



Response to the Winnipeg Community Crisis Response

Model Report:

Toward a Community-Led, Consent-Based, Non-Criminalizing Crisis Response System

Executive Position:

PAC supports the development of a 24/7 Winnipeg Community Crisis Response (WCCR) system that reduces unnecessary police involvement in mental health, substance-use, poverty-related, and other non-criminal crises. We support the report's objectives of community response, de-escalation, stabilization, service navigation, and connection to ongoing supports.

However, significant clarification and revision are required before implementation.

WCCR should be an opportunity to redesign how Winnipeg responds to crisis not simply to divert a limited number of calls away from police. A genuinely community-led and consent-based system requires clear limits on police involvement and coercive intervention, meaningful community governance that includes Indigenous, newcomer, 2SLGBTQQIA+, and other equity deserving communities, people with lived experience, fulsome commitment to harm reduction, transparent triage, privacy protections, sustainable funding and measurable outcomes.

The central question should be:

What response is most appropriate for the person experiencing a crisis, and what is the response system required to make that possible?

PAC recommends a community-first model in which trained community responders are empowered to respond to genuine mental health, substance-use, and social crises. Police, fire, and emergency medical services should remain available when there is a clearly defined need for their particular authority or capacity.

PAC is prepared to work with the City toward that goal, provided that implementation reflects these principles.

Core Principles

Community-first, non-criminalizing response

A community response should be the primary response to non-criminal crises, rather than a diversion option offered only after police or emergency services have assessed the situation. Mental health crisis, substance use, homelessness, poverty, emotional distress, and unusual or disruptive behaviour should not, by themselves, be treated as criminal or inherently dangerous.

The response system should be able to distinguish between:

- mental health or substance-use crisis;
- social or poverty-related crisis;
- behavioural concern;
- immediate risk of serious harm; and
- criminal activity.

Police and emergency services should be engaged when there is a clearly articulated need for their specialized authority or capacity.

The guiding principle should be the least coercive response reasonably available.

Consent

Consent should be the default as articulated in the core values.

Where consent is overridden through involuntary assessment, detention, or another coercive intervention, the City and the Province, must establish clear statutory thresholds, decision-making responsibilities, documentation requirements, safeguards, review mechanisms, and public reporting.

The use of the Mental Health Act and Intoxicated Persons Detention Act should be clearly addressed, with safeguards against scope creep.

Crisis prevention

Crisis response cannot be separated from the conditions that create and intensify crises.

The City should recognize the importance of investment in housing, poverty reduction, food security, mental health services, voluntary substance-use treatment, harm reduction, disability supports, recreation, culturally grounded services, peer support, and other community infrastructure and work with the Provincial and Federal governments to ensure these evidenced-based approaches are prioritized.

WCCR should not simply manage the consequences of inadequate social infrastructure.

Crisis Response Model

The City should clearly define the WCCR system, including its crisis line, mobile teams, crisis hub, partner agencies, and relationship to emergency services

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The model should identify:

1. the function of each component;
2. operating organizations and responsibilities;
3. operational and clinical authority;
4. who conducts triage and its criteria;
5. deployment and escalation protocols;
6. 24/7 service capacity; and
7. pathways from crisis response into ongoing care.

Community Mobile Crisis Response

Community teams should be equipped to provide crisis intervention, de-escalation, stabilization, assessment, safety planning, harm reduction, service navigation, connection to supports, and post-crisis follow-up.

They should not be restricted primarily to low-risk situations. With appropriate training, supervision, and safety protocols, community responders should be able to respond to genuine mental health and substance-use crises.

Deployment philosophy

PAC recommends moving from a diversion model to a community-first model:

Current implied model:

911 / WPS / WFPS → assess → determine whether community diversion is appropriate

PAC-recommended model:

Community crisis line / community response → assess → stabilize and support → engage specialized emergency services when necessary

This does not eliminate police or emergency services. It ensures their involvement is based on an actual need for their authority or expertise.

Triage, Risk and Safety

The City should publicly define the criteria used to distinguish:

- immediate emergency;
- elevated risk;
- crisis without immediate risk;
- concern requiring support;
- criminal activity; and
- circumstances requiring no emergency intervention

The term “elevated risk” must have a specific, evidence-based definition.

Triage criteria should be developed with community responders, Indigenous organizations, people with lived experience, harm-reduction practitioners, clinicians, and other relevant partners.

The City should also clearly identify who performs triage, their qualifications and training, their authority, and their accountability.

Human decision-making

Crisis triage and risk decisions must remain human, transparent, reviewable, and accountable.

The City should explicitly prohibit artificial intelligence or automated decision-making from determining:

- crisis-call triage or eligibility;
- risk level;
- police or emergency-service deployment;
- intoxication or substance-use status;
- involuntary assessment;
- disposition; or
- other decisions affecting a person's liberty or access to care.

Substance use and harm reduction

Substance use or intoxication should not, by itself, trigger police or fire deployment. Community responders with appropriate harm-reduction, clinical, and crisis expertise should be able to respond to substance-use crises where there is no immediate emergency requiring specialized emergency-service capacity.

Harm reduction should be incorporated into WCCR's clinical, operational, training, and safety standards, with meaningful participation from organizations with relevant expertise.

Indigenous Leadership, Lived Experience and Governance

Indigenous leadership

Indigenous cultural competence should be a minimum standard across WCCR.

Indigenous organizations and First Nations, Inuit, and Métis people should have meaningful participation in governance, program design, triage, training, hiring, evaluation, service standards, and accountability.

Other equity deserving groups

Newcomers to Canada, ethno-cultural, 2SLGBTQIA+, and other equity deserving communities must also have meaningful participation in governance, program design, triage, training, hiring, evaluation, service standards, and accountability.

Lived experience

People with lived experience should have meaningful decision-making power throughout the system.

The Community Living Experience Advisory Council should have clearly defined authority, including appropriate representation, compensation, transparent appointments, and mechanisms for demonstrating how its recommendations are considered and incorporated.

Governance

Before implementation, the City should publish a governance structure identifying:

- lead and operating agencies;

- operational and clinical authority;
- community partner responsibilities;
- police and emergency-service responsibilities;
- funding authority;
- data governance;
- complaints and investigations; and
- public accountability.

Community organizations should have a central role in leadership and governance rather than functioning solely as contracted service providers.

Funding and Continuum of Care

A 24/7 crisis-response system requires sustainable investment.

The City should identify the full cost of implementation and ongoing operation, including staffing, overnight coverage, training, supervision, vehicles, equipment, technology, administration, partner funding, evaluation, and long-term sustainability.

Community organizations should not be expected to absorb new responsibilities within existing budgets. Contracts should cover the full cost of service delivery.

Resource redistribution

If community response reduces police demand, the City should establish a mechanism for reinvesting a portion of those savings into community crisis services and prevention and the infrastructure required to sustain them.

Continuum of care

Crisis response cannot function as a standalone service. WCCR should have established pathways to:

- voluntary treatment and withdrawal management;
- harm reduction;
- supportive and transitional housing;
- mental health and primary health care;
- peer support and case management;
- culturally appropriate services; and
- ongoing community supports.

The City should identify provincial and federal dependencies before presenting WCCR as a fully functional 24/7 system.

Evaluation and Accountability

WCCR should be evaluated based on outcomes for people accessing the system, rather than simply the number of calls diverted from police.

The City should publicly report system-level measures including:

- police and emergency-service involvement;
- apprehensions and involuntary assessments;
- emergency-department transports;
- use of force;
- criminal charges;
- connections to community services; and
- repeat crisis contacts.

It should also measure outcomes such as:

- perceived safety
- dignity and respect;
- successful connection to services;
- follow-up completion;
- hospitalization;
- involuntary intervention;
- police contact;
- housing stability;
- treatment access;
- service satisfaction from the person requiring the service; and
- culturally appropriate outcomes.

Evaluation should be conducted by a third-party independent organization that includes participation from people with lived experience. Evaluation reports must be non-identifying and be made publicly available.

Eligibility Matrix as Articulated in the City Report Appendix

Suicide-related calls

Mention of suicide should not automatically result in police involvement. Where there is no clearly identified need for police powers, trained community crisis responders should be considered the primary response, with escalation based on transparent clinical and safety criteria.

Wellness checks

Poverty, homelessness, intoxication, visible distress, or unusual behaviour should not, by themselves, constitute grounds for police involvement.

The City should develop an upstream prevention strategy addressing why residents and service providers rely on emergency systems to respond to social conditions.

Substance-use crises

Substance use should not automatically trigger WPS or WFPS. Community teams with appropriate harm-reduction and crisis expertise should be able to respond where there is no immediate emergency requiring specialized police, fire, or medical capacity.

Mandatory RFP Requirements

If the City proceeds with procurement or partnership development, PAC recommends that the following be mandatory requirements.

Community leadership and governance

The successful proponent must demonstrate:

- meaningful community participation in operational leadership;
- meaningful lived-experience decision-making;
- Indigenous leadership and cultural competence;
- Newcomer, Ethno-Cultural and 2SLGBTQQIA+; and
- transparent governance and accountability.
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Community-first, non-criminalizing response

The model must demonstrate:

- community response as the primary response to appropriate non-criminal crises;
- clear criteria for police and emergency-service involvement; and
- safeguards against treating mental health crisis, substance use, homelessness, poverty, or public distress as inherently criminal or dangerous.
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Consent and least coercion

The model must include:

- consent as the default;
- clearly defined legal thresholds for involuntary intervention;
- safeguards, documentation, and review; and
- public reporting of coercive interventions.

Harm reduction and substance use

The model must include:

- harm reduction as a core practice;
- appropriate community response to substance-use crises;
- relevant expertise and training; and
- meaningful participation from harm-reduction organizations.

Human decision-making

The model must explicitly prohibit AI or automated decision-making in triage, eligibility, risk assessment, police deployment, involuntary intervention, and disposition.

24/7 capacity and sustainable funding

The model must demonstrate:

- sustainable 24/7 operations;
- adequate overnight staffing, training, and supervision; and

- full-cost compensation for community partners.

Continuum of care

The model must demonstrate established pathways to housing, treatment, harm reduction, mental health and health care, cultural supports, and ongoing community services.

Transparency and evaluation

The model must include:

- public eligibility and triage criteria;
- reporting on police and emergency-service involvement;
- tracking of use of force and involuntary interventions;
- client/participant outcome measurement;
- lived-experience evaluation; and
- independent evaluation.

Conditions for Moving Forward

Before implementation, PAC recommends that the City provide clear public answers to the following priority questions:

1. Who performs triage, and who approves the eligibility and risk framework?
2. What specifically constitutes “elevated risk,” and what criteria trigger police involvement?
3. How will consent, involuntary intervention, and the use of relevant legislation be reconciled?
4. How will substance-use crises and harm-reduction needs be addressed by community teams?
5. What decision-making authority will Indigenous organizations and people with lived experience have?
6. Who governs WCCR, and what authority will community organizations hold?
7. What is the full cost of a sustainable 24/7 system, and how will community partners be funded?
8. What continuum of housing, treatment, health, cultural, and community supports will be available following crisis response?
9. How will police involvement, use of force, apprehension, involuntary intervention, and client outcomes be measured and publicly reported?
10. What technology and data systems will be used, and will the City explicitly prohibit AI in triage, risk assessment, eligibility, and disposition?

Conclusion

PAC supports the City's objective of creating a more effective, humane, and community-based crisis response system. Achieving that objective, however, requires more than adding community responders to an existing emergency-response structure.

WCCR should be an opportunity to fundamentally change Winnipeg's approach to crisis.

People experiencing mental health, substance-use, poverty-related, or social crises should receive support rather than punishment, care rather than automatic medicalization, and community response rather than automatic police intervention.

Achieving this requires meaningful community governance, sustainable funding, Indigenous leadership, lived-experience participation, harm reduction, transparent limits on coercive intervention, strong privacy protections, and a continuum of housing, treatment, health, cultural, and social supports.

PAC is prepared to work with the City toward that goal.

The measure of success should not be how effectively Winnipeg diverts people from police to community services. It should be whether people in crisis receive the right response, from the right people, at the right time, with the least coercion possible and whether fewer people are placed in crisis in the first place.