



Social Navigator Program (SNP) & Rapid Intervention & Support Team (RIST)

High
Enforcement

Numerous Arrests

Identify
Repeat
Offenders

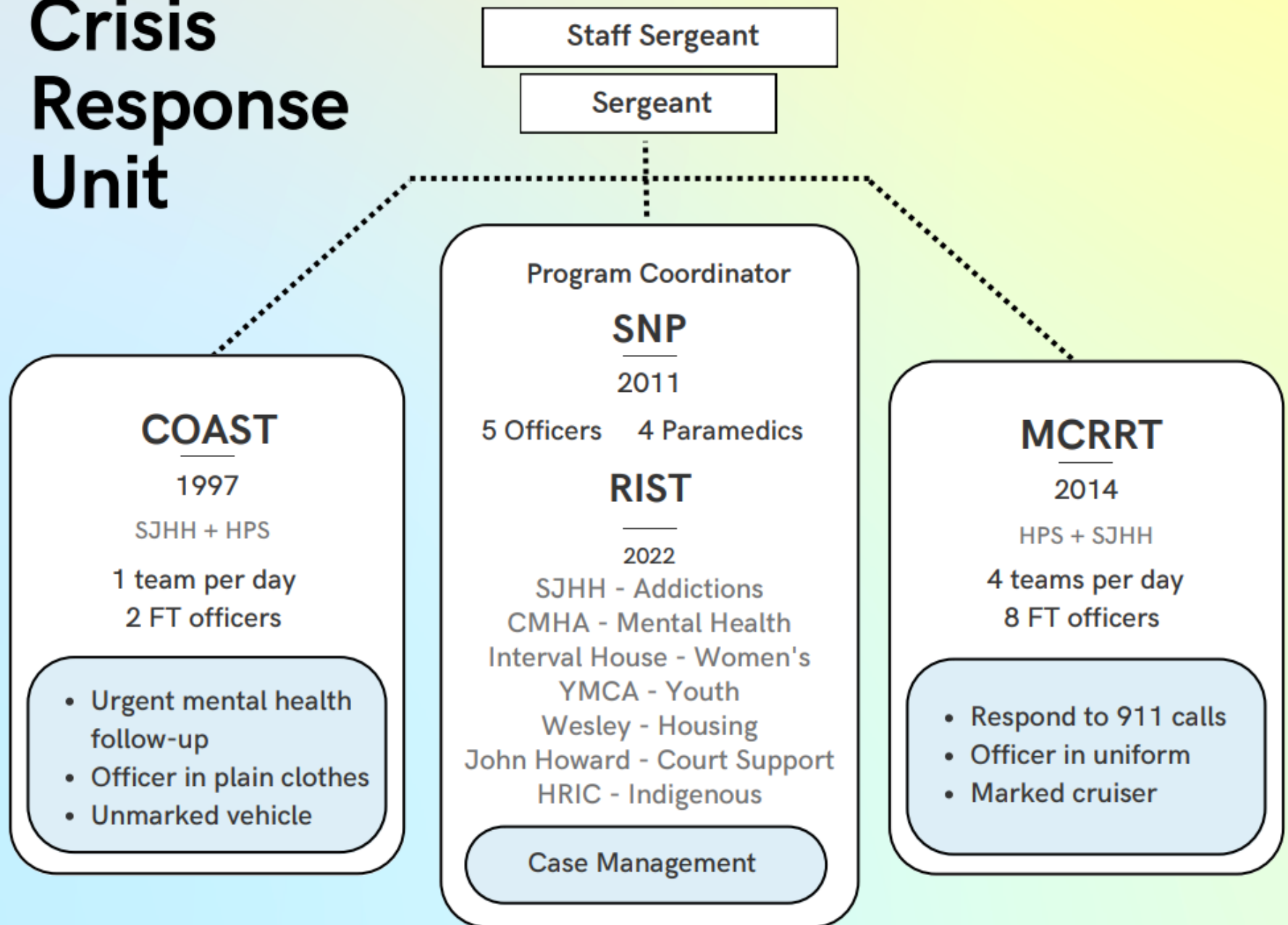


Introduce
the Social
Navigator
Program



- 2015

Crisis Response Unit



SNP Goals

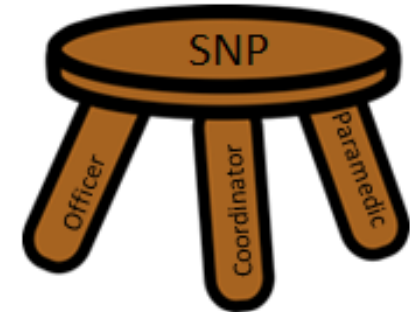


- Connect and support individuals through a referral process, by engaging all social and healthcare agencies in the City of Hamilton.
- Reduce reliance on the judicial and healthcare system by navigating our clients towards the appropriate agency while improving the health, safety, and quality of life for all citizens.

SNP Team Roles & Advantages

Paramedic (Health Care)

- Mobile and visible in the community
- Medical knowledge
- Positive public perception
- 4 fulltime paramedics Mon- Sun 7am-7pm



SNP Officer (Justice System)

- Knowledge of the criminal justice system
- Focus on public safety especially when dealing with court mandated clients
- Companies the team for individuals with a history of violence (enhance team safety)
- 5 SNP Officers (2 youth); Mon-Sun 8am-6pm

Program Coordinator (Community Social Services)

- Coordination, organization, client follow-up and administration

Referral Criteria

- Repeat police interaction
- Repeat use of ambulance services
- Mental Health concerns
- Addiction
- Homeless or at-risk of becoming homeless
- Lacking primary care
- Someone who asks for help



Who can refer?

- Officers
- Paramedics
- Community referrals
 - Can assist if an urgent need is expressed and all other options have been exhausted

Program Need

 **40%**

	2016	2017	2018	2019	2020	2021	2022
Number of referrals	208	244	264	283	479	506	400
Number of referrals made by SNP	231	203	208	241	334	467	457
Total Contacts (unique individuals)	n/a	257	312	406	589	908	832

- In 2022 interacted with an average of **215 ppl** per month

Services Provided

Examples:

- Transports
- Snacks/Water, Clothing and Footwear
- Warming and Cooling Supplies
- Hygiene products
- Wound Care
- Medication Assistance
- Replace Health cards
- Narcan and harm reduction
- Complete various paperwork
- Court support (get disclosure)
- Guarantor for birth certificate
- Relayed information from worker
- Direct to services



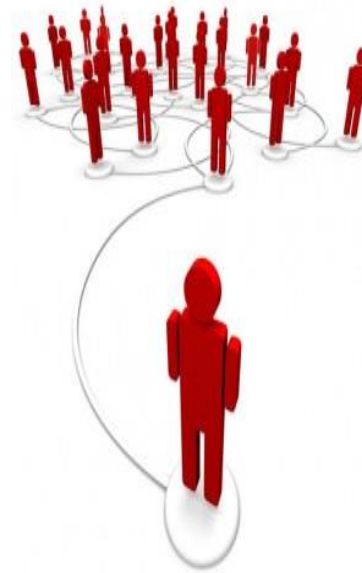
Challenges

- Attending appointments is not their priority (focus=survival)
- Struggle with keeping track of appointments
- Lack of transportation (no money for bus)
- Hard to reach (inconsistent access to phones, change locations)
- Waitlists
- Communication methods (youth= texting)
- Not enough outreach and services are not flexible
- Expectations too high (give pamphlet and expect them to find their way)
- Complex needs (cross over sectors); what comes first mental health or addiction?
- Trauma- little services



What we do

- **Refer** clients to services in the community
- Offer an urgent social response
 - **Advocate** for services
 - **Assist** through court process
 - Supervise court mandated clients
 - **Transport** clients to important appointments
 - Provide case management
 - **Coordinate care** (part of circle of care)



Outcomes

Between 2016-2020, on average **61%** of SNP clients had a decrease in negative police interactions 3 months after SNP involvement



COVID Lockdowns & Encampments

Made us rethink the needs in our community and search for better solutions

--Community Safety and Policing Grant --



-first 3 months of COVID focus was providing food and water

-In 2021 estimated 190 active encampments across City



- An extension of the Social Navigator Program
- A multi-disciplinary outreach team of experts from the community who work together daily in a team led setting to provide resources and support to the most complex and marginalized individuals in Hamilton

Pilot started summer of 2022

- 2 Housing Navigators- Wesley
- Addiction Navigator- St.Joes
- Mental Health Navigator- CMHA
- Women's Navigator- Interval House
- Indigenous Navigator- HRIC
- Concurrent Disorder Navigator-St.Joes
- Youth Navigator- YMCA
- Court Liaison Worker- JHS



Approach

Combination of:

- System navigation
- Outreach
- Case management

- Low barrier supports

RIST workers now attending drop in centres

- Provide rapid follow up supports vs client sitting on waitlists
- Proactive visits- opportunities for positive interactions
- Attempt to review referral within 3-5 days and follow up within 1 week of reviewing the referral (if deemed as high priority)

[Play RIST video \(1\) RIST- Rapid Intervention Support Team - YouTube](#)



Conclusion

- Offer an urgent social response (holistic approach)
 - Wrap around services
 - Outreach
 - Building positive relationships
- Focus on engagement and outreach
- RIST= more timely access to diverse supports
 - Team supports each other with complex clients
- Client appreciate having low barrier access to supports



Questions



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