THE OFFICE OF

GOVERNOR MAURA T. HEALEY

LT. GOVERNOR KIMBERLEY DRISCOLL

Kiame Mahaniah, MD, MBA

Secretary of the Executive Office of Health and Human Services

Emily Bailey

Commissioner

JAIL & ARREST DIVERSION GRANT PROGRAM

FY 2025 ANNUAL REPORT

January 2026

MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH

TABLE OF CONTENTS

EXECUTIVE SUMMARY **3**

KEY OUTCOMES FOR FY25: **3**

JDP WITHIN THE CRISIS RESPONSE LANDSCAPE **2**

WHAT JDP ACTUALLY DOES **4**

THE CENTER FOR POLICE TRAINING IN CRISIS INTERVENTION **6**

CROSS-AGENCY COLLABORATION **7**

FY25 GRANT PROGRAM OVERVIEW **8**

- INVESTMENT SUMMARY 9
- FUNDING TRAJECTORY 10
- GRANT DEMAND 10

TRAINING AND TECHNICAL ASSISTANCE **11**

PROGRAM OUTCOMES AND IMPACT **13**

COST-EFFECTIVENESS **16**

LOOKING AHEAD **17**

REFERENCES **19**

APPENDIX I: LIST OF DMH GRANT AWARDEES IN FY25 ..... **21**

APPENDIX II: GRANT TYPES AND DESCRIPTIONS **26**

APPENDIX III: IMPACT NARRATIVES **27**

Executive Summary

This report covers operations from July 1, 2024, through June 30, 2025, fulfilling the legislative mandate established under Chapter 41 of the Acts of 2019. Beyond compliance, this document offers a comprehensive view of how jail diversion programs (JDPs) operate within, and strengthen, the broader crisis response system. Understanding this positioning helps clarify why these programs matter and how they connect to other Commonwealth initiatives. It also illustrates how JDP supports statewide priorities: reducing avoidable justice involvement, improving crisis response quality, and promoting continuity between law enforcement, emergency systems, and community-based treatment. Taken together, these elements show how JDP functions as both a frontline service and a structural anchor within Massachusetts' crisis response landscape.



The year marked significant advances in program coordination, cross-agency collaboration, and quality assurance. The Massachusetts Department of Mental Health's Jail and Arrest Diversion Initiatives conducted audits of Training and Technical Assistance Centers and expanded partnerships with the Municipal Police Training Committee, 911 dispatch systems, and the Department of Correction. The Division's Center for Police Training in Crisis Intervention supported these efforts and launched a public-facing website and learning management system, providing training, technical assistance, data collection, and infrastructure support across the statewide system. These developments reflect the maturation of JDP from a collection of local programs into a coordinated statewide system.

In Fiscal Year 2025, DMH awarded $17,210,417 in grant funding through the Jail and Arrest Diversion Initiatives.

Key outcomes for FY25:

- 29,386 documented interventions by funded programs
- 3,328 diversions from arrest
- 6,517 diversions from emergency department visits

- 2,136 law enforcement personnel attended TTAC training
- 904 officers certified through the statewide CIT certification process
- Estimated cost savings of $42,818,428 to public safety and healthcare systems

These results reflect the sustained commitment of law enforcement agencies, behavioral health providers, and community partners working together to improve outcomes for individuals in crisis while enhancing public safety across Massachusetts.

JDP Within the Crisis Response Landscape

Jail and arrest diversion initiatives, which include training, programming, clinical expertise, and hospital or emergency department diversion services, function as one element of an interconnected infrastructure designed to meet people in crisis with the right response at the right time. These initiatives are collectively referred to as Jail and Arrest Diversion Programs (JDP). Understanding where JDP sits within this landscape clarifies both its value and its relationship to other crisis response resources. JDP also contributes to evidence-based interventions and knowledge development, although this is a secondary role compared with its operational focus.

Where JDP Fits

When someone in Massachusetts experiences a behavioral health crisis, several pathways may activate: a call to 988, contact with the Behavioral Health Help Line (BHHL), a call to a Community Behavioral Health Center's mobile crisis team, or a 911 call. These pathways increasingly intersect.

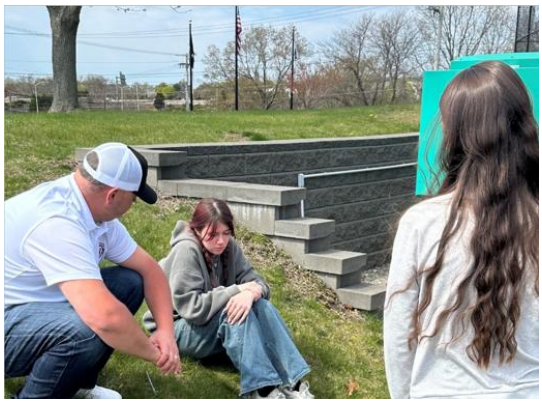
JDP occupies the point where crisis response meets law enforcement. When a 911 call brings police to a scene involving someone in behavioral or psychiatric distress, jail diversion programs shape what happens next. Whether through officers with specialized training (e.g., CIT, ICAT) or embedded co-responders, these programs influence whether that encounter leads to arrest, emergency department transport, community-based intervention, or on-scene resolution.

Research estimates that approximately 20% of police calls for service involve someone experiencing a mental health or substance use crisis, though local estimates often run higher (Abramson, 2021; Wood et al., 2017). This means police officers will continue encountering people in behavioral health crises as a routine part of their work, regardless of other available resources. JDP ensures that when they do, they arrive equipped with specialized training and, in many communities, immediate access to clinical support.

Better Crisis Responses, Enhanced Public Safety

These programs exist both to improve outcomes for individuals in crisis and to enhance public safety. These objectives reinforce rather than conflict with each other.

When officers receive advanced training in de-escalation techniques, encounters that might otherwise escalate become opportunities for intervention and connection to services. When clinicians ride alongside officers, real-time clinical assessment replaces guesswork. The result: fewer injuries to officers and civilians, reduced use of force, more efficient allocation of emergency resources, and better outcomes for individuals who receive appropriate care rather than inappropriate incarceration.



The stakes are substantial. People with untreated mental illness are 16 times more likely to die during a law enforcement encounter than the general population (Treatment Advocacy Center, 2015). JDP directly addresses this disparity by transforming these encounters into opportunities for help rather than harm.

Connections Across Systems



JDP does not operate in isolation. Officers encounter individuals in behavioral health crisis through multiple pathways: dispatched to a 911 call, flagged by 988 or the BHHL for law enforcement response, or encountered during routine patrol. Regardless of how the encounter begins, JDP equips officers and co-responders to assess the situation, de-escalate when needed, and connect individuals to appropriate resources. Community Behavioral Health Centers serve as referral destinations, providing follow-up care that transforms a single intervention into sustained treatment. When JDP diverts individuals from emergency departments, it frees ED capacity for cases that genuinely require emergency medical care. And each pre-arrest diversion interrupts the cycle that funnels people with behavioral health conditions into courts, jails, and prisons, systems already strained by populations with high rates of mental illness.

These connections matter for how we understand the return on JDP investment. Cost savings do not stop at avoided arrests or ED visits. They cascade through systems that would otherwise absorb the downstream consequences of untreated crisis: repeat calls, deteriorating health, deeper system involvement, and higher long-term costs. Investing in JDP strengthens the entire crisis response infrastructure, not just the programs themselves.

What JDP Actually Does

The term "jail diversion" can obscure as much as it reveals. This section explains what these programs do in practice.

Pre-Arrest Intervention

Jail and Arrest Diversion Programs create intervention points during police encounters, before any arrest occurs. When officers respond to a call involving someone in behavioral health crisis, JDP offers alternatives to arrest and booking. Officers can connect individuals with services, stabilize the situation on scene, or transport to a treatment setting rather than a cell.

This is pre-arrest diversion, which differs fundamentally from post-booking programs like mental health courts that redirect individuals after they have already entered the system. Pre-arrest diversion prevents the harms of incarceration entirely: the trauma of arrest, the disruption to treatment and housing, and the criminal record that complicates future employment and recovery.

Beyond Diversion: Behavioral Health Crisis Response

In practice, JDP has evolved beyond its original diversion mandate. FY25 data shows that in nearly 87% of documented encounters, no chargeable offense was involved. These are behavioral health crises where arrest was never on the table, but jail diversion programs still provided de-escalation, assessment, and connection to services.

This pattern is not a departure from the program's purpose but an extension of it. The name "jail diversion" captures one function, but the underlying competency is broader: helping law enforcement respond skillfully to behavioral health crises regardless of whether arrest is a possibility. This broader crisis response function reflects the reality of police work: officers routinely encounter individuals in distress who have committed no crime but need help navigating a mental health or substance use crisis. A person in psychosis on a street corner, a family requesting a welfare check on an elderly parent, a young person threatening self-harm: none of these situations involve criminal conduct, but all of them benefit from the training, clinical partnership, and referral pathways that JDP provides. JDP equips officers to respond effectively to these situations, not just to divert from arrest when applicable.

Three Core Strategies

DMH funds three primary strategies for achieving pre-arrest diversion.

Crisis Intervention Team (CIT) Training and Development is a 40-hour program that equips officers to recognize signs of mental illness, de-escalate crisis situations, and connect individuals with appropriate services. CIT has become an internationally recognized model for improving law enforcement response to behavioral health calls. In Massachusetts, officers must pass both a written knowledge assessment and a practical

demonstration of de-escalation skills to receive certification, ensuring that certification reflects actual competency. After officers complete CIT training, departments begin developing their CIT program by designating a CIT coordinator, ensuring an adequate proportion of CIT-trained officers for coverage, and aligning policies and dispatch procedures with CIT's core elements.
Co-Response Programs embed licensed behavioral health clinicians directly into police operations. These clinicians accompany officers on calls involving behavioral health concerns, providing real-time clinical assessment and intervention at the scene. Co-responders bring capabilities that training alone cannot provide: formal mental status examinations, clinical suicide risk assessment, and expert navigation of the behavioral health system for referrals.
Training and Technical Assistance Centers (TTACs) serve as regional hubs for developing and sustaining CIT and co-response programs across the Commonwealth. They deliver standardized curricula, provide specialized trainings, assist departments in launching new programs, and offer ongoing consultation to established programs. TTACs also verify that officers completing CIT training meet uniform standards regardless of which center provided their training.

The Population Served

JDP serves individuals experiencing behavioral health crises, most often when that crisis brings them into contact with law enforcement, but also through planned encounters such as proactive outreach and follow-up engagement. This includes people in acute psychiatric emergencies, individuals with chronic mental illness who have cycled through crises repeatedly, people in substance-induced states, and those whose behavioral health conditions intersect with poverty, homelessness, and trauma. It also includes individuals with no prior psychiatric history who find themselves in crisis for the first time. Each situation requires individualized assessment and response.

National data provides context: approximately 2 million arrests annually in the United States (16.9% of all arrests) involve people with serious mental illness (Leifman, 2019), and an estimated 37% of people in state prisons and 44% in local jails have a history of mental health conditions (National Alliance on Mental Illness, n.d.). JDP programs intervene at the front end of this pipeline, potentially interrupting trajectories that could lead to repeated arrests, incarceration, and deteriorating health. But they also serve the far larger population of individuals in crisis who never face arrest, ensuring that police encounters become opportunities for help rather than harm.

The Center for Police Training in Crisis Intervention



Established under Chapter 208 of the Acts of 2018, the Center for Police Training in Crisis Intervention serves as the Commonwealth's hub for coordinating, supporting, and advancing crisis intervention training for law enforcement and public safety personnel. The Center is now fully operational, supporting programs and providing oversight across the Commonwealth.

Mission and Statutory Authority

In accordance with Mass. General Laws c.19 § 25, the Massachusetts Center for Police Training in Crisis Intervention (the Center) operates within the Department of Mental Health with statewide scope. Housed at Boston College, the Center is tasked with establishing and supporting community policing and behavioral health training for law enforcement, serving as a clearinghouse for best practices, providing technical assistance to communities, establishing metrics for success and evaluation, facilitating data maintenance, and conducting relevant research.

This framework positions the Center as a hub strengthening local programs rather than a gatekeeper controlling them. Local programs retain their community connections and ability to adapt to local conditions. The Center provides infrastructure, coordination, and quality assurance that individual programs could not efficiently develop on their own.

FY25 Areas of Responsibility

TTAC Audits and Model Fidelity

In FY25, the Center supported audits of Training and Technical Assistance Centers, assessing adherence to curriculum standards, certification procedures, documentation practices, and training quality. The goal was developmental: identifying strengths worth replicating and gaps requiring targeted support.

Alongside this work, the Center conducted an environmental scan of existing audit processes across program types, examining current systems, documentation practices, and reporting standards. This assessment establishes a foundation for developing a standardized auditing framework to strengthen consistency statewide. The Center continues working closely with DMH JDPs to align data processes and maintain shared standards.

Website and Learning Management System

The Center launched its public-facing website in September 2024, establishing a centralized platform for training resources, program information, and research findings. The website houses the DMH Jail Diversion Programs Learning Management System (LMS), providing streamlined access to training materials and educational resources while tracking completion of training modules. The site also offers guidance for prospective grant applicants, reducing barriers to program participation.

Data Management and Quality Assurance

The Center maintains rigorous oversight of program data through weekly incident data reviews, ensuring accuracy and consistency across participating programs. Incident-level and quarterly certification data are reviewed alongside TTAC audit feedback to identify operational challenges, training needs, and emerging research opportunities.

Recertification Development

As the first wave of CIT-certified officers approaches the three-year mark, the Center consulted on the recertification curriculum in FY25 to ensure officers maintain and update their crisis intervention skills over time. This work recognizes that competency in behavioral health response requires ongoing development, not just initial training. The curriculum revision process incorporates feedback from TTACs, law enforcement partners, and subject matter experts to ensure recertification content reflects current best practices and addresses gaps identified through field experience. Development is ongoing, with implementation anticipated in FY26.

Research Initiatives

The Center's research portfolio expanded in FY25, directly supporting its statutory mandate to promote evidence-based practices. Two studies examining diversion outcomes were published, three manuscripts are under journal review, and two additional studies are in data collection. Beyond contributing to the scholarly literature, this work has direct operational value: findings inform training content, technical assistance priorities, and program standards across DMH JDP. Housed at Boston College and led by a clinician-researcher, the Center is structured to bridge academic evidence and field practice.

Community and Law Enforcement Engagement

The Community Policing and Behavioral Health Advisory Council met during FY25, focusing on strengthening community engagement and increasing LMS utilization among departments. TTAC engagement remained strong throughout the year, with increased participation and feedback informing local implementation strategies. The statewide co-responder roster continued to expand, reflecting sustained growth in program capacity across departments.

Cross-Agency Collaboration

JDP's effectiveness depends on partnerships that extend beyond DMH and local police departments. FY25 saw significant expansion of cross-agency collaboration, positioning JDP as a connected component of the Commonwealth's public safety and behavioral health infrastructure.

Municipal Police Training Committee Partnership

The Center strengthened its working relationship with the Municipal Police Training Committee (MPTC) in FY25, aligning JDP training content with broader law enforcement professional development requirements. This partnership creates pathways for integrating behavioral health content into recruit and in-service curricula and facilitates recognition of JDP training for professional development credit.



911 and Dispatch Coordination

Effective crisis response begins before officers arrive on scene. In FY25, JDP expanded engagement with 911 dispatch systems, working to improve how behavioral health calls are identified, triaged, and communicated. Several TTACs now offer specialized training for dispatchers, equipping them to recognize indicators of behavioral health crisis during intake calls and relay relevant information to responding units.

Department of Correction Collaboration

FY25 marked new collaboration between JDP and the Department of Correction, recognizing that crisis intervention principles apply across correctional settings as well as community policing. This partnership represents an expansion of JDP's scope, acknowledging that the same individuals may encounter multiple systems and that consistency in crisis response benefits both individuals and systems.

Massachusetts State Police

The Massachusetts State Police maintained and expanded their JDP participation in FY25, with co-response programming and training reimbursement supporting crisis intervention capacity across state police operations. State Police involvement extends JDP's geographic reach and ensures consistency of response regardless of which agency handles a call.

FY25 Grant Program Overview

DMH's Jail and Arrest Diversion grant program provides direct funding to municipalities and behavioral health providers, enabling them to develop and sustain diversion programming tailored to local needs and resources. This funding model, state investment supporting locally designed and operated programs, balances the benefits of coordination with the advantages of community-level responsiveness. Since an initial investment of $100,000 in FY2007, the program has grown substantially in both scale and

sophistication, now representing a major component of the Commonwealth's behavioral health crisis infrastructure.

Investment Summary

Total FY25 Investment: $17,210,417
Number of Funded Projects: 113

This investment supports a diverse portfolio of program types, from small grants covering training costs for individual departments to substantial awards supporting regional co-response networks serving multiple communities. The variety of grant types reflects the variety of local needs and capacities. Not every community requires or can sustain a full co-response program, but nearly every community can benefit from some level of JDP engagement.

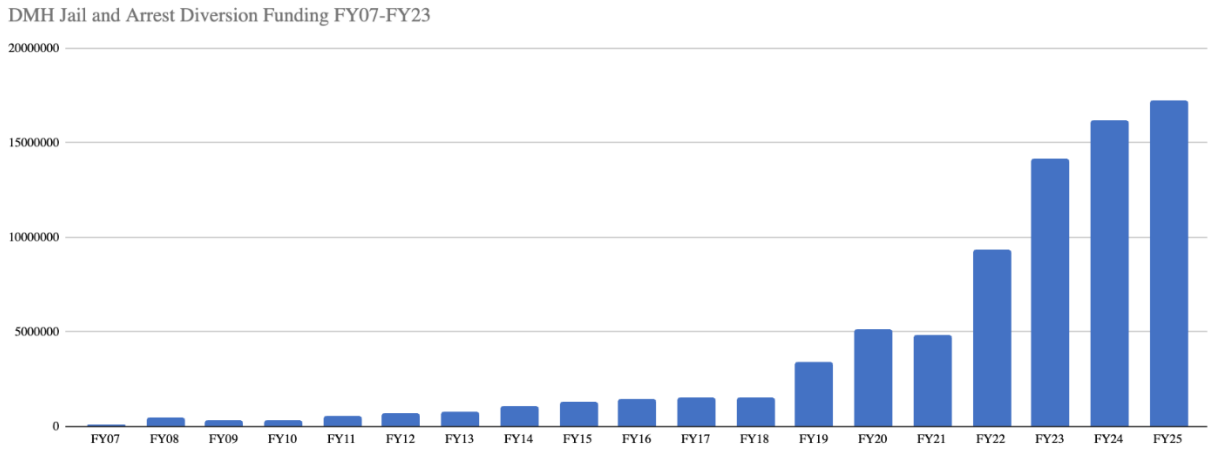
Grant Distribution by Type

Program Type	Number of Grants	Percentage of Total
Co-Response TTAC	1	0.9%
Behavioral Health Integrated Partnership (BHIP)	2	1.8%
Trainer/ Consultant/ Researcher	4	3.5%
Crisis Intervention Team TTAC	8	7.1%
Crisis Intervention Team	8	7.1%
Backfill /Training Reimbursement	11	9.7%
Component	33	29.2%
Co-Response Program	46	40.7%
Total	**113**	**100%**

Co-response programs represent the largest category of grants, reflecting the demonstrated effectiveness of embedding clinicians in police operations and the strong demand from communities that have seen these programs work. Component JDP grants provide flexibility for communities to design customized approaches, while backfill and training reimbursement grants reduce barriers to officer participation in training by covering overtime and replacement costs.

Funding Trajectory

The growth of JDP funding over time reflects sustained legislative commitment and documented program effectiveness. From the initial $100,000 investment in FY2007, the JDP experienced modest annual growth that enabled the program to expand as interest and demand increased. Beginning in FY22, DMH benefited from the designation of federal ARPA funds, both from federal funds allocated directly to DMH and through legislatively appropriated federal funds. This infusion of ARPA funding enabled through JDP program to double its annual budget, from $8.5M in FY20 to $17,210,417 in FY25. This budget growth coincided with increased demand from communities seeking to participate and confidence in the returns these programs generate. As we move forward into Fiscal Year 27, with the ending of the ARPA funds, DMH's base funding for JDP is $4 million.



Grant Demand

During FY25, DMH received 29 applications for grant funding and technical assistance, representing an 81% increase over the prior year. This sustained and growing demand demonstrates continued interest from law enforcement agencies, behavioral health organizations, and municipalities across the Commonwealth. While not every application progressed to an active grant due to timing, capacity, or local decisions to pause or postpone, this level of interest signals a robust pipeline. Although the number of active grants declined slightly, the increased application volume positions us well for continued growth in the year ahead.

Importantly, demand consistently exceeds available funding. This gap indicates that the limiting factor for program expansion is resources rather than community interest. The continued growth and sustainability of the JDP program are key considerations for DMH and its partners to consider in the years ahead.

Training and Technical Assistance

Training transforms how officers understand and respond to behavioral health crises. It provides the knowledge, skills, and perspective shifts that enable different outcomes than traditional policing approaches would produce. Technical assistance helps programs translate that training into sustainable local systems that continue functioning effectively over time. Together, training and technical assistance form the foundation on which successful diversion programs are built.

TTAC Network

In FY25, the Training and Technical Assistance Center network continued evolving to meet community needs. The Eastern Essex TTAC began operations, expanding regional coverage and bringing training resources closer to communities in that area. Meanwhile, the Sherborn TTAC concluded its work, with its service area absorbed by other centers. These changes reflect the dynamic nature of the network, responding to shifting needs and opportunities rather than remaining static.

The TTAC network in FY25 included the Boston CIT-TTAC, Brookline CIT-TTAC (Norfolk County), Braintree CIT-TTAC (South Shore and the Cape), South Hadley CIT-TTAC (Western Mass), Beverly CIT-TTAC (Eastern Essex), Open Sky CIT-TTAC (Central Mass), Somerville CIT-TTAC (Metro Boston), and William James College CR-TTAC (statewide). Each TTAC serves a defined geographic region, providing training and consultation to departments within that area. This regional model ensures that departments across the Commonwealth have access to training without requiring extensive travel, while concentrating expertise in centers that can develop deep knowledge of local resources and relationships.

Training Delivered

TTACs delivered 154 training sessions and over 50,133 hours of training in FY25, reaching law enforcement personnel across the Commonwealth.

Training Metric	FY21	FY22	FY23	FY24	FY25
Total TTAC Trainings	53	83	116	119	154
Total Officers Trained	834	1,468	1,528	1,489	2,136
CIT Trained (40-hour)	399	747	718	675	767
Dispatchers (CIT for Dispatch)	50	121	134	122	140
Mental Health First Aid	162	447	350	304	192

Engaged Departments	114	168	173	211	237
Total Training Hours	19,241	37,036	39,242	41,564	50,133

The multi-year trend shows substantial growth in training capacity since FY21, with the number of engaged departments nearly doubling and total training hours more than doubling. This expansion reflects both increased TTAC capacity and growing departmental interest in crisis intervention training.

CIT Certification Process

Massachusetts implemented a statewide CIT certification process that ensures officers completing the 40-hour curriculum demonstrate both knowledge and practical skills. The certification process includes a 25-question Knowledge Check covering core topics from the training, plus a practical assessment in which officers must demonstrate de-escalation skills in scenario-based exercises. Clinicians and experienced officers observe and assess performance across six specific dimensions of de-escalation.

In FY25, 904 officers completed the Knowledge Check, with only 11 requiring a retake before passing. All participants demonstrated the required de-escalation skills, resulting in 904 CIT-certified officers for the fiscal year. This represents a significant increase from 675 certifications in FY24.

The certification process serves multiple functions beyond credentialing individual officers. It creates accountability for training quality; if large numbers of officers were failing assessments, that would signal problems with curriculum delivery requiring attention. It also establishes that Massachusetts CIT certification means something consistent across the state, regardless of which TTAC provided the training.

Curriculum Revision

The Massachusetts CIT Standardized Curriculum underwent comprehensive revision in FY24, with the updated curriculum distributed in September 2024. This revision, the first major update in over five years, incorporated current research on behavioral health conditions, updated information on available resources and treatment approaches, and refined best practices for de-escalation based on accumulated experience.

The revision process gathered input from TTAC Directors, clinicians, law enforcement officers, and other subject matter experts. The goal was both to update content that had become outdated and to continue harmonizing training across the Commonwealth, ensuring that the CIT experience is substantially similar regardless of where an officer receives it.

Technical Assistance

Beyond formal training, TTACs provided 1,936 hours of technical assistance in FY25, more than four times the support delivered in FY24. This substantial increase

reflects growing program complexity and expanded TTAC capacity to meet consultation needs.

Technical assistance covered topics including developing new CIT and co-response programs, managing complex recurring cases, updating departmental policies, preparing grant applications, strengthening partnerships between law enforcement and behavioral health providers, and implementing evidence-informed diversion strategies. This support helps programs navigate challenges that arise between formal training sessions and ensures that initial training translates into sustained operational capacity.

Co-Response Training and Technical Assistance Center (CR-TTAC)



The William James College continued its role as the Commonwealth's Co-Response Training and Technical Assistance Center. Operating within an academic setting, CRBH offers a 10-credit graduate-level certificate program in Crisis Response and Behavioral Health, providing deeper education for clinicians and officers seeking advanced expertise. In FY25, CRBH held one Graduate Certificate in Crisis Response and Behavioral Health program, with 16 participants graduating.

In addition to the graduate certificate program, CR-TTAC expanded its training and technical assistance reach in FY25. Across 23 trainings and events, CR-TTAC engaged 513 participants through in-person intensives, communities of practice, webinars, and gatherings. Programming included multi-day Co-Response Intensives that incorporate MILO (Multiple Interactive Learning Objectives) simulation technology, allowing participants to practice realistic scenarios in a controlled setting where mistakes become learning opportunities. Additional offerings included monthly Communities of Practice, webinars, and the Third Annual Co-Response Research Symposium. Attendance ranged from small, practice-focused cohorts to large-scale webinars drawing 60–80 participants, reflecting both depth of engagement and broad reach across audiences.

Program Outcomes and Impact

The ultimate measure of JDP effectiveness is what happens during and after crisis encounters: whether individuals receive appropriate care, whether arrests are avoided when arrest is not the right response, whether officers and civilians remain safe, and whether communities are better served. As part of the Commonwealth's broader crisis response infrastructure, JDP contributes to these outcomes at the point where behavioral health crisis meets law enforcement. This section presents outcome data from FY25,

situating current results within multi-year trends and explaining what the numbers mean in practical terms.

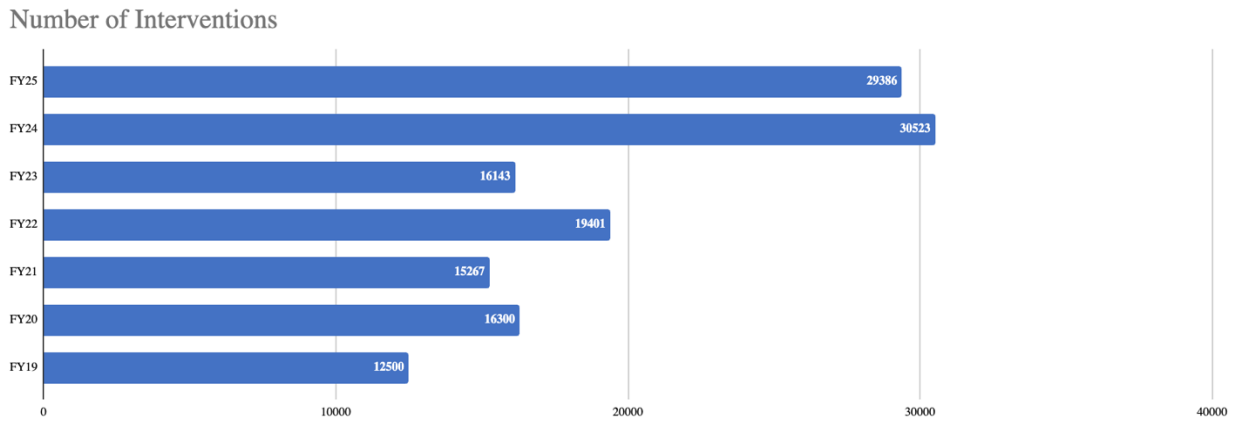
Data Infrastructure

Understanding program outcomes requires reliable data, and DMH has invested substantially in data infrastructure to ensure that outcome information is comprehensive and accurate. The online, real-time, secure system for intervention tracking implemented in recent years has dramatically improved data collection, enabling more complete documentation of program activities than was previously possible.

FY25 continued this commitment to data-driven management, with enhanced systems for quarterly reporting producing substantially higher submission rates from active programs. Standardized data monitoring for CIT certification ensures consistent tracking of training outcomes across all TTACs. These improvements mean that FY25 data provides a more accurate picture of program activity than earlier years, when inconsistent reporting likely undercounted actual interventions.

Total Interventions

In FY25, funded programs documented 29,386 interventions, consistent with the 30,523 recorded in FY24. The significant increase from FY23 to FY24 reflected both program expansion and improved data capture through the new tracking system. With two years of data under the current system, these figures now represent a stable baseline for measuring program activity.

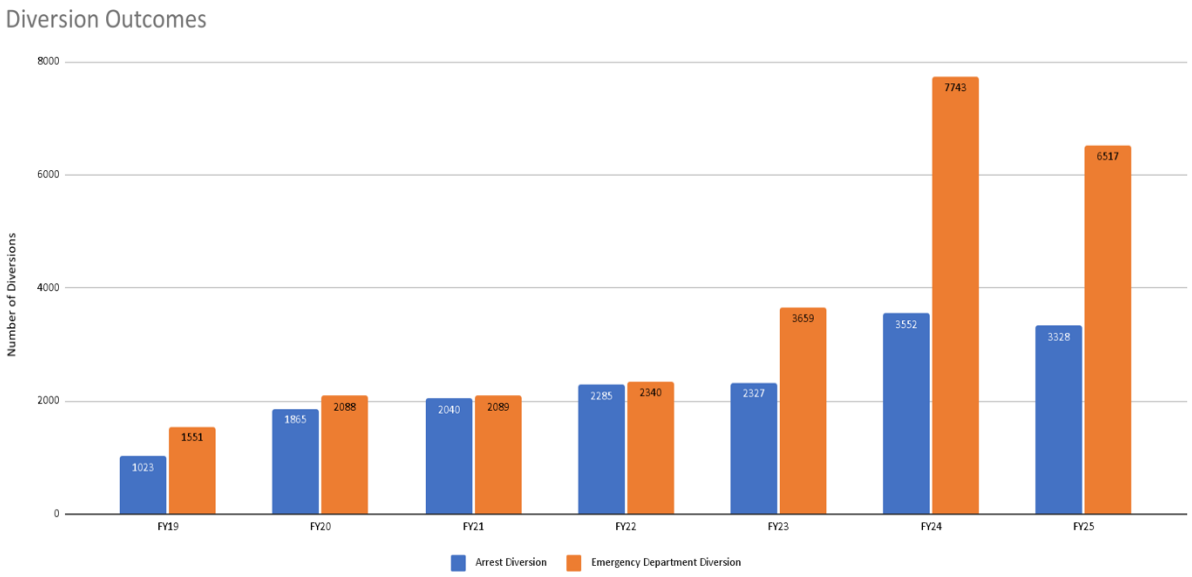


Diversion Outcomes

Diversion figures represent one measure of JDP impact, but not the full picture. Of the 29,386 documented interventions in FY25, many did not involve diversion-eligible situations: 25,480 encounters involved no chargeable offense, and 15,770 involved situations where ED transport was never indicated. In these cases, JDPs provided crisis response, de-escalation, and connection to services, fulfilling the program's broader

mission of improving behavioral health crisis response regardless of whether diversion was applicable.

Where diversion was applicable, programs continued to redirect individuals from unnecessary arrest and emergency department utilization.



Each arrest diversion represents an individual who received an alternative to criminal justice processing, typically connection to services, on-scene stabilization, or transport to an appropriate treatment setting. Each ED diversion represents an individual whose needs were met without utilizing emergency department resources, freeing that capacity for cases requiring emergency medical care.

Communities and Agencies Served

In FY25, TTACs impacted more than 235 Massachusetts communities, serving public safety agencies statewide—including 25 campus police departments and 210 other police departments. This year, 64 new agencies participated in TTAC training: 35 police departments and 29 non-police organizations (colleges or universities, health systems or alliances, hospitals, and municipal protective/services departments) that partner in public safety, further expanding the statewide reach of CIT practices.

This breadth of coverage means that residents across the Commonwealth increasingly benefit from JDP responses to behavioral health crises, regardless of which jurisdiction they happen to be in when crisis occurs.

Cost-Effectiveness

Beyond humanitarian benefits, JDP programs generate substantial cost savings across public safety and healthcare systems. By emphasizing on-scene stabilization over arrest or emergency department transport, these programs avoid costs that would otherwise cascade through criminal justice and healthcare systems. Understanding these economics helps contextualize JDP investment as fiscally sound as well as ethically appropriate.

Cost Estimation Methodology

Comprehensively quantifying cost savings from diversion programs presents methodological challenges. Healthcare and criminal justice costs interconnect in complex ways, long-term impacts are difficult to measure, and intangible benefits, such as reduced injuries, preserved employment, and avoided trauma, resist monetization. The estimates presented here are therefore conservative, focusing on direct costs that can be reasonably attributed to avoided events.

Estimated Public Safety Costs per Arrest
On average, the cost of police and court activity incurred is calculated at a rate of $7,169 per arrest (Hunt et al., 2017; Hunt et al., 2019; RAND, 2023).

These projections encompass law enforcement personnel's collective time and expenses, including police officers, judges, public defenders, prosecutors, and support staff, addressing reported crimes. Law enforcement activities, such as responding to scenes, managing crime scenes, investigations, paperwork, interrogations, arrests, and court appearances, contribute to these estimates. Costs include equipment, supplies, fuel, administrative staff, and utilities.

Estimated Incarceration Costs per Incident
On average, the cost of incarceration resulting from an arrest/incident incurs an average cost of $5,650 (Vera Institute of Justice, 2015).

Since only a subset of all arrests results in pretrial incarceration, we have applied the multiplier of 25% to the overall number of arrest diversions to derive the cost savings estimate. In Massachusetts, incarceration expenses average $143.72 per day. This encompasses court-related transportation/security, correctional officer and personnel costs, facility maintenance, medical/mental health care, meals, clothing, supplies, and inmate necessities.

Estimated Health Care Costs per ED Visit
On average, the Emergency Department level of care for mental health assessment/treatment incurs a cost of $2,188 per day for an individual (Consumer Health Ratings, 2023). Emergency Department diversions not only reduce healthcare expenses but also ensure more efficient resource allocation for urgent cases by preventing unnecessary wait times

FY25 Estimated Cost Savings

# of Arrest Diversions	# Incarceration Diversions	#Emergency Department Diversions
3,328 estimated diversions x $7,169 (per incident)	832 estimated diversions x $5,650 (per incident)	6,517 estimated diversions x $2,188 (per incident)
$23,858,432	**$4,700,800**	**$14,259,196**

FY25 Total Estimated Cost Savings = $42,818,428

FY25 savings of $42,818,428, combined with FY24 savings of $47,423,172, bring the two-year total to over $90 million in avoided costs across public safety and healthcare systems.

Return on Investment

The Commonwealth's investment in JDP generates returns that substantially exceed program costs. Using FY25 figures as illustration: $17,210,417 in grant funding generated an estimated $42,818,428 in avoided costs, a ratio of approximately $2.49 saved for every $1 invested. This conservative estimate excludes numerous benefits that resist quantification: reduced injuries, avoided trauma, preserved employment, prevented homelessness, and improved long-term health outcomes.

The actual return likely exceeds this estimate considerably, as successful diversion often interrupts trajectories that would generate costs for years into the future.

Looking Ahead

The demand for JDP services continues to grow, reflecting both community recognition of program value and ongoing need for improved crisis response across the Commonwealth. As Massachusetts continues building its crisis response infrastructure through 988, BHHL and Community Behavioral Health Center enhancements, JDP remains essential—ensuring that individuals in distress encounter trained responders equipped to help. Looking ahead to FY26 and beyond, DMH remains committed to working with its

valued, trusted partners to sustain effective programs, advance best practices, and expand capacity to meet documented needs.

FY26 Priorities

Key priorities for the coming fiscal year include sustaining support for evidence-based interventions by continuing investment in CIT training, co-response programs, and TTAC operations that have demonstrated effectiveness in improving crisis outcomes. DMH will focus on advancing best practices by building on curriculum revision and TTAC audit findings to continuously improve training quality and program fidelity across the Commonwealth.

Expanding capacity remains a priority, responding to documented demand by supporting new programs and expanding existing ones where resources allow. Strengthening cross-agency collaboration will deepen partnerships with MPTC, 911 systems, DOC, and other agencies to enhance system-wide coordination. Finally, ensuring full Chapter 208 implementation will continue progress toward comprehensive implementation of mental health and crisis intervention training requirements for law enforcement officers as outlined in Chapter 208 of the Acts of 2018.

Conclusion

The Massachusetts Jail and Arrest Diversion Initiatives continue to demonstrate their value as essential components of the Commonwealth's crisis response infrastructure. Programs strengthen community support systems, enhance law enforcement capacity to respond effectively to behavioral health calls, improve public safety outcomes, promote better health outcomes for individuals in crisis, and generate substantial cost savings across public safety and healthcare systems.

Law enforcement agencies maintain strong enthusiasm for JDP participation, with grant applications reaching record levels. The Center for Police Training in Crisis Intervention has established the coordination infrastructure needed to support continued growth while ensuring quality and consistency. Cross-agency partnerships position JDP as an integrated system component rather than an isolated program.

Massachusetts' approach to jail and arrest diversion has been recognized as a model for other states. That recognition reflects the Commonwealth's sustained commitment to these programs and the outcomes that commitment has produced. Looking ahead, DMH remains dedicated to building on this foundation: expanding access to effective crisis intervention training, supporting communities in implementing and sustaining diversion programs, and continuing to demonstrate that better responses to behavioral health crises benefit everyone.

References

Abramson, A. (2021). Building mental health into emergency responses. Monitor on Psychology, 52(5), 30.

Broadway, E. D., & Covington, D. W. (2018). A comprehensive crisis system: Ending unnecessary emergency room admissions and jail bookings associated with mental illness. National Association of State Mental Health Program Directors.

Consumer Health Ratings. (2023). Emergency room: Typical average cost of ED visit. https://consumerhealthratings.com/how-much-does-er-visit-cost/

Hunt, P., Anderson, J., & Saunders, J. (2017). The price of justice: New national and state-level estimates of the judicial and legal costs of crime to taxpayers. American Journal of Criminal Justice, 42, 231-254.

Hunt, P. E., Saunders, J., & Kilmer, B. (2019). Estimates of law enforcement costs by crime type for benefit-cost analyses. Journal of Benefit-Cost Analysis, 10(1), 95-123.

Leifman, S. (2019). Ending the criminalization of mental illness. Schizophrenia Bulletin, 45(2), S89.

National Alliance on Mental Illness. (n.d.). Jailing people with mental illness. https://www.nami.org/Advocacy/Policy-Priorities/Stopping-Harmful-Practices/Jailing-People-with-Mental-Illness

Prins, S. J. (2014). Prevalence of mental illnesses in US state prisons: A systematic review. Psychiatric Services, 65(7), 862-872.

RAND Corporation. (2023). Costs of responding to crime: Police, court, and legal services. https://www.rand.org/pubs/tools/TLA517-1/tool.html

Timmer, A., & Nowotny, K. M. (2021). Mental illness and mental health care treatment among people with criminal justice involvement in the United States. Journal of Health Care for the Poor and Underserved, 32(1), 397-422.

Treatment Advocacy Center. (2015). Overlooked in the undercounted: The role of mental illness in fatal law enforcement encounters. https://www.treatmentadvocacycenter.org/key-issues/criminalization-of-mental-illness/2976-people-with-untreated-mental-illness-16-times-more-likely-to-be-killed-by-law-enforcement

Vera Institute of Justice. (2015). The price of jails: Measuring the taxpayer cost of local incarceration. https://www.vera.org/publications/the-price-of-jails-measuring-the-taxpayer-cost-of-local-incarceration

Wood, J. D., Watson, A. C., & Fulambarker, A. J. (2017). The "gray zone" of police work during mental health encounters: Findings from an observational study in Chicago. Police Quarterly, 20(1), 81-105.

Appendix I: List of DMH Grant Awardees in FY25

Vendor Name	Program Type	FY 25 Amount	Communities
Abington	Component	$50,000.00	
Abbott Solutions for Justice	Trainer/Consultant/Research	$39,000.00	
Acton	Co-Response	$95,500.00	
Agawam	Co-Response	$116,600.00	
Amherst	CIT	$24,756.00	
Andover	Co-Response	$110,000.00	
Arlington	Co-Response	$101,550.00	
Ashburnham	Training/Backfill	$12,000.00	
Ashfield	Component	$202,099.00	Colrain, Conway, Goshen, Hawley, Heath, Monroe, Plainfield, Rowe, Williamsburg
Ashland	Co-Response	$100,000.00	
Attleboro	Component	$100,000.00	
Ayer	Component	$269,000.00	Ashby, Boxborough, Dunstable, Groton, Littleton, Shirley, Townsend, Westford
Barnstable	Co-Response	$185,000.00	
Barnstable	CIT	$117,500.00	
Boston	Co-Response	$110,000.00	
Boston	Training/Backfill	$100,000.00	
Boston	CIT/TTAC	$307,304.00	
Bedford	Co-Response	$199,000.00	Concord, Carlisle, Lexington, Lincoln, Maynard

Belchertown	Component	$23,852.00	
Belmont	Co-Response	$100,300.00	
Beverly	CIT/TTAC	$123,000.00	
Beverly	Co-Response	$200,000.00	Gloucester, Manchester-by-the Sea, Essex, Ipswich, Rockport
Boston College	Trainer/Consultant/Research	$808,000.00	
Braintree	Training/Backfill	$80,000.00	
Braintree	CIT/TTAC	$315,024.00	
Braintree	Co-Response	$202,450.00	
Brockton	Component	$243,100.00	
Brookline	CIT/TTAC	$311,799.00	
Cambridge	Co-Response	$120,000.00	
Canton	Component	$150,000.00	
Chelsea	Training/Backfill	$11,200.00	
Chelsea	Co-Response	$119,000.00	
Danvers	Component	$103,300.00	Topsfield
Deerfield	CIT	$55,329.00	
Dennis	Component	$133,000.00	
Easthampton	Co-Response	$94,500.00	
Erving	Component	$195,353.00	Bernardston, Gill, Northfield, Leverett, Wendell, Warwick
Everett	Component	$124,600.00	
Fall River	CIT	$59,640.00	
Fitchburg	Component	$86,000.00	
Framingham	Co-Response	$268,200.00	
Franklin	Co-Response	$100,000.00	
Grafton	Co-Response	$100,300.00	Millbury, Sutton

Greenfield	CIT	$100,000.00	
Greenfield	Co-Response	$200,000.00	
Holliston	Co-Response	$105,000.00	Sherborn, Hopkington
Holyoke	Component	$45,000.00	
Hudson	Co-Response	$110,220.00	Sudbury
Leominster	CIT	$125,000.00	
Longmeadow	Co-Response	$101,177.00	East Longmeadow
Lowell	Co-Response	$100,000.00	
Lowell	Training/Backfill	$20,000.00	
Lynn	BHIP	$455,000.00	
Lynn	Component	$116,200.00	
Lynnfield	Component	$106,000.00	Swampscott
Malden	Component	$125,000.00	
Mansfield	Co-Response	$105,000.00	
Marblehead	Component	$126,000.00	
Marlborough	Co-Response	$105,000.00	
Marshfield	Co-Response	$100,200.00	Duxbury, Norwell
Mashpee	Component	$56,250.00	
Massachusetts State Police	Co-Response/CIT	$511,925.00	
Medford	Component	$338,400.00	
Milford	BHIP	$160,000.00	
NAMI	Trainer/Consultant/Research	$334,000.00	
Natick	Co-Response	$100,000.00	
Newbury	Component	$106,700.00	Boxford, Georgetown, Rowley
Norfolk	Co-Response	$99,999.00	

Northbridge	Component	$348,000.00	Uxbridge, Millville, Blackstone, Grafton, Millbury, Douglas, Sutton
Northampton	Co-Response	$214,992.00	
North Reading	Training/Backfill	$21,600.00	
Norwood	Co-Response	$110,300.00	
Open Sky	CIT/TTAC	$276,800.00	
Pembroke	Training/Backfill	$47,400.00	
Pembroke	Co-Response	$102,220.00	
Pepperell	Component	$61,100.00	Ashby, Boxborough, Dunstable, Groton, Littleton, Shirley, Townsend, Westford
Quincy	Co-Response	$200,000.00	
Randolph	Training/Backfill	$75,000.00	
Randolph	Co-Response	$104,700.00	
Raynham	Component	$200,000.00	Norton
Revere	Training/Backfill	$25,500.00	
Rowley	Component	$40,700.00	Boxford, Newbury, Georgetown
Salem	Co-Response	$138,514.00	
SEG	Trainer/Consultant/Research	$38,060.00	
Sharon	Co-Response	$100,200.00	Westwood
Sherborn	CIT/TTAC	$118,000.00	
Shrewsbury	Co-Response	$100,400.00	
Somerville	CIT/TTAC	$335,635.00	
Somerville	Component	$40,021.00	

Southborough	Co-Response	$100,300.00	Northborough
South Hadley	Co-Response	$103,709.00	Granby, Belchertown
South Hadley	CIT/TTAC	$346,826.00	
South Hadley	Component	$23,100.00	
Springfield	Co-Response	$369,000.00	
Stoneham	Training/Backfill	$20,000.00	
Stoneham	Co-Response	$135,000.00	Melrose
Stow	Co-Response	$100,100.00	Harvard
Sturbridge	Component	$116,000.00	
Sunderland	Component	$128,665.00	Hatfield, Whately
Taunton	Component	$298,700.00	
Tewksbury	Co-Response	$400,000.00	Billerica, Chelmsford, Dracut
Walpole	Co-Response	$109,600.00	
Wakefield	Component	$100,000.00	
Waltham	Component	$95,000.00	
Watertown	Co-Response	$100,150.00	
Westborough	Co-Response	$100,200.00	
Westfield	Co-Response	$279,546.00	
Wilbraham	Training/Backfill	$10,000.00	
Winthrop	Component	$120,000.00	
William James College	CR-TTAC	$812,100.00	
Worcester	CIT	$226,852.00	
Yarmouth	Component	$197,100.00	
Total		$17,210,417.00	

Appendix II: Grant Types and Descriptions

During FY25, DMH provided several types of diversion projects for local law enforcement, behavioral health organizations, and their respective communities to consider. Below are summaries of each project type:

✓**Behavioral Health Interdisciplinary Program (BHIP) Grants:** Support municipalities or regional clusters to expand mobile crisis response for individuals with co-occurring substance use disorder and mental health conditions through specialized behavioral health teams consisting of a program coordinator, behavioral health clinician, EMT, and SUD outreach worker. Large metropolitan areas are prioritized.

✓**Crisis Intervention Team (CIT) Grants:** Support police departments in developing CIT programs by sending officers to CIT training for certification, establishing CIT policies and coordinators, maintaining communication with behavioral health stakeholders, and ensuring administrative oversight of the CIT initiative.

✓**CIT Training and Technical Assistance Center (CIT-TTAC) Grants:** Support regional centers offering standardized CIT curricula, training delivery, and consultation to police departments adopting the CIT model.

✓**Co-Response Grants:** Support embedding crisis clinicians in law enforcement operations to participate in ride-alongs, respond to 911 calls, de-escalate crises, cross-train law enforcement partners, collect data, and coordinate program leadership meetings.

✓**Co-Response Training and Technical Assistance Center (CR-TTAC) Grants:** Support graduate-level education, evidence-based training, and technical assistance to co-response practitioners and law enforcement statewide through advanced training, scenario-based experiences, webinars, and specialized curricula.

✓**Component JDP Grants:** Support local municipalities in implementing customized arrest diversion strategies addressing community-specific needs through training, technical assistance, and co-response clinician support as appropriate.

✓**Training/Backfill Grants:** Support law enforcement agencies in providing advanced and specialized training by covering reimbursement for CIT training participation, graduate certificate programs, national conference attendance, and other specialized behavioral health training.

✓**Trainer/Consultant/Researcher Grants:** Support individuals and organizations offering jail and arrest diversion consultation services including subject matter expertise, specialized training curriculum development, and advanced research.

Appendix III: Impact Narratives

Impact Narratives

Quantitative data captures program scale but can obscure the human reality of individual encounters. The following narratives, drawn from program reports, illustrate what effective crisis intervention looks like in practice.

Narrative 1:

The Worcester Police Department first encountered this individual in 2025 when he called 911 reporting that his phone was being hacked. Over the course of several months, his paranoid delusions escalated, resulting in numerous calls for service. We learned he was a service-connected Veteran who also struggled with substance use.

Despite outreach efforts, he remained resistant to care and eventually decompensated severely, barricading himself in his apartment and threatening that he had a loaded firearm. Our CIT unit had developed a rapport with him, and negotiators were able to leverage that relationship to get him to exit safely. He was then transported via Section 12 to the nearest emergency department.

This event became a turning point for collaboration. CIT connected with his providers at the VA. After discharge, he stepped down to intensive outpatient treatment but refused to engage with VA outpatient services. The VA reached out to CIT to alert the team that he would be re-entering the community with minimal support. CIT decided that proactive follow-up visits would benefit him.

Since implementing this plan, he has remained stable in the community. He reaches out to CIT or self-presents to the police department lobby when he feels the need between follow-ups, and has allowed CIT to make outpatient referrals on his behalf. Over the course of this collaboration, he has gone from experiencing active delusions and substance use to living more stably in the community and engaging with mental health care.

Narrative 2:

A co-responder from the Taunton Police Department was contacted by a neighboring police department regarding a client involved in an incident in their town. The client had a history of serious mental illness, medication refusal, and violence towards family members. His behavior had decompensated, and he had made credible threats against multiple individuals and institutions, prompting involvement from local, state, and federal law enforcement.

The co-responder provided clinical consultation to detectives, state police, and federal agents regarding the client's mental status and treatment history and contacted DMH to explore forensic evaluation options. This coordination enabled law enforcement to take the client into custody without incident. When the client's condition continued to deteriorate following release, the co-responder worked with probation to facilitate a court-ordered

evaluation, ultimately resulting in transfer to a state facility for comprehensive forensic assessment.

This case illustrates how coordinated crisis response can protect public safety while ensuring individuals with serious mental illness receive forensic evaluation rather than default incarceration. When diversion is not clinically appropriate, JDP expertise still shapes outcomes by informing law enforcement strategy, facilitating safe custody, and connecting justice system partners with clinical context that supports appropriate disposition.

Narrative 3:

The Greenfield Police Department has partnered with Clinical & Support Options (CSO) for approximately 4.5 years, embedding a mental health clinician as a co-responder. Greenfield, the largest city in Franklin County, hosts numerous behavioral health services that draw individuals from across the region, meaning officers regularly encounter people in psychiatric crisis.

Co-responders have handled thousands of calls during this partnership, ranging from follow-up check-ins with juveniles to active suicide attempts. They bring clinical knowledge, community resources, and referral pathways that patrol officers would not otherwise have access to. Before co-response, someone experiencing a mental health crisis in Greenfield was typically sectioned, arrested, or left without adequate support. Now, that same person can be assessed on scene and connected to appropriate services without default reliance on emergency departments or the criminal justice system.