributing to the other services being more successful with the client. In sum, obtaining buy-in and establishing trust with the client, ensuring meaningful collaboration among the service providers who volunteered to be part of the intervention team as part of the fourth stage of the Situation Table meeting, clear communication between members and between the intervention team members and the client, accurately identifying what were the client's needs, having a strong lead agency, and timely contact with the client were viewed as necessary aspects of a successful intervention.

In terms of interventions that were viewed by Chairs as being less successful, there were some challenges expressed with the functioning and availability of homeless shelters. Some Chairs reported a general lack of space or that there were particular limitations with their local shelters, such as a lack of shelters that allowed couples to be together. Some Chairs believed that some forms of interventions were less successful because there was a disconnect between the level of buy-in the Situation Table received from an agency's leadership. As mentioned above, this could manifest as a lack of consistent representation at the weekly meetings that restricted the ability of that agency to participate in interventions. In effect, there were two main themes that several Chairs mentioned in relation to the lack of success of some forms of interventions. The first was related to the length of time the Situation Table was connected to the client and the effect of this on intervention success. The concern was that the Situation Table was not connected long enough with the client to ensure success and that there was no process in place that allowed the Situation Table to check back with clients to determine whether they were connected to services beyond the initial one or two weeks that a case typically remained open. As will be discussed below, while the Chairs that raised these concerns were not suggesting direct case management of clients for their Situation Tables, they were concerned that many of their clients were limited to just a brief connection to a few services that were put in place by the Situation Table's intervention team, but soon became disconnected from services again. Given this common concern, **Situation Tables might consider having a mechanism where the lead agency reported to the Situation Table every six months or once per year on whether clients who had their files closed were still connected to services or no longer needed services.** This reporting could be done in an aggregate manner to respect the anonymity and privacy of the client but would allow the Situation Table to have a better understanding of whether their clients were still connected to services, no longer required services, or were still living within the jurisdiction of the Situation Table.

The second area of concern, which was shared by many Chairs, was related to the 'door knock' or the initial contact of the lead agency or intervention team with the subject of the referral. While Chairs felt that there was a lot of discussion about how to conduct the 'door knock' during their initial training or during Situation Table meetings, some Chairs believed that the process was not appropriate in all situations and was not always trauma informed. Other Chairs felt that some members were not very comfortable doing 'door knocks' or had negative experiences with this process and were unable to find partners who had positive experiences. Importantly, Chairs felt that an unsuccessful or poor initial contact with clients resulted in the intervention strategy failing or never being implemented. Other Chairs believed that the cold call aspect of the 'door knock' was problematic and did not facilitate a very positive first interaction, which could negatively affect the entire intervention plan. To address these concerns, **it is recommended that, whenever possible and appropriate, someone with a prior relationship with the client should be involved in the 'door knock'**. Moreover, given their inherent position as law enforcement officers, whenever possible, the police should not be the agency doing the 'door knock'. Clearly, they have a support role in ensuring the safety of those conducting the 'door knock' and the client, but **police should not be the lead agency conducting the 'door knock'**.

There were several types of interventions that Chairs felt were either not always available or were not connected to the Situation Table that could better serve clients given the risk profile of those

being referred. The first area was housing. In additional to simply having more housing options in the community, it was considered important for a Situation Table in British Columbia to always have a representative from BC Housing or other organizations that addressed housing so that all members had a better understanding of the current housing situation in the community, the rate of vacancies, and how to best navigate the housing needs of clients. As mentioned above, several Chairs mentioned that stable housing was not only important in and of itself but also contributed to the success of other interventions. Moreover, several Chairs highlighted housing issues as one of the most common issues their clients were facing. In terms of other interventions that were needed, Chairs identified the need for more drug detoxification beds when dealing with people with substance use issues. This was based on the experience of members that when someone was willing to enter a substance abuse program, it was critical that a space be available in real time, rather than at some point in the future. The concern expressed by some Chairs was that this was not always possible in their community, even though those clients connected to the Situation Table could, if needed, jump the queue for space in an addiction program.

Given the increase in the number of clients who were elderly, some Chairs identified a growing need for interventions that were specifically designed to address seniors with significant health issues. Related in part to this issue, some Chairs felt that there was a need for the Situation Table to have greater access to health outreach supports in terms of the number of people on the ground who could engage with those in need. To that end, it might be a good idea for **Situation Tables to consider having a physician as a standing member that could connect clients to needed programs, services, or resources**. It was not surprising that some Chairs also identified mental health as another intervention that was not always available but frequently needed. Some Chairs stated that their local police officers were more reluctant to become involved with or to participate in mental health assessments with someone who was suffering from a mental health issue but not engaged in criminal behaviour. Some Chairs also indicated that their Situation Table struggled with s. 28 of the *Mental Health Act* as there was no mechanism for the Situation Table to get people in need who were suffering from a mental health issue to the hospital. The strain on resources also resulted in some Chairs reporting that they struggled to get interventions in place in a timely fashion for those requiring mental health services. The final areas identified by Chairs as issues that they were struggling to address successfully through their Situation Tables involved clients with brain injuries, Fetal Alcohol Spectrum Disorder, those with complex care housing needs, and those who were not legally in the country. Given this, if it was not possible to have a physician as a standing member of a Situation Table, **consideration should be given to having a forensic nurse either as a standing member or an identified 'buddy service provid**er'.

Even with these concerns, all Chairs believed that their Situation Tables were effective at mobilizing support from within the Situation Table for an intervention. Most Chairs reported that, by the end of a Situation Table meeting, for those referrals that were accepted by the Situation Table, they had a team of members identified to contact the client and connect them to appropriate services, and that this initial contact occurred within 24 to 48 hours. Of note, some Chairs believed that the Situation Table could be more effective at coordinating between those members who would be involved in the 'door knock' and those who would be providing the various interventions. Again, related to the issue of resources and training, the theme of being able to connect with the client

effectively and deliver interventions in a timely fashion was a concern for some Chairs. While Chairs functioned under the understanding that if a member was participating in a Situation Table meeting and volunteered to be part of the Four Filter process, they were prepared to deliver interventions. However, Chairs reported that this was not always the case. The outcome of this was that nearly half of the Chairs were concerned that members took too long to connect clients to services. Again, it is important to remember that clients progressed to the fourth filter because members agreed that the client met the criteria for AER. Given this, Chairs believed that connecting clients to interventions quickly was both paramount and one of the primary purposes of a Situation Table. As such, Chairs believed that connecting clients to needed services, programs, and resources should always happen very quickly, which was not always the case in the view of some Chairs.

Chairs also identified some systemic barriers that prevented Situation Table partners from successfully implementing interventions. Again, it is important to acknowledge that the interviews with Chairs occurred during the COVID-19 pandemic that resulted in Situation Table meeting being virtual rather than in person and the need to change how some interventions were delivered to clients. With that caveat in mind, systemic barriers identified by Chairs included the different ways that various agencies did their work that made it challenging for them to collaborate more effectively with others. For example, some Chairs reported that the police were typically very entrenched in doing things in a particular way that made it difficult for them to work with other agencies, particularly in the areas of information sharing and participating in certain types of interventions. Other barriers were resource constraints, capacity issues, some agencies not having an outreach component, and some members not wanting to add to the workload of their agency, therefore, not volunteering to participate in the intervention plan.

Nonetheless, overall, Chairs believed that Situation Tables had positively affected clients' overall ability to access needed services in a timely fashion. Chairs reported that they believed that clients felt that their participation in the interventions provided by Situation Table members were helpful and that their connection to a Situation Table allowed clients to find out more about the types of interventions available in the community. Chairs also believed that being able to connect a client to multiple interventions all at once and in one meeting was very effective and efficient. Chairs also believed that the Situation Table served to connect clients to particularly useful or beneficial interventions that the client might otherwise never connect with in the absence of a Situation Table, especially in larger communities.

The opinion of Chairs varied on the issue of whether they felt their Situation Table had resulted in a reduced demand for emergency and police services. Some Chairs felt that, specifically in reference to their clients, individuals who were connected to interventions through the Situation Table did not use emergency services as much as they had prior to the Situation Table intervening with them. As a result, some Chairs believed that this had contributed to an overall reduction in calls for service in the community. This claim was not directly based on an analysis of calls for service or other empirical data, but a belief that the work of the Situation Table reduced criminality and the downward spiraling of their client's mental health, which had to result in a reduction of calls to emergency and police services. Moreover, Situation Table files were closed because of a reduction in AER, so Chairs believed that this likely reduced the volume of calls for service or demand for emergency services. Still, most Chairs reported that they either did not have any evidence to reach a

definitive conclusion to this question or believed that their Situation Table did little to reduce the overall demand for police or emergency services in their community. Similarly, most Chairs either did not know if or did not believe that their Situation Table contributed to the reduction of direct or indirect costs of crime. The basis for this view was not because these Chairs felt that their Situation Tables were ineffective, but rather because there was no follow-up with clients once a file was closed. Given this, Chairs did not feel that they were able to assess the longer-term outcomes of a referral to the Situation Table. Still, some Chairs indicated that the work they did in connecting people in need or in crisis to services likely had positive outcomes for the client specifically and the community more generally. Moreover, by addressing AER and meeting the needs of individuals, some Chairs believed that Situation Tables must be contributing, in some way, to reducing the costs of crime.

On the specific issue of information sharing protocols, generally, Chairs did not feel that this was a systemic barrier to the successful operation of their Situation Table. Still, some Chairs felt that there were, at times, a communication barrier between agencies that resulted in creating an obstacle to bringing situations forward to the Situation Table. This manifested itself as a lack of trust between members or agencies that needed to constantly be rebuilt because of turnover at the management level of the agency participating in the Situation Table or in the turnover in Situation Table representatives. This concern was also related to training, as the combination of a lack of training and a high turnover in Situation Table membership resulted in people being unsure or uncomfortable sharing information or members deciding to err on the side of caution and withhold important details for fear of violating privacy or confidentiality policies. While this is understandable, it again speaks to the need of **all new members to be properly trained and for refresher training for longstanding members** to ensure that all members and their agencies fully understand what they can and cannot share and at which stage of the Situation Table process certain types of information can and should be shared.

In a very positive development, most Chairs stated that they had been approached by other communities about how to set up a Situation Table and how a Situation Table should function. This is a positive development as it prevents each community 'reinventing the wheel' and new Situation Tables can learn from the experiences of more established Situation Tables. Some key advice that Chairs provided to other Situation Tables included providing strategies for getting agencies and service providers to join the Situation Table and outlining their processes and procedures to ensure that each stage of the Four Filter process was carried out effectively and appropriately. Chairs also allowed members from other Situation Tables to sit in on their discussions to observe how referrals were presented and moved through the process. Some Chairs reported that they made presentations to other municipalities considering whether to adopt the Situation Table model, while some Chairs served as a support to other Situation Tables by providing general guidance or advice.

THE RISK TRACKING DATABASE

Nearly all Situation Tables were using a risk tracking database for recording information during discussions. Most Chairs viewed their database as effective for tracking general information that

could be used for basic statistical purposes, such as how many referrals were made to the Situation Table and how many were accepted or rejected. It was also used to provide updates and reports on the activities of the Situation Table to funders, the Steering Committee, and other agencies. Another important use of the database was that it allowed members to keep track of their role with each client. However, Chairs identified a number of limitations to the database. Given the nature and purpose of the database, some Chairs stated that it was very difficult to connect repeat clients to their previous interactions with the Situation Table. It was also challenging if members wanted to come back to a case that had been closed for contextual information about the client or what Situation Table members did for the client. Chairs also indicated that it could be difficult to add additional risk factors to the database, as well as adding information about a new agency that had joined the Situation Table. In effect, Chairs thought that the risk tracking database was essential to the operation of the Situation Table but wished that **it was more user-friendly or somewhat more customizable to the specific needs of each individual Situation Table**. For example, if a user selected 'Other' for criminal offences, it might not be possible or easy for the user to input the specific crime types that they wanted to enter.

GENERAL PERCEPTIONS OF SITUATION TABLES

There are both formal and informal indicators of success for Situation Tables. For example, formal measures for success may be the number of referrals that are closed within two weeks as a result of a reduction of AER or a client being connected to services, while an informal measure of success may be increased collaboration among Situation Table members. When Chairs were asked to identify what they thought were indicators that their Situation Table was successful, several common themes emerged. In addition to closing cases, some Chairs identified receiving referrals to the Situation Table on a consistent basis as a sign of success, while others indicated that not receiving any referrals for a substantial period of time was an indication of success because it indicated that people were being connected to services before they became AER. In this case, while there was no way for the authors of this report to determine that this was the reason that no referrals were being brought forward to the Situation Table, having consistent referrals might be an indication that members and 'buddy agencies' had some degree of confidence in the Situation Table model and were comfortable using the Situation Table. To that point, another theme raised by Chairs was that standing members were attending Situation Table meetings and made time in their busy schedules to attend and participate in meetings. In very practical terms, another key theme was that the intervention team being able to locate the client, connect them to services in a timely fashion, and reduce the client's AER were clear indicators of success.

Another informal indicator of success was when Situation Tables were able identify gaps in agencies or services connected to the Situation Table to be better positioned to respond to these developing trends through an analysis of the types of risk factors that were emerging in the community. While training was frequently mentioned in the context of either lacking or requiring additional training, some Chairs indicated that they had success in their Situation Table being better able to assess AER and having a better understanding of what was available in the community to address AER. Related to this point was that members were much more aware of what was happening in other agencies, who they could reach out to in dealing with a client who was

either connected or not connected to the Situation Table, and the increased sense of collaboration across agencies because of the presence of a Situation Table. These outcomes were characterised as success stories for Situation Tables. A final theme was that some Chairs believed that frontline workers felt less isolated when working with Situation Table clients because there was much more cooperation, collaboration, and a team approach to responding to clients.

When asked directly how successful or unsuccessful Chairs felt their Situation Table were, all but one participant indicated that their Situation Table was successful. When asked what was working well and what gave them this feeling of success, Chairs indicated that there was consistent attendance at the weekly Situation Table meetings, collaboration was working well as most members were comfortable connecting with each other during Situation Table meetings and outside of the structure of the Situation Table, there was an increased knowledge among members about what services, programs, and resources were available in the community, how the various agencies supported clients with and without AER, there was an increased sense of trust between members that enabled communication between agencies, and agencies did not see each other as competitors for scarce resources and funding. Other reasons for seeing the Situation Table as successful were that members were adhering to and comfortable with the structure of the Four Filter approach, they were making appropriate referrals to the Situation Table, AER levels were being reduced through the intervention plans established by the Situation Table Filter Four members, Situation Tables were meeting even if there was not a new or ongoing referral which kept members connected, and members were not violating privacy or confidentiality during Situation Table meetings.

However, there were several reasons why Chairs assessed their Situation Table as merely "successful," rather than "very successful." One common reason, especially among Situation Tables from smaller communities, was their overall number of referrals. While Chairs did not want to see more people in their communities with AER, some felt that the number of referrals to the Situation Table was not reflective of the actual number of people with AER in the community or presenting to agencies. For example, Indigenous persons who required Indigenous-based interventions were viewed as not receiving sufficient reach-out by Situation Tables. As mentioned above, another theme was related to training and the need for more training and education to better understand the needs of the community and how to best address these needs. Another theme was the timeliness of interventions. It was felt by some Chairs that more timely responses were needed to be more successful in assisting clients. These last two themes were, in part, based on the challenges associated with having frequent changes in which agencies attended Situation Table meetings and who represented these agencies at the meetings. The frequent changes in representatives and the addition and subtraction of agencies resulted in a weakening in the connections that the Situation Table had with individuals and their agencies, the knowledge, experience, and training of Situation Table members, the comfort level and willingness of agencies to identify and bring cases to the Situation Table, and the willingness of members to share information with others during the various stages of the Four Filter process.

Given this, there were several commonly identified themes that were recognized as challenges to the successful operation of the Situation Table. As outlined above, it was not uncommon for a small number of agencies from each Situation Table to make most of the referrals or to participate in

most of the interventions. This could result in burnout or fatigue in members and their agencies, especially since the clients that the Situation Table dealt with were often the most difficult and challenging people in the community. Contributing to this challenge was that not all agencies could contribute to the intervention strategy given the risk factors associated to a client. In this way, it was not uncommon for the same agencies to volunteer or be recruited for involvement and assistance with clients. So, in some cases, **Situation Tables needed to be aware of the capacity of agencies to contribute to the Filter Four process, while, in other cases, there was a need for Chairs to ensure that the necessary resources, services, or programs that were commonly needed to assist AER clients were represented at the Situation Table and were contributing to interventions, when appropriate**. Another identified challenge was the disconnect at some Situation Tables between the representatives at the meetings and the decision makers from their respective agencies. This is one of the important roles that **a leadership or steering committee should play; namely ensuring that the representative who attended Situation Table meetings had the permission, ability, and authority to commit their agency to participate in information sharing, collaboration, and the Four Filter process**.

In terms of ways to address these challenges or to improve Situation Tables, Chairs provided several suggestions. Given the comments outlined above, it was not surprising that many Chairs indicated that greater training for Situation Table members and their agencies was needed. It was rather commonly felt that yearly training on the rules and procedures of the Situation Table, the development of a standardized toolkit and online supports that could be easily accessed by all members, training on how to conduct a successful 'door knock', and how to build and deliver a collaborative intervention plan would be extremely beneficial. Other suggestions were to ensure that the people who attended the Situation Table meetings were those who were committed to the Situation Table model and were passionate about delivering timely interventions to those with AER. Finally, there was also some support for developing an evaluation framework that allowed the Situation Table to have a better understanding of the longer-term outcomes for clients.

Although many Chairs wanted information about the longer-term outcomes for clients, nearly all Chairs were not in favour of Situation Tables moving into a case management role. The general sentiment was that Situation Table members were already doing a lot of hard work and that the appropriate role of the Situation Table was to reduce AER by connecting clients quickly to resources and services. Most agreed that it was more appropriate for the lead agency and the partner agencies to be responsible for the case management of clients, rather than the Situation Table. Moreover, most Chairs were very comfortable with the role of the Situation Table, believed that this role contributed to the sustained momentum of the Situation Table, and that once a Situation Table accepted a client as meeting the criteria for AER and put in place a collaborative and cooperative intervention plan, the case should be closed by the Situation Table and short, medium, and long term case management should remain the responsibility of those agencies directly interfacing and assisting the client.

Survey Data Analyses with Situation Table Members

As outlined in the methodology section, all members from each Situation Table in British Columbia were invited to participate in an on-line survey. In total, 60 Situation Table members responded to the opportunity to complete a survey. Of note, each of the 10 Situation Tables were represented, but for three of the Situation Tables, only one member completed the survey.

THE GOALS OF SITUATION TABLES

Similar to the interviews with the Chairs, members were asked what they perceived to be the goals of their Situation Table. Their responses are highlighted in Figure 1 in the form of a word cloud. Not surprisingly, member responses coalesced around a few themes. Some of the key words used by Situation Table members included support, risk, community, services, individuals, and vulnerable. Cumulatively, respondents indicated that the primary goals of Situation Tables were to identify and mitigate instances of elevated risk among people in their communities. To this end, Situation Tables aimed to connect vulnerable individuals to services and agencies in the community that could offer support tailored to their individual needs.

FIGURE 1: THE GOALS OF SITUATION TABLES

EXPERIENCE AND TRAINING

The Situation Table members who responded had a wide range of experience with their respective Situation Tables. Still, most members had considerable experience participating with their Situation Table. More than one-third of the members had been with their Situation Table for over two years, while another 30% had been involved with their Situation Table for over one year. In contrast, the remaining members had been with their Situation Table for less than one year; about half of these

members had been engaged for fewer than six months. In terms of the agencies represented by at least one member completing the survey, only a few had not been part of the Situation Table for at least one year. More than half of the agencies represented had been Situation Table participants for more than two years. As indicated by Table 10, survey members represented a vast array of agencies.

TABLE 10: AGENCIES REPRESENTED BY MEMBERS (N = 60)

Agency	N	%	Agency	N	%
Ministry of Children and Family Development	8	13.3	Bylaw Services	1	1.7
Outreach Programs/Services	8	13.3	Disability Services	1	1.7
Transition House/Shelter	6	10.0	Fire Department	1	1.7
Ministry of Social Development and Poverty Reduction	6	10.0	Non-Profit Advocacy	1	1.7
City/Local Government	4	6.8	Security	1	1.7
Police	3	5.0	Sources Community Resource Centre	1	1.7
Mental Health/Substance Use Agency/Program	3	5.0	Provincial Corrections	1	1.7
School District	3	5.0	Victim Services	1	1.7
Health (e.g., hospital, clinic, physical, health authority)	2	3.3	Counselling/Intimate Partner Violence Treatment Program	1	1.7
Ministry of Mental Health and Addictions	2	3.3	Missing	2	3.3
Indigenous Organization	2	3.3			
Community Living British Columbia	2	3.4			

Nearly three-quarters of respondents reported receiving training on the Situation Table model. Of those who had received training, most received their training within the first week of joining their Situation Table. Only four members (fewer than 10% of those who were trained) reported that their training occurred more than one month following their introduction to their Situation Table. There was no discernable pattern that explained why roughly one-quarter of respondents had yet to receive any training. In other words, these respondents were from disparate Situation Tables and had been with their Situation Tables for a variable range of time.

The training received by members was almost universally regarded as positive. In total, 97% of members indicated that they felt "very" or "mostly" prepared for their role with their Situation Table because of the training they received. When asked what they regarded as the key strengths of the training, respondents reported that obtaining a better understanding of the role of Situation Tables and how the Four Filter process worked was helpful. In addition, being trained on the meaning of each risk factor and being provided with numerous examples of how to assess AER was also helpful. In more general terms, respondents felt that the trainers or facilitators were good, that the training was comprehensive, and that the use of scenarios were beneficial. Several members also expressed satisfaction with how they received their training. Some who had received their training online mentioned the accessibility or flexibility of the training as a positive, while those

who had received in-person training were happy that this form provided them an opportunity to ask questions, role play, and connect with members from other Situation Tables.

Few respondents had any negative comments about their training. In response to a question about what they felt was missing from their training, no particular themes emerged, and no responses were provided by more than one member. However, when asked what areas of training could be improved, the main themes were related to alternatives to in-person 'door knocks', how to best coordinate getting referrals to the Situation Table, conflict management training, and how to deal all the various needs or risk factors that clients presented with.

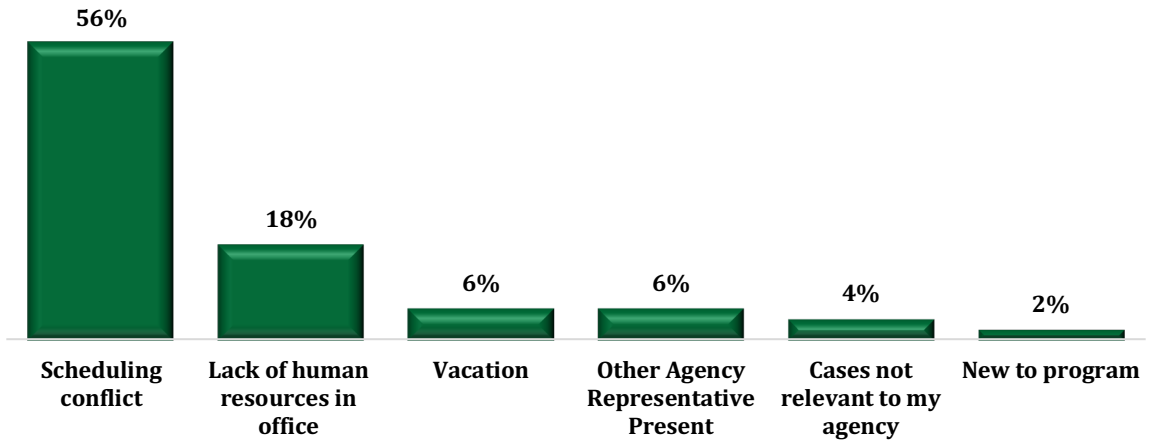
In terms of suggestions for how to improve Situation Table training, responses coalesced around the theme of training delivery. Some members noted that they wished they had the option for online training, while others expressed a desire to engage in more in-person training. Another theme that was expressed by several respondents was related to wanting more opportunities to role play, particularly around conducting the 'door-knock', and having more mock scenarios for the Situation Table to work through. In conjunction with the key strengths of the training highlighted above, it was clear that the role playing and mock scenarios were generally deemed to very important, that many respondents felt that more opportunities to practice the 'door knock' and work through scenarios was critical, and that, in general, more training was better. Another theme that emerged from responses was in relation to refresher training. Other suggestions for improving training included **a short follow-up session after a Situation Table is launched to assess whether members were experiencing any challenges or issues, how to on-board or incorporate new members to the Situation Table, and developing training materials based on the British Columbia experience with Situation Table so that the training is not reliant on examples from other jurisdictions**.

PARTICIPATION IN SITUATION TABLES

Of the members that responded (n = 50), the vast majority (94 per cent) indicated that their Situation Table met, on average, once per week. Critically, only 30% of respondents indicated that they "always" attended these meeting, while another 45% characterized their participation as "often". Conversely, 8% of respondents answered that they "rarely" or "never" attended Situation Table meetings. The reasons for respondents not attending meetings are presented in Figure 2.[9] By far, the most common reason provided was scheduling conflicts. Many Situation Table members were active professionals who were required to balance their work on the Situation Table with all their other professional responsibilities. From a scheduling perspective, this can prove very challenging. The second most cited reason for not always attending Situation Table meetings was a lack of human resources in the member's office or organization.

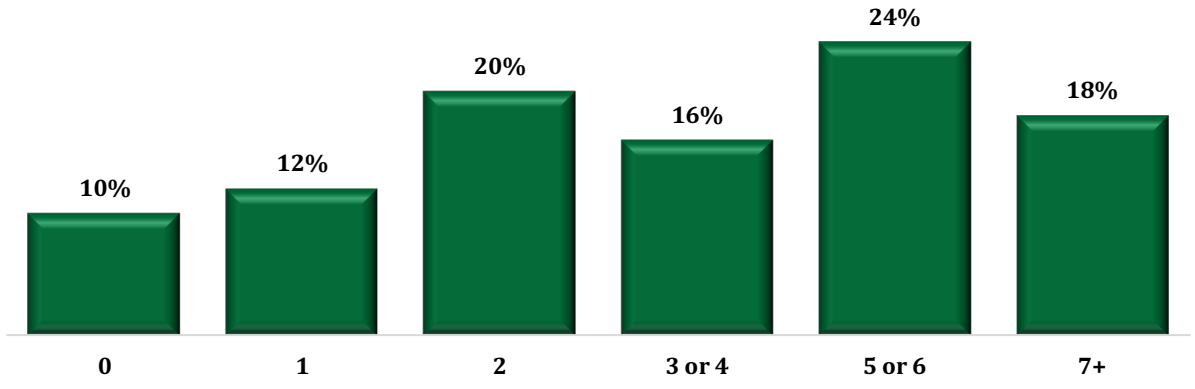
[9] Multiple responses were possible for this question.

FIGURE 2: MAIN REASONS WHY MEMBERS WERE NOT ALWAYS PRESENT AT SITUATION TABLE MEETINGS (N = 50)



As demonstrate in Figure 3, there was wide variability in the number of unique cases discussed by the various Situation Tables in a typical month. On average, the Situation Tables represented by the sample respondents discussed one unique client per week. At the busier end of the spectrum, nearly one in five Situation Tables discussed seven or more clients per month. The largest number reported by any one respondent was 15 unique clients. Conversely, some Situation Tables discussed far fewer clients. About one-third (32 per cent) of Situation Tables discussed only one or two clients per month, while another 10% were averaging fewer than one client discussion per month.

FIGURE 3: NUMBER OF UNIQUE CLIENTS DISCUSSED IN A TYPICAL MONTH (N = 50)



ADHERENCE TO THE FOUR FILTER PROCESS

The Four Filter process plays a central role in the protection of privacy and confidentiality during Situation Table meetings. Given the sensitive nature of the cases that are brought to Situation

Tables, it is important that Situation Tables adhere to these protocols in determining AER. For this reason, respondents were asked questions related to the functioning of the Four Filter process in their Situation Table. For each question about how often a particular aspect of the process was followed, the anticipated answer was "always." Given the varieties of practice and the complications wrought by the COVID-19 pandemic, "often" was also somewhat expected. However, responses other than "often" or "always" suggested that the Four Filter process was not being applied consistently or was not being followed to the degree expected.

Filter One

With respect to the first filter, respondents were asked how often their Situation Table adhered to the following considerations.

1. The presenting risk factors extend beyond the scope of one or two agencies, and
2. All options available have been exhausted within the originating agency

The responses to these questions are presented in Table 11.[10] For both, a sizeable majority of members (73 per cent and 77 per cent, respectively) reported that these conditions were true "always" or "often". Put another way, one-quarter of respondents suggested that these Filter One protocols were, at best, followed only "sometimes." In a small proportion of cases (6 per cent and 8 per cent, respectively), respondents answered that the protocols were "rarely" or "never" followed. Based on the information provided here, it is not possible to discern why the Filter One protocols were not always being followed. To confuse matters somewhat, for respondents who represented the same Situation Table, there was also some inconsistency in the answers provided. For example, one respondent indicated that their Situation Table "rarely" followed the Filter One protocols, while other respondents from the same Situation Table reported that their Situation Table "sometimes" or "always" adhered to the protocols.

TABLE 11: FILTER ONE PROTOCOLS (N = 48)

	Never	Rarely	Sometimes	Often	Always
The presenting risk factors extend beyond the scope of one or two agencies	**2%**	**4%**	**17%**	**33%**	**44%**
All options available have been exhausted within the originating agency	**2%**	**6%**	**21%**	**27%**	**44%**

Filter Two

To assess the fidelity of Filter Two, respondents were again asked to comment on "how often" the following statements held true.

[10] Twelve members chose not to provide answers for the questions in this section.

1. The referring agency introduces and provides carefully de-identified information to the other Situation Table members about the situation.
2. The Situation Table members collectively decide whether the risk factors identified place the situation at a level of acutely elevated risk.
3. If the group decides that not enough criteria are met to propose the situation for further discussion at the Situation Table, the originating agency will be encouraged to revisit their original support strategies.
4. If participants collectively agree and determine that the situation is one of acutely elevated risk, the situation will move forward to Filter Three.

The responses displayed in Table 12 paint a general portrait of Filter Two operations. Regarding the first three criteria, at least 90% of members indicated that their Situation Tables complied "always" or "often." For the fourth criteria, the proportion indicating "always" or "often" was just slightly lower (88 per cent). In contrast to Filter One, the "sometimes" response was rarely selected when considering the elements of Filter Two. Interestingly, the "never" or "rarely" responses noted for Filter Two did not correspond to the same responses for Filter One. In other words, those respondents who provided "never" or "rarely" responses in relation to the Filter Two questions were different from the respondents who provided those responses for the Filter One questions. Given this and once again, there was not an obvious pattern among the less positive responses.

TABLE 12: FILTER TWO PROTOCOLS (N = 48)

	Never	Rarely	Sometimes	Often	Always
The referring agency provides carefully de-identified information	**2%**	**4%**	**17%**	**33%**	**44%**
The Situation Table decide whether the risk factors identified place the situation at AER	**0**	**4%**	**6%**	**21%**	**69%**
If group decides that not enough criteria were met, originating agency will revisit their original support strategies	**0**	**4%**	**2%**	**8%**	**85%**
If the situation is one of AER, the situation will move forward to Filter Three	**2%**	**2%**	**8%**	**23%**	**65%**

Filter Three

To assess the fidelity of Filter Three, respondents were asked how often:

1. basic, identifiable information about the individual or family was shared
2. only enough information shared to determine whether other agencies were already involved with the client, and which agencies should be but were not
3. a lead agency was determined based on the relevance of the highest priority risk factors to the mandate of the agency, or, in some cases, based on the best established and trusted access that an agency could provide
4. assisting agencies were also identified to help develop and execute an intervention

5. there was no further discussion at the Situation Table about the referral at this point. Only the de-identified data introduced in Filter Two and the agencies who were to be involved as identified in Filter three were added to the Risk Tracking Database

As shown in Table 13, there was widespread adherence to Filter Three protocols. In total, 94% of respondents maintained that basic identifying information was shared with their Situation Table. No respondents characterized adherence to this criterion as "rarely" or "never". While nearly two-thirds of respondents (63 per cent) suggested that appropriately only the bare minimum of information was shared "always", a small minority (12 per cent) indicated that this was sometimes not the case. Though comparatively uncommon, there were circumstances when more information than was necessary or appropriate was shared at this stage of the process. It is possible that these results reflected subjective variation in what constituted "only enough information." According to Table 13, members noted a high degree of fidelity in the processes of selecting lead and assisting agencies. In total, 94% of respondents confirmed that a lead agency was "always" or "often" determined by a correspondence of risk factors and agency mandate or because of a pre-existing relationship of trust. In terms of the identification of assisting agencies, the comparable statistic was 100%. Although most respondents (83 per cent) claimed that discussion of situations "always" or "often" ceased after the designation of lead and assisting agencies, the responses from the remainder suggested that there appeared to be circumstances where this was not the case.

TABLE 13: FILTER THREE PROTOCOLS (N = 48)

	Never	Rarely	Sometimes	Often	Always
Basic, identifiable information was shared	**0**	**0**	**6%**	**23%**	**71%**
Just enough information was shared	**0**	**2%**	**10%**	**25%**	**63%**
Lead agency determined by relevant considerations	**0**	**4%**	**2%**	**8%**	**85%**
Assisting agencies also identified	**2%**	**2%**	**8%**	**23%**	**65%**
Discussion concluded following identification of lead and assisting agencies	**0**	**2%**	**15%**	**27%**	**56%**

Filter Four

In relation to the process and procedures during the Filter Four stage, respondents were asked how often:

1. The lead and assisting agencies (i.e., Intervention Team) met privately to engage in intervention planning.
2. The Intervention Team identified the assets or supports in the community that may become critical in the sustainability of their collaborative intervention.
3. The Intervention Team coordinated and scheduled an integrated meeting with the client(s) as soon as possible.

The patterns of responses displayed in Table 14 were very similar to those demonstrated in the previous filters. Most respondents (87 per cent) stated that the intervention team "always" or "often" met privately to engage in planning, while a very small minority (13 per cent) suggested

that this was only "sometimes" the case. Similarly, a large majority of members (91 per cent) noted that the intervention team "always" or "often" identified important community supports, while only a few (8 per cent) of respondents felt that this only occurred "sometimes."

There was somewhat less consensus surrounding the efficiency with which intervention teams were able to schedule meetings with clients. While over three-quarters (79 per cent) of respondents indicated that these meetings "always" or "often" took place as soon as possible, only one-fifth of respondents indicated that these meetings only "sometimes" or "rarely" occurred as soon as possible. It was not clear from the data what might account for delays in meeting with clients. Anecdotal evidence indicated that part of the challenge way in trying to find or contact the client. At the same time, it was likely that this was a facet of Situation Table work that was adversely affected by the COVID-19 pandemic.

TABLE 14: FILTER FOUR PROTOCOLS (N = 48)

	Never	Rarely	Sometimes	Often	Always
Intervention team meets in private to create intervention plan	**0**	**0**	**13%**	**29%**	**58%**
Intervention team identifies community supports	**0**	**0**	**8%**	**35%**	**56%**
Intervention team coordinates with client as soon as possible	**0**	**10%**	**10%**	**33%**	**46%**

PARTNER CONTRIBUTIONS TO SITUATION TABLES

An important aspect of Situation Tables is the way partners work collaboratively toward solutions. To this end, respondents were asked to assess the contributions of their Situation Table partners. In particular, respondents were asked to evaluate the extent to which partners contributed to the Four Filter process of identifying AER, the sharing of relevant information in the appropriate filters, bringing referrals to the Situation Table, and updating the Situation Table on the status of a planned intervention.

Overall, the data presented in Table 15 demonstrates a generally positive assessment by respondents on how often members contributed in various ways to their Situation Tables. Two-thirds of respondents felt that partners "always" contributed to the Four Filter process, and nearly the same proportion (64 per cent) believed that Situation Table members always shared relevant information. Most respondents (59 per cent) also felt that Situation Table members always provided referral status updates. In terms of room for improvement, the data presented in Table 15 suggested that more could be done by the Chair of the Situation Table to ensure that all members who represented lead agencies responsible for the intervention team could provide updates on the status of clients more often.

An area of greater contention was that of bringing forward referrals. Only about one-third (39 per cent) of respondents noted that this form of contribution to the Situation Table was done by members "all of the time", while slightly less respondents (34 per cent) answered "some of the time". This finding corresponded with the insights provided by the Situation Table Chairs. While it

was not always possible for all members to bring referrals to the Situation Table, and respondents did not appear to suggest that there were some members who never brought a referral to the Situation Table, it does appear to be a challenge to get some members to bring referrals to the Situation Table more than occasionally. Put another way, there was the feeling among some respondents that some agencies were contributing more than their fair share when it came to bringing referrals to the Situation Table.

TABLE 15: PARTNER CONTRIBUTIONS TO THEIR SITUATION TABLE (N = 44)

	None of the Time	Some of the Time	Most of the Time	All the Time
Four Filter Process	**0.2%**	**0.02%**	**27%**	**66%**
Sharing of Relevant Information	**0.2%**	**0**	**32%**	**64%**
Bringing Forward Referrals	**0**	**34%**	**25%**	**39%**
Updating the Status of Referrals	**0.2%**	**18%**	**16%**	**59%**

THE IMPACTS AND EFFECTIVENESS OF SITUATION TABLES

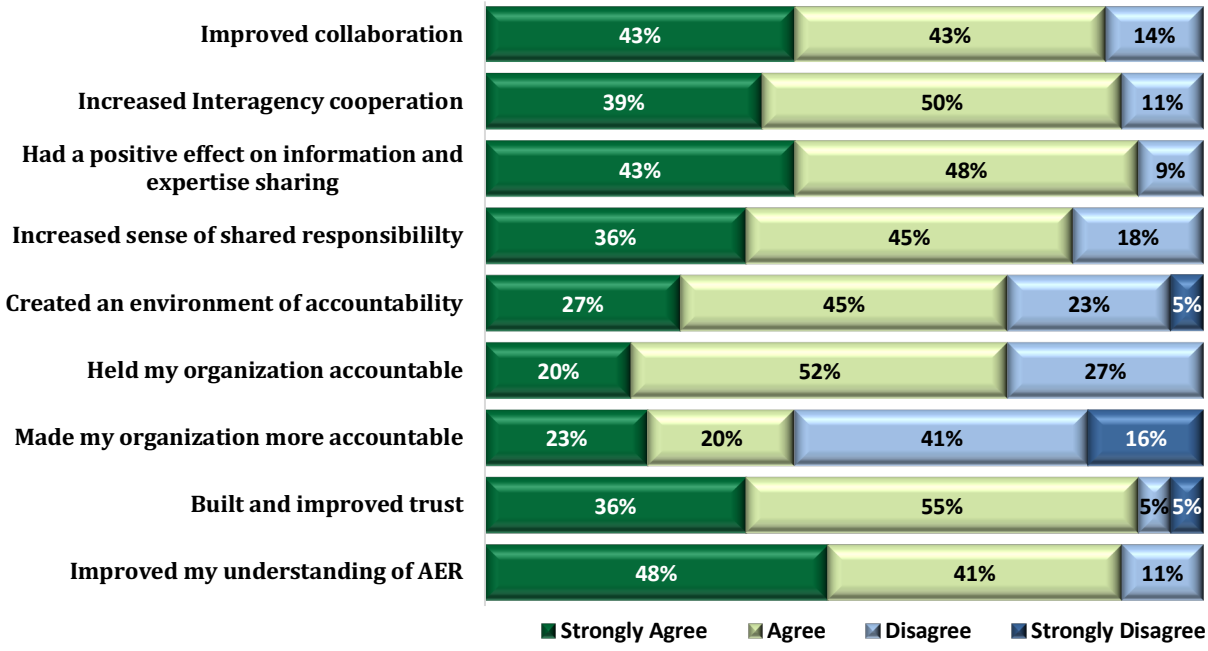
Owing to the complexity of their operational environments, Situation Tables require considerable collaboration among partner agencies and members. To gauge the degree to which Situation Tables have been functioning successfully at a structural level, respondents were asked to comment on the degree to which they agreed or disagreed with the following statements.

A. My Situation Table has improved collaboration among service providers.
B. My Situation Table has increased interagency cooperation.
C. My Situation Table has had a positive effect on information- and expertise-sharing among partner agencies.
D. My Situation Table has increased a sense of shared responsibility among partner agencies/service providers.
E. My Situation Table has created an environment of accountability.
F. My Situation Table consistently holds my organization accountable for service delivery.
G. My organization is more accountable for service delivery than it would be without the Situation Table.
H. My Situation Table builds and improves trust amongst service providers.
I. My involvement with the Situation Table has improved my understanding of acutely elevated risk.

As shown in Figure 4, respondents noted many positive aspects of their Situation Table's operations. Over 85% of members "strongly agreed" or "agreed" that theirs Situation Table had improved collaboration, increased interagency cooperation, built and improved trust, and had a positive effect on the sharing of both information and expertise, while over 80% felt that their Situation Table had produced an increased sense of shared responsibility. On a personal level, almost 90% of respondents argued that their Situation Table had improved their understanding of AER. In short, from the perspective of respondents, Situation Tables succeeded in fostering a more collaborative environment for addressing clients with AER.

The responses regarding accountability were somewhat less positive. While just over 70% agreed with the idea that their Situation Table created an environment of accountability, a significant minority (28 per cent) disagreed. Virtually the same results were found when members were asked whether their Situation Table held the respondent's organization accountable for bringing forward referrals, contributing to discussions, sharing information, volunteering to participate in interventions, and fulfilling their intervention commitments to Situation Table clients. More noticeably, 57% of members disagreed (some strongly) with the notion that their Situation Table made their organizations more accountable than they otherwise would have been if the Situation Table did not exist. On their face, these findings suggests that Situation Tables' records for promoting accountability may be somewhat mixed. But, taken together, these findings may also suggest that members felt that their organization was already sufficiently accountable, and that Situation Tables did not appreciably alter that reality. More work would be needed to further explain the precise nature of members' perceptions about the role of Situation Tables in fostering accountability.

FIGURE 4. MY SITUATION TABLE HAS ... (N = 44)

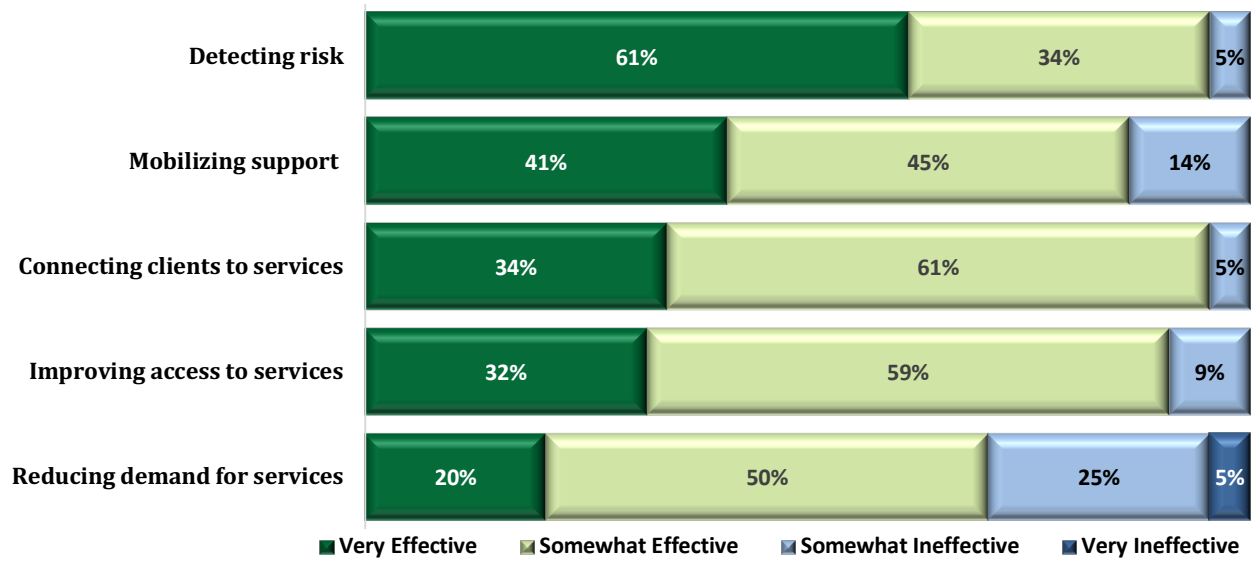


Members were also asked to judge the effectiveness of their Situation Table along the criteria of detecting risk, mobilizing support for an intervention, connecting clients to the services they required, improving overall client access to services, and reducing demand for emergency and police services. The results of these assessments are presented in Figure 5 and were generally very positive.

In total, 95% of respondents indicated that their Situation Table was "very" or at least "somewhat" effective in detecting risk and connecting clients to services. A very large proportion of respondents

(91 per cent) also considered their Situation Table to be effective at improving overall client access to services and a similar proportion (86 per cent) felt that their Situation Table was effective at mobilizing support for interventions. While a notable majority (70 per cent) also maintained that their Situation Table was effective at reducing demand for services, 30% of respondents disagreed with this conclusion. Considering the information provided by Situation Table Chairs, it is possible that some of these responses may reflect ambiguity in the wording of the questions. For example, it is possible that some respondents interpreted the phrase "demand for emergency and police services" at the citywide level, while others only considered the effect of this from the perspective of their clients. Similar to the comments made by Situation Table Chairs, it is also very possible that Situation Table members are not in a position to comment on the former, and it is possible that "ineffective" might actually mean "I don't know." In contrast, anecdotal evidence suggested that Situation Tables may reduce demand for service in relation to clients. More generally, given the highly individualized and personalized nature of Situation Table interventions, it may be inappropriate to frame overall Situation Table outcomes in terms of systemic effects. Conversely, members overwhelmingly argued that their Situation Table had aided in the timely identification of AER cases (91 per cent), been successful in decreasing AER (86 per cent), and contributed toward risk reduction in their communities (86 per cent).

FIGURE 5. HOW EFFECTIVE IS YOUR SITUATION TABLE AT ...? (N = 44)



THE BENEFITS AND CHALLENGES OF SITUATION TABLES

In the final section of the survey, respondents were asked several open-ended questions pertaining to their Situation Table. The most favorably commented-upon aspect of Situation Tables was how they encouraged cooperation and collaboration among agencies. Relatedly, in the view of respondents, the Situation Table model fostered interagency contacts and communication. Taken together, these positive features resulted in clients being better served through a multi-agency

approach that focused on reducing AER. The second theme consistently cited by numerous respondents pertained to the Situation Table meetings themselves. Although many respondents noted difficulties in holding meetings during the COVID-19 pandemic, which will be discussed in greater detail below, similar to the Chairs, respondents indicated that the consistency of meetings and the fact that many agencies regularly attended the Situation Table meetings constituted a measure of success. Additionally, several members specifically pointed to the efforts of the Chairs of their Situation Table as an integral part of this success, suggesting that the Chairs were adept at holding agencies responsible for participating in meetings and running effective sessions. Although it was not mentioned directly, the tone of the responses seemed to indicate that there was, in fact, a reciprocal relationship between the effectiveness of the meetings and the enhanced levels of cooperation and collaboration between agencies.

In contrast to these positive assessments, respondents' perceptions were more diverse about the challenges faced by Situation Tables. In other words, respondents identified many challenges, but, with one notable exception, these perceptions did not coalesce around particular themes in the same way. The notable exception, and the most often recurring challenge, was in relation to funding and lack of resources. In some cases, respondents referred to a general shortage of resources that contributed to a general lack of available services to provide solutions to clients. Of note, this type of comment was not directed at a particular agency but rather the notion that human and financial resources were not attached to the Situation Table model, so agencies might want to participate in the Situation Table, but there were no additional resources provided to those who did participate in the meetings or who joined intervention plans. Similarly, some respondents felt that there were too many people in the community with AER and not enough resources to help.

In other instances, respondents pointed to very specific resourcing challenges. Like the comments provided by Situation Table Chairs, the most common of these resourcing challenges was in relation to the critical shortfall in housing options across British Columbia. According to one respondent, even when a client was connected to a housing worker, that worker had no resources to house the client. In this way, AER may not be reduced, not due to a problem with the intervention plan or the outreach being provided by the Situation Table member, but the lack of resources available through BC housing or the approach taken by the municipality to address the housing crisis.

The difficulties posed by inadequate housing are such that some respondents suggested that Situation Tables should be engaged in trying to remedy the situation by directly challenging different levels of government to address critical gaps in resources identified in the community. While specific to certain Situation Tables, when asked about the existence of systemic barriers, several respondents pointed to the fact that BC Housing was not a standing member of the Situation Table. According to several respondents, and acknowledged by Situation Table Chairs, without access to housing and funds to support housing, many clients' AER were not being addressed adequately because housing was the primary risk factor driving AER. In this way, affordable and available housing was seen by many respondents as the biggest systemic barrier to the success of some Situation Tables.

Because housing is particularly difficult for individuals with drug addictions or serious mental health issues, a few respondents highlighted how housing problems produced other secondary

effects, such as the inappropriate use of treatment centres as housing options. It was felt by these respondents that this, in turn, caused friction between agencies that felt that their resources were being misused or used as a substitute for a lack of more appropriate resources. While Situation Tables are not going to solve the housing crisis in the communities they operate in, **it is important for the leadership or steering committee to discuss this type of challenge, develop solutions, and communicate options to Chairs so that appropriate intervention teams and strategies are developed in the Fourth Filter**.

A second area that presented considerable challenges for Situation Tables was mental health. Although insufficient resources and a shortage of mental health services was mentioned by several respondents, an even greater challenge was related to the issue of consent or voluntary versus involuntary mental health treatment. Connected to this issue were the policies and practices of various Health Authorities. Regarding the former, in some cases, it was viewed as important and necessary for service providers to address situations without the consent of the client. In effect, the inability to provide involuntary assistance hampered efforts to respond to AER quickly. Several respondents expressed concerns about the Health Authorities in their regions. In one example, a respondent took exception to the unwillingness of the Health Authority to invoke the parts of the *Mental Health Act* to get a person into acute treatment. Another respondent was critical of the assumption that people with serious mental health and addiction issues could navigate their way to the necessary and available supports. Again, these comments spoke of the need to have mental health and addictions service providers as members of the Situation Table. More importantly, it is critical that when these types of agencies are members of the Situation Table, they are empowered to share information, be part of the intervention team, and, when appropriate, to attend the 'door knock'. While Health Authorities might have a policy requiring clients to come to them directly to request assistance or access to services, AER clients might not be able to or aware that they need to identify themselves for mental health support. Instead, those involved in the Situation Table discussion could identify the need for mental health support for a client and have a partner volunteer to provide this assistance prior to the client self-identifying or approaching the Health Authority for assistance. In fact, this was one of the key benefits and purposes of Situation Tables. Clients did not have to go from agency to agency asking for support, but **the lead agency could create an intervention team from among Situation Table members to develop both a broad and more complete approach to reducing a client's AER quickly, including addressing mental health and/or addiction issues**.

Respondents from several Situation Tables expressed concern that their Situation Tables were not receiving enough referrals. In some instances, the lack of referrals was attributed to the unavailability of specific intervention options, most notably housing. Some members also attributed the low number of referrals to the effects of the COVID-19 pandemic. Structurally, concerns were also raised that the small number of referrals reflected an imbalance in who was bringing referrals to the Situation Table. Simply put, respondents argued that not all agencies were active in forwarding referrals. More broadly, some respondents were critical of agencies, including their own, who were not sufficiently invested in their Situation Table. This was often characterized as a lack of "buy-in" on the part of some agencies. Again, this is a possible role that members of the leadership or steering committee could serve. Without sufficient support or a mandate from agency

directors or senior management, those attending Situation Table meetings may feel little pressure, need, or support to provide or share information with other members, or to volunteer to be part of an intervention team.

Although cooperation and collaboration were noted by many respondents as a main positive aspect of Situation Tables, several respondents pointed to "siloing" or a lack of integration as a continuing problem for their Situation Table. For example, in response to a question about systemic barriers, one respondent identified a tendency to revert to traditional methods of intervention within their respective organizations rather than working collectively as part of a broader intervention team. Others traced ineffective outcomes to the fragmentation of services and how their Situation Table operated at the fourth stage of the Four Filter process. It was felt by some respondents that lead agencies were identified at this stage of the process, but there was rarely a secondary meeting with the lead agency and other agencies to coordinate a focused intervention plan. Instead, counter to the intended process of the fourth filter, each agency simply provided resources on their own after the Situation Table determined that the client was AER. It is important to note that, while these comments were clearly concerning, they did not characterize respondents' views on the whole.

The COVID-19 pandemic had several deleterious consequences for Situation Tables. While some of these have been identified and discussed above, the most notable effect, from the perspective of respondents, was related to Situation Table meetings. Simply put, many respondents commented on how much they were looking forward to returning to in-person meetings. Although, as noted earlier, many respondents offered praise for their Chairs in how they were able to run effective meetings, there was a general sentiment that in-person meetings were better, especially in the areas of Situation Table member communication, network building, and maintaining connections between members. However, the effects of the COVID-19 pandemic extended beyond the meetings themselves. As outlined earlier, there were concerns that the pandemic was also at least partially responsible for the reduction in referrals being made to Situation Tables. Respondents also felt that the COVID-19 pandemic was also partially responsible for operational challenges, including reduced capacity to provide interventions, the ability to meet with clients in person, a requirement to only provide on-line services, which might not be the best option for certain types of interventions, challenges with service accessibility for clients, and limited outreach capacity for agencies and service providers. It was not stated directly, but there seemed to be a pervasive feeling that things would get better when the restrictions related to the COVID-19 pandemic shifted to allow Situation Tables to function in the way they were originally envisioned.

There were a handful of other issues that were identified by respondents. In terms of main challenges, if a Situation Table member was not part of the intervention team, they rarely heard about the outcome of a client, other than perhaps that the file was closed. Moreover, there was no update provided on the longer-term outcomes for clients. Moreover, as mentioned above, there was some degree of concern that important stakeholders or service providers were not always present at Situation Table meetings. As expected, there was also some concern over privacy issues and, therefore, some agency representatives not fully participating in meetings by sharing information.

In terms of things that respondents believed their Situation Table should stop doing, the two main themes were discussing cases and sharing individual, personal information with everyone at the

Situation Table, rather than just when appropriate, as outlined in the Four Filter process. The other theme was members referring cases knowing that there were no services available to connect the client too. Again, these concerns did not reflect the views of many respondents, but they were, nonetheless, worthy of mention because a few respondents felt strongly enough about these issues to mention them directly.

It was interesting to note that the most common response to the question of "what should your Situation Table start doing?" was to address existing problems. However, the challenge with this is that many of most pressing problems for Situation Tables are beyond their purview. The overall lack of systemic resources, broader concerns about housing availability, the rules around mental health interdictions, and the challenges wrought by the COVID-19 pandemic are all significant difficulties that Situation Tables are powerless to address. While Situation Tables' Chairs and leadership or steering committees could, as a few respondents suggested, attempt to advocate for greater resources or try to cajole reluctant agencies and community service providers to participate with Situation Tables, these activities fall outside of the Situation Table's mandate.

Still, from the perspective of respondents, there were areas where Situation Tables could continue to grow and improve. One area relates to the diversity of Situation Tables. For example, various respondents argued for greater awareness around barriers and challenges facing those from the BIPOC and LGBTQ2S+ communities, more services for seniors, especially those with drug addiction, mental health, or chronic physical health issues, more services for women, and more services for those with physical disabilities. It was also suggested that Situation Table intervention teams needed to increase their ability to function in languages other than English. More generally, several respondents commented that Situation Tables needed to ensure that service providers were well versed in practicing trauma- informed care.

Another area identified by respondents was centered around training. Specifically, respondents argued that more opportunities for training were required, especially for those who may have missed the initial training sessions. Respondents also suggested ongoing or refresher training. As stated above, while most members expressed satisfaction with the content of their initial training, it appears that the dynamic nature and complexity of the environments within which Situation Tables must operate required at least annual training.

Finally, a few respondents commented on **the need for Situation Tables to be more proactive in seeking out opportunities for growth**. For example, Situation Tables could actively search for new organizations or agencies that worked with young people and their families to join the Situation Table. More generally, some respondents maintained that Situation Tables needed to have a strategic plan for growth, training, and opportunities in place and to allocate appropriate resources to achieve the plan. While there were several issues that Situation Tables needed to confront and solve, it was probably fair to argue that Situation Tables have moved beyond their infancy stage in British Columbia. To that end, respondents believed that their Situation Tables no longer needed to function in "survival mode" but should think about and plan for how they will continue to develop, grow, and evolve.

Recommendations

This report identified several benefits and challenges associated with the implementation of Situation Tables in British Columbia. The interviews with Situation Table Chairs and the survey with Situation Table members identified that there were several consistent themes related to organizational structure, process, procedures, and outcomes of Situation Tables. As a result, the recommendations presented below are focused on how to improve the operation of Situation Tables and to ensure that they operate effectively and efficiently. While there were several suggestions highlighted throughout this report, this section focuses on several key recommendations.

1. ALL SITUATION TABLES SHOULD HAVE A LEADERSHIP OR STEERING COMMITTEE

As there are several valuable roles that a leadership or steering committee could serve, it is recommended that every Situation Table have one, regardless of the size of the Situation Table. Moreover, it is also recommended that every agency or service provider that is represented at the Situation Table as a standing member should have a member serve on the leadership or steering committee. It is important that each person who serves on the leadership or steering committee has the authority and support to commit their agency or organization to the mission and purpose of the Situation Table, the privacy and confidentiality agreements that Situation Tables have in place, and to participating in interventions when appropriate. With this in place, leadership or steering committees should receive annual or semi-annual reports from the Situation Table Chair to assess the operation of the Situation Table. These reports should contain information on the number of referrals made and accepted by the Situation Table, which agencies or service providers are making referrals, the types of risk factors that clients present with, which organizations or service providers are participating in interventions, the attendance report of standing members, any gaps in needed agencies or service providers to participate with the Situation Table, and any challenges that Chairs are facing to ensure the effective and efficient operation of the Situation Table.

Given some of the concerns raised throughout this report, an important role for the leadership or steering committee should be to address inconsistent attendance or participation at Situation Table meetings by their representative, especially when this is due to scheduling conflicts; any confusion that Situation Table members might have about how their agency and the Situation Table interface when it comes to information sharing, confidentiality, and participating in interventions; ensuring that their representative at Situation Table meetings is well informed about the resources, capabilities, and services of their home agency so they can volunteer to contribute to an intervention when appropriate; that their Situation Table representative is provided with the necessary time and resources to be well trained on the Situation Table model and the assessment of AER; and that frontline workers who will be doing the intervention work on behalf of their agency are well supported and resourced so that interventions can occur in a timely fashion.

Another important role for the leadership and steering committee members is to serve as an external and internal ambassador for the Situation Table. This role can be very helpful in securing

the support of local and provincial governments, as well as recruiting other agencies or service providers to join the Situation Table to address possible gaps in the types of interventions that the Situation Table can provide to clients. As important as getting other needed agencies or service providers to join the Situation Table, leadership or steering committee members should also ensure that the existence of the Situation Table is well known within their own agencies so that those working in the agency understand that they can speak to their representative to make referrals and that working within the Situation Table model, when appropriate, is expected. Finally, the leadership or steering committee should play the role as mitigator between the Situation Table Chair and its members. While most Chairs did not report many instances of conflict or tension between members or between a member and the Chair, it is useful to have a body where the Chair can discuss their concerns, and a body that can focus on ensuring that the Situation Table fulfills its mandate, continues to be helpful to the community, and improves agency collaboration, information sharing, and cooperation.

2. THE TRAINING OF SITUATION TABLE MEMBERS

As outlined throughout this report, one of the most consistent concerns among Situation Table Chairs was the amount of training that new members received and the lack of ongoing or refresher training for members who have served on a Situation Table for some time. While most Chairs spoke positively about the training they received from Global Community Safety and the online training provided through Sir Wilfred Laurier University, the authors of this report did not have an opportunity to review or evaluate these training programs. As such, rather than endorsing one training approach or another, it is recommended that formal training should occur for all new members before joining a Situation Table. Moreover, ongoing training should occur for all standing members of a Situation Table on an annual basis. However, in terms of the structure of training, it appears that online training might be suitable for increasing one's understanding of the Situation Table model and the Four Filter process; however, in-person training might be more beneficial for things like conducting the 'door knock' and working through mock scenarios. Still, given the importance of both initial training and refresher training, it is likely cost effective and time effective to offer some degree of flexibility in training.

To this end, ongoing training could be limited to a half-day or full day of training that focuses on the latest methods and tools of assessing AER, the latest research on successful intervention strategies for different clusters of risk factors, the particular or specific rules and procedures of the Situation Table in terms of each of the four filters and how to present a referral, and how to build and deliver a collaborative intervention plan. Perhaps the two most important areas that the annual training for all members should focus on are how to conduct a successful 'door knock' and how to work within the privacy and confidentiality rules of the province, one's home agency, and the Situation Table. With respect to the 'door knock', in addition to training on who should conduct the 'door knock', how to ensure the safety of the client and the service provider, and what are the most effective ways of conducting a 'door knock' so that the experience is positive for the client, training should also include a focus on trauma-informed practices. With respect to having initial and ongoing training on privacy and confidentiality protocols, emphasis should be placed on making sure that all

Situation Table members are aware of what needs to be shared and at which stage of the Four Filter process different types of information can be shared. This is important because without Situation Table members knowing what they can share and at which stage, it is very possible that some medical, financial, educational, mental health, public safety, and other relevant information is not being shared, when this information could be shared and would result in a better intervention plan for the client. Connecting to the previous recommendation, the leadership or steering committee could resolve any privacy, confidentiality, or information sharing issues so that all Situation Table members were fully aware of the protocols in place and what and when they can share their information with other Situation Table members.

While it can be difficult to schedule training sessions for everyone to attend, especially for larger Situation Tables, Chairs could experiment with learning sessions that occur immediately following a Situation Table meeting. This could also occur during those meeting where there are no new referrals. In addition to the issues outlined above, and a decision about the utility of in-person versus online training, these sessions could also be used as opportunities for Situation Table members to enhance their knowledge base about other agencies and service provides, and to create and expand members' awareness of other resources and services that might be available in the community or in other jurisdictions that can serve clients better. In effect, when possible, Chairs should set aside time for Situation Table members to provide updates or changes related to their agencies or areas of expertise for the benefit of all members.

3. VIRTUAL VERSUS IN-PERSON SITUATION TABLE MEETINGS

As a result of the COVID-19 pandemic and the various health mandates that were put in place in British Columbia, agencies and organizations shifted their in-person meetings to virtual platforms, such as Microsoft Teams and Zoom. Moreover, other common practices, policies, and procedures that involved face-to-face interactions between people were also shifted to an online environment. Many agencies found a range of efficiencies in moving some of their professional practices online, including meetings. To be compliant with health mandates, Situation Tables also shifted their meetings to an online environment. While some Chairs and members reported that they saved time because they did not have to travel to the location of the Situation Table meeting and did not linger there after meetings to discuss professional and personal matters, it is not recommended that Situation Table continue to meet virtually once the health mandates have been lifted. While some aspects of Situation Table meetings can be conducted efficiently through video conferencing technology, there are practical and intangible benefits associated with holding meetings in person. Building and maintaining trust was reported as an important aspect of a successful Situation Table and this can be difficult to achieve when members are meeting over the phone of through video conferencing. There may also be concerns related to sharing confidential information, as well as privacy concerns, when meeting over the phone or virtually. Therefore, it is recommended that as soon as practical to ensure the health and safety of all members, Situation Table meetings occur in person. Until such time, it is recommended that Situation Table meetings use video conferencing solutions rather than just speaking over the phone so that members can see each other, which should contribute to maintaining familiarity, comfort, and trust among members.

4. AD HOC SITUATION TABLE MEETINGS

While none of the Chairs or respondents suggested that this was a problem, Situation Tables might consider establishing a protocol for instances where a member has a client who might be at AER, but the next Situation Table meeting is not scheduled to occur for several days. When asked about this type of scenario, there were several different approaches taken. Some Chairs indicated that they did not have a formal process in place but that they might try to connect the member with others who the Chair believed would be best to address the potential client's needs. In other words, the Chair and the member would ask members who might be supportive at the Four Filter stage, rather than reaching out to the entire Situation Table. At the next Situation Table, the Chair would brief the other members to notify those who were not directly involved. It was interesting to note that some Situation Tables felt that the entire membership of the Situation Table was needed for deciding AER and accepting a referral, therefore, they preferred to have a full meeting rather than doing something ad hoc; others reported that members would reach out to other agencies based on their own established networks and would not call the Chair to arrange an ad hoc meeting. Another approach was for the Chair to send an e-mail out to the membership to determine who might volunteer to assist, and other Chairs stated that they would call an ad hoc meeting.

While it is not necessary for all Situation Tables in British Columbia to adopt the same practices for dealing with this type of scenario, there is a need for each Situation Table to consider the balance between the concerns of the member who has a potentially AER client with the purpose and integrity of the Situation Table. It is recommended that Chairs consult with their leadership or steering committee, if they have one, to discuss this possible scenario and seek advice; however, whatever process each Situation Table ultimately decides to adopt, the process should be communicated clearly to all Situation Table members to maintain trust between members and to avoid some members feeling as if others may be bypassing the mandate, structure, and procedures of the Situation Table. If the process selected does not involve the entire Situation Table going through the Four Filter process, it is strongly recommended that the lead agency and the Chair inform Situation Table members at the next meeting of what occurred and which agencies engaged with the client.

5. SITUATION TABLE MEMBER'S PARTICIPATION IN DELIVERING INTERVENTIONS

While the decision to participate in the delivery of interventions for Situation Table members is based on several factors, primary among them should be the ability of the member and their agency or organization to assist in addressing the risk factors that were contributing to AER in clients. Moreover, it is extremely important that there are representatives from agencies that have the resources, expertise, mandate, and experience in addressing the risk factors that clients present with, such as addictions, mental health, and housing issues. However, Situation Tables can only function if there is a tacit understanding that members of Situation Tables will volunteer to be part of the Four Filter process and deliver interventions, when appropriate. However, some Chairs and members who responded to the survey reported that it was not always that case that agencies with expertise addressing a particular risk factor volunteered to join the intervention team and deliver timely interventions. Therefore, it is recommended that Chairs ensure that all members understand

that participation with a Situation Table comes with joining intervention teams, when appropriate. In effect, an agency agreeing to join a Situation Table should understand that this comes with a commitment to share information and to participate in the delivery of interventions. Given the mandate and purpose of Situation Tables, this agreement must also include a commitment to connecting clients to services within 48 hours of the initial 'door knock' and the 'door knock' should always occur within 48 hours of the Situation Table meeting, with consideration for challenges or situations that are outside the capabilities of the lead agency or the intervention team, such as an inability to locate the client. If an agency is not able or unwilling to make this type of commitment, the Chair in consultation with the leadership or steering committee should consider reassigning the agency from a standing member to a buddy agency.

6. THE RISK TRACKING DATABASE

Chairs were clear that the risk tracking database was useful for tracking information that could be used for very basic analyses on the number and nature of referrals made to the Situation Table, what were the most common risk factors, and which agencies or service providers were involved in delivering interventions. However, Chairs also identified several limitations to the database that hindered record keeping and analyses of the information. For example, to protect the privacy of clients, identifiable information was purged from the system once a case was closed. This made it difficult to link the interventions used in the past for return or repeat clients and it also make it difficult for Situation Table members to obtain information related to which interventions were considered successful. The current form of the risk tracking database also did not include contextual information related to each risk factor. Instead, it just recorded whether there was consensus among Situation Table members that a client's AER was related or associated to the specific risk factors included in the database.

To address these concerns, it is recommended that Chairs work with those who have expertise in developing databases to make it easier to add risk factors to the risk tracking database to provide a more accurate profile of each client. Similarly, given the addition and removal of agencies and service providers to the Situation Table, it should be made easier for Situation Table recorders to add or remove agencies from the risk tracking database. Moreover, the risk tracking database should include a drop-down menu for things like criminal offence or diagnosed mental disorders. It is also recommended that a column be added next to each risk factor to allow the recorder to include contextual information about identified risk factors, without including any identifiable information that could violate client's privacy or agency confidentiality. To provide a clearer picture of the work done by Situation Table members, the risk tracking database could also record information about ad hoc meetings and when agencies had conversations with others around the Situation Table that resulted in informal interventions that were not directly part of the work of the Situation Table but occurred because people were part of the Situation Table.

7. SUCCESSION PLANNING FOR SITUATION TABLE CHAIRS AND MEMBERS

Some Chairs expressed the concern that the continuation of their Situation Table might be too dependent on the personality and passion of the Chair. As with all programs, it is important that the existence or operation of a Situation Table be based on the force of will of one person. Moreover, as it is not uncommon for people to be promoted, change responsibilities, or leave their place of work, it is important that each Situation Table have a succession plan in place. Still, the duties and responsibilities of the Chair are such that not everyone would be well suited to serve in this role. As outlined throughout this report, the chair plays an important role in getting people to attend and participate in Situation Table meetings, the Chair is critical in creating an environment where members are comfortable bringing referrals, sharing information, and volunteering in interventions, and the Chair must resolve conflicts between members and between agencies and the Situation Table. Moreover, and equally important, Chairs are cheerleaders while also having the ability, skill, and authority to hold members and agencies accountable to the Situation Table.

As recommended in various places throughout this report, it is critical that Situation Tables have a strategic plan in place for growth, which should include Chair succession planning. One good step in this direction is for all Situation Tables to have a co-chair that could move into the position of Chair if a current Chair left their position. Similarly, Situation Table members should assign an alternate who could sit at the Situation Table to gain experience about the Situation Table's procedures, protocols, practices, and processes so that there is as little interruption in an agency's participation if their representative is no longer able to serve on the Situation Table. This could also serve to mitigate delays in getting a new person formally trained as they would have some experience with the Situation Table.

As is the practice in all Situation Tables in British Columbia, it is also recommended that Chairs continue to not have a role in interventions. It is important for Chairs to remain neutral and to act as a convener, rather than being part of the intervention team responsible for making changes in the lives of clients and their families. While police officers are the most frequent service providers making referrals and very frequently a member of the intervention team, it would likely be best if a police officer was not the Chair of a Situation Table. Another reason for this is that it removes the stigma of Situation Tables being another community-based program established by and under the authority of the police that will only exist as long as the police remain responsible for the operation of the program.

8. OPPORTUNITIES FOR SITUATION TABLES

The existence of a Situation Table provides many opportunities to its members and the communities served by the Situation Table. In addition to being a one-stop-shop to address AER among clients that have risk factors that exceed the mandate or resources of one or two agencies, Situation Tables provide an economy of scale advantage that cannot be matched by the siloed delivery of interventions. Having all members consider the risk factors of clients, assess these risk factors for AER, and ask questions of those presenting the case increases the chances that important issues, concerns, or risk factors are not missed when developing an intervention team

and intervention strategy. Moreover, having many agencies or service providers members of a Situation Table should make it much easier for clients to receive the services and resources they need in a timely fashion. The commitment of municipal and provincial governments, as well as agencies and service providers, to the Situation Table also could also provide the necessary leverage and influence to engage new partners in areas of vulnerability that are not represented already by the Situation Table.

Presenting the profile of past and current clients could also be influential in getting agencies or organizations that are not part of the Situation Table to join. For example, empirically demonstrating the proportion of AER clients with housing concerns might be instrumental in getting BC Housing to be a standing member of every Situation Table. While the authors of this report understand the privacy issues that contributed to BC Housing not participating with some Situation Tables, perhaps there might be emerging opportunities to re-engage with BC Housing to develop workable privacy protocols and to address other concerns when data is presented demonstrating the valuable contributions that BC Housing, among other agencies and service providers, can make to reduce AER and contribute to the wellbeing of communities.

Moreover, Situation Table Chairs are encouraged to disseminate information about the existence, purpose, and operation of their Situation Table to the public to engage and inform the community about how the Situation Table can assist community members in need. The more that the community, agencies, and service providers are aware of the existence of Situation Table and their contributions to public safety and wellbeing, it is likely that the number of referrals will increase. It was good to hear that Situation Table Chairs were approached by others about implementing the Situation Table model and to serve as a resource to other Situation Tables. While this is occurring to some degree, **it is recommended that Situation Table Chairs meet at least annually** to share information not just related to the volume and nature of referrals and how they overcame specific challenges, but also to share information about successful interventions and emerging risk factors trends. In other words, the existence of Situation Tables around British Columbia provides an opportunity to share information about social indicators of AER regionally and across the province.

Finally, in addition to reviews of Situation Tables, such as this report, every Situation Table should provide opportunities for critical feedback from Situation Table members and service providers about the process, procedures, and practices of Situation Tables based on their professional experience. Moreover, each Situation Table should implement an annual evaluation clients could complete to help improve the operation of the Situation Table, particularly around the impact of Situation Table interventions on clients.

9. MEASURES OF SUCCESS

As mentioned above, while not the same for all Situation Tables in British Columbia, in general, there is a lack of empirical data and analysis on the effects of Situation Tables on clients and how well Situation Tables achieve the goals of increasing interagency information sharing, collaboration, and cooperation. Despite gathering important information about the processes associated with Situation Tables, there is a growing need for more systematic, multi-site evaluations to uncover

what is working well and what requires improvement, in what contexts the Situation Table model is proving effective or ineffective and why, and whether the Situation Table model is cost-effective. In other words, is there evidence of the model's success and efficacy in terms of client and system impacts? It is important for Situation Tables to be able to demonstrate that individual client risks are being lowered, how AER is being lowered, how risk reduction contributes to improvements in public safety and community wellness, and, in what ways Situation Tables contribute to an overall reduction of risk in the community. Answering these types of questions requires tracking certain activities and outcomes over time, and completing rigorous, in-depth outcome, impact, summative, and economic evaluations. Given this, it is recommended that evaluations should continue to be conducted on Situation Tables that focus on tracking service usage, barriers to interventions, and user outcomes, as this may deepen our understanding of how well these multisystem, collaborative risk-management approaches affect client and community safety and well-being.

However, it is important to keep in mind that there are several challenges associated with conducting this type of research on Situation Tables. Given their unique structures, Situation Tables are not considered to be conducive to Random Control Trial (RCT) evaluations that have become the gold standard for evidence-based evaluations (Taylor, 2021). Because of the types of cases Situation Tables are designed to capture and address, developing control group studies would be both impossible and unethical (Taylor, 2021). AER situations cannot be identified in advance of their becoming AER. Moreover, once cases are identified as AER status, they require an immediate response. Delays in the process created by the need to find a suitable comparative sample would remove the benefit of the immediate, collaborative Situation Table response (Taylor, 2021). Furthermore, due to the limited information sharing across sectors (need-to-know basis) and that Situation Table's actors are required to operate within their own sector's ethical framework, conducting RCT-type evaluations of the processes and outcomes at different stages of the care path may pose a risk of violating the carefully crafted privacy provisions of the Situation Tables (Taylor, 2021).

Obtaining sufficient data to complete rigorous evaluations of all components of the Situation Table model is yet another challenge. This is especially true in relation to obtaining client feedback. Although it is widely recognized that gaining a better understanding of the effects of the collaborative risk-driven intervention on clients and their families from their own perspective would provide invaluable insight into the strengths and limitations of this model (Nilson, 2016b), due to a variety of barriers associated with accessing clients, obtaining information directly from Situation Table clients remains a challenge for researchers or evaluators. For example, due to privacy concerns and limited information shared amongst Situation Table agencies, obtaining information about clients requires addressing several research ethics and privacy-related issues (Newberry & Brown, 2017). Identifying and contacting clients, can, therefore, be a lengthy and tedious endeavour. Furthermore, even if clients can be identified, it is challenging to contact many of the clients, as they may be transient and difficult to locate (Newberry & Brown, 2017). Obtaining consent to participate as research subjects is yet another hurdle, as individuals may outright decline to participate, or consent but fail to follow-through with their participation (Newberry & Brown, 2017). Moreover, there is the concern that some clients may refuse to participate with

interventions if they were informed at the outset that they will also be requested to participate in an evaluation. There may also be concerns about reaching out to clients as they may be in a vulnerable position (e.g., experiencing too much difficulty, vulnerability, or a disability). Being unfamiliar, threatening, or confusing, the research process may serve to damage clients' trust in and rapport with service providers (Newberry & Brown, 2017). Thus, accessing and obtaining client feedback (via interviews or surveys) remains an obstacle and an issue that must be considered seriously prior to implementing any evaluation involving the participation of Situation Table clients.

Conclusion

This review of Situation Tables in British Columbia focused on the perspectives of Situation Table Chairs and a sample of Situation Table members to identify common themes on several substantive issues related to the mandate, structure, and operation of Situation Tables. In reviewing and interpreting the information presented in this report, it is important to keep in mind that Situation Tables are not programs, but rather informal collaborations of organizations, agencies, and service providers. They are designed to mobilize services in situations of AER to reduce risk quickly. Given this, when considering the implementation of a Situation Table and how to define success, it can be challenging to demonstrate some of the key components of the Situation Table model, including the validity of how AER is assessed by individual Situation Tables, the degree of collaboration, cooperation, and information sharing that occurs at Situation Table meetings, and the short- and long-term effects of the intervention strategy. Still, from the perspective of those Chairing and participating in Situation Table meetings, while there are several issues that require the attention of those responsible for improving the operation and functioning of Situation Tables, these people should also focus on opportunities to expand the reach of Situation Tables, increase the membership of Situation Tables through the addition of needed service providers and agencies, and develop intervention strategies to address current and emerging trends in the profile of AER among community members and their families to enhance the lives of clients, as well as contributing to public safety and wellbeing.

Given the various caveats presented above with respect to evaluating Situation Tables, assessing the Situation Table model requires a novel approach to evaluation. New questions, new measures, new data sources, and methods of analysis must be considered to create an effective evaluation framework. Nilson (2014) suggested several starting points for developing this framework, including: (1) identifying the leading practices in the community mobilization process and the types of conditions, criteria, and assets required to enable a Situation Table to function properly; (2) determining what data can be collected to improve the consistency in Situation Table model practices; (3) asking questions pertaining to how the Situation Table model effects client satisfaction with interventions and connections to services (e.g., speed and extent); and (4) determining how to assess what effect the Situation Table model has on long-term community safety and wellness. Future research should focus on working with Situation Tables, and municipal and provincial governments to develop these type of evaluation measures and tools to address these issues.

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