# Public Safety and Public Health

A new 911 response system

Report for the city of Winnipeg

**Harvard Bloomberg City Leadership Initiative**

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## INTRODUCTION AND DISCLAIMER:

Non-emergent 911 calls are currently attended by police, fire and emergency medical services in Winnipeg. The goals of the City of Winnipeg Bloomberg Harvard City Leadership Initiative are to reduce the number of calls attended by these three agencies and to provide a response that is aligned with the callers' needs. This report provides an overview of a) the current situation in Winnipeg –some of the root causes of the current situation, the response system in place and the existing agencies that already play a role in it or that might be useful in a potential reform of the system–; b) the models used in other jurisdictions in Canada and the US; c) a model for generating change; d) areas where changes could be performed to achieve the ultimate goal; and e) different implementation options (including a soft recommendation). The report has been elaborated after a 10-weeks internship with the City of Winnipeg as part of the Bloomberg Harvard City Leadership Initiative summer fellowship. The ideas provided in this report are a product of the reflections of the author after qualitative interviews with members of the different agencies participating in the current emergency response scheme of the city and bibliographic research. Access to quantitative data has been limited throughout the process. The main goal of this report is to provide a framework and a discussion guide for the team created for the initiative and to inform future policies in the city.

**BACKGROUND:**

## 1. The context in Winnipeg

### 1.1 Non-emergent calls are, for the most part, related to underlying situations of lack of social support[1].

- Resources from WPS, WFPS and EMS are diverted to respond to non-emergent calls even though these might not be the best suited agencies to attend the needs of these callers.
- Most of 911 callers for non-emergent issues may be disproportionally affected by social determinants.
- The needs of those individuals who contact 911 for non-emergent situations may not be significantly different in the group of calls handled by WPS and the group handled by WFPS.
- There is no lack of organizations than can provide the services frequent 911 callers may need, but Winnipeg lacks an agency or body that can effectively reach persons in a vulnerable situation, holistically assess their context, liaise them with appropriate services and guide them through the process.
- Some calls may need a unit to be dispatched, but some others could be resolved with a telephonic follow-up or with the proper information or referral.

According to data from the Winnipeg Police Service, approximately, 50% of the calls received by 911 are related to non-emergent circumstances[2]. Emergencies are defined as situations where there is a crime in progress, property or people are at risk or life-threatening medical cases. With the current system, the existing emergency response agencies (police, fire and emergency medical services –EMS– ) are being dispatched to non-emergency calls, diverting human and financial resources away to situations they are not best suited to manage. Moreover, the response provided by these three agencies may not always be aligned with the needs of the callers.

Data from non-urgent calls is treated differently after a call is referred to the WFPS or the WPS by the 911 operator once the location of emergency and the details of the situation have been asked. At the WPS side, 48% of non-urgent calls are classified as related to "assistance" (a miscellaneous category that –according to qualitative data– includes, for the most part, wellbeing checkups –that may include assistance to persons living in a situation of homelessness–). If we incorporate to this group those calls related to some kind of medical assistance, the percentage raises to 53%. 15% of the calls are related to mental health and intoxications. 13% appear under the category of "disputes", 12% under "disturbances" and 6% of non-emergent calls are related to missing persons. In total, these three last categories represent 25% of all non-emergent calls. At the WFPS and EPIC side, non-urgent calls are mostly related to socially isolated elderly people, patients who struggle with medication compliance, persons living with mental health conditions, and patients with chronic respiratory diseases and mobility issues.

Most of the non-emergent calls channeled through 911 are related with or motivated by different social determinants –on which preventative action is possible– and the lack of social support. After a mapping of social services and resources provided in the city[3], it is appropriate to say that there is no

[1] Most of these assumptions are drawn from qualitative data obtained through interviews with members of the different agencies involved in the current 911 response system. Access to quantitative data from 911 calls has been limited.

[2] See supporting document 1 (WPS 2020 non-urgent dispatched events)

[3] See supporting document 2 (resource guide for EPIC) and 221 Manitoba webpage: https://mb.211.ca

lack of supply of resources: 211 Manitoba (United Way Winnipeg) has mapped 2048 non-profit resources available at the province of Manitoba (most of them physically located in the city of Winnipeg) in the fields of housing and homelessness, food and clothing, health, mental health and addictions, abuse and assault, financial resources, employment and training, legal issues, youth, older adults, newcomers, children, people living with disabilities, indigenous peoples and LGBT2SQ+ persons. EPIC (Emergency Paramedics in The Community) elaborated a resource guide of 51 providers than can offer the needed services to the persons they attend.

However, there might be a problem in reaching those in need, assessing the appropriate resources for them, connecting them to the available and suited providers and guiding them through the bureaucratic barriers of the system. EPIC may fill part of this gap, yet a more comprehensive option (that provides a wider range of services) or an option that collaborates more effectively with the WPS might be needed. With the current 911 response system, the only variable that differentiates the response provided to an urgent situation from that provided to a non-urgent issue is the time delay between the call and the dispatch of an agency.

Furthermore, not all non-emergent calls that arrive at the 911 call center require a unit to be dispatched: some calls may be resolved with a telephonic follow-up or with the proper information and referral. Not providing a response to non-urgent calls is not an option for Winnipeg: 911 is a widely known resource that the most vulnerable, and those who do not know how to navigate the system, use to ask for help.

### 1.2 The current 911/emergency response system is not designed to effectively respond to non-emergent calls

- Few of the services already in place in Winnipeg could provide an adequate response to the current volume of non-emergent calls: we have selected three programs that could play a key role in a potential reform of the current 911 response model.
- There is a fragmented and siloed system of service provision: the referral mechanisms between some services and providers and phone lines available to citizens –311/911/(211)– are weak or non-existent.
- Perception of safety and risk, mechanism to identify the risk associated with a call, institutionalized risk aversion and the perception of those service providers dealing with potentially risky scenarios play an important role in the current dispatch and referral model.

*a) Most services for persons negatively impacted by social determinants do not have the infrastructure to act as dispatchable units for non-emergent calls:*

Just one of the services listed in the 211 database and the EPIC resource guide, the WRHA Mobile Crisis Unit[1] seemed to have part of the infrastructure and organization to act as a dispatchable option –as WPS, WFPS and EMS– for a group of non-emergent calls (those involving persons who live with mental health disorders). However, the Mobile Crisis Unit is not a dispatchable crisis unit. It provides telephonic services to individuals experiencing a mental health or psychosocial crisis. They also offer crisis intervention, mental health assessment, referral to community services, support to family members and short-term follow-up, but do not travel to the site where the episode is taking place. Moreover, it needs to be considered that acting as a dispatchable agency may also represent an added burden to any organization's work in a context where resources are scarce.

*b) Some services already in place (or in an implementation phase) could be utilized or expanded as part of a 911 response reform:*

*<u>EPIC: Emergency Paramedics in the Community</u> (second responders)*[4]

EPIC[1,2] is a WFPS program that consists of a mobile paramedic service that proactively brings health care services to vulnerable individuals in Winnipeg. EPIC teams consist of a van staffed by one paramedic. Currently, the program operates 2 vehicles for 12 hours a day: coverage is not 24-hours, but the two vehicles overlap during part of the day to provide coverage during peak hours. EPIC teams provide active care in 10-15% of the cases, assess the context of the individual and connect them with agencies and community resources that can provide the needed services. EPIC itself does not engage in police and justice issues or the provision of services that could feed in the social sphere. Some of the results of the program show a 56% drop in 911 calls by the program's patients, a 62% drop in ambulance trips to the ER in that group[5].

EPIC teams respond to calls from their own patients –around 40 and increasing – identified through previous interactions or referrals from WFPS units or because they are frequent 911 callers. An EPIC analysis of 911 data at the WFPS identified over 200 frequent 911 callers (individuals calling at least ten times in the preceding six months). The reasons of these calls are congruent with the 911 data regarding non-emergent calls at the WFPS side described above (mental health and addiction and patients with chronic respiratory diseases and mobility issues). There is already a referral mechanism between the WFPS and EPIC: when a WFPS unit is dispatched to a 911 call and a lack of social support is identified by the team, an "at-risk referral" is filled to EPIC, so that an EPIC team can assess the social determinants impacting the wellbeing of an individual and connect them to the proper services.

EPIC already deals with a small amount of the 911 non-emergent calls that currently arrive at 911. If a call is referred from the 911 call center to the WFPS and the number is identified as a frequent caller, an EPIC unit might be dispatched. However, EPIC units are not dispatched to 911 calls from the 911 call center –they act as second responders–: another agency is dispatched and might, a posteriori, fill a referral to EPIC. Therefore, it could be said that the program has four focus areas: 911 frequent callers, at-risk individuals (those with a lack of social support at risk of becoming frequent callers), commonly visited addresses, and lab and diagnostic follow-up for the emergency department. They do not only act as second (or sometimes first) responders, they assess the social context of an individual and connect them to the proper services provided in the city.

Even though calls at the 911 call center are either referred to WPS or WFPS, an EPIC team and a unit from the WPS Vulnerable Persons Unit respond to some calls together 2-3 times per week (normally related to agitated people due to drug consumption). However, nowadays, there is no formal combined dispatched system and no official channels for the WPS and the police vulnerable persons unit to fill out at-risk referrals: when a police unit identifies an individual at risk of becoming a frequent caller, there are no mechanisms to connect this person to the program.

*<u>WPS Vulnerable Persons Unit</u> (second responder)*

The Winnipeg Police Service Vulnerable Persons Unit consists of an unmarked police car staffed with a multidisciplinary team of one uniformed police officer and one social worker. The unit hardly

[4] We consider first responders those agencies that are dispatched to a 911 call (WPS, WFPS, EMS) and second responders those who travel to the location of a call when a referral from a first responder agency has been filled or petitioned. Therefore, the VPU and EPIC act as second responders.
[5] According to supporting document 3 (EPIC NAEMSP Abstract).

ever act as a first responder to 911 calls: for the most part, the unit responds to referrals from a regular patrol after this one has been dispatched to a site, interrogated the caller and assessed the situation. In some occasions, when the person in need is a frequent 911 caller, the VPU is the unit dispatched as a first responder. The unit's mission is to act as a resource for WPS members in dealing with occurrences involving vulnerable persons –as identified by the service–; and to coordinate service options and resources available for these persons.

*211 Manitoba (managed, in partnership, by United Way Winnipeg and Volunteer Manitoba)*

211 works as a telephonic line (and also through website, text and online chat) in many jurisdictions across North America and connects individuals and families in need with the appropriate community-based organizations and government services. 211 Manitoba has existed since 2017 as an online searchable database (www.mb.211.ca). As of August 2020, phone service is not available yet in Manitoba, but it is expected to be launched in October 2020.

In other Canadian jurisdictions, having a 211-phone service has been associated with a decrease of non-urgent calls handled by 911 and referrals by frontline law enforcement. Moreover, it has been correlated with a change of the emergency response model: from a reactive response to preventative proactive interventions to social and community issues. 211 has established interesting collaborations in some Canadian cities: in Edmonton, 211 does not just provide telephonic service and connection to providers. They are able to dispatch a mobile crisis unit serving individuals dealing with homelessness. Moreover, 211 Central East Ontario receives referrals from the paramedic service in Simcoe County when paramedics identify that a person's health and wellbeing is severely impacted by social determinants of health[6].

211 Manitoba has already started conversations with PSAP-911 to discuss the logistic of a potential coordination between 211 and 911 Winnipeg. United Way also aims to discuss a potential coordination between 211 and 311 in the city.

c) *The current referral pathways between first responders and providers of services for vulnerable persons and between the different phone lines available to the population for emergencies and non-emergencies are not effective:*

There is a lack of coordination between service providers. There are many agencies in the city that provide the different kind of services that persons living in a vulnerable context (and at risk of becoming 911 frequent callers) might need. However, the system of service provision is fragmented and siloed: each organization usually provides a particular, concrete, service and there are no formal coordination mechanisms nor functional referral pathways between most of them. Furthermore, there is no unifying command that can hold them to a certain degree of accountability. The heterogeneity of funding sources also hampers coordination and potential collaborations between these bodies.

There is some lack of effective coordination between first responders and second responders and between second responders. The WPS, the WFPS and EMS act as 911 first responders and, for the most part, the VPU and EPIC function as second responders for the WPS and the WFPS, respectively –at least, for a small proportion of the calls–. It is important to underline that these referrals just take place when a) the first responders are able to identify that the caller lives in a vulnerable context impacted by social determinants; b) the first responders find it appropriate to ask for a follow-up from EPIC or the VPU; c) the teams dispatched know about the existence of EPIC and the VPU; and d) they are able to petition the referral. Currently, there are no formal channels for the WPS to fill referrals to EPIC, nor

[6] See support document 4 (211 Manitoba Backgrounder. June 2020).

for the WFPS to petition a case follow-up by the VPU. Moreover, even though the VPU and EPIC respond to some cases together, coordination between them takes place, for the most part, through informal channels[7].

There are no existing referral mechanisms between information and service provision phone lines available to the citizens. 911 is the phone line available for emergencies. There are different lines for non-emergencies and more specialized services: 311 (for questions regarding city services), Health Links (for medical triage and counseling) and 204-986-622 (WPS phone line for non-emergent issues: e.g. suspicious circumstances or crimes in which the offender has left and is not returning). 211 –not yet operational through phone service– could also be included in this list. Currently, warm referrals are not possible between these lines: when the triage system of one of these lines detects that the reason of the call is more appropriate for another line, the caller is asked to hang up and call another number, which may lead to patients being lost in the process of asking for help and time delays. There is just one exception to this statement: low acuity medical complaints from WFPS (a very small number of cases) are sometimes dispatched to Health Links.

d) *The perception and assessment of risk plays an important role in deciding which agency is dispatched to what calls. There is an institutionalized tendency to risk aversion that needs to be taken into account when redesigning the emergency response system.*

There is a considerable amount of uncertainty regarding the potential outcomes of a call. Moreover, the information concerning the risk of a situation is limited due to the time and capacity constraints of 911. After two traumatic events occurred in Winnipeg in the recent years, which led to a scrutiny of the WPS from the media and the public opinion –damaging the reputation of the agency–, there is a tendency from law enforcement bodies to avoid risk: WPS units might be dispatched to low-risk situations in order to avoid a fatal outcome as the two cases previously mentioned. However, it is also important to acknowledge that police officers might be needed to respond to some calls due to an element of self-security: the VPU works as a multidisciplinary team (a social worker and a police officer). According to the Winnipeg Community Services, some social workers might not feel comfortable and secure being dispatched to some of the scenarios without a law enforcement official. As regards to EPIC, the staff refers that the proportion of the calls they respond to that pose a tangible risk is minimal.

Taking into account that those issues that do not constitute an emergency do not require an immediate response, more time could be invested with these 911 calls (if the appropriate infrastructure and staff is available) to determine the potential risk of each situation.

## 2 The context in Canada and the US

This report, in the section "Appendix" includes a description of a variety of models adopted by different jurisdictions in the US and Canada to respond to non-emergent calls or part of the calls that we have classified as non-emergent. Broadly speaking, we can group the different models in five big categories:

- Crisis diversion teams acting as second responders. Agencies or organizations just providing services to a limited group of individuals (a fraction of the calls) as second responders (either paramedics in the community or outreach mental health teams). This model is present, among

[7] See support documents 5 and 6 (WFPS-CAD workflow and process map for 911 calls)

other cities, in Halifax, Calgary, Hamilton (COAST program) or Toronto (Mobile Crisis Intervention Teams).

- Crisis diversion teams acting as first responders. Agencies or organizations providing mental health services to individuals in crisis as first responders (directly dispatched from 911): MACRO program in Oakland, MCRRT in Hamilton and Halton or Dallas (RIGHT care program).
- The PACT model: multidisciplinary teams including a police officer responding (in some cases) to a fraction of non-emergent calls received by 911 through the police service (those related to mental health and homelessness). PACT teams are already present in Edmonton, Calgary, Regina and Saskatoon.
- The CAHOOTS model: multidisciplinary teams not including a law enforcement official being dispatched to a fraction of the non-emergent calls channeled through 911 (those related to mental health and homelessness): CAHOOTS program in Eugene, STAR program in Denver, CRU-Familiar Faces in Olympia.
- The Albuquerque model (not yet implemented and just proposed in Albuquerque, New Mexico, US), that envisions the creation of a new 4th agency to comprehensively respond to a wide range of non-emergent calls.

If we focus on the two models with multidisciplinary teams that respond to non-emergent calls (the PACT model and the CAHOOTS model), we see different trends in Canada and the US as regards to the presence of law enforcement official as part of these teams. Three reasons may explain this phenomenon:

a) The "defund the police" movement, that supports divesting funds from police departments and reallocating them to non-policing forms of public safety and community support, has been gaining influence in the US and has encouraged city governments to adopt response models for non-emergent calls that do not include a law enforcement official or to shift from teams resembling the PACT model to the CAHOOTS model. Academic studies[4,5,6] also show how non-policing responses to mental health crisis also improve the outcomes of these calls and how community support decreases the number of detentions, ambulance trips and ER visits.
b) Policies governing police are more restrictive in Canada. US police is more militarized and police union contracts might be worse in the US (regarding misconduct records, reinstating fired officers, accountability systems…). Therefore, the perception of the public regarding having a police officer as part of these multidisciplinary teams and, therefore, the predisposition of public institutions to use this model, might be different in the two contexts.
c) Proximity between cities implementing the different models and communication between police services can lead to a certain model being implemented more widely in a certain country.

Since both PACT and CAHOOTS teams just focus on providing assistance to calls related to mental health crisis, addictions and homelessness, the professionals that are part of these teams (all of them formed by 2 members) are: social workers (37.5% of the cases), crisis workers –specially trained for the task with different backgrounds– (37.5%), nurses (12.5%), mental health professionals (50%) and paramedics (50%).

**POINTS OF ACTION AND STRATEGIES:**

There are different points of action where interventions can be implemented in order to obtain the two main goals of this initiative: a) the reduction of WPS, WFPS and EMS units dispatched to non-emergent situations; and b) an improvement in the alignment between the response provided by the agencies dispatched through 911 and the needs of the caller.

When an issue that needs short- or medium-term support (but is not an emergency) takes place, there can be different potential outcomes: a) an issue is perceived as an emergency by the caller and, therefore, they call 911; b) the issue is not perceived as an emergency but 911 is the only known resource; c) the issue is identified as non-emergent and the individual refers to another available phone lines (311, Health Links, 204-986-622 or 211 –when available–); d) the caller does not seek for help and the problem becomes chronic or resolves without intervention. Once a call gets to 911, a unit of the three first responder agencies (WPS, WFPS and EMS) ends up being dispatched to the location where the call originated (with a time delay that depends on the volume of calls at the moment and the priority given to the call).

Therefore, the different points in the sequence of steps that takes place from the issue that can generate a 911 call to the dispatch of a unit, where action is possible, are:

Before the call gets to the 911 call center:

- Issues that do not constitute an emergency should no longer be perceived as an emergency by the caller because there is the proper social support: to reduce the total number of non-emergent situations perceived as "emergencies" by callers, there is a need for strengthening and improving the provision of social services to individuals at risk of becoming frequent callers. In this case, strengthening the network of social services does not mean increasing the amount of services provided, but rather improving a) the mechanisms used to reach individuals at risk; b) the assessment of their situation and environment; c) the selection of appropriate services; and d) the support provided to connect the individuals with the available services and help them navigate the system.
- Issues that are not perceived as an emergency by the caller should be channeled through other numbers because 911 is not the only resource known by the caller. The public has been educated regarding the presence of other numbers and the resources each of them can provide. This measure also requires that the services offered by these alternative lines align with the needs of potential 911 callers experiencing issues that do not constitute an emergency.

After the call gets to the 911 call center:

A new dispatchable option and a new non-dispatchable option are needed since some non-emergent calls require in person assistance and some other could be resolved through the phone.

- Another agency that is not WPS, WFPS or EMS should be dispatched to the location where the call originated because those units might not have the proper skills to resolve the call. The creation of a 4$^{th}$ dispatchable option that can be dispatched to those situations that, despite not needing an emergent response, do need assistance that can only be provided in person may result in a) the reduction of WPS, WFPS and EMS units sent to the locations where these calls have originated ; and b) an improvement on the alignment between the response provided and the needs of the caller.

- There should be an alternative mechanism to deal with those non-urgent calls that do not need an agency to be dispatched. Not all non-emergent calls that the 911 call center receives require some kind of assistance that needs to be provided in person. Some of these calls could be resolved by providing the proper information or referral, or with a follow-up call.

## 3. A "fourth" dispatchable option

### 3.1 An agency that reaches, assesses, connects, guides and provides follow-up.

An ideal 4th dispatchable option should be able to:

- Reach those individuals in a vulnerable context (at-risk of becoming frequent 911 callers);
- In the short-term, solve the non-emergent issue that motivated the 911 call in a relatively timely manner;
- In the medium- and long-term, respond to referrals from first responders (WPS, WFPS and EMS) and provide follow-up to these persons (which in some cases may be reluctant to seek care or may be disconnected from the system);
- Assess the context –the social environment– of these persons, the social determinants impacting their wellbeing and identify the services and providers that could be helpful;
- Connect the individuals to these services;
- Help them navigate the system.

Therefore, this 4th dispatchable option would not just act as a reactive resource: it would also proactively connect individuals with the services that would have a preventative effect in their situation: if an individual has the proper social support, less issues that require assistance may occur or may be perceived as emergencies. If a person is connected to organizations and providers in the system, their concerns or petitions might not be channeled through 911 and they may rather turn to their trusted organizations.

### 3.2 The team and their skills

The skills of the professionals that may comprise these teams will depend on the comprehensiveness of the response that the city is willing to provide. However, the following two skills should be fundamental for any team that aims at responding to non-emergent calls:

- The capacity to assess the social context of a vulnerable person and to identify the social determinant impacting their wellbeing;
- A wide knowledge of the resources and providers available in the city and the ability to navigate the system and help others in the process.

At the WFPS, most non-emergent calls are already being resolved by paramedics (as part of the EPIC program). However, active health care is administered in just 10-15% of the dispatches, which may indicate that these tasks could, in some cases, be performed by people with different trainings. All agencies responding to non-emergent situations in other jurisdictions just deal with mental health and homelessness. Therefore, the multidisciplinary teams responding to these calls are staffed with a mental health officer or a paramedic and a social worker or a crisis worker.

### 3.3 Possible models

There are two main question marks that need to be answered regarding the model that the city of Winnipeg wants to implement:

- What services this 4th dispatchable option should offer?
- Should this 4th dispatchable option incorporate a law enforcement officer?

*a) The comprehensiveness of the response to non-emergencies*

Regarding the first questions, the comprehensiveness of the response that can be offered by a 4th dispatchable option, the following information regarding the situations that motivate non-emergent calls received by 911 should be taken into account:

1. At the WPS side, 48% of the non-emergent calls are related to "assistance" (mostly wellbeing checkups and support to persons living in a situation of homelessness);
2. Most of the calls at the WFPS side, plus 5% of the calls at the WPS side deal with non-emergent health issues that involve a health concern, a chronically ill patient or a socially isolated person that disproportionally finds their health impacted by social determinants;
3. 29% of the calls at the WPS side deal with situations that may benefit from conflict resolution skills (disputes, disturbances and runaways);
4. 15% of the calls at the WPS side are related to mental health crisis (or people living with a mental health condition) and intoxications.

The services already in place (their capacity, staff and current areas of action) will also play a role in the chosen model. Important points to take into account:

- EPIC and the VPU already provide services to callers in the categories (1) and (2): assistance, persons dealing with health conditions and socially isolated individuals.
- The VPU capacity, however, is very limited and some of the non-emergent calls classified as "assistance" end up with a regular WPS unit being dispatched.
- Even though there are certain mechanisms that allow EPIC and the VPU to function as first responders, they provide, for the most part, assistance to these groups as second responders.
- Referrals between first responders and second responders are in almost all the cases, from WPS to VPU and from WFPS and EMS to EPIC. There are no official and functioning referral mechanisms from WPS to EPIC nor from WFPS and EMS to the VPU.
- EPIC respond to non-emergent calls in their area of expertise without having a law enforcement official as part of their team and do not refer to deal with situations that may imply a safety risk. The VPU does include a police officer as part of the team to ensure the safety of the social workers being dispatched.
- Currently, there are no specialized agencies in place to respond to calls included in categories (3) and (4): conflict resolution and mental health and intoxication.
- How equipped and skilled are the teams dispatched to calls in categories (3) and (4) to deal, on the one hand, with conflict resolution and mediation and, on the other hand, with mental health crisis and intoxication problems?

*b) Response teams with or without police officers*

Looking at the type of non-emergent calls Winnipeg's 911 is receiving, and using the models in other cities as example, the professionals that may have the skills to deal with the situations that motivate these calls are: paramedics + mental health professionals + social workers; all of them –and, specially, the social worker– equipped with conflict resolution skills. Therefore, if a new unit able to respond to the non-emergent calls in all the abovementioned categories was to be created, a multidisciplinary team including these professionals seems an ideal solution.

The presence of a law enforcement official as part of these "4th dispatchable options" has been a discussion point in many other jurisdictions, specially amidst the "defund the police" movement, which has pushed some cities to move from multidisciplinary teams including a police officer to multidisciplinary teams without a law enforcement official. We propose not to look at this issue as a "yes" or "no" discussion, but to study it according to different premises. As described in section 2, successful results have been obtained in other jurisdictions with both models, although those teams just respond to calls related to mental health, intoxications and assistance to people living in a situation of homelessness. If a new multidisciplinary unit was to be created, the decision to include a police officer should depend on the following points:

- What type of calls this "4th dispatchable option" would be dispatched to (according to the previously described categories) and what risks these calls might represent: we have EPIC data showing that almost none of the calls they respond to entail a safety risk, for example.
- What mechanisms the 911 call center has to properly evaluate the potential risk that a situation may represent.
- What is the institutionalized tolerance to risk, the predisposition of the Winnipeg Police Service (especially those in leadership positions) to accept not being dispatched to certain calls and the predisposition of the city to accept potentially critical discourses to an organizational change of the emergency response system that still includes a law enforcement official amidst a global movement that demands changes in a different direction.

The fact that there are two existing agencies providing some services that may align with a proper "4th dispatchable option" and, therefore, could be utilized as first responders in a reform of the system, enables us to expand this discussion. A 4th option does not have to be conceptualized as a unique agency and can be thought as different organizations that may respond to the calls they are skilled to deal with. Therefore, a law enforcement official could be present in some of these teams and not present in others, as described in the section "options": "4th dispatchable" option teams including a police officer could be responding to those non-emergent calls with a higher uncertainty regarding potential risks (some of the calls in categories 1 and 4 – assistance and disputes–) and teams without a law enforcement official could be dispatched to non-emergent calls included in categories 2 and 3 (health, mental health, intoxications and socially isolated persons) and those that deal with people living in a situation of homelessness. In order to propose this kind of system, there is the need to enable a proper mechanism at the 911 call center so that operators can obtain enough information regarding the risk of a situation and the characteristics of the call, as explained in the following section.

## 4. A non-dispatchable option

As mentioned in "background", not all non-emergent calls channeled through 911 need a unit to be dispatched in order to be resolved. Some could be addressed with a more in-depth diagnosis of the situation –through the phone – and the proper information or referral or with a follow-up call. This is why, an ideal non-dispatchable option should:

- Enable warm referrals between the different phone lines available to the public (311, 204-986-622, Health Links, 911 and, in the short future, 211), so that if a call is not best suited for one of the lines, it can be directly referred to another call center without asking the caller to hang up and call a different number.
- Perform a detailed assessment of the situation of the call and the needs of the caller (which may require a considerable amount of time) to provide the adequate information or referral to organizations providing the needed services in the city (that may not offer mobile services).
- Have trained operators in identifying potential social determinants impacting a person's wellbeing, and who have a comprehensive knowledge of all providers, resources and services available at the local level.
- Be able to dispatch the "4th dispatchable units" for non-emergent calls if, after an in-depth assessment, it is considered that the issue that motivated the call needs in person assistance in order to be resolved.

Since one element that determines if a call is an emergency or not and, if not, what kind of unit should be dispatched is the presence of potential risk –for the person calling and for those providing assistance–, the assessment of risk should be performed as one of the first steps at the call center. Therefore, the process map at the call center should take the following points into account:

- The first brief interaction with the caller should determine if the call is an emergency or not.
- Right now, the potential risk of a call is assessed once the call is referred to the WPS side. It would be optimal if risk can be assessed at the 911 call center at the first stages: operators should be trained on risk assessment (with the protocol WPS uses or with those in international guidelines) or a police officer should be part of the telephonic response.
- Once the call is deemed as non-emergent and the risk is assessed, the call should be referred to another trained operator who would perform an in-depth assessment of the situation (over a longer period of time) and would decide if the call needs an in-person response. If the answer is "yes", the operator would select what "4th dispatchable unit" is the most suited according to the needs of the caller and the risk associated with the situation (or if the call needs to be transferred to police, fire or EMS). If no unit is needed, the operator should provide the proper information or referral and, if needed, a telephonic follow-up.

## OPTIONS AND RECOMMENDATIONS

In this section, we propose different options in reference to how to implement a "4th dispatchable option" and a non-dispatchable option.

### 5. How to implement "a fourth" or "multiple fourth" dispatchable options

All the options described for "a fourth" or "multiple fourth" dispatchable options have the following characteristics in common and would also need the implementation of the measures explained below:

a) In all the different options provided, the 4th dispatchable option would acts as both a first responder and a second responder, accepting referrals from those three agencies now in charge of providing assistance to emergent situations (WPS; WFPS and EMS).
b) All options are able to provide in-person assistance to address the reason of the call but would also perform an assessment of the social context of the caller, identify the social determinants impacting their wellbeing, refer the person to the proper services and guide the individual through the system.
c) All options acknowledge that some situations may pose a risk to those being dispatched to assist nonemergent calls and, therefore, include a police officer as part of the response in a proportion of the calls. These proposals also recognize that some non-urgent calls that deal with health and disease and some socially isolated persons are already responded by EPIC teams –as second responders– without a law enforcement official and no situations that represent a safety risk for the professionals being dispatched has been reported.
d) All options require the establishment of formal referral mechanisms between the current first responders and the organizations acting as a 4th dispatchable option (for those cases in which the 4th dispatchable option acts as a second responder). These pathways should enable referrals from each of the first responders to all the second responders (not just WPS to VPU and WFPS/EMS to EPIC), which should be performed according to the needs of the caller.
e) All options should also consider the inclusion of community members (from indigenous groups, who have lived in a situation of homelessness in the past, who live or have lived with mental health conditions and drug dependency…), so that the legitimacy of the program increases and the response can be partially provided from a peer-to-peer perspective, better aligned with the needs and concerns of the callers.

#### 5.1 A multidisciplinary single agency: a comprehensive response with low feasibility.

The first option (similar to RIGHT Care in Dallas) consists on the creation of a new agency that would result from merging the EPIC program and the WPS-VPU, and would also incorporate new professionals trained in conflict resolution, social workers and mental health professionals, to be able to align the response provided with the needs of the callers reaching 911 for non-emergent issues. The characteristics of this option are:

- It could respond to all the non-emergent calls that currently reach 911 (assistance, wellbeing check-ups and homelessness, health, socially isolated patients, mental health and addictions, and disputes, disturbances and runaways)
- There is the possibility to create multidisciplinary teams with a police officer in each of them. However, it is also an option to have some teams with a social worker and a law enforcement official (like, currently, the VPU), and some teams with a paramedic and a mental health professional. This division responds to the classification of calls included in section 3.3. Teams

including a police officer could respond to those calls that may entail a certain risk for the professionals dispatched, while those without a law enforcement official could respond to calls related to health, mental health and social isolation, which are currently responded by EPIC and about which academia has shown better response in the results if police officers are not first responders.

- From an organizational point of view, this option would ease the response provided: all non-emergent calls reaching 911 that need an in-person response, would be referred to this new agency. However, this options also changes the organizational scheme of the city, merging already functioning agencies: therefore, it could raise opposition from EPIC and the VPU. Moreover, in terms of financing, it could be challenging to unite funding coming from two different bodies (WFPS and WPS) in one single new agency.

### 5.2 A 4th dispatchable options with 3 organizations: a fragmented –and perhaps costly– comprehensive response.

The second option envisages a response to non-emergent calls by three different agencies: the VPU (with an expanded capacity), EPIC and a new mobile crisis unit that would provide services to persons living with mental health conditions in crisis and individuals dealing with addictions; and which could be created under the umbrella of the Winnipeg Regional Health Authority. This option is characterized by:

- It would be able to respond to the fourth categories of non-emergent calls that currently reach 911.
- It maintains EPIC and the VPU as different agencies, which would respond to different kind of calls: EPIC to those related to health and socially isolated patients, not representing a risk for the dispatched team and the VPU (which would need to expand its capacity) to those calls were there is a component of uncertainty regarding potential safety risks, and those that involve disputes and disturbances. The Mobile Crisis Unit would be dispatched to the last group of calls: mental health and addiction.
- From an organizational point of view, the response provided is fragmented, which may difficult a comprehensive analysis of the situation of the caller and might reduce the number of appropriate long-term referrals and follow-up.
- From a feasibility standpoint, the main barrier would be the creation of a new unit. Similar services (without the capacity to provide in-person assistance) are already provided in the city. The WRHA already has a phone service for patients dealing with mental health crisis and a mental health crisis response center, and Shared Health manages a “crisis stabilization unit” that provides short-term supportive care and treatment for individuals in psychiatric or psychosocial crisis. There is also a MKO (Manitoba Keewatinowi Okimakanak) response team that provides trauma intervention by mobile crisis teams that are staffed with indigenous people. There is the possibility that these agencies would like to expand the scope of their work and offer mobile services.

### 5.3 A 4th dispatchable options with 2 organizations: minimal organizational changes but a limited response.

The third option is the one that involves the minimum number of organizational changes. As described at the beginning of section 5, it requires that the VPU and EPIC function both as first and second responders and that referral mechanisms between emergency responders (WPS, WFPS and

EMS), and non-emergency responders (VPU and EPIC) are established and functional in all directions. Moreover, this option also requires that the capacity of the VPU is expanded, so they are able to respond to a higher volume of calls and referrals. Even though the feasibility of this option is high –since it does not require many organizational changes– the response provided is limited, since the categories of calls addressed would be 1,2 and 3 (assistance, wellbeing checkups, health and disturbances), but no specific service would be provided to persons dealing with mental health crisis.

### 5.4 A dual 4th dispatchable option with minimal organizational and internal changes: a feasible comprehensive response.

The last option provided maintains the separation between EPIC and the VPU but encourages both organizations to make certain internal changes to be able to create a dual 4th dispatchable option that can provide a comprehensive response to all the non-emergent calls that now reach 911. EPIC could train their paramedics in mental health responses –or, ideally, incorporate mental health professionals as part of their team– in order to be able to provide a response to those calls in the fourth category (mental health crisis and addictions). The VPU would need to expand its capacity (more officers, more social workers and more cars) to be a functional "4th dispatchable agency" and train their teams in conflict resolution skills (to respond to those calls in the third category –disputes, disturbances and runaways–). Another option is that EPIC scope remains intact, but the VPU is the agency incorporating mental health professionals to respond to calls involving persons living with mental health conditions that are in crisis. Option 5.4 seems to have a higher implementation feasibility and, therefore, the one recommended in this report:

- It presents a comprehensive response to all the calls received at 911.
- Provides both a reactive and a proactive preventative response to the context generating a high volume of 911 calls and tries to address the social determinants impacting the lives and wellbeing of the people in Winnipeg.
- Involves minimal organizational changes and does not fragment the response offered in excess: utilizes the schemes and organizations already in place and tries to improve the referral mechanisms between them and to align the services provided with the needs of the callers.
- Acknowledges the presence of a safety risk in some of the calls to which the units would be dispatched and the institutionalized risk avoidance but enables the response in some fields (those with minimum risk) to be provided by teams without a police officer.
- It might be feasible in terms of the supports needed from the different actors involved: the Winnipeg Police Service seems excited with the idea of multidisciplinary teams to respond to certain non-emergent calls. An expanded version of the VPU could represent this idea.
- The implementation of this option would still require the improvement of the referring mechanisms between agencies, and the execution of some changes at the 911 call center level (to enable a proper triage, risk assessment and referral). The two organizations involved in the response to non-emergent calls (EPIC and the VPU) would need to decide what kind of calls are responded by each of the agencies –a general recommendation has been provided in this report– and what level of risk EPIC would be comfortable bearing in the calls they respond to.

## 6. How to implement a non-dispatchable option

As presented in section 4, a non-dispatchable option should be able to provide the adequate information and referrals to non-emergent calls. We have considered two different options that are described below. Since this option would be closely related to the 4th dispatchable option, the reform that includes this mechanism (regardless of the chosen option), should also:

- Incorporate professionals with the skills to assess the context and situation of a call and the social determinants in place and identify the agency that should be dispatched.
- Enable referrals between the different phone lines available to the public.
- Establish a new 911 call center process map so that the first steps when a call is received are: a) to identify if the call is urgent or not; b) to assess the risk of the situation; and c) to determine if the call can be referred to another of the available phone lines.

### 6.1 Internal changes at the 911 call center

The first option consists, solely, on incorporating operators trained in social determinants, referral pathways and provider options at the 911 call center that, once a call has been deemed as non-urgent and their risk assessed, can spend a longer time with the caller and, after the proper interview, provide the proper information or referral and determine the need for a follow-up call. If a call needs in person assistance, they could dispatch either EPIC or the VPU (or the mobile crisis unit or the multidisciplinary new agency) depending on the reason of the call and the potential risk associated with the situation. These operators could be trained according to the WPS and WFPS requirements. This option might be more complicated from an organizational point of view, since it requires the introduction of some changes at the 911 call center level. Moreover, it would require the creation of a database with all the resources available where the callers could be dispatched (like the 211 database). However, it might be cheaper as compared to the one described below (depending on the funding sources 211 Manitoba is able to get from different sources).

### 6.2 Incorporating 211 Manitoba as part of the system

The second option provided envisions to include 211 Manitoba as part of the response system to non-emergent calls. 211 Manitoba's phone service is expected to be launched in October 2020. The 211call center in other jurisdictions is staffed with AIRS (Alliance of Information and Referral Systems) certified referral specialists, who interview the caller and identify the needed information and provide the proper guidance and referrals. The training of these specialists is fundamentally theoretical: they do not receive practical training in environments where the persons they might be attending may live. Therefore, it should be considered if their training satisfies the WPS and WFPS standards. In Edmonton, 211 dispatches crisis diversion teams to non-emergent calls that need in-person assistance. If 211 is incorporated in the system, once a non-emergent call gets to the 911 call center and is deemed as non-urgent, it could be referred to 211, where a referral specialist would interview the caller, identify the social determinants in place and determine if a unit needs to be dispatched. If this is the case, they could dispatch a 4$^{th}$ dispatchable option. If the warm referral mechanisms are established, if an emergency gets to the 211call center, they should be able to directly refer the call to 911. Since 211 has already started conversations with 911 and 311, it would be interesting to study the possibility to implement this option.

**CONCLUSIONS AND NEXT STEPS:**

An ideal 911 response system for the city of Winnipeg that can reduce the number of police, fire and emergency medical services dispatched to non-emergent issues needs to combine a reactive and a proactive and preventative response: it needs to be able to respond (in-person and through the telephonic assistance) to the reasons that motivate the calls and, at same time, address the social determinants impacting the wellbeing of those in vulnerable situations (who are at risk of becoming frequent 911 callers). Therefore, it has to follow the following action scheme: to reach those in vulnerable situations, to assess their environment and the social determinants impacting their wellbeing, to identify the services that can address the lack of social support, to connect the individuals with the right providers and to guide them through the bureaucratic barriers of the system. Since not all the non-emergent calls that are channeled through 911 need an in-person response, an ideal reform should include the implementation of a 4th dispatchable unit –that can act both as a first responder to 911 calls, but also as a second responder (to referrals from the three agencies being dispatched to emergent situations)–, the establishment of a non-dispatchable option and the creation of functional referral pathways between first and second responders. This report recommends the creation of a dual 4th dispatchable option that utilizes two existing agencies providing services to 911 callers in vulnerable situations who are at risk of becoming (or already are) frequent callers: EPIC and the WPS-VPU. By encouraging the two programs to introduce certain changes in the scope of their services, a comprehensive response can be provided to most of non-emergent issues that currently motivate 911 calls. Moreover, as this option requires minimal organizational changes and since the WPS has already shown some predisposition to create multidisciplinary teams to respond to a fraction of the calls received, the capacity to generate legitimacy for this project and the feasibility to implement it seem promising. By introducing 211 Manitoba in the equation –or by executing some organizational changes at the 911 call center–, the system should be able to effectively assess the risks of the situations motivating non-emergent calls and determine the appropriate units to dispatch or the service that should be offered. Moreover, this project represents an opportunity to redesign and homogenize the 911 data systems (at the WPS and the WFPS side) and increase the transparency of the analyzed results –that should not include confidential information– so that data-driven decision-making processes can be carried out.

In the future, the initiative should study the predisposition of the different agencies mentioned in this report to introduce the proposed changes in order to evaluate the feasibility of each of the options. Even though the recommended system may not require a substantial financial injection, conversations should be held with WPS and the WFPS to evaluate their predisposition to increase the funding to EPIC and the VPU. We also propose that the Bloomberg Harvard City Leadership Initiative holds a convention for police departments and emergency response systems to exchange best practices and share the mechanisms they use to approach the response to emergent and non-emergent issues reaching 911. Conversations between the WPS and 211 are already taking place. We suggest that all the different agencies participating in the initiative are involved in the conversations, so the role of 211 in the system can be useful to the new potential model and not just to the current structures. Finally, once a response model has been decided, the team should coordinate their efforts with Winnipeg's Downtown Community Safety Partnership to avoid duplications in the services provided and find synergies.

The COVID-19 pandemic creates a sense of urgency to increase the effectivity of the response the city of Winnipeg can offer to emergent and non-emergent situations and to the most vulnerable. It also opens a window of opportunity to advance changes that can have a critical effect on the wellbeing of the inhabitants of the city: minimal interventions like the ones recommended in this report might represent a change of framework and a shift from one model to another, but may not require major organizational changes or economic efforts. The willingness of those in decision-making and leadership positions is key for a new 911 response system.

**References:**


1. Mobile Crisis Service – Winnipeg Regional Health Authority [Internet]. Wrha.mb.ca. 2020 [cited 1 August 2020]. Available from: https://wrha.mb.ca/mental-health/mobile-crisis-service/
2. Fire paramedic service to expand program that connects with frequent users to reduce 911 calls, ER visits | CBC News [Internet]. CBC. 2020 [cited 1 August 2020]. Available from: https://www.cbc.ca/news/canada/manitoba/winnipeg-epic-community-paramedics-1.5153293
3. EPIC mobile paramedic service looks to more than double fleet in Winnipeg [Internet]. CJOB. 2020 [cited 1 August 2020]. Available from: https://globalnews.ca/news/6188365/epic-mobile-paramedic-service-looks-to-more-than-double-fleet-in-winnipeg/
4. Yokum D, Ravishankar A, Coppock A. A randomized control trial evaluating the effects of police body-worn cameras. Proceedings of the National Academy of Sciences. 2019;116(21):10329-10332.
5. Delehanty C, Mewhirter J, Welch R, Wilks J. Militarization and police violence: The case of the 1033 program. Research & Politics. 2017;4(2):205316801771288.
6. Sharkey P, Torrats-Espinosa G, Takyar D. Community and the Crime Decline: The Causal Effect of Local Nonprofits on Violent Crime. American Sociological Review. 2017;82(6):1214-1240.