Commission on Mental Health and Substance Use Disorder
Final Report

September 1, 2026

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Message from the Chair

Thank you for taking the time to read the State of Florida's Commission on Mental Health and Substance Use Disorder Final Report. In 2021, the Florida Legislature created the Commission on Mental Health and Substance Use Disorder (Commission) to review the mental health and substance use disorder treatment and delivery systems in the State of Florida and to make recommendations to ensure that Florida provides the best possible behavioral healthcare for Floridians and their families. The first Commission report, issued in January 2023, presented the initial results of that review and offered a series of recommendations. During the 2023 legislative session, the Legislature extended both the timeframe and scope of the Commission and directed the submission of annual Interim Reports over the next two years, with a final report due September 1, 2026. This document represents the Commission's legislatively directed final report.

Over its five-year existence, the Commission has heard hundreds of hours of testimony and presentations on the wide range of mental health and substance use disorder treatment systems, approaches, and philosophies used across Florida and the nation. Subject matter experts have generously contributed their time and expertise, gathering and presenting data for the Commission's consideration. Family members and individuals with lived experience have also played a central role – as appointed Commissioners, subject matter experts, and meeting participants – ensuring that the voices of those most directly affected remain at the forefront of the Commission's work.

As detailed in this report, many of the Commission's recommendations have been enacted by the Legislature, particularly through the Commission Bill co-sponsored by Commissioners Senator Darryl Rouson and Representative Christine Hunschofsky during the 2025 Legislative Session. Over the past five years, this Commission has engaged in the most in-depth, cross-agency and collaborative examination of Florida's behavioral health system to date, resulting in the broadest range of recommendations to be incorporated into statute or Executive Agency practice. Commissioners and subject matter experts alike have demonstrated remarkable dedication and passion, and it has been noted repeatedly that this is not a Commission whose recommendations were simply published and set aside. Instead, the Commission's work has directly contributed to meaningful improvements across Florida's behavioral health system of care, driven largely by the insights of individuals with firsthand experience in leading, managing, delivering, and receiving care.

With the publication of this Final Report, the Commission has completed the task set forth by the Legislature. As Chair, I extend my sincere gratitude to the individuals who made this work possible. First and foremost, I thank Governor DeSantis, the President of the Florida Senate, and the Speaker of the Florida House. Since its inception in 2021, the Commission has received unwavering support from Florida's elected leaders, and this effort has been thoroughly bipartisan. The Commission's success reflects their

commitment to examining and improving Florida's mental health and substance use disorder treatment capacity.

The State of Florida and I also owe a deep debt of gratitude to my fellow Commissioners. Thank you so much for your dedication and passion for improving the lives of Floridians living with mental and behavioral health challenges. Your work has been effective, inspiring, and a testament to your collective and extraordinary public service. Thank you for your commitment, your willingness to roll up your sleeves and examine such a breadth of complex data and proposals, and mostly for your passion for the individuals and families we serve.

The Commission's achievements have been made possible by our team of more than 50 subject matter experts. Experts in this field came from across Florida and across the United States, giving their time, giving their attention, giving their passion, and most of all, giving their energy and considerable talents to this project. Everyone impacted by behavioral health issues and receiving behavioral health care in Florida should recognize the absolute dedication of this group of exceptional individuals. I especially want to acknowledge the subject matter experts with lived experience, both family members and peers. Your willingness to come forward and speak from the most painful parts of your history for the improvement of care is awe inspiring. It has been a privilege to work alongside you. Thank you all for being such an extraordinary and dedicated group.

I also extend special thanks to Florida Department of Children and Families (DCF) Secretary Taylor Hatch, Assistant Secretary Amanda VanLaningham, Staff Director Amanda Regis and DCF as a whole, as well as to Agency for Health Care Administration (AHCA) Secretary Shevaun Harris and Chief of Staff Erica Floyd-Thomas, for your tireless involvement and for providing such excellent staff support for this Commission, both in terms of the organization of the Commission and the organization and production of our reports throughout this Commission. I must give particular recognition to Mr. Aaron Platt, who has served as the prime organizer and helmsman for the Commission since its inception. Mr. Platt's work has been invaluable. The Commission could not have made it here without his organizational skills, dedication, flexibility and calm mastery of the logistics of this undertaking. Coordinating a Commission of this scope and magnitude involves complex logistics, technical challenges, and a whole lot of very passionate and unusually articulate people, and Mr. Platt managed this with grace, skill and complete dedication. I am forever grateful to have worked side by side with him for the past three years on this most important project.

Finally, 2026 marks my 41st year working in the field of behavioral health. Throughout my career, I have witnessed extraordinary people meet challenges in amazing and unsung ways. Yet, I have never before had the opportunity to watch, firsthand, one of the largest states in the nation come together to improve care for individuals and families living with behavioral health conditions, mental illness and substance use disorders. This

Commission marks the high point, for me, of my professional career. I am so grateful to the Governor, the Legislature and my fellow Commissioners for the rare opportunity to learn from the best, to be part of the process, and to watch mental health history being made in the State of Florida – my adopted home. Thank you for giving me the privilege of being part of this Commission!

Jay Reeve, PhD
Chair, State of Florida Commission on Mental Health and Substance Use Disorder

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Introduction

The Commission on Mental Health and Substance Use Disorder (Commission) is charged with examining the implementation of mental health and substance use disorder services across Florida and identifying ways to strengthen the effectiveness of existing practices, procedures, programs, and initiatives. Its responsibilities include assessing gaps and barriers in service delivery, evaluating the adequacy of the 988 Florida Suicide & Crisis Lifeline and the broader crisis care continuum, and identifying any statutory or policy changes needed to support a more coordinated and effective behavioral health system. The Commission met quarterly, or at the call of the chair, through a combination of in-person and teleconference meetings.

Beginning January 2023, the Commission submitted annual interim reports outlining its findings and evidence-based recommendations for improving the delivery of mental health and substance use disorder services statewide. These reports were provided to the President of the Senate, the Speaker of the House of Representatives, and the Governor each year, culminating in this final report submitted on September 1, 2026.

To fulfill its statutory mandate, the chairperson designated subcommittees to examine specific components of the behavioral health system and to explore potential improvements based on data, testimony, and stakeholder input. These subcommittees allowed the Commission to focus on complex issues in greater depth and ensured that diverse expertise informs its work.

As this is the Commission's final report prior to its scheduled sunset in 2026, it not only summarizes the findings and activities of the past year but also highlights the Commission's broader impact on legislation, policy, and statewide behavioral health coordination. This concluding report reflects both the progress made and the ongoing needs that will remain beyond the Commission's tenure.

2025-2026 Commission Subcommittees

The Commission subcommittee structure evolved over time to better align membership with statutory responsibilities and to create opportunities for more focused, effective engagement. As the Commission's work progressed and statewide needs became clearer, subcommittees were reorganized, added, or consolidated to ensure the right expertise was applied to emerging priorities.

The graphic below illustrates how the subcommittee structure evolved from 2022 through 2025, reflecting the Commission's ongoing effort to adapt its work to Florida's behavioral health needs and system complexities.

In 2025, the Commission continued this adaptive approach by operating with four subcommittees dedicated to specific focus areas. Under this structure, the Commission advanced its work to examine and identify opportunities to strengthen Florida's behavioral health system. Descriptions of the Commission's 2025-2026 subcommittees are provided below.

Data Analysis

The Data Analysis subcommittee was responsible for reviewing behavioral health data collection and reporting practices across all available data systems and to identify options for developing a searchable statewide behavioral health data repository that can improve assessment of service quality and effectiveness, highlight gaps in current mental health and substance use disorder systems, and inform future data-driven goals and promising practices.

Dual Diagnosis Treatment

The Dual Diagnosis Treatment subcommittee was responsible for evaluating how Florida's system serves individuals with co-occurring behavioral health, substance use, developmental disability, and age-related conditions. Section 394.9086, F.S., including subsection 4(a)2, directed the Commission to consider the unique needs of people who are dually diagnosed. In 2025, the Subcommittee heard presentations and testimony on the assessment and treatment of individuals with dual disorders, including those with mental health diagnoses alongside substance use disorders, major medical conditions, developmental delays, autism spectrum disorders, or age-related brain and behavioral conditions such as Alzheimer's disease and dementia. It reviewed current and emerging best practices for emergency response and ongoing care and developed

recommendations for any needed modifications or additions to Florida's publicly funded behavioral health treatment system to better meet the needs of this population.

Funding

The Funding subcommittee was responsible for examining Florida's behavioral health funding mechanisms and recommending options for a more effective and coordinated financing structure. Section 394.9086, F.S., directs the Commission to evaluate and recommend optimal financing and contracting approaches for the state's mental health and substance use disorder treatment system. In 2025, the subcommittee reviewed current and emerging best practices in behavioral health financing and contracting – including the varied methodologies used by the Agency for Health Care Administration (AHCA), the Department of Children and Families (DCF), the Department of Education (DOE), the Department of Juvenile Justice (DJJ) and other public funders – to inform future options for improving funding and contracting practices across publicly funded behavioral health systems.

Strategy and Planning

The Strategy and Planning subcommittee was responsible for developing a cross-agency framework for statewide behavioral health strategy and planning. Section 394.9086, F.S., directs the Commission to address the optimal development of Florida's mental health and substance use disorder treatment system, and as the federally designated single state authority for behavioral health, DCF conducts annual planning to guide the delivery and financing of publicly funded services. The Subcommittee was charged with recommending an ongoing planning and evaluation structure that engages all state agencies funding behavioral health services, along with key stakeholders such as providers, managing entities, managed care organizations, advocates, individuals with lived experience, and subject-matter experts. In preparing for the Commission's anticipated sunset in 2026, the subcommittee reviewed best practices for cross-agency, publicly accessible statewide planning and developed recommendations for a sustainable framework through which the Legislature and Governor's Office can receive regular guidance on best-practice development of mental health and substance use disorder services across all publicly funded systems.

Florida Behavioral Health System of Care

DCF and AHCA play central roles in Florida's behavioral health system, overseeing services, supports, and recovery-oriented care for children and adults. DCF serves as the state's single authority for mental health and substance use disorders, acts as the state opioid treatment authority, and designates Baker Act receiving facilities. AHCA administers Florida's Medicaid program, guides statewide health policy and planning, and licenses key behavioral health facilities, including Crisis Stabilization Units and inpatient psychiatric hospitals.

DCF and AHCA work closely with other state partners, including the Department of Health (DOH), DOE, Agency for Persons with Disabilities (APD), and local governments, to deliver a coordinated continuum of mental health and substance use disorder services. These partnerships strengthen prevention efforts, crisis response, clinical treatment, and long-term recovery supports for Floridians.

Behavioral health services funded by DCF are administered through seven regional Managing Entities, which plan, coordinate, and subcontract for community-based mental health and substance use disorder services. This structure improves access, promotes continuity of care, and supports efficient and effective service delivery. Services coordinated through the Managing Entities include assessments, outpatient mental health and substance use treatment, case management, care coordination, residential services, peer support, crisis stabilization, Mobile Response Teams (MRTs), and supportive services such as housing and employment. A map of the seven Managing Entities and their coverage areas is provided in Appendix 1.

Florida Medicaid Behavioral Health Services

AHCA serves as the single state agency responsible for administering the Florida Medicaid program under Title XIX of the Social Security Act. In that role, AHCA has a direct responsibility to ensure that Medicaid recipients have access to medically necessary services that support health, stability, recovery, and long-term independence. Behavioral health is central to that mission. Mental health and substance use disorders affect individuals, families, caregivers, schools, providers, law enforcement, and communities across Florida. For that reason, AHCA's work in this area is not limited to compliance with federal and state requirements; the agency is committed to using Medicaid as a tool to improve access, strengthen coordination, support recovery, and help individuals receive the right care in the right setting at the right time.

Florida Medicaid covers a broad array of inpatient and outpatient behavioral health services designed to support a comprehensive approach to treatment and recovery. These services include assessments and evaluations, behavioral therapies, recovery support, targeted case management, crisis services, inpatient psychiatric care, substance use disorder treatment, and services that support children, youth, adults, and families with complex behavioral needs. Through the Florida Statewide Medicaid Managed Care (SMMC) program, Medicaid enrollees also have access to additional services or expanded benefits that support individuals with mental illness or substance use disorders, including short-term residential treatment, inpatient and ambulatory detoxification, intensive outpatient treatment, partial hospitalization, community-based wraparound services, evidence-based family therapies, crisis stabilization, mobile response services, day treatment for adults, and caregiver supports, such as respite, therapy, and training.

In 2025, AHCA implemented the third iteration of the SMMC program, known as SMMC 3.0. Through this procurement, AHCA secured new contractual commitments designed to improve access, coordination, accountability, and outcomes for Medicaid enrollees, including recipients with behavioral health needs. These contracts include enhanced care coordination and case management requirements, stronger provider and plan performance monitoring, expanded opportunities for value-based purchasing, and new managed care coverage of Florida Medicaid behavior analysis services. AHCA also negotiated plan commitments specifically aimed at improving behavioral health outcomes, including targets related to Screening, Brief Intervention, and Referral to Treatment (SBIRT) for pregnant enrollees, Medication Assisted Treatment (MAT) for pregnant enrollees diagnosed with opioid use disorder, and minimum requirements for after-hours and telemedicine appointment availability among child and adult psychiatrists.

AHCA recognizes that access to behavioral health services requires more than a covered benefit. It requires a functioning continuum of care that includes prevention; early intervention; crisis response; inpatient stabilization, when necessary; community-based treatment; recovery supports; and ongoing coordination. To advance that continuum, AHCA has pursued several significant behavioral health initiatives in 2025.

One of AHCA's most substantial efforts is its work to expand access to services provided in Institutions for Mental Diseases (IMDs) through federal waiver authority. IMDs are inpatient facilities primarily engaged in the diagnosis, treatment, or care of individuals with mental health or substance use disorders. Federal Medicaid law generally prohibits Medicaid reimbursement for services provided to adults ages 21 through 64 in IMDs, creating a longstanding gap in the behavioral health continuum for individuals who require intensive inpatient treatment. AHCA has worked to address this gap by developing and advancing an IMD waiver request that would allow Florida Medicaid to cover IMD services for eligible individuals for up to 90 days. This effort is intended to increase access to medically necessary inpatient behavioral health care, reduce pressure on other parts of the crisis system, and better support individuals with serious mental illness or substance use disorders who need a higher level of care.

Additionally, AHCA has advanced work related to Certified Community Behavioral Health Clinics (CCBHCs). CCBHCs are designed to provide comprehensive, evidence-based mental health and substance use disorder services and to improve access regardless of a person's ability to pay. In 2025, AHCA, in consultation with DCF and other stakeholders, submitted a state plan amendment to the Centers for Medicare & Medicaid Services (CMS) to seek federal approval for a prospective payment system for Medicaid reimbursement of behavioral health ambulatory services provided by CCBHCs. This work reflects AHCA's commitment to supporting an integrated, accountable, and sustainable model of community-based behavioral health care.

AHCA has also supported increased reimbursement for Mental Health Targeted Case Management services. Effective October 1, 2025, further funding was authorized to increase Medicaid rates for these services due to their critical contribution to the behavioral health continuum, helping adult, child, and adolescent Medicaid recipients with

mental health needs connect to services, navigate systems, maintain treatment engagement, and access supports that promote stability in the community.

In addition to these efforts, AHCA has proposed a new home and community-based services waiver for adults with serious mental illness. The proposed waiver would support individuals who are at-risk of institutionalization, including high utilizers of crisis services, by making additional community-based services available to recipients, caregivers, and families. The proposed service array includes independent living and skill building; peer support; supportive housing, living, and employment; transitional housing; intensive outpatient services; partial hospitalization; day treatment; ambulatory detoxification; residential services; and intensive multidisciplinary teams. This proposal is grounded in a person-centered approach to care that promotes independence, supports recovery, and helps individuals remain in their preferred living environments whenever clinically appropriate.

AHCA proposed changes to strengthen the Statewide Inpatient Psychiatric Program (SIPP), which provides intensive inpatient mental health treatment for Medicaid-eligible children and adolescents under age 21 with serious emotional disturbances. AHCA also requested funding during the 2026 Legislative Session to implement a tiered reimbursement rate design for SIPP services based on acuity and resource needs. This approach is intended to ensure that providers are appropriately compensated for serving children with the most complex behavioral health needs, reduce placement denials, and help prevent costly out-of-state placements when Florida children need intensive psychiatric care.

Quality improvement is another core component of AHCA's behavioral health strategy. Under SMMC 3.0, AHCA requires all managed care plans to conduct a Performance Improvement Project focused on improving child and adolescent mental health. This effort requires plans to work closely with hospitals on discharge planning and community aftercare and to use the Florida Encounter Notification Service to support timely communication among plans, primary care providers, behavioral health providers, and enrollees. Plan performance will be measured using nationally recognized Healthcare Effectiveness Data and Information Set (HEDIS) measures related to follow-up after hospitalization for mental illness and follow-up after emergency department visits for mental illness. By focusing on timely follow-up after a crisis or inpatient event, AHCA is seeking to close one of the most important gaps in the behavioral health continuum: the transition from acute care back to treatment and support in the community.

AHCA's behavioral health work also depends on strong interagency collaboration. AHCA continues to work closely with DCF to align Medicaid policy, service definitions, fee coding, and program operations with Florida's broader behavioral health system. This coordination is essential to ensure that Medicaid recipients experience a more connected system of care and that state resources are used effectively to support access, accountability, and measurable outcomes.

Collectively, these efforts reflect AHCA's commitment to improving behavioral health access and outcomes for Floridians served by Medicaid. AHCA's work in this area is both practical and deeply mission-driven: enhancing the service array, strengthening community-based care, supporting children and adults with complex needs, improving transitions after crisis events, investing in sustainable reimbursement models, and pursuing federal authority where needed to close gaps in care. AHCA's goal is always to advance innovative, person-centered, and accountable behavioral health solutions that help individuals receive timely care, support recovery, and live with dignity in their communities.

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Florida Behavioral Health Data

DCF supports Floridians facing behavioral health challenges by allocating funding to expand and sustain mental health and substance use disorder services. During Fiscal Year (FY) 2024-25, DCF funded services to 228,245 individuals, with 17.32 percent of those served being under the age of 18. More than 1,700 distinct diagnostic codes were recorded for individuals receiving DCF-funded mental health services. The three most common diagnoses were generalized anxiety disorder, major depressive disorder (recurrent and moderate), and schizoaffective disorder (bipolar type). Similarly, over 1,000 diagnostic codes were documented for individuals receiving DCF-funded substance use disorder services. The top three diagnoses were opioid dependence (uncomplicated), alcohol dependence (uncomplicated), and cannabis dependence (uncomplicated). The tables below present the top ten diagnoses for mental health and substance use disorder treatment programs for FY 2024-25.

Top Ten Mental Health Diagnosis Codes, FY 2024-2025	
Diagnostic Code	**# of Unique Individuals**
Generalized Anxiety Disorder	19,271
Major Depressive Disorder (Recurrent, Moderate)	16,865
Schizoaffective Disorder (Bipolar Type)	12,554
Schizophrenia (Unspecified)	12,374
Post-Traumatic Stress Disorder (Unspecified)	12,372
Attention-Deficit Hyperactivity Disorder (Combined Type)	9,816
Bipolar Disorder (Unspecified)	8,315
Major Depressive Disorder (Single Episode, Unspecified)	7,505
Major Depressive Disorder (Recurrent Severe Without Psychotic Features)	7,370
Major Depressive Disorder (Recurrent, Unspecified)	5,508

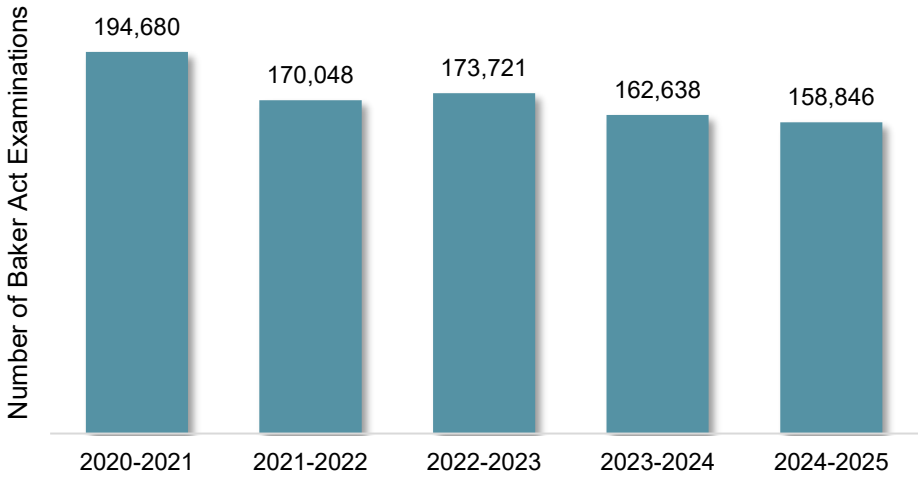
Top Ten Substance Use Diagnosis Codes, FY 2024-2025	
Diagnostic Code	**# of Unique Individuals**
Opioid Dependence (Uncomplicated)	20,798
Alcohol Dependence (Uncomplicated)	14,397
Cannabis Dependence (Uncomplicated)	7,730
Other Stimulant Dependence (Uncomplicated)	6,614
Cocaine Dependence (Uncomplicated)	6,079
Illness (Unspecified)	4,174
Cannabis Abuse (Uncomplicated)	4,152
Alcohol Abuse (Uncomplicated)	3,850

Generalized Anxiety Disorder	3,566
Opioid Dependence (In Remission)	2,597

Source: *Florida Department of Children and Families*

Baker Act Data

The Baker Act, formally known as the Florida Mental Health Act, authorizes families, courts, law enforcement and certain medical and mental health professionals to initiate emergency mental health evaluations. Individuals with mental illnesses may experience crisis episodes and require an examination by certain licensed behavioral health professionals. During FY 2024-25, there were 158,846 involuntary Baker Act examinations for 106,360 individuals, representing a two percent decrease in examinations from the previous fiscal year. Adults accounted for 81 percent of individuals examined; among adults, 58 percent were male, while among children, 60 percent were female. Across all age groups, 51 percent of examinations were initiated by law enforcement, 46 percent by health professionals, and three percent through the courts. Statewide trends over the past five fiscal years show an 18 percent decrease in involuntary examinations from FY 2020–21 to FY 2024–25. Additional information on Florida's Baker Act data are available on the Baker Act Annual Report: myflfamilies.com/services/samh/publications.



Source: Florida Department of Children and Families

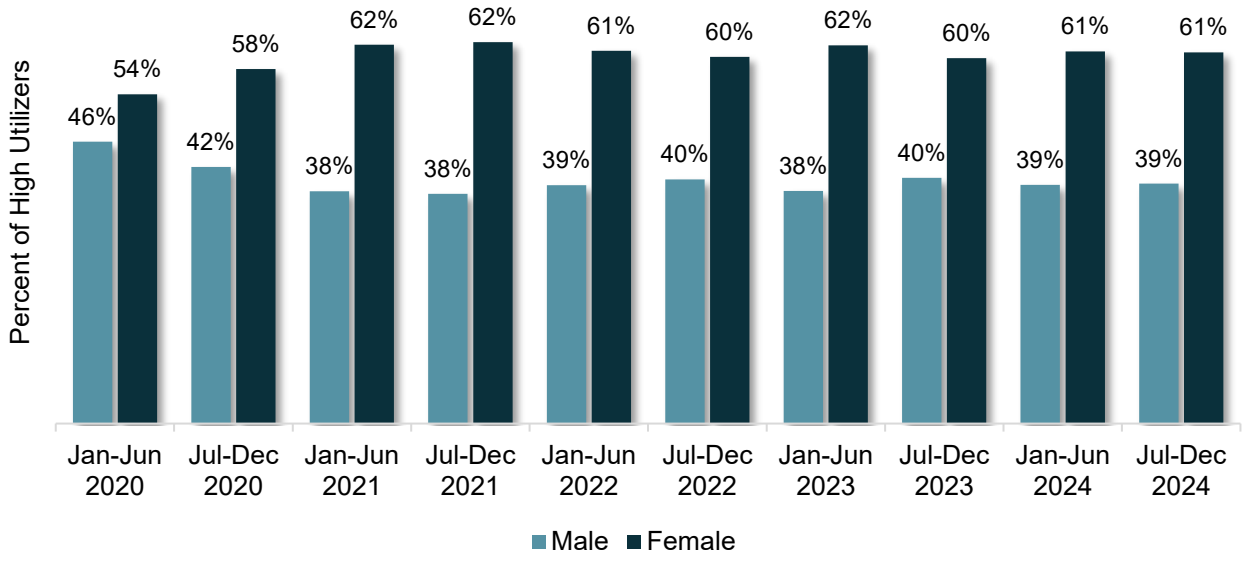
According to the DCF Baker Act Dashboard, additional data trends during FY 2024-25 indicate that among minors, the 15 to 17-year-old age group had the highest number of involuntary examinations, followed by 12 to 14-year-olds, with females comprising the majority in both groups. There were 8,435 high utilizers, defined as individuals with more than three involuntary Baker Act examinations within a 180-day period. Regionally, the DCF Southern Region (Miami-Dade and Monroe Counties) had the highest rate of high utilizers at 0.56 per 1,000 residents, followed by the Northeast Region at 0.48 per 1,000

residents. The Northwest and Southeast Regions reported the lowest rates at 0.29 and 0.33 per 1,000 residents, respectively. A map of the six DCF regions and their coverage areas is provided in Appendix 1. The DCF Baker Act dashboard can be viewed at: myflfamilies.com/BakerActDashboard.

High Utilizers of Crisis Stabilization Services

In 2020, House Bill 945 revised section 394.493, F.S., to direct AHCA and DCF to identify children and adolescents who are the highest users of crisis stabilization services and to work collaboratively, within available resources, to more effectively address their behavioral health needs. This legislative charge emphasizes early identification, coordinated intervention, and improved continuity of care for youth experiencing frequent behavioral health crises.

High utilization is defined in Rule 65E-5.100, Florida Administrative Code (F.A.C.), as an individual with three or more evaluations or admissions into a Crisis Stabilization Unit (CSU) or inpatient psychiatric hospital within a 180-day period or acute care admissions that last 16 days or longer. According to DCF data, which consists of individuals served by both DCF and Medicaid, females have consistently comprised more than half of high utilizer cases since 2020.



Source: Florida Department of Children and Families

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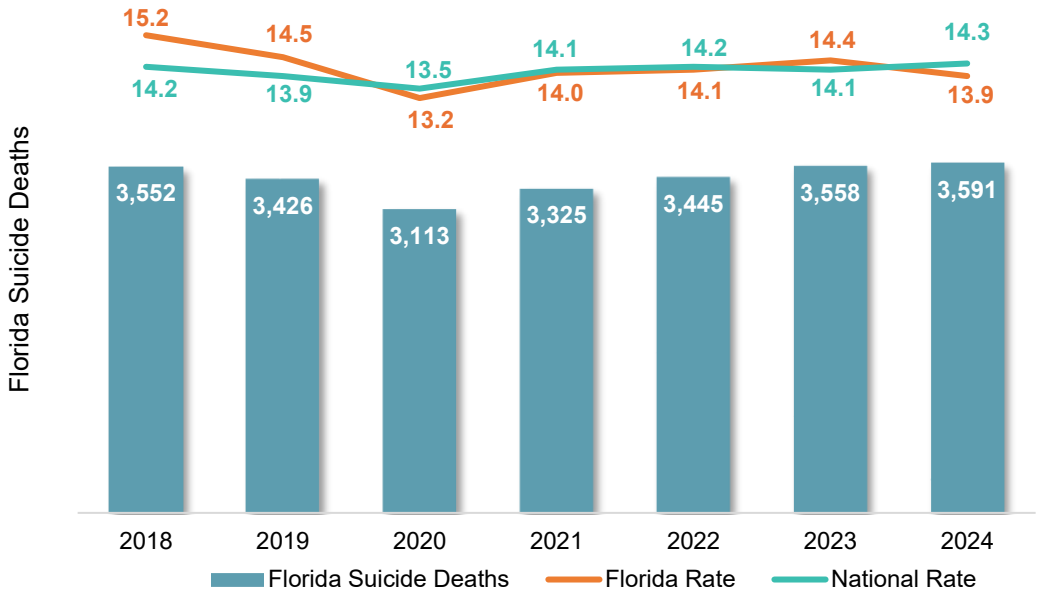
Suicide Data

In 2024, suicide was the eighth leading cause of death in Florida, with 3,591 lives lost, reflecting a rate of 13.9 per 100,000 individuals, marking a 3.5 percent decrease from 2023.[1] Since 2020, Florida's suicide trends have closely mirrored national patterns. However, in 2024, the national rate showed a slight increase while Florida experienced a modest decrease.[2] This divergence underscores the continued need to prioritize suicide prevention policies and practices across the state.



Source: Florida Health Charts and Centers for Disease Control and Prevention

When examining demographic differences, males in Florida continue to experience disproportionately higher suicide mortality. In 2024, males died by suicide at a rate of 22.6 per 100,000, more than four times the female rate of 5.6 per 100,000, a pattern that has persisted for more than 50 years. Additional information on Florida's suicide data and initiatives are available on the Suicide Prevention Coordinating Council's Annual Report: myflfamilies.com/services/samh/publications.

[1] Florida Department of Health. Suicide and Behavioral Health Profile. Accessed 4/2026. Retrieved from https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=SuicideBehavioralHealthProfile.DeathsHospED&tabid=DeathsHospED.

[2] Centers for Disease Control and Prevention. (2025). Suicide data and statistics. Accessed 4/2026. Retrieved from https://www.cdc.gov/suicide/facts/data.html#cdc_data_surveillance_section_4-suicide-rates.

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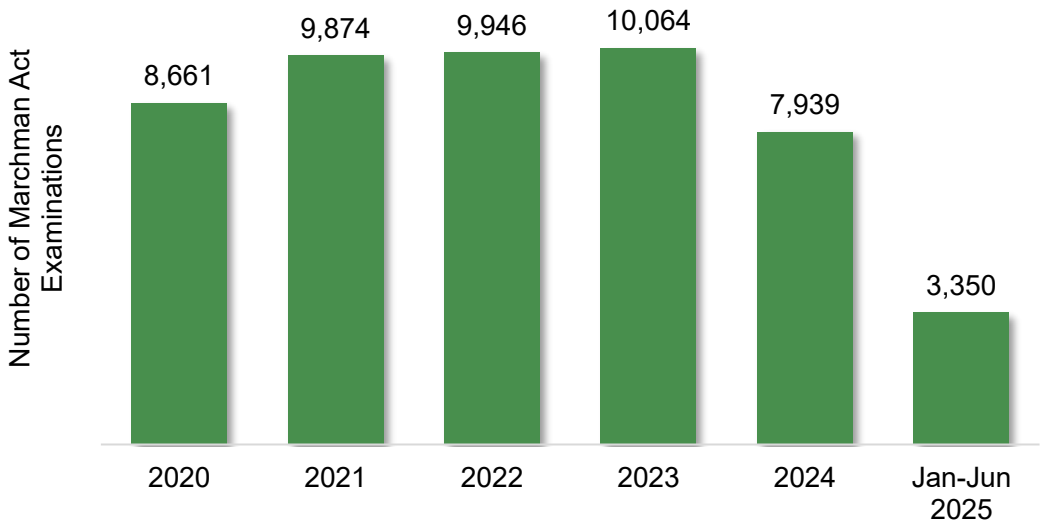
Marchman Act Data

The Hal S. Marchman Act provides for voluntary admission and involuntary assessment, stabilization, and treatment of youth and adults who are severely impaired due to substance use. Data from the Office of the State Courts Administrator indicates a 21 percent decrease in involuntary Marchman Act examinations from Calendar Years (CYs) 2023 to 2024 – marking not only the first decline in the past five years but also the lowest number of cases filed during that period. Provisional data show that 3,350 involuntary cases were filed between January and June 2025.



Source: Office of the State Court Administrator

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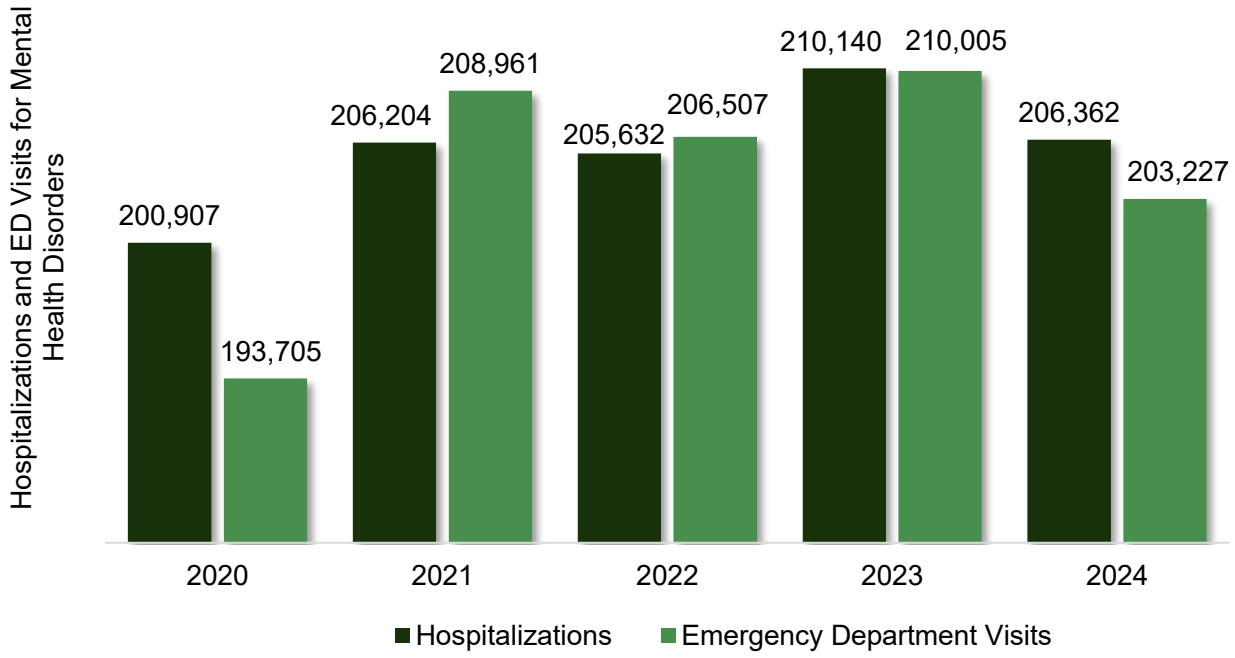
Hospitalizations and Emergency Department Visits for Behavioral Health Disorders

In CY 2024, hospitalizations for mental disorders totaled 206,362, encompassing conditions such as schizophrenia, mood disorders, intellectual disabilities, and drug- or alcohol-induced mental disorders. Mood and depressive disorders accounted for 44 percent of hospitalizations.[3] Adults ages 25 to 44 represented the largest share at 34 percent, followed by adults 45 to 64 at 28 percent of mental health–related hospitalizations.[4]

Emergency departments (EDs) recorded 203,227 visits for mental disorders in CY 2024, representing two percent of all ED visits that year.[5] In addition, there were 11,655 ED visits for intentional self-harm injuries, reflecting a four percent decrease from the previous year.[6]



Source: Florida Agency for Health Care Administration

[3] Florida Agency for Healthcare Administration. Hospitalizations from mental disorders. Accessed 4/2026. Retrieved from https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=NonVitalInd.Dataviewer&cid=9877.
[4] Florida Agency for Healthcare Administration. Suicide and behavioral health profile. Accessed 4/2026. Retrieved from Suicide and Behavioral Health Profile: Mental and Behavioral Health Disorders | FLHealthCHARTS.gov - Florida Department of Health.
[5] Florida Agency for Healthcare Administration. Emergency department visits. Accessed 4/2026. Retrieved from https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=NonVitalInd.Dataviewer&cid=9834.
[6] Florida Department of Health. Suicide and behavioral health profile. Accessed 4/2026. Retrieved from https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=SuicideBehavioralHealthProfile.DeathsHospED&tabid=DeathsHospED

Florida Behavioral Health Initiatives

Expansion of Behavioral Health Services

DCF continues to strengthen Florida's behavioral health system through sustained investment and system-wide improvements. Over the past five years, the state has allocated more than $7.9 billion to support behavioral health services for both youth and adults. During FY 2024–25, this investment enabled nearly 73,000 individuals to receive substance use disorder services, more than 171,000 individuals to access mental health services, and close to 6,000 individuals to receive care in State Mental Health Treatment Facilities (SMHTFs).

988 Florida Suicide & Crisis Lifeline

On October 17, 2020, the National Suicide Hotline Designation Act amended the Communications Act of 1934 to designate 988 as the new, three-digit dialing code that connects individuals experiencing suicidal thoughts, substance use, mental health crises, or any other kind of emotional distress to a crisis counselor in their immediate area. 988 crisis counselors are equipped with specialized skills and knowledge to de-escalate and, if needed, link callers to community-based providers who can deliver a full range of crisis care services.

The 988 Florida Lifeline is outlined in section 394.4573, F.S., as a crisis service and an essential element of the coordinated system of care. It provides a single-point-of-entry to a crisis care continuum that serves individuals with a variety of crisis care needs through three essential elements: someone to talk to, someone to respond, and somewhere to go. The framework for this modernized crisis continuum of care begins when an individual experiencing emotional distress dials 988 and has their call answered by a local crisis counselor at one of Florida's thirteen 988 call centers. In FY 2024-25, 96 percent of calls to the 988 Florida Lifeline were resolved at this stage without the need for higher-level intervention. In cases where a call cannot be de-escalated over the phone, a warm hand-off is provided to a local Mobile Response Team. This was the case for 2.96 percent of 988 calls in Florida in FY 2024-25. The 988 Florida Lifeline centers also work in coordination with local 911 Public Service Answering Points (PSAPs) to dispatch an immediate law enforcement or Emergency Medical Services (EMS) response when a caller is at imminent risk of suicide in progress – in FY 2024-25, this was the case for 1.24 percent of 988 Florida Lifeline calls.

1. The 988 Florida Lifeline is made up of thirteen call centers, statewide. Twelve are primary call centers that provide primary coverage for all sixty-seven counties in Florida. When a caller dials 988, their call is immediately routed to the primary call

center associated with their general location, connecting callers to local counselors with specialized knowledge of service networks and regional factors. Through a process called geo-routing, the network uses the nearest cell phone tower to route the call using proximity-based routing technology, without revealing the caller's exact location and protecting their anonymity. Seven of the twelve primary centers also serve as in-state backup centers, with the state's thirteenth center serving solely as an in-state backup. The primary and backup centers each have 120 seconds to answer a call. If neither the primary nor backup center is able to answer the call within that timeframe, the call is routed to 988's national backup line, where trained counselors provide immediate support while local centers remain best positioned to offer region-specific knowledge of the crisis care system. In FY 2024-25, seven percent of 988 Florida Lifeline calls were routed to the national backup line.

In FY 2024-25, the 988 Florida Lifeline:

- Answered 144,981 calls from individuals experiencing suicidal thoughts, substance use, and/or emotional distress.
- Reported a 96 percent diversion rate, or crisis calls that did not require an in-person response after telephonic support.
- Experienced a call volume increase of approximately 15 percent, going from an average of about 13,000 calls per month in FY 2023-24 to averaging over 15,000 calls per month in FY 2024-25.
- Answered 7,642 calls from individuals experiencing substance use and/or addiction concerns.
- Answered 1,382 calls that included a suicide attempt in progress, with zero resulting in a death by suicide while on the phone with a 988 crisis counselor. Meaning, every individual that reached out to 988 with an active suicide reached the next phase of care alive.

As required by section 14.2019, F.S., DCF is responsible for increasing health communication around topics related to suicide prevention and acting as a clearinghouse for information and resources related to suicide prevention by disseminating and sharing evidence-based best practices relating to suicide prevention. In June 2024, DCF began collaborating with a creative design vendor to increase public outreach and marketing efforts for Suicide Prevention and the 988 Florida Lifeline.

DCF's increased outreach and education efforts have helped expand awareness of available crisis services, contributing to continued growth in utilization of the 988 Florida Lifeline. In FY 2024-25, DCF developed and disseminated 988 Florida Lifeline outreach and educational materials to high-risk groups such as middle-aged males, youth, and individuals in rural areas. Outreach activities included the development and publishing of the 988 Florida Lifeline website and marketing toolkit in October 2024, distribution of educational materials directing individuals to 988 and the state's suicide prevention website, and development of a public service announcement (PSA) video that debuted on November 1, 2025, during the University of Georgia-University of Florida football game

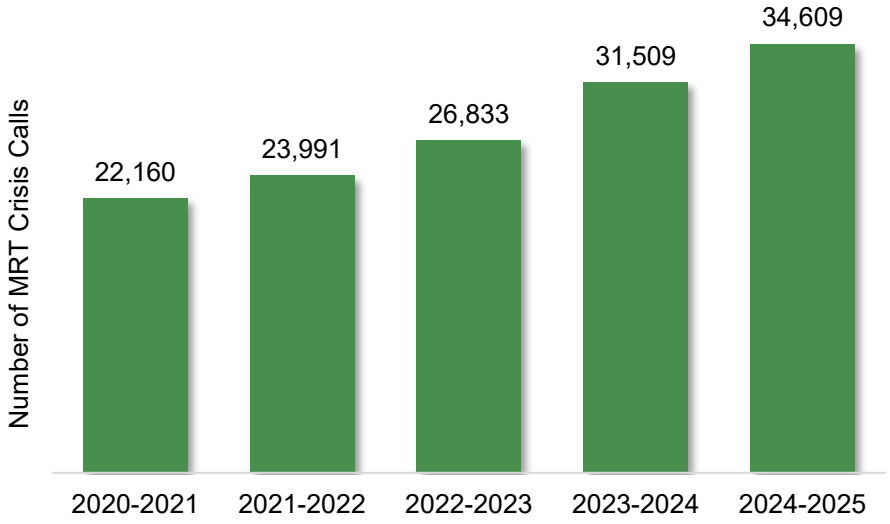
in Jacksonville, Florida. The PSA video played in-stadium between each quarter of play for over 75,000 fans in attendance. The PSA follows three individual storylines (youth, veteran, and rural/elderly) to inform viewers of the service 988 provides and encourage them to reach out if they or someone they know is experiencing suicidal thoughts, mental health or substance use crisis, or any other kind of emotional distress. The video is currently housed on the 988 Florida Lifeline website and can be accessed for use by community partners via the marketing toolkit.

Additionally, DCF was able to secure a space at the University of Georgia-University of Florida college football game. This space for education, awareness, and support was directly in front of the stadium entrance, to serve as a highly visible, interactive hub to engage attendees as they approached the venue. 988-branded educational items were distributed alongside Naloxone kits and a short survey to capture data regarding awareness of the Lifeline prior to attending the event which will be utilized to inform and further future strategy and approach.

Mobile Response Teams (MRTs)

MRTs provide crisis intervention services to individuals experiencing a behavioral health crisis 24 hours a day, 365 days a year. MRTs use a team of specially trained professionals, including licensed mental health professionals, Certified Recovery Peer Specialists, and access to an on-call psychiatrist or psychiatric nurse practitioner, to provide a variety of crisis intervention services to eligible individuals. These teams conduct independent assessments to determine if an individual can safely be diverted from an emergency room visit, unnecessary psychiatric hospitalization, juvenile justice or criminal justice setting.

In 2020, House Bill 945 (2020) amended section 394.495, F.S., to require DCF to contract with Managing Entities for MRTs throughout the state to provide immediate, onsite behavioral health crisis services to children, adolescents, and young adults ages 18 to 25. With additional funding from the Legislature, DCF expanded MRTs in FY 2022-23 to provide crisis response services to individuals of all ages. In FY 2024-25, the Florida Legislature allocated an additional $11.5 million to MRTs allowing for the expansion of existing teams and the creation of new teams to increase capacity and availability in areas with service gaps. There are currently 54 MRTs statewide. To find a team that serves your county, visit: Specialty Treatment Team Maps | Florida DCF



Source: Florida Department of Children and Families

The total calls received by MRTs over the past five fiscal years has steadily increased, resulting in a 56 percent increase in the total number of calls received since FY 2020-21. This trend is in line with the expansion of MRT outlined above and highlights the need for ongoing mobile crisis services.

Historically, Mobile Response Teams (MRTs) have maintained a statewide diversion rate of 80 percent or higher, demonstrating their effectiveness in stabilizing individuals in crisis and connecting them to appropriate community-based supports. During FY 2024–25, the MRT diversion rate decreased slightly by 2 percent. Despite this modest decline, MRT implementation continues to contribute to a sustained reduction in Baker Act involuntary examinations statewide.

One possible explanation for this trend is that MRTs are increasingly serving individuals with the most acute behavioral health needs. As MRTs successfully divert many crises from escalating to involuntary examination, the individuals who ultimately require Baker Act intervention tend to present with higher levels of acuity and complexity.

A similar pattern may be emerging with the implementation of the 988 Florida Lifeline. Anecdotal reports suggest that because many callers are able to receive effective support, de-escalation, and linkage to services through 988, a substantial number of crises are resolved before an in-person response is needed. As a result, the individuals referred to MRTs may represent a more acute subset of people in crisis, who are more likely to require intensive intervention and less likely to be diverted from involuntary examination. This reflects the complementary impact of both 988 and MRT services in ensuring that individuals receive the least restrictive level of care appropriate to their

needs while reserving higher levels of intervention for those experiencing the most serious crises.

Opioid Abatement

In 2023, section 397.335, F.S., established the Statewide Council on Opioid Abatement (Council) within DCF to strengthen the development and coordination of state and local efforts to abate the opioid epidemic and to support individuals and families affected by it. Opioid settlement funds may be used for a range of activities, including prevention, treatment, recovery support services, and other opioid abatement strategies. The Council publishes an annual report, which is available at: myflfamilies.com/services/samh/publications.

Naloxone Distribution

Since 2016, DCF's Overdose Prevention Program has distributed naloxone, a fast-acting medication that reverses opioid overdoses by blocking opioid receptors, to individuals at risk of experiencing or witnessing an overdose, resulting in thousands of lives saved. In CY 2024 alone, 767,931 naloxone kits were distributed, with more than 16,000 reported overdose reversals, reflecting the program's growing reach and accessibility. This expansion underscores Florida's commitment to reducing opioid-related fatalities, with the state reporting 3,726 opioid-caused deaths in 2024 – a 32 percent decline from 2023. Information related to the strategies promoted through DCF and the Opioid Abatement Council can be found at the Council's website floridaopioidsettlement.com/.

Naloxone Kits Distributed, Opioid-Caused Deaths, and Opioid-Caused Death Rate (per 100,000) (Calendar Years 2017-2024)

Year	Kits Distributed	Opioid-Caused Deaths	Death Rate (per 100,000)
2017	6,210	4,280	20.8
2018	18,898	3,727	17.8
2019	36,703	4,294	20.2
2020	69,557	6,089	28.1
2021	132,269	6,442	29.3
2022	191,053	6,157	27.6
2023	404,422	5,476	24.1
2024	767,931	3,726	16.2

Florida Department of Education (DOE)

Building resiliency for Florida's students and families remains a central priority for DOE. Through sustained leadership and a focus on whole-child development, Florida continues to lead nationally in ensuring students have the skills and supports needed to navigate both everyday challenges and major life events.

Youth Resiliency Initiative

In October 2022, Florida updated its mental health instruction requirements to create a unified framework: Resiliency Education, Civic and Character Education, and Life Skills Education. This five-hour annual requirement for students in grades 6–12 represents a first-in-the-nation approach designed to help students build the resilience needed to overcome adversity. These skills support students across academic, social, and real-world situations, from improving a course grade to navigating the aftermath of a natural disaster.

0Since 2022, approximately 1.5 million students in grades 6-12 receive instruction in resiliency education annually. To support this effort, DOE has developed free, downloadable resources for students, parents, educators, and volunteers, spanning kindergarten through grade 12. These materials are available at https://www.buildresiliency.org/.

School-Based Mental Health Care

Florida continues to strengthen its approach to student mental health by investing in training and school-based supports. Districts receive two sources of state funding: the Mental Health Assistance Allocation (MHAA) and Youth Mental Health Awareness Training (YMHAT). MHAA funding supports school-based mental health services, staff training to identify and respond to student mental health needs, and connections to appropriate behavioral health providers. Since the initial $75 million allocation in FY 2019-20, Florida has significantly expanded its investment in student mental health, with funding rising to $180 million in FY 2025-26. Through YMHAT, more than 80 percent of school personnel across all Florida school districts have received training through DOE, further strengthening schools' capacity to recognize concerns early and support student well-being.

Florida Department of Corrections (FDC)

FDC is the third largest state prison system in the nation, operating with an annual budget of nearly $3.75 billion. As of April 2026, FDC houses more than 90,000 inmates in its correctional facilities and supervises over 145,000 individuals through community supervision. FDC's mission is to "Provide a continuum of services to meet the needs of those entrusted to our care, creating a safe and professional environment with the outcome of reduced victimization, safer communities, and an emphasis on the premium of life."

Comprehensive Mental Health Services

FDC provides comprehensive mental health services to all inmates from the reception process through release. Approximately 25 percent of the inmate population is diagnosed with a major mental illness – such as major depressive disorder, bipolar disorder, or thought disorders – that affects daily functioning. Over the past decade, the proportion of inmates diagnosed with a mental illness has increased by nearly 50 percent (from 17 to

24 percent), significantly impacting daily operations as the department works to meet the needs of a growing behavioral health population while maintaining safety and security.

Mental health services are delivered across multiple levels of care based on symptom severity and functional impairment, including two outpatient and four inpatient levels. All inmates receive comprehensive mental health evaluations and clinical interviews during reception and are assigned an initial mental health grade that may change as their needs evolve. For example, individuals experiencing acute crises may be briefly placed on Self Harm Observation Status, and those requiring more intensive intervention may be transitioned to higher levels of inpatient care.

Mental Health Re-Entry Program

FDC partners with DCF to ensure continuity of care for inmates receiving psychiatric services prior to release. Inmates with less severe mental health needs also receive counseling to support their transition back into the community.

The Mental Health Re-Entry Program maintains agreements with DCF, the Social Security Administration, and the U.S. Department of Veterans Affairs to help individuals access follow up care, benefits, and support services as soon as possible after release.

Correctional Substance Use Treatment

FDC provides both in prison and community-based substance use treatment programs statewide. Substance use remains a pervasive and costly issue, with incarcerated individuals being seven times more likely than the general population to have a substance use disorder and more than two thirds of individuals in jails being dependent on or having abused alcohol or drugs. Recidivism further compounds the challenge, as over half of incarcerated individuals with a substance use history have one or more prior incarcerations, compared with 31 percent of those without such a history.

As of April 2026, FDC estimates that at least 59 percent of the more than 90,000 incarcerated individuals meet screening criteria for substance use treatment; however, only about 36 percent receive services due to limited resources. Contracted providers also face persistent challenges recruiting and retaining qualified staff, driven in part by the geographic locations of institutions and the demanding realities of correctional settings. Among the 115,576 individuals on active community supervision, approximately 57 percent have a history of substance use disorder, and roughly 52 percent receive treatment services due to limited resources. Treatment outcomes are further affected by offender noncompliance, and stipulations in court orders can inadvertently limit the ability to address individualized treatment needs.

Department of Juvenile Justice Initiatives (DJJ)

DJJ serves youth who are at risk of entering, or who have already entered, the juvenile justice system. Mental health and substance abuse (MHSA) services are embedded throughout DJJ's continuum of care – including prevention, detention, probation, and residential services. All youth in DJJ custody receive screening, assessment, suicide prevention services, crisis intervention, and referrals for treatment. Those who remain in

custody receive individual, group, and family therapy based on their individualized treatment plans.

DJJ ensures access to MHSA services across all program settings. Detention centers are staffed with contracted full-time mental health clinicians who provide daily on-site treatment, including psychiatric services when clinically indicated. Youth under probation supervision receive outpatient mental health, substance abuse, and juvenile sexual offender treatment through contracted community providers, who also conduct comprehensive psychological evaluations. Residential commitment programs offer specialized MHSA services that vary in intensity, including Mental Health Overlay Services, Substance Abuse Overlay Services, Juvenile Sexual Offender Treatment, Developmental Disability and Borderline Developmental Disability services, Intensive Mental Health Treatment, and comprehensive treatment for co-occurring disorders.

To further support youth, staff, and partner agencies, DJJ leads the following initiatives that enhance crisis response, strengthen suicide prevention efforts, and promote employee wellness across the department.

Mobile Response and Community Action Treatment Teams

DJJ's Office of Health Services (OHS) continues to partner with the DCF to ensure MRTs are available to detention centers and residential programs when mental health staff are not on site. OHS staff also participate in the Department's State Review Team, collaborating with Community Action Teams and local review teams to assist with youth placement needs, including cases where no immediate placement options exist. Through these partnerships, OHS works with DCF and other agencies to improve coordination and continuity of mental health and substance abuse services.

Baker Act Data Collection and Suicide Prevention Policy Enhancement

In alignment with DJJ's commitment to data-informed decision-making, OHS completed a six-month study in July 2025 examining factors associated with Baker Act initiations in detention and residential programs. All youth in the residential treatment programs received a comprehensive evaluation and had at least one MHSA diagnosis. Findings from this analysis guided resource allocation for suicide-prevention garments and other safety tools, strengthening DJJ's suicide-prevention practices and reducing the need for off-site Baker Act evaluations.

Employee Wellness Program

Under the direction of Secretary Matt Walsh, DJJ established an Employee Wellness Program (EWP) to provide short-term therapy, Post-Critical Incident Seminars, and other therapeutic supports for staff. The department has hired its first licensed therapist, who has already provided services to probation and detention units following critical incidents. Plans are underway to expand the program with a wellness application that offers physical health monitoring, peer support and chaplain integration, psychoeducation, and additional resources tailored to employees in high-stress roles.

Impact of the Commission

Throughout its work, the Commission has advanced a series of recommendations that have shaped Florida's behavioral health system over the past several years. Many of these earlier recommendations have already informed legislation, guided agency policy, and supported long-term improvements in access, quality, and coordination of care. The following section summarizes the impact of these prior recommendations across four key areas – (1) clinical practice, (2) system coordination, (3) workforce development, and (4) data infrastructure – and highlights the progress achieved through sustained effort.

(1) Clinical Practice and Service Delivery Improvements

The following recommendations focused on strengthening the quality, consistency, and effectiveness of behavioral health services across Florida. Many have since informed statutory changes, updated practice standards, and expanded evidence-based approaches to crisis response and treatment. Together, they reflect the Commission's foundational work to improve how care is delivered statewide.

Modernize the Baker Act and Marchman Act and Establish Regional Collaboratives (Interim Reports #1 and #2)

Two of the Commission's most influential recommendations focused on modernizing the Baker Act and Marchman Act and establishing regional collaboratives to strengthen crisis response and improve coordination across communities. These recommendations directly informed House Bill 7021 (2024), which expanded law enforcement discretion when initiating a Baker Act, strengthened discharge planning, created the Office of Children's Behavioral Health Ombudsman within DCF, and required DCF and AHCA to establish regional collaboratives.

DCF implemented these changes by updating policy guidance, clarifying the 72-hour examination period, strengthening expectations for discharge planning, and improving communication with parents and guardians when minors are involved. To support consistent statewide understanding, DCF updated and published the Baker Act FAQ and Reference Guide and launched extensive training efforts. A live webinar in September 2024 issued nearly 8,000 CEUs, and nine additional training modules were released covering law enforcement, receiving facilities, minors, the Marchman Act, long-term care, guardian advocacy, medical personnel, and EMS. Rulemaking is underway to translate statutory changes into operational standards and ensure long-term consistency.

To implement the regional collaborative recommendation, DCF hired six Regional Collaboration Coordinators to lead engagement across the state. Quarterly meetings are publicly noticed, widely promoted, and open to a broad membership that includes providers, Managing Entities, hospitals, schools, law enforcement, and individuals with lived experience. These collaboratives are now actively identifying regional needs,

strengthening coordination, and advancing statewide priorities. Information on future meetings can be found here: Public Events & Meetings | Florida DCF

Increase use of Long Acting Injectables Prior to Discharge (Interim Report #2)

In 2024, the Commission identified the need to increase the use of long-acting injectable (LAI) antipsychotic medications for individuals with mental illness, citing research showing that LAIs support steady medication release, improve symptom control, and reduce relapse – particularly at discharge from inpatient psychiatric settings when adherence may be uncertain. To advance this recommendation, a public hearing was held on November 18, 2025, for Rule 65E-5.1303, F.A.C., "Discharge from Receiving and Treatment Facilities," to address authorization of LAIs for clinically appropriate individuals being discharged. Rule language was revised following the hearing and is undergoing final refinement. Additionally, DCF updated and published the Baker Act Manual on October 1, 2025, to strengthen guidance on considering LAIs as part of discharge planning.

Share Best Practices on Mental Health First Aid, Person First Language, and Trauma Responsive Care (Interim Report #2)

Senate Bill 1620 (2025) amended section 394.9082, F.S., to advance the Commission's recommendation to promote best practices in behavioral health care by defining person-first language as the standard in professional medical settings and requiring its use statewide. The bill also reinforced the importance of crisis intervention best practices and trauma-informed care, supporting a more respectful, person-centered approach across the behavioral health system.

As part of implementation, DCF updated Behavioral Health Managing Entity contracts to require the promotion of person-first language and trauma-informed, responsive care through training initiatives, the dissemination of best practices, and revised Guidance Document 35 to further clarify Managing Entity responsibilities related to these efforts.

Increase Crisis Response Teams Focused on Seniors (Interim Report #2)

To better meet the needs of older adults, Senate Bill 1620 (2025) amended section 394.457, F.S., to require DCF's rule for Mobile Crisis Response Services or MRTs to include clear, effective training tools or requirements designed to enhance the delivery of crisis services tailored to individuals aged 65 and older. Rule 65E-5.603, F.A.C. (Minimum Standards for MRTs), was adopted on October 20, 2025. In alignment with this requirement, DCF amended its contract with its training vendor to develop and host specialized training on serving seniors in crisis. As of April 2026, 95 percent of MRT

providers have completed this training, strengthening the system's ability to respond effectively to older adults experiencing behavioral health crises.

Increase Short-Term Residential Treatment Capacity (Interim Report #2)

Short-term residential treatment (SRT) facilities provide intensive, structured 24/7 mental health care that helps reduce inpatient lengths of stay and supports successful transitions back into the community. Recognizing the need for expanded capacity, Senate Bill 1620 (2025) amended section 394.875, F.S., to require DCF to conduct biennial reviews of SRT needs and directed AHCA to prioritize licensing SRT facilities in underserved counties and high-need areas. To support this expansion, DCF submitted a Legislative Budget Request for FY 2026-27 to increase SRT capacity statewide. The Governor's recommended budget included $11.6 million in recurring General Revenue to add 80 new beds, 40 for adults and 40 for children, helping address critical gaps in residential treatment availability.

(2) Access and System Coordination

The Commission's prior recommendations in this area aimed to reduce fragmentation and improve how individuals move through the behavioral health system. Several of these recommendations have already shaped legislation and agency policy, helping to strengthen crisis pathways, expand diversion options, and improve access for children, adults, and families. These efforts laid important groundwork for a more coordinated and responsive system of care.

Complete a Statewide Gap Analysis (Interim Report #2)

To support long-term planning and ensure resources align with community needs, the Commission recommended completing a statewide gap analysis of behavioral health treatment capacity. Senate Bill 330 (2024), known as the Behavioral Health Teaching Hospitals Act, advanced this recommendation by requiring a Mental Health Inpatient Treatment Services Capacity Study, which included completion of a gap analysis. DCF competitively procured a vendor to conduct a detailed inpatient capacity study for adults and children. The study examined current capacity, projected demand, the system's ability to meet that demand, and opportunities to expand inpatient and community-based alternatives. The final report, completed January 31, 2025, with needs projections through 2029, now serves as a foundational planning tool for the state.

Recognize 988 as Part of the Behavioral Health System of Care (Interim Report #2)

From October 2022 to May 2024, the 988 Lifeline answered more than 170,000 calls from individuals experiencing suicidal thoughts, substance use concerns, or emotional

distress. Recognizing that 988 is often the first point of contact for individuals in crisis, the Commission recommended formally integrating 988 into the behavioral health system of care and strengthening coordination between the 988 Florida Suicide and Crisis Lifelines and crisis service providers such as MRTs and CSUs.

House Bill 1091 (2025) advanced this recommendation by expanding statutory definitions of crisis services to include the 988 Lifeline, repealing the needs assessment requirement for MAT licensure, and establishing enhanced training standards for forensic evaluators. DCF implemented the 988 provisions by developing and adopting rule 65E-5.604, F.A.C. pertaining to minimum standards for 988 Florida Lifeline Call Centers on February 18, 2026, establishing minimum operational standards and ensuring consistent expectations statewide. Florida now has 13 active 988 Lifeline centers providing free, 24/7 behavioral health support across the state. The Legislature appropriated $7 million to support ongoing sustainability; recognizing that the expiration of a key federal grant in 2026 could significantly affect workforce capacity and the ability to maintain life-saving crisis services.

Limit the Use of Competency Restoration for Cases Suitable for Dismissal or Diversion (Interim Report #1)

The Commission recommended limiting the use of competency restoration for individuals charged with misdemeanors or low-level felonies and expanding diversion pathways, specialty courts, and competency-alternative programs. Senate Bill 168 (2025), known as the Tristan Murphy Act, advanced this recommendation by creating new diversion pathways for individuals with mental illness, authorizing counties and municipalities to establish misdemeanor and pretrial felony diversion programs, and including a $6,000,000 appropriation for the expansion of the reinvestment grant program. In response, DCF developed procurement documents for the Reinvestment Grants, with awards expected by August 2026, and distributed legislative summaries to Managing Entities, the USF Technical Assistance Center, and other partners to support consistent and informed implementation.

Assess School Based Behavioral Health Access Through Telehealth (Interim Report #2)

To improve access to behavioral health services for children and adolescents, Senate Bill 1620 (2025) required DCF, in consultation with DOE, to conduct a biennial review of school-based behavioral health services and behavioral health telehealth access. DCF and DOE collaborated to assess current service availability, identify innovative models, and highlight best practices for expanding school-based behavioral health supports. The report was published in January 2026. DCF also updated Managing Entities' contract Guidance Document 35 to reflect new statutory requirements. This document provides direction for implementing Recovery Management practices within Network Service Providers and supports consistent application of school-based behavioral health expectations statewide.

(3) Workforce Development & Sustainability

Recognizing longstanding workforce shortages, the Commission's earlier recommendations focused on building a stronger, more stable behavioral health workforce. These recommendations guided the creation of new infrastructure, data systems, and training supports that are now helping Florida better understand workforce needs and invest in long-term solutions.

Conduct a Workforce Compensation Study (Florida Center for Behavioral Health Workforce) and Provide Stipends, Compensation, and/or Support for Clinical Supervisors and/or Employers, Students, and Registered Interns
(Interim Report #2)

Since its establishment by the Florida Legislature through Senate Bill 330 in July 2024, the Florida Center for Behavioral Health Workforce (FCBHW) has focused on building a strong operational foundation to advance the Commission's recommendation for a statewide workforce compensation study. The Center completed 15 key hires across Operations, Research & Dissemination, Education & Professional Development, and Policy Analysis & Implementation, and launched its inaugural three-year strategic plan. The plan outlines five priorities:

1. Build foundational infrastructure and collaborative relationships across the state to execute the legislative charge and vision of the FCBHW.
2. Define and quantify Florida's behavioral health workforce and assess its capacity to meet the needs of Floridians statewide.
3. Develop a program of Florida-grounded research to grow, retain and innovate Florida's behavioral health workforce.
4. Align FCBHW education and workforce initiatives with broader Florida education and health care strategic imperatives, policies and programs to maximize collective impact.
5. Reduce barriers to education, training and licensure along behavioral health provider pathways.

FCBHW introduced a comprehensive website and developed a workforce mapping and supply-and-demand model using 24 years of historical data and 10-year projections. This model identified a baseline 555:1 population-to-provider ratio and a 24 percent gap between workforce supply and demand. In parallel, the Center has cultivated statewide, cross-sector partnerships to support long-term system alignment.

Consistent with its strategic priorities, the Center advanced research and data infrastructure by conducting a statewide retention survey of licensed behavioral health providers, examining barriers affecting certified recovery peer specialists, and implementing a recurring workforce survey at license renewal in partnership with the Florida Department of Health Medical Quality Assurance team. More than $2 million in

research grants have been awarded to support researchers and community agencies in developing scalable solutions for critical workforce and education challenges in Florida.

In education and professional development, FCBHW launched pilot initiatives to strengthen the workforce pipeline, including a mentorship program for advanced undergraduates pursuing clinical graduate training, career navigation supports, and emergency financial assistance for graduate students. The Center also introduced the "Stay Supervised, Stay on Track" campaign to reduce unlicensed practice and prevent avoidable delays in licensure.

With a strong foundation and statewide partnerships in place, FCBHW is well-positioned to fulfill its legislative charge to grow, retain, and strengthen Florida's behavioral health workforce.

(4) Data, Evaluation & Infrastructure

The Commission's prior recommendations emphasized the need for integrated data systems and standardized tools to support long-term planning and system improvement. While still in progress, these efforts have initiated the development of statewide data infrastructure and began building the foundation for more consistent analysis of service use and outcomes. As implementation continues, this work is expected to strengthen Florida's capacity for data-driven planning, evaluation, and decision-making across the behavioral health system.

Develop a Florida Behavioral Healthcare Data Repository (Interim Reports #1–2)

From its first Interim Report, the Commission emphasized the need for a unified behavioral health data repository capable of integrating information from multiple state agencies – including DCF, AHCA, DJJ, Florida Department of Law Enforcement (FDLE), and others – to better understand access, quality, costs, and outcomes across the system. To advance this recommendation, Senate Bill 168 established the Florida Behavioral Health Care Data Repository (FBHDR) within the Northwest Regional Data Center (NWRDC). The repository is designed to collect, harmonize, and analyze statewide behavioral health data and will initially focus on three core domains:

1. Descriptions of behavioral health clients, services, and outcomes
2. Prediction of client outcomes based on service use patterns
3. Cost analysis based on client and service characteristics

To guide this work, the project was organized into three aims (goals).

1. Aim 1 focused on formalizing a statewide stakeholder coalition to identify priority data sources and desired outcomes.
2. Aim 2 centers on building the repository itself, including data harmonization, cleaning, and preparation for analysis.

3. Aim 3 will assess the availability and adequacy of behavioral health resources for high-risk individuals.

As of April 2026, Aim 2 is underway. A draft governance structure has been developed outlining roles, responsibilities, and decision-making processes. Next steps include executing data-sharing agreements among DCF, AHCA, DOC, DJJ, and the Office of the State Courts Administrator (OSCA), onboarding priority data sources, developing dashboards and reporting tools, and planning for long-term sustainability.

Once fully implemented, the FBHDR will serve as an ongoing statewide resource to support operational decision-making, evaluate program effectiveness, identify best practices, model the impact of proposed service changes, and describe the prevalence and service continuum for mental health and substance use disorders. This work lays the foundation for a more transparent, data-driven behavioral health system.

Encourage Statewide Implementation of the Daily Living Activities-20 Functional Assessment Tool
(Interim Reports #2)

Recognizing the need for a reliable, standardized tool to assess functional abilities and support appropriate service planning, the Commission recommended statewide implementation of the Daily Living Activities-20 (DLA-20) functional assessment tool. The DLA-20 is applicable across a wide range of programs, service types, and behavioral health conditions, making it a strong foundation for consistent assessment and outcome measurement.

Senate Bill 1620 (2025) advanced this recommendation by requiring statewide integration of the DLA-20. In response, DCF secured a vendor to provide DLA-20 training for providers, with phase 1 of statewide training completed in Spring 2026. Additional training opportunities will be made available during FY 2026-2027. DCF also revised Managing Entity contracts to require use of the DLA-20, drafted rule language for Rule 65E-14.021, F.A.C., and added DLA-20 resources to their website to support implementation. As statewide implementation progresses, the DLA-20 is anticipated to improve consistency in functional assessment and support more informed service planning and evaluation efforts.

These initiatives reflect the substantial progress made through the Commission's earlier recommendations and the collaborative efforts of state agencies, providers, and community partners. While this work has strengthened many aspects of Florida's behavioral health system, continued attention is needed to address emerging challenges and evolving community needs. The Commission's ongoing efforts build on this

foundation and support Florida's commitment to improving behavioral health outcomes statewide.

Commission Recommendations

Building on the progress achieved through its earlier recommendations, the Commission continued its work in 2025 to identify additional opportunities to strengthen Florida's behavioral health system. Throughout the year, the Commission met bi-monthly and incorporated input from behavioral health experts, state agencies, providers, and individuals with lived experience. These discussions informed the development of the Commission's recommendations, which reflect emerging needs and areas where continued attention is warranted.

For 2026, the Commission has put forth eight recommendations that focus on:

- Advancing Clinical Practice, Specialized Services and Integrated Care;
- Expanding Access, Capacity and System Navigation; and
- Strengthening System Governance, Coordination and Strategic Planning.

Advancing Clinical Practice, Specialized Services and Integrated Care

Florida's behavioral health system continues to evolve as the needs of older adults, individuals with developmental disabilities, and people with co-occurring conditions become increasingly complex. This section outlines targeted strategies to strengthen clinical practice and expand specialized services, including enhanced MRT training, increased supportive housing capacity, replication of community integrated health teams, and greater integration of primary and behavioral health care. Together these recommendations are designed to reduce system fragmentation, improve continuity of care, and ensure that individuals receive timely, appropriate support across settings.

Recommendation 1: Enhance training for Mobile Response Team staff to include knowledge regarding developmental disabilities and seniors.

Older adults and individuals with developmental disabilities represent a growing share of those experiencing behavioral health crises, highlighting the need for MRTs to be equipped with specialized training. Data from DCF show that adults aged 65 and older accounted for approximately eight percent of involuntary examinations in FY 2024–25 – nearly 13,000 individuals.

National Center for Disease Control and Prevention (CDC) data further indicate that adults ages 75 to 84 and 85+ had the highest suicide rates in the country in 2023, at 19.4 and 22.7 per 100,000, respectively.[7] Individuals with developmental disabilities face similarly elevated risks. APD reports that an average of 1,900 individuals served under the iBudget Florida waiver are hospitalized annually under the Baker Act, and CDC

[7] Centers for Disease Control and Prevention. (2025). Disability and health data now. Retrieved from https://www.cdc.gov/disability-and-health/articles-documents/disability-and-health-data-now.html.

findings show that adults with intellectual disabilities are more than four times as likely to experience mental health challenges as the general population.[8]

Because individuals with co-occurring developmental disabilities and mental health conditions often navigate two separate systems of care, they frequently have complex needs that benefit from coordinated, integrated crisis response. As such, the Commission recommends enhancing MRT staff training to include knowledge regarding developmental disabilities and seniors to help ensure that individuals receive appropriate, informed support during behavioral health emergencies. MRTs already play a critical role in diverting individuals from more restrictive settings – with DCF reporting that nearly 80 percent of MRT encounters successfully divert individuals from hospitals or jails – so strengthening their training will further enhance their ability to respond effectively to this population.

Recent state investments reflect initial progress toward expanding MRT capacity. During FY 2024–25, the Legislature provided APD, in partnership with DCF, with over $9.9 million to pilot an expansion of MRTs in Orange, Broward, Hillsborough, and Leon counties. The initiative funds specialized training for frontline staff serving dually diagnosed individuals and adds Board Certified Behavior Analysts (BCBAs) and Registered Behavior Technicians to MRT teams. BCBAs enhance crisis de-escalation, reduce unnecessary CSU placements, and coach caregivers on identifying triggers and implementing coping strategies. APD also partnered with the National Center for START Services to deliver four six-week training sessions beginning in Spring 2024, with more than 200 waiver support coordinators and direct support professionals completing the course. This pilot establishes a strong foundation for improving support and services for this population, and with evaluation, could help guide the development and replication of similar programs statewide.

Senate Bill 1620 (2025) has also advanced on this recommendation by requiring DCF to include clear and effective training requirements for serving individuals aged 65 and older in its Mobile Crisis Response Services rule, 65E-5.603, F.A.C.. As of April 2026, 95 percent of MRT providers have completed this training, improving the system's ability to respond to older adults in crisis. The cost of developing and delivering this type of training varies depending on the format such as a one-time webinar, an online CEU-eligible course, or a fully developed online training module with average costs ranging from $7,000 to $25,000. Similar costs are anticipated for training focused on developmental disabilities. Implementing this expanded training will require coordination among key partners, including DCF, APD, AHCA, first responders, law enforcement, and other stakeholders involved in crisis response.

Recommendation 2: Increase availability of supportive housing services for individuals with developmental disabilities and mental health/dually diagnosed disabilities.

[8] Cree, R.A., Okoro, C.A., Zack, M.M., & Carbone, E. (2020). Frequent mental distress among adults, by disability status, disability type, and selected characteristics — United States, 2018. *MMWR Morb Mortal Wkly Rep*; 69:1238–1243. DOI: http://dx.doi.org/10.15585/mmwr.mm6936a2.

Florida continues to invest in supports and implement strategies to advance the obtainment and availability of affordable and supportive housing, a challenge that significantly affects individuals with developmental disabilities and co-occurring behavioral health conditions. According to the 2025 Florida Council on Homelessness report, which presents 2024 data, 28 percent of individuals experiencing homelessness are age 54 or older, 19 percent have a disability with long-term homelessness, 17 percent have a severe mental illness, and 13 percent have a substance use disorder – figures are not mutually exclusive.[9] This statewide trend is reflected in the 2025–2026 Assessment of Behavioral Health Services, where all seven Managing Entities identified housing as a critical regional need and requested funding to expand supportive housing options, with five specifically prioritizing individuals with mental illness, substance use disorders, or other co-occurring conditions.[10] Moreover, Adult Protective Services reports that its Home and Community-Based Services programs, which help adults with disabilities remain safely in their homes and communities, are currently fully encumbered, further underscoring the statewide strain on housing resources.[11]

Recognizing these needs, the Commission recommends expanding supportive housing capacity and increasing funding to ensure that individuals with developmental disabilities and co-occurring behavioral health conditions have access to stable, community-based living options. Supportive Housing is an evidence-based model that pairs affordable housing with individualized services to help people with complex needs maintain stability, autonomy, and community integration. Effective programs coordinate with key partners to address challenges related to mental health, substance use, and other crises; promote housing stability; and connect tenants with community-based resources, social supports, and opportunities for meaningful engagement.[12] Research demonstrates that supportive housing improves long-term housing stability, supports recovery, increases employment outcomes, and reduces reliance on costly crisis-driven services such as hospitals, EDs, and jails.[13] Expanding supportive housing capacity is essential to strengthening Florida's behavioral health system and better positioning individuals with developmental disabilities and co-occurring conditions to live safely and successfully in their communities.

The Office of Substance Abuse and Mental Health (SAMH) at DCF is actively working to address these gaps by expanding access to housing and strengthening long-term stability for individuals with serious mental illness, co-occurring substance use disorders, and other disabling conditions who are at risk of or currently experiencing homelessness. Recent initiatives, such as the Boley Center proposal, reflect this commitment. The

[9] Department of Children and Families. Publications and reports on homelessness. Accessed 4/2026. Retrieved from https://www.myflfamilies.com/services/abuse/homelessness/publications-and-reports.
[10] Department of Children and Families. Publications. Accessed 4/2026. Retrieved from https://myflfamilies.com/services/samh/publications.
[11] Department of Children and Families. Persons with Disabilities. Accessed 4/2026. Retrieved from https://www.myflfamilies.com/services/abuse/aps/about/clients-we-serve/persons-disabilities.
[12] Corporation for Supportive Housing. (2013). Dimensions of quality supportive housing. Retrieved from https://coresonline.org/sites/default/files/documents/CSH_Dimensions_of_Quality_Supportive_Housing_guidebook.pdf.
[13] Substance Abuse and Mental Health Services Administration. (2024). Housing supports recovery and well-being: Definitions and shared values. Retrieved from https://library.samhsa.gov/product/housing-supports-recovery-and-well-being-definitions-and-shared-values/pep24-08-007.

project, funded at $3.6 million over three years, has provided supported housing for 133 individuals and delivers key wraparound services, including psychosocial rehabilitation (849 individuals), in-home/on-site services (554), and tenancy-sustaining supports (388) in FY 2024–2025.

An additional recent initiative includes the utilization of grant dollars to select qualified provider(s) capable of developing, expanding, and sustaining recovery housing and wraparound service coordination services for young adults aged 18-24 with opioid or stimulant use disorders through a Request for Applications (RFA) process.

More specifically, this initiative is intended to address gaps in Florida's behavioral health continuum by expanding access to safe, stable, and recovery-oriented housing paired with coordinated, trauma-informed services. Funded programs will demonstrate the ability to develop and deliver the required services and supports within the specified timeframe, thereby expanding Florida's access to recovery housing and coordinated recovery supports for young adults. Programs will incorporate Level III recovery residences standards and provide care coordination using a System of Care, aligned wraparound approach characterized by team-based planning, individualized goal setting, and youth-guided decision-making.

These efforts demonstrate meaningful progress but also highlight the importance of addressing needs across the state. Achieving broader, sustained impact will require continued coordinated action among DCF, AHCA, the Florida Housing Coalition, local housing agencies, Managing Entities, and community partners to expand supportive housing capacity statewide.

Recommendation 3: Replicate successful community integrated health teams to address the dual diagnosis needs of seniors with mental health disabilities or others with complex co-morbidities.

Florida's older adult population is projected to grow by nearly nine percent between 2024 and 2030, increasing the number of seniors who may require behavioral health support.[14] According to the 2024 Behavioral Risk Factor Surveillance System (BRFSS) survey, almost one-quarter of older adults live alone, 15 percent report having been told they have a depressive disorder, and nearly 11 percent experienced poor mental health on 14 or more days in the past month. AHCA data further show that this population experiences 10 ED visits and 21.2 hospitalizations per 100,000 for self-harm, and 556.6 hospitalizations per 100,000 for mental disorders.[15] Given these trends, the Commission recommends replicating successful community integrated health teams to better support high-risk older adults and individuals with complex behavioral health needs.

[14] Florida Department of Health. Aging in Florida dashboard overview. Accessed 4/2026. Retrieved from https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=AgingInFlorida.Overview&rdDataCache=4252963982.
[15] Florida department of Health. Aging in Florida dashboard report. Accessed 4/2026. Retrieved from https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=AgingInFlorida.Profile&tabid=Report&islCounty=69.

Community Integrated Health (CIH) teams provide coordinated, in-home and community-based support through multidisciplinary professionals such as paramedics, social workers, and other healthcare providers. In Florida, 52 counties operate some form of integrated health team.[16] Community Paramedicine, also referred to as Mobile Integrated Health (MIH), is an emerging model in which EMS personnel operate in expanded roles to connect underserved populations with needed services as a viable solution to reduce healthcare disparities and improve access in underserved areas.[17]

Another CIH model includes PanCare, a Federally Qualified Health Center (FQHC) that operates a Mobile Behavioral Health Unit providing comprehensive care across a 4,000-square-mile service area. The unit offers primary care, behavioral health counseling, substance use assessment, and MAT, and is equipped with telehealth capabilities and an outreach case manager who provides education, screenings, and support. By bringing services directly to patients, the unit helps address common barriers such as transportation. These teams can complement MRTs, which provide 24/7 emergency behavioral health care statewide. While MRTs respond to individuals experiencing acute emotional or behavioral crises, CIH teams can continue engagement once the individual is stabilized, offering follow-up support, monitoring, and linkage to ongoing services. Likewise, CIH teams can contact MRTs when an individual they are serving enters a behavioral health crisis requiring specialized intervention.

Because CIH teams vary across regions based on local needs and resources, assessing programs that specifically serve older adults and individuals with complex co-morbidities would help identify effective practices that could be replicated in other counties. Strengthening and expanding these models would enhance Florida's capacity to support high-risk populations, reduce avoidable hospitalizations, and improve continuity of care across the behavioral health system. Fiscal impacts will depend on the type of CIH model, the services offered, and the number of individuals and counties served, and will require further assessment to fully understand associated costs. Key stakeholders include DCF, AHCA, DOH, Managing Entities, and providers such as EMS agencies, FQHCs, hospital and health system partners, behavioral health organizations, primary care providers, and community-based service agencies that can collaborate to deliver integrated care.

Recommendation 4: Continue to evaluate opportunities for enhanced integration of primary care and behavioral health into the statewide planning and evaluation framework, including evaluating the implementation of a validated screening tool. Integration of primary care services and behavioral health services is associated with improved outcomes in multiple domains.[18] Ongoing opportunities for enhanced

[16] Florida Department of Health. Mobile Integrated Health Programs. Accessed 4/2026. Retrieved from https://open-fdoh.hub.arcgis.com/apps/FDOH::mih-programs/explore?path=.
[17] Centers for Disease Control and Prevention. (2024). The value of community paramedicine. Retrieved from https://www.cdc.gov/ems-community-paramedicine/php/data-research/community-paramedicine/index.html#cdc_report_pub_study_section_2-social-factors-and-health.
[18] Maeng, D.D., et al. (2022). Primary care behavioral health integration and care utilization: Implications for patient outcome and healthcare resource use. *Journal of General Internal Medicine, 37*(11), 2691-2697; Coates, D., et al. (2020). Integrated physical and

integration of primary care and behavioral health services are reflected in the most recent findings from the 2024 National Substance Use and Mental Health Services Survey. According to responses from 674 mental health treatment facilities throughout Florida, only 29 percent offer integrated primary care services. Responses from 693 substance use treatment providers indicate that only 35 percent offer integrated primary care services. A higher proportion, 57 percent, offer a complete medical history and physical exam performed by a healthcare provider.[19] Comparable opportunities for integration of behavioral health capacity through Family Medicine, for example, with only about 39 percent of family physicians working collaboratively with behavioral health professionals.[20] Given these gaps, the Commission recommends continued evaluation of opportunities to strengthen integration of primary care and behavioral health within the statewide planning and evaluation framework, including validated screening tools.

An important aspect of integrated frameworks and models is the use of validated screening tools which can be used by primary care providers to screen for behavioral health conditions, and by behavioral health providers to screen for other health conditions. The Agency for Healthcare Research and Quality's (AHRQ) Academy for Integrating Behavioral Health and Primary Care identifies validated screening tools for depression, anxiety, substance use, suicidality, trauma, and more through various Playbooks and Topic Briefs.[21] The AHRQ also synthesizes evidence for the U.S. Preventive Services Task Force (USPSTF) to use when making recommendations about health screenings. The recommendations published by the USPSTF on screenings cover various health conditions like cardiovascular disorders, infectious diseases, metabolic conditions, etc., in addition to behavioral health topics like anxiety, depression, drug use, and child maltreatment.[22]

Implementing this recommendation may result in fiscal impacts that are indeterminate at this time. Key stakeholders include DCF, AHCA, DOH, Managing Entities, and providers, among others.

Expanding Access, Capacity and System Navigation

Improving access to behavioral health services in Florida depends on strengthening the points where individuals first encounter the system and expanding the treatment options

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mental healthcare: An overview of models and their evaluation findings. *International Journal of Evidence-Based Healthcare, 18*, 38-57; Unutzer, J., et al. (2002). Collaborative care management of late-life depression in the primary care setting. A randomized controlled trial. *JAMA, 288*(22), 2836-2845; Fallucco, E.M., et al. (2017). Collaborative care: A pilot study of a child psychiatry outpatient consultation model for primary care providers. *Journal of Behavioral Health Services & Research, 44*, 386-398.

[19] Substance Abuse and Mental Health Services Administration. (2025). *National Substance Use and Mental Health Services Survey (N-SUMHSS) State Profiles 2024*. Retrieved from https://www.samhsa.gov/data/sites/default/files/reports/rpt56698/2024-nsumhss-state-profiles.pdf.

[20] Tong, S.T., et al. (2023). Characteristics of family physicians practicing collaboratively with behavioral health professionals. *The Annals of Family Medicine, 21(2), 157-160.*

[21] Agency for Healthcare Research and Quality. (2026). The academy – Integrating behavioral health & primary care. Retrieved from https://integrationacademy.ahrq.gov/.

[22] U.S. Preventive Services Task Force. (2025). USPSTF recommendation topics. Retrieved from https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics.

available to them. This section focuses on enhancing “no wrong door” access through a more robust Central Receiving Facility (CRF) system and expanding SRT options. These recommendations aim to reduce fragmentation, address persistent gaps in service availability, and ensure that individuals experiencing mental health or substance use challenges can be connected to timely, clinically appropriate care.

Recommendation 5: Expand central receiving facilities/systems for “no wrong door” access including both mental health and substance use.

Section 394.4573, F.S., establishes the state’s responsibility to maintain a coordinated, recovery-oriented system of care that ensures individuals can access behavioral health services regardless of where they enter the system. CRFs advance this statutory framework by serving as a unified, standardized point of entry for individuals experiencing mental health or substance use crises. CRFs eliminate the guesswork for law enforcement, first responders, and families by providing a designated location equipped for clinical assessment and stabilization rather than defaulting to hospitals, EDs or jails. Through immediate triage, assessment, and linkage to appropriate levels of care, CRFs reduce fragmentation and support timely access to clinically appropriate services across the continuum.

Florida currently operates 21 CRFs serving 38 counties, all functioning 24 hours a day, seven days a week, and designated to receive both children and adults who voluntarily present or are brought in by law enforcement for emergency stabilization. As a large and rapidly growing state, Florida continues to face increasing demand for crisis services. To strengthen system coordination and reduce barriers created by fragmented service pathways, the Commission recommends expanding CRFs and enhancing “no wrong door” access for individuals experiencing mental health and substance use crises. Initial progress is underway as DCF has planned three new facilities that will extend coverage to four additional counties, bringing the total to 42 counties served.

Despite these efforts, the Commission notes additional work is needed to continue to close remaining gaps, particularly for individuals with co-occurring mental health and substance use disorders who often encounter siloed systems in which one condition is prioritized over the other, resulting in delayed or incomplete care. The Commission further recommends strengthening CRF operations through consistent protocols, cross-agency collaboration (including robust partnerships with hospitals and providers for individuals requiring medically complex care), and integrated data systems to improve service navigation, enhance continuity of care, and ensure individuals receive the right level of support at the right time.

For FY 2026–27, the Legislature appropriated $7,044,138 in recurring General Revenue funds under the Grants and Aids – Central Receiving Facilities category to DCF. Continuing and expanding this work will require coordinated engagement from key stakeholders, including, but not limited to, DCF, AHCA, Managing Entities, providers, community partners, and law enforcement.

Recommendation 6: Continue to increase programmatic and bed availability of short term residential (non-CSU) treatment programs for youth, particularly in high need areas.

This recommendation builds on the Commission's earlier work in Interim Report #2, which called for increasing SRT capacity. SRTs function as an extension of crisis stabilization services, providing additional treatment and support when individuals are not yet ready to return to a community setting. At the time of last year's report, Citrus Health Network in Miami-Dade County had opened Florida's first 16-bed SRT for children. Since then, the model has expanded to three providers across three Managing Entities, increasing capacity to 28 children's beds statewide. The statewide gap analysis finalized in 2025, using 2024 data that reflected only the initial 16-bed capacity, further underscored the need for additional resources. The analysis recommended increasing capacity by 72 to 106 beds across SRT and therapeutic group home programs and called for at least one children's SRT facility in every region.

Recognizing these needs, Senate Bill 1620 directed DCF to conduct biennial reviews of SRT capacity and required AHCA to prioritize licensing SRT facilities in underserved counties and high-need areas. To support this expansion, DCF submitted a Legislative Budget Request for FY 2026–27 to increase statewide SRT capacity. According to the statewide gap analysis, an additional 80 children's SRT beds would cost an estimated $12,964,800 annually (approximately $162,060 per bed), while adding 46 to 67 adult beds would cost an estimated $7,197,253 annually (approximately $127,385 per bed). While these actions represent meaningful progress, the Commission notes that current capacity remains below what is needed to meet statewide demand, particularly for youth in high-need areas, and therefore recommends continuing to expand programmatic and bed availability. Ongoing investment and collaboration will be essential to ensuring that SRT availability keeps pace with Florida's growing behavioral health needs. Advancing this work will require coordinated involvement from key stakeholders, including DCF, AHCA, Managing Entities, providers, and community partners, among others.

Strengthening System Governance, Coordination and Strategic Planning

Strengthening Florida's behavioral health system requires coordinated leadership, consistent planning, and shared accountability across state agencies and local partners. This section focuses on improving statewide governance structures, enhancing cross-agency collaboration, and establishing routine processes for identifying system needs and aligning resources. Together, these recommendations support a more unified, data-driven approach to planning and oversight, helping ensure that Florida's behavioral health system remains responsive, efficient, and prepared to meet emerging challenges.

Recommendation 7: Complete a gap analysis every three years.

In its second Interim Report, the Commission recommended completing a statewide gap analysis to better understand Florida's behavioral health treatment capacity and future needs. Florida completed its first comprehensive analysis on January 31, 2025. This analysis examined a range of indicators, including current bed allocation, admissions,

discharges, and average lengths of stay by facility, program type, and region for children, adolescents, and adults. It also assessed current and projected demand for civil and forensic inpatient placements, bed needs by facility and placement type, and lengths of stay for Medicaid statewide inpatient psychiatric services. The resulting report now serves as a foundational planning tool for the state and underscores the importance of regularly assessing Florida's behavioral health system to identify emerging barriers and service gaps.

To maintain a consistent, evidence-driven planning cycle, the Commission recommends conducting a statewide gap analysis every three years, beginning in 2030, following the 2025–2029 analysis period. Regular evaluation will ensure Florida's behavioral health planning remains data-informed, with each analysis providing actionable guidance to support appropriations, workforce planning, system design, and long-term accountability.

The 2025–2029 gap analysis cost DCF $700,000 for contracted services with the selected vendor. Similar costs should be anticipated for each subsequent analysis. Successful implementation will require continued collaboration among key partners, including DCF, Managing Entities, AHCA, APD, DJJ, Florida Sheriff's Association, Florida Hospital Association (FHA), Florida Behavioral Health Association (FBHA), National Alliance on Mental Illness (NAMI), and other stakeholders.

Recommendation 8: Convene a meeting of Health and Human Services' State Agency leaders (open to the public/stakeholders) at least annually to elevate and address system-wide issues emerging from regional collaborative meetings.
As the Commission approaches its sunset in Fall 2026, it remains essential that evolving gaps in Florida's behavioral health system continue to be identified and addressed. In its first Interim Report, the Commission recommended establishing regional collaboratives to support this work. This recommendation was enacted through House Bill 7021 (2024), which requires DCF and AHCA to jointly establish behavioral health interagency collaboratives across the state. These collaboratives are designed to identify local challenges and strengthen the accessibility, availability, and quality of behavioral health services.

To build on this foundation, the Commission recommends convening an annual public meeting of Health and Human Services state agency leaders. These meetings would provide a structured venue to review information emerging from the regional collaboratives, gather public input, and translate local insights into statewide strategies.

The collaboratives' findings can serve as a springboard for higher-level discussions on system design and improvement, offering decision makers an opportunity to collectively address systemic gaps and consider stakeholder recommendations.

DCF and AHCA would serve as co-leads in bringing together key partners, particularly as both agencies develop Legislative Budget Requests each year. Hearing directly from regional collaboratives and stakeholders would support more informed planning and resource allocation. Key stakeholders include DCF; AHCA; regional collaboratives;

Managing Entities; providers; Medicaid managed care plans; DOH; DJJ; FDC; DOE; local governments; law enforcement; advocacy organizations; individuals with lived experience; and representatives from small, medium, and rural counties, among others. While specific costs have not yet been established, this recommendation is expected to be achievable within existing resources.

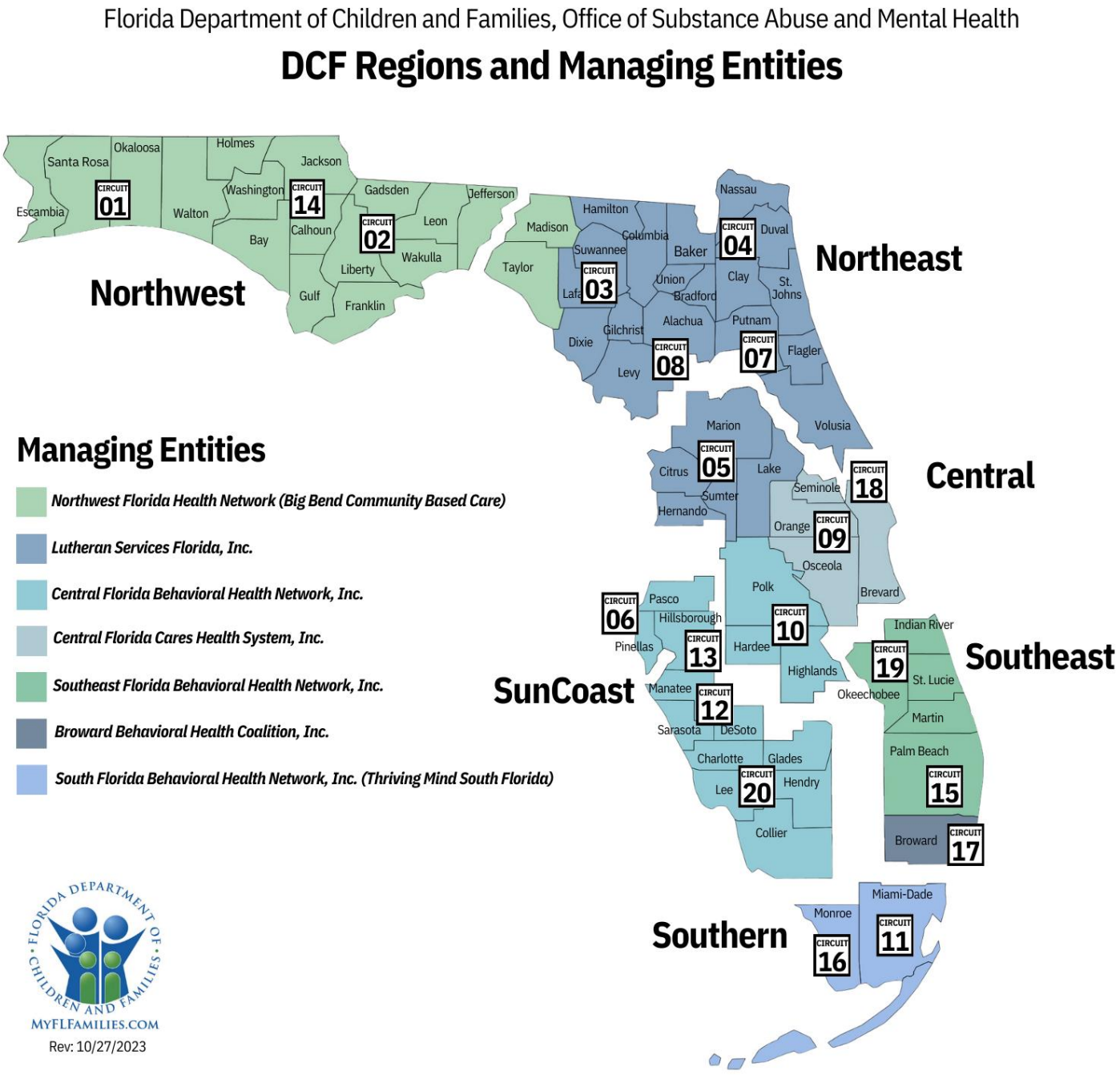
Conclusion

Since its establishment, the Commission has worked to evaluate Florida's behavioral health system, identify gaps in service delivery, and elevate strategies that strengthen coordination, access, and outcomes across the continuum of care. Over the past several years, the Commission's work has focused on building a stronger, evidence-informed foundation for the system improving data infrastructure, enhancing services and workforce capacity, strengthening community networks, and advancing cross-agency collaboration and financial stewardship. These efforts have informed legislative action, budget investments, and system-level improvements that continue to shape Florida's behavioral health landscape.

Building on this foundation, the Commission's final year centered on advancing clinical practice and specialized services, expanding access and system navigation, and strengthening governance, coordination, and strategic planning. These priorities reflect both the progress achieved to date and the ongoing needs that remain as Florida's behavioral health system evolves to meet the complex needs of individuals, families, and communities.

As the Commission completes its statutory charge, this final report is intended to support policymakers, agencies, and community partners in carrying forward the work that remains. The Commission's findings and recommendations offer a roadmap for continued, evidence-based improvement and a foundation for building a more coordinated and person-centered behavioral health system. Sustained leadership, cross-agency collaboration, and strategic investment will be essential to ensure that all Floridians have access to the care and support they need to thrive.

Appendix


Florida Department of Children and Families, Office of Substance Abuse and Mental Health
DCF Regions and Managing Entities
Managing Entities
Northwest Florida Health Network (Big Bend Community Based Care)
Lutheran Services Florida, Inc.
Central Florida Behavioral Health Network, Inc.
Central Florida Cares Health System, Inc.
Southeast Florida Behavioral Health Network, Inc.
Broward Behavioral Health Coalition, Inc.
South Florida Behavioral Health Network, Inc. (Thriving Mind South Florida)
Northwest
Northeast
Central
Southeast
SunCoast
Southern
CIRCUIT 01
CIRCUIT 02
CIRCUIT 03
CIRCUIT 04
CIRCUIT 05
CIRCUIT 06
CIRCUIT 07
CIRCUIT 08
CIRCUIT 09
CIRCUIT 10
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Volusia
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Gilchrist
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Levy
Marion
Citrus
Lake
Sumter
Hernando
Seminole
Orange
Osceola
Brevard
Polk
Pasco
Hillsborough
Pinellas
Hardee
Highlands
Manatee
Sarasota
DeSoto
Charlotte
Glades
Lee
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