TO: Mayor and Council

FROM: Milton Dohoney Jr., City Administrator

CC: Andre Anderson, Police Chief
Jonathan Laye, Supportive Connections Director
Mariah Walton, Deputy City Administrator

SUBJECT: July 20, 2026 Council Agenda Response Memo

DATE: July 16, 2026

CA-20 - Resolution to Approve Unarmed Response Program through Supportive Connections and Approve the Addition of 4.0 Full Time Equivalent Positions (8 Votes Required)

Question #1: What specific metrics or checkpoints will we use to evaluate whether the model is working, and on what timeline will Council see that data? (Councilmember Harrison)

Response: Reporting is projected to include aggregate demographic information, calls for service, contact type, dispatch modality, and outcome-related measures, consistent with applicable privacy requirements under HIPAA and 42 CFR Part 2. No Personally Identifiable Information (PII) or Protected Health Information (PHI) will be included in any public reporting.

As the program develops, our ability to evaluate outcomes will continue to evolve. The implementation of the Ann Arbor Police Department's new Records Management System (RMS) will allow for more meaningful analysis of cross-system data, helping to better understand call diversion, response patterns, and community outcomes while maintaining appropriate confidentiality protections. Council will receive regular updates as the program develops, with formal reporting incorporated into the City Administrator's Annual Report.

Question #2: What's the plan if Supportive Connections has trouble hiring or retaining clinicians for these roles? Is there a contingency built in so the program doesn't stall out? (Councilmember Harrison)

Response: Recruitment and retention are important considerations for any behavioral health response program and requires flexibility into our staffing approach. Our initial recruitment efforts will focus on fully Licensed Master Social Workers (LMSWs), whose training in crisis intervention, trauma-informed care, and systems navigation aligns closely with the goals of the SPROUT program. Our priority is to ensure that SPROUT remains staffed by qualified professionals who share the program's commitment to trauma-informed, harm reduction, and person-workforce and ensure continuity of services.

The team is prepared to consider modified deployment if staffing challenges arise. This may include adjustments to hours of operation, prioritizing high-call coverage, narrowing the geographic service area, or temporarily reducing to a single clinician team while maintaining core low-acuity response functions. These modifications allow SPROUT to remain operational and responsive without compromising clinician safety or service quality.

To support continuity, SPROUT will also utilize internal supplemental staffing strategies as available, including redeployment of clinicians from other Supportive Connection programs.

Question #3: Can you say more about how SPROUT's information-sharing with A2 REACH and CMH will work in practice? Is there an MOU or data-sharing agreement, or is that still being developed? (Councilmember Harrison)

Response: The SPROUT Pilot is designed to work collaboratively with community partners to ensure individuals experience a seamless transition to the services and supports that best meet their needs. Information sharing with partner agencies will occur on a case-by-case basis when it is necessary to coordinate care, facilitate a warm handoff, or support ongoing engagement in services. Any exchange of information will occur with the individual's informed consent through a signed Release of Information and in accordance with all applicable privacy laws, including HIPAA and 42 CFR Part 2. This approach protects individual privacy while allowing providers to coordinate services effectively and support continuity of care.

Question #4: How will dispatch actually decide, in the moment, whether a call goes to SPROUT versus police versus A2 REACH? Who makes that determination and how quickly? (Councilmember Harrison)

Response: The dispatch process for the SPROUT pilot will be developed collaboratively with Washtenaw County Dispatch, AAPD, and AAFD to ensure that individuals are connected with the most appropriate response based on the nature of their needs. Conversations with County Dispatch will focus on establishing best practices for call triage, response protocols, and decision-making processes for when a call is most

appropriately assigned to SPROUT, A2 REACH, or another public safety response. As with any new response model, protocols will be refined throughout implementation to promote timely, consistent, and appropriate responses while prioritizing community safety and the well-being of those experiencing a crisis.

Question #5: Since funding comes through the millage rebate resolution, what happens to program continuity if that funding structure changes down the road? Is there a plan to evaluate the vendor relationship itself as part of the pilot review, separate from evaluating the model? (Councilmember Harrison)

Response: The current funding for the SPROUT pilot is supported through the Washtenaw County Community Mental Health and Public Safety Preservation Millage rebate. This millage was reaffirmed by voters in November 2024 and is currently authorized through 2034, providing a stable funding source for the program over the coming years.

While no long-term funding source can be guaranteed indefinitely, the City is committed to planning for program sustainability. Should the availability or structure of these funds change in the future, we would actively pursue alternative funding opportunities to maintain these services. This could include grants, intergovernmental partnerships, or other funding sources, as well as recommendations made through the City's annual budget process and the policy priorities established by City Council.

Question #6: What are the anticipated operating hours for the two SPROUT teams at launch, and how will that compare to peak call volume for the situations this program is meant to address? (Councilmember Harrison)

Response: Operating hours will be informed by available data, including call volume, call types, trends in service demand, and the time required to provide meaningful, person-centered interventions in the field. As the pilot progresses, this information will help identify when behavioral health and social service responses are most needed and allow the program to adjust staffing and hours accordingly. This data-informed approach will ensure that SPROUT resources are deployed where they can have the greatest impact while maintaining high-quality, trauma-informed services for community members.

Question #7: Beyond Critical Incident and Stress Management certification, what training will SPROUT clinicians receive before they're in the field, particularly around de-escalation, risk assessment, and knowing when a situation exceeds their scope and requires law enforcement or A2 REACH? (Councilmember Harrison)

Response: The SPROUT pilot training curriculum has been designed to prepare clinicians to respond safely, effectively, and within the appropriate scope of their role. Training will include solution-focused engagement, situational awareness, behavioral health risk assessment, conflict management, WELLE verbal de-escalation and non-combative self-defense, and trauma-informed, person-centered response practices.

Clinicians will also receive training on the roles and capabilities of law enforcement, fire, and EMS to support effective interdisciplinary collaboration and ensure a clear understanding of when a situation exceeds SPROUT's scope and requires another emergency response.

Additional training will include familiarization with local community resources, City policies and processes, and the service systems available to support individuals experiencing behavioral health, substance use, or social service needs. The goal is to equip SPROUT staff with the knowledge, skills, and judgment necessary to provide safe, compassionate, and coordinated responses while prioritizing the well-being of both community members and responders.

Question #8: SPROUT clinicians will be handling sensitive information about unhoused residents, welfare checks, and behavioral health needs. What privacy protections or data-sharing standards will govern how that information is documented and shared with the City, CMH, and A2 REACH? (Councilmember Harrison)

Response: SPROUT service documentation will be maintained through the Julota case management platform, which is currently utilized by the City's Supportive Connections Program to securely document client interactions, service coordination, and outcomes. All documentation and information management practices will adhere to applicable federal and state privacy requirements, including HIPAA and 42 CFR Part 2, to ensure the confidentiality of individuals receiving services.

Information will be shared when necessary to support care coordination, facilitate appropriate referrals or warm handoffs, and only in accordance with applicable privacy laws and client authorization requirements. The program is committed to balancing effective collaboration with community partners while safeguarding the privacy, dignity, and trust of the individuals it serves.

Question #9: Will SPROUT calls come through standard 911/AAPD dispatch, a separate line, or a new number entirely, and how will residents and other responders know when to route a situation to SPROUT versus A2 REACH versus police? (Councilmember Harrison)

Response: The City will continue collaborating with Washtenaw County Dispatch, the Ann Arbor Police Department, and the Ann Arbor Fire Department to establish best practices for routing calls and determining the most appropriate dispatch pathways. These discussions will evaluate a variety of potential access points to ensure community members are connected to the right response based on the nature of the situation.

Question #10: What is the anticipated timeline from hiring to full field deployment, and what accounts for that timeline beyond CISM certification and de-escalation training already referenced? (Councilmember Harrison)

Response: The anticipated timeline for full field deployment of the SPROUT pilot is approximately 8–10 months following City Council approval. This timeframe allows for thoughtful program development, including the implementation of policies and procedures, recruitment and onboarding of staff, specialized training, procurement of vehicles and equipment, and the establishment of operational protocols. Hiring clinicians early in the process will allow them to actively participate in program development, helping to ensure the pilot launches with a well-prepared team and a strong operational foundation.

Question #11: Will preference be given to candidates with prior experience working in Washtenaw County? (Councilmember Harrison)

Response: Candidates from all communities will be encouraged to apply for SPROUT positions. While experience working in Washtenaw County and familiarity with the local behavioral health and human services systems are valuable qualifications, the City is committed to fair and equitable hiring practices and cannot give hiring preference based solely on prior local experience. The selection process will focus on identifying candidates with the knowledge, skills, experience, and values necessary to provide high-quality, person-centered, and trauma-informed services to our community.

Question #12: Will scheduling be adjusted seasonally based on community needs (e.g., unsheltered population support in colder months)? (Councilmember Harrison)

Response: As a pilot program, SPROUT is intended to remain flexible and responsive to changing community needs. Operating hours, staffing patterns, and service delivery may be adjusted based on data from service encounters, dispatch activity, calls for service, and emerging community trends, including seasonal needs. This adaptive approach will help ensure resources are aligned with where and when they can have the greatest impact.

Question #13: Will SPROUT vehicles and staff be visually distinct from police vehicles, and what will that look like? (Councilmember Harrison)

Response: Yes. SPROUT vehicles and staff will be intentionally distinguishable from police vehicles and uniforms to clearly reflect the program's role as a civilian, behavioral health-focused response. This approach is consistent with successful alternative response programs in communities such as Durham, North Carolina, and Madison, Wisconsin, where clearly identifiable vehicles help promote public understanding, reduce confusion, and support engagement with individuals who may be hesitant to interact with traditional public safety responders.

The specific vehicle design, branding, and staff attire are still under development and will be finalized as part of the pilot implementation process. The goal will be to create a professional, welcoming, and easily recognizable identity that reflects SPROUT's mission of providing compassionate, person-centered crisis response.

Question #14: Will SPROUT responders carry any protective equipment, or will they be entirely unarmed and unprotected in all circumstances? (Councilmember Harrison)

Response: The SPROUT pilot is designed as a fully unarmed, civilian response program. SPROUT clinicians will not carry weapons or equipment intended for the use of force. The program's approach emphasizes prevention, de-escalation, clinical assessment, and voluntary engagement. Clinicians will be trained to recognize when a situation exceeds the scope of a civilian response and will coordinate with public safety partners when necessary to ensure the safety of community members, responders, and others involved.

Question #15: What is the anticipated caseload per caseworker once the program is fully staffed? (Councilmember Harrison)

Response: Caseload expectations will be informed by community demand. The complexity of client needs, the time required to deliver high-quality, person-centered care, and the intensity of follow-up required for stabilization will all shape how caseloads are assigned and managed. The goal is to develop manageable caseloads that allow clinicians to provide meaningful engagement, effective follow-up, and sustainable service delivery while maintaining staff well-being.

Question #16: Since the positions to administer SPROUT were not included in the approved FY2027 budget pending this approval, what is the process and timeline for finalizing that budget component? (Councilmember Harrison)

Response: The request to establish the four clinician positions needed to implement the SPROUT pilot is included as part of the resolution before City Council. Upon approval, these positions will be funded through the Washtenaw County Community Mental Health and Public Safety Preservation Millage rebate. Following Council approval, the City will move forward with the necessary administrative and hiring processes to support program implementation in accordance with the anticipated project timeline.

Question #17: Beyond the information-sharing agreement with A2 REACH and CMH, how will SPROUT coordinate with CMH's existing mobile crisis team specifically to avoid duplicating services? (Councilmember Harrison)

Response: SPROUT will coordinate with community partners on a case-by-case basis to promote continuity of care and avoid unnecessary duplication of services. When appropriate, information will be shared to facilitate care coordination and warm handoffs, with the individual's informed consent through a signed Release of Information and in accordance with HIPAA and 42 CFR Part 2. This collaborative approach helps ensure individuals are connected to the provider or service best suited to meet their needs while maintaining appropriate privacy protections.

Question #18: Are there plans to expand SPROUT services to other municipalities in Washtenaw County? (Councilmember Harrison)

Response: There are no plans to expand SPROUT services to other municipalities in Washtenaw County for this pilot period.

CA-21 - Resolution to Approve the Intergovernmental Agreement with Washtenaw County Community Mental Health for a Licensed Clinician to Support the Co-Response Program through Ann Arbor Police Department ($405,000.00)

Question #1: What criteria will dispatch use to route a call to A2 REACH specifically, versus SPROUT or a traditional police response, and how quickly can that determination be made? (Councilmember Harrison)

Response:

A2 REACH – CO RESPONSE	SPROUT – CLINICIAN RESPONSE
• Calls for Service where the main response involves someone in a behavioral health crisis. • A person causing ongoing, repetitive or major disruptions, viewed as problematic by the community, acquaintances, family, or themselves. • These calls may involve emotional distress, disruptive behavior, suicide attempts with a weapon, or threats. • An individual where a court order requires a police officer to escort them to a facility for treatment	• An individual (s) contemplating suicidal ideations • An individual experiencing an addiction to perceived alcoholism or other drug dependence • Individuals in need of resources due to homelessness • An individual lacking basic physical needs such as food, clothing, or shelter • An individual with mental illness whose impaired judgment requires treatment or clinical intervention to prevent harmful deterioration. • Victims of crime where they can be used to provide victims rights, and domestic violence safety plans

Additional calls for service to be dispatched will be considered. A timeline for dispatch protocols can be better decided after the resolution is approved and regularly scheduled meeting intervals are set with Dispatch and Community Mental Health.

Question #2: With one clinician position funded under this agreement, what is the coverage plan for vacation, illness, or turnover, so residents aren't left without access to the co-response option? (Councilmember Harrison)

Response: Discussions with Community Mental Health leadership indicate that efforts to address coverage gaps are ongoing. It is important to recognize that the current organizational structure and staffing allocations do not permit comprehensive gap coverage under existing contracts, which allow for officer vacations and sick leave. Employee turnover will be managed by filling vacancies through a formal testing process.

Question #3: The 2,080 annual hours cover response time, training, and outreach combined. How were those hours calibrated to anticipated call volume, and what happens if actual need exceeds that capacity? (Councilmember Harrison)

Response: The 2,080-hour metric represents the baseline annual capacity of a single Full-Time Equivalent (FTE) position. To calibrate this capacity against anticipated call volume, the department utilizes a community policing philosophical approach built on a shared-resource model, rather than dedicating these hours strictly to an isolated A2 REACH Co-Response unit.

- **The Shared-Responsibility Outreach Model:** Instead of relying solely on standard Co-Response officers to handle outreach, these 2,080 hours are integrated into a citywide, multi-departmental approach. This network includes the Office of the Police Chief, Community Engagement, Public Information Officers, Crisis Intervention Team (CIT) Officers, the A2-REACH Co-Response team, and other city entities. By spreading the workload across these specialized units, the department maximizes the outreach efficiency of those baseline hours.
- **Dual-Purpose Training Hours:** Training hours—include advanced Crisis Intervention, Trauma-Informed Policing, and De-Escalation— These are standardized so they do not completely subtract from call availability. Because in-city training allows officers to monitor their radios and remain active for service calls, training time and call-response capacity are utilized simultaneously.
- When training occurs out of the city, it is important to recognize that the current organizational structure and staffing allocations do not permit comprehensive gap coverage under existing contracts, which allow for officer vacations and sick leave.

Question #4: What does the joint training for the officer-clinician pairing actually cover, and how does it prepare the two to work together on scene rather than just alongside each other? (Councilmember Harrison)

Response: Joint training for the co-responder team and the paired officer covers crisis de-escalation, specialized training to assist individuals experiencing psychiatric emergencies, fair and impartial policing, and trauma-informed care, to name a few. As

they train in unison, their frequent interaction will help both the clinician and the officer bring their respective expertise to the table to provide a tailored response. Depending on the call, the clinician will evaluate the situation in real-time while the officer simultaneously maintains safety, and vice versa.

Question #5: For someone whose needs turn out to be better suited to SPROUT's longer-term follow-up model, what does that handoff from A2 REACH actually look like, and how do we make sure the person doesn't fall through the gap between the two programs? (Councilmember Harrison)

Response: Each situation is handled based on what is transpiring at the time. While ensuring safety is the number one priority, the overall objective is to identify specific needs and tailor an approach that successfully connects the individual to appropriate resource.

Question #6: How will the AAPD officer for this unit be chosen: is this a volunteer assignment, a department selection, or a new hire, and how does that decision affect continuity if that officer moves on? (Councilmember Harrison)

Response: The selection of officers is governed by union contract language and the criteria outlined in the official job posting. As it stands, this position is not a new hire and an officer from patrol will be assigned full time to meet this council priority.

Question #7: Given how model depends on the success of the partnership, beyond CIT certification, is there any minimum experience level, education or additional screening for the officer paired with the clinician. (Councilmember Harrison)

Response: Eligible candidates must be post-probationary police officers who are certified in Crisis Intervention Team (CIT) response. Selection is conducted via a competitive testing process, which includes an oral board consisting of members from Community Mental Health and the broader mental health leadership field. All selections are made in accordance within general policy and the officer union contract.

Question #8: The agreement references HIPAA and 42 CFR Part 2 compliance for information sharing. In practice, what clinical information does the officer see on scene, what stays with the clinician and CMH, and how is that boundary maintained operationally? (Councilmember Harrison)

Response: An officer at the scene is not permitted to view or access protected HIPAA and/or 42 CFR Part 2 clinical information. Conversely, the clinician is not permitted to access secure criminal justice data via the Michigan Law Enforcement Information Network (LEIN). To manage this, each person will not have access or credentials for view sensitive information based on professional role. Information is properly managed by each practitioner based on the current laws protecting privacy.

Question #9: What will the unit's operating hours and days be at launch, and how will that schedule be determined? (Councilmember Harrison)

Response: The hours of operation will be data-driven, targeting the times and locations throughout the city that demonstrate the greatest need for service calls. This schedule will be established in concert with the police officers' collective bargaining agreement, which dictates scheduling guidelines and personnel movement subject to change.

Question #10: Will both the officer and clinician be required to wear protective equipment (e.g., vests)? Will the officer remain armed? (Councilmember Harrison)

Response: Both the clinician and the officer will be required to wear protective body armor (Kevlar vests). The police officer will be armed in a manner consistent with standard police issued equipment which will include a firearm.

Question #11: What will the vehicle and uniform look like, and how will they be visually distinguished from standard patrol units? (Councilmember Harrison)

Response: The vehicle's logo design and the team's uniforms will be developed based on feedback from the community and members of the organization prior to the official launch.

Question #12: What criteria will guide whether the officer or the clinician takes the lead in engaging an individual once a scene is safe? (Councilmember Harrison)

Response: The determination of who takes the lead is call and subject specific. If there is an active safety concern, the police officer is the primary responder for safety, while the clinician is the primary responder for care, and vice versa. However, the initial response for every call is managed in a way that is uniquely tailored to best assist the individual's needs.

Question #13: What specific practices or protocols will be used to avoid unnecessary criminalization of individuals experiencing behavioral health crises or low-level quality-of-life situations? (Councilmember Harrison)

Response: To avoid unnecessary criminalization, officers assigned to this role will prioritize connecting individuals with appropriate care and utilizing existing or future diversion programs. Restorative care, rather than criminal justice intervention, will be the standard operational norm.

Question #14: Is there a plan or threshold for expanding A2 REACH to additional units in the future? (Councilmember Harrison)

Response: Evaluating the initial rollout, hours of operation, program outcomes, and overall effectiveness will determine future plans and thresholds for expanding the A2 REACH program.