# WINNIPEG COMMUNITY CRISIS RESPONSE (WCCR) MODEL

HEALTHY PEOPLE

STRONG COMMUNITIES

SAFER WINNIPEG


Prepared for
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Special thanks are extended to the individuals with lived experience of crisis, as well as their families and caregivers, whose stories and insights ensured this work remained grounded in the realities faced by those navigating crisis. Their contributions reinforced the importance of person-centred, accessible, and responsive supports.

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Special recognition is extended to the Winnipeg Police Service and Winnipeg Fire Paramedic Service for their openness, expertise, and commitment to collaboration. Their contributions helped ensure the proposed model reflects operational realities and opportunities for greater system integration.

Finally, sincere appreciation is extended to Mayor Scott Gillingham and the Mayor's Office for their leadership, trust, and commitment to exploring new approaches to crisis response. Their support created the opportunity for partners from across sectors to come together around a shared vision for strengthening crisis response in Winnipeg.

This report reflects the collective commitment of many individuals and organizations working to improve outcomes for people in crisis. It is hoped that the relationships and momentum generated through this work will help advance a more coordinated, responsive, and person-centred approach to crisis response in Winnipeg.

# EXECUTIVE SUMMARY



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## Why This Matters

Winnipeg's emergency services are increasingly responding to individuals experiencing mental health challenges, substance use concerns, emotional distress, wellness-related issues, and other non-emergent crises. While police, fire, and paramedic services are critical components of Winnipeg's emergency response system, many crises do not require enforcement, emergency medical intervention, or other emergency services and may be more effectively addressed through community-based intervention.

Preliminary analysis conducted as part of this project identified approximately 3,855 Winnipeg Police Service calls and more than 6,300 Winnipeg Fire Paramedic Service calls (annually), that may be appropriate for diversion to a community-based crisis. At the same time, emergency departments continue to experience significant volumes of crisis-related presentations. Together, these pressures highlight an opportunity to better align individuals in crisis with the most appropriate response while strengthening coordination across the broader crisis response system.

## Key Findings

A consistent finding emerged throughout the project: Winnipeg's primary challenge is not the absence of services, but the limited integration and formal pathways connecting existing services and systems. Individuals experiencing crisis often encounter difficulties navigating available supports and frequently access assistance through emergency services, even when a community-based response may be more appropriate.

The review also found that jurisdictions across Canada and internationally are increasingly implementing community-based crisis response models that operate alongside traditional emergency services and provide additional response options for non-emergent crises. These models have demonstrated that appropriate call diversion and community-based responses can improve outcomes for individuals while reducing pressure on emergency and healthcare systems. The findings suggest that Winnipeg has an opportunity to build on proven approaches and lessons learned from other jurisdictions and take the next step toward a more coordinated and effective crisis response system.

While the review identified opportunities to strengthen broader crisis system coordination over time, the primary opportunity for immediate action is the creation of a Fourth Crisis Response Pathway that enables appropriate 911 calls to be diverted to community-based crisis responders.

# EXECUTIVE SUMMARY

## Recommended Direction

This report recommends implementation of a Fourth Crisis Response Pathway as the next step in strengthening crisis response in Winnipeg. The proposed Winnipeg Community Crisis Response (WCCR) provides the framework through which this pathway can be implemented while establishing the foundation for broader system coordination and integration over time.

The proposed WCCR establishes a coordinated, community-based crisis response system that operates alongside police, fire, and paramedic services. Its purpose is to ensure individuals receive the right response, from the right provider, at the right time.

The model is built on four core components:

**1. Access Pathways** that provide multiple entry points to crisis response services. The model begins with a Fourth Crisis Response Pathway that enables appropriate 911 calls to be diverted to community-based responders and, over time, expands to include additional community-based access pathways.

**2. A Community Crisis Dispatch and Coordination Hub** responsible for receiving dispatch requests, matching needs to the appropriate response, dispatching and coordinating services, monitoring active responses, and supporting system-wide coordination.

**3. Designated Community Crisis Response Teams** delivered through community-based partners and equipped to provide mobile, person-centred crisis intervention and support.

**4. Post-Crisis Follow-Up and Connection to Community Supports** that help individuals access ongoing services, strengthen recovery and resilience, address underlying needs, and reduce the likelihood of future crises.

Together, these four foundational components support a coordinated "**From Call to Care**" approach that connects people in crisis to the right support at the right time.

Implementation of the WCCR is expected to:

- Improve access to timely and appropriate crisis support.
- Expand community-based response options for non-emergent crises.
- Strengthen coordination across emergency, health, and community systems.
- Improve continuity of care and connection to ongoing services.
- Reduce unnecessary reliance on emergency services.

# EXECUTIVE SUMMARY

## Implementation Approach

Recognizing the complexity of crisis response systems and the importance of sustainable implementation, this report recommends a phased approach beginning with the development of a Fourth Crisis Response Pathway for appropriate 911 call diversion while establishing the foundation for broader system integration over time.

Successful implementation will require shared leadership and ongoing collaboration among municipal and provincial governments, emergency services, healthcare providers, community organizations, Indigenous partners, and people with lived experience.

The report concludes with five recommendations intended to guide implementation and support the development of a more coordinated, effective, and sustainable crisis response system for Winnipeg.

**Recommendation 1: Adopt the Winnipeg Community Crisis Response (WCCR) Model**
Endorse the WCCR Model as the future direction for crisis response reform in Winnipeg and support the development of a Fourth Crisis Response Pathway for appropriate 911 calls.

**Recommendation 2: Establish a Municipal-Provincial Partnership Framework**
Create a shared commitment among governments and system partners to support implementation, governance, accountability, funding, and long-term sustainability.

**Recommendation 3: Establish the Foundation for Implementation**
Undertake Phase 1 planning and mobilization activities, including governance, operational planning, business planning, workforce development, technology, information-sharing, and performance measurement.

**Recommendation 4: Implement the Model Through a Phased Approach**
Proceed with phased implementation beginning with a Fourth Crisis Response Pathway for appropriate 911 calls and expanding over time based on evaluation and system learning.

**Recommendation 5: Strengthen Coordination Across Existing Crisis Response Services**
Enhance coordination among emergency services, healthcare providers, and community-based crisis response services while clarifying the future role of co-response models within the broader crisis response continuum.

Together, these recommendations provide a practical roadmap for moving from system design to implementation while strengthening Winnipeg's ability to respond to mental health, substance use, and wellness-related crises.

# FOUNDATIONAL COMPONENTS
## OF THE COMMUNITY CRISIS RESPONCE MODEL

An integrated and coordinated crisis response system that connects people to the right support, at the right time, through the most appropriate pathway.

### 2 PATHWAYS INTO CARE

**911 DIVERSION PATHWAY**
Appropriate 911 calls diverted to community-based crisis response.

**COMMUNITY ACCESS PATHWAY**
Direct access through crisis lines and designated community entry points.

### 1 COORDINATED SYSTEM FUNCTION

**COMMUNITY CRISIS DISPATCH & COORDINATION HUB**

One entry point.
Coordinated response.
Right support.
Right time.

Intake · Match · Dispatch · Coordinate & Communicate

### DESIGNATED COMMUNITY CRISIS RESPONSE TEAMS




Only designated Community Crisis Response Teams through formalized arrangements with designated community service delivery partners can be dispatched for mobile crisis response through the Community Crisis Dispatch & Coordination Hub.

Post-crisis follow-up and connection to community supports to promote recovery, resilience and prevent future crises.



**TOGETHER, THESE COMPONENTS CREATE A CONNECTED SYSTEM THAT:**

- Connects people to the right support
- At the right time
- Through the most appropriate pathway
- Strengthens community well-being and prevents future crises

2 PATHWAYS INTO CARE → 1 COORDINATED SYSTEM FUNCTION → DESIGNATED COMMUNITY CRISIS RESPONSE TEAMS AND CIRCLE OF SUPPORT

**Access • Coordination • Response • Connection • Prevention**

# 1. INTRODUCTION



# 1. INTRODUCTION

## Purpose of the Report

The purpose of this report is to present a proposed WCCR Model and implementation pathway for a Fourth Crisis Response in Winnipeg.

The project was commissioned by the Mayor of Winnipeg to explore how crisis response can be strengthened for individuals experiencing mental health, substance use, wellness, and other non-emergent crises.

A fourth response refers to a community-based crisis response pathway that operates alongside police, fire, and paramedic services and provides an alternative response option for appropriate non-emergent crises.

The intent is not to replace existing emergency services, but rather to ensure individuals receive the most appropriate response based on the nature of their needs while allowing emergency responders to focus on situations requiring their specialized expertise, authority, and response capabilities.

The proposed model establishes an additional response that will be available within Winnipeg's emergency response system. Its purpose is to improve access to appropriate supports, reduce pressure on emergency services, and improve outcomes for individuals and families experiencing crisis.

**The intent is not to replace existing emergency services, but rather to ensure individuals receive the most appropriate response based on the nature of their needs while allowing emergency responders to focus on situations requiring their specialized expertise, authority, and response capabilities.**

# 1. INTRODUCTION CONTINUED

## Scope of Work

The primary mandate of this project was to develop a Fourth Crisis Response pathway for individuals who access support through 911 and whose circumstances may be more appropriately addressed through a community-based response than through police, fire, or paramedic services. The focus of the work was therefore the design of another service option for Winnipeg's existing emergency response system.

The effectiveness of a Fourth Crisis Response pathway is influenced by the broader crisis response system in which it operates. As a result, this report considers the proposed model within the context of Winnipeg's larger crisis response continuum and identifies opportunities to strengthen coordination, integration, and continuity of care over time.

Importantly, this report is not intended to redesign Winnipeg's entire crisis response system. Rather, it presents a practical and achievable approach to implementing a Fourth Crisis Response pathway for individuals entering through the 911 system while identifying future opportunities that could support broader crisis system integration and improvement.

The scope of work includes:

- An overview of Winnipeg's current crisis response landscape, including key strengths, challenges, and opportunities;
- Evidence, leading practices, and lessons learned from jurisdictions across Canada and internationally;
- A proposed Fourth Crisis Response Model integrated with existing emergency response systems;
- Considerations related to access, intake, triage, dispatch, governance, workforce development, service delivery, and continuity of care;
- A phased implementation approach designed to support system readiness, sustainability, and long-term success;

and

- Identification of future opportunities for broader crisis system integration beyond the scope of the Fourth Crisis Response pathway.

While the proposed model includes discussion of future Community Access Pathways and broader crisis system integration opportunities, these concepts are presented as longer-term considerations rather than recommendations for immediate implementation. Given that many of these opportunities extend beyond the City's mandate and involve healthcare, mental health, addictions and social services, future advancement around Community Access Pathways and broader system integration opportunities would require provincial leadership, cross-sector collaboration, and additional planning beyond the scope of this project.

Detailed operational planning, governance design, funding models, costing, technology requirements, procurement processes, and implementation activities will require further development through future planning and collaboration with implementation partners.

**This report is not intended to redesign Winnipeg's entire crisis response system.**

# 2. DESIGN APPROACH



# 2. DESIGN APPROACH

The proposed WCCR Model was developed through a collaborative design process informed by stakeholder engagement, Indigenous engagement, lived experience perspectives, research evidence, jurisdictional review, operational observations, and local system analysis.

Several key design principles informed the development of the model:

- **Right Response, Right Time** – Individuals experiencing crisis should receive the most appropriate response based on their needs, circumstances, and level of risk.
- **Person-Centred and Culturally Responsive** – Services should promote dignity, safety, stabilization, and connection to care while reflecting trauma-informed, recovery-oriented, and culturally responsive practices.
- **Build on Existing Strengths** – The model should leverage existing services, expertise, infrastructure, and partnerships wherever possible rather than creating duplicative systems.
- **Safe, Sustainable, and Scalable** – The model should be operationally feasible, support responder and public safety, and allow for future growth and system integration over time.

The resulting model reflects both the project's primary mandate and a broader objective of strengthening access, coordination, and continuity of care across Winnipeg's crisis response system. The intent was to develop a model that is both aspirational and achievable, balancing long-term system transformation with practical implementation realities.
These considerations helped ensure the proposed model is operationally feasible, scalable, and responsive to the realities of Winnipeg's crisis response environment.

Further details regarding project governance, methodology, stakeholder engagement, jurisdictional review and research activities are provided in Appendices B through E.

# 3. FUTURE STATE VISION: THE PROPOSED MODEL



# 3. FUTURE STATE VISION: THE PROPOSED MODEL

The proposed WCCR Model establishes a community-based Fourth Response pathway that operates alongside existing emergency services and provides an alternative response option for appropriate non-emergent mental health, substance use, wellness, and social crises.

The primary focus of the model is to support the diversion of appropriate 911 calls to designated community-based crisis response teams when emergency intervention is not required. The model also recognizes opportunities to strengthen broader crisis system coordination, continuity of care, and future community-based access pathways over time.

## Guiding Principles of the WCCR Model

The proposed model is guided by a set of foundational principles that reflect research evidence, leading practices, and engagement conducted throughout this project. Together, these principles establish the values, expectations, and approaches that should guide service delivery, governance, partnerships, decision-making, and continuous improvement across the crisis response system.

**Foundational principles that reflect research evidence, leading practices, and engagement.**

# PRINCIPLES OF EFFECTIVE CRISIS RESPONSE



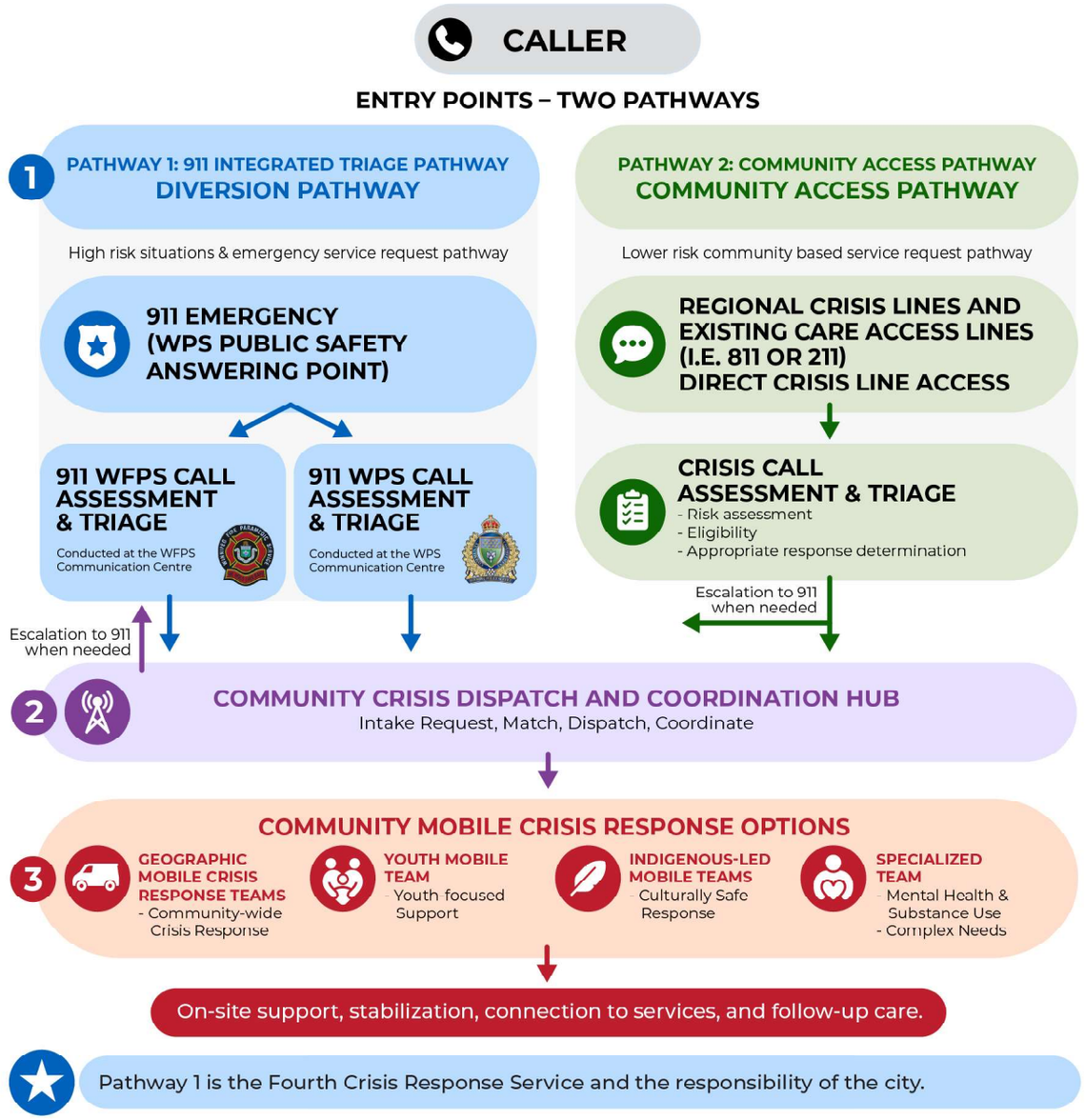




These values are embedded across all principles and guide how services, partnerships, policies, and practices are designed and delivered.

# WINNIPEG COMMUNITY CRISIS RESPONSE
# OPERATIONAL SERVICE FLOW

The figure below illustrates the proposed WCCR Operational Service Flow and the key operating components that define the Fourth Response Pathway.



# 3.2 THE PROPOSED WINNIPEG COMMUNITY CRISIS RESPONSE MODEL CONTINUED

The following sections describe each component of the model and how they work together to support a coordinated, community-based crisis response system.

## 3.2.1 Community Partnership Model

The proposed WCCR Model is founded on a Community Partnership Model that brings together emergency services, healthcare providers, community organizations, Indigenous-led organizations, and government partners around a shared objective: delivering coordinated, person-centred crisis response services that promote safety, stabilization, and connection to care.

A defining feature of the model is the role of community organizations as primary crisis response partners. They are often best positioned to address the health and social factors that contribute to crisis and play an important role in prevention, intervention, stabilization and ongoing support.

The model also recognizes the essential role of police, fire, paramedic, and emergency healthcare services in responding to situations involving significant safety risks, criminal activity, medical emergencies, or other circumstances requiring emergency intervention. The intent is not to replace existing emergency services, but to ensure individuals are connected to the most appropriate response based on their needs and circumstances.

Through shared leadership, coordinated decision-making, and ongoing collaboration, the Community Partnership Model provides the foundation for the proposed crisis response operating model, supporting integrated access pathways, coordinated service delivery and continuity of care across participating partners.

## 3.2.2 Access Model: Pathways into Crisis Response

The proposed WCCR Model is designed to ensure individuals can access crisis response services through the pathway most appropriate to the nature, urgency, and risk level associated with their situation.

The primary component of the model is a 911 Integrated Triage and Diversion Pathway that enables appropriate calls to be referred to community-based crisis response services when emergency intervention is not required. The model also contemplates a future Community Access Pathway that would allow individuals to access crisis response services directly through designated community entry points.

**A defining feature of the model is the role of community organizations as primary crisis response partners.**

# 3.2 THE PROPOSED WINNIPEG COMMUNITY CRISIS RESPONSE MODEL CONTINUED

## PATHWAY 1:

### 911 Integrated Triage and Diversion Pathway

Individuals who contact 911 continue to be assessed and triaged through existing emergency communications systems. Through enhanced triage protocols, risk assessment processes, and diversion criteria, appropriate calls may be referred to community-based crisis response services when police, fire, paramedic intervention is not required.

This pathway creates an opportunity to divert eligible calls from traditional emergency response pathways while maintaining public safety and ensuring timely access to emergency services when required.

A key component of the 911 Integrated Triage and Diversion Pathway is the establishment of a standardized Crisis Response Eligibility and Diversion Framework to support consistent, informed, and safe diversion decision-making within emergency communications systems.

The framework provides clear criteria and processes for determining when a community-based response may be appropriate while ensuring emergency services remain responsible for situations requiring police, fire, paramedic, or emergency healthcare intervention. Individual safety, public safety, and responder safety remain the primary considerations in all diversion decisions.

A preliminary Crisis Response Eligibility and Diversion Framework has been developed as part of this work to support future implementation planning, operational protocol development, testing, and validation. The framework identifies proposed call types, eligibility criteria, and diversion considerations that may be appropriate for community-based crisis response.

The proposed diversion pathway is intended primarily for individuals who are willing and able to engage with services on a voluntary basis. Analysis conducted as part of this project suggests that a significant proportion of crisis-related calls entering through the 911 system involve individuals who are cooperative, non-violent, and appropriate for a community-based response when supported by standardized triage processes and clear escalation protocols. Situations involving elevated risk, significant impairment, medical complexity, safety concerns, or circumstances requiring apprehension, detention, involuntary assessment, or transportation under legislative authorities such as The Mental Health Act, The Intoxicated Persons Detention Act, The Youth Drug Stabilization (Support for Parents) Act, and other applicable legislation would continue to require emergency, healthcare, or co-response involvement. Existing co-response models, such as the Alternative Response to Citizens in Crisis (ARCC) program, remain an important component of the broader crisis response continuum for situations requiring specialized clinical expertise, higher-acuity intervention, or legislative authorities.

The preliminary Crisis Response Eligibility and Diversion Framework is provided in Appendix G.

# 3.2 THE PROPOSED WINNIPEG COMMUNITY CRISIS RESPONSE MODEL CONTINUED

## PATHWAY 2:

### Community Access Pathway

The future-state model also contemplates direct access to crisis response services through designated community entry points, including crisis lines, regional crisis services, and other approved access channels.

Using standardized triage, risk assessment, and eligibility processes, individuals are connected to the most appropriate crisis response option based on their needs and circumstances. Situations requiring emergency intervention are escalated to 911 when necessary.

Together, these pathways support a coordinated approach to crisis response access, ensuring individuals can be connected to the most appropriate response regardless of how they enter the system.

# 3.2 THE PROPOSED WINNIPEG COMMUNITY CRISIS RESPONSE MODEL CONTINUED

## 3.2.3 Community Crisis Dispatch and Coordination Hub

The Community Crisis Dispatch and Coordination Hub, the “Hub”, serves as the central coordination and dispatch function of the proposed WCCR Model. Operating 24 hours a day, seven days a week, the Hub supports the deployment of designated Community Crisis Response Teams in Winnipeg.

The Hub is not a public-facing service and is not intended to function as a crisis line, call centre, or public access point. Individuals do not contact the Hub directly, and 911 calls are not transferred to the Hub for assessment or triage. Primary intake, call-taking, and triage remain within established access pathways, including Winnipeg Police Service (WPS), Winnipeg Fire Paramedic Service (WFPS), and, in a future state, designated Community Access Pathway partners.

Once a determination has been made that a community-based response is appropriate, a dispatch request is generated and sent to the Hub. The Hub is then responsible for matching the request to the most appropriate and available Community Response Partner and coordinating deployment based on established protocols. Dispatch decisions may consider factors such as risk, need, geography, specialization, cultural considerations, service availability, and operational capacity.

To support safe and efficient operations, the Hub should maintain interoperability with emergency communications and dispatch systems, including Computer-Aided Dispatch (CAD) technology where feasible. This capability would support the secure transfer of dispatch requests, coordinated deployment of community response teams, real-time operational awareness, and rapid escalation when emergency service involvement becomes necessary.

Interoperability would also support referrals from WPS and WFPS personnel already attending a scene where emergency involvement is no longer required but community-based stabilization, navigation, or follow-up support would be beneficial. This capability would strengthen continuity of care while allowing emergency responders to return to service more quickly.

In addition to dispatch coordination, the Hub would support system oversight through data collection, performance monitoring, evaluation, reporting, and quality improvement activities. This function would support accountability, identify service gaps, and inform future planning and resource allocation.

The Community Crisis Dispatch and Coordination Hub serves as the operational backbone of the model, connecting access pathways to community response resources and helping ensure individuals are connected to the most appropriate response and support.

# 3.2 THE PROPOSED WINNIPEG COMMUNITY CRISIS RESPONSE MODEL CONTINUED

## 3.2.4 Community Crisis Response Teams

Community Crisis Response Teams represent the primary service delivery component of the proposed Fourth Crisis Response Model. Delivered through established community organizations operating within the Community Crisis Response Network, these teams provide the community-based response capacity that forms the foundation of the Fourth Crisis Response pathway. Collectively, Community Crisis Response Teams are intended to provide a coordinated 24 hours a day, seven days a week response capability across Winnipeg.

Rather than creating a standalone service, the model builds upon existing community expertise, relationships, and service capacity through formal service agreements and integrated dispatch and coordination processes.

Community Crisis Response Teams are intended to respond to non-violent, non-criminal, and non-life-threatening situations that do not require police, fire, paramedic, or emergency healthcare intervention. This includes situations involving mental health and emotional distress, wellness concerns, social and situational crises, and substance use-related concerns where the individual is medically stable, able to engage, and does not present acute safety risks.

The presence of substance use alone would not necessarily preclude a community-based response. However, situations involving overdose, severe intoxication, acute withdrawal, medical instability, significant impairment, or elevated safety risks would remain within emergency service or healthcare response pathways. Clear triage criteria and escalation protocols are essential to ensuring individuals receive the most appropriate response based on their needs and circumstances.

The primary functions of Community Mobile Crisis Response Teams include crisis intervention, de-escalation, stabilization, assessment, safety planning, service navigation, connection to supports, and post-crisis follow-up where appropriate.

# THE FOURTH CRISIS RESPONSE TEAMS ARE EXPECTED TO RESPOND TO:

**MENTAL HEALTH CRISIS**
Support for individuals experiencing emotional or psychological distress.

**SUICIDE IDEATION**
Compassionate support for individuals having thoughts of suicide.

**WELLNESS CHECKS**
Ensuring the safety and well-being of individuals in need of a check-in.



**FOURTH CRISIS RESPONSE**

**SUBSTANCE USE CRISIS**
Support for individuals struggling with substance use or experiencing a related crisis.

**SOCIAL AND SITUATION CRISES**
Support and stabilization for individuals and families experiencing any type of crisis or life challenge.

**YOUTH AND ADULT SITUATIONS**
Support for both youth and adults facing challenges in their daily lives.

**NON-VIOLENT, NOT CRIMINAL, NON-LIFE THREATENING**

**COMPASSIONATE CARE**
We lead with empathy and respect.

**RIGHT RESPONSE RIGHT TIME**
Connecting people to the right help, sooner.

**COMMUNITY FOCUSED**
Building trust and stronger communities.

**SUPPORT, NOT PUNISHMENT**
Our goal is stability, healing, and connection — not enforcement.

# 3.2 THE PROPOSED WINNIPEG COMMUNITY CRISIS RESPONSE MODEL CONTINUED

## 3.2.5 Deployment Model

The proposed model utilizes a hybrid deployment approach that combines geographically-based and specialized mobile crisis response capacity. This approach is intended to balance accessibility, efficiency, and equitable service delivery across Winnipeg.

The model is designed to be delivered through a limited number of designated Community Response Partners formally integrated into the WCCR Service. Participating organizations would operate under common service standards, operating protocols, training requirements, and accountability expectations while maintaining the flexibility to leverage their unique expertise, community relationships, and service strengths.

Geographically-based Community Crisis Response Teams would provide broad crisis response coverage across designated catchment areas of Winnipeg and serve as the primary response resource for most community crisis requests. Geographic response areas should be informed by service demand, population needs, existing community infrastructure, and operational considerations. Particular consideration should be given to Winnipeg's downtown and core area, where demand for crisis response services is consistently highest.

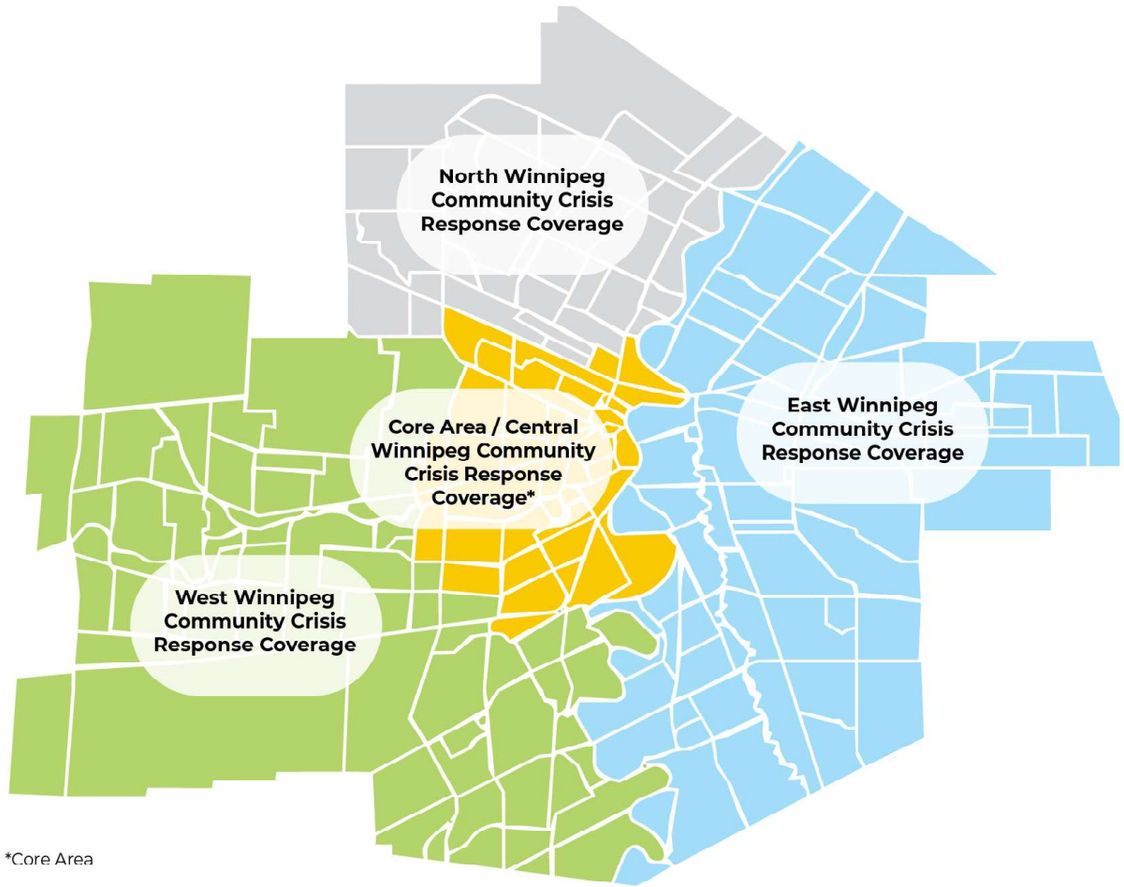
In addition to geographically-based coverage, the model contemplates specialized response services that provide population-specific expertise, culturally responsive supports, or enhanced clinical capacity where appropriate. Examples may include Indigenous-led teams, youth-focused teams, and specialized mental health and substance use teams. Depending on the service model adopted, specialized response functions may be delivered by the same organizations responsible for geographically-based coverage.

The Community Crisis Dispatch and Coordination Hub would be responsible for matching the most appropriate and available response team based on information obtained through the intake, assessment, and triage process, including factors such as urgency, geography, age, cultural considerations, presenting needs, specialization requirements, and operational capacity.

Together, geographically-based and specialized response services provide broad 24/7 city-wide coverage while ensuring specialized expertise and culturally responsive supports are available when needed. The deployment model is designed to match individuals with the most appropriate response while maximizing the strengths, expertise, and existing capacity of participating Community Response Partners.

**Geographically-based Community Mobile Crisis Response Teams would provide broad crisis response coverage across designated catchment areas.**

# WINNIPEG COMMUNITY CRISIS RESPONSE DEPLOYMENT MODEL (HYBRID)




*Core Area

Highest concentration of mental health, wellness, substance use, and crisis-related calls.

Includes Downtown, Point Douglas, Exchange District, and surrounding core neighbourhoods.

NOTE: This map is intended to illustrate a potential service deployment approach. It does not represent final service boundaries, agency assignments, staffing models, or implementation decisions.

### COMMUNITY CRISIS DISPATCH AND COORDINATION HUB

All requests are screened and assessed by the Community Crisis Coordination Hub, which determines the most appropriate response based on risk, urgency, geography, population served, cultural considerations, specialization needs, and operational capacity.

**Goal: Match the right team to the right crisis, at the right time, in the right place.**

## SPECIALIZED RESPONSE TEAMS

These specialized teams are available across Winnipeg and deployed based on need, appropriateness, and dispatch criteria.

### YOUTH MOBILE CRISIS TEAMS

- City-wide coverage
- Primary response for children and youth in crisis
- Specialized training, approaches, and service connections for youth and families

### INDIGENOUS-LED MOBILE CRISIS TEAMS

- City-wide coverage
- Available by request or based on dispatch criteria
- Culturally grounded response and connections to Indigenous community supports

### MENTAL HEALTH & SUBSTANCE USE COMPLEX CARE TEAMS

- City-wide coverage
- Enhanced assessment, stabilization, and care coordination
- Specialized clinical response for complex mental health and substance use situations

# 3.2 THE PROPOSED WINNIPEG COMMUNITY CRISIS RESPONSE MODEL CONTINUED

## 3.2.6 Continuum of Care and Post-Crisis Follow-up

A key feature of the proposed WCCR Model is the inclusion of short-term post-crisis follow-up and system navigation. The model recognizes that crisis stabilization is often the beginning of an individual's recovery journey rather than the end of the response.

Following an in-person crisis intervention, Community Response Partners would provide, or facilitate access to, transitional supports based on individual needs. This may include wellness check-ins, safety planning, service navigation, referrals, warm handoffs, and connection to mental health, substance use, healthcare, cultural, and other community-based supports.

Consideration should be given to dedicated follow-up and navigation capacity within the service model to help individuals access services and maintain connection to supports during the critical period following a crisis.

Importantly, the model is not intended to provide long-term case management or ongoing intensive support. Its purpose is to provide short-term stabilization, navigation, and transitional support while facilitating successful connection to the broader system of care.

**The model is not intended to provide long-term case management but transitional support and connections to the broader system of care.**

# 3.2 THE PROPOSED WINNIPEG COMMUNITY CRISIS RESPONSE MODEL CONTINUED

## Transportation and Mobility Supports

Where safe and appropriate, Community Crisis Response Teams should have the ability to assist individuals in accessing a safe and appropriate destination as part of a crisis response intervention. This may include transportation to a shelter, crisis stabilization service, community agency, healthcare setting, or other location identified through assessment and care planning.

Transportation should be considered a supportive function of crisis response rather than a standalone service. Its purpose is to help resolve a crisis, reduce barriers to accessing care, and facilitate connection to appropriate supports when transportation challenges would otherwise impede an individual's ability to reach a safe destination.

Consistent with practices observed in other jurisdictions, transportation should only be provided when it is directly related to the crisis response, clinically and operationally appropriate, and safe for both the individual and responding staff. Alternative transportation options, such as transit passes, taxi vouchers, family supports, or other community resources, may also be utilized where appropriate.

To ensure service capacity is maintained for urgent crisis response, Community Crisis Response Teams should not function as a routine transportation service. Clear policies, risk assessment protocols, and safety procedures should guide decisions regarding transportation and support the use of alternative transportation options when appropriate.

# A CIRCLE OF COORDINATED SUPPORT

## FROM CRISIS TO CONNECTION, SUPPORT, AND STABILITY

**STEP 1: IMMEDIATE RESPONSE**

CommunityCrisis Response Team arrives to provide compassionate, non-enforcement support.

**STEP 2: STABILIZATION**

The team de-escalates, assesses, and supports safety and immediate needs.

**STEP 3: POST-CRISIS FOLLOW-UP**

Before the response concludes, a follow-up plan is created together based on needs and preferences.

**STEP 4: CONNECTION TO CARE**

Warm handoffs and navigation connect individuals to the right services, supports, and resources.

**STEP 5: ONGOING SUPPORT**

Follow-up contacts and check-ins provide continued support and help maintain stability.

**STEP 6: STRONGER COMMUNITIES**

Connected individuals and supported families build safer, healthier, more resilient communities.

SEAMLESS • COORDINATED • CONTINUOUS



PERSON-CENTERED
COMPASSIONATE
COMMUNITY-FOCUSED

COORDINATED BY THE COMMUNITY CRISIS DISPATCH & COORDINATION HUB

# KEY FEATURES
## OF THE PROPOSED CRISIS RESPONSE MODEL

The proposed WCCR Model combines coordinated access pathways, centralized dispatch and coordination, community-based response capacity, and short-term follow-up supports within a single integrated framework.



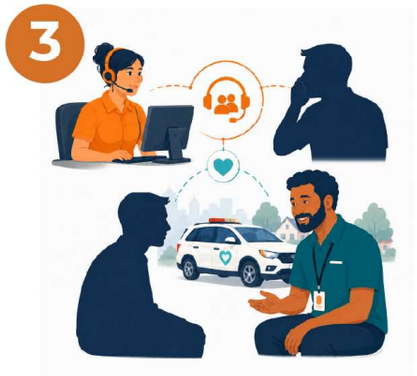
### 24/7 ACCESS

Crisis support is available anytime, every day of the year. Help is always within reach.



### RIGHT RESPONSE, RIGHT TIME

Individuals receive the most appropriate response based on need, risk and circumstances — when they need it.



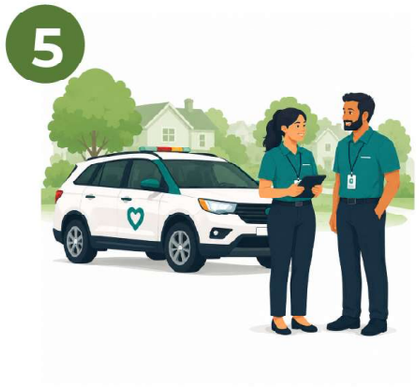
### INTEGRATED 911 & COMMUNITY ACCESS

People can access support through both 911 and community pathways, creating a more connected system.



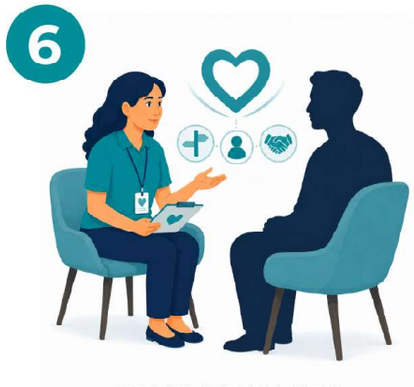
### SHARED TRIAGE & COORDINATION

A unified triage and coordination process ensures the right resources are matched quickly and effectively.



### COMMUNITY MOBILE RESPONSE

Specialized mobile teams respond in the community to provide on-site, person-centred support.



### CONSENT-BASED SERVICE DELIVERY

Services are voluntary, respectful and guided by informed consent, empowering individuals and supporting dignity and trust.



### CONTINUITY OF CARE & FOLLOW-UP

Ongoing support and follow-up help individuals stay connected to services and supports beyond the initial response.




### ESCALATION PATHWAYS & SAFETY SUPPORTS

Clear escalation pathways and safety supports ensure the right level of response when situations change.

# 4. CURRENT STATE AND CONTEXT



# 4. CURRENT STATE AND CONTEXT

## 4.1 Understanding Crisis

There is no universally accepted definition of crisis. Definitions vary across disciplines, service settings, and the populations being served. While many definitions focus primarily on mental health or psychiatric crises, this report adopts a broader understanding that reflects the range of circumstances encountered through community crisis response systems.

For the purposes of this report, a crisis is defined as:

***A situation in which an individual, or those around them, perceive an immediate need for support due to distress, risk, or instability that exceeds the person's current ability to cope.***

Adapted from Roberts and Ottens (2005), Hudson et al. (2024), and SAMHSA (2025).

Crises may arise from a wide range of circumstances, including mental health challenges, substance use, trauma, interpersonal conflict, housing instability, poverty, homelessness, family challenges, and significant life events. Crisis is not limited to emergencies and exists along a continuum of acuity and need. Some situations involve immediate risks to safety and require emergency intervention, while others may be more appropriately addressed through community-based, health, social, or culturally responsive supports. Evidence demonstrates that crises are influenced by a complex interaction of health, social, environmental, and personal factors. As a result, effective crisis response systems require a continuum of response options rather than a single intervention pathway.

Police, fire, and paramedic services play an essential role in responding to emergencies involving immediate threats to life, public safety, criminal activity, fire, and medical emergencies. However, many crises do not fit neatly within traditional emergency response mandates. Across North America, emergency services are increasingly responding to situations involving mental health challenges, substance use, homelessness, behavioural crises, and other complex social needs. While emergency services provide critical support in these situations, many of the underlying factors contributing to crisis extend beyond the scope of traditional emergency response.

This reality does not reflect a limitation of emergency services. Rather, it highlights the need for a broader continuum of crisis response options that complement existing emergency response systems and ensure individuals can access the most appropriate support based on their needs and circumstances.

**Effective crisis response systems require a continuum of response options rather than a single intervention pathway.**

# 4. CURRENT STATE AND CONTEXT CONTINUED

## 4.2 Existing Strengths and Assets

Winnipeg benefits from a strong network of emergency, healthcare, community, and Indigenous-led services that support individuals experiencing crisis.

Emergency services provide 24-hour city-wide response capacity supported by established communications, dispatch, and coordination systems. These services are complemented by a range of healthcare and crisis response programs, including mobile crisis services, the ARCC program, crisis stabilization services, emergency department mental health supports, and specialized mental health and addictions programs.

Winnipeg is further supported by a diverse network of community organizations, Indigenous-led services, outreach programs, youth-serving organizations, and community wellness initiatives that provide crisis intervention, stabilization, navigation, and connection to care. Together, these services provide a strong foundation of crisis response, intervention, stabilization, and support across Winnipeg.

Stakeholders consistently emphasized that Winnipeg is not starting from a position of absence, but rather from a position of significant strength, expertise, and commitment across multiple sectors. Existing partnerships and collaborative initiatives demonstrate that meaningful system integration is achievable and provide a strong foundation for future crisis response improvements.

**Stakeholders consistently emphasized that Winnipeg is not starting from a position of absence, but rather from a position of significant strength, expertise, and commitment across multiple sectors.**

# 4. CURRENT STATE AND CONTEXT CONTINUED

## 4.3 Current Challenges and Opportunities

Despite these strengths, opportunities remain to strengthen access, coordination, and continuity of care across Winnipeg's crisis response system.

A consistent finding throughout engagement was that the crisis response system can be difficult to navigate. Individuals, families, and service providers often struggle to determine what services are available, how to access them, and which option is most appropriate during a crisis. As a result, familiar entry points such as 911 and emergency departments frequently become the default response, even when alternative services may be better suited to meet an individual's needs.

Also noted were challenges related to timely access to support, service navigation, continuity of care, and after-hours response. Stakeholders described difficulties navigating available services and obtaining timely mental health assessments, crisis supports, and other interventions during periods of acute need contributing to repeated crisis presentations and avoidable reliance on emergency services.

A second recurring theme was fragmentation across the broader crisis response system. While examples of cross-sector integrated crisis response models already exist, including the ARCC program and Downtown Community Safety Partnership, opportunities remain to strengthen referral pathways, information sharing, service coordination and continuity of care across organizations and sectors. Stakeholders noted that legislative and privacy requirements, differing organizational mandates, funding structures, and the distributed nature of responsibility across multiple sectors can make coordination more challenging.

**A key finding of this review was the absence of a dedicated community-based crisis response pathway integrated into Winnipeg's emergency communications and dispatch systems.**

# 4. CURRENT STATE AND CONTEXT CONTINUED

## 4.3 Current Challenges and Opportunities CONTINUED

A key finding of this review was the absence of a dedicated community-based crisis response pathway formally integrated into Winnipeg's emergency communications and dispatch systems. Winnipeg's emergency communications, triage, and dispatch systems were designed primarily to support police, fire, and paramedic. As a result, current call-taking and dispatch processes have limited ability to consistently assess and route appropriate calls to community-based crisis response services. When individuals contact 911, available response options are generally limited to traditional emergency response pathways.

While crisis lines, support services, and mobile crisis programs exist throughout the community, most are not connected to emergency dispatch systems and cannot be directly deployed through the 911 Communications Centre. This can create gaps between identifying an individual's needs and mobilizing the most appropriate response, resulting in increased reliance on police, fire, paramedic, or emergency department services when a community-based response may be more appropriate. The absence of a coordinated community-based response pathway also limits the ability of existing community services to fully contribute to crisis response, despite significant expertise, relationships, and capacity already existing within the community.

Responsibility for crisis response is shared across many organizations and sectors, yet no single organization is responsible for coordinating the full crisis journey. As a result, individuals may interact with multiple services during a crisis without experiencing a seamless pathway from initial contact through stabilization and connection to ongoing support.

*"Everyone owns a piece of the crisis journey, but nobody owns the crisis journey."*

- Shared by community stakeholder during consultation

# 4. CURRENT STATE AND CONTEXT CONTINUED

## 4.4 Summary of Current State



Winnipeg possesses many of the services, partnerships, and capabilities required to support individuals experiencing crisis. The opportunity lies in strengthening coordination, access, continuity of care, and community-based response pathways across the system.

Collectively, these findings suggest that Winnipeg's primary challenge is not the absence of services, but the need for stronger integration between existing services to ensure individuals are connected to the most appropriate response and support.

**The need for stronger integration between existing services to ensure individuals are connected to the most appropriate response and support.**

# 5. EVIDENCE AND SYSTEM IMPACT: WHY CHANGE IS NEEDED



# 5. EVIDENCE AND SYSTEM IMPACT: WHY CHANGE IS NEEDED

## 5.1 Growing Demand and System Pressures

“We can’t keep doing what we’re doing.”

This sentiment was expressed consistently throughout engagement activities conducted as part of this project. While Winnipeg benefits from a strong foundation of crisis response services and community supports, increasing demand and growing system pressures highlight the need to strengthen crisis response pathways and improve access to appropriate supports.

Winnipeg is well positioned to advance crisis response reform. The opportunity is not to create an entirely new system, but to strengthen how existing services and resources work together to support individuals experiencing crisis.

Demand on emergency and healthcare systems continues to increase. Recent Winnipeg Police Service data demonstrates that while overall crime volume declined for the second consecutive year in 2024, calls for service remain at historically high levels.

In 2024, the Winnipeg Police Service Communications Centre received more than 772,000 calls and interactions, averaging over 2,000 contacts per day.[1] Wellbeing checks have remained the most common citizen-generated event type for five consecutive years, highlighting the growing role of police in responding to mental health concerns, emotional distress, wellness checks, and other non-criminal crisis situations.[2]

1 Winnipeg Police Service. 2024 Annual Statistical Report. Winnipeg Police Service, 2025. Communications Centre received 772,452 calls/interactions; average of approximately 2,116 calls per day and 85 calls per hour.

2 Winnipeg Police Service. 2024 Annual Statistical Report; Winnipeg Police Board. The Environment for Policing in Winnipeg 2025 – Quick Reference Guide. Wellbeing checks identified as the most common citizen-generated event type and citizen-generated dispatched events have increased since 2019.

**3,855 annual Winnipeg Police Service dispatched events that may be appropriate for diversion.**

# 5. EVIDENCE AND SYSTEM IMPACT: WHY CHANGE IS NEEDED CONTINUED

## 5.1 Growing Demand and System Pressures Continued

10,000 + annual crisis-related calls for WPS and WFPS combined that may be appropriate for community-based response pathways.

Project-specific analysis conducted as part of this review identified approximately 3,855 annual Winnipeg Police Service dispatched events that may be appropriate for diversion to a community-based crisis response. These calls consume an estimated 7,986 hours of combined officer time, annually.[3]

Similar pressures are evident within Winnipeg Fire Paramedic Service. Analysis identified approximately 6,356 annual crisis-related calls that may be suitable for alternative response pathways, including more than 5,100 wellness-check related calls.[4]

Demand is also increasing within Winnipeg's healthcare system. In 2025, the Adult Health Sciences Centre Emergency Department (ED) recorded more than 4,200 mental health presentations, with approximately 26% resulting in admission and nearly 3,100 individuals discharged following ED assessment and treatment.

During the same period, the Children's Hospital Emergency Department recorded 2,236 mental health presentations, with approximately 23% resulting in admission and more than 1,700 individuals were not admitted and discharged following ED assessment and treatment.[5]

Collectively, the evidence demonstrates growing demand across emergency and healthcare systems. Thousands of individuals experiencing crisis interact with these services each year despite many not requiring enforcement action, emergency medical intervention, or inpatient hospitalization, creating opportunities to better align individuals with the most appropriate response and support.

3 Winnipeg Police Service data analysis conducted for the Fourth Crisis Response Project (2026). Analysis based on approximately 3,855 potentially divertible crisis-related calls and median officer time on scene. FTE calculation based on 2,080 annual working hours per full-time position.

4 Winnipeg Fire Paramedic Service data analysis provided to the Fourth Crisis Response Project (2026). Includes crisis-related calls categorized as psychiatric concerns, abnormal behaviour, wellness checks, and related determinants.

5 Shared Health Manitoba. Health Sciences Centre Emergency Department Mental Health Presentation and Admission Data (2025). Data provided to the Fourth Crisis Response Project.

**Collectively, the evidence demonstrates growing demand across emergency and healthcare systems.**

# 5. EVIDENCE AND SYSTEM IMPACT: WHY CHANGE IS NEEDED CONTINUED

## 5.2 Equity, Access and System Mismatch

### Crisis and System Mismatch

Evidence consistently demonstrates that many crises are driven by health, social, housing, substance use, trauma, and wellness-related factors rather than criminal activity or public safety concerns. However, emergency services frequently become the default response because they are among the most visible, accessible, and consistently available entry points into the system.

This reality is not unique to Winnipeg. Across Canada and internationally, police and emergency services are increasingly responding to crises rooted in mental health, substance use, homelessness, and other complex social needs that extend beyond traditional emergency response mandates.

Research demonstrates that individuals living with mental health and substance use challenges are disproportionately represented within the criminal justice system and frequently interact with police during periods of crisis. The Mental Health Commission of Canada reports that approximately 40% of individuals living with mental illness are arrested at least once during their lifetime.[6] Research further suggests that many police interactions involving individuals experiencing mental health crises occur in non-criminal circumstances, yet approximately one in seven encounters results in an arrest.[7] In many cases, interactions are resolved through apprehensions under provincial mental health legislation rather than criminal charges. One Canadian study found that more than half of police interactions involving individuals experiencing mental illness resulted in apprehensions under the Mental Health Act.[8]

These findings do not suggest that police should not respond when public safety concerns are present. Rather, they highlight a system design challenge: when alternative crisis response pathways are unavailable or difficult to access, emergency services frequently become the default response regardless of whether they are best positioned to address an individual's underlying needs.

6 Mental Health Commission of Canada. Mental Health and the Criminal Justice System: What We Heard (2020).

7 Mental Health Commission of Canada. Interactions of Police and People with Mental Illness (2013).

8 Mental Health Commission of Canada. Interactions of Police and People with Mental Illness (2013).

**The Mental Health Commission of Canada reports that approximately 40% of individuals living with mental illness are arrested at least once during their lifetime.**

# 5. EVIDENCE AND SYSTEM IMPACT: WHY CHANGE IS NEEDED CONTINUED

**Equity, Access and Social Determinants**

Crisis is often influenced by broader social, economic, health, and community factors. Justice Canada recognizes that social and economic conditions such as income, employment, education, housing stability, and health status can significantly influence an individual's interaction with the justice system.[9]

Research demonstrates that poverty, homelessness, mental illness, substance use, trauma, social exclusion, and limited access to services can increase vulnerability to crisis and the likelihood of justice system involvement, often because individuals are unable to access appropriate supports before situations escalate.[10] This reflects a broader system gap, where emergency services are called upon to respond to complex social and health-related issues in the absence of accessible alternatives.

These impacts are not experienced equally and can disproportionately affect Indigenous Peoples, newcomers, individuals experiencing housing instability, people living with mental illness, and members of equity-deserving communities, including racialized and 2SLGBTQ+ individuals. These groups face disproportionate barriers accessing care and are more likely to encounter emergency and justice systems during periods of crisis.

Access barriers continue to exist in relation to timely support, system navigation, continuity of care, and after-hours services. While Winnipeg benefits from a broad range of services, individuals often encounter barriers accessing support during periods of crisis, contributing to repeated crisis presentations and avoidable reliance on emergency services.

Collectively, the evidence suggests that strengthening crisis response requires more than additional service capacity. It requires accessible pathways to support, improved coordination across systems, and response options that better align with the needs and circumstances of individuals experiencing crisis.

9 Justice Canada. Social Determinants of Justice (2025).

10 Mental Health Commission of Canada. Mental Health and the Criminal Justice System: What We Heard; Housing and Justice Report.

# 5. EVIDENCE AND SYSTEM IMPACT: WHY CHANGE IS NEEDED CONTINUED

## 5.3 Evidence and Leading Practices

A growing body of research supports the need for a broader range of crisis response options beyond traditional emergency service models. Many individuals experiencing crisis benefit from responses that are tailored to their needs and connected to appropriate supports and follow-up care.
Consistent with this evidence, jurisdictions across Canada and internationally have increasingly explored alternative approaches to crisis response. While models vary in structure and governance, a jurisdictional review identified common themes related to access pathways, continuity of care, and collaboration among participating organizations. A summary of the jurisdictions reviewed and key findings from the jurisdictional scan is provided in Appendix D.

SAMHSA identifies three key components of an effective crisis response system: someone to talk to, someone to respond, and a safe place to go for help. Together, these elements help ensure that people experiencing a mental health, substance use, or behavioural crisis can access the support they need, when and where they need it.[11]

Collectively, the evidence suggests that effective crisis response depends less on any single program and more on how services work together to connect individuals with the right support at the right time. This conclusion aligns with broader evidence on systems change and collective impact, which suggests that complex social challenges are most effectively addressed through shared goals, coordinated action, and collaboration across sectors (Kania & Kramer, 2011).[12] It also reflects findings from the Manitoba Health Status Report 2025[13], which identifies multisectoral collaboration and shared responsibility as essential to improving outcomes and addressing complex health, social, and community challenges.

**Evidence suggests that effective crisis response depends less on any single program and more on how services work together to connect individuals with the right support at the right time.**

11 "Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services." SAMHSA, January 15, 2025. https://library.samhsa.gov/sites/default/files/model-definitions-pep24-01-037.pdf
"2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care" SAMHSA, January 15, 2025. https://library.samhsa.gov/sites/default/files/national-guidelines-crisis-care-pep24-01-037.pdf
12 Kania, John, and Mark Kramer. "Collective Impact." Stanford Social Innovation Review, vol. 9, no. 1, 2011, pp. 36–41.
13 A Healthier Manitoba for All. 2025 Health Status of Manitobans Report. https://www.manitoba.ca/asset_library/en/cppho/docs/health-status-2025.pdf

# 6. GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY



# 6. GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY

## 6.1 Proposed Governance Model

The WCCR Model requires a governance framework that provides strategic oversight, accountability, and coordinated decision-making across participating organizations. Given the cross-sector nature of crisis response, governance should include representation from municipal and provincial governments, emergency services, healthcare organizations, Community Response Partners, Indigenous partners, and people with lived experience.

The proposed governance framework consists of four interconnected functions:

- Strategic Oversight Table
- Operational Leadership Committee
- Clinical and Practice Advisory
- Community and Lived Experience Advisory

# 6. GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY CONTINUED

## 6.2 Proposed Governance Structure

### 6.2.1 Strategic Oversight Table

The Strategic Oversight Table would provide overall leadership, direction, and accountability for the WCCR Model. Responsibilities would include establishing strategic priorities, monitoring system performance, reviewing outcomes, supporting long-term sustainability, and ensuring alignment with the model's vision and objectives.

Membership should include senior representatives from key system partners, including:

- City of Winnipeg Representatives
- Winnipeg Police Service
- Winnipeg Fire Paramedic Service
- Shared Health Services
- Winnipeg Regional Health Authority
- Provincial Government Representatives
- Community Crisis Dispatch and Coordination Hub Partner
- Community Response Partners
- Indigenous Community Response Partners

### 6.2.2 Operational Leadership Committee

The Operational Leadership Committee would oversee implementation, service integration, operational coordination, and cross-sector problem solving. Responsibilities would include operational planning, protocol development, service coordination, performance monitoring, and the resolution of issues affecting service delivery.

Membership should include operational leaders from organizations directly involved in service delivery and system operations, including the Community Crisis Dispatch and Coordination Hub, Community Response Partners, emergency services, health system representatives, crisis line partners, WPS & WFPS 911 Communications Centre, and other operational stakeholders.

# 6. GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY CONTINUED

### 6.2.3 Clinical, Practice and Safety Advisory

The Clinical, Practice & Safety Advisory would provide guidance related to service quality, clinical and supportive practice standards, responder safety, risk management, and continuous quality improvement. Responsibilities would include supporting the development and review of diversion criteria, triage frameworks, safety protocols, training requirements, clinical guidance practice standards, and quality assurance processes.

Membership should include representatives with expertise in mental health, addictions, crisis intervention, healthcare, emergency services, Indigenous wellness, community service providers, quality improvement, and risk management.

### 6.2.4 Community and Lived Experience Advisory

The Community and Lived Experience Advisory would provide ongoing community input and accountability to the broader governance structure. Responsibilities would include providing advice on service accessibility, cultural safety, equity considerations, service experience, and emerging community needs while supporting continuous improvement and system responsiveness. Membership should include people with lived experience, family members, peer support workers, Indigenous representatives, and community organizations with experience supporting individuals in crisis.

# 6. GOVERNANCE, LEADERSHIP AND ACCOUNTABILITY CONTINUED

## 6.3 Governance Implementation Considerations

Future implementation planning should address several governance considerations to support long-term accountability, sustainability, and effective system coordination:

**Formal Partnership Agreements:**
Establish clear roles, responsibilities, decision-making authority, accountability relationships, and information-sharing requirements through mechanisms such as Memorandums of Understanding, service agreements, and information-sharing agreements.

**Indigenous Participation and Leadership:**
Ensure Indigenous voices, perspectives, and leadership are meaningfully incorporated throughout governance, oversight, planning, and decision-making structures.

**Governance Sustainability:**
Establish formal governance mechanisms, including terms of reference, partnership agreements, and accountability frameworks, to support continuity through changes in leadership, political priorities, organizational priorities, and funding environments.

**Sustainable Funding:**
Establish stable funding and accountability mechanisms to support coordination, response capacity, technology, evaluation, quality improvement, and long-term sustainability.

The proposed governance framework provides a foundation for shared accountability, coordinated leadership, meaningful community participation, and long-term stewardship of the WCCR Model.

# COMMUNITY PARTNERSHIP MODEL

A collaborative network of partners working together to ensure the right response, by the right partner, at the right time.

### WINNIPEG POLICE SERVICE
Provides emergency response for public safety, situations involving violence, criminal activity, or when law enforcement authority is required. Through the 911 Communications Centre, also supports call-taking, assessment, triage, and diversion of appropriate calls to community-based crisis response services.

### CITY OF WINNIPEG
Provides leadership, oversight, accountability, and strategic investment for the Fourth Crisis Response Model. Supports system coordination, cross-sector partnerships, and alignment with community safety and emergency response systems, while working collaboratively with partners to advance a proactive, community-led crisis response system that complements existing emergency services.

### COMMUNITY ACCESS & INTAKE PARTNERS (211/811/988/CRISIS LINES)
Alternate call intake and triage for mental health and/or substance use crisis calls. Provides assessment, navigation and connects individuals to the right level of response.

### COMMUNITY CRISIS MOBILE TEAMS
Community-based, multidisciplinary teams of professionals and peers who provide crisis intervention, de-escalation, support and connection to resources. Teams include participating service providers from the community.

## PEOPLE & COMMUNITY AT THE CENTRE
Compassionate, coordinated responses that support safety, well-being and connection.

### DISPATCH & COORDINATION PARTNER
Coordinates and dispatches the appropriate crisis response based on assessed need and urgency. Acts as the central coordinating body.

### HEALTH PARTNERS
Support connection to mental health and addictions services post-crisis and provide ongoing care, treatment and follow-up supports.

### GOVERNMENT OF MANITOBA
Provides leadership, oversight, accountability, and strategic investment for the Fourth Crisis Response Model. Supports system integration and alignment across health, mental health and addictions, justice, and community service systems, while working collaboratively with partners to advance coordinated, person-centered crisis response and continuity of care.

### WINNIPEG FIRE & PARAMEDICS SERVICES
Provides emergency medical assessment, health response, and paramedic services when medical intervention is required. Through the 911 Communications Centre, also supports call-taking, assessment, triage, and diversion of appropriate calls to community-based crisis response services.

### STRONGER TOGETHER
Working together across systems and communities to build a compassionate, integrated crisis response system for all.

**CONNECTED PARTNERS**

**SHARED COLLABORATION & PARTNERSHIP**

**INFORMATION SHARING & SYSTEM CONNECTION**

# 7. WORKFORCE, TRAINING AND SERVICE STANDARDS



# 7. WORKFORCE, TRAINING AND SERVICE STANDARDS

The Community Crisis Response Model requires a skilled, supported, and sustainable workforce capable of responding safely and effectively to a broad range of crisis situations. The workforce should reflect a combination of professional expertise, lived experience, cultural knowledge, and community-based practice to support effective engagement, stabilization, and connection to care.

## 7.1 Workforce Model

The model is intended to be delivered through Community Response Partners operating within the Community Crisis Response Network. While participating organizations may vary in structure, specialization, and populations served, all would operate within a common crisis response framework and service expectations.

Community Crisis Response Teams should be multidisciplinary and may include crisis responders, social workers, mental health and addictions professionals, outreach workers, Indigenous service providers, nurses, and peer support workers with lived experience.

Peer support should be considered a core component of service delivery. Grounded in shared experience, peer support can strengthen engagement, build trust, and support recovery.

The model supports both generalist and specialized response approaches. While some organizations may provide broad crisis response services, others may focus on specific populations, cultural communities, age groups, geographic areas, or areas of expertise. This flexibility supports diverse community needs while maintaining a coordinated city-wide response system.

# 7. WORKFORCE, TRAINING AND SERVICE STANDARDS CONTINUED

## 7.2 Training and Competency Framework

To support service quality, consistency, and responder safety, a standardized Community Crisis Response Training and Competency Framework should be established across participating organizations.

The framework should define core competencies, onboarding requirements, and ongoing professional development standards while allowing organizations flexibility in how services are delivered.

Core competencies should include:

- Crisis assessment, intervention, and stabilization
- De-escalation and conflict resolution
- Mental health and substance use response
- Trauma-informed and person-centred practice
- Cultural safety, humility, and anti-oppressive approaches
- Indigenous perspectives and culturally responsive practices
- Community resource navigation and system coordination
- Communication, engagement, and relationship-building skills
- Safety awareness, situational assessment, and risk management
- Basic Life Support (BLS) and First Aid

Training should include standardized onboarding, ongoing professional development, scenario-based learning, and opportunities for cross-sector training.

A sample curriculum and competency framework are provided in Appendix F.

# 7. WORKFORCE, TRAINING AND SERVICE STANDARDS CONTINUED

## 7.3 Workforce Wellness and Sustainability

Crisis response work is complex, demanding, and often involves supporting individuals experiencing significant distress and vulnerability. As a result, workforce wellness, safety, retention, and long-term sustainability should be central considerations in the design and implementation of the proposed model.

Participating organizations should provide appropriate supervision, peer support, psychological health resources, responder safety protocols, training, and professional development opportunities. Workforce planning should also consider recruitment, retention, workload management, and career development to support long-term sustainability.

Compensation approaches should reflect the complexity and demands of crisis response work and seek to promote consistency across the Community Crisis Response Partner Network.

A healthy, well-supported workforce is essential to maintaining service quality, responder safety, and long-term system sustainability.

# 8. CRITICAL SUCCESS FACTORS FOR IMPLEMENTATION



# 8. CRITICAL SUCCESS FACTORS FOR IMPLEMENTATION

Successful implementation of the WCCR Model will require coordinated action across participating organizations and sustained investment in the operational foundations necessary to support long-term success.

## 8.1 Leadership, Governance and Partnerships

Implementation will require ongoing leadership, shared accountability, and strong partnerships among municipal and provincial government lead departments, emergency services, healthcare organizations such as Shared Health and WRHA, Indigenous partners, Community Crisis Dispatch and Coordination Hub Partner and the Community Response Partners. Clear governance structures, defined roles and responsibilities, and formal partnership agreements will be essential to supporting coordinated implementation and long-term sustainability.

Successful implementation will require participating organizations to identify crisis response reform as a strategic priority and dedicate the leadership, authority, resources, and organizational capacity necessary to support implementation and ongoing system improvement.

# 8. CRITICAL SUCCESS FACTORS FOR IMPLEMENTATION CONTINUED

## 8.2 System Integration and Service Alignment

Successful implementation will require the WCCR Model to function as an integrated component of Winnipeg's broader crisis response system rather than as a standalone service. This includes alignment with existing emergency communications, triage, dispatch, referral, and coordination processes, supported by clear operational protocols, service pathways, information-sharing agreements, and escalation procedures. Implementation will also require coordinated approaches to continuity of care, including effective transitions between services and strong connections to appropriate health, mental health, addictions, and community-based supports.

Successful implementation will further require clarity regarding the relationship between community-based crisis response services, co-response models, and existing crisis response teams.

The proposed WCCR Model is intended to complement, rather than replace, existing co-response services. While community-based crisis response is designed for appropriate non-violent, non-criminal, and non-life-threatening situations, co-response models continue to play an important role in circumstances involving elevated risk, Mental Health Act considerations, criminal justice involvement or history of involvement, complex risk assessment, and other situations requiring specialized clinical expertise and police partnership.

The implementation of the WCCR Model creates an opportunity to better align individuals with the most appropriate response based on their needs and circumstances. This may allow co-response services such as the Alternative Response to Citizens in Crisis (ARCC) program, to focus more consistently on higher-acuity situations aligned with their core mandate, while community-based crisis response teams support individuals whose needs can be safely addressed through a non-enforcement, community-based approach.

Co-response services may also remain appropriate for certain situations that do not meet Fourth Crisis Response eligibility criteria but require specialized clinical assessment, enhanced risk evaluation, or a more comprehensive understanding of an individual's history and circumstances.

Successful implementation will require clear service criteria, triage pathways, referral processes, and operational interfaces between co-response services, community-based crisis response teams, and emergency communications systems to ensure individuals receive the most appropriate response based on their needs, circumstances and level of risk.

**The implementation of the WCCR Model creates an opportunity to better align individuals with the most appropriate response based on their needs and circumstances.**

# 8. CRITICAL SUCCESS FACTORS FOR IMPLEMENTATION CONTINUED

## 8.3 Workforce, Safety and Service Standards

Implementation will depend on the availability of a skilled, supported, and sustainable workforce. Consideration should be given to workforce capacity, training requirements, responder safety, supervision, recruitment and retention strategies, and the establishment of consistent service standards across participating organizations.

## 8.4 Balancing Standardization and Flexibility

Successful implementation will require balancing the need for consistent service standards with the flexibility necessary to reflect the strengths, expertise, and diversity of participating organizations.

Elements such as triage and escalation pathways, response eligibility criteria, minimum response time standards, safety protocols, documentation requirements, information-sharing practices, training expectations, reporting and acountability requirements, and quality assurance processes should remain standardized across the system. At the same time, Community Response Partners should retain flexibility in areas such as care methodologies, cultural approaches, Indigenous-led practices, staffing models and community engagement strategies. This balance will support both system integration and community innovation.

## 8.5 Evaluation and Continuous Improvement

A performance measurement and evaluation framework must be established to support accountability, system learning, and continuous improvement. Evaluation should include service utilization, response times, client outcomes, responder safety, continuity of care, equity considerations, and system-level impacts.

Evaluation should be informed by both quantitative and qualitative data, including feedback from Community Response Partners and governance bodies. Incorporating diverse perspectives will support ongoing learning, service refinement and system improvement.

# 8. CRITICAL SUCCESS FACTORS FOR IMPLEMENTATION CONTINUED

## 8.6 Sustainability and Change Management

Long-term success will depend on stable funding, effective change management and continued partner commitment. Successful implementation will require participating organizations to adopt shared protocols, referral pathways, communication processes, and coordinated service delivery practices that support a seamless experience for individuals accessing crisis services through the emergency services diversion pathway.

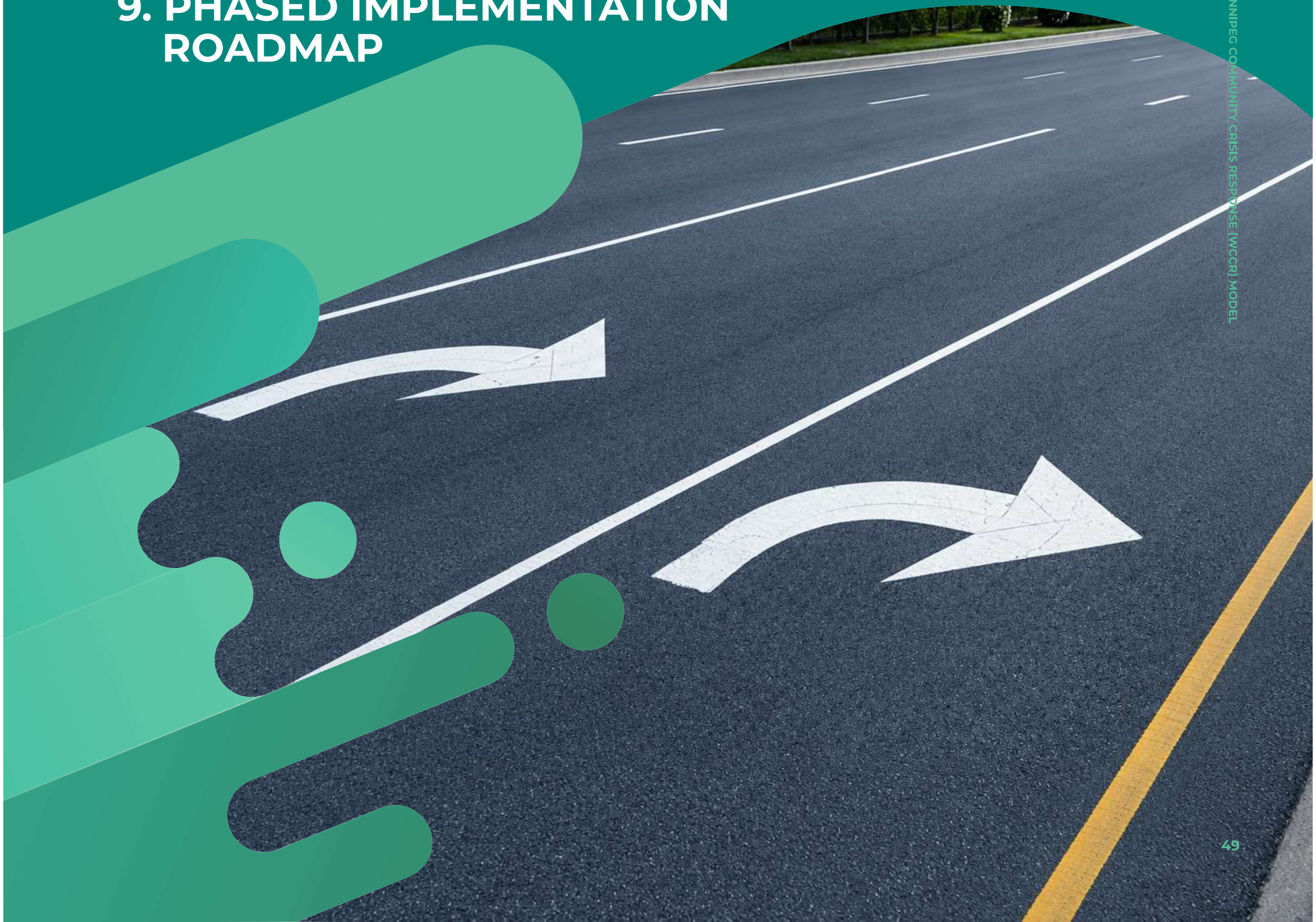
Implementation should be approached as a phased and iterative process that supports learning, adaptation, and continuous improvement over time.

## 8.7 Selecting Community Crisis Response Partners

Community Crisis Response Partners should be selected through a structured designation process based on clearly defined organizational, operational, and service delivery requirements. Designated providers should demonstrate the governance, workforce capacity, operational readiness, policies, quality assurance, and collaborative partnerships necessary to safely and sustainably deliver crisis response services through the 911 diversion pathway. This approach supports consistent, high-quality service delivery, public confidence, and the long-term success of the WCCR Model.

**Long-term success will depend on stable funding, effective change management and continued partner commitment.**

# 9. PHASED IMPLEMENTATION ROADMAP



# 9. PHASED IMPLEMENTATION ROADMAP

Implementation of the WCCR Model should occur through a phased approach that supports organizational readiness, operational learning, evaluation, and continuous improvement. Progression between phases should be informed by performance monitoring, evaluation findings and operational readiness.

The proposed roadmap consists of four phases: Planning and Mobilization, Initial Implementation, Expansion and System Integration, and Full-Scale Implementation and Continuous Improvement.

## 1 BUILD IT

**ESTABLISH THE FOUNDATION**

- Governance
- Enhanced 911 Triage
- Crisis Coordination & Dispatch Hub
- Workforce
- Technology & Data
- Evaluation Framework

## 2 LAUNCH IT

**INTRODUCE THE FOURTH CRISIS RESPONSE PATHWAY**

- Community Mobile Response
- Appropriate 911 Diversion
- 24/7 Operations
- Evaluation Framework
- Performance Monitoring and Initial Evaluation

## 3 EXPAND IT

**GROW REACH AND CAPACITY**

- Additional Partners
- Expanded Geography
- Additional Team Types
- Refined Operations
- Evaluation and Scale Readiness

## 4 SCALE IT

**FULLY INTEGRATED CRISIS RESPONSE SYSTEM**

- 24/7 City-Wide Coverage
- Community Access Pathways
- Matuer System Integration
- Continuous Improvement

# 9. PHASED IMPLEMENTATION ROADMAP CONTINUED

## 1 Planning and Mobilization Build it

**Purpose:**
Establish the governance, partnerships, infrastructure, workforce, funding, and operational foundations required to launch the model.

**Key Activities:**
- Establish governance structures, partnership agreements, implementation leadership, and organizational responsibilities;
- Complete detailed business planning and financial analysis to confirm operating models, implementation costs, resource requirements, short-term and long-term funding needs, and opportunities to leverage existing community assets, infrastructure, services, and investments;
- Develop a detailed implementation and project plan;
- Secure funding and identify the resources required to support implementation and initial operations;
- Consideration should also be given to establishing dedicated municipal capacity to support implementation leadership, governance coordination, partnership development, performance monitoring, and ongoing system stewardship;
- Identify Community Response Partners and establish service agreements, performance expectations, and accountability mechanisms;
- Finalize the Community Crisis Dispatch and Coordination Hub model, operational requirements, and technology needs;
- Develop diversion criteria operating process, triage protocols, dispatch processes, referral pathways, and safety procedures;
- Establish information-sharing, privacy, data governance, and evaluation frameworks;
- Complete workforce recruitment and training, communications, and readiness planning;

and
- Identify and establish the technology infrastructure required to support implementation and operations.

**Outcome:**
Governance, funding, workforce, operational, and system infrastructure established to support implementation.

# 9. PHASED IMPLEMENTATION ROADMAP CONTINUED

## 2 Initial Implementation Launch It

**Purpose:**
Launch the Fourth Crisis Response pathway within a defined geographic area and validate core operating processes.

**Key Activities:**
- Launch enhanced 911 triage and diversion processes;
- Operationalize the Community Crisis Dispatch and Coordination Hub;
- Deploy limited Community Response Partners and mobile crisis response teams;
- Implement geographic crisis response teams within an initial high-demand service area;
- Launch 24/7 service delivery within the identified implementation area;
- Proceed with diversion of approved crisis response call categories;
- Implement performance monitoring and reporting processes; and
- Complete formal six-month and twelve-month evaluations.

**Outcome:**
A functioning Fourth Crisis Response pathway with validated operational processes, performance data, and evaluation findings.

# 9. PHASED IMPLEMENTATION ROADMAP CONTINUED

## 3 Expansion and System Integration - Expand It

**Purpose:**
Expand service capacity and strengthen integration across the crisis response continuum.

**Key Activities:**
- Expand geographic coverage;
- Implement specialized response pathways where appropriate;
- Increase community response capacity based on demand;
- Strengthen coordination with healthcare, Indigenous, emergency service, and community partners;
- Expand post-crisis follow-up and continuity-of-care pathways;
- Formalize referral, transition, and service coordination pathways across participating systems;

and

- Refine operational processes based on evaluation findings.
- Evaluate service performance, outcomes, and implementation readiness to inform progression to full-scale implementation.

**Outcome:**
Expanded service capacity and stronger integration across participating systems and service providers.

# 9. PHASED IMPLEMENTATION ROADMAP CONTINUED

## 4 Full-Scale Implementation and Continuous Improvement Scale It

**Purpose:**
Establish the model as a fully integrated component of Winnipeg's crisis response system.

**Key Activities:**
- Achieve city-wide 24/7 service coverage;
- Expand implementation of specialized response pathways where appropriate;
- Fully integrate crisis coordination, triage, dispatch, response, follow-up, and referral functions;
- Maintain ongoing evaluation, quality improvement, and public reporting;

and

- Use performance data and outcomes to inform future service enhancements.

**Outcome:**
A sustainable, 24/7 city-wide community crisis response system providing coordinated and person-centred crisis support.

# 9. PHASED IMPLEMENTATION ROADMAP CONTINUED

The roadmap outlined in this report focuses on the project's primary mandate: establishing a Fourth Crisis Response pathway for appropriate 911 calls through a coordinated community-based crisis response system. As the model matures, opportunities exist to further strengthen Winnipeg's broader crisis response continuum and system of care.

## OPPORTUNITY 1:

### Strengthen Coordination and Continuity of Care

The proposed Fourth Crisis Response Model focuses on establishing a community-based response pathway for appropriate 911 calls. While this represents an important step forward, additional opportunities do exist to strengthen coordination across Winnipeg's broader crisis response continuum.

Future development may focus on improving how individuals move between services as their needs evolve. Opportunities may include enhanced referral pathways, shared protocols, information-sharing mechanisms, and continuity-of-care processes that support more coordinated and seamless service delivery.

Over time, greater coordination could also create opportunities for community crisis response providers to access and leverage shared system resources and specialized supports.

Examples may include direct access to virtual mental health assessments, virtual crisis consultation services, virtual opioid use disorder treatment supports, Manitoba Connect, Project ECHO (Extension for Community Healthcare Outcomes) and other centralized resources that can assist responders in assessing needs, providing timely interventions, and connecting individuals to appropriate care. Such approaches can enhance continuity of care, improve service navigation, reduce barriers to access, and help ensure individuals receive the right support at the right time.

# 9. PHASED IMPLEMENTATION ROADMAP CONTINUED

## OPPORTUNITY 2:

### Expand Community Access Pathways

The proposed model is designed primarily as a 911 diversion pathway. Future phases of system development may explore opportunities to extend access beyond the 911 system by enabling approved community-based access points to connect individuals directly with community crisis response services through the Community Crisis Dispatch and Coordination Hub.

This could create additional pathways to support for individuals seeking help through community organizations, crisis lines, healthcare providers, Indigenous-led services, or other approved access points. Such an approach could strengthen access, improve system navigation, and support a “no wrong door” approach to crisis response.

# 9. PHASED IMPLEMENTATION ROADMAP CONTINUED

## OPPORTUNITY 3:

### Enhance Accessibility and Equity

Future planning should consider how crisis response services can be made more accessible and responsive to Winnipeg's diverse communities. Opportunities may include the use of multiple communication channels, such as telephone, text, chat, and other digital access options, as well as multilingual services, culturally responsive approaches, and Indigenous-led access pathways.

Consideration should also be given to reducing barriers for individuals who may experience challenges accessing traditional crisis services, including youth, people who are deaf or hard of hearing, individuals experiencing anxiety, newcomers, refugees, and others who may benefit from alternative methods of engagement and support.

These opportunities are not presented as recommendations for implementation by the City of Winnipeg as part of the Fourth Response Model. Rather, they represent potential future directions that could build upon the foundation established through implementation of the Fourth Crisis Response pathway, with the long-term objective of creating a more accessible, coordinated, equitable, and person-centred crisis response system.

# 9. PHASED IMPLEMENTATION ROADMAP CONTINUED

## OPPORTUNITY 4:

### Strengthen Involuntary Assessment and Protective Custody Pathways

While the proposed Fourth Crisis Response Model focuses on voluntary and consent-based crisis response, stakeholders consistently identified growing pressures associated with involuntary apprehensions and transports under legislative authorities such as The Mental Health Act, The Intoxicated Persons Detention Act, and other applicable legislation.

These situations often require police, paramedic, and emergency department involvement and remain an important component of the broader crisis response continuum. The volume and complexity of these situations appear to be increasing, placing significant demands on emergency services and hospital emergency departments. In particular, emergency responders may spend considerable time waiting to transfer care of individuals transported for involuntary assessment or protective custody, reducing the availability of those resources to respond to other community emergencies.

Future system planning should prioritize improving coordination between emergency services, healthcare providers, and hospital-based mental health services to support more efficient care transitions and reduce handoff delays. Such efforts could help improve system capacity, enhance the experience of individuals in crisis, and support the more effective use of emergency service resources while maintaining safety, rights, and dignity.

# 10. EXPECTED OUTCOMES AND SYSTEM BENEFITS



# 10. EXPECTED OUTCOMES AND SYSTEM BENEFITS

While outcomes will ultimately depend on implementation, service utilization, partner participation, and ongoing evaluation, the proposed WCCR Model is expected to generate benefits for individuals and families, communities, emergency services and public safety partners, and the healthcare system. Together, these outcomes contribute to a more coordinated, effective, and person-centred approach to crisis response in Winnipeg.

## EXPECTED BENEFITS OF THE WCCR MODEL

### FOR INDIVIDUALS

Right care, right time, right provider.

Compassionate, person-centred crisis response.

Recovery through post-crisis follow up support and connection to care.

Better outcomes for individuals and families.

### FOR COMMUNITIES

Stronger community wellbeing and resilience.

Greater confidence in crisis response.

Stronger partnerships across community services.

More connected and coordinated systems of care.

### FOR EMERGENCY SERVICES, PUBLIC SAFETY & JUSTICE

Reduced demand and pressure on emergency services.

More time and resources for emergencies and crime response.

Improved response effectiveness and system responsiveness.

Reduced unnecessary justice system involvement.

### FOR HEALTHCARE

Better coordinated care across systems.

Improved recovery through continuity of care.

Reduced reliance on emergency and acute care.

Better health outcomes and resource utilization.

# 10. EXPECTED OUTCOMES AND SYSTEM BENEFITS CONTINUED

## 10.1 Improved Outcomes for Individuals and Families

The WCCR Model is intended to improve the experience and outcomes of individuals and families seeking support during times of crisis. By providing the right response from the right provider at the right time, individuals can receive timely, compassionate, and appropriate care in the least intrusive setting capable of meeting their needs. Through proactive follow-up, continuity of care, and connections to ongoing health, mental health, substance use, social, cultural, and community supports, the model is intended to help individuals stabilize, recover, and achieve greater long-term wellbeing. Families and caregivers may also benefit from improved support, navigation, and confidence that their loved ones are receiving appropriate care.

# 10. EXPECTED OUTCOMES AND SYSTEM BENEFITS CONTINUED

## 10.2 Stronger Communities and Community Wellbeing

By providing support before situations escalate, the WCCR Model has the potential to strengthen community wellbeing, resilience, and public confidence in crisis response services. At its core, the model is intended to ensure individuals experiencing crisis receive the right support in the right setting, helping communities respond through care, connection, and support rather than relying solely on emergency interventions. By helping individuals stabilize, recover, and connect to ongoing health, social, and community supports, the model has the potential to reduce repeated crises, strengthen overall community wellbeing, and improve quality of life for residents. It also supports greater confidence among residents, businesses, and community partners that individuals experiencing crisis will receive timely, compassionate, and appropriate care.
The model builds upon existing community strengths while fostering greater collaboration between community organizations, Indigenous-led partners, healthcare providers, emergency services, and other system partners to create a more connected, coordinated, and resilient community response to crisis.

# 10. EXPECTED OUTCOMES AND SYSTEM BENEFITS CONTINUED

## 10.3 Benefits for Emergency Services, Public Safety, and Justice

The WCCR Model is expected to support more appropriate utilization of police, fire, paramedic, and emergency communications resources by directing eligible non-emergent crisis situations to community-based responders. This approach allows police officers to spend more time responding to crime, public safety concerns, and situations requiring enforcement authorities, while enabling firefighters and paramedics to focus on medical emergencies, rescue incidents, fires, and other emergency responses requiring their specialized expertise and capabilities. By ensuring individuals receive the most appropriate response for their needs, the model also has the potential to reduce unnecessary involvement with the justice system, improve public confidence in emergency response, and support safer outcomes for both responders and the community. Overall, reducing demand associated with eligible non-emergent crisis calls can improve emergency resource availability, response effectiveness, and system responsiveness across Winnipeg's emergency services.

**By providing responses that are better aligned with underlying needs, the model may reduce stigma, promote dignity, and improve outcomes for individuals who would otherwise encounter emergency or justice systems when enforcement is not required.**

# 10. EXPECTED OUTCOMES AND SYSTEM BENEFITS CONTINUED

## 10.4 Benefits for Healthcare Systems

The WCCR Model is expected to strengthen coordination between healthcare, crisis response, and community-based services while improving access to appropriate care for individuals experiencing crisis. By providing timely intervention, proactive follow-up, and connections to ongoing health, mental health, substance use, social, and community supports, the model can help individuals stabilize, recover, and address underlying needs before they escalate into future crises. This continuity of care has the potential to improve individual and population health outcomes while reducing reliance on emergency departments, hospital admissions, and other acute care responses where they are not clinically required.

Over time, the model supports more effective use of healthcare resources by ensuring individuals receive the right care, in the right setting, at the right time.

# 11. RECOMMENDATIONS



# 11. RECOMMENDATIONS

Based on the findings and conclusions of this report, the following recommendations are proposed for consideration by the City of Winnipeg and key system partners. The recommendations should be considered as an integrated package, as each recommendation supports the successful implementation and long-term sustainability of the WCCR Model.

## RECOMMENDATION 1:

### Adopt the Winnipeg Community Crisis Response Model

That the City of Winnipeg adopt the WCCR Model outlined in this report as the future direction for crisis response reform in Winnipeg and support the development of a Fourth Crisis Response pathway for the diversion of appropriate 911 calls to community-based crisis response services.

## RECOMMENDATION 2:

### Establish a Municipal-Provincial Partnership Framework

That the City of Winnipeg initiate discussions with the Province of Manitoba and key system partners to establish a shared commitment to the WCCR Model and a collaborative framework to support implementation, governance, funding, accountability, and long-term sustainability.

This partnership should support a coordinated whole-of-government and whole-of-community approach to implementation, recognizing that sustainable crisis response reform cannot be achieved by any single organization, sector, or order of government acting alone.

## RECOMMENDATION 3:

### Establish the Foundation for Implementation

That the City of Winnipeg and implementation partners undertake Phase 1: Planning and Mobilization key activities required to support implementation of the WCCR Model, including establishing governance and accountability structure, developing the operating model and detailed implementation plan, completing detailed business planning and costing, securing funding, advancing workforce development, establishing technology and information-sharing requirements and developing a performance measurement and evaluation framework.

Consideration should also be given to establishing dedicated municipal capacity to support implementation leadership, governance coordination, partnership development, performance monitoring, and ongoing system stewardship.

# 11. RECOMMENDATIONS CONTINUED

## RECOMMENDATION 4:

### Implement the Model Through a Phased Approach

That the City of Winnipeg and implementation partners proceed with the phased implementation approach outlined in this report, beginning with Phase 2: Initial Implementation and the launch of the WCCR Model within a defined catchment area. Initial implementation should operationalize the core components of the Fourth Crisis Response pathway and be supported by ongoing evaluation, quality improvement, and continuous learning to guide future expansion and model refinement.

## RECOMMENDATION 5:

### Strengthen Coordination Across Existing Crisis Response Services

That the City of Winnipeg, Winnipeg Police Service, Winnipeg Fire Paramedic Service, Shared Health, and other system partners undertake further planning to strengthen coordination among existing mobile crisis response services, including co-response and community-based crisis response models, within the broader crisis response continuum.

Particular consideration should be given to reviewing the future role of the Alternative Response to Citizens in Crisis (ARCC) program within the crisis response continuum, including its mandate, service criteria, triage pathways, and relationship to the WCCR Model. This work should establish clear guidance regarding when a co-response model is required and when individuals can be more appropriately supported through a community-based crisis response pathway.

# 12. APPENDICES



# 12. APPENDICES

## APPENDIX A: GLOSSARY OF TERMS AND ACRONYMS

| TERM / ACRONYM | DEFINITION |
|---|---|
| ARCC | Alternative Response to Citizens in Crisis, a co-response program involving police officers and mental health professionals that responds to individuals experiencing mental health crises requiring both health and public safety expertise. |
| Community Access Pathway | A proposed future non-emergency pathway that would allow individuals, families, service providers, and community organizations to directly access community-based crisis response services outside of the 911 system. |
| Community Crisis Dispatch and Coordination Hub | The centralized coordination function proposed within the WCCR Model, responsible for receiving, matching, dispatching, and coordinating crisis response requests across participating community-based crisis response providers. |
| Community Response Partner | A designated community organization responsible for delivering community-based mobile crisis response services within the proposed model. |
| DCSP | Downtown Community Safety Partnership. |
| FIPPA | Freedom of Information and Protection of Privacy Act (Manitoba). |
| Fourth Response Pathway | A proposed emergency communications pathway that diverts appropriate non-emergent mental health, substance use, wellness, and social crises 911 calls to community-based crisis responders when police, fire, or paramedic response is not required. |
| From Call to Care | The guiding vision underpinning of the proposed WCCR model, emphasizing a coordinated pathway that moves individuals from the point of seeking help to appropriate care, support, stabilization, and recovery. |
| Indigenous | Throughout this document, the term Indigenous is used to describe the experiences of First Nation, Inuit and Métis service users. |
| MHA | Mental Health and Addiction |
| No Wrong Door | A service principle that ensures individuals can access support through multiple entry points and be connected to the most appropriate service regardless of where they first seek help. |
| PSAP | Public Safety Answering Point, the communications centre responsible for receiving and processing 911 calls. |
| PWLE | People with Lived Experience |
| WCCR | The proposed Winnipeg community-based crisis response service model that integrates access pathways, coordination functions, mobile crisis response, and post-crisis supports. |
| WFPS | Winnipeg Fire Paramedic Service |
| WPS | Winnipeg Police Service |
| WRHA | Winnipeg Regional Health Authority |

## Additional Terms

**Collective Impact**
A structured approach to collaboration in which organizations from different sectors work together toward a shared goal using common objectives, coordinated action, continuous communication, and shared accountability.

**Continuum of Care**
A coordinated approach that supports individuals from the point of crisis through stabilization, follow-up and connection to ongoing services and supports.

**Integrated Crisis Response System**
A coordinated network of emergency services, healthcare providers, community organizations, Indigenous-led organizations, crisis services, and other partners working together to provide timely, appropriate and person-centred responses to individuals experiencing crisis.

**Integrated Triage**
A structured assessment process used to determine the most appropriate response based on an individual's needs, presenting circumstances, level of risk and available response options.

# 12. APPENDICES
# APPENDIX B: DESIGN PROCESS AND METHODOLOGY

## Project Governance

The project was supported by an Executive Advisory Committee, a multidisciplinary Taskforce, and ongoing engagement with system partners, service providers, community organizations, Indigenous-led organizations, and people with lived experience. Together, these groups provided strategic advice, operational expertise, and feedback throughout the design process.

## Design Methodology

The proposed WCCR Model was developed using a multi-method design approach that combined stakeholder and community engagement, research evidence, jurisdictional review, operational observations, and local system analysis.

Engagement findings were considered alongside evidence from Canadian and international literature, jurisdictional reviews, operational observations, site visits, administrative data, and partner-provided information. Together, these activities informed the identification of current-state challenges, opportunities for improvement, future-state design considerations, and implementation requirements.

The project included direct engagement with crisis response systems operating in other jurisdictions, in-person site visits and meetings with organizations involved in the Toronto Community Crisis Service, operational observations within emergency communications and crisis response environments, and analysis of local Winnipeg data. These activities provided practical insight into frontline operations, service coordination, system pressures, implementation considerations, and emerging leading practices.

# 12. APPENDICES

## APPENDIX C: STAKEHOLDER AND COMMUNITY ENGAGEMENT SUMMARY

### Purpose of Engagement

Stakeholder and community engagement was a foundational component of the project and was undertaken to inform the design of a proposed Fourth Crisis Response Model for Winnipeg. Engagement activities were intended to gather perspectives on current system strengths, challenges, opportunities, priorities, and future directions for crisis response services.

The engagement process emphasized collaboration, co-design, validation, and continuous feedback to ensure the proposed model reflected operational realities, community priorities, evidence-informed practices, and the experiences of individuals who interact with the crisis response system.

### Engagement Activities

Engagement activities included:

- Project Taskforce meetings;
- Executive Advisory Committee meetings;
- Individual meetings and consultations with system partners;
- Community service provider and stakeholder engagement sessions;
- Indigenous-focused engagement and consultation sessions;
- Engagement sessions with people with lived experience;
- Operational discussions with emergency services, healthcare providers, and community organizations;
- Observational reviews, ride-alongs, site visits, and direct operational exposure with crisis response teams, community-based service providers, and emergency communications personnel;
- Direct observation of emergency communications, call-taking, dispatch, and crisis response processes within the 911 communications environment;
- Jurisdictional interviews, site visits, and knowledge exchange discussions with external crisis response systems and service providers;

and

- Ongoing validation and feedback sessions throughout the design process.

# 12. APPENDICES

## APPENDIX C: STAKEHOLDER AND COMMUNITY ENGAGEMENT SUMMARY

### Participation Overview

The engagement process included representation from a broad range of sectors, disciplines, organizations, and perspectives involved in crisis response, community safety, health, wellness, and social service delivery in Winnipeg, including:

- Municipal government and civic administration;
- Provincial government representatives and system leaders;
- Emergency services, including police, fire, paramedic, and emergency communications representatives;
- Healthcare organizations, mental health services, addiction services, and crisis response providers;
- Academic and research partners;
- Community health organizations and service providers;
- Community social service organizations and support agencies;
- Community-based crisis response organizations and mobile crisis service providers;
- Community safety and outreach organizations;
- Service navigation and information services;
- Indigenous organizations, service providers, community leaders, and Knowledge Keepers;
- Shelter providers and homelessness-serving organizations;
- Youth-serving organizations and youth-focused service providers;
- Peer support organizations and individuals with lived experience; and
- Former healthcare, policing, and community sector executives and subject matter experts.

Engagement was intentionally designed to ensure diverse perspectives informed the development and validation of the proposed model.

# 12. APPENDICES
## APPENDIX D: JURISDICTIONAL SCAN SUMMARY

A jurisdictional scan was undertaken to examine a broad range of Canadian and international crisis response models, programs, and system reforms designed to provide community-based, non-enforcement alternatives or complements to traditional emergency service responses for mental health, substance use, wellness, and social crises. The review included established and emerging models, as well as relevant literature, evaluations, policy reports, and implementation frameworks.

Particular attention was given to jurisdictions demonstrating strong alignment with the objectives of this project, including models that integrate community-based responders with emergency communications, healthcare, and public safety systems. The jurisdictions highlighted below represent a selection of the models most closely aligned with the proposed WCCR Model and are not intended to represent the full scope of jurisdictions reviewed.

# 12. APPENDICES

## APPENDIX D: JURISDICTIONS REVIEWED

| JURISDICTION | PROGRAM | DESCRIPTION |
|---|---|---|
| Toronto, Ontario | Toronto Community Crisis Service (TCCS) | A community-based mobile crisis response program accessed through 911 diversion and 211 pathways. Teams are led by community agencies and typically include crisis workers and mental health professionals who respond to non-emergent mental health and wellness crises without police involvement. |
| Ottawa, Ontario | Alternate Neighbourhood Crisis Response (ANCHOR) | A community-led crisis response program accessible through both 211 and 911 referral pathways. Multidisciplinary teams of crisis responders provide non-police intervention and support individuals experiencing mental health, substance use and social crises. |
| Halifa, Nova Scotia | Community Assessment, Response and Engagement (CARE) Team | A mobile crisis response service dispatched through 211 and 911 pathways for appropriate non-emergent calls. Teams consist of mental health clinicians and community outreach workers who provide crisis intervention, assessment, stabilization, and service navigation. |
| British Columbia | Crisis Response and Community-Led (CRCL) Program | A provincially funded, community-led crisis response model accessed through dedicated crisis line, text, and community referral pathways rather than 911 dispatch. Teams typically include civilian crisis responders, peer support workers, and mental health professionals, with police involvement only when required for safety. |
| Edmonton, Alberta | 24/7 Crisis Diversion Program | Dispatched primarily through 211 and referrals from emergency services, this crisis diversion program redirects appropriate non-emergency calls from police, EMS, and other responders to community-based crisis teams. Teams are typically composed of crisis intervention workers and social service professionals who provide immediate crisis support and connect individuals to appropriate community services. |
| Eugene, Oregon | Crisis Assistance Helping Out On The Streets (CAHOOTS) | Dispatched through the 911 emergency communications system, teams consisting of a paramedic and a crisis worker provide a community-based response to mental health, substance use, homelessness, and wellness-related calls as an alternative to police response. |
| Denver, Colorado | Support Team Assisted Response (STAR) | A 911-dispatched alternative response program for low-risk behavioural health, substance use, and social service calls. Teams consist of a mental health clinician and a paramedic who provide a health-focused response and connect individuals to appropriate community supports. |
| Minneapolis, Minnesota | Behavioral Crisis Response (BCR) | A 911-dispatched mobile crisis response program that deploys unarmed teams of mental health professionals and crisis practitioners, supported by peer-informed and recovery-oriented approaches. |
| Durham, North Carolina | Holistic Empathetic Assistance Response Team (HEART) | A 911-integrated crisis response model that combines crisis call diversion, clinical triage, and civilian mobile response. Multidisciplinary teams, which may include mental health clinicians, peer support specialists and paramedics depending on the nature of the crisis. |
| United Kingdom | Right Care, Right Person (RCRP) | A national policing framework that redirects health, mental health and social care incidents to the most appropriate service rather than police by default. The model relies on existing health, crisis, and community response teams rather than dedicated police-led crisis units, emphasizing system-wide triage and referral pathways. |

# 12. APPENDICES
# APPENDIX D: JURISDICTIONAL SCAN SUMMARY

## Key Themes Identified Across Jurisdictions

The jurisdictional review identified several common themes across leading crisis response systems:

- Community-based, non-enforcement crisis response is increasingly recognized as an appropriate response for many non-violent mental health, substance use, wellness, and social crises.
- Mature crisis response models are integrated with emergency communications, healthcare, and public safety systems rather than operating independently.
- Effective models rely on strong cross-sector partnerships and coordinated pathways among municipalities, provincial governments, emergency services, healthcare providers, community organizations, crisis lines, and Indigenous-led organizations.
- Multiple access pathways, supported by shared triage, referral, and escalation protocols, help ensure individuals receive the right response at the right time and can move seamlessly between services as needs change.
- Successful models extend beyond immediate crisis response to include follow-up support, service navigation, and connection to ongoing care.
- People with lived experience, Indigenous leadership, cultural safety, and culturally responsive approaches are increasingly recognized as essential components of crisis response systems.
- Successful models emphasize coordinated system responses that leverage and strengthen existing community resources rather than creating standalone services.

The findings from the jurisdictional scan informed the development of the proposed WCCR Model and were considered alongside local data analysis, engagement activities, evidence review, operational observations, and consultation with community partners.

# 12. APPENDICES
## APPENDIX E: DATA SOURCES

The findings, observations, and recommendations contained within this report were informed through a combination of stakeholder engagement, administrative data, jurisdictional review, site observations, and publicly available literature.

| SOURCE | DESCRIPTION |
|---|---|
| Stakeholder and Partner Engagement | Input gathered through Taskforce meetings, individual interviews, working sessions, community engagement sessions, Indigenous engagement sessions, and focus groups involving people with lived experience. |
| Winnipeg Fire Paramedic Service (WFPS) | Administrative and operational data related to call volumes, response patterns, service demand, dispatch processes, and crisis-related interactions. |
| Healthcare System Partners | Information and perspectives provided by Shared Health, the Winnipeg Regional Health Authority, crisis services, healthcare providers, and other system partners. |
| Community Organizations and Indigenous Partners | Input gathered through individual meetings, engagement and working sessions and focus groups involving community-based organizations, Indigenous-led organizations, outreach services, peer support organizations, and crisis response providers. |
| People with Lived Experience (PWLE) | Perspectives and experiences shared by people with lived experience through focus groups and engagement sessions and consultations. |
| Jurisdictional Review | Review of crisis response models, implementation approaches, evaluations, and leading practices from jurisdictions across Canada, the United States, Australia, and the United Kingdom. |
| Site Visits and Observations | Direct observations conducted with emergency communications centres, crisis response services, and community-based crisis response partners, including jurisdictional site visits and partner meetings in Toronto. |
| Publicly Available Reports and Literature | Government reports, evaluation reports, academic literature, policy documents, and other publications related to crisis response, mental health, substance use, community safety, and integrated service delivery. |
| Freedom of Information and Protection of Privacy Act (FIPPA) Requests | Information obtained through formal information requests where applicable and available. |

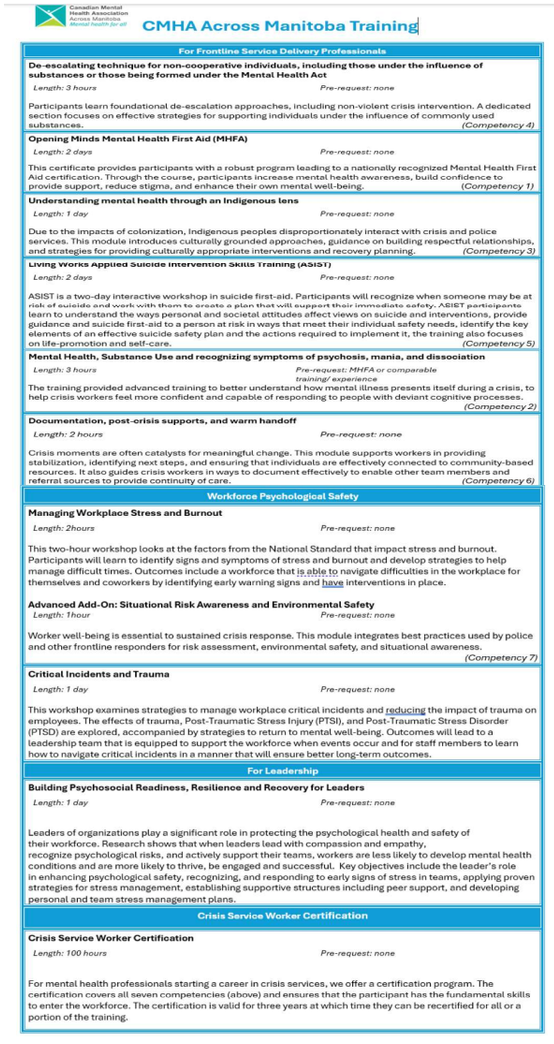
# 12. APPENDICES

## APPENDIX F: SAMPLE CURRICULUM AND COMPETENCY FRAMEWORK

This appendix presents a sample curriculum and competency framework for psychological and behavioural crisis response developed by the Canadian Mental Health Association.

Training may be provided during onboarding and throughout employment to support ongoing competency development. The framework also explores a crisis worker certification program to promote standardized practice, among service providers and support the professionalization of the crisis response workforce.

As a locally developed Manitoba framework, it could be adopted or adapted to support workforce development, training and competency requirements associated with implementation of the WCCR Model.



Canadian Mental Health Association Across Manitoba

**CMHA Across Manitoba Training**

**For Frontline Service Delivery Professionals**

**De-escalating technique for non-cooperative individuals, including those under the influence of substances or those being formed under the Mental Health Act**

*Length: 3 hours* *Pre-request: none*

Participants learn foundational de-escalation approaches, including non-violent crisis intervention. A dedicated section focuses on effective strategies for supporting individuals under the influence of commonly used substances. *(Competency 4)*

**Opening Minds Mental Health First Aid (MHFA)**

*Length: 2 days* *Pre-request: none*

This certificate provides participants with a robust program leading to a nationally recognized Mental Health First Aid certification. Through the course, participants increase mental health awareness, build confidence to provide support, reduce stigma, and enhance their own mental well-being. *(Competency 1)*

**Understanding mental health through an Indigenous lens**

*Length: 1 day* *Pre-request: none*

Due to the impacts of colonization, Indigenous peoples disproportionately interact with crisis and police services. This module introduces culturally grounded approaches, guidance on building respectful relationships, and strategies for providing culturally appropriate interventions and recovery planning. *(Competency 3)*

**Living Works Applied Suicide Intervention Skills Training (ASIST)**

*Length: 2 days* *Pre-request: none*

ASIST is a two-day interactive workshop in suicide first-aid. Participants will recognize when someone may be at risk of suicide and work with them to create a plan that will support their immediate safety. ASIST participants learn to understand the ways personal and societal attitudes affect views on suicide and interventions, provide guidance and suicide first-aid to a person at risk in ways that meet their individual safety needs, identify the key elements of an effective suicide safety plan and the actions required to implement it, the training also focuses on life-promotion and self-care. *(Competency 5)*

**Mental Health, Substance Use and recognizing symptoms of psychosis, mania, and dissociation**

*Length: 3 hours* *Pre-request: MHFA or comparable training/ experience*

The training provided advanced training to better understand how mental illness presents itself during a crisis, to help crisis workers feel more confident and capable of responding to people with deviant cognitive processes. *(Competency 2)*

**Documentation, post-crisis supports, and warm handoff**

*Length: 2 hours* *Pre-request: none*

Crisis moments are often catalysts for meaningful change. This module supports workers in providing stabilization, identifying next steps, and ensuring that individuals are effectively connected to community-based resources. It also guides crisis workers in ways to document effectively to enable other team members and referral sources to provide continuity of care. *(Competency 6)*

**Workforce Psychological Safety**

**Managing Workplace Stress and Burnout**

*Length: 2hours* *Pre-request: none*

This two-hour workshop looks at the factors from the National Standard that impact stress and burnout. Participants will learn to identify signs and symptoms of stress and burnout and develop strategies to help manage difficult times. Outcomes include a workforce that is able to navigate difficulties in the workplace for themselves and coworkers by identifying early warning signs and have interventions in place.

**Advanced Add-On: Situational Risk Awareness and Environmental Safety**

*Length: 1hour* *Pre-request: none*

Worker well-being is essential to sustained crisis response. This module integrates best practices used by police and other frontline responders for risk assessment, environmental safety, and situational awareness. *(Competency 7)*

**Critical Incidents and Trauma**

*Length: 1 day* *Pre-request: none*

This workshop examines strategies to manage workplace critical incidents and reducing the impact of trauma on employees. The effects of trauma, Post-Traumatic Stress Injury (PTSI), and Post-Traumatic Stress Disorder (PTSD) are explored, accompanied by strategies to return to mental well-being. Outcomes will lead to a leadership team that is equipped to support the workforce when events occur and for staff members to learn how to navigate critical incidents in a manner that will ensure better long-term outcomes.

**For Leadership**

**Building Psychosocial Readiness, Resilience and Recovery for Leaders**

*Length: 1 day* *Pre-request: none*

Leaders of organizations play a significant role in protecting the psychological health and safety of their workforce. Research shows that when leaders lead with compassion and empathy, recognize psychological risks, and actively support their teams, workers are less likely to develop mental health conditions and are more likely to thrive, be engaged and successful. Key objectives include the leader's role in enhancing psychological safety, recognizing, and responding to early signs of stress in teams, applying proven strategies for stress management, establishing supportive structures including peer support, and developing personal and team stress management plans.

**Crisis Service Worker Certification**

**Crisis Service Worker Certification**

*Length: 100 hours* *Pre-request: none*

For mental health professionals starting a career in crisis services, we offer a certification program. The certification covers all seven competencies (above) and ensures that the participant has the fundamental skills to enter the workforce. The certification is valid for three years at which time they can be recertified for all or a portion of the training.

Canadian Mental Health Association Across Manitoba
*Mental health for all*

# CMHA Across Manitoba Training

| For Frontline Service Delivery Professionals |
|---|
| **De-escalating technique for non-cooperative individuals, including those under the influence of substances or those being formed under the Mental Health Act**<br>*Length: 3 hours* — *Pre-request: none*<br>Participants learn foundational de-escalation approaches, including non-violent crisis intervention. A dedicated section focuses on effective strategies for supporting individuals under the influence of commonly used substances. *(Competency 4)* |
| **Opening Minds Mental Health First Aid (MHFA)**<br>*Length: 2 days* — *Pre-request: none*<br>This certificate provides participants with a robust program leading to a nationally recognized Mental Health First Aid certification. Through the course, participants increase mental health awareness, build confidence to provide support, reduce stigma, and enhance their own mental well-being. *(Competency 1)* |
| **Understanding mental health through an Indigenous lens**<br>*Length: 1 day* — *Pre-request: none*<br>Due to the impacts of colonization, Indigenous peoples disproportionately interact with crisis and police services. This module introduces culturally grounded approaches, guidance on building respectful relationships, and strategies for providing culturally appropriate interventions and recovery planning. *(Competency 3)* |
| **Living Works Applied Suicide Intervention Skills Training (ASIST)**<br>*Length: 2 days* — *Pre-request: none*<br>ASIST is a two-day interactive workshop in suicide first-aid. Participants will recognize when someone may be at risk of suicide and work with them to create a plan that will support their immediate safety. ASIST participants learn to understand the ways personal and societal attitudes affect views on suicide and interventions, provide guidance and suicide first-aid to a person at risk in ways that meet their individual safety needs, identify the key elements of an effective suicide safety plan and the actions required to implement it, the training also focuses on life-promotion and self-care. *(Competency 5)* |
| **Mental Health, Substance Use and recognizing symptoms of psychosis, mania, and dissociation**<br>*Length: 3 hours* — *Pre-request: MHFA or comparable training/ experience*<br>The training provided advanced training to better understand how mental illness presents itself during a crisis, to help crisis workers feel more confident and capable of responding to people with deviant cognitive processes. *(Competency 2)* |
| **Documentation, post-crisis supports, and warm handoff**<br>*Length: 2 hours* — *Pre-request: none*<br>Crisis moments are often catalysts for meaningful change. This module supports workers in providing stabilization, identifying next steps, and ensuring that individuals are effectively connected to community-based resources. It also guides crisis workers in ways to document effectively to enable other team members and referral sources to provide continuity of care. *(Competency 6)* |

## Workforce Psychological Safety

### Managing Workplace Stress and Burnout

*Length: 2hours* *Pre-request: none*

This two-hour workshop looks at the factors from the National Standard that impact stress and burnout. Participants will learn to identify signs and symptoms of stress and burnout and develop strategies to help manage difficult times. Outcomes include a workforce that is able to navigate difficulties in the workplace for themselves and coworkers by identifying early warning signs and have interventions in place.

### Advanced Add-On: Situational Risk Awareness and Environmental Safety

*Length: 1hour* *Pre-request: none*

Worker well-being is essential to sustained crisis response. This module integrates best practices used by police and other frontline responders for risk assessment, environmental safety, and situational awareness.

*(Competency 7)*

### Critical Incidents and Trauma

*Length: 1 day* *Pre-request: none*

This workshop examines strategies to manage workplace critical incidents and reducing the impact of trauma on employees. The effects of trauma, Post-Traumatic Stress Injury (PTSI), and Post-Traumatic Stress Disorder (PTSD) are explored, accompanied by strategies to return to mental well-being. Outcomes will lead to a leadership team that is equipped to support the workforce when events occur and for staff members to learn how to navigate critical incidents in a manner that will ensure better long-term outcomes.

## For Leadership

### Building Psychosocial Readiness, Resilience and Recovery for Leaders

*Length: 1 day* *Pre-request: none*

Leaders of organizations play a significant role in protecting the psychological health and safety of their workforce. Research shows that when leaders lead with compassion and empathy, recognize psychological risks, and actively support their teams, workers are less likely to develop mental health conditions and are more likely to thrive, be engaged and successful. Key objectives include the leader's role in enhancing psychological safety, recognizing, and responding to early signs of stress in teams, applying proven strategies for stress management, establishing supportive structures including peer support, and developing personal and team stress management plans.

## Crisis Service Worker Certification

### Crisis Service Worker Certification

*Length: 100 hours* *Pre-request: none*

For mental health professionals starting a career in crisis services, we offer a certification program. The certification covers all seven competencies (above) and ensures that the participant has the fundamental skills to enter the workforce. The certification is valid for three years at which time they can be recertified for all or a portion of the training.

# 12. APPENDICES

## APPENDIX G: PRELIMINARY CRISIS RESPONSE ELIGIBILITY, DIVERSION FRAMEWORK AND ILLUSTRATIVE SCENARIOS

### DETERMINED CALL TYPES

**WPS**
**Suicide Threat:**
A person in mental health crisis who is not actively attempting suicide or being physically violent.

**WPS**
**Check the Wellbeing:**
Callers concerned about the welfare of a non-violent person who may be experiencing distress, mental health crisis, or other circumstances affecting their wellbeing.

**WPS**
**Cause a Disturbance:**
Non-violent behavior that appears erratic, unusual, or disruptive, often with no clear purpose or objective, and that may be linked to a mental health or substance-related crisis.

**WFPS – SPECIFIC CARD USAGE**

| 25 CARD | 32 CARD |
|---|---|
| Psychiatric/ Abnormal Behavior/ Suicide Attempt | Unknown Problem (Person Down) |

### CRITERIA FOR CALL DIVERSION

No Police/Paramedics or Firefighters required:

- No criminal act has been implied or committed
- No imminent or potential danger of serious bodily harm or death (not life threatening)
- No weapons
- No violence / non-violent person
- Voluntary – likely does not require powers or authority (detention and transport)
- Cooperative / Asking for help
- Level of agitation is low–medium
- No forced entry required
- No injury or medical concerns
- Check on conditions / welfare call for a non-violent person in crisis

FOCUS: Safety, Support, and Appropriate Response
The right response starts with the right call type.



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## APPENDIX G: PRELIMINARY CRISIS RESPONSE ELIGIBILITY, DIVERSION FRAMEWORK AND ILLUSTRATIVE SCENARIOS

The following examples are provided for illustrative purposes only. Actual diversion decisions would be based on triage, risk assessment, available information, and operational protocols.

| CALL TYPE | EXAMPLE POTENTIALLY APPROPRIATE FOR COMMUNITY RESPONSE* | EXAMPLE REQUIRING EMERGENCY RESPONSE |
|---|---|---|
| Wellness Check | A caller reports an individual lying on the ground in the downtown area. The individual appears awake, responsive, and able to communicate, but is inadequately dressed for the weather and may be experiencing homelessness, substance use, or a mental health crisis. No immediate medical concerns, violence, or suspicious circumstances are reported. | A caller reports an individual lying unresponsive on the ground. The person cannot be awakened and there are concerns about a medical emergency, overdose, injury, or exposure. Immediate paramedic and emergency response would be required. |
| Wellness Check | A neighbour reports an older adult with dementia who appears confused and disoriented in their apartment building but is cooperative and not at immediate risk of harm. | A family member reports that an older adult with dementia has gone missing during extreme weather conditions and may be at immediate risk of harm. |
| Suicide Threat | An 18-year-old calls 911 stating they are depressed and do not want to live anymore. The individual is cooperative, denies any immediate plan or intent to harm themselves, and supportive family members are present in the home. | A youth reports an active suicide attempt, has a specific plan and immediate intent to act, or has access to lethal means and is unwilling to engage with responders. |
| Suicide Threat | A 66-year-old man contacts 911 reporting that he is hearing voices and experiencing thoughts of suicide. He is cooperative, able to participate in assessment, denies any immediate plan or intent to act, and agrees to engage with crisis responders. | A 66-year-old man reports hearing voices directing him to harm himself or others, has a specific suicide plan, or presents an immediate risk to his own safety or the safety of others. |
| Cause Disturbance | A business owner calls 911 regarding a man who is refusing to leave the premises and appears confused and disoriented. The individual tells staff he is filming a movie, is not making sense, but is not threatening anyone, damaging property, or displaying weapons. | A business owner calls 911 regarding an individual who is threatening staff, damaging property, physically aggressive, or displaying a weapon. |
| Cause Disturbance | Multiple callers report a shirtless individual walking in public, talking to himself, and appearing confused or disoriented. The individual is not threatening others and no weapons or criminal activity are reported. | Multiple callers report an individual walking into moving traffic, creating an immediate risk of serious injury to themselves or others, or actively threatening members of the public. |

# 12. APPENDICES
## APPENDIX H: PRELIMINARY COSTING CONSIDERATIONS

Detailed costing was beyond the scope of this project and will require further analysis during implementation planning. The proposed WCCR Model has been intentionally designed as a flexible framework that can be implemented through a range of governance, staffing, and service delivery models. As a result, implementation costs will depend on future decisions regarding governance, operating model, workforce composition, technology, geographic deployment, the number and type of Community Crisis Response Teams, and the extent to which existing community resources and infrastructure can be leveraged or expanded. Accordingly, total implementation costs cannot be accurately determined until these decisions are made during the implementation planning phase.

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## APPENDIX H: PRELIMINARY COSTING CONSIDERATIONS

The figures presented below are intended solely as illustrative planning ranges to inform future implementation planning and funding discussions. They are not budget estimates, funding recommendations, or implementation costs.

*Illustrative planning ranges are based on jurisdictional review, comparable services, preliminary discussions, and publicly available information.

| COST COMPONENT | ILLUSTRATIVE ANNUAL PLANNING RANGE* | KEY CONSIDERATIONS |
|---|---|---|
| Community Crisis Dispatch and Coordination Hub | ~$750,000–$1.5 million annually | Costs will vary depending on whether the Hub is established through a new organization, an existing service with partial infrastructure, or an existing organization capable of assuming coordination responsibilities. Costs will be influenced by staffing levels, operating hours, dispatch functions, technology requirements, reporting responsibilities, and existing infrastructure. |
| Community Crisis Response Capacity | Estimated ~ $500,000 to 3 million annually | Costs will vary depending on the number of mobile response units required to achieve the desired service coverage, staffing model and clinical mix, operating hours, geographic coverage, expected call demand, specialization, supervision, vehicles, technology, and whether existing Community Response Providers and infrastructure are leveraged or expanded, or new Community Response Providers and service capacity are established.<br><br>The planning range reflects the estimated annual operating costs of providing Community Crisis Response capacity and associated infrastructure and is not intended to represent a prescribed staffing or deployment model. |
| Technology and Communications Infrastructure | Starting at approximately $500,000 | Dependent on dispatch requirements, communications platforms, reporting systems, interoperability needs, and integration with existing emergency communications and Computer-Aided Dispatch (CAD) systems. |
| Enhanced Emergency Communications and Diversion Capacity | Estimated ~$300,000 | May include staffing, enhancements to triage processes and diversion protocols, decision-support tools, technology integration, staff training, workflow modifications, quality assurance, and operational support within existing emergency communications systems to enable enhanced triage and diversion. |
| Workforce Development and Training | Estimated ~$5000 per crisis worker | Includes recruitment, onboarding, core competency training, role-specific certifications (e.g., Basic Life Support or Standard First Aid and CPR, as appropriate), responder safety, workforce wellness, supervision, and ongoing professional development. |
| Governance, Implementation and System Coordination | Estimated ~ $500,000 during implementation phase | Includes detailed implementation and business planning, project management and implementation leadership, governance and administrative support, partner engagement and coordination, policy and protocol development, communications and change management, legal, procurement and contracting support (as required), evaluation planning, and overall system coordination and stewardship during planning, mobilization, and early implementation. |

# 12. APPENDICES
# APPENDIX H: PRELIMINARY COSTING CONSIDERATIONS

## Jurisdictional Cost Comparators

Publicly reported investments in comparable Canadian crisis response models demonstrate the range of funding required depending on service scope, geography, and operating model.

- **Ottawa ANCHOR (2024):** Approximately **$2.47 million** for a 24/7 community-led mobile crisis response pilot integrated with 211 and 911 pathways. An additional $700,000 was later approved to support expansion and enhanced follow-up services. This was a 24/7 operation with a defined pilot catchment area.
- **Toronto Community Crisis Service (TCCS):** Expanded from a pilot investment of approximately **$13.7 million annually** to a citywide service reported between **$26.8 million** and **$35 million annually**, supporting multiple mobile crisis teams, 24/7 operations, and integrated crisis response pathways.

These examples illustrate that costs vary significantly based on service scope, operating hours, staffing, technology requirements, governance structures, and the degree to which existing infrastructure can be leveraged.

Detailed costing should be completed during the Planning and Mobilization Phase. Future work should validate resource requirements, assess existing assets and infrastructure, and refine cost estimates in collaboration with implementation partners.

# 12. APPENDICES

## APPENDIX I: REFERENCES AND RESOURCES REVIEWED

The following sources informed the research, jurisdictional review, stakeholder engagement, system analysis, and development of the Fourth Crisis Response Model. While not all documents are directly cited within the report, they contributed to the evidence base, environmental scan, and design considerations that informed the findings and recommendations presented herein.


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## APPENDIX I: REFERENCES AND RESOURCES REVIEWED


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