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 886
INTRODUCER:	Senator Leek
SUBJECT:	Coordinated Systems of Care
DATE:	March 31, 2025
REVISED:	

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

I. Summary:

SB 886 establishes the Crisis Care Coordination Pilot Program in Polk and Volusia Counties, contingent upon legislative appropriation. The Department of Children and Families (DCF), through the managing entities (MEs), is tasked with administering the program, which is designed to offer community-based care coordination and support services to individuals following a mental health-related contact with law enforcement, including instances involving involuntary examinations.

The program must provide interventions such as assessment, safety planning, supportive counseling, and help accessing recommended services. These services are required to be delivered by nationally accredited community mental health centers in partnership with local law enforcement agencies. The primary goals include reducing the number of repeat involuntary examinations, decreasing the time law enforcement spends on post-crisis follow-up, improving access to mental health care, and offering an alternative to law enforcement involvement in future crisis situations.

DCF is required to submit a report by January 1, 2026, to the Governor and Legislature evaluating the program's outcomes and recommending whether it should be expanded to other local governments. The pilot program and the statute establishing it are repealed effective July 1, 2027, unless reenacted.

The bill will likely have an indeterminate negative fiscal impact. *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

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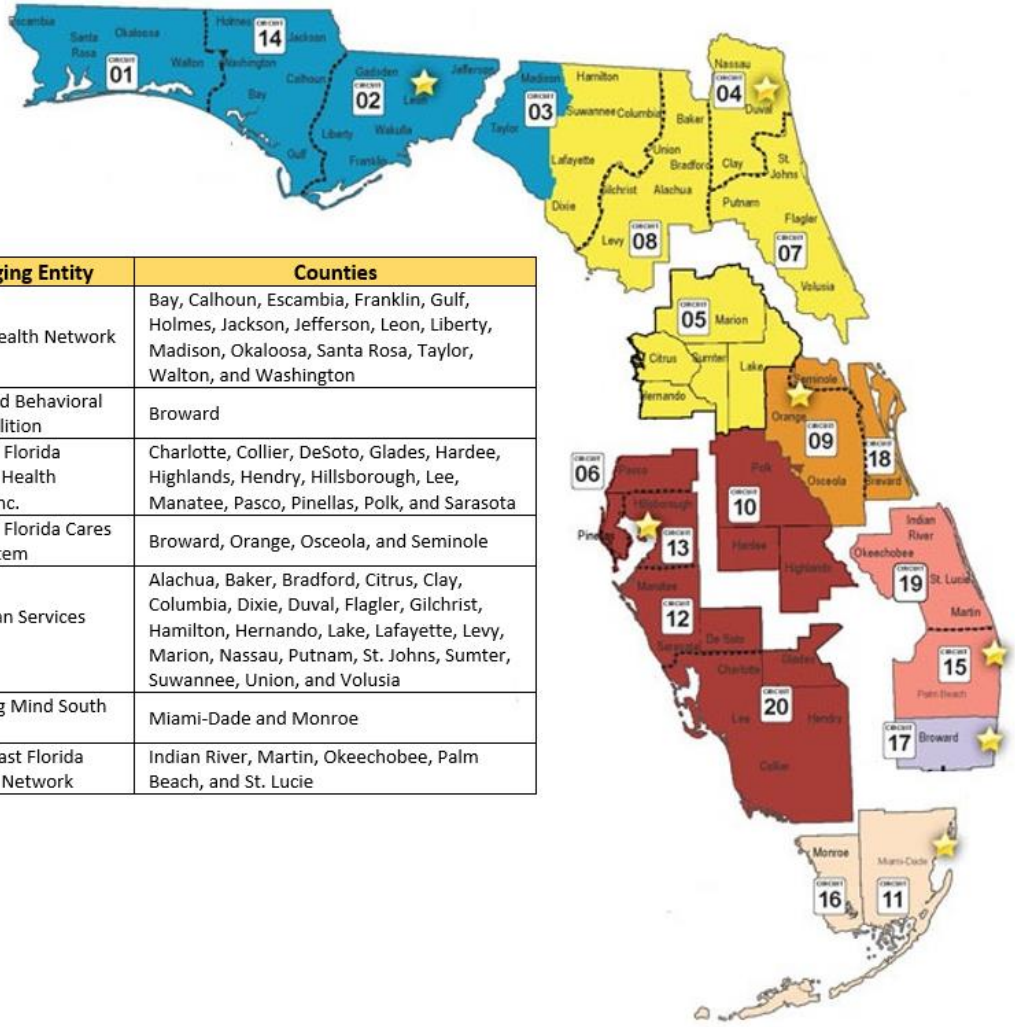
[1] World Health Organization, *Mental Health: Strengthening Our Response*, available at: https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (last visited last visited 3/7/25).
[2] Centers for Disease Control and Prevention, *Mental Health Basics*, available at: 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.

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 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 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

[8] Ch. 2008-243, Laws of Fla.
[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.

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]

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

Coordinated System of Care

MEs 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 an ME 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 MEs.[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;

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[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).
[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.

- Family support;
- Respite services;
- Outpatient treatment;
- Crisis stabilization;
- Therapeutic foster care;
- 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 network of qualified providers to deliver services.
- Monitor network provider performance and compliance with contract requirements.[24]

Mobile Response Teams

As of March 21, 2025, the DCF supports 55 Mobile Response Teams (MRTs) positioned throughout the state to deliver 24/7, on-site behavioral health crisis services.[2526] These teams are deployed in emergency situations and are funded through contracts between MEs and local behavioral health providers.[27] Each MRT is staffed with a multidisciplinary team, including

[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] Section 394.495, F.S.
[26] Florida Department of Children and Families, *Mobile Response Teams*, available at https://www.myflfamilies.com/services/samh/mobile-response-teams (last visited March 26, 2025).
[27] Section 394.495(7)(c), F.S.

licensed mental health professionals, psychiatric nurse practitioners, on-call psychiatrists, certified peer recovery specialists, and support personnel[28]. The core function of MRTs is to provide short-term crisis intervention, which includes conducting assessments, de-escalating and stabilizing individuals in crisis, offering counseling and safety planning, delivering psychoeducation, and ensuring a smooth transition to long-term care services.[29]

Current law requires MRTs to serve, at a minimum, children, adolescents, and young adults ages 18 to 25 who manifest any of the following acute mental health crisis symptoms:[30]

- Have an emotional disturbance;
- Are experiencing an actual mental or emotional crisis;
- Are experiencing escalating emotional or behavioral reactions and symptoms that impact their ability to function typically within the family, living situation, or community environment; or
- Are served by the child welfare system and are experiencing or are at high risk of placement instability.

Current law sets the minimum standards for MRTs and they must:[31]

- Triage and prioritize requests, then, to the extent permitted by available resources, respond in person within 60 minutes of prioritization;
- Respond to a crisis in the location where the crisis is occurring;
- Provide behavioral health crisis-oriented services that are responsive to the needs of the child, adolescent, or young adult and his or her family and enable them to deescalate and respond to behavioral health challenges through evidence-based practices;
- Provide screening, standardized assessments, early identification, and referrals to community services;
- Provide care coordination by facilitating the transition to ongoing services;
- Ensure a process for informed consent and confidentiality compliance measures is in place;
- Promote information sharing and the use of innovative technology; and
- Coordinate with the managing entity and other key entities providing services and supports to the child, adolescent, or young adult and their family.

The Baker Act

The Florida Mental Health Act, commonly referred to as the Baker At, was enacted in 1971 to revise the state's mental health commitment laws.[32] The Act includes legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It, additionally, protects the rights of all individuals examined or treated for mental illness in Florida.[33]

[28] Florida Department of Children and Families, *Mobile Response Teams*, available at https://www.myflfamilies.com/services/samh/mobile-response-teams (last visited March 26, 2025).
[29] *Id.*
[30] Section 394.495(7)(a), F.S., Section 394.495(5)(q), F.S., Section 394.495(1), F.S.
[31] Section 394.495(7)(b), F.S.
[32] The Baker Act is contained in Part I of Ch. 394, F.S.
[33] Section 394.459, F.S.

DCF is responsible for the operation and administration of the Baker Act, including publishing an annual Baker Act report. According to the Fiscal Year (FY) 2021-2022 Baker Act Annual Report, over 170,000 individuals were involuntarily examined under the Baker Act; of those, just over 11,600 individuals were 65 years of age or older. This age group is the most likely to include individuals with Alzheimer's disease or related dementia. It is important to note the number of Baker Acts per year decreased during FY 2018-2019, FY 2019-2020, FY 2020-2021, across all age groups.[34]

Receiving Facilities and Involuntary Examination

Individuals in an acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[35] Individuals receiving services on an involuntary basis must be taken to a facility that has been designated by DCF as a receiving facility.

Receiving facilities, often referred to as Baker Act receiving facilities, are public or private facilities designated by DCF to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider.[36] A public receiving facility is a facility that has contracted with an ME to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose.[37] Funds appropriated for Baker Act services may only be used to pay for services diagnostically and financially eligible persons, or those who are acutely ill, in need of mental health services, and the least able to pay.[38] Currently, there are 120 DCF designated receiving facilities.[39]

Involuntary Examination

An involuntary examination is required if there is reason to believe that the person has a mental illness and, because of his or her mental illness, has refused voluntary examination, is likely to refuse to care for him or herself to the extent that such refusal threatens to cause substantial harm to that person's well-being, and such harm is unavoidable through the help of willing family members or friends, or will cause serious bodily harm to him or herself or others in the near future based on recent behavior.[40]

An involuntary examination may be initiated by:

- A court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;[41] or
- A physician, clinical psychologist, psychiatric nurse, an autonomous advanced practice registered nurse, mental health counselor, marriage and family therapist, or clinical social worker executing a certificate stating that he or she has examined a person within the

[34] DCF, *Agency Bill Analysis* (2023), on file with the Senate Children, Families, and Elder Affairs Committee.
[35] Sections 394.4625 and 394.463, F.S.
[36] Section 394.455(40), F.S. This term does not include a county jail.
[37] Section 394.455(38), F.S.
[38] R. 65E-5.400(2), F.A.C.
[39] DCF, *SB 1620 Agency Bill Analysis* (2025), on file with the Senate Children Families, and Elder Affairs Committee.
[40] Section 394.463(1), F.S.
[41] Section 394.463(2)(a)1., F.S. The order of the court must be made a part of the patient's clinical record.

preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination, including a statement of the professional's observations supporting such conclusion.[42]

Unlike the discretion afforded courts and medical professionals, current law mandates that law enforcement officers must initiate an involuntary examination of a person who appears to meet the criteria by taking him or her into custody and delivering or having the person delivered to a receiving facility for examination.[43] When transporting, officers are currently required to restrain the person in the least restrictive manner available and appropriate under the circumstances.[44] The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made part of the patient's clinical record. The report must also include all emergency contact information for the person that is readily accessible to the law enforcement officer, including information available through electronic databases maintained by the Florida Department of Law Enforcement (FDLE) or by the Department of Highway Safety and Motor Vehicles.

Involuntary patients must be taken to either a public or private facility that has been designated by DCF as a Baker Act receiving facility. Under the Baker Act, a receiving facility has up to 72 hours to examine an involuntary patient.[45] During those 72 hours, an involuntary patient must be examined by a physician, clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist at a facility to determine if the criteria for involuntary services are met.[46] Current law does not indicate when the examination period begins for an involuntary patient. However, if the patient is a minor, a receiving facility must initiate the examination within 12 hours of arrival.[47]

Within that 72-hour examination period, one of the following must happen:[48]

- The patient must be released, unless he or she is charged with a crime, in which case, law enforcement will assume custody;
- The patient must be released for voluntary outpatient treatment;
- The patient, unless charged with a crime, must give express and informed consent to be placed and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.

If the patient's 72-hour examination period ends on a weekend or holiday, and the receiving facility:[49]

- Intends to file a petition for involuntary services, the patient may be held at a receiving facility through the next working day and the petition for involuntary services must be filed no later than such date. If the receiving facility fails to file a petition at the close of the next

[42] Section 394.463(2)(a)3., F.S. The report and certificate must be made a part of the patient's clinical record.
[43] Section 394.463(2)(a)2., F.S.
[44] *Id.*
[45] Section 394.463(2)(g), F.S.
[46] Section 394.463(2)(f), F.S.
[47] Section 394.463(2)(g), F.S.
[48] *Id.*
[49] Section 394.463(2)(g)4., F.S.

working day, the patient must be released from the receiving facility upon documented approval from a psychiatrist or clinical psychologist.
- Does not intend to file a petition for involuntary services, the receiving facility may postpone release of a patient until the next working day if a qualified professional documents that adequate discharge planning and procedures and approval from a psychiatrist or clinical psychologist are not possible until the next working day.

The receiving facility may not release an involuntary examination patient without the documented approval of a psychiatrist or a clinical psychologist. However, if the receiving facility is owned or operated by a hospital or health system, or a nationally accredited community mental health center, a psychiatric nurse performing under the framework of an established protocol with a psychiatrist is permitted to release a Baker Act patient in specified community settings. However, a psychiatric nurse is prohibited from approving a patient's release if the involuntary examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist.[50]

Law Enforcement

Individuals in mental health crisis are more likely to encounter law enforcement than to receive a coordinated crisis care response.[51] The Florida Criminal Justice Executive Institute (FCJEI), the research and educational arm of the FDLE,[52] published a commanding officer's independent research project to document law enforcement's response to community mental health crisis events. The literature review component emphasized the dangers associated with mental health crisis, the strain on police resources, criticism of police response, liability issues, and training challenges. The poll-based survey of 68 police departments across the state measured the amount of Baker Acts completed during the 2021 calendar year. Of the 33 police departments that responded,[53] 23 departments completed more than 90 Baker Act crisis calls during 2021. In addition, all 33 responding departments indicated they repeatedly respond to certain individuals experiencing recurring mental health crises.[54]

The FCJEI survey also revealed that any partnership between law enforcement and mental health professionals in Florida is a discretionary decision made at the police department level. At the time of the report's publication:[55]
- Seven police departments were considering partnerships.
- Six police departments were not considering partnerships.

[50] Section 394.463(2)(f). F.S.
[51] National Council of State Legislatures, *Crisis Intervention and Community-Based Services*, available at https://www.ncsl.org/civil-and-criminal-justice/crisis-intervention-and-community-based-services (last visited March 27, 2025).
[52] Florida Department of Law Enforcement, Florida Criminal Justice Executive Institute, *FCJEI History*, available at https://www.fdle.state.fl.us/FCJEI/History/FCJEI-History-Home.aspx (last visited March 27, 2025).
[53] Florida Department of Law Enforcement, Florida Criminal Justice Executive Institute, SLP Research Papers Author Index, *Officer's Response to Community Mental Health Crisis* (Ramirez, Marcos), available at https://www.fdle.state.fl.us/FCJEI/Programs/SLP/Documents/Full-Text/Ramirez,-Marcos-paper.aspx (last visited March 27, 2025).
[54] *Id.*
[55] Policy Research Inc. and The National League of Cities, *Responder Models: The Roles of Cities, Counties, Law Enforcement, and Providers*, available at https://www.nlc.org/wp-content/uploads/2020/10/RespondingtoBHCrisisviaCRModels.pdf (last visited March 27, 2025).

- Ten police departments entered partnerships.
- Three police departments offered nuanced answers.

Co-Responder Models

The co-responder model is a collaborative approach that pairs law enforcement officers with mental health or substance use professionals to address behavioral health crises in real-time.[56] The co-responder model offers a number of key advantages that are reshaping how communities respond to behavioral health crises. One of the most significant benefits is its role in de-escalation and diversion.[57] By embedding mental health professionals alongside law enforcement, these teams are better equipped to calm potentially volatile situations and steer individuals away from arrest or hospitalization. Instead of being taken to jail or an emergency department, individuals in crisis can be connected directly to appropriate mental health or substance use services.[58] Communities implementing these programs also report improved outcomes. Jurisdictions frequently see reductions in repeat 911 calls involving the same individuals, lower arrest rates for people with mental health issues, and increased linkage to care.[59]

Another strength of the co-responder model is its flexibility and adaptability to local contexts. In some cities, clinicians are embedded directly within police departments, promoting real-time collaboration between officers and behavioral health professionals. In other areas, law enforcement agencies partner with community-based mental health organizations to provide the same support through external coordination.[60] Additionally, many co-responder programs are connected to mobile crisis units and include follow-up case management, creating a continuum of care that supports individuals beyond the immediate crisis[61]

The U.S. Department of Justice's Bureau of Justice Assistance offers the Connect and Protect: Law Enforcement Behavioral Health Response Program, providing grants to support collaborative efforts between law enforcement and behavioral health agencies.[62] Similarly, the Substance Abuse and Mental Health Services Administration (SAMHSA) has recognized the

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[56] National Criminal Justice Association, *Nearly Half of Police Agencies Have Co-Responder Programs*, available at https://www.ncja.org/crimeandjusticenews/nearly-half-of-police-agencies-have-co-responder-programs (last visited March 27, 2025).
[57] The International Association of Chiefs of police (IACP), *Assessing the Impact of Co-Responder Team Programs: A Review of Research, Academic Training to Inform Police Responses, Best Practice Guide*, available at https://www.theiacp.org/sites/default/files/IDD/Review%20of%20Co-Responder%20Team%20Evaluations.pdf (last visited March 27, 2025).
[58] *Id.*
[59] Stanford Graduate School of Education, *Stanford study shows significant benefits when mental health clinicians and police officers respond to 911 calls*, available at https://gardnercenter.stanford.edu/news/stanford-study-shows-significant-benefits-when-mental-health-clinicians-and-police-officers?utm_source=chatgpt.com (last visited March 27, 2025).
[60] The International Association of Chiefs of police (IACP), *Assessing the Impact of Co-Responder Team Programs: A Review of Research, Academic Training to Inform Police Responses, Best Practice Guide*, available at https://www.theiacp.org/sites/default/files/IDD/Review%20of%20Co-Responder%20Team%20Evaluations.pdf (last visited March 27, 2025).
[61] *Id.*
[62] United States Department of Justice, Bureau of Justice Assistance, *FY 2024 Connect and Protect: Law Enforcement Behavioral Health Response Program*, available at https://bja.ojp.gov/funding/fy24-sol-overview-connect.pdf (last viewed March 27, 2025).

importance of these collaborations and aims to enhance the capacity of mobile crisis response teams and improve crisis stabilization in communities.[63] These developments underscore a growing recognition of the co-responder model as a vital component of a more humane and effective public safety system.

Crises Care Coordination Pilot

A crisis care coordination program is a targeted intervention that supports individuals shortly after a behavioral health crisis, such as a psychiatric hospitalization, suicidal episode or behavioral health crises involving law enforcement interaction.[64] Within a short window, often 7 to 10 days following the crisis, trained professionals provide follow-up contact to assess the individual's current needs, reinforce treatment plans, and connect them with local mental health services, housing support, or other resources.[65] The primary goals are to reduce the likelihood of repeat crises, improve treatment engagement, and support long-term recovery.[66]

Over the past three years this model has been operational within Polk County Florida; funded through approved GAA funds, the model seeks to improve mental health and reduce the recidivism of individuals who were under a Baker Act initiated by law enforcement.[67] The provision of follow up services within 10 days of discharge by this Community Mobile Support Team (CMST) has shown decreased suicidality and improved overall mental health, as demonstrated by the Columbia Suicide Risk Assessment and PHQ-9/PSC-17 assessments.[68] The Polk County CMST reported that in 2023, the team provided more than 7,000 follow up services to 2,620 people resulting in a 16% reduction in Baker Acts initiated by law enforcement.

III. Effect of Proposed Changes:

Section 1 creates s. 394.45731, F.S., to establish the Crisis Care Coordination Pilot Program in Polk and Volusia Counties, subject to appropriation. The program must be administered by the DCF and is designed to provide community-based care coordination and follow-up support to individuals who have had a mental health-related encounter with law enforcement. This includes individuals who have been subject to involuntary examinations initiated by law enforcement under the Baker Act.

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[63] Department of Health and Human Services, *Substance Abuse and mental Health Servies Administration, FY 2022 Cooperative Agreement s for Innovative Community Crisis response Partnerships*, available at https://www.samhsa.gov/sites/default/files/grants/pdf/fy-22-community-crisis-response-partnerships.pdf (last visited March 27, 2025).

[64] Substance Abuse and Mental Health Services Administration, *National Behavioral Health Crisis Care Guidelines*, available at https://www.samhsa.gov/mental-health/national-behavioral-health-crisis-care (last viewed March 27, 2025).

[65] Centers for Medicare and Medicaid Services, *Improving Behavioral Health Follow-up Care Affinity Group Fact Sheet,* available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/improvement-initiatives/behavioral-health-ag-factsheet.pdf?utm_source=chatgpt.com (last viewed March 27, 2025).

[66] Substance Abuse and Mental Health Services Administration, *2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care*, available at https://988crisissystemshelp.samhsa.gov/sites/default/files/2024-12/National%20Guidelines%20for%20a%20Behavioral%20Health%20Coordinated%20System%20of%20Crisis%20Care-12-2-2024_508.pdf?utm_source=chatgpt.com (last visited March 27, 2025).

[67] The Florida Senate Local Funding Initiative Request, Fiscal Year 2025-2026, *LFIR #1007*, Senator Burton, available at: https://www.flsenate.gov/PublishedContent/Session/FiscalYear/FY2025-26/LocalFundingInitiativeRequests/FY2025-26_S1007.pdf (last visited March 26, 2025).

[68] *Id.*

The bill requires that the pilot program deliver a set of specified intervention services, including assessment, safety planning, supportive counseling, and assistance in accessing recommended mental health services. These services must be delivered by nationally accredited community mental health centers, as defined in s. 394.907(1), F.S., and must be implemented in partnership with local law enforcement agencies.

The bill also directs the DCF to submit a report to the Governor, President of the Senate, and Speaker of the House of Representatives by January 1, 2026. This report must evaluate whether the pilot program has been effective in achieving its intended outcomes and include recommendations on whether the program should be expanded to other local governments.

The statute includes a sunset provision, repealing the pilot program effective July 1, 2027, unless reenacted by the Legislature.

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:

None.

C. Government Sector Impact:

The bill will have an indeterminate, significant negative fiscal impact.

Below are the approved Florida GAA funds for Peace River CMST, an analogous program to the proposed pilot, since 2022.

Peace River CMST is seeking $850,000 for FY 2025-2026 (SF 1007).[69]

Florida GAA Funding for Peace River CMST since 2022.		
Year	Source	Amount
FY 2024-25	Specific Appropriation 377[70] (SF 3136[71])	$425,000
FY 2023-24	Specific Appropriation 378[72] (SF 2077[73])	$425,000
FY 2022-23	Specific Appropriation 372[74] (SF 2377[75])	$850,000

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates Section 394.45731 of the 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.

[69] The Florida Senate Local Funding Initiative Request, Fiscal Year 2025-2026, *LFIR #1007*, Senator Burton, available at: https://www.flsenate.gov/PublishedContent/Session/FiscalYear/FY2025-26/LocalFundingInitiativeRequests/FY2025-26_S1007.pdf (last visited March 26, 2025).
[70] Chapter 2024-231, L.O.F.; Specific Appropriation 377
[71] The Florida Senate Local Funding Initiative Request, Fiscal Year 2024-2025, *LFIR #3136*, Senator Albritton, available at: https://www.flsenate.gov/PublishedContent/Session/FiscalYear/FY2024-25/LocalFundingInitiativeRequests/FY2024-25_S3136.pdf (last visited March 26, 2025).
[72] Chapter 2023-239, L.O.F.; Specific Appropriation 378
[73] The Florida Senate Local Funding Initiative Request, Fiscal Year 2023-2024, *LFIR #2077*, Senator Albritton, available at: https://www.flsenate.gov/PublishedContent/Session/FiscalYear/FY2023-24/LocalFundingInitiativeRequests/FY2023-24_S2077.PDF (last visited March 26, 2025).
[74] Chapter 2022-156, L.O.F.; Specific Appropriation 372
[75] The Florida Senate Local Funding Initiative Request, Fiscal Year 2022-2023, *LFIR #2377*, Senator Albritton, available at: https://www.flsenate.gov/PublishedContent/Session/FiscalYear/FY2022-23/LocalFundingInitiativeRequests/FY2022-23_S2377.PDF (last visited March 26, 2025).

B. Amendments:

None.