Tab 1	**SB 1310** by **Bradley;** Similar to CS/H 00969 Reporting of Student Mental Health Outcomes

Tab 2	**SB 1354** by **Trumbull;** Similar to CS/H 00633 Behavioral Health Managing Entities				
797766	D	S	CF, Trumbull	Delete everything after	03/24 03:53 PM

Tab 3	**SB 1620** by **Rouson;** Similar to H 01439 Mental Health and Substance Use Disorders				
657304	A	S	CF, Rouson	Delete L.122 - 151:	03/24 03:54 PM
420638	A	S	CF, Rouson	Delete L.220 - 395:	03/24 03:55 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

CHILDREN, FAMILIES, AND ELDER AFFAIRS
Senator Grall, Chair
Senator Garcia, Vice Chair

MEETING DATE: Tuesday, March 25, 2025
TIME: 4:00—6:00 p.m.
PLACE: 301 Senate Building

MEMBERS: Senator Grall, Chair; Senator Garcia, Vice Chair; Senators Brodeur, Harrell, Rouson, Sharief, and Simon

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 1310** Bradley (Similar CS/H 969, Compare S 1470)	Reporting of Student Mental Health Outcomes; Requiring the Department of Children and Families to annually submit a specified evaluation to the Governor and Legislature by a specified date; removing a provision authorizing a mental health professional to be available to the school district through specified agreements; requiring each district school board's mental health coordinator to serve as the Department of Children and Families' primary point of contact and coordinate with the department to prepare certain evaluations, etc. CF 03/25/2025 AHS FP	
2	**SB 1354** Trumbull (Similar CS/H 633)	Behavioral Health Managing Entities; Requiring the Department of Children and Families to contract for specified functions; requiring the department to recommend certain transparency improvements; requiring managing entities to report required information to the department in a standardized electronic format; requiring managing entities to submit documents to the department electronically in a specified format and with specified metadata, etc. CF 03/25/2025 AHS FP	
3	**SB 1620** Rouson (Similar H 1439)	Mental Health and Substance Use Disorders; Defining the term "person-first language"; revising the minimum standards for a mobile crisis response service; requiring that an individualized treatment plan be reevaluated within a specified timeframe to ensure the recommended care remains necessary for a patient; requiring a service provider to provide a patient with certain medication for a specified timeframe upon discharge from certain treatment facilities; requiring the department to reevaluate assessment services at specified intervals to ensure a patient's clinical needs are being met, etc. CF 03/25/2025 AHS FP	

TAB	OFFICE and APPOINTMENT (HOME CITY)	FOR TERM ENDING	COMMITTEE ACTION

Senate Confirmation Hearing: A public hearing will be held for consideration of the below-named executive appointment to the office indicated.

Secretary of Children and Families

4	Hatch, Taylor N. ()	Pleasure of Governor	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION

Other Related Meeting Documents

By Senator Bradley

6-01457A-25 20251310__

A bill to be entitled

An act relating to the reporting of student mental health outcomes; creating s. 394.4575, F.S.; requiring the Department of Children and Families to annually submit a specified evaluation to the Governor and Legislature by a specified date; providing evaluation requirements; requiring the department to create a survey tool for specified purposes; authorizing the department to include survey results in the evaluation; amending s. 1001.212, F.S.; requiring the coordinator to report specified referrals to the department for reporting and evaluation purposes; deleting an obsolete provision; amending s. 1006.041, F.S.; requiring each school district to provide specified information to the department for reporting and evaluation purposes; revising certain plan requirements to include mobile response teams; removing a provision authorizing a mental health professional to be available to the school district through specified agreements; requiring each school district to submit certain approved plans and reports to the Department of Children and Families rather than the Department of Education; requiring the Department of Children and Families to annually certify receipt of and compliance with certain requirements to the Department of Education by specified dates; amending s. 1006.07, F.S.; requiring each district school board's mental health coordinator to serve as the Department of Children and Families' primary point of

contact and coordinate with the department to prepare certain evaluations; requiring the coordinator to annually provide certain policies and procedures to the department; revising membership of a threat management team to include specified mental health providers; requiring the team to provide specified information to the department for reporting and evaluation purposes; requiring a threat management coordinator to report certain data to the department; amending s. 1012.584, F.S.; requiring each school district to notify certain school personnel of the availability of specified mental health providers; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 394.4575, Florida Statutes, is created to read:

394.4575 Student mental health assistance program evaluation.—

(1) On or before December 1 each year, the department shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives and publish on its website an evaluation of mental health services and supports provided to students pursuant to ss. 1001.212(11), 1006.041, and 1012.584(4). The department shall provide an evaluation of expenditure plans and program outcome reports submitted by school districts as required in s. 1006.041, and assess treatment outcomes and the effectiveness of mental health

services provided pursuant to s. 1006.041(2)(a) and (b). The department shall also utilize other relevant information collected by the department to evaluate treatment outcomes, system capacity, and performance. School district threat management coordinators and mental health coordinators as described in s. 1006.07 shall provide information and reports to the department for evaluation and inclusion in the report.

(2) The department shall create a survey tool for students using mental health services and supports described in this section for the purpose of assessing the patient experience and self-reported treatment outcomes. The results shall be deidentified before being transmitted to the department. Students or their parents or legal guardians may complete the survey. The department may include survey results in the annual evaluation under subsection (1).

Section 2. Paragraph (a) of subsection (11) of section 1001.212, Florida Statutes, is amended to read:

1001.212 Office of Safe Schools.—There is created in the Department of Education the Office of Safe Schools. The office is fully accountable to the Commissioner of Education. The office shall serve as a central repository for best practices, training standards, and compliance oversight in all matters regarding school safety and security, including prevention efforts, intervention efforts, and emergency preparedness planning. The office shall:

(11) Develop a statewide behavioral threat management operational process, a Florida-specific behavioral threat assessment instrument, and a threat management portal.

(a)1. ~~By December 1, 2023,~~ The office shall develop a

statewide behavioral threat management operational process to guide school districts, schools, charter school governing boards, and charter schools through the threat management process. The process must be designed to identify, assess, manage, and monitor potential and real threats to schools. This process must include, but is not limited to:

a. The establishment and duties of threat management teams.

b. Defining behavioral risks and threats.

c. The use of the Florida-specific behavioral threat assessment instrument developed pursuant to paragraph (b) to evaluate the behavior of students who may pose a threat to the school, school staff, or other students and to coordinate intervention and services for such students.

d. Upon the availability of the threat management portal developed pursuant to paragraph (c), the use, authorized user criteria, and access specifications of the portal.

e. Procedures for the implementation of interventions, school support, and community services.

f. Guidelines for appropriate law enforcement intervention.

g. Procedures for risk management.

h. Procedures for disciplinary actions.

i. Mechanisms for continued monitoring of potential and real threats.

j. Procedures for referrals to mental health services identified by the school district or charter school governing board pursuant to s. 1012.584(4). Referrals to mental health services originating from the behavioral threat process or assessment instrument shall be reported, in the aggregate, by the threat management coordinator, designated in s.

1006.07(7)(j), to the Department of Children and Families for reporting and evaluation purposes pursuant to s. 394.4575.

k. Procedures and requirements necessary for the creation of a threat assessment report, all corresponding documentation, and any other information required by the Florida-specific behavioral threat assessment instrument under paragraph (b).

2. Upon availability, each school district, school, charter school governing board, and charter school must use the statewide behavioral threat management operational process.

3. The office shall provide training to all school districts, schools, charter school governing boards, and charter schools on the statewide behavioral threat management operational process.

4. The office shall coordinate the ongoing development, implementation, and operation of the statewide behavioral threat management operational process.

Section 3. Section 1006.041, Florida Statutes, is amended to read:

1006.041 Mental health assistance program.—Each school district must implement a school-based mental health assistance program that includes training classroom teachers and other school staff in detecting and responding to mental health issues and connecting children, youth, and families who may experience behavioral health issues with appropriate services. Each school district must provide information relating to student mental health programs, services, and treatments to the Department of Children and Families for reporting and evaluation purposes pursuant to s. 394.4575.

(1) Each school district must develop, and submit to the

district school board for approval, a detailed plan outlining the components and planned expenditures of the district's mental health assistance program. The plan must include all district schools, including charter schools, unless a charter school elects to submit a plan independently from the school district. A charter school plan must comply with all of the provisions of this section and must be approved by the charter school's governing body and provided to the charter school's sponsor.

(2) A plan required under subsection (1) must be focused on a multitiered system of supports to deliver evidence-based mental health care assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance abuse diagnoses and to students at high risk of such diagnoses. The provision of these services must be coordinated with a student's primary mental health care provider and with other mental health providers involved in the student's care. At a minimum, the plan must include all of the following components:

(a) Direct employment of school-based mental health services providers to expand and enhance school-based student services and to reduce the ratio of students to staff in order to better align with nationally recommended ratio models. The providers shall include, but are not limited to, certified school counselors, school psychologists, school social workers, and other licensed mental health professionals. The plan must also identify strategies to increase the amount of time that school-based student services personnel spend providing direct services to students, which may include the review and revision of district staffing resource allocations based on school or

student mental health assistance needs.

(b) Contracts or interagency agreements with one or more local community behavioral health providers, mobile response teams, or providers of Community Action Team services to provide a behavioral health staff presence and services to students at district schools. Services may include, but are not limited to, mental health screenings and assessments, individual counseling, family counseling, group counseling, psychiatric or psychological services, trauma-informed care, mobile crisis services, and behavior modification. These behavioral health services may be provided on or off the school campus and may be supplemented by telehealth as defined in s. 456.47(1).

(c) Policies and procedures, including contracts with service providers, which will ensure that:

1. Students referred to a school-based or community-based mental health service provider for mental health screening for the identification of mental health concerns and students at risk for mental health disorders are assessed within 15 days after referral. School-based mental health services must be initiated within 15 days after identification and assessment, and support by community-based mental health service providers for students who are referred for community-based mental health services must be initiated within 30 days after the school or district makes a referral.

2. Parents of a student receiving services under this subsection are provided information about other behavioral health services available through the student's school or local community-based behavioral health services providers. A school may meet this requirement by providing information about and

Internet addresses for web-based directories or guides for local behavioral health services.

3. Individuals living in a household with a student receiving services under this subsection are provided information about behavioral health services available through other delivery systems or payors for which such individuals may qualify, if such services appear to be needed or enhancements in such individuals' behavioral health would contribute to the improved well-being of the student.

(d) Strategies or programs to reduce the likelihood of at-risk students developing social, emotional, or behavioral health problems; depression; anxiety disorders; suicidal tendencies; or substance use disorders.

(e) Strategies to improve the early identification of social, emotional, or behavioral problems or substance use disorders; to improve the provision of early intervention services; and to assist students in dealing with trauma and violence.

(f) Procedures to assist a mental health services provider or a behavioral health provider as described in paragraph (a) or paragraph (b), respectively, or a school resource officer or school safety officer who has completed mental health crisis intervention training in attempting to verbally de-escalate a student's crisis situation before initiating an involuntary examination pursuant to s. 394.463. Such procedures must include strategies to de-escalate a crisis situation for a student with a developmental disability as defined in s. 393.063.

(g) Policies of the school district which must require that in a student crisis situation, school or law enforcement

personnel must make a reasonable attempt to contact a mental health professional as described in paragraph (a) or paragraph (b) who may initiate an involuntary examination pursuant to s. 394.463, unless the child poses an imminent danger to themselves or others, before initiating an involuntary examination pursuant to s. 394.463. Such contact may be in person or through telehealth. ~~The mental health professional may be available to the school district either by a contract or interagency agreement with the managing entity, one or more local community-based behavioral health providers, or the local mobile response team, or be a direct or contracted school district employee.~~

(3) Each school district shall submit its approved plan, including approved plans of each charter school in the district, to the Department of Children and Families ~~Department of Education~~ by August 1 of each fiscal year. The Department of Children and Families shall certify receipt of and compliance with all of the requirements of this subsection to the Department of Education by September 1 of each fiscal year.

(4) Annually by September 30, each school district shall submit to the Department of Children and Families ~~Department of Education~~ a report on its program outcomes and expenditures for the previous fiscal year. The Department of Children and Families shall certify receipt of and compliance with all the requirements of this subsection to the Department of Education by October 1 of each fiscal year. ~~that,~~ At a minimum, the report must include the total number of each of the following:

(a) Students who receive screenings or assessments.

(b) Students who are referred to school-based or community-based providers for services or assistance.

(c) Students who receive school-based or community-based interventions, services, or assistance.

(d) School-based and community-based mental health providers, including licensure type.

(e) Contract-based or interagency agreement-based collaborative efforts or partnerships with community-based mental health programs, agencies, or providers.

Section 4. Paragraph (b) of subsection (6) and paragraphs (b), (i), and (j) of subsection (7) of section 1006.07, Florida Statutes, are amended to read:

1006.07 District school board duties relating to student discipline and school safety.—The district school board shall provide for the proper accounting for all students, for the attendance and control of students at school, and for proper attention to health, safety, and other matters relating to the welfare of students, including:

(6) SAFETY AND SECURITY BEST PRACTICES.—Each district school superintendent shall establish policies and procedures for the prevention of violence on school grounds, including the assessment of and intervention with individuals whose behavior poses a threat to the safety of the school community.

(b) *Mental health coordinator.*—Each district school board shall identify a mental health coordinator for the district. The mental health coordinator shall serve as the district's and the Department of Children and Families' primary point of contact regarding the district's coordination, communication, and implementation of student mental health policies, procedures, responsibilities, and reporting, including:

1. Coordinating with the Department of Children and

Families and the Office of Safe Schools, established pursuant to s. 1001.212.

2. Maintaining records and reports regarding student mental health as it relates to the mental health assistance program under s. 1006.041 and school safety.

3. Facilitating the implementation of school district policies relating to the respective duties and responsibilities of the school district, the superintendent, and district school principals.

4. Coordinating with the Department of Children and Families to prepare evaluations on student mental health programs, services, and treatments provided pursuant to s. 394.4575. The coordinator shall assist the Department of Children and Families in the evaluation of treatment outcomes and the development of a survey tool as described in s. 394.4575(2).

5.~~4.~~ Coordinating with the school safety specialist on the staffing and training of threat management teams and facilitating referrals to mental health services, as appropriate, for students and their families.

6.~~5.~~ Coordinating with the school safety specialist on the training and resources for students and school district staff relating to youth mental health awareness and assistance.

7.~~6.~~ Reviewing annually the school district's policies and procedures related to student mental health for compliance with state law and alignment with current best practices and making recommendations, as needed, for amending such policies and procedures to the superintendent and the district school board. Policies and procedures shall be provided to the Department of

Children and Families annually.

(7) THREAT MANAGEMENT TEAMS.—Each district school board and charter school governing board shall establish a threat management team at each school whose duties include the coordination of resources and assessment and intervention with students whose behavior may pose a threat to the safety of the school, school staff, or students.

(b) A threat management team shall include persons certified under s. 1012.584(4) with expertise in counseling, instruction, school administration, and law enforcement. All members of the threat management team must be involved in the threat assessment and threat management process and final decisionmaking. At least one member of the threat management team must have personal familiarity with the individual who is the subject of the threat assessment. If no member of the threat management team has such familiarity, a member of the instructional personnel or administrative personnel, as those terms are defined in s. 1012.01(2) and (3), who is personally familiar with the individual who is the subject of the threat assessment must consult with the threat management team for the purpose of assessing the threat. The instructional or administrative personnel who provides such consultation may ~~shall~~ not participate in the decisionmaking process.

(i) The threat management team shall prepare a threat assessment report required by the Florida-specific behavioral threat assessment instrument developed pursuant to s. 1001.212(11). A threat assessment report, all corresponding documentation, and any other information required by the Florida-specific behavioral threat assessment instrument in the

threat management portal is an education record. Information relating to treatment referrals and mental health assessments shall be provided to the Department of Children and Families for reporting and evaluation purposes pursuant to s. 394.4575.

(j) Each district school board shall establish a threat management coordinator to serve as the primary point of contact regarding the district's coordination, communication, and implementation of the threat management program and to report quantitative data to the Department of Children and Families and the Office of Safe Schools in accordance with guidance from the office.

Section 5. Subsection (4) of section 1012.584, Florida Statutes, is amended to read:

1012.584 Continuing education and inservice training for youth mental health awareness and assistance.—

(4) Each school district shall notify all school personnel who have received training pursuant to this section of mental health services that are available to students from mental health services providers as described in s. 1006.041(2)(a) and (b) ~~in the school district~~, and the individual to contact if a student needs services. The term "mental health services" includes, but is not limited to, community mental health services, health care providers, and services provided under ss. 1006.04 and 1006.041.

Section 6. This act shall take effect July 1, 2025.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	SB 1310
INTRODUCER:	Senator Bradley
SUBJECT:	Reporting of Student Mental Health Outcomes
DATE:	March 24, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rao	Tuszynski	CF	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 1310 requires the Department of Children and Families (DCF) to evaluate the mental health services and supports provided to students in schools.

The bill requires school district boards, threat management coordinators, and mental health coordinators to report specified information to the DCF, rather than the Department of Education. The DCF is required to certify receipt of and compliance with specified requirements to the DOE.

The bill requires the DCF to create a survey tool for students that utilize mental health services in schools. The deidentified survey results may be included in the DCF's annual evaluation of mental health services and supports.

The bill defines mental health service providers that may train school personnel to provide mental health services.

Indeterminate negative fiscal impact on government sector. *See* Section V. Fiscal Impact Statement.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Mental Health in Schools

Mental illnesses are conditions that affect an individual's thinking, feeling, mood, and behavior.[1] While many children may not experience mental distress,[2] some children may experience prolonged mental distress that may affect their ability to connect with their peers, participate in activities, and affect their day-to-day lives.[3] It is estimated that one in six youth aged 6-17 years of age experience a mental health disorder annually.[4] Receiving school-based early treatment from trained mental health professionals may help students manage their mental health and have positive school outcomes.[5]

Department of Children and Families

The Department of Children and Families (DCF) is directed to work in partnership with local communities to protect the vulnerable, promote strong and economically self-sufficient families, and advance personal and family recovery and resiliency.[6] The DCF provides services relating to the following[7]:

- Adult protection.
- Child care regulation.
- Child welfare.
- Domestic violence.
- Economic self-sufficiency.
- Homelessness.
- Mental health.
- Refugees.
- Substance Abuse.

The DCF is required to prepare a state master plan for the delivery and financing of a system of publicly funded, community-based substance abuse and mental health services throughout the state. This plan must include strategies for meeting the treatment and support needs of children and adolescents who have, or are at risk of having, mental, emotional, or substance abuse problems.[8]

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[1] National Library of Medicine, *Mental Disorders*, available at: https://medlineplus.gov/mentaldisorders.html (last visited 3/20/25).
[2] U.S. Centers for Disease Control, *Data and Statistics on Children's Mental Health,* available at: https://www.cdc.gov/children-mental-health/data-research/index.html (last visited 3/20/25).
[3] National Library of Medicine, Mental Disorders, available at: https://medlineplus.gov/mentaldisorders.html (last visited 3/20/25); and National Alliance on Mental Illness, *Mental Health in Schools*, available at: https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-in-Schools/ (last visited 3/20/25).
[4] National Alliance on Mental Illness, *Mental Health in Schools*, available at: https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-in-Schools/ (last visited 3/20/25).
[5] National Alliance on Mental Illness, Mental Health in Schools, available at: https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-in-Schools/ (last visited 3/20/25).
[6] Section 20.19, F.S.
[7] Section 20.19, F.S.
[8] Section 394.75, F.S.

State Board of Education

The State Board of Education is the chief implementing and coordinating body of public education in Florida.[9] It consists of seven members appointed by the Governor and confirmed by the Senate.[10] The State Board of Education appoints the Commissioner of Education and is the Executive Director of the Department of Education (DOE).[11]

The State Board of Education exercises general supervision over the divisions of the Department of Education.[12] The divisions of the Department of Education include the following[13]:

- Division of Florida Colleges.
- Division of Public Schools.
- Division of Early Learning.
- Division of Career and Adult Education.
- Division of Vocational Rehabilitation.
- Division of Blind Services.
- Division of Accountability, Research, and Measurement.
- Division of Finance and Operations.
- Office of K-20 Articulation.
- The Office of Independent Education and Parental Choice.
- The Office of Safe Schools.

Office of Safe Schools

The Office of Safe Schools (Office) was codified within the Department of Education in 2018, after the mass shooting at Marjory Stoneman Douglas High School in Parkland, Florida on February 14, 2018.[14] The mission of the Office is to support school districts in providing a safe learning environment for students and educators through prevention, intervention, and emergency preparedness planning.[15]

In 2023, the Legislature directed the Office to develop a statewide behavioral threat management operational process, a Florida-specific behavioral threat assessment instrument, and a threat management portal.[16] Florida law requires the statewide behavioral threat management operational process to guide school districts, schools, charter school governing boards, and charter schools through the threat management process that identifies, assesses, manages, and monitors potential and real threats to schools. This process must include, but is not limited to the following[17]:

- The establishment and duties of threat management teams.

[9] Section 1001.02, F.S.
[10] Section 2, Article IX of the State Constitution.
[11] Section 20.15, F.S.
[12] Section 1001.02, F.S.
[13] Section 20.15(3), F.S.
[14] Chapter 2018-3, L.O.F. and Florida Department of Education, *Office of Safe Schools: What We Do,* available at: https://www.fldoe.org/safe-schools/what-we-do.stml (last visited 3/20/25).
[15] Florida Department of Education, *Office of Safe Schools,* available at: https://www.fldoe.org/safe-schools/ (last visited 3/20/25).
[16] Chapter 2023-18, L.O.F.
[17] Section 1001.212(11)(a), F.S.

- Defining behavioral risks and threats.
- The use of the Florida-specific behavioral threat assessment instrument developed to evaluate the behavior of students who may pose a threat to the school, school staff, or other students and to coordinate intervention and services for such students.
- Upon the availability of the threat management portal, the use, authorized user criteria, and access specifications of the portal.
- Procedures for the implementation of interventions, school support, and community services.
- Guidelines for appropriate law enforcement intervention.
- Procedures for risk management.
- Procedures for disciplinary actions.
- Mechanisms for continued monitoring of potential and real threats.
- Procedures for referrals to mental health services identified by the school district or charter school governing board pursuant to the statutory requirement for education and inservice training for youth mental health awareness and assistance.
- Procedures and requirements necessary for the creation of a threat assessment report, all corresponding documentation, and any other information required by the Florida-specific behavioral threat assessment instrument.

Each school district, school, charter school governing board, and charter school are required to use the statewide behavioral threat management operational process. The Office is required to provide training on the operational process and coordinate the ongoing development, implementation, and operation of the operational process.[18]

Student Mental Health

Each school district is required to implement a school-based mental health assistance program that includes training classroom teachers and other school staff in detecting and responding to mental health issues and connecting children, youth, and families who may experience behavioral health issues with appropriate services.[19]

Generally, school-based mental health services may include mental health screenings and assessments, and referrals to school-based or community-based providers for interventions, services, or assistance.[20] These services must be initiated in a timely manner, according to the following timeline[21]:

- Students referred to a school-based or community-based mental health service provider for mental health screening for the identification of mental health concerns must be assessed within 15 days after referral;
- School-based mental health services must be initiated within 15 days after identification and assessment; and
- Community-based mental health services must be initiated within 30 days of the referral.

[18] Section 1001.212(11)(a)2.-4., F.S.
[19] Section 1006.041, F.S.
[20] Section 1006.041, F.S.
[21] Section 1006.041(c), F.S.

Mental Health Assistance Allocation

The mental health assistance allocation provides funding to assist school districts in implementing the required school-based mental health assistance program.[22] Each school district must receive a minimum of $100,000 annually, with additional funding based on each school district's proportionate share of the state's total unweighted full-time equivalent student enrollment.[23]

To receive the funding, each school district must develop a detailed plan outlining the components of the mental health assistance program and submit the plan to the district school board for approval.[24] All district schools, including charter schools, must be included in the plan, unless a charter school elects to submit a plan independently from the school district.[25]

The plan must be focused on a multi-tiered system of supports to deliver evidence-based mental health care assessment, diagnosis, intervention, treatment, and recovery services to students with mental health and/or substance abuse diagnoses and to students at high risk of such diagnoses.[26] The provision of these services must be coordinated with a student's primary mental health care provider and with other mental health providers involved in the student's care.

At a minimum, the plan must include the following components[27]:

- Direct employment of school-based mental health services providers to expand and enhance school-based student services and to reduce the ratio of students to staff. The plan must identify strategies to increase the amount of time that school-based student services personnel spend providing direct services to students.
- Contracts or interagency agreements with local community health providers or providers of Community Action Team services to provide a behavioral health staff presence and services at district schools.[28]
- Policies and procedures, including contracts with service providers, which will ensure that students who are referred to a school-based or community-based mental health service provider are timely assessed following referral, and that parents and other members of the student's household are provided with information about available community mental health resources.
- Strategies or programs to reduce the likelihood of at-risk students developing social, emotional, or behavioral health problems; depression; anxiety disorders; suicidal tendencies; or substance use disorders.
- Strategies to improve the early identification of social, emotional, or behavioral problems or substance use disorders; to improve the provision of early intervention services; and to assist students in dealing with trauma and violence.

[22] Section 1011.62, F.S.
[23] Section 1011.62(13), F.S.
[24] Section 1006.041, F.S.
[25] Section 1006.041, F.S.
[26] Section 1006.041(2), F.S.
[27] *Id.*
[28] Services may include, but are not limited to, mental health screenings and assessments, individual counseling, family counseling, group counseling, psychiatric or psychological services, trauma-informed care, mobile crisis services, and behavior modification. These behavioral health services may be provided on or off the school campus and may be supplemented by telehealth.

- Procedures to assist a mental health services provider, a behavioral health provider, or a school resource officer of school safety officer who has completed mental health crisis intervention training in attempting to verbally de-escalate a student's crisis situation before initiating an involuntary examination.
- School district policies which require that school or law enforcement personnel make a reasonable attempt to contact a mental health professional who may initiate an involuntary examination, unless the child poses an imminent danger to themselves or others, before initiating an involuntary examination.

Each school district is required to submit its approved plans, including approved plans of each charter school in the district, to the Department of Education by August 1 of each fiscal year.[29]

The following chart displays the funding for the Mental Health Assistance Allocation since it was established in 2018:

Mental Health Assistance Allocation FY 2018-2025	
Fiscal Year	**Funding Amount**
2018-2019[30]	$69,237,286
2019-2020[31]	$75,000,000
2020-2021[32]	$100,000,000
2021-2022[33]	$120,000,000
2022-2023[34]	$140,000,000
2023-2024[35]	$160,000,000
2024-2025[36]	$180,000,000
Total	**$844,237,286**

District School Boards

Each district school board is responsible for attending to the health, safety, and other matters relating to the welfare of students in the district's geographic area.[37] Each district school superintendent is required to establish policies and procedures for the prevention of violence on school grounds, including the assessment of and intervention with individuals whose behavior poses a threat to the safety of the school community.[38]

Mental Health Coordinator

[29] Section 1006.041(3), F.S.
[30] Section 36, ch. 2018-3, L.O.F.
[31] Specific Appropriations 6 and 93, s. 2, ch. 2019-115, L.O.F.
[32] Specific Appropriations 8 and 92, s. 2, ch. 2020-111, L.O.F.
[33] Specific Appropriations 7 and 90, s. 2, ch. 2021-36, L.O.F.
[34] Specific Appropriations 5 and 86, s. 2, ch. 2022-156, L.O.F.
[35] Specific Appropriations 5 and 80, s. 2, ch. 2023-239, L.O.F.
[36] Specific Appropriations 5 and 84, s. 2, ch. 2024-231, L.O.F.
[37] Section 1001.42(8), F.S.
[38] Section 1006.07(6), F.S.

Each school district board is required to identify a mental health coordinator for the district that shall serve as the district's primary point of contact regarding the district's coordination, communication, and implementation of student mental health policies, procedures, responsibilities, and reporting, including the following[39]:

- Coordinating with the Office of Safe Schools.
- Maintaining records and reports regarding student mental health as it relates to the mental health assistance program and school safety.
- Facilitating the implementation of school district policies relating to the respective duties and responsibilities of the school district, the superintendent, and district school principals.
- Coordinating with the school safety specialist on the staffing and training of threat management teams and facilitating referrals to mental health services, as appropriate, for students and their families.
- Coordinating with the school safety specialist on the training and resources for students and school district staff relating to youth mental health awareness and assistance.
- Reviewing annually the school district's policies and procedures related to student mental health for compliance with state law and alignment with current best practices and making recommendations, as needed, for amending such policies and procedures to the superintendent and the district school board.

Threat Management Coordinator

Each district school board and charter school governing board is required to establish a threat management team at each school. Threat management teams are tasked with utilizing resources, assessment, and intervention services with students whose behavior may pose a threat to the safety of the school, school staff, or students.[40] The teams are required to inform students, faculty, and staff how to recognize threatening or aberrant behavior that may represent a threat to the community, school, or self. Further, threat management teams are required to inform students, faculty, and staff which members of the school community to whom they can report threatening behavior.[41]

Individuals on the threat management team have expertise in counseling, instruction, school administration, and law enforcement. Upon a suspected immediate mental health or substance abuse crisis, threat management teams direct school personnel to engage behavioral health crisis resources.[42] These behavioral health crisis resources provide emergency intervention and assessments, make recommendations, and refer the student for appropriate services.[43]

Each district school board is required to establish a threat management coordinator who serves as the primary point of contact regarding the district's coordination, communication, and implementation of the threat management program. The threat management coordinator must report quantitative data from the program to the Office of Safe Schools.[44]

[39] Section 1006.07(6)(b), F.S.
[40] Section 1006.07(7), F.S.
[41] Section 1006.07(7)(c), F.S.
[42] Section 1006.07(7)(h), F.S.
[43] *Id.*
[44] Section 1006.07(7)(j), F.S.

Evidence-Based Mental Health Awareness and Assistance Program

In 2018 the Legislature required the Department of Education to establish an evidence-based youth mental health awareness training program to help school personnel identify and understand the signs of emotional disturbance, mental illness, and substance use disorders.[45] The DOE was tasked with providing school personnel with the skills necessary to help a person who is developing or experiencing an emotional disturbance, mental health, or substance use problem.[46] Every school district has at least one certified youth mental health awareness and assistance trainer that can train all school personnel within the school district.[47]

The training program must include, but is not limited to, the following[48]:

- An overview of mental illnesses and substance use disorders and the need to reduce the stigma of mental illness.
- Information on the potential risk factors and warning signs of emotional disturbance, mental illness, or substance use disorders, including, but not limited to, depression, anxiety, psychosis, eating disorders, and self-injury, as well as common treatments for those conditions and how to assess those risks.
- Information on how to engage at-risk students with the skills, resources, and knowledge required to assess the situation, and how to identify and encourage the student to use appropriate professional help and other support strategies, including, but not limited to, peer, social, or self-help care.

Each school district is required to notify all school personnel who have received this youth mental health awareness and assistance training, and the individual to contact if a student needs services. The term "mental health services" includes, but is not limited to, community mental health services, health care providers, and services provided by multiple agencies for students with severe emotional disturbance, and services provided from the mental health assistance program.[49]

Charter Schools

Charter schools are public schools that operate under a performance contract, or a "charter" between the charter school governing board and the charter school's sponsor.[50] They are held to the same evaluation and "grading" standards as traditional public schools and may be closed if they fail to meet these standards.[51] Further, they are funded through the same funding sources as traditional public schools. During the 2023-2024 school year, there were over 730 charter schools in Florida, serving 397,656 students.[52]

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[45] 2018-3, L.O.F.
[46] *Id.*
[47] *Id.*
[48] Section 1012.584(3), F.S.
[49] Section 1012.584(4), F.S.
[50] Florida Department of Education, *Charter Schools*, available at: https://www.fldoe.org/schools/school-choice/charter-schools/charter-school-faqs.stml (last visited 3/21/25).
[51] *Id.*
[52] Florida Department of Education, *School Choice*, available at: https://www.fldoe.org/schools/school-choice/charter-schools/ (last visited 3/21/25).

III. Effect of Proposed Changes:

Section 1 of the bill creates s. 394.4575, F.S. to require the DCF to evaluate mental health services and supports provided to students by the statewide behavioral threat management operational process, the mental health assistance program, and continuing education and inservice training for youth mental health awareness and assistance. The bill requires the DCF to provide an evaluation of expenditure plans, program outcome reports and assess the treatment outcomes and effectiveness of services provided through the mental health assistance program pursuant to s. 1006.041, F.S.

The bill requires the DCF to evaluate treatment outcomes, system capacity, and performance utilizing other relevant information currently collected by the DCF. The bill requires school district threat management coordinators and mental health coordinators to provide information and reports to the DCF for evaluation and inclusion in the report.

The bill requires this evaluation to be published on the DCF's website and submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives on or before December 1 each year.

The bill requires the DCF to create a survey tool for students using mental health services and supports for the purpose of assessing the patient's experience and self-reported treatment outcomes. The bill allows students, parents, or legal guardians to complete the survey, and requires the results of the survey to be deidentified before transmission to the DCF. The bill allows the DCF to include the survey results in its annual evaluation of mental health services and supports.

Section 2 of the bill amends s. 1001.212, F.S. to remove the December 1, 2023 date requirement for the Office of Safe Schools within the Department of Education to develop a statewide behavioral threat management operational process.

The bill requires the threat management coordinator in the Office to report, in the aggregate, referrals to mental health services originating from the behavioral threat process or assessment instrument to the DCF for reporting and evaluation purposes.

Section 3 of the bill amends s. 1006.041, F.S. to require each school district to provide information relating to student mental health programs, services, and treatments to the DCF for reporting and evaluation purposes.

The bill makes several changes to the requirements of the plan the school district is required to develop and submit to the district school board that outlines the district's mental health services provided to students. Specifically, the bill:

- Integrates mobile response teams into the plan.
- Clarifies school districts may contract for a behavioral health staff presence and services *for students*.

The bill requires each school district to submit its approved plan, including the approved plans of each charter school in the district to the DCF, rather than the DOE. The bill requires the DCF to

certify receipt of and compliance with the required provisions of the plan to the DOE by September 1 of each fiscal year.

The bill requires each school district to submit to the DCF, rather than the DOE, a report on its program outcomes and expenditures for the previous fiscal year annually by September 30. The bill requires the DCF to certify receipt of and compliance with the report to the DOE by October 1 of each fiscal year.

Section 4 of the bill amends s. 1006.07, F.S. to require the mental health coordinator of each district school board to serve as the district's and the DCF's primary point of contact regarding the district's coordination, communication, and implementation of student mental health policies, procedures, responsibilities, and reporting. The bill includes coordination with the DCF in the requirements of the mental health coordinator. The bill requires this coordination to include the preparation of evaluation on student mental health programs, services, and treatments and for the coordinator to assist the DCF in the evaluation of treatment outcomes and the development of a survey tool.

The bill requires the mental health coordinator to provide the school district's policies and procedures related to student mental health service compliance with state law and best practices to the DCF annually.

The bill requires threat management teams to include persons certified by the evidence-based youth mental health awareness and assistance training program.

The bill requires the threat management team to provide information relating to treatment referrals and mental health assessments to the DCF for reporting and evaluation purposes.

The bill includes the DCF as a recipient of quantitative data provided by threat management coordinators.

Section 5 of the bill amends s. 1012.584, F.S. to define mental health service providers that may train school personnel in providing mental health services. These service providers shall include, but are not limited to, certified school counselors, school psychologists, school social workers, and other licensed mental health professionals.

Section 6 of the bill provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

Indeterminate negative fiscal on the Department of Children and Families for workload. The bill requires the development of a survey and annual evaluation and reporting duties by the DCF, in collaboration with all school districts in the state.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill amends ss. 1001.212, 1006.041, 1006.07, and 1012.584 of the Florida Statutes.
This bill creates s. 394.4575, Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Trumbull

2-01280A-25 20251354__

A bill to be entitled

An act relating to behavioral health managing entities; amending s. 394.9082, F.S.; requiring the Department of Children and Families to contract for specified functions; requiring the department to recommend certain transparency improvements; requiring the department to prepare and present to the Governor and Legislature a specified final report by a date certain; requiring managing entities to report required information to the department in a standardized electronic format; providing requirements for the such format; requiring managing entities to submit documents to the department electronically in a specified format and with specified metadata; requiring managing entities to report certain specific measures to the department; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (7) of section 394.9082, Florida Statutes, is amended, and paragraph (n) is added to subsection (3) and paragraphs (v) and (w) are added to subsection (5) of that section, to read:

394.9082 Behavioral health managing entities.—

(3) DEPARTMENT DUTIES.—The department shall:

(n)1. Contract for all of the following:

a. Operational and financial audits of each managing entity to include all of the following:

(I) A review of business practices, personnel, financial records, related parties, compensation, and other areas as determined by the department.

(II) The services administered, the method of provider payment, expenditures, outcomes, and other information as determined by the department.

(III) Referral patterns, including managing entity referral volume; provider referral assignments; services referred; length of time to obtain services; and key referral performance measures.

(IV) Provider network adequacy and provider network participation in the department's available bed platform, the Opioid Data Management System, the Agency for Health Care Administration Event Notification Service, and other department required provider data submissions.

b. Audits of each managing entity's expenditures and claims, in which such audit must do both of the following:

(I) Compare services administered through each managing entity, the outcomes of each managing entity's expenditures, each managing entity's Medicaid expenditures for behavioral health services, and any other information as determined by the department.

(II) Analyze the claims paid by each managing entity for Medicaid recipients.

c. Recommendations to improve transparency of system performance including the metrics and criteria used to measure performance and outcomes in behavioral health systems and the format and method used to collect and report data and information.

2. Prepare a report of the information gathered in subparagraph 1. and present the final report on or before December 1, 2025, to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(5) MANAGING ENTITY DUTIES.—A managing entity shall:

(v) Report all required information to the department in a standardized electronic format to ensure interoperability and to facilitate data analysis. The submission format must meet all of the following criteria:

1. Provider payments must be reported using a standardized format for electronic data interchange that is used for health care claims processing.

2. Information must be organized into discrete, machine-readable data elements that allow for efficient processing and integration with other datasets.

3. All data fields must comply with established protocols as specified by the department.

4. The standardized format must be compatible with automated systems to enable the downloading, parsing, and combining of data with other sources for analysis.

5. Submissions must pass validation checks to confirm adherence to the required data structure and format before the submission is accepted.

(w) Submit all documents to the department in a format that allows for accurate text recognition and data extraction, such as in Portable Document Format or machine-readable text files. Documents must be submitted electronically and accompanied by metadata containing key information to ensure proper organization, processing, and integration into the department's

systems. The required metadata must include, but is not limited to, all of the following elements:

1. A descriptive and unique name for the document, following any naming conventions prescribed by the department.

2. The date the document is uploaded.

3. A predefined classification indicating the nature or category of the document.

4. Any relevant identifiers, such as application numbers, case numbers, or tracking codes, as specified by the department.

5. The name, contact information, and any other required identification number, such as a license or registration number, of the person or organization submitting the document.

6. Any other metadata fields as prescribed by the department to facilitate accurate processing and analysis.

(7) PERFORMANCE MEASUREMENT AND ACCOUNTABILITY.—

(a) Managing entities shall collect and submit data to the department regarding persons served, outcomes of persons served, costs of services provided through the department's contract, and other data as required by the department. The department shall evaluate managing entity performance and the overall progress made by the managing entity, together with other systems, in meeting the community's behavioral health needs, based on consumer-centered outcome measures that reflect national standards, if possible, that can be accurately measured. The department shall work with managing entities to establish performance standards, including, but not limited to:

1.~~(a)~~ The extent to which individuals in the community receive services, including, but not limited to, parents or caregivers involved in the child welfare system who need

behavioral health services.

2.~~(b)~~ The improvement in the overall behavioral health of a community.

3.~~(c)~~ The improvement in functioning or progress in the recovery of individuals served by the managing entity, as determined using person-centered measures tailored to the population.

4.~~(d)~~ The success of strategies to:

a.~~1.~~ Divert admissions from acute levels of care, jails, prisons, and forensic facilities as measured by, at a minimum, the total number and percentage of clients who, during a specified period, experience multiple admissions to acute levels of care, jails, prisons, or forensic facilities;

b.~~2.~~ Integrate behavioral health services with the child welfare system; and

c.~~3.~~ Address the housing needs of individuals being released from public receiving facilities who are homeless.

5.~~(e)~~ Consumer and family satisfaction.

6.~~(f)~~ The level of engagement of key community constituencies, such as law enforcement agencies, community-based care lead agencies, juvenile justice agencies, the courts, school districts, local government entities, hospitals, and other organizations, as appropriate, for the geographical service area of the managing entity.

(b) Managing entities must submit all of the following specific measures to the department:

1. The number and percentage of high utilizers.

2. The number and percentage of individuals who receive outpatient services within 7 days after a hospitalization for

behavioral health-related issues.

3. The average wait time for initial appointments for behavioral health services.

4. The number and percentage of individuals who are able to schedule an urgent behavioral health appointment within 24 hours.

5. The number and percentage of emergency room visits per capita for behavioral health-related issues, and whether such number and percentage are a decrease from the last report.

6. The incidence of medication errors in behavioral health treatment plans.

7. The number and percentage of adverse incidents, such as self-harm, in inpatient and outpatient settings.

8. The number and percentage of individuals with co-occurring conditions who receive integrated care.

9. The number and percentage of individuals successfully transitioned from acute care to community-based services.

10. The rate of behavioral health readmissions within 30 days after discharge.

11. The average length of stay for inpatient behavioral health services.

Section 2. This act shall take effect July 1, 2025.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	SB 1354
INTRODUCER:	Senator Trumbull
SUBJECT:	Behavioral Health Managing Entities
DATE:	March 24, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Kennedy	Tuszynski	CF	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 1354 requires the Department of Children and Families (DCF) to contract for operational and financial audits of the seven behavioral health managing entities (ME) that are charged with coordinating the state's safety-net mental health and substance use disorder services for the uninsured and underinsured. A final report must be submitted to the Governor and Legislature by December 1, 2025.

The bill requires MEs to submit required data in a standardized electronic format for interoperability, compliance with health care claims processing standards, and analysis.

The bill also establishes performance standards, requiring MEs to report on service accessibility, community behavioral health outcomes, diversion from acute care, and integration with child welfare services. MEs must track key performance metrics, including high-utilizer rates, post-hospitalization outpatient care, appointment wait times, and emergency room visits for behavioral health issues.

The bill has a significant negative fiscal impact on the government and private sector. *See* Section V. Fiscal Impact Statement.

This bill takes effect July 1, 2025.

II. Present Situation:

Mental Health and Mental Illness

Mental health is a state of well-being in which the individual realizes his or her own abilities can cope with normal stresses of life, can work productively and fruitfully, and is able to contribute

to his or her community.[1] The primary indicators used to evaluate an individual's mental health are:[2]

- Emotional well-being: perceived life satisfaction, happiness, cheerfulness, peacefulness;
- Psychological well-being: self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- Social well-being: social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being. Mental illness affects millions of people in the United States each year. More than one in five adults lives with a mental illness.[4] Young adults aged 18-25 had the highest prevalence of any mental illness[5] (36.2%) compared to adults aged 26-49 (29.4%) and aged 50 and older (16.8%).[6]

Mental Health Safety Net Services

DCF administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g., crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.

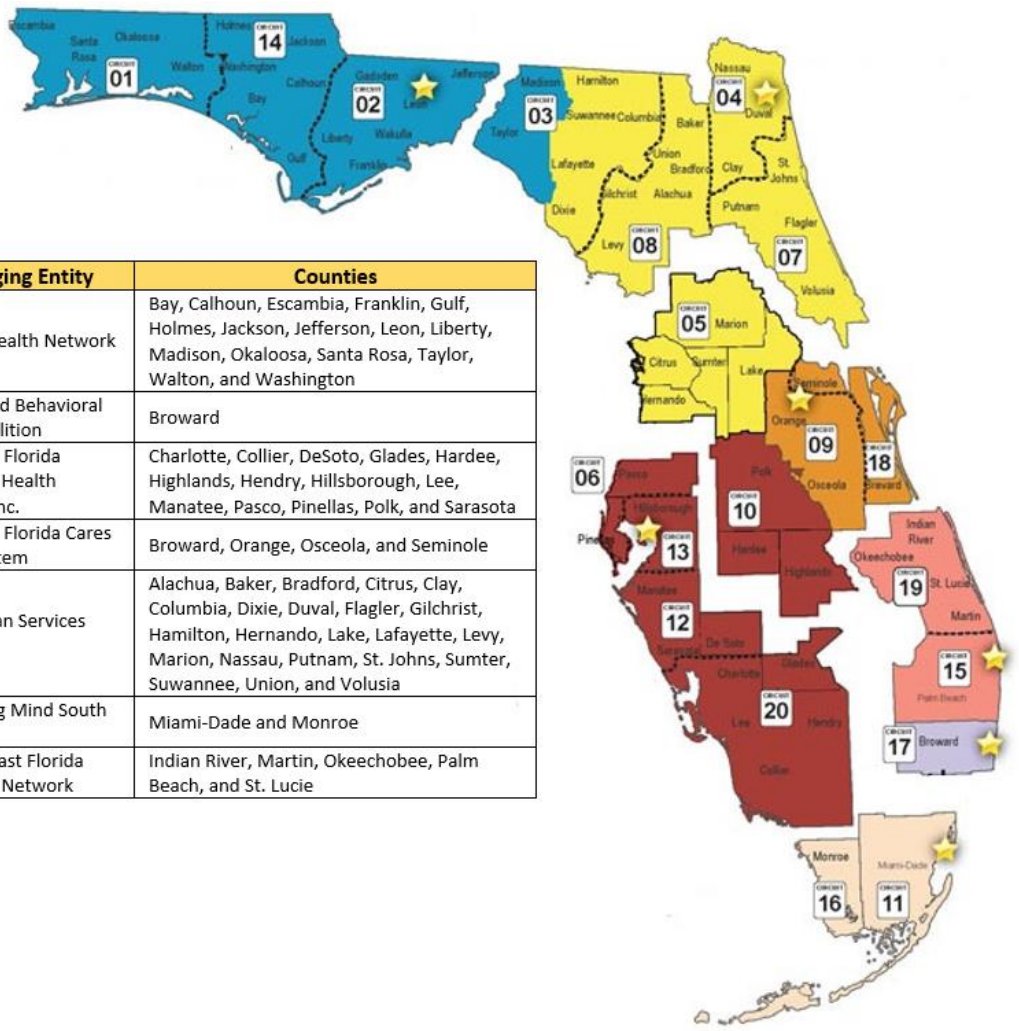
Behavioral Health Managing Entities

In 2001, the Legislature authorized the DCF to implement behavioral health MEs as the management structure for the delivery of local mental health and substance abuse services.[7] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized the DCF to implement MEs statewide.[8] MEs were fully implemented statewide in 2013, serving all geographic regions.

The DCF currently contracts with seven MEs for behavioral health services throughout the state. These entities do not provide direct services; rather, they allow the department's funding to be

[1] World Health Organization, Mental Health: Strengthening Our Response, available at: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (last visited last visited 3/7/25).
[2] Centers for Disease Control and Prevention, Mental Health Basics, available at: http://medbox.iiab.me/modules/en-cdc/www.cdc.gov/mentalhealth/basics.htm (last visited last visited 3/7/25).
[3] *Id.*
[4] National Institute of Mental Health (NIH), Mental Illness, available at: https://www.nimh.nih.gov/health/statistics/mental-illness (last visited last visited 3/7/25).
[5] Any mental illness (AMI) is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness).
[6] National Institute of Mental Health (NIH), Mental Illness, available at: https://www.nimh.nih.gov/health/statistics/mental-illness (last visited March 14, 2025).
[7] Ch. 2001-191, Laws of Fla.
[8] Ch. 2008-243, Laws of Fla.

tailored to the specific behavioral health needs in the various regions of the state. The regions are divided as follows:[9]



Managing Entity	Counties
NWF Health Network	Bay, Calhoun, Escambia, Franklin, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Walton, and Washington
Broward Behavioral Health Coalition	Broward
Central Florida Behavioral Health Network, Inc.	Charlotte, Collier, DeSoto, Glades, Hardee, Highlands, Hendry, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, and Sarasota
Central Florida Cares Health System	Broward, Orange, Osceola, and Seminole
Lutheran Services Florida	Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, and Volusia
Thriving Mind South Florida	Miami-Dade and Monroe
Southeast Florida Behavioral Network	Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie

In the latest comprehensive, multiyear review of the revenues, expenditures, and financial positions of the MEs,[10] these contracts totaled $1.083 billion for FY 2022-23, with $919 million spent on direct services.[11] MEs subcontract with community providers to serve clients directly; this allows services to be tailored to the specific behavioral health needs in the various regions of the state.[12]

[9] DCF, Managing Entities, available at: https://www.myflfamilies.com/services/samh/providers/managing-entities (last visited March 14, 2025).
[10] DCF, *A Comprehensive, Multi-Year Review of the Revenues, Expenditures, and Financial Positions of the Managing Entities Including a System of Care Analysis*, p. 5, available at https://myflfamilies.com/document/57451, (last visited March 21, 2025); Section 394.9082(4)(I), F.S.
[11] *Id.* at 11.
[12] Department of Children and Families, *Managing Entities*, available at https://www.myflfamilies.com/services/samh/provIders/managing-entities, (last visited March 16, 2025).

In FY 2022-23, in the aggregate, DCF reported serving 243,403 unduplicated behavioral health clients.[13]

Coordinated System of Care

Managing entities are required to promote the development and implementation of a coordinated system of care.[14] A coordinated system of care means a full array of behavioral and related services in a region or community offered by all service providers, participating either under contract with a managing entity or by another method of community partnership or mutual agreement.[15] A community or region provides a coordinated system of care for those with a mental illness or substance abuse disorder through a no-wrong-door model, to the extent allowed by available resources. If funding is provided by the Legislature, the DCF may award system improvements grants to managing entities.[16] MEs must submit detailed plans to enhance crisis services based on the no-wrong-door model or to meet specific needs identified in the DCF's assessment of behavioral health services in this state.[17] The DCF must use performance-based contracts to award grants.[18]

There are several essential elements which make up a coordinated system of care, including:[19]

- Community interventions;
- Case management;
- Care coordination;
- Outpatient services;
- Residential services;
- Hospital inpatient care;
- Aftercare and post-discharge services;
- Medication assisted treatment and medication management; and
- Recovery support.

A coordinated system of care must include, but is not limited to, the following array of services:[20]

- Prevention services;
- Home-based services;
- School-based services;
- Family therapy;
- Family support;
- Respite services;
- Outpatient treatment;
- Crisis stabilization;
- Therapeutic foster care;

[13] S*upra*, Note 10, p. 14.
[14] Section 394.9082(5)(d), F.S.
[15] Section 394.4573(1)(c), F.S.
[16] Section 394.4573(3), F.S.
[17] *Id.*
[18] *Id.*
[19] Section 394.4573(2), F.S.
[20] Section 394.495(4), F.S.

- Residential treatment;
- Inpatient hospitalization;
- Case management;
- Services for victims of sex offenses;
- Transitional services; and
- Trauma-informed services for children who have suffered sexual exploitation.

The DCF must define the priority populations which would benefit from receiving care coordination.[21] In defining priority populations, the DCF must consider the number and duration of involuntary admissions, the degree of involvement with the criminal justice system, the risk to public safety posed by the individual, the utilization of a treatment facility by the individual, the degree of utilization of behavioral health services, and whether the individual is a parent or caregiver who is involved with the child welfare system.

MEs are required to conduct a community behavioral health care needs assessment once every three years in the geographic area served by the managing entity, which identifies needs by sub-region.[22] The assessments must be submitted to DCF for inclusion in the state and district substance abuse and mental health plan.[23] In addition to the needs assessment, the ME is generally required to also:

- Determine the optimal array of services to meet the community's needs.
- Promote a coordinated system of care.
- Assist counties in development of designated receiving systems and transportation plans.
- Develop strategies to divert persons with mental illness or substance abuse from criminal and juvenile justice systems and integrate behavioral health services with the child welfare system.
- Develop a compressive network of qualified providers to deliver services.
- Monitor network provider performance and compliance with contract requirements.[24]

Under Florida Administrative Code, MEs are required to implement a Care Coordination Policy applicable to all subcontracted service providers.[25] This policy must ensure that services are delivered based on eligibility, clinical appropriateness, individual need, and with fiscal accountability.[26] The rule requires care coordination policies that reduce, manage, and eliminate waitlists, support service planning for individuals with co-occurring substance use and mental health disorders and promote the use of clinical screening and assessment tools to determine the appropriate level of care. In addition, the policy must ensure that individuals are served in the least restrictive setting appropriate to their clinical needs and that system changes are monitored to improve service efficiency. The rule also calls for the use of outcome data to inform service delivery and to support continuous improvement across the behavioral health system.

[21] Section 394.9082(3)(c), F.S.
[22] Section 394.9082(5)(b), F.S.
[23] Section 394.75(3), F.S.
[24] Section 394.9082(5), F.S.
[25] Rule 65E-14.014, F.A.C.
[26] *Id.*

Data Collection and Reporting by Managing Entities

MEs are responsible for collecting and reporting specific data to the DCF.[27] Current law requires MEs to establish performance standards related to:

- Service Reach: The extent to which individuals in the community receive services, including parents or caregivers involved in the child welfare system who need behavioral health services.
- Community Behavioral Health Improvement: The overall improvement in the behavioral health of the community.
- Individual Progress: The improvement in functioning or progress in recovery of individuals served by the ME, using person-centered measures tailored to the population.
- Diversion Strategies: The success of strategies to divert admissions from acute levels of care, jails, prisons, and forensic facilities, including metrics on clients experiencing multiple admissions to such facilities.
- Integration with Child Welfare: The effectiveness of integrating behavioral health services with the child welfare system.
- Housing Needs: Addressing the housing needs of individuals being released from public receiving facilities who are homeless.
- Consumer and Family Satisfaction: Levels of satisfaction among consumers and their families.
- Community Engagement: The level of engagement with key community constituencies, such as law enforcement agencies, community-based care lead agencies, juvenile justice agencies, courts, school districts, local government entities, hospitals, and other relevant organizations.

Florida Administrative Code further, establishes standards for service providers under direct contract with the DCF or subcontract with an ME.[28] It requires providers to report services using defined Substance Abuse and Mental Health (SAMH) covered services and to adhere to specified measurement and reporting standards.

MEs are also required by contract to submit multiple reports, forms, and documents at specific intervals to the DCF.[29] Some of these include Regional Planning Documents, Provider Tangible Property Inventory, Triennial Needs Assessments, Managing Entity Annual Business Operations Plans (including SAMHTF Discharge Reintegration Plan, Triennial Needs Assessment, Care Coordination Plan, Quality Assurance Plan, Assisted Living Facility (ALF)-LMH Plan, Annual Network Service Provide Monitoring Plan), Enhancement Plan, Care Coordination Plan, Quality Assurance Plan, Fraud and Abuse Prevention Protocol, Network Services Provider Monitoring Plan, Information Technology Plan, etc.[30]

MEs are also required by contract to submit multiple minimum performance measures.[31] This includes measures of things such as:

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[27] Section 394.9082(7), F.S.
[28] Rule 65E-14.021, F.A.C
[29] Department of Children and Families, Managing Entity Standard Contract, *Exhibit C3*, available at: https://www.myflfamilies.com/document/30496 (last visited 3/21/25).
[30] *Id.*
[31] Department of Children and Families, Managing Entity Standard Contract, Exhibit E, available at: https://www.myflfamilies.com/document/52831 (last visited 3/21/25).

- On-site performance monitoring of network providers.
- Service level compliance.
- Federal block grant implementation.
- Network service provider measures.
- Corrective action for performance deficiencies.[32]

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 394.9082(3), F.S., to require the DCF to contract for an operational and financial audit and expenditure and claims audit of each ME.

The operational and financial audits must include:
- Business practices, personnel, financial records, provider payments, expenditures, referral patterns, and provider network adequacy.
- Services administered, the method of provider payment, expenditures, outcomes, and other information as determined by the department.
- Referral patterns, including ME volume, provider assignments, services referred, length of time to obtain services, and key referral performance measures.
- Provider network adequacy and provider network participation in the DCF's available bed platform, the Opioid Data Management System, the Agency for Health Care Administration Event Notification Service, and other required provider data submissions.

The expenditure and claims audit of each ME must analyze the claims paid by each managing entity for Medicaid recipients and also compare:
- Services administered through each ME;
- Outcomes of ME expenditures:
- ME Medicaid expenditures for behavioral health services: and
- Any other information as determined by the DCF.

The contracted audit and review of ME operations and finances must include recommendations to improve transparency of system performance, to include metrics and criteria used to measure performance and outcomes and the format and method used to collect and report data.

A final report summarizing audit findings and recommendations must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2025.

The bill amends s. 394.9082(5), F.S., to require an ME to submit all required information to the DCF in a standardized electronic format to ensure interoperability and facilitate data analysis. This format must meet all of the following criteria:
- Provider payments must be reported using a standardized format for electronic data interchange.
- Organized into discrete, machine-readable data elements that allow for efficient processing and integration with other datasets.

[32] *Id.*

- Comply with established protocols specified by the DCF.
- Compatible with automated systems to enable downloading, parsing, and combining of data.
- Pass validation checks to confirm adherence to required data structure and format.

The bill requires MEs to submit all documents in an electronic format that supports accurate text recognition and data extraction. Documents must be accompanied by metadata, including a unique document name, upload date, classification, relevant identifiers, and submitter information.

The bill amends s. 394.9082(7), F.S., to require MEs to collect and submit data on persons served, service outcomes, and costs. MEs are mandated to collect and submit data to the DCF regarding persons served, service outcomes, service costs, and other required data.
The DCF will evaluate ME performance and overall progress in meeting community behavioral health needs based on consumer-centered outcome measures that reflect national standards, where possible.

The bill requires MEs to submit the following new specific measures to the DCF:
- High Utilizers: The number and percentage of high utilizers of services.
- Post-Hospitalization Services: The number and percentage of individuals who receive outpatient services within seven days after hospitalization for behavioral health-related issues.
- Appointment Wait Times: The average wait time for initial appointments for behavioral health services.
- Urgent Appointments: The number and percentage of individuals able to schedule urgent behavioral health appointments within 24 hours.
- Emergency Room Visits: The number and percentage of emergency room visits per capita for behavioral health-related issues, and whether such visits could have been avoided with appropriate behavioral health services.

Section 2 of the bill provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The Managing Entities and Community Providers

Indeterminate, likely significant negative fiscal impact on private-sector managing entities and community providers. The bill proposes expanded reporting and audit requirements based on claims processing. This likely does not align with current behavioral health ME funding and reporting systems, which do not rely on diagnosis-based or Medicaid billing structures. Additionally, the bill introduces new performance metrics and audit expectations that may exceed current data capabilities. Adapting to this model will likely require system updates, technical support, and staff training.

C. Government Sector Impact:

Significant negative fiscal impact on government sector. The bill requires the DCF to procure auditing services for the operational and financial audits of its seven Managing Entity contracts. The DCF estimates a fiscal impact of $3,000,000.[33]

Below is DCF's estimated cost breakdown for implementing this new system. Cost figures are based on the assumptions provided (e.g., number of contractors, Cloud infrastructure, professional services, etc.). IT System Modernization is estimated at $6,900,000 nonrecurring.[34]

Item	Cost	Description
IT Contractors (8)	$1,920,000	- 8 contractors (data architects, developers, analysts, report developers) - $120/hour * 2,000 hours each = $240,000 per FTE
Cloud Infrastructure & Security	$800,000	- Hosting, cloud storage, cybersecurity measures
Business Advisory & Project Management	$1,500,000	- Oversight, requirement gathering, stakeholder engagement, risk management
Training, OCM for MEs	$700,000	- Training managing entities on new processes, data formats, portal usage
Upgrading ME Systems	$1,000,000	- Grants or funding assistance to help MEs modernize/replace legacy systems to ensure interoperability

[33] Florida Department of Children and Families, *SB 1354 (2025) Agency Analysis*, 3/7/25, p.7 (on file with the Children, Families, and Elder Affairs Committee).
[34] *Id*, p. 9

Item	Cost	Description
Additional Software, licensing's	$1,000,000	- Integrates Edifecs with new portal, back-end APIs, data ingestion, and partner credentialing
Total	$6,920,000	

Estimated Recurring Costs are estimated at $3,900,000 for maintenance and operation.[35]

The current platform used by the DCF for managing mental health and substance abuse data is the Financial and Services Accountability Management System (FASAMS). The data reporting provisions introduced in the proposed legislation would necessitate extensive modifications to the existing system.[36] The new platform will require vendor support, infrastructure, training, and staffing and is expected to take 12 to 18 months to complete.[37]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 394.9082 of Florida Statute:

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[35] *Id.*
[36] *Id.*, p. 8
[37] *Id.*

797766

LEGISLATIVE ACTION

Senate . House

. . . . .

The Committee on Children, Families, and Elder Affairs (Trumbull) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (7) of section 394.9082, Florida Statutes, is amended, paragraph (n) is added to subsection (3), and paragraphs (v) and (w) are added to subsection (5) of that section, to read:

394.9082 Behavioral health managing entities.—

(3) DEPARTMENT DUTIES.—The department shall:

797766

(n)1. Contract for all of the following:

a. Biennial operational and financial audits of each managing entity to include all of the following:

(I) A review of business practices, personnel, financial records, related parties, compensation, and other areas as determined by the department.

(II) The services administered, the method of provider payment, expenditures, outcomes, and other information as determined by the department.

(III) Referral patterns, including managing entity referral volume; provider referral assignments; services referred; length of time to obtain services; and key referral performance measures.

(IV) Provider network adequacy and provider network participation in the department's available bed platform, the Opioid Data Management System, the Agency for Health Care Administration Event Notification Service, and other department required provider data submissions.

(V) Audits of each managing entity's expenditures and claims. Such an audit must do both of the following:

(A) Compare services administered through each managing entity, the outcomes of each managing entity's expenditures, each managing entity's Medicaid expenditures for behavioral health services, and any other information as determined by the department.

(B) Analyze services funded by each managing entity rendered to individuals who are also Medicaid beneficiaries to, at a minimum, assess the extent to which managing entities are funding services that are also available as covered services

797766

under the Medicaid program.

b. Recommendations to improve transparency of system performance, including, but not limited to, metrics and criteria used to measure each managing entity's performance and patient and system outcomes, and the format and method to be used to collect and report necessary data and information.

2. Prepare a report of the information gathered in subparagraph 1. and present the final report on or before December 1, 2025, to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(5) MANAGING ENTITY DUTIES.—A managing entity shall:

(v) Report all required data to the department in a standardized electronic format to ensure interoperability and to facilitate data analysis. The submission format must meet all of the following criteria:

1. Provider payments must be reported using a standardized format for electronic data interchange that is used for health care claims processing.

2. Information must be organized into discrete, machine-readable data elements that allow for efficient processing and integration with other datasets.

3. All data fields must comply with established protocols as specified by the department.

4. The standardized format must be compatible with automated systems to enable the downloading, parsing, and combining of data with other sources for analysis.

5. Submissions must pass validation checks to confirm adherence to the required data structure and format before the submission is accepted.

797766

(w) Submit to the department all documents that are required under contract for submission on a routine basis in an electronic format that allows for accurate text recognition and data extraction as specified by the department, which may include, but is not limited to, Portable Document Format or machine-readable text files. The documents must be accompanied by metadata containing key information that ensures proper organization, processing, and integration into the department's systems. The required metadata must include, but is not limited to, all of the following elements:

1. A descriptive and unique name for the document, following any naming conventions prescribed by the department.

2. The date the document is uploaded.

3. A predefined classification indicating the nature or category of the document.

4. Any relevant identifiers, such as application numbers, case numbers, or tracking codes, as specified by the department.

5. The name, contact information, and any other required identification number, which may include, but is not limited to, a contract, license, or registration number, of the person or organization submitting the document.

6. Any other metadata fields as prescribed by the department to facilitate accurate processing and analysis.

(7) PERFORMANCE MEASUREMENT AND ACCOUNTABILITY.—

(a) Managing entities shall collect and submit data to the department regarding persons served, outcomes of persons served, costs of services provided through the department's contract, and other data as required by the department. The department shall evaluate managing entity performance and the overall

797766

progress made by the managing entity, together with other systems, in meeting the community's behavioral health needs, based on consumer-centered outcome measures that reflect national standards, if possible, that can be accurately measured. The department shall work with managing entities to establish performance standards, including, but not limited to:

1.~~(a)~~ The extent to which individuals in the community receive services, including, but not limited to, parents or caregivers involved in the child welfare system who need behavioral health services.

2.~~(b)~~ The improvement in the overall behavioral health of a community.

3.~~(c)~~ The improvement in functioning or progress in the recovery of individuals served by the managing entity, as determined using person-centered measures tailored to the population.

4.~~(d)~~ The success of strategies to:

a.~~1.~~ Divert admissions from acute levels of care, jails, prisons, and forensic facilities as measured by, at a minimum, the total number and percentage of clients who, during a specified period, experience multiple admissions to acute levels of care, jails, prisons, or forensic facilities;

b.~~2.~~ Integrate behavioral health services with the child welfare system; and

c.~~3.~~ Address the housing needs of individuals being released from public receiving facilities who are homeless.

5.~~(e)~~ Consumer and family satisfaction.

6.~~(f)~~ The level of engagement of key community constituencies, such as law enforcement agencies, community-

797766

based care lead agencies, juvenile justice agencies, the courts, school districts, local government entities, hospitals, and other organizations, as appropriate, for the geographical service area of the managing entity.

(b) Managing entities must submit specific measures to the department regarding individual outcomes and system functioning, which the department must post to, and maintain on, its website by the 15th of every month. The posted measures must reflect performance for the previous calendar month. Each managing entity must report each measure using a standard methodology determined by the department and submit the data to the department by the deadline specified by the department. The measures shall include data from individuals served by each managing entity for services funded by the managing entity, to the extent feasible and appropriate. The measures shall be reported and posted stratified by, at a minimum, whether the individual is a child or an adult and whether the individual is a Medicaid recipient. Such measures shall include, at a minimum, all of the following:

1. The number and percentage of individuals who are high utilizers of crisis behavioral health services.

2. The number and percentage of individuals referred to outpatient behavioral health services after their discharge from a receiving or treatment facility, an emergency department under this chapter, or an inpatient or residential licensed service component under chapter 397 and who begin receiving such services within 7 days after discharge.

3. The average wait time for initial appointments for behavioral health services, categorized by the type of service.

797766

4. The number and percentage of individuals with significant behavioral health symptoms who are seeking urgent but noncrisis acute care and who are scheduled to be seen by a provider within 1 business day after initial contact with the provider.

5. The number and percentage of emergency department visits per capita for behavioral health-related issues.

6. The incidence of medication errors.

7. The number and percentage of adverse incidents, including, but not limited to, self-harm, occurring during inpatient and outpatient behavioral health services.

8. The number and percentage of individuals with co-occurring conditions who receive integrated care.

9. The number and percentage of individuals discharged from a receiving or treatment facility under this chapter or an inpatient or residential licensed service component under chapter 397 who successfully transition to ongoing services at the appropriate level of care.

10. The rate of readmissions to emergency departments due to behavioral health issues or to crisis stabilization units, addictions receiving facilities, or other inpatient levels of care under this chapter and chapter 397 within 30 days after discharge from inpatient or outpatient behavioral health services.

11. The average length of stay for inpatient behavioral health services.

Section 2. This act shall take effect July 1, 2025.

========== T I T L E A M E N D M E N T ==========

797766

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to behavioral health managing entities; amending s. 394.9082, F.S.; requiring the Department of Children and Families to contract biennially for specified functions; requiring the department to contract for recommendations for certain transparency improvements; requiring the department to prepare and present to the Governor and Legislature a specified final report by a specified date; requiring managing entities to report required data to the department in a standardized electronic format; providing requirements for such format; requiring managing entities to electronically submit to the department certain documents in a specified format and with specified metadata; requiring managing entities to submit certain specific measures to the department; requiring the department to post and maintain such measures on its website by a specified date every month; requiring managing entities to report each measure using a standard methodology determined by the department; providing requirements for such measures; providing an effective date.

By Senator Rouson

16-00602C-25 20251620__

A bill to be entitled

An act relating to mental health and substance use disorders; amending s. 394.455, F.S.; defining the term "person-first language"; amending s. 394.457, F.S.; revising the minimum standards for a mobile crisis response service; amending s. 394.459, F.S.; requiring that an individualized treatment plan be reevaluated within a specified timeframe to ensure the recommended care remains necessary for a patient; amending s. 394.468, F.S.; requiring a service provider to provide a patient with certain medication for a specified timeframe upon discharge from certain treatment facilities; providing exceptions; amending s. 394.495, F.S.; requiring the department to reevaluate assessment services at specified intervals to ensure a patient's clinical needs are being met; revising such assessment services' evaluations and screening areas; amending s. 394.659, F.S.; requiring the Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center at the Louis de la Parte Florida Mental Health Institute at the University of South Florida to disseminate certain evidence-based practices and best practices among grantees; amending s. 394.875, F.S.; requiring the Department of Children and Families, in consultation with the Agency for Health Care Administration, to conduct a review every other year to identify certain counties that require additional resources for short-term residential treatment facilities; requiring the

department to prioritize specified facilities in issuing licenses; requiring the department to adopt rules in consultation with the agency; amending s. 394.9086, F.S.; revising the duties of the Commission on Mental Health and Substance Use Disorder; amending s. 1004.44, F.S.; revising the assistance and services the Louis de la Parte Florida Mental Health Institute is required to provide; revising the requirements of the Florida Center for Behavioral Health Workforce to promote behavioral health professions; creating the Center for Substance Abuse and Mental Health Research within the institute; specifying the purpose of the center; specifying the goals of the center; specifying the responsibilities of the center; requiring the center to submit a report by a specified date each year to the Governor and the Legislature; specifying the contents of the report; amending s. 1006.041, F.S.; revising the plan components for mental health assistance programs; requiring the Department of Children and Families, in consultation with the Department of Education, to conduct a review every other year to identify effective models of school-based behavioral health access; requiring the Department of Children and Families to submit its findings to the Governor and the Legislature by a specified date every other year; amending s. 394.9085, F.S.; conforming a cross-reference; reenacting s. 394.463(2)(g), F.S., relating to involuntary examination, to incorporate the amendment made to s.

394.468, F.S., in a reference thereto; reenacting s. 394.4955(2)(c) and (6), F.S., relating to coordinated system of care and child and adolescent mental health treatment and support, to incorporate the amendment made to s. 394.495, F.S., in references thereto; reenacting s. 1001.212(7), F.S., relating to the Office of Safe Schools, to incorporate the amendment made to s. 1004.44, F.S., in a reference thereto; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Present subsections (33) through (50) of section 394.455, Florida Statutes, are redesignated as subsections (34) through (51), respectively, and a new subsection (33) is added to that section, to read:

394.455 Definitions.—As used in this part, the term:

(33) "Person-first language" means language used in a professional medical setting which emphasizes the patient as a person rather than his or her disability or illness.

Section 2. Paragraph (c) of subsection (5) of section 394.457, Florida Statutes, is amended to read:

394.457 Operation and administration.—

(5) RULES.—

(c) The department shall adopt rules establishing minimum standards for services provided by a mental health overlay program or a mobile crisis response service. Minimum standards for a mobile crisis response service must:

1. Include the requirements of the child, adolescent, and

young adult mobile response teams established under s. 394.495(7) and ensure coverage of all counties by these specified teams; ~~and~~

2. Ensure access to mobile response services for persons 65 years of age or older; and

3. Create a structure for general mobile response teams which focuses on crisis diversion and the reduction of involuntary commitment under this chapter. The structure must require, but need not be limited to, the following:

a. Triage and rapid crisis intervention within 60 minutes;

b. Provision of and referral to evidence-based services that are responsive to the needs of the individual and the individual's family;

c. Screening, assessment, early identification, and care coordination; ~~and~~

d. Sharing of best practices with medical professionals, including the use of person-first language and trauma-responsive care, to improve patient experiences and outcomes and encourage cooperative engagement from patients seeking treatment; and

e. Confirmation that the individual who received the mobile crisis response was connected to a service provider and prescribed medications, if needed.

Section 3. Paragraph (e) of subsection (2) of section 394.459, Florida Statutes, is amended to read:

394.459 Rights of patients.—

(2) RIGHT TO TREATMENT.—

(e) Not more than 5 days after admission to a facility, each patient must ~~shall~~ have and receive an individualized treatment plan in writing which the patient has had an

opportunity to assist in preparing and to review before ~~prior to~~ its implementation. The plan must ~~shall~~ include a space for the patient's comments. An individualized treatment plan must be reevaluated no less than every 6 months to ensure the treatment plan's recommended care remains necessary for the patient.

Section 4. Subsection (2) of section 394.468, Florida Statutes, is amended to read:

394.468 Admission and discharge procedures.—

(2) Discharge planning and procedures for any patient's release from a receiving facility or treatment facility must include and document the patient's needs, and actions to address such needs, for, at a minimum:

(a) Follow-up behavioral health appointments;

(b) Information on how to obtain prescribed medications; ~~and~~

(c) Information pertaining to:

1. Available living arrangements; and

2. Transportation; ~~and~~

(d) Referral to:

1. Care coordination services. The patient must be referred for care coordination services if the patient meets the criteria as a member of a priority population as determined by the department under s. 394.9082(3)(c) and is in need of such services.

2. Recovery support opportunities under s. 394.4573(2)(l), including, but not limited to, connection to a peer specialist; and~~.~~

(e) Upon discharge, provision of a sufficient supply necessary prescribed medication to cover the patient's scheduled

dosage until his or her scheduled follow-up appointment or for at least 30 days, unless contraindicated in the patient's treatment plan or the provider has clinical safety concerns for giving the patient a supply of medication based on a safety risk assessment. Such medication may include, but is not limited to, long-acting injectables.

Section 5. Subsection (2) of section 394.495, Florida Statutes, is amended to read:

394.495 Child and adolescent mental health system of care; programs and services.—

(2) The array of services must include assessment services that provide a professional interpretation of the nature of the problems of the child or adolescent and his or her family; family issues that may impact the problems; additional factors that contribute to the problems; and the assets, strengths, and resources of the child or adolescent and his or her family. The assessment services to be provided must ~~shall~~ be determined by the clinical needs of each child or adolescent. The department shall reevaluate the services no less than every 6 months to ensure the child's clinical needs are being met. Assessment services include, but are not limited to, evaluation and screening in the following areas:

(a) Physical and mental health for purposes of identifying medical and psychiatric problems.

(b) Psychological functioning, as determined through a battery of psychological tests.

(c) Intelligence and academic achievement.

(d) Social and behavioral functioning.

(e) Family functioning.

(f) Functional daily living through the implementation of the Daily Living Activities-20 functional assessment tool as described in s. 1006.041(2)(b).

The assessment for academic achievement is the financial responsibility of the school district. The department shall cooperate with other state agencies and the school district to avoid duplicating assessment services.

Section 6. Paragraph (d) of subsection (1) of section 394.659, Florida Statutes, is amended to read:

394.659 Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center.—

(1) There is created a Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center at the Louis de la Parte Florida Mental Health Institute at the University of South Florida, which shall:

(d) Disseminate and share evidence-based practices and best practices among grantees, including, but not limited to, the use of person-first language and trauma-responsive care, to improve patient experiences and outcomes and encourage cooperative engagement for patients seeking treatment.

Section 7. Subsection (11) is added to section 394.875, Florida Statutes, and paragraph (c) of subsection (1) and paragraph (a) of subsection (8) of that section are republished, to read:

394.875 Crisis stabilization units, residential treatment facilities, and residential treatment centers for children and adolescents; authorized services; license required.—

(1)

(c) The purpose of a residential treatment center for children and adolescents is to provide mental health assessment and treatment services pursuant to ss. 394.491, 394.495, and 394.496 to children and adolescents who meet the target population criteria specified in s. 394.493(1)(a), (b), or (c).

(8)(a) The department, in consultation with the agency, must adopt rules governing a residential treatment center for children and adolescents which specify licensure standards for: admission; length of stay; program and staffing; discharge and discharge planning; treatment planning; seclusion, restraints, and time-out; rights of patients under s. 394.459; use of psychotropic medications; and standards for the operation of such centers.

(11) The department, in consultation with the agency, shall conduct a review every other year to identify counties that require additional resources for short-term residential treatment facilities. The department, in consultation with the agency, shall give priority in issuing licenses to short-term residential treatment facilities located in counties identified by the review. The department, in consultation with the agency, shall adopt rules prescribing procedures for prioritizing short-term residential treatment facilities in such counties.

Section 8. Paragraph (a) of subsection (4) of section 394.9086, Florida Statutes, is amended to read:

394.9086 Commission on Mental Health and Substance Use Disorder.—

(4) DUTIES.—

(a) The duties of the Commission on Mental Health and Substance Use Disorder include the following:

1. Conducting a review and evaluation of the management and functioning of the existing publicly supported mental health and substance use disorder systems and services in the department, the Agency for Health Care Administration, and all other departments which administer mental health and substance use disorder services. Such review must ~~shall~~ include, at a minimum, a review of current goals and objectives, current planning, services strategies, coordination management, purchasing, contracting, financing, local government funding responsibility, and accountability mechanisms.

2. Considering the unique needs of persons who are dually diagnosed.

3. Addressing access to, financing of, and scope of responsibility in the delivery of emergency behavioral health care services.

4. Addressing the quality and effectiveness of current mental health and substance use disorder services delivery systems, and professional staffing and clinical structure of services, roles, and responsibilities of public and private providers, such as community mental health centers; community substance use disorder agencies; hospitals, including emergency services departments; law enforcement agencies; and the judicial system.

5. Addressing priority population groups for publicly funded mental health and substance use disorder services;~~,~~ identifying the comprehensive mental health and substance use disorder services delivery systems;~~,~~ mental health and substance use disorder needs assessment and planning activities, including, but not limited to, the use of the Daily Living

Activities-20 functional assessment tool as described in s. 1006.041(2)(b); and local government funding responsibilities for mental health and substance use disorder services.

6. Reviewing the implementation of chapter 2020-107, Laws of Florida.

7. Identifying any gaps in the provision of mental health and substance use disorder services.

8. Providing recommendations on how behavioral health managing entities may fulfill their purpose of promoting service continuity and work with community stakeholders throughout this state in furtherance of supporting the 988 Suicide and Crisis Lifeline system and other crisis response services.

9. Conducting an overview of the current infrastructure of the 988 Suicide and Crisis Lifeline system.

10. Analyzing the current capacity of crisis response services available throughout this state, including services provided by mobile response teams and centralized receiving facilities. The analysis must include information on the geographic area and the total population served by each mobile response team along with the average response time to each call made to a mobile response team; the number of calls that a mobile response team was unable to respond to due to staff limitations, travel distance, or other factors; and the veteran status and age groups of individuals served by mobile response teams.

11. Evaluating and making recommendations to improve linkages between the 988 Suicide and Crisis Lifeline infrastructure and crisis response services within this state.

12. Identifying available mental health block grant funds

that can be used to support the 988 Suicide and Crisis Lifeline and crisis response infrastructure within this state, including any available funding through opioid settlements or through the American Rescue Plan Act of 2021, Pub. L. No. 117-2; the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136; or other federal legislation.

13. In consultation with the Agency for Health Care Administration, identifying sources of funding available through the Medicaid program specifically for crisis response services, including funding that may be available by seeking approval of a Section 1115 waiver submitted to the Centers for Medicare and Medicaid Services.

14. Making recommendations regarding the mission and objectives of state-supported mental health and substance use disorder services and the planning, management, staffing, financing, contracting, coordination, and accountability mechanisms which will best foster the recommended mission and objectives.

15. Evaluating and making recommendations regarding the establishment of a permanent, agency-level entity to manage mental health, substance use disorder, and related services statewide. At a minimum, the evaluation must consider and describe the:

a. Specific duties and organizational structure proposed for the entity;

b. Resource needs of the entity and possible sources of funding;

c. Estimated impact on access to and quality of services;

d. Impact on individuals with behavioral health needs and

their families, both those currently served through the affected systems providing behavioral health services and those in need of services; and

e. Relation to, integration with, and impact on providers, managing entities, communities, state agencies, and systems which provide mental health and substance use disorder services in this state. Such recommendations must ensure that the ability of such other agencies and systems to carry out their missions and responsibilities is not impaired.

16. Evaluating and making recommendations regarding skills-based training that teaches participants about mental health and substance use disorder issues, including, but not limited to, Mental Health First Aid models.

Section 9. Paragraph (a) of subsection (6) of section 1004.44, Florida Statutes, is amended, and paragraph (h) of subsection (1) and subsection (8) are added to that section, to read:

1004.44 Louis de la Parte Florida Mental Health Institute.—There is established the Louis de la Parte Florida Mental Health Institute within the University of South Florida.

(1) The purpose of the institute is to strengthen mental health services throughout the state by providing technical assistance and support services to mental health agencies and mental health professionals. Such assistance and services shall include:

(h) Analysis of publicly funded substance abuse and mental health services to identify gaps in patients' insurance coverage, monitor quality of care and cost management, enhance provider networks by identifying areas where additional

providers are needed, and ensure compliance.

(6)(a) There is established within the institute the Florida Center for Behavioral Health Workforce. The purpose of the center is to support an adequate, highly skilled, resilient, and innovative workforce that meets the current and future human resources needs of the state's behavioral health system in order to provide high-quality care, services, and supports to Floridians with, or at risk of developing, behavioral health conditions through original research, policy analysis, evaluation, and development and dissemination of best practices. The goals of the center are, at a minimum, to research the state's current behavioral health workforce and future needs; expand the number of clinicians, professionals, and other workers involved in the behavioral health workforce; and enhance the skill level and innovativeness of the workforce. The center shall, at a minimum, do all of the following:

1. Describe and analyze the current workforce and project possible future workforce demand, especially in critical roles, and develop strategies for addressing any gaps. The center's efforts may include, but need not be limited to, producing a statistically valid biennial analysis of the supply and demand of the behavioral health workforce.

2. Expand pathways to behavioral health professions through enhanced educational opportunities and improved faculty development and retention. The center's efforts may include, but need not be limited to:

a. Identifying best practices in the academic preparation and continuing education of behavioral health professionals.

b. Facilitating and coordinating the development of

academic-practice partnerships that support behavioral health faculty employment and advancement.

c. Developing and implementing innovative projects to support the recruitment, development, and retention of behavioral health educators, faculty, and clinical preceptors.

d. Developing distance learning infrastructure for behavioral health education and the evidence-based use of technology, simulation, and distance learning techniques.

3. Promote behavioral health professions. The center's efforts may include, but need not be limited to:

a. Conducting original research on the factors affecting recruitment, retention, and advancement of the behavioral health workforce, such as designing and implementing a longitudinal study of the state's behavioral health workforce.

b. Developing and implementing innovative projects to support the recruitment, development, and retention of behavioral health workers.

4. Analyze compensation and benefit data biennially to identify factors that have led to the shortage of behavioral health workers in this state and make recommendations for funding programs to support the growth and retention of the behavioral health workforce, such as stipends or other financial support for clinical supervisors, workers, interns, and students currently working in the field of behavioral health.

5. Request from the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, and the board must provide to the center upon its request, any information held by the board regarding the clinical social work, marriage and family therapy, and mental health counselors licensed in

this state or information reported to the board by employers of such counselors, other than personal identifying information.

6. Develop and routinely analyze a behavioral health workforce survey to increase insight into service provision and access, inform priorities that support retention, strategically address critical gaps, and inform workforce-related policy decisions. In conjunction with the Department of Health, the center shall conduct the survey at the time of initial licensure and license renewal for psychologists licensed under chapter 490 and social workers, marriage and family therapists, and mental health counselors licensed under chapter 491. The survey must solicit information including, but not limited to:

a. The frequency and geographic location of practice.

b. Participation in interjurisdictional practice and percentage of Florida and non-Florida residents served.

c. Practice setting and populations served, including availability for critically needed services.

d. Percentage of time spent in direct patient care.

e. Compensation and benefits.

f. Anticipated change to license or practice status.

(8)(a) There is created within the institute the Center for Substance Abuse and Mental Health Research. The purpose of the center is to conduct rigorous and relevant research intended to develop knowledge and practice in prevention and intervention for substance abuse and mental health issues, to serve the people and economy in this state in reducing the gap between population needs and the availability of effective treatments and other interventions to improve the capacity of the state to have healthy, resilient communities prevailing over substance

abuse, addiction, and mental health challenges.

(b) The goals of the center are, at a minimum, to advance the scientific understanding of the relationship between substance abuse and mental health issues, improving treatment outcomes, and reducing the societal impact and burden of substance abuse and mental health conditions. The center shall, at a minimum, do all of the following:

1. Analyze publicly funded substance abuse and mental health services to identify gaps in insurance coverage, monitor quality of care and cost management, and enhance provider networks by identifying gaps in service provision by type and geographic location.

2. Research and study the complex relationship between substance abuse and mental health disorders, including analyzing how substances may contribute to the onset of mental health conditions, how those conditions can lead to substance abuse, and how both can interact to create and worsen negative outcomes, such as violence, infectious disease, suicide, and overdose. The center must also study the range, distribution, and concentration of such negative outcomes.

3. Develop and test strategies to prevent the development of both substance use and mental health disorders, including early risk factor identification and interventions designed for at-risk populations, specifically in rural settings, where resources may be limited and integrated care is essential.

4. Conduct research on alternative, low-cost strategies for prevention and early intervention.

5. Conduct outcomes and implementation research on optimizing application of technology for efficient and effective

dissemination of evidence-based treatment across this state, with specific attention to rural and other low-resource areas, using telehealth, mobile device remote monitoring, delivery of patient-specific prompts via technology platforms for self-management, and other aspects of care.

6. Investigate and improve treatment options for individuals suffering from co-occurring substance use and mental health disorders, including developing integrated treatment programs that address both issues simultaneously.

7. Generate evidence-based data to inform public policy and promote substance use disorder services and mental health disorder services.

8. Develop community-based sharing agreements, local infrastructure, and methodologies to encourage data-informed decisionmaking to encourage economic efficiency and targeted service delivery.

9. Develop and provide training for health care professionals, social workers, counselors, and researchers on the latest findings related to substance abuse and mental health, fostering a workforce capable of providing effective care.

10. Articulate methods to align and adapt training approaches for delivering evidence-based practices to locally identified needs, including implementing evidence-based training and tools at community health centers to improve identification of mental health and substance use disorders and create plans for referral and continuity of care.

11. Collaborate with community organizations to offer resources and education about substance use and mental health to

reduce stigma and raise awareness.

(c) By July 1 of each year, the center shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives providing details of its activities during the preceding calendar year in pursuit of its goals and in the execution of its duties under paragraph (b).

Section 10. Paragraph (b) of subsection (2) of section 1006.041, Florida Statutes, is amended, and subsection (5) is added to that section, to read:

1006.041 Mental health assistance program.—Each school district must implement a school-based mental health assistance program that includes training classroom teachers and other school staff in detecting and responding to mental health issues and connecting children, youth, and families who may experience behavioral health issues with appropriate services.

(2) A plan required under subsection (1) must be focused on a multitiered system of supports to deliver evidence-based mental health care assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance abuse diagnoses and to students at high risk of such diagnoses. The provision of these services must be coordinated with a student's primary mental health care provider and with other mental health providers involved in the student's care. At a minimum, the plan must include all of the following components:

(b) Contracts or interagency agreements with one or more local community behavioral health providers or providers of Community Action Team services to provide a behavioral health staff presence and services at district schools. Services may

include, but are not limited to, mental health screenings and assessments, individual counseling, family counseling, group counseling, psychiatric or psychological services, trauma-informed care, mobile crisis services, and behavior modification. These behavioral health services may be provided on or off the school campus and may be supplemented by telehealth as defined in s. 456.47(1). In addition to the services in this paragraph, the department shall implement the Daily Living Activities-20 (DLA-20) functional assessment tool to further assist providers in creating recommended treatment plans. The department shall review the DLA-20 functional assessment tool every other year to implement the most updated version. The department is authorized to replace the DLA-20 functional assessment tool if it determines that a better alternative is available.

(5) The Department of Children and Families, in consultation with the Department of Education, shall conduct a review every other year to identify effective models of school-based behavioral health access, with an emphasis on underserved and rural communities. Such models must include, but are not limited to, telehealth services. The Department of Children and Families shall submit its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1 every other year, beginning in 2026.

Section 11. Subsection (6) of section 394.9085, Florida Statutes, is amended to read:

394.9085 Behavioral provider liability.—

(6) For purposes of this section, the terms

"detoxification," "addictions receiving facility," and "receiving facility" have the same meanings as those provided in ss. 397.311(27)(a)4., 397.311(27)(a)1., and 394.455 ~~394.455(40)~~, respectively.

Section 12. For the purpose of incorporating the amendment made by this act to section 394.468, Florida Statutes, in a reference thereto, paragraph (g) of subsection (2) of section 394.463, Florida Statutes, is reenacted to read:

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.—

(g) The examination period must be for up to 72 hours and begins when a patient arrives at the receiving facility. For a minor, the examination shall be initiated within 12 hours after the patient's arrival at the facility. Within the examination period, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;

2. The patient shall be released, subject to subparagraph 1., for voluntary outpatient treatment;

3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient and, if such consent is given, the patient shall be admitted as a voluntary patient; or

4. A petition for involuntary services shall be filed in the circuit court or with the county court, as applicable. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the

patient's condition shall be made available. The petition shall be filed by one of the petitioners specified in s. 394.467, and the court shall dismiss an untimely filed petition. If a patient's 72-hour examination period ends on a weekend or holiday, including the hours before the ordinary business hours on the morning of the next working day, and the receiving facility:

a. Intends to file a petition for involuntary services, such patient may be held at the facility through the next working day thereafter and the petition must be filed no later than such date. If the facility fails to file the petition by the ordinary close of business on the next working day, the patient shall be released from the receiving facility following approval pursuant to paragraph (f).

b. Does not intend to file a petition for involuntary services, the receiving facility may postpone release of a patient until the next working day thereafter only if a qualified professional documents that adequate discharge planning and procedures in accordance with s. 394.468, and approval pursuant to paragraph (f), are not possible until the next working day.

Section 13. For the purpose of incorporating the amendment made by this act to section 394.495, Florida Statutes, in references thereto, paragraph (c) of subsection (2) and subsection (6) of section 394.4955, Florida Statutes, are reenacted to read:

394.4955 Coordinated system of care; child and adolescent mental health treatment and support.—

(2)

(c) To the extent permitted by available resources, the coordinated system of care shall include the array of services listed in s. 394.495.

(6) The managing entity shall identify gaps in the arrays of services for children and adolescents listed in s. 394.495 available under each plan and include relevant information in its annual needs assessment required by s. 394.9082.

Section 14. For the purpose of incorporating the amendment made by this act to section 1004.44, Florida Statutes, in a reference thereto, subsection (7) of section 1001.212, Florida Statutes, is reenacted to read:

1001.212 Office of Safe Schools.—There is created in the Department of Education the Office of Safe Schools. The office is fully accountable to the Commissioner of Education. The office shall serve as a central repository for best practices, training standards, and compliance oversight in all matters regarding school safety and security, including prevention efforts, intervention efforts, and emergency preparedness planning. The office shall:

(7) Provide data to support the evaluation of mental health services pursuant to s. 1004.44. Such data must include, for each school, the number of involuntary examinations as defined in s. 394.455 which are initiated at the school, on school transportation, or at a school-sponsored activity and the number of children for whom an examination is initiated.

Section 15. This act shall take effect July 1, 2025.

657304

LEGISLATIVE ACTION

Senate . House

. . . . .

The Committee on Children, Families, and Elder Affairs (Rouson) recommended the following:

Senate Amendment (with title amendment)

Delete lines 122 - 151

and insert:

Section 4. Subsection (4) is added to section 394.468, Florida Statutes, to read:

394.468 Admission and discharge procedures.—

(4) The department must review the discharge procedure for all receiving facilities and evaluate current policy, strategies, and actions taken to meet the need for access to

657304

prescribed behavioral health medications at discharge. The evaluation must include data related to medication adherence and readmission rates of discharged patients. The department must, in collaboration with the Agency for Health Care Administration, report findings from the evaluation and provide actionable policy recommendations and cost estimates to increase medication adherence of patients after discharge, increase access to prescribed behavioral health medications for uninsured and underinsured patients at discharge, and increase the use of long-acting injectables as a discharge medication. The report must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31, 2025.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete lines 10 - 13

and insert:

amending s. 394.495, F.S.; requiring an evaluation and report to the Legislature on receiving facility discharge procedures and access to prescribed behavioral health medications on discharge by a specified date; amending

420638

LEGISLATIVE ACTION

Senate . House

. . . . . .

The Committee on Children, Families, and Elder Affairs (Rouson) recommended the following:

Senate Amendment (with title amendment)

Delete lines 220 - 395

and insert:

treatment facilities. The agency shall give priority in issuing licenses to short-term residential treatment facilities located in counties identified by the review.

Section 8. Paragraph (a) of subsection (4) of section 394.9086, Florida Statutes, is amended to read:

394.9086 Commission on Mental Health and Substance Use

420638

Disorder.—

(4) DUTIES.—

(a) The duties of the Commission on Mental Health and Substance Use Disorder include the following:

1. Conducting a review and evaluation of the management and functioning of the existing publicly supported mental health and substance use disorder systems and services in the department, the Agency for Health Care Administration, and all other departments which administer mental health and substance use disorder services. Such review must ~~shall~~ include, at a minimum, a review of current goals and objectives, current planning, services strategies, coordination management, purchasing, contracting, financing, local government funding responsibility, and accountability mechanisms.

2. Considering the unique needs of persons who are dually diagnosed.

3. Addressing access to, financing of, and scope of responsibility in the delivery of emergency behavioral health care services.

4. Addressing the quality and effectiveness of current mental health and substance use disorder services delivery systems, and professional staffing and clinical structure of services, roles, and responsibilities of public and private providers, such as community mental health centers; community substance use disorder agencies; hospitals, including emergency services departments; law enforcement agencies; and the judicial system.

5. Addressing priority population groups for publicly funded mental health and substance use disorder services;~~,~~

420638

identifying the comprehensive mental health and substance use disorder services delivery systems;~~,~~ mental health and substance use disorder needs assessment and planning activities, including, but not limited to, the use of the Daily Living Activities-20 functional assessment tool as described in s. 1006.041(2)(b); and local government funding responsibilities for mental health and substance use disorder services.

6. Reviewing the implementation of chapter 2020-107, Laws of Florida.

7. Identifying any gaps in the provision of mental health and substance use disorder services.

8. Providing recommendations on how behavioral health managing entities may fulfill their purpose of promoting service continuity and work with community stakeholders throughout this state in furtherance of supporting the 988 Suicide and Crisis Lifeline system and other crisis response services.

9. Conducting an overview of the current infrastructure of the 988 Suicide and Crisis Lifeline system.

10. Analyzing the current capacity of crisis response services available throughout this state, including services provided by mobile response teams and centralized receiving facilities. The analysis must include information on the geographic area and the total population served by each mobile response team along with the average response time to each call made to a mobile response team; the number of calls that a mobile response team was unable to respond to due to staff limitations, travel distance, or other factors; and the veteran status and age groups of individuals served by mobile response teams.

420638

11. Evaluating and making recommendations to improve linkages between the 988 Suicide and Crisis Lifeline infrastructure and crisis response services within this state.

12. Identifying available mental health block grant funds that can be used to support the 988 Suicide and Crisis Lifeline and crisis response infrastructure within this state, including any available funding through opioid settlements or through the American Rescue Plan Act of 2021, Pub. L. No. 117-2; the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136; or other federal legislation.

13. In consultation with the Agency for Health Care Administration, identifying sources of funding available through the Medicaid program specifically for crisis response services, including funding that may be available by seeking approval of a Section 1115 waiver submitted to the Centers for Medicare and Medicaid Services.

14. Making recommendations regarding the mission and objectives of state-supported mental health and substance use disorder services and the planning, management, staffing, financing, contracting, coordination, and accountability mechanisms which will best foster the recommended mission and objectives.

15. Evaluating and making recommendations regarding the establishment of a permanent, agency-level entity to manage mental health, substance use disorder, and related services statewide. At a minimum, the evaluation must consider and describe the:

a. Specific duties and organizational structure proposed for the entity;

b. Resource needs of the entity and possible sources of funding;

c. Estimated impact on access to and quality of services;

d. Impact on individuals with behavioral health needs and their families, both those currently served through the affected systems providing behavioral health services and those in need of services; and

e. Relation to, integration with, and impact on providers, managing entities, communities, state agencies, and systems which provide mental health and substance use disorder services in this state. Such recommendations must ensure that the ability of such other agencies and systems to carry out their missions and responsibilities is not impaired.

16. Evaluating and making recommendations regarding skills-based training that teaches participants about mental health and substance use disorder issues, including, but not limited to, Mental Health First Aid models.

Section 9. Paragraph (a) of subsection (6) of section 1004.44, Florida Statutes, is amended, and subsection (8) are added to that section, to read:

1004.44 Louis de la Parte Florida Mental Health Institute.—There is established the Louis de la Parte Florida Mental Health Institute within the University of South Florida.

(6)(a) There is established within the institute the Florida Center for Behavioral Health Workforce. The purpose of the center is to support an adequate, highly skilled, resilient, and innovative workforce that meets the current and future human resources needs of the state’s behavioral health system in order to provide high-quality care, services, and supports to

420638

Floridians with, or at risk of developing, behavioral health conditions through original research, policy analysis, evaluation, and development and dissemination of best practices. The goals of the center are, at a minimum, to research the state's current behavioral health workforce and future needs; expand the number of clinicians, professionals, and other workers involved in the behavioral health workforce; and enhance the skill level and innovativeness of the workforce. The center shall, at a minimum, do all of the following:

1. Describe and analyze the current workforce and project possible future workforce demand, especially in critical roles, and develop strategies for addressing any gaps. The center's efforts may include, but need not be limited to, producing a statistically valid biennial analysis of the supply and demand of the behavioral health workforce.

2. Expand pathways to behavioral health professions through enhanced educational opportunities and improved faculty development and retention. The center's efforts may include, but need not be limited to:

a. Identifying best practices in the academic preparation and continuing education of behavioral health professionals.

b. Facilitating and coordinating the development of academic-practice partnerships that support behavioral health faculty employment and advancement.

c. Developing and implementing innovative projects to support the recruitment, development, and retention of behavioral health educators, faculty, and clinical preceptors.

d. Developing distance learning infrastructure for behavioral health education and the evidence-based use of

420638

technology, simulation, and distance learning techniques.

3. Promote behavioral health professions. The center's efforts may include, but need not be limited to:

a. Conducting original research on the factors affecting recruitment, retention, and advancement of the behavioral health workforce, such as designing and implementing a longitudinal study of the state's behavioral health workforce.

b. Developing and implementing innovative projects to support the recruitment, development, and retention of behavioral health workers.

4. Analyze compensation and benefit data every other year to

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete lines 30 - 37

and insert:

agency to prioritize specified facilities in issuing licenses; amending s. 394.9086, F.S.; revising the duties of the Commission on Mental Health and Substance Use Disorder; amending s. 1004.44, F.S.; revising the requirements of