STATE OF FLORIDA

BEHAVIORAL HEALTH GAP ANALYSIS

January 31, 2025

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Table of Contents

Legislative Charge

On March 21, 2024, Governor Ron DeSantis signed Senate Bill 330, also known as the Behavioral Health Teaching Hospitals Act. 2024 Legislature, Senate Bill 330, Section 7, upon which the study and report are guided by and based on, indicates that:

Effective upon this act becoming a law, the Department of Children and Families must contract for a detailed study of capacity for inpatient treatment services for adults with serious mental illness and children with serious emotional disturbance or psychosis in this state's forensic inpatient, safety-net voluntary and involuntary civil inpatient placement, and Medicaid statewide inpatient psychiatric programs. The study must include analyses of current capacity, current and projected future demand, and the state's current and projected future ability to meet that demand and must include recommendations for enhancing the availability of inpatient treatment services and for providing alternatives to such services. The study must be completed by January 31, 2025, and must include, at a minimum, the following:

1) By facility and by program type, the current number and allocation of beds for inpatient treatment, the number of individuals admitted and discharged annually, and the lengths of stay.
2) By department region, the current number and allocation of beds in receiving, treatment, and state treatment facilities and residential treatment centers for children and adolescents for inpatient treatment between forensic and civil placements, the number of individuals admitted and discharged annually, the types and frequency of diagnoses, and the lengths of stay.
3) By department region, the current and projected future demand for civil and forensic inpatient placements at receiving, treatment, and state treatment facilities and residential treatment centers for children and adolescents, any gaps in current and projected future availability of these services compared to current and projected future service demand, and the number of inpatient beds needed by facility type and placement type to meet current and projected future demand.
4) By agency region, the number of individuals admitted and discharged annually, the types and frequency of diagnoses, and the lengths of stay for Medicaid statewide inpatient psychiatric program services, the current and projected future demand for these services, any gaps in current and projected future availability of these services compared to current and projected future service demand, and the number of inpatient beds needed by facility type to meet current and projected future demand.
5) Policy recommendations for ensuring sufficient bed capacity for inpatient treatment at treatment facilities, state treatment facilities, or receiving facilities, or at residential treatment centers for children and adolescents, and for enhancing services that could prevent the need for involuntary inpatient placements.
6) A gap analysis as recommended by the Commission on Mental Health and Substance Use Disorder in the Annual Interim Report dated January 1, 2024.

Executive Summary

The Florida Department of Children and Families is committed to supporting local communities to protect vulnerable populations, promote strong and economically self–sufficient families, and support personal and family recovery and resiliency. The agency accomplishes this through public and private partnerships with other governmental agencies, Managing Entities and providers of mental health and substance use services and supports. These partnerships support service delivery for adults, children, and adolescents across the statewide system of prevention, treatment and recovery services and supports.

Behavioral health includes both mental health and substance use conditions and has become more broadly used to describe a whole person approach to supporting the needs of children, adolescents, and adults. The growing need for mental health and substance use services experienced throughout our nation requires state governments to focus on the extent of mental health and substance use experienced, assess individuals' needs for services and support, and thoroughly understand the capabilities and capacity of the system of care.

In Florida, approximately 5% of the state's civilian population have serious mental illness[1] and over 400,000 children and youth experience emotional, behavioral, and developmental issues, but only about half are able to access services.[2,3] Additionally, an estimated 13% of Florida's citizens, or roughly 2.9 million people, used illicit drugs within the past month, and an estimated 15% of individuals have struggled with substance use disorder within the past year.[4]

To address the state's behavioral health challenges, the Florida Legislature allocates funds to the Department of Children and Families (DCF) for behavioral health services, including through multiple specific appropriations to designated state funded providers of these services. Additional funding for core behavioral health services includes time–limited federal grants, such as grants to combat the opioid epidemic and support case management for homeless individuals with behavioral health condition (e.g., Projects for Assistance in Transition from Homelessness –PATH, State Opioid Response Grant– SOR, Mental Health Block Grant– MHBG). During the past two years there have been investments of nearly $1.47 billion. Additionally, the state of Florida is receiving $3 billion in Opioid Abatement Settlement Funds over an 18-year period to support opioid addiction and recovery services, harm reduction services, school, and community prevention campaigns.

To further the state's efforts at mitigating the factors contributing to the mental health and substance use disorder crisis, on March 21, 2024, Senate Bill 330, known as the Behavioral Health Teaching Hospitals Act was signed, requiring the DCF to conduct a detailed study on the capacity of behavioral health facilities. The study includes information on several indicators such as (but not limited to) current bed allocation, admissions, discharges, and average lengths of stay by facility, program type, and region for children, adolescents, and adults; 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. Additionally, a gap analysis, including demographic profile, service availability and costs will be conducted to evaluate the behavioral health system of care. Policy recommendations will be developed to address opportunities to enhance services, supports, and bed capacity.

Data presented in this assessment describes gaps in capacity across the following behavioral health facilities and services included in the scope of the study: public and private hospitals, state mental health treatment facilities (SMHTF) – civil, forensic, and juvenile incompetent to proceed programs (JITP), facilities providing inpatient psychiatric treatment services, crisis stabilization units (i.e. emergency receiving), and residential treatment centers and facilities. This assessment examined the availability of behavioral health community-based services and gaps in the system of care and offered options for service enhancement.

[1] SAMHSA, 2022 State-by-state estimates of serious mental illness

[2] Florida Department of Health, Behavioral Health and Related Topics | Florida Department of Health

[3] Ibid

[4] SAMHSA, 2022 NSDUH State Estimates

Further this assessment identified factors impacting the behavioral health system of care including Florida's behavioral health workforce shortages and outdated behavioral health service reimbursement rates. The assessment is organized by service type as detailed above, and by services that support children and adolescents and adults.

The analysis examined bed availability and projected demand based on 75%, 85%, and baseline utilization rates across psychiatric inpatient facilities, including emergency receiving/Baker Act facilities, state treatment facilities, and residential treatment centers for inpatient treatment between forensic (inpatient hospital that provides a secured level of care for individuals committed as incompetent to proceed or not guilty by reason of insanity) and civil (inpatient hospital that serves individuals who do not require a secured level of care) placements. Projected gaps in bed capacity are presented in the tables below, for children, adolescents, and adults. The projected number of additional beds that will be need throughout the 2025 to 2029 timeframe are indicated in the table. Instances where there are surpluses in bed capacity, a positive symbol (+) is noted in the table. Instances where a specific facility type is not present in a region and consequently, projections could not be calculated are denoted with a N/A. Details on the surpluses as well as on gaps in bed capacity across regions can be found in Appendix B:

Table 1: Summary of projected gaps in bed capacity for children and adolescents (2025-2029)

Facility/Service Type	Region	Projected Gaps in Bed Capacity (i.e., the projected number of additional beds that will be needed)				
		2025	2026	2027	2028	2029
Hospital with psychiatric beds/inpatient units	Northeast	1	1	1	2	2
	Northwest	0	1	1	1	1
	Central	4	5	6	8	9
	Southeast	9	10	10	11	11
	Suncoast	2	3	3	4	5
	Southern	0	0	0	0	0
Specialty psychiatric hospital (Class 3)	Northeast	2	2	3	4	4
	Northwest	0	1	1	1	3
	Central	4	5	6	8	11
	Southeast	1	1	2	2	3
	Suncoast	2	3	3	4	10
	Southern	N/A	N/A	N/A	N/A	N/A
Crisis Stabilization Units (i.e., Emergency receiving)	Northeast	1	1	2	2	2
	Northwest	N/A	N/A	N/A	N/A	N/A
	Central	3	4	5	6	7
	Southeast	+	+	+	+	1
	Suncoast	+	+	+	+	5
	Southern	+	+	+	+	0
Residential Treatment Center	Northeast	2	3	4	5	5
	Northwest	+	+	+	+	+
	Central	72	74	76	78	80
	Southeast	+	+	+	+	+
	Suncoast	+	+	+	+	+
	Southern	+	+	+	+	+
Specialized Therapeutic Group Home	Northeast	+	+	0	0	0
	Northwest	N/A	N/A	N/A	N/A	N/A
	Central	1	1	2	2	2
	Southeast	2	2	2	3	3
	Suncoast	1	1	1	1	1
	Southern	0	0	0	0	0
Short-term Residential Treatment Unit	Northeast	N/A	N/A	N/A	N/A	N/A
	Northwest	N/A	N/A	N/A	N/A	N/A
	Central	N/A	N/A	N/A	N/A	N/A
	Southeast	N/A	N/A	N/A	N/A	N/A
	Suncoast	N/A	N/A	N/A	N/A	N/A
	Southern	0	0	0	0	0

Notes: + indicates a projected surplus in bed capacity for the given region; surplus details can be found in the Appendix B. N/A indicates that there were none of the given type of facility in the specified region and thus demand projections could not be calculated.

Table 2: Summary of projected bed capacity gaps for adults (2025-2029)

Facility /Service Type	Region	Projected Gaps in Bed Capacity (i.e., the projected number of additional beds that will be needed)				
		2025	2026	2027	2028	2029
Hospital with psychiatric beds/inpatient units	Northeast	12	16	21	26	31
	Northwest	6	9	11	14	16
	Central	12	17	22	27	32
	Southeast	13	19	24	30	36
	Suncoast	15	22	28	35	41
	Southern	12	17	22	28	33
Specialty psychiatric hospital (Class 3)	Northeast	6	9	11	14	17
	Northwest	3	5	6	8	9
	Central	23	32	42	52	62
	Southeast	9	13	17	21	25
	Suncoast	19	27	35	44	52
	Southern	1	2	3	3	4
Crisis Stabilization Units (i.e., Emergency receiving)	Northeast	2	3	4	5	7
	Northwest	1	2	3	3	4
	Central	10	14	18	22	27
	Southeast	2	3	4	5	6
	Suncoast	5	8	10	12	14
	Southern	2	2	3	4	4
Residential Treatment Facility	Northeast	22	27	32	36	41
	Northwest	+	+	+	+	+
	Central	2	8	13	19	25
	Southeast	27	37	47	58	68
	Suncoast	20	26	32	39	45
	Southern	14	17	20	23	26
Short-term Residential Treatment Unit	Northeast	N/A	N/A	N/A	N/A	N/A
	Northwest	9	9	9	10	10
	Central	+	+	+	+	+
	Southeast	0	1	1	2	2
	Suncoast	10	10	10	11	11
	Southern	N/A	N/A	N/A	N/A	N/A

Notes: + indicates a projected surplus in bed capacity for the given region; surplus details can be found in the Appendix B. N/A indicates that there were none of the given type of facility in the specified region and thus demand projections could not be calculated.

Additionally, an assessment of the behavioral health system of care and support was conducted based on publicly available information, data provided by the Florida Department of Children and Families and the Agency for Health Care Administration, and insights gathered from interviews with Managing Entities and providers. Ranges of proposed increases in bed counts reflect low and high bed demand estimates based on differences in projected bed utilization rates, including 75% and 85% utilization, as well as the utilization rate at baseline. Key opportunities to improve services and supports are as follows:

Opportunities for Enhancement

Conduct broad scale, multi–channel, community public information campaigns to spread information about behavioral health services and access (e.g., messaging via social media, public transportation, roadways, movie theaters). These campaigns should be designed to reach diverse audiences, including youth, adults, and individuals from various cultural backgrounds.

Enhance the availability of targeted care coordination to ensure that individuals with complex behavioral health needs receive personalized, coordinated care and appropriate navigation of services that address their unique circumstances and supports their long–term treatment and recovery goals.

Increase availability of integrated behavioral and physical health services. Models include physicians and nurses physically located within a behavioral health clinic, and/or the co–location of behavioral health specialists (e.g., psychiatrists, psychologists, and clinical social workers) within a primary care setting.

Increase co–located services for the uninsured and underinsured population of individuals across the state to promote a comprehensive health care system that meets the primary and behavioral health needs of individuals, decreasing reliance on emergency department visits and subsequent inpatient admissions.

Clubhouses are community–based settings staffed by behavioral health professionals and paraprofessionals that provide structured support and socialization for adults and youth living with behavioral health needs. Clubhouses are intended to improve quality of life, create purpose and connection with the community.

Increase the availability of recovery clubhouses by at least one in the Northwest region to provide recovery–oriented supports for individuals with behavioral health conditions.

Increase the number of adult residential beds by 149-205, and child and adolescent residential beds by 72-106, across short-term residential treatment, and therapeutic group home facilities throughout the state. These transitional beds provide a structured and supportive living environment for individuals with behavioral health needs, and crucial stabilization and treatment for individuals transitioning out of psychiatric inpatient care, helping to reduce inpatient lengths of stay and support successful community reintegration.

Addition of at least 29 Florida Assertive Community Treatment community–based services to support diversion from inpatient admission and readmission across the state. Additional FACT teams by region: Southern – 4, Suncoast – 4, Southeast – 8, Central – 8, Northeast – 4, and Northwest – 1. Addition of at least one Intermediate Level FACT team each in the Southern, Suncoast, and Central regions.

State of Florida needs:

- At least 34 additional psychiatrists to provide sufficient coverage and availability such that each county has at least one psychiatrist and that no county has fewer than 1 psychiatrist per 30,000 residents.
- 25,133 additional mental health professionals are needed statewide. Mental health provider, in this context, refers to marriage and family therapists, clinical social workers, and mental health counselors. Of note is the newly created USFs Florida Center for Behavioral Health Workforce implemented in SB330, Section 6.

Expand the availability of short-term residential treatment services for adults and children and adolescents such that there is at least one facility present in each region for each of the two populations.

Expand the availability of crisis stabilization unit beds (additional 62–369 for adults and 26–48 for children and adolescents) to provide community–based alternatives to inpatient and ensure that each county has sufficient capacity to meet the needs of individuals experiencing a behavioral health crisis, help prevent unnecessary hospitalizations, and provide timely, appropriate care in a less restrictive setting.

The state mental health facilities gap for civil beds in 2025 is estimated to be 248 beds. If no new civil beds are added, the gap is forecast to grow to 770 beds in 2029. The state mental health facilities gap for forensic beds in 2025 is estimated to be 612 beds. If no new forensic beds are added, the gap is forecast to grow to 1,074 beds by 2029.

The following table provides the number of proposed additional units and the corresponding unit(s) costs (estimated) per year for services, and beds across facility type. The estimated time to implement service enhancements (e.g., includes operationalization and implementation but not construction) will vary based on the types of new services implemented, priority of service needs (i.e., short, medium, or long-term), staffing needs, and facility construction, if applicable. It is anticipated to take at least twelve to twenty-four months accounting for procurement, staff training, and resource acquisition factors and constraints. Construction may increase the timeline to thirty-six months.

Table 3. Estimated Number of Additional Service and Supports Needed and Associated Costs Per Year

Services	Cost per unit per Year	Total Units	Average Estimated Total Costs per Year
Recovery clubhouse*	$125,000	1	$125,000
Florida Assertive Community Treatment*	$1,401,639	29	$40,647,531
Intermediate Level Florida Assertive Community Treatment*	$1,000,000	3	$3,000,000
Mobile response team*	$647,058	7	$4,529,406
Adults – Additional Beds			
State Mental Health Treatment Facility – Civil**	$268,640	770 – 934	$228,881,280
State Mental Health Treatment Facility – Forensic**	$271,560	1,074 – 1,429	$339,857,340
Hospital with psychiatric beds/inpatient units**	$318,645	53 – 190	$38,715,368
Specialty psychiatric hospital (Class 3)**	$318,645	137 – 177	$50,027,265
Crisis stabilization unit**	$166,440	62 – 369	$35,867,820
Residential treatment**	$71,631	149 – 205	$12,678,687
Short–term residential treatment**	$127,385	46 – 67	$7,197,253
Children and Adolescents – Additional beds			
Juvenile Incompetent to Proceed (JITP)**	$161,695	22 – 37	$4,770,003
Hospital with psychiatric beds/inpatient units**	$187,245	29 – 102	$12,264,548
Specialty psychiatric hospital (Class 3)**	$187,245	57	$10,672,965
Crisis stabilization unit**	$169,360	26 – 48	$6,266,320
Residential treatment**	$96,238	72 – 106	$8,565,182
Short–term residential treatment**	$162,060	80	$12,964,800
Specialized therapeutic group home**	$49,175	17	$835,975
Total	**NA**	**NA**	**$817,866,741**

Notes: Total costs per service are calculated as the product of total units and annual cost per unit. Ranges of additional units, high and low estimates for projected bed need, are calculated based on projected service demand sensitivity analysis as described in Tables 9 and 16-18 in addition to estimated beds per new facility where relevant.
*Additional unit estimates identified based on current utilization and demand.
**Additional unit estimates identified based on projected gap in bed availability by 2029.

Behavioral Health Prevalence

Behavioral health includes an individual's emotional, psychological, social state of wellbeing[5], and the consumption of selected substances[6]. Mental illnesses and substance use disorders involve a range of conditions including:

- Mood disorders (e.g., anxiety, bipolar, major depression)
- Thought disorders (e.g., schizophrenias, psychosis, delusional disorders)
- Stress and trauma related disorders (e.g., post–traumatic stress disorder (PTSD))
- Eating disorders (e.g., anorexia, bulimia)
- Impulse control disorders (e.g., conduct disorder, oppositional defiant disorder)
- Self–injury, suicidal thoughts, suicidal attempts
- Substance use disorders (e.g., alcohol, nicotine, cocaine, opioid, cannabis)

Behavioral health can be negatively impacted by lack of access to safe and stable housing, and inadequate healthcare. Exposure to violence and trauma also negatively impacts individuals' behavioral health. Behavioral health disorders can be influenced by genetic, biological, and environmental factors. Depending on the severity of symptoms and impact on functioning, individuals' behavioral health needs may be met by various community–based, outpatient, crisis, residential or inpatient services.

Nationally:

- Suicide death rate was 17.2 per 100,000[7]
- 8.8% of adults experienced a major depressive event (MDE), and of those 6.2% experienced a MDE with severe impairment[8]
- 12.3% of adolescents (12–17 years) had serious thoughts of suicide, 5.6% of adolescents made a suicide plan, and 3.3% attempted suicide[9]
- All–drug overdose rate was 32.69 per 100,000[10]
- The opioid-related overdose death rate was 32.6 per 100,000[11]

In Florida:

- Suicide death rate was 17.2 per 100,000[12]
- 17.8% of adults have ever been told that they had a depressive disorder[13]
- 34.8% of students have thought about committing suicide one or more times in the past 12 months, and 9.1% attempted suicide[14]
- All–drug overdose rate was 35.9 per 100,000[15]
- The opioid-related overdose death rate was 29 per 100,000 and 19,782 opioid–involved non–fatal overdoses emergency department visits [16]

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[5] SAMHSA, What is Mental Health, https://www.samhsa.gov/mental-health

[6] CDC, National Center for Health Statistics, Substance use, https://www.cdc.gov/nchs/hus/sources-definitions/substance-use.htm

[7] CDC, Suicide Data and Statistics | Suicide Prevention, 2022 suicide rate, https://www.cdc.gov/suicide/facts/data.html#cdc_data_surveillance_section_4-suicide-rates

[8] SAMHSA, 2022 National Survey on Drug Use and Health

[9] Ibid

[10] Spencer MR, Garnett MF, Miniño AM. Drug overdose deaths in the United States, 2002–2022.NCHS Data Brief, no 491. Hyattsville, MD: National Center for Health Statistics. 2024. DOI:https://dx.doi.org/10.15620/cdc:135849

[11] Ibid

[12] FLHealthCHARTS, Suicide and Behavioral Health, Suicide and Behavioral Health Profile, 2022 suicide deaths

[13] Florida Department of Health, 2022 Behavioral Risk Factor Surveillance System (BRFSS)

[14] Florida Department of Children and Families, 2022 FYSAS State Report, https://www.myflfamilies.com/sites/default/files/2022-12/2022%20Statewide%20FYSAS%20Report%20Per%20Section%20C2-2.3.pdf

[15] Florida Department of Health, FLHealthCHARTS, 2022 Substance Use Dashboard, Substance Use Dashboard: Overview | CHARTS

[16] Ibid

- Naloxone was administered 51,752 times[17]

Behavioral Health Workforce

Nationally, there is a shortage of behavioral health professionals, including addiction counselors, marriage and family therapists, mental health counselors, psychologists, psychiatric physician assistants/associates, psychiatrists, and school counselors[18]. Florida's patient-–to-–mental health provider ratio, 550:1, is higher than the national average patient-–to-–mental health provider ratio of 340:1, indicating that Floridians, on average, have less access to mental health providers than the national population.[19]

As illustrated in Figure 1, 98.5% of the counties in Florida have either partial or complete shortage of mental health professionals. Only one county – Clay County – does not have a shortage of mental health professionals.[20]

Specific to psychiatrists, according to the Health Resources and Services Administration, the prevalence of fewer than one psychiatrist per 30,000 individuals in an area indicates a shortage of mental health professionals. In Florida, the following 20 counties (with populations below 30,000) do not have a resident psychiatrist.

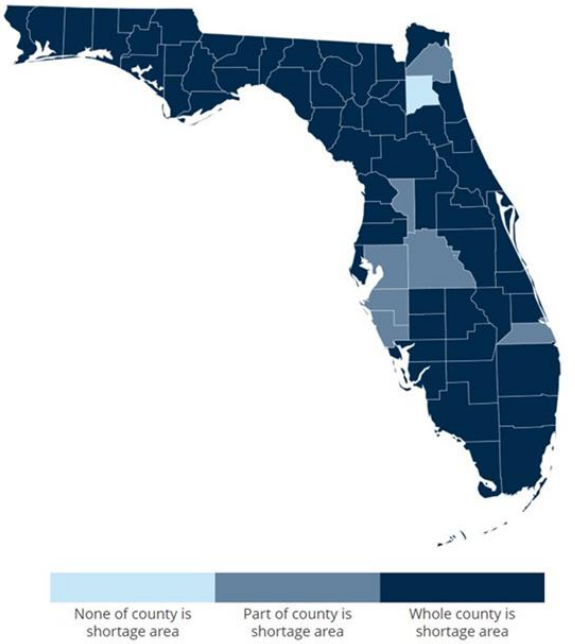


Figure 1: Health Professional Shortage Areas: Mental Health, by County, October 2024 - Florida

Counties with no resident psychiatrist:
Calhoun, Dixie, Franklin, Gilchrist, Glades, Gulf, Hamilton, Hardee, Holmes, Jackson, Jefferson, Lafayette, Liberty, Madison, Suwannee, Taylor, Union, Wakulla, Walton, Washington

Florida's Behavioral Health Care Landscape

Florida's behavioral health system of care provides mental health and substance abuse services to residents. These services are supported through a combination of state legislative allocations, federal grants, and county funding. Over the past two-years, investments in Florida's behavioral health system of care include enhancement to the healthcare workforce by passing the "Live Healthy" legislation ($1.1 billion, Chapter 2024-015, Laws of Florida), $313 million appropriation for a behavioral health teaching hospital (Chapter 2024-012, Laws of Florida), $11.5 million appropriation for mobile response teams and enhancement of access to emergency mental health services (Chapter 2024-015, Laws of Florida), and $50 million for mental health and substance use crisis services (Chapter 2024-245, Laws of Florida). Further, the State of Florida is receiving $3 billion in Opioid Abatement Settlement Funds, which can be used to support opioid addiction and recovery services, harm reduction services, and school and community prevention campaigns.

Several government agencies contribute significantly to addressing the diverse behavioral health needs of individuals and communities. These agencies collaborate to ensure that mental health initiatives are integrated into educational settings, correctional facilities, services for individuals with disabilities, and juvenile justice programs.

[17] Ibid
[18] HRSA, State of the Behavioral Health Workforce, 2024, November 2024
[19] 2024 State of Mental Health in America Report, Mental Health America
[20] Rural Health Information Hub, https://www.ruralhealthinfo.org/charts/7?state=FL

The Florida Department of Children and Families (DCF) is responsible for overseeing a statewide system of care focused on the prevention, treatment, and recovery of children and adults with serious mental illnesses or substance use disorders. These include community–based programs, crisis services, and state mental health treatment facilities. This array of programs, services, and support for children and adults is funded via the Florida legislature and federal block grant funds. Public funds are contracted through regional Managing Entities to local community behavioral health providers. DCF funds behavioral health (mental health and substance use) services to both adults and children, encompassing a variety of community–based programs such as outpatient and inpatient psychiatric care, crisis intervention, residential treatment, in–home care, and therapeutic foster homes.

The Department of Children and Families directly operates six state mental health facilities: three that are state–owned and operated, and three that are state–owned but privately operated under contract. Additionally, there are 20 local Substance Abuse and Mental Health (SAMH) offices distributed across Florida's Judicial Circuits, which manage and oversee the public behavioral health system within each Circuit.

Managing Entities

The mission of the seven Managing Entities across the state is to educate, promote, facilitate, collaborate, and advance the behavioral health recovery of individuals and their families in Florida – Broward Behavioral Health Coalition (BBHC), Central Florida Cares Health System (CFCHS), Central Florida Behavioral Health Network (CFBHN), Lutheran Services Florida Health Systems (LSFHS), Northwest Florida Health Network (NWFHN)/Big Bend Community Based Care (BBCBC), Thriving Mind South Florida (TMSF) (South Florida Behavioral Health Network (SFBHN)), and Southeast Florida Behavioral Health Network (SEFBHN). Managing Entities are local nonprofit organizations with community boards that oversee the state and federal substance abuse and mental health system of care throughout Florida, ensure the accountability of state and federal funds allocated for substance use and mental health services, and collaborate with various systems of care, including child welfare, local governments, law enforcement, private care providers, state hospitals, courts, the Department of Corrections, the Department of Juvenile Justice, local school districts, and other community partners.[21]

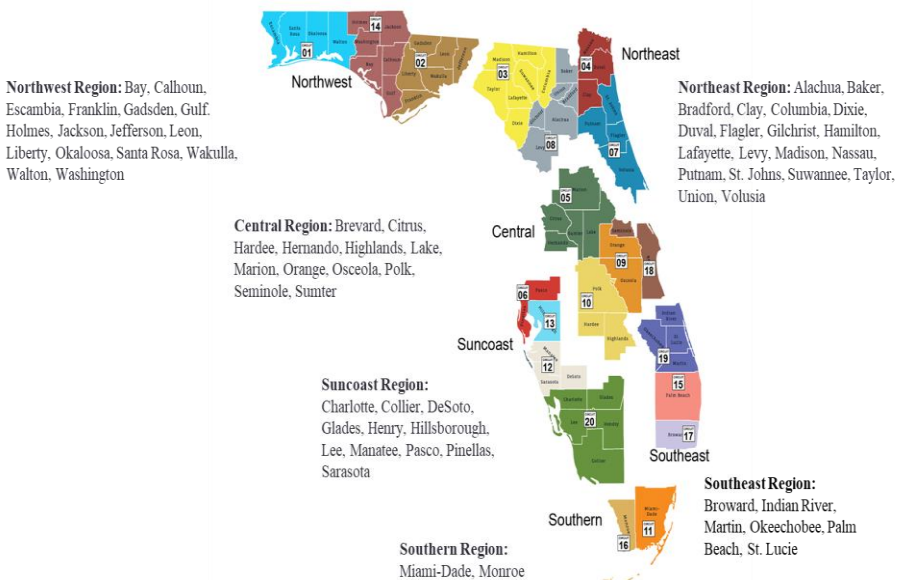


Figure 2: Map of DCF Regions and Circuits

The Florida Agency for Health Care Administration (AHCA) administers the state's Medicaid program, providing health coverage to low–income individuals and families, and is primarily responsible for the state's estimated $35 billion Medicaid program, which serves 4.3 million Floridians in SFY 2024–25. Additionally, the Agency for Health Care Administration licenses and regulates over 50,500 health care facilities, including hospitals, nursing homes,

[21] Source: *Florida DCF 2022 Florida Cultural Health Disparity and Behavioral Health Needs Assessment: An Analysis of the Managing Entities Behavioral Health System of Care*

and assisted living facilities, ensuring they meet established standards of care and safety. The agency also disseminates health care data through the Florida Center for Health Information and Policy Analysis, engages in health policy development, collects health care data, and implements health care reforms to improve the efficiency and effectiveness of the state's health care delivery system.

Health Insurers

Health insurers across Florida provide coverage for mental health services enabling residents to have access to care. Plans are offered by various health insurance providers and include coverage for services such as therapy, counseling, psychiatric evaluations, medication management, and inpatient and outpatient treatment for mental health and substance use disorders. The state has implemented regulations to ensure that mental health coverage is on par with physical health coverage. Additionally, Florida's Medicaid program, administered by the Agency for Health Care Administration, provides mental health services to eligible low–income individuals, guaranteeing that even the most vulnerable populations have access to necessary care. The Agency for Health Care Administration's role in managing Medicaid is crucial, as it ensures that mental health services are available to low–income populations, thereby promoting health equity and improving the overall well–being of Florida's residents.

Behavioral Health Service Providers

Behavioral health service providers are spread across all regions of Florida and address the diverse behavioral health needs of the state's population. These providers include a wide range of professionals and organizations, such as psychiatrists, psychologists, licensed counselors, social workers, and include community–based agencies. They offer an array of services, including individual and group therapy, psychiatric evaluations, medication management, crisis intervention, and support for substance use disorders. Florida's behavioral health service providers are dedicated to improving access to care, particularly for underserved and vulnerable populations. Through these efforts, service providers have created a supportive and responsive system that promotes mental wellbeing and resilience across the state.

The Florida Department of Education (FLDOE) oversees public education in Florida. The Florida Department of Education plays a crucial role in implementing mental health education programs, providing school–based mental health services, and collaborating with other state agencies to coordinate support for students. Additionally, FLDOE offers training for educators to identify and assist students with behavioral health needs, advocates for policies that integrate behavioral health services within schools and establishes crisis intervention protocols. Through these efforts, the FLDOE ensures that students receive comprehensive support to thrive both academically and personally.[22]

The Florida Department of Juvenile Justice (DJJ) is dedicated to preventing, intervening, and treating juvenile delinquency and enhancing public safety by reducing juvenile crime through effective services that strengthen families and rehabilitate youth. DJJ plays a crucial role in the behavioral health system of care by addressing the mental and emotional well–being of at–risk and delinquent youth. The DJJ integrates comprehensive behavioral health services into its programs, including mental health assessments, counseling, substance abuse treatment, trauma–informed care, and family involvement. By collaborating with mental health professionals and community organizations, the DJJ Justice creates a holistic support system that addresses the root causes of delinquent behavior, reduces recidivism, and promotes the overall well–being and resilience of the youth it serves.

[22] Florida Department of Education. (n.d.). About us. Retrieved from https://www.fldoe.org/about-us/

The Florida Department of Health (DOH) is committed to protecting and promoting the health of all Floridians through comprehensive public health services, disease prevention, and health education. The DOH provides mental health assessments, counseling, substance abuse treatment, crisis intervention services, implements public health initiatives, and develops integrated care models. By offering resources and training to communities and healthcare providers, the DOH aims to improve health outcomes, reduce behavioral health issues, and foster healthier communities.

The Agency for Persons with Disabilities (APD) serves the needs of over 60,000 Floridians with developmental disabilities who may receive social, medical, behavioral, residential, and/or therapeutic services. The APD assists individuals with unique abilities and their families in living, learning, and working within their communities by creating multiple pathways to possibilities.

The Florida Department of Corrections (FDC), the state's largest agency and the third–largest state prison system in the U.S., is responsible for the custody and rehabilitation of inmates and the supervision of offenders in the community[23]. The FDC provides mental health assessments, counseling, and treatment, as well as substance abuse programs aimed at long–term recovery. The FDC also offers crisis intervention services and implements evidence–based rehabilitation programs to address behavioral health issues and equip inmates with skills for successful reintegration. Collaborating with mental health professionals and community organizations, the FDC creates a comprehensive support system for inmates and offenders, aiming to improve their well–being, reduce recidivism, and enhance public safety through a holistic approach to correctional management.

The Florida System of Services and Supports

A comprehensive behavioral health system is characterized by its ability to provide children, adolescents, and adults with services and supports that meet the varied behavioral health needs and leads to fulfilling lives. The Florida Department of Children and Families behavioral health system includes treatment, rehabilitation, and supports[24].

Treatment	**Florida Assertive Community Treatment (FACT)**	Teams provide a 24–hour–a–day, seven–days–a week, multidisciplinary approach to deliver comprehensive care to people where they live, work, or go to school, and spend their leisure time. The programmatic goals are to prevent recurrent hospitalization and incarceration and improve community involvement and overall quality of life for program participants.
	Intermediate Level FACT	Teams provide a 24–hour–a–day, seven–days–a week, multidisciplinary approach to assist continued recovery and ease of service access until a full transition to community–based care is optimal. The programmatic goals are to prevent recurrent hospitalization with the promotion and maintenance of independent living in the community.
	Crisis Support /Emergency	Non–residential care is generally available twenty–four hours per day, seven days per week, or some other specific time period, to intervene in a crisis or provide emergency care. Examples include mobile response teams, crisis support, crisis/emergency screening, crisis telephone, and emergency walk–in.
	Crisis Stabilization	Acute care service offered twenty–four hours per day, seven days per week, provides brief, intensive mental health inpatient treatment services. This service meets the needs of individuals who are experiencing an acute crisis and who, in the absence of a suitable alternative, would require hospitalization.
	Community Action Treatment Teams (CAT)[25]	Strive to help children and young adults with behavioral health concerns to recover at home safely. These teams also assist families in building and maintaining a support system within their community. CAT is a safe and effective alternative to out-of-home treatment or residential care for children with serious behavioral health conditions.

[23] Florida Department of Corrections. (n.d.). About the Florida Department of Corrections. Retrieved from https://www.fdc.myflorida.com/about

[24] Florida Department of Children and Family Services The System of Services and Support,https://www.myflfamilies.com/services/samh/treatment-services/AMH/system-of-services-and-support, Children's Mental Health Program, https://www.myflfamilies.com/services/samh/childrens-mental-health-program

[25] Florida Department of Children and Families, Community Action Treatment Teams (CAT), https://www.myflfamilies.com/catt

	In–Home and On–Site Services	Therapeutic services and supports rendered in non–mental health provider settings, such as nursing homes, assisted living facilities (ALFs), residences, schools, detention centers, commitment settings, foster homes, and other community settings.
	Inpatient Services	These services are provided in psychiatric units within hospitals licensed under Chapter 395, F.S., as general hospitals and psychiatric specialty hospitals. They are designed to provide intensive treatment to persons exhibiting violent behaviors, suicidal behaviors, and other severe disturbances due to substance abuse or mental illness.
	Medical Services	Primary medical care, therapy, and medication administration. Designed to improve the functioning or prevent further deterioration of persons with mental health or substance abuse problems, including psychiatric mental status assessment. For adults with mental illness, medical services are usually provided on a regular schedule with arrangements for non–scheduled visits during times of increased stress or crisis.
	Intervention	Intervention services focus on reducing risk factors generally associated with the progression of substance abuse and mental health problems. Intervention is accomplished through early identification of persons at risk, performing basic individual assessments, and providing supportive services that emphasize short–term counseling and referral. These services are targeted toward individuals and families.
	Outpatient Services	Provide a therapeutic environment that is designed to improve the functioning or prevent further deterioration of persons with mental health and/or substance abuse problems. Outpatient services are usually provided on a regularly scheduled basis by appointment, with arrangements made for non–scheduled visits during times of increased stress or crisis. This may include evidence-based treatments (EBTs) such as trauma informed care (TIC), dialectal behavioral therapy (DBT), and multisystemic family therapy (MFT), motivational interviewing (MI), integrated dual disorder treatment (IDDT), and cognitive behavioral therapy (CBT).,
	Residential Level I	Licensed services that provide structured, live–in, non–hospital settings with 24–hour supervision, seven days per week. There is a nurse on duty in these facilities at all times. For adult mental health, these services include two different kinds of programs: group homes and short–term residential treatment services. Group homes are for residents who may require longer lengths of stay.
	Residential Level II	Licensed, structured rehabilitation–oriented group facilities that have 24–hour a day, seven days per week supervision. Level II facilities house individuals who have significant deficits in independent living skills and need extensive support and supervision.
	Short–term Residential Treatment (SRT)	Individualized, acute, and immediately sub–acute care services provide short and intensive mental health residential and rehabilitative services 24 hours a day, seven days per week. These services meet the needs of individuals who are experiencing an acute or immediately sub–acute crisis and who, in the absence of a suitable alternative, would require hospitalization.
	Residential Treatment	In some cases, residential treatment may be necessary for children who have been diagnosed with severe emotional disturbance and are recommended for residential level of mental health treatment by a Florida licensed psychologist or psychiatrist, and who are not eligible for public or private insurance.
	Juvenile Incompetent to Proceed (JITP) Program	Juvenile Incompetent to Proceed (JITP) Program provides competency restoration services to juveniles who have been charged with a felony prior to their 18th birthday and do not have the ability to participate in legal proceedings due to their mental illness, intellectual disability, or autism.
Rehabilitation	**Aftercare services**	These services include but are not limited to relapse prevention and are a vital part of recovery in every service level. Aftercare activities include customer participation in daily activity functions that were adversely affected by mental illness and/or substance abuse impairments.
	Comprehensive Community Service Team – Individual or Group	Comprehensive Community Service Team (CCST) services render assistance in identifying goals and making choices to promote resiliency and facilitate recovery for adults and children with mental illnesses. Services take place in either an outpatient or community setting.
	Day–night Services	These services provide a structured schedule of non–residential services for three (when Medicaid funded) or four or more consecutive hours per day. This may include delivery of services during evening hours. Activities for children and adult mental health programs are designed to assist individuals to attain the skills and behaviors needed to function successfully in the living, learning, work, and social environments of their community.
	Educational Services	Include providing educational assessments; day treatment; case management; drop–in, self–help centers; and the Florida Assertive Community Treatment Team (FACT) program's specific educational service entitled Education, Support and Consultation to Family, and Other Major Supports. With the exception of the Florida Assertive Community Treatment Team –specific service

		for education, most educational services may be provided on–site of providers, with instructors funded through local school boards.
	Florida Self–Directed Care	Florida Self–Directed Care is available in two parts of the state – the Jacksonville area and Southwest Florida. People eligible for public mental health services are given a budget and can choose the services and supports they want to purchase, and from whom they will purchase them.
	Supportive Housing	Supported housing/living services are designed to help people with substance abuse or psychiatric disabilities find and keep living arrangements of their choice. Supported housing/living services also provide services and supports to ensure continued successful living in the community. The goal of Supportive Housing is to ensure that everyone has the opportunity to live as independently as possible.
	Supported Employment	An evidence-based practice that helps individuals with mental health conditions attain or regain productive employment. Supported Employment services are community–based and take place in an integrated work setting, which provides regular contact with non–disabled co–workers or the public. A job coach provides long–term ongoing support as needed to give an individual every opportunity to maintain employment.
	Mental Health Clubhouse	Structured, community–based interventions where members can strengthen and/or regain interpersonal skills, get psycho–social therapy toward rehabilitation, develop the environmental supports necessary to thrive in the community, meet employment and other life goals, and recover from the effects of a mental illness.
	Residential Level 3	Licensed facilities, provide 24–hour a day, seven days per week supervised residential alternatives and structured care to persons who have developed a moderate functional capacity for independent living. For adults with serious mental illnesses, these are supervised apartments.
Supports	**Case Management**	Case managers help people identify their needs, plan services, link them to the service system, coordinate the various system components, monitor service delivery, and evaluate the effect of the services received.
	Day Care Services	Day Care Services provide a structured schedule of activities for four hours or more consecutive hours per day for children of individuals who are participating in a substance abuse or mental health day–night service or residential service.
	Drop–In/Self–Help Centers	These centers are intended to provide a range of opportunities for persons with serious and persistent mental illnesses to independently develop, operate, and participate in social, recreational, and networking activities. Many are operated by consumers of mental health services.
	Incidental Expenses	These may include the costs of medications that can't be paid for any other way, as well as things like clothing, medical care, educational needs, housing subsidies, transportation, or one–time expenses like the cost of turning on utilities for a new place to live.
	Information and Referral	Provides information about resources in the community, and agencies/organizations that offer assistance; links individuals needing assistance with service providers.
	Prevention	Prevention services involve strategies that avoid or deter the development of substance abuse and mental health problems. Prevention services include increasing public awareness through information, education, and alternative–focused activities.
	Residential Level 4	The facility may have less than 24 hours per day, seven days per week on–premises supervision. This is the least intensive level of residential care and is primarily a support service. For adults with serious mental illnesses, this includes satellite apartments, satellite group homes, and therapeutic foster homes.
	Respite Services	Respite service is an organized program designed to sustain the family or other primary caregiver by providing time–limited, temporary relief from the ongoing responsibility of care giving.
	Room and Board with Supervision Levels 1–3	Payment for room and board costs for people living in Medicaid–funded residential programs. Medicaid pays for the clinical services, and the SAMH program pays for non-clinical services.
	Service Planning and Coordination	Multi–disciplinary planning teams, often called Family Service Planning Teams are family–focused and community–based and serve as a focus for identifying supports and service planning for the family.

	Peer Support[26]	A system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain and is delivered by individuals with lived experience with mental health and or substance use conditions and recovery

Bed Capacity Analysis

The study evaluates the capacity of facilities to meet the demand for inpatient mental health care, for children, adolescents, and adults and identifies critical bed capacity gaps by examining bed availability and usage. This analysis spans various facility types, including civil and forensic state mental health treatment facilities (SMHTF) for adults, Juvenile Incompetent to Proceed (JITP), hospitals with psychiatric beds, specialty psychiatric hospitals (Class 3), crisis stabilization units for children and adults, and residential treatment centers for both children and adults, including short-term units and specialized therapeutic group homes.

An assessment of the current system of care capacity was conducted to identify potential gaps in meeting the mental health needs of children, adolescents, and adults across the six DCF regions. The analysis examined bed availability and usage across psychiatric inpatient facilities, including emergency receiving, treatment facilities, state treatment facilities and residential treatment centers for inpatient treatment between forensic and civil placements. Two key metrics that measure the utilization of beds are described below.

- *Total bed days:* Total bed days are estimated as the number of discharges per year times the average length of stay. It represents the total number of days that all beds in a facility are occupied each year.
- *Occupancy rate*: The occupancy rate is calculated as the average daily occupancy of the facility (i.e., the average number of patients occupying a bed on any given day of the year) divided by the total number of beds at the facility.

Current Bed Capacity– Children and Adolescents

Number of Facilities by Region and Type, Children and Adolescents

There are 93 facilities serving children and adolescents:

- One Juvenile Incompetent to Proceed program (JITP)
- 37 inpatient treatment facilities (including 18 hospitals with psychiatric beds/inpatient units and 19 specialty psychiatric hospitals, Class 3)
- 22 crisis stabilization units (CSUs)
- 33 residential facilities.

The residential treatment centers include the 8 Statewide Inpatient Psychiatric Program (SIPP) facilities and 13 therapeutic group homes. The Central and Suncoast regions have the highest number of facilities, 21 each, while the Southern region has the fewest, 8 facilities. SIPP facilities and the JITP facility accept applications for children across Florida (and beyond), regardless of where they reside.

[26] Florida Department of Children and Families, Florida Peer Services Handbook, https://nuance.myflfamilies.com/sites/default/files/2022-12/DCF-Peer-Guidance.pdf

Table 4. Number of Facilities by Region and Facility Type, Children and Adolescents, 2024

Children and Adolescents								
Region	DJJ – Juvenile incompetent to proceed program	Inpatient treatment services		Crisis stabilization units (i.e., emergency receiving)	Residential facilities			State–wide total
		Hospital with psychiatric beds/inpatient units	Specialty psychiatric hospital (Class 3)		Residential treatment centers	Short–term residential treatment unit	Specialized therapeutic group home for children and adolescents	
Northeast	0	1	3	4	2	0	4	14
Northwest	1	1	4	2	1	0	0	9
Central	0	4	4	8	2	0	3	21
Southern	0	3	0	1	2	1	1	8
Suncoast	0	4	5	6	5	0	1	21
Southeast	0	5	3	1	7	0	4	20
Total	**1**	**18**	**19**	**22**	**19**	**1**	**13**	**93**

Source: AHCA licensed bed data provided by Florida Department of Children and Families.
Note: Facilities that serve both children and adolescents, and adults are included in both counts of facilities. Residential treatment centers include the 8 SIPP facilities. Data is as of Nov 2024. Numbers may not sum due to rounding.

There are 1,965 child and adolescent beds across the 93 facilities (Table 3): 900 inpatient treatment beds (406 in hospitals with psychiatric beds/inpatient units and 494 in specialty psychiatric hospitals), 237 beds in crisis stabilizations units, 780 in residential facilities, and 48 beds in the JITP facility.[27]

Number of Licensed Beds by Region and Facility Type, Children and Adolescents

The Southeast and Central regions have the greatest number of beds, with 506 and 485, respectively, while the Northwest region has the lowest number of beds with 171. The Central region has the highest number (260) of beds for inpatient treatment services and crisis stabilization units (93). Concentrating these higher–level services in one region may limit access for children and adolescents outside the Central region. Residential treatment centers are concentrated in the Southeast region with a total of 289 beds.

Table 5. Number of Licensed Beds by Region and Facility Type, Children and Adolescents, 2024

Region	DJJ – Juvenile incompetent to proceed program	Inpatient treatment services		Crisis stabilization units (i.e., emergency receiving)	Residential facilities		Specialized therapeutic group home for children and adolescents	Statewide total
		Hospital with psychiatric beds/inpatient units	Specialty psychiatric hospital (Class 3)		Residential treatment centers	Short–term residential treatment unit		
Northeast	0	34	67	39	78	0	38	256
Northwest	48	26	73	0	24	0	0	171
Central	0	120	140	93	104	0	28	485
Southern	0	70	0	16	14	16	6	122
Suncoast	0	73	144	69	127	0	12	425
Southeast	0	83	70	20	289	0	44	506
Total	**48**	**406**	**494**	**237**	**636**	**16**	**128**	**1,965**

Source: AHCA licensed bed data provided by Florida Department of Children and Families.
Note: Residential treatment centers include the 14 SIPP facilities. Data is as of November 2024. Numbers may not sum due to rounding.

Current Bed Utilization – Children and Adolescents

Discharges and Bed Days by Facility Type and Region, Children and Adolescents

Over 50,000 children and adolescents were discharged from psychiatric beds in 2023; 78% (39,222) were from inpatient treatment services and 19% (9,755) from crisis stabilization units (Table 4). The Central region had

[27] The facility treats children and adolescents who require in-patient services for competency restoration. This is the most restrictive care setting for Juvenile Incompetent to Proceed patients and is only used if less restrictive interventions have not been successful.

29% (14,506) of the total discharges in the state and the Northwest region had the lowest number of discharges (3,801) from all types of providers. Discharges and bed utilization (bed days) for residential treatment centers are greatest in the Southeast region (Table 6 and Table 7).

Table 6. Number of Discharges by Region and Facility Type, Children and Adolescents, 2023

Region	DJJ – Juvenile incompetent to proceed program	Inpatient treatment services		Crisis stabilization units (i.e., emergency receiving)	Residential facilities		Specialized therapeutic group home for children and adolescents	Statewide total
		Hospital with psychiatric beds/inpatient units	Specialty psychiatric hospital (Class 3)		Residential treatment centers	Short–term residential treatment unit		
Northeast	*N/A*	1,659	2,973	1,337	111	*N/A*	26	6,106
Northwest	105	1,618	2,128	*N/A*	55	*N/A*	*N/A*	3,801
Central	*N/A*	4,528	5,651	4,088	199	*N/A*	40	14,506
Southern	*N/A*	3,302	998	862	11	23	5	5,201
Suncoast	*N/A*	4,915	5,047	3,346	163	*N/A*	11	13,481
Southeast	*N/A*	3,917	2,487	122	358	*N/A*	39	6,923
Total	**105**	**19,939**	**19,283**	**9,755**	**897**	**23**	**121**	**50,123**

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Residential treatment centers include the 8 SIPP facilities. Data is as of November 2024. N/A represents "not applicable" because the facility type does not exist in the region. Numbers may not sum due to rounding.

Table 7. Number of Bed Days by Region and Facility Type, Children and Adolescents, 2023

Region	DJJ – Juvenile incompetent to proceed program	Inpatient treatment services		Crisis stabilization units (i.e., emergency receiving)	Residential facilities		Specialized therapeutic group home for children and adolescents	Statewide total
		Hospital with psychiatric beds/inpatient units	Specialty psychiatric hospital (Class 3)		Residential treatment centers	Short–term residential treatment unit		
Northeast	*N/A*	8,028	11,752	-	23,142	-	8,511	51,433
Northwest	16,065	6,265	12,777	-	4,340	-	-	39,447
Central	*N/A*	54,436	23,634	12,464	50,365	-	6,630	147,528
Southern	*N/A*	14,799	3,768	5,140	2,374	2,190	1,456	29,726
Suncoast	*N/A*	20,486	28,233	13,680	32,385	-	2,911	97,696
Southeast	*N/A*	15,108	13,483	5,195	75,084	-	10,675	119,544
Bed days	**16,065**	**119,122**	**93,647**	**36,478**	**187,688**	**2,190**	**30,182**	**485,373**

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Total bed days are estimated as the number of discharges per year times the average length of stay. It represents the total number of days that all beds in a facility are occupied each year. Residential treatment centers include the 8 SIPP facilities. Data is as of November 2024. N/A represents "not applicable" because the facility type does not exist in the region. Numbers may not sum due to rounding.

Average Length of Stay (in Days) by Region and Facility, Children and Adolescents

Hospitals have the shortest average length of stay: 4.9 days for specialty psychiatric hospitals, 6.6 days for hospitals with psychiatric beds, and 3.7 days for crisis stabilization units. The residential treatment centers have the highest average length of stay, exceeding 200 days on average. The Central region has the highest average length of stay for hospitals with psychiatric beds/inpatient units and residential treatment centers. The Southeast region has the highest average length of stay for crisis stabilization units.

Table 8. Average Length of Stay in Days by Region and Facility type, Children and Adolescents, 2023

Region	DJJ – Juvenile incompetent to proceed program	Inpatient treatment services		Crisis stabilization units (i.e., emergency receiving)	Residential facilities		
		Hospital with psychiatric beds/inpatient units	Specialty psychiatric hospital (Class 3)		Residential treatment centers	Short–term residential treatment unit	Specialized therapeutic group home for children and Adolescents
Northeast	*N/A*	4.8	4.0	0.0	209.3	*N/A*	326.0
Northwest	153	3.9	6.0	0.0	78.9	*N/A*	*N/A*
Central	*N/A*	12.0	4.2	3.0	253.0	*N/A*	166.7
Southern	*N/A*	4.5	3.8	6.0	209.3	95.2	273.1
Suncoast	*N/A*	4.2	5.6	4.1	199.1	*N/A*	273.1
Southeast	*N/A*	3.9	5.4	42.6	209.7	*N/A*	273.1
Average	**153**	6.0	4.9	3.7	209.3	**95.2**	**249.6**

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Residential treatment centers include the SIPP facilities. Data is as of November 2024. Numbers may appear not to sum due to rounding. N/A represents "not applicable" because the facility type does not exist in the region.

Occupancy Rate by Facility Type, Children and Adolescents

The occupancy rate – beds occupied or in use as a percentage of available beds – is a measure of how busy a facility is. When an inpatient facility is too busy, quality of care can deteriorate, putting both patients and staff at risk. For children and adolescents, occupancy rates tend to be highest at residential treatment centers (81%) and lowest at specialty psychiatric hospitals (50%). Suncoast region crisis stabilization units and Central region hospitals with psychiatric beds/inpatient units have occupancy rates over 100%.[28] The Juvenile Incompetent to Proceed program at the Apalachicola Forest Youth Camp located in the Northwest region has an occupancy rate of 92%.

Table 9. Occupancy Rates by Facility Type Under the Baseline Scenario for Children and Adolescents, 2023

Occupancy Rates	Northeast	Northwest	Central	Southeast	Suncoast	Southern	Florida
Hospital with psychiatric beds/inpatient units	**65%**	**66%**	**124%**	**50%**	**77%**	**58%**	**63%**
Specialty psychiatric hospital (Class 3)	**48%**	**48%**	**46%**	**53%**	**54%**	N/A	**50%**
Crisis Stabilization Units (i.e., Emergency receiving)	**61%**	N/A	**42%**	**71%**	**105%**	**88%**	**73%**
Residential Treatment Center	**81%**	**81%**	**81%**	**81%**	**81%**	**81%**	**81%**
Specialized Therapeutic Group Home	**65%**	N/A	**65%**	**65%**	**65%**	**65%**	**65%**
Short-term Residential Treatment Unit	N/A	N/A	N/A	N/A	N/A	**38%**	**38%**
Juvenile incompetent to proceed (JITP)	N/A	**92%**	N/A	N/A	N/A	N/A	**92%**

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: The occupancy rate is calculated as the average daily occupancy of the facility (i.e., the average number of patients occupying a bed on any given day of the year) divided by the total number of beds at the facility. Rates are calculated at the regional level for inpatient facilities and crisis stabilization units and at the statewide level for residential facilities. For inpatient facilities, the 2022–2023 average is used. Due to limited data availability for the remainder of the facility types, the occupancy rates are estimated based on 2023 data. Residential treatment centers include the 8 SIPP facilities. Numbers may appear not to sum due to rounding. N/A represents "not applicable" because the facility type does not exist in the region.

In the subsequent sections, to calculate the gap in psychiatric beds, three different occupancy rate scenarios are considered. The baseline forecast utilizes average occupancy rates from historic discharge and bed data (2023) as identified above.

[28] Occupancy rates exceeding 100% are attributed to reported AHCA data that include discharge data for hospitals that do not report licensed beds.

Facilities operate at different occupancy rates than the average, some operate at higher rates, while others operate at lower rates. To account for these variations, the analysis includes a scenario–based sensitivity analysis. Scenario 1 forecasts the bed capacity gap assuming the supply of beds is constrained by a 75% occupancy rate, which is defined in Florida Administrative Code as the occupancy rate assumed when forecasting psychiatric bed needs.[29] Scenario 2 forecasts the bed capacity gap assuming the supply of beds is constrained by an 85% occupancy rate, which is an industry standard for inpatient psychiatric hospitals.[30]

Bed gap assessment – Children and Adolescents

2029 Projected Bed Gaps, Children and Adolescents

The 2029 projected bed gaps are summarized by facility acuity level – Juvenile Incompetent to Proceed program (JITP), inpatient treatment facilities, including hospitals with psychiatric beds/inpatient units, specialty psychiatric hospitals (Class 3), crisis stabilization units for children, residential treatment centers, short–term residential treatment beds, and specialized therapeutic group homes.

Generally, bed gaps are expected to increase over time in line with Florida's population growth. The magnitude of the gap varies by type of facility and facility occupancy rate. The baseline forecast presented in this study uses the average occupancy rate from the most recent year(s) of data, 2019-2023.[31] Some facilities are operating at a higher occupancy rate than the average, while others are operating at a lower occupancy rate. To account for occupancy rate variations, the analysis uses a scenario–based sensitivity analysis. In addition to results from the baseline scenario which uses the occupancy rate from the most recent year(s) of data, two additional scenarios (Scenario 1 and Scenario 2 as described earlier) are analyzed. See Appendix A for a full description of the methodology.

Juvenile Incompetent to Proceed (JITP):

The Apalachicola Forest Youth Camp (AFYC) serves children across the state who are in the Juvenile Incompetent to Proceed program (JITP). This single JITP facility has 48 beds and treats children and adolescents who require in–patient services for competency restoration; it is the most restrictive care setting for JITP patients and only used when less restrictive interventions have been unsuccessful. The JITP bed demand projection is based on the growth of Florida's child and adolescent population and the historical growth in demand at the AFYC.

If the baseline occupancy rate of 92% is maintained, four more beds are needed to meet capacity for the demand of this service in 2025 and the need will increase to 22 additional beds by 2029. If the JITP inpatient facility maintains the industry standard occupancy rate of 85%, the gap in 2025 increases to 8 new beds and the need is expected to increase to 27 new beds by 2029. If the JITP inpatient facility maintains the 75%occupancy rate defined in Florida Administrative Code, the need for new beds in 2025 increases to 11 beds and is expected to increase to 37 new beds by 2029.

[29] 59C-1.040 : New Hospital Inpatient Psychiatric Services https://www.flrules.org/gateway/ruleNo.asp?id=59C-1.040

[30] Virtanen, M., Vahtera, J., Batty, G. D., Tuisku, K., Pentti, J., Oksanen, T., Salo, P., Ahola, K., & Kivimäki, M. (2011). https://pubmed.ncbi.nlm.nih.gov/21282786/

[31] Depending on the availability of data, for some categories, average occupancy rates were calculated based on a single year or multiple years. Similarly, in some cases, regional occupancy variations were estimated, while in others, the analysis only includes the statewide average. The range of years covered includes 2019-2023.

Table 10. JITP Bed Gap Forecast, 2025–2029

		2021	2022	2023	2024	2025	2026	2027	2028	2029
Total JITP AFYC beds		48	48	48	48	48	48	48	48	48
Average daily occupancy		22	31	36	44	48	51	55	59	64
Bed demand	**Baseline: 92% occupancy**	**24**	**34**	**40**	**48**	**52**	**56**	**60**	**65**	**70**
At various occupancy level	S1: 75% occupancy	29	41	49	59	63	68	74	79	85
	S2: 85% occupancy	**26**	**36**	**43**	**52**	**56**	**60**	**65**	**70**	**75**
Bed gaps	**Baseline: 92% occupancy**	24	14	8	0	-4	-8	-12	-17	-22
At various occupancy level	S1: 75% occupancy	19	7	-1	-11	-15	-20	-26	-31	-37
	S2: 85% occupancy	22	12	5	-4	-8	-12	-17	-22	-27

Note: The forecast demand for JITP beds is based on the 7.5% compound annual growth rate of JITP average daily occupancy from 2019–2024.
Source: State Mental Health Treatment Facility data provided by Florida Department of Children and Families. Numbers may appear not to sum due to rounding. The baseline scenario uses the occupancy rate from the most recent year(s) of data.

Other facilities providing services to children and adolescents also face challenges in maintaining adequate bed capacity. Table 9 summarizes the total gaps by region and facility type for 2029. Please refer to Appendix B for a detailed analysis of the 2025–2029 forecasts by facility type.

Statewide, the study suggests by 2029, Florida will need 86 more beds within residential treatment centers, the most of any type. Specialty psychiatric hospitals (Class 3) will need 31 more beds respectively under the baseline occupancy scenario, which uses the current occupancy rate. The current occupancy rates vary by region and facility type and can be found in Table 7 above. Hospitals with psychiatric beds/inpatient units have the next largest gap needing 29 beds more at current baseline occupancy.

Table 11. Forecasted Bed Gap by Facility Type and Region for Children and Adolescents, 2029

Facility type	Scenario	Northeast	Northwest	Central	Southeast	Suncoast	Southern	Statewide total gap*
Hospital with psychiatric beds/inpatient units	**Baseline**	**-2**	**-1**	**-9**	**-11**	**-5**	**-0**	**-29**
	S1: 75%	+3	+2	-95	+18	-7	+16	-102
	S2: 85%	+6	+5	-69	+24	+2	+22	-69
Specialty psychiatric hospital (Class 3)	**Baseline**	**-4**	**-3**	**-11**	**-3**	**-10**	**N/A**	**-31**
	S1: 75%	+21	+24	+47	+19	+34	N/A	0*
	S2: 85%	+27	+30	+58	+25	+47	N/A	0*
Crisis Stabilization Units (i.e., Emergency receiving)	**Baseline**	**-2**	**N/A**	**-7**	**-1**	**-5**	**-0**	**-15**
	S1: 75%	+5	N/A	+37	+0	-34	-3	-37
	S2: 85%	+9	N/A	+43	+3	-22	-1	-22
Residential Treatment Center	**Baseline**	**-5**	**+9**	**-80**	**+25**	**+10**	**+6**	**-86**
	S1: 75%	-12	+7	-95	+4	+1	+5	-106
	S2: 85%	-1	+9	-71	+38	+15	+6	-72
Specialized Therapeutic Group Home	**Baseline**	**-0**	**N/A**	**-2**	**-3**	**-1**	**-0**	**-7**
	S1: 75%	+5	N/A	+2	+4	+1	+1	0*
	S2: 85%	+9	N/A	+5	+8	+2	+1	0*
Short-term Residential Treatment Unit	**Baseline**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**-0.1**	**-0.1**
	S1: 75%	N/A	N/A	N/A	N/A	N/A	+8	0*
	S2: 85%	N/A	N/A	N/A	N/A	N/A	+9	0*

Source: Data provided by AHCA, DCF and the provider survey.
Note: *Statewide total sums the negative bed gaps across all regions and does not consider surplus. Accessing care across regions poses a barrier to patients. Therefore, the statewide gap is calculated excluding regional surpluses, as they do not offset gaps in other regions. The baseline scenario uses the occupancy rate from the most recent year(s) of data (see Table 7). Baseline occupancy levels may vary by facility, with some operating at very high rates that can be considered unsustainable, necessitating a scenario–based sensitivity analysis in the bed capacity assessment. Scenario 1 assumes a 75% occupancy rate as defined by Florida Administrative Code, while Scenario 2 assumes an 85% occupancy rate, the industry standard for inpatient psychiatric hospitals. Residential treatment centers include the 8 SIPP facilities. Numbers may appear not to sum due to rounding. N/A represents “not applicable” because the facility type does not exist in the region.

Key findings on the projected bed gaps by regions for children and adolescents are summarized below.

Inpatient treatment facilities

- The Central region has the highest projected need for inpatient treatment beds. Under the current baseline scenario (i.e., occupancy rates are maintained at current levels), bed shortages are expected across hospitals with psychiatric beds/inpatient units and special psychiatric hospitals (Class 3). The Southeast region is expected to need 11 additional hospital psychiatric beds under the baseline occupancy rate scenario. The Central region will need 9 additional beds. For specialty psychiatric hospital beds (Class 3), the Central region will need 11 additional beds; the Suncoast region will need 10 additional beds.
- Hospitals with psychiatric beds in the Central region are operating over 100% occupancy, which is not sustainable. Reducing occupancy rates will increase the need for additional beds. To maintain 75% and 85% occupancy rates, 95 and 69 additional psychiatric beds will be needed, respectively. It should be noted that the current occupancy at the specialty psychiatric Class 3 facilities is lower than 50%, hence increasing the occupancy levels will decrease the number of beds that will be needed. However, even at higher occupancy levels, the surplus in specialty psychiatric Class 3 facilities will not be enough to compensate for the bed shortages in hospitals with psychiatric beds.

Crisis stabilization units (i.e., emergency receiving)

- Suncoast and Southern regions will have the highest need for additional crisis stabilization unit beds. Under the baseline scenario, when current occupancy rates are maintained, there will be shortages across all six regions. Under the baseline scenario, the Central and Suncoast regions are projected to need 7 and 5 additional beds, respectively. However, Suncoast and Southern regions are operating at 85% occupancy rate. Lowering the occupancy rate will result in a projected need of 34 additional beds for crisis stabilization units in the Suncoast region.

Residential facilities

- The Central region has the highest need for residential treatment center beds, followed by the Northeast region. Under the current baseline scenarios, where occupancy rates are maintained at current levels (81%), the Central region will have a gap of 80 beds, and the Northeast region a gap of 5 beds. Increasing the occupancy rate to 85% will decrease the magnitude of the shortage.
- The Southeast region is projected to need three beds for specialized therapeutic group homes with a gap of 3 beds followed by the Central and Suncoast regions with a gap of 2 and 1 beds respectively, under the baseline scenario where their occupancy rates are maintained at current levels (65%).
- The Southern region is the only region with a child and adolescent short–term residential treatment unit. This is a newly available level of care for children in Florida, implemented in FY 2023-2024 after policy change was made to allow for reimbursement for children. With its current baseline occupancy rate of 38%, it is not projected to have any bed gaps and a small surplus of beds under higher occupancy rate scenarios. However, given data limitations, this surplus is likely overestimated.

Current Bed Capacity– Adults

Number of Facilities by Region and Type, Adults

There were 302 facilities for adults including six state mental treatment health facilities, 104 inpatient treatment facilities (including 71 hospitals with psychiatric beds/inpatient units and 33 Class 3 specialty psychiatric hospitals), 42 crisis stabilization units (CSUs), and 150 residential facilities. The Southeast and Suncoast regions have the highest number of facilities, with 84 and 64 respectively, while the Northwest region has the fewest, with 27 facilities. The Southeast region also contains one forensic and one civil state mental health treatment facility, bringing its total number of facilities to 84. While the Northwest has one additional state mental health treatment facility that serves both forensic and civil patients, bringing its total number of facilities

to 28.

There are 11,318 adult beds across 302 facilities: 4,573 inpatient treatment beds, with 2,573 in hospitals with psychiatric beds or inpatient units and 2,000 in specialty psychiatric hospitals, 726 beds in crisis stabilization units, and 2,834 in residential facilities. There are also 3,185 beds in the state mental health treatment facilities, with 1,335 in forensic and 1,850 in civil.

Table 12. Number of Facilities by Region and Facility Type, Adults, 2024

Region	State mental health facilities			Inpatient treatment services		Crisis stabilization units (i.e., emergency receiving)	Residential facilities		Statewide total
	Forensic	Civil	Forensic and Civil	Hospital with psychiatric beds/inpatient units	Specialty psychiatric hospital (Class 3)		Residential treatment centers	Short–term residential treatment unit	
Northeast	**	**	**	13	3	6	12	0	34
Northwest	**	**	**	9	3	3	10	2	27
Central	**	**	**	12	9	12	16	3	52
Southern	**	**	**	12	2	5	16	0	35
Suncoast	**	**	**	13	9	10	31	1	64
Southeast	**	**	**	12	7	6	56	3	84
Total facilities	**3**	**2**	**1**	**71**	**33**	**42**	**141**	**9**	**302**

Notes: Data is as of November 2024. Facilities that serve both children and adolescents and adults are included in both counts of facilities. Numbers may not sum due to rounding.
Source: AHCA licensed bed data provided by Florida Department of Children and Families.

Number of Beds by Region and Facility Type, Adults

The Suncoast region has the highest number of beds for inpatient treatment services with 981 beds, and the Central region has the highest number of beds for crisis stabilization units with 252 beds. Residential treatment centers are concentrated in the Southeast region with 1,032 beds out of a total of 2,634 beds. State mental health treatment facility forensic and civil beds are concentrated in the Northwest and Northeast regions. The Northwest region has 720 civil beds and 609 forensic beds, while the Northeast region has 628 civil beds.

Table 13. Number of Licensed Beds by Region and Facility Type, Adults, 2024

Region	State mental health facilities		Inpatient treatment services		Crisis stabilization units (i.e., emergency receiving)	Residential facilities		Statewide total
	Forensic	Civil	Hospital with psychiatric beds/inpatient units	Specialty psychiatric hospital (Class 3)		Residential treatment centers	Short–term residential treatment unit	
Northeast	**	**	359	190	75	327	0	951
Northwest	**	**	265	149	60	127	32	633
Central	**	**	306	586	252	358	91	1,593
Southern	**	**	597	72	76	339	0	1,084
Suncoast	**	**	472	596	165	451	12	1,696
Southeast	**	**	574	407	98	1,032	65	2,176
Total beds	**1,335**	**1,850**	**2,573**	**2,000**	**726**	**2,634**	**200**	**11,318**

Notes: Data is as of November 2024. N/A represents “not applicable” because the facility type does not exist in the region. **Not applicable because SMHTF facilities serve the entire state and are not segmented by region. Numbers may not sum due to rounding.
Source: AHCA licensed bed data provided by Florida Department of Children and Families.

Current Bed Utilization – Adults

Discharges by Region and Facility Type, Adults

Over 241,000 adults were discharged from psychiatric beds in 2023. The largest number of discharges were from inpatient treatment services facilities (180,427), followed by crisis stabilization units (48,260). By region, the Suncoast region had the highest number of discharges from inpatient treatment centers (39,931), including both types of hospitals), while the Northwest region has the fewest discharges (12,323). Inpatient treatment center beds account for over 80% of total beds throughout Florida. As a result, the Suncoast region generally

has the highest number of total discharges, with the Central and Southeast regions being second and third, respectively. The highest number of discharges from crisis stabilization units were in the Central region.

Table 14. Discharges by Region and Facility Type, Adults, 2023

Region	State mental health facilities		Inpatient treatment services		Crisis stabilization units (i.e., emergency receiving)	Residential facilities		Statewide total
	Forensic	Civil	Hospital with psychiatric beds/inpatient units	Specialty psychiatric hospital (Class 3)		Residential treatment centers	Short–term residential treatment unit	
Northeast	**	**	13,577	8,132	3,165	721	N/A	25,596
Northwest	**	**	7,907	4,416	628	228	103	13,281
Central	**	**	17,242	21,786	13,461	734	317	53,540
Southern	**	**	23,455	8,978	5,396	3,327	N/A	41,156
Suncoast	**	**	20,112	19,279	22,750	1,608	30	63,779
Southeast	**	**	22,120	13,512	2,860	2,206	241	40,940
Discharges	**2,505**	**819**	104,414	76,103	48,260	8,823	691	241,615

Note: Data is as of November 2024. N/A represents "not applicable" because the facility type does not exist in the region. **Not applicable because SMHTF facilities serve the entire state and are not segmented by region. Numbers may not sum due to rounding.
Source: Analysis of data provided by AHCA, DCF and the provider survey.

Bed Days by Region and Facility Type, Adults

With respect to bed days, the Suncoast region had the highest number of inpatient treatment bed days as well as overall number of beds. The Central region also has the highest number of CSU bed days. and the number of bed days from residential treatment centers are greatest in the Southeast region and from short-term residential treatment units were in the Central region.

Table 15. Bed days by Region and Facility Type, Adults, 2023

Region	State Mental Health Facilities		Inpatient treatment services		Crisis stabilization units (i.e., emergency receiving)	Residential facilities		Statewide total
	Forensic	Civil	Hospital with psychiatric beds/inpatient units	Specialty psychiatric hospital (Class 3)		Residential treatment centers	Short–term residential treatment unit	
Northeast	**	**	71,505	50,925	18,620	90,760	N/A	231,810
Northwest	**	**	40,925	30,619	24,852	29,892	7,757	134,045
Central	**	**	85,595	134,426	77,284	92,906	14,837	405,048
Southern	**	**	119,745	61,545	9,324	92,652	N/A	283,266
Suncoast	**	**	122,083	126,997	49,079	122,271	4,128	424,558
Southeast	**	**	118,167	98,349	26,515	277,555	12,310	532,896
Bed days	462,628	584,022	558,020	502,861	205,674	706,035	39,031	3,058,271

Note: Data is as of November 2024. N/A represents "not applicable" because the facility type does not exist in the region. **Not applicable because SMHTF facilities serve the entire state and are not segmented by region. Numbers may not sum due to rounding.
Source: Analysis of data provided by AHCA, DCF and the provider survey.

Average Length of Stay (ALOS) by Region and Facility Type, Adults

State mental health facilities had an average length of stay of 185 days for forensic patients and 713 days for civil patients. Average lengths of stay in inpatient treatment services range from 5 to 7 days, with the Suncoast region having the highest ALOS. Crisis stabilization units ranged from 2 to 39 days, with the Northwest region having the highest. The Northwest region had the highest ALOS at 131 days for residential treatment centers, while the Suncoast region had the highest ALOS at 138 days in short–term residential treatment units. There were significant regional variations in ALOS across different mental health facilities and services.

Table 16. Average Length of Stay by Region and Facility Type, Adults, 2023

Region	State Mental Health Facilities			Inpatient treatment services		Crisis stabilization units (i.e., emergency receiving)	Residential facilities	
	Forensic	Civil	Forensic and Civil	Hospital with psychiatric beds/inpatient units	Specialty psychiatric hospital (Class 3)		Residential treatment centers	Short–term residential treatment unit
Northeast	**	**	**	5.3	6.3	5.9	125.8	N/A
Northwest	**	**	**	5.2	6.9	39.6	131.4	75.5
Central	**	**	**	5.0	6.2	5.7	126.5	46.9
Southern	**	**	**	5.1	6.9	1.7	27.9	N/A
Suncoast	**	**	**	6.1	6.6	2.2	76.0	137.6
Southeast	**	**	**	5.3	7.3	9.3	125.8	51.0
ALOS	185	713	315	5.3	6.6	4.3	80.0	56.5

Note: Data is as of November 2024. N/A represents "not applicable" because the facility type does not exist in the region. **Not applicable because SMHTF facilities serve the entire state and are not segmented by region. Numbers may not sum due to rounding.
Source: Analysis of data provided by AHCA, DCF and the provider survey.

Occupancy Rates, Adults

Table 17 and Table 18 show average occupancy rates by facility type and region. In state mental health treatment facilities, both civil and forensic occupancy rates have increased over the past four years. Civil occupancy rates have increased by over 20 percentage points during this period. Forensic bed occupancy has consistently been greater than 90%, recently reaching 98% (2024). It is important to note that this level of occupancy is considered unsustainable.[32]

Table 17. Trends in Historic Occupancy Rate in State Mental Health Treatment Facilities, 2021–2024

Facility type	2021	2022	2023	2024
Civil	70%	74%	87%	90%
Forensic	92%	93%	95%	98%

Note: 2024 occupancy rates are based on latest available data. Source: State Mental Health Treatment Facility data provided by Florida Department of Children and Families.

Occupancy Rates by Facility Type, Baseline Scenario, Adults

High occupancy rates were seen at crisis stabilization units (107%) and specialty psychiatric hospitals (92%). Short–term residential treatment units had the lowest occupancy rates (53%). Occupancy rates above 100%, particularly for crisis stabilization units across the state, indicate that they are operating above capacity. Across regions, occupancy rates tend to range from 68% to 77%, on average across facility types with the exception of the Southern region which had an average occupancy rate of 103%. Occupancy rates were generally lower in the Northwest and higher in the Suncoast and Southern regions.

Table 18. Occupancy Rates by Facility Type Under the Baseline Scenario for Adults, 2023

Facility Type	Northeast	Northwest	Central	Southeast	Suncoast	Southern	Florida
Hospital with psychiatric beds/inpatient units	**55%**	**42%**	**77%**	**56%**	**71%**	**55%**	**59%**
Specialty psychiatric hospital (Class 3)	**73%**	**56%**	**63%**	**66%**	**58%**	**--**	**92%**
Crisis Stabilization Units (i.e., Emergency receiving)[33]	**107%**	**113%**	**84%**	**111%**	**131%**	**97%**	**107%**
Residential Treatment Center	**73%**	**73%**	**73%**	**73%**	**73%**	**73%**	**73%**
Short-term Residential Treatment Unit	N/A	**53%**	**53%**	**53%**	**53%**	N/A	**53%**

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Rates are calculated at the regional level for inpatient facilities and crisis stabilization units and at the statewide level for residential facilities. For inpatient facilities, the 2022–2023 average is used. Due to limited data availability for the remainder of the facility types, the occupancy rates are estimated based on 2023 data.

32 Virtanen, M., Vahtera, J., Batty, G. D., Tuisku, K., Pentti, J., Oksanen, T., Salo, P., Ahola, K., & Kivimäki, M. (2011). https://pubmed.ncbi.nlm.nih.gov/21282786/

33 Occupancy rates are calculated based on reported admissions and length of stay data. Occupancy rates greater than 100% maybe attributable to overstated lengths of stay due to the way the discharges are recorded. The CSU analysis uses data from the Florida Department of Children and Families, AHCA, and provider survey.

Gaps in Adult Psychiatric Beds

In the subsequent sections, to calculate gaps in adult psychiatric beds, three different occupancy rate scenarios were considered. The baseline forecast utilized average occupancy rates from historic discharge and bed data.

However, some facilities providing services to adults operated at higher occupancy rates than the average, while others operated at lower rates. To account for these variations, the bed capacity analysis includes a scenario–based sensitivity analysis. Scenario 1 forecasts the bed capacity gap assuming the supply of beds is constrained by an occupancy rate of beds at 75%, which is defined in Florida Administrative Code as the occupancy rate assumed when forecasting psychiatric bed needs.[34] Scenario 2 forecasts the bed capacity gap assuming the supply of beds is constrained by an occupancy rate of beds at 85%, which is an industry standard for inpatient psychiatric hospitals.[35]

Bed Gap Assessment– Adults

The 2025 – 2029 forecasted bed gaps are summarized by facility acuity level, i.e. state mental health treatment facilities, inpatient treatment facilities, including hospitals with psychiatric beds/inpatient units, specialty psychiatric hospitals (Class 3), crisis stabilization units and residential treatment facilities serving the adult population.

Across all facility types, bed gaps are projected to grow over time, in line with Florida's adult population growth as well as historical trend in mental health services demand. The magnitude of the gap varies by type of facility. Additionally, the gap also depends on the facilities' occupancy rates. The baseline forecast presented in this study uses the average occupancy rate from the most recent year(s) of data.[36] Some facilities are operating at a higher occupancy rate than the average, while others are operating at a lower occupancy rate. To account for these variations, a scenario–based sensitivity analysis was used. In addition to the baseline scenario, two additional scenarios (Scenario 1 and Scenario 2 as described earlier) were analyzed. See Appendix A for a full description of the methodology.

Civil and Forensic Waitlist Forecast through 2029, Adults

State mental health treatment facilities

Forensic and civil bed (includes both Baker Act and step downs) gaps are projected to grow over time faster than Florida's adult population growth. The recent data shows that the compound annual growth rate for the average forensic daily census is 5.9% and 19% for civil beds from 2021 to 2024, which are higher than the 1.5% growth rate for the adult population. Additionally, the state mental health treatment facilities are continuously seeing elevated levels of waitlists for civil and forensic beds, 121 and 492 waitlisted respectively in 2024. The civil waitlist increased 7% on average annually from 2021 to 2024. The forensic waitlist increased 6% on average annually during the same period.

The DCF hospital administration team reported that civil and forensic facilities are at capacity, with waitlists growing significantly over the past six months. Forensic facilities reached full capacity in July 2024, with the waitlist increasing by 36% (from 354 to 482 patients) in less than five months. Civil facilities hit capacity in August 2024, with the waitlist increasing by 67% in approximately four months. Given the uncertainty of whether this sharp increase will continue in the long term or is a short-term discrete jump, a five-year historical annual average growth rates was used to forecast the waitlists for both civil and forensic facilities from 2025-2029. The bed gap assessment below considers the waitlists and estimates the new beds needed to address both the current waitlist and future demand. However, if the waitlist grows faster than the projected 7% for civil

[34] 59C-1.040 : New Hospital Inpatient Psychiatric Services https://www.flrules.org/gateway/ruleNo.asp?id=59C-1.040

[35] Virtanen, M., Vahtera, J., Batty, G. D., Tuisku, K., Pentti, J., Oksanen, T., Salo, P., Ahola, K., & Kivimäki, M. (2011). https://pubmed.ncbi.nlm.nih.gov/21282786/

[36] Depending on the availability of data, for some categories, average occupancy rates were calculated based on a single year or multiple years. Similarly, in some cases, regional occupancy variations were estimated, while in others, the analysis only includes the statewide average.

and 6% for forensic, the forecasted bed gaps will be underestimated.

Table 19. Civil and Forensic Waitlist Forecast, 2025–2029

Facility Type	2021	2022	2023	2024	2025	2026	2027	2028	2029
Civil	120	155	92	121	129	137	146	156	166
Forensic	431	389	372	492	522	553	586	622	659
Total	**551**	**543**	**464**	**613**	**651**	**690**	**733**	**778**	**825**

Source: State Mental Health Treatment Facility data provided by Florida Department of Children and Families.
Note: The civil waitlist increased 7% on average annually from 2021 to 2024. The forensic waitlist increased 6% on average annually during the same period. Both waitlists are forecasted to increase at these average annual rates from 2025 to 2029.

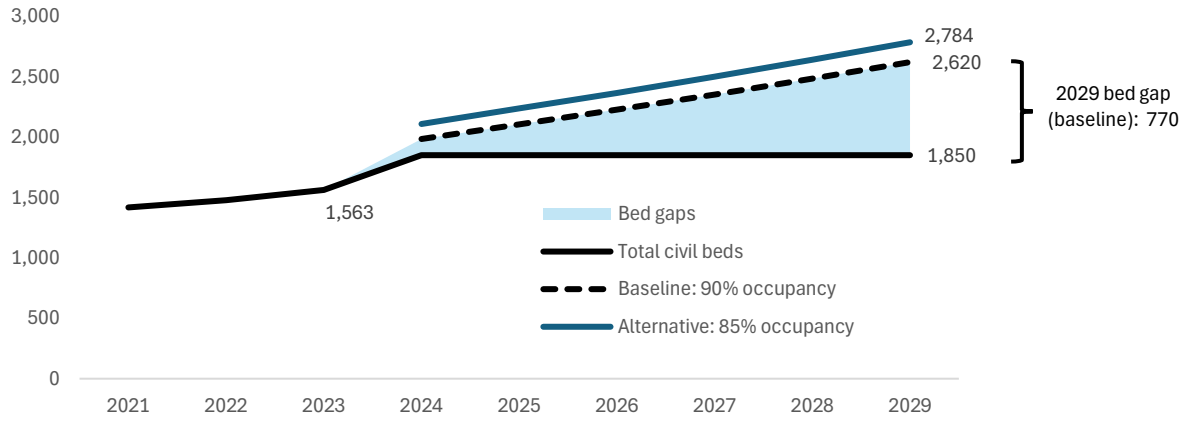
To maintain the current occupancy rate of 90%, state mental health treatment facilities need to add at least 770 additional civil beds within the next five years to meet demand. If civil state mental health treatment facilities maintain the industry standard occupancy rate of 85%, the gap is estimated to be 934 beds by 2029.

Table 20. Civil Bed Gap Forecast, 2025–2029

		2021	2022	2023	2024	2025	2026	2027	2028	2029
Total civil beds		1,418	1,477	1,563	1,850	1,850	1,850	1,850	1,850	1,850
Average daily occupancy		986	1,100	1,353	1,671	1,772	1,873	1,978	2,087	2,200
Bed demand *At various occupancy levels*	**Baseline: 98% occupancy**	**1,224**	**1,389**	**1,600**	**1,984**	**2,105**	**2,226**	**2,352**	**2,484**	**2,620**
	Alternative: 85% occupancy	1,301	1,477	1,700	2,108	2,237	2,366	2,500	2,639	2,784
Bed gaps *At various occupancy levels*	**Baseline: 98% occupancy**	**194**	**88**	**-37**	**-134**	**-255**	**-376**	**-502**	**-634**	**-770**
	Alternative: 85% occupancy	117	1	-137	-258	-387	-516	-650	-789	-934

Source: State Mental Health Treatment Facility data provided by Florida Department of Children and Families.
Note: Civil bed gaps are projected to expand over time faster than Florida's adult population growth, based on the 6.2% compound annual growth rate in admissions from 2020 through 2024. The growth rate in admissions was used as a more conservative estimate instead of average daily census which grew 19% annually during the same period. Numbers may not sum due to rounding. **The total civil beds (1,850) provided between 2025 and 2029 is based on the actual bed count from 2024 and is included for illustrative purposes for future years, assuming that no new beds will be added.**

Figure 3. Civil Bed Gap Over Time



Source: State Mental Health Treatment Facility data provided by Florida Department of Children and Families.

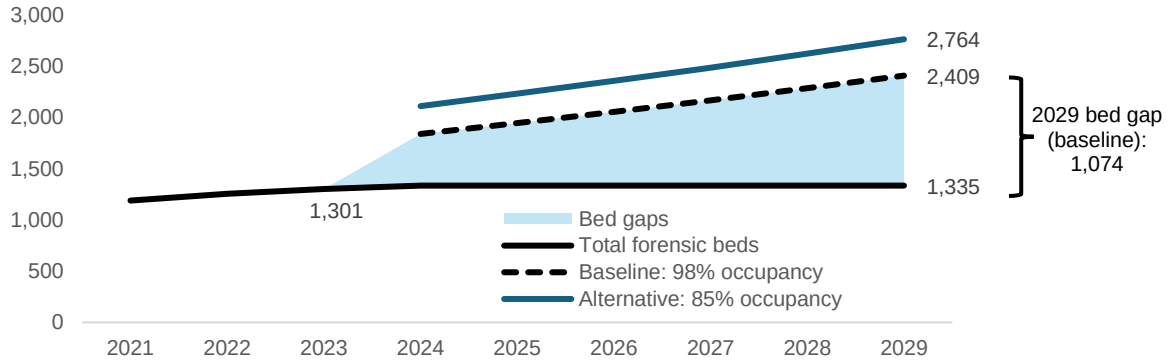
To maintain the current occupancy rate of 98%, state mental health treatment facilities would need to add at least 1,602 additional forensic beds within the next five years to meet demand. If the state mental health treatment facilities maintain the industry standard occupancy rate of 85%, the forensic beds gap is projected to be even higher (2,034) by 2029.

Table 21. Forensic Bed Gap Forecast, 2025–2029

		2021	2022	2023	2024	2025	2026	2027	2028	2029
Total forensic beds		1,189	1,257	1,301	1,335	1,335	1,335	1,335	1,335	1,335
Average daily occupancy		1,097	1,173	1,239	1,302	1,377	1,451	1,528	1,607	1,690
Bed demand *At various occupancy levels*	**Baseline: 98% occupancy**	**1,567**	**1,601**	**1,652**	**1,839**	**1,947**	**2,055**	**2,168**	**2,286**	**2,409**
	Alternative: 85% occupancy	1,798	1,837	1,895	2,111	2,234	2,358	2,487	2,622	2,764
Bed gaps *At various occupancy levels*	**Baseline: 98% occupancy**	**-378**	**-345**	**-351**	**-504**	**-612**	**-720**	**-833**	**-951**	**-1,074**
	Alternative: 85% occupancy	-609	-581	-594	-776	-899	-1023	-1,152	-1,287	-1,429

Source: State Mental Health Treatment Facility data provided by Florida Department of Children and Families.
Note: Forensic bed gaps are projected to expand over time faster than Florida's adult population growth, based on the 5.9% compound annual growth rate in daily census from 2020 through 2024. Numbers may appear not to sum due to rounding. **The total forensic beds (1,335) provided between 2025 and 2029 is based on the actual bed count from 2024 and is included for illustrative purposes for future years, assuming that no new beds will be added.**

Figure 4. Forensic Bed Gap Over Time



Source: State Mental Health Treatment Facility data provided by Florida Department of Children and Families.

Projected Bed Gaps by Region and Facility Type, Adults

In addition to the state mental health treatment facilities, other inpatient treatment facilities, CSUs, and residential treatment facilities providing services to the adult population are also facing challenges in maintaining bed capacity given increasing bed demand. Table 17 summarizes the total gaps by region and facility type for the year 2029. For a detailed analysis of the forecasts between 2025–2029 by facility type, please refer to Appendix B.

Statewide, the largest gaps in beds are in adult residential treatment facilities and hospitals with psychiatric beds, with 205 and 190 beds, respectively under the baseline occupancy scenario. Specialty psychiatric hospitals (Class 3) have the next largest gap at 169 beds at baseline occupancy.

Table 22. Estimated Bed Gap by Facility Type and Region for Adult, 2029

Facility type	Scenario	Northeast	Northwest	Central	Southeast	Suncoast	Southern	Statewide total gap*
Hospital with psychiatric beds/inpatient units	**Baseline**	**-31**	**-16**	**-32**	**-36**	**-41**	**-33**	**-190**
	S1: 75%	+75	+106	-40	+115	-13	+136	-53
	S2: 85%	+108	+125	+1	+169	+44	+190	0*
Specialty psychiatric hospital (Class 3)	**Baseline**	**-17**	**-9**	**-62**	**-25**	**-52**	**-4**	**-169**
	S1: 75%	-12	+30	+43	+25	+92	-165	-177
	S2: 85%	+12	+44	+107	+70	+151	-137	-137
Crisis Stabilization Units (i.e., Emergency receiving)	**Baseline**	**-7**	**-4**	**-27**	**-6**	**-14**	**-4**	**-62**
	S1: 75%	-41	-36	-60	-56	-148	-27	-369
	S2: 85%	-27	-25	-23	-38	-111	-15	-240
Residential Treatment Center	**Baseline**	**-41**	**+9**	**-25**	**-68**	**-45**	**-26**	**-205**
	S1: 75%	-33	+11	-17	-45	-35	-18	-149
	S2: 85%	+9	+25	+27	+82	+22	+24	0*
Short-term Residential Treatment Unit	**Baseline**	**N/A**	**-10**	**+7**	**-2**	**-11**	**N/A**	**-23**
	S1: 75%	N/A	+2	+31	+17	-4	N/A	-4
	S2: 85%	N/A	+5	+38	+23	-2	N/A	-2

Source: Data provided by AHCA, DCF and the provider survey. Statewide total sums the negative bed gaps across all regions.
Note: *Statewide total sums the negative bed gaps across all regions and does not consider surplus. Accessing care across regions poses a barrier to patients. Therefore, the statewide gap is calculated excluding regional surpluses, as they do not offset gaps in other regions. The baseline scenario uses the occupancy rate from the most recent year(s) of data (see Table 7). Baseline occupancy levels may vary by facility, with some operating at very high rates that can be considered unsustainable, necessitating a scenario–based sensitivity analysis in the bed capacity assessment. Scenario 1 assumes a 75% occupancy rate as defined by Florida Administrative Code, while Scenario 2 assumes an 85% occupancy rate, the industry standard for inpatient psychiatric hospitals. Numbers may appear not to sum due to rounding. N/A represents “not applicable” because the facility type does not exist in the region.

Key findings on bed gaps by regions, adults, are summarized below.

Inpatient treatment facilities

- The Central and Suncoast regions have the two highest needs for inpatient treatment beds, 94 and 93 additional hospital beds needed by 2029. Using the current baseline scenario, where occupancy rates are maintained at current levels, bed shortages are estimated across both hospitals with psychiatric beds/inpatient units and special psychiatric hospitals (Class 3) and across all regions. The Suncoast region is expected to experience the largest gap in hospital psychiatric beds, with a shortage of 41 beds, followed by the Southeast region with a shortage of about 36 beds. For specialty psychiatric hospital beds (Class 3), the Central region has the highest need, with a gap of 62 beds, and the Suncoast region comes in second with a need for 52 beds.
- Occupancy rates are generally higher at the specialty psychiatric hospitals, particularly in the Southern region. Lowering this rate to more manageable 85% or 75% levels would result in large bed gaps, ranging from 137 to 165 beds.

Crisis stabilization units (i.e., emergency receiving)

- The Central and Suncoast regions have the highest need for additional crisis stabilization unit beds. Using the current baseline scenario, where occupancy rates are maintained at current levels, there is a shortage across all six regions. The Central and Suncoast regions are expected to see the largest gaps of 27 and 14 beds respectively under the baseline scenarios. However, all regions are generally operating at high occupancy levels, i.e., above 80%. Therefore, the gaps under the current occupancy are underestimated. If the occupancy rate is lowered, the need for beds increases.

Residential facilities

The Southeast, Suncoast, and Northeast regions have the largest need for residential treatment facility beds. This is under the current baseline scenario, where the occupancy rate is maintained at current levels (73%). The Suncoast region also has the largest gap in short–term residential treatment beds. However, given the current baseline occupancy rate of 53%, which is below the industry standard, the gap is not significant. The Northeast and Southern regions have no short–term residential treatment units. At least one residential treatment facility – each requiring 22 beds – needs to be opened in each region.

Drive–time Analyses

The following section provides an analysis of the estimated drive time to behavioral health services by zip–code. While it is considered best practice to have specialty services accessible within a 60–minute drive time[37], we have utilized a 45–minute drive time radius in the following analyses due the acuity of services involved and the current gap in bed capacity identified in the prior section.

Crisis Stabilization Units

Currently, over 94% of residents live within 45 minutes of a crisis stabilization unit facility, while six percent, who mostly reside in rural and exurban areas, are outside of the driving radius.

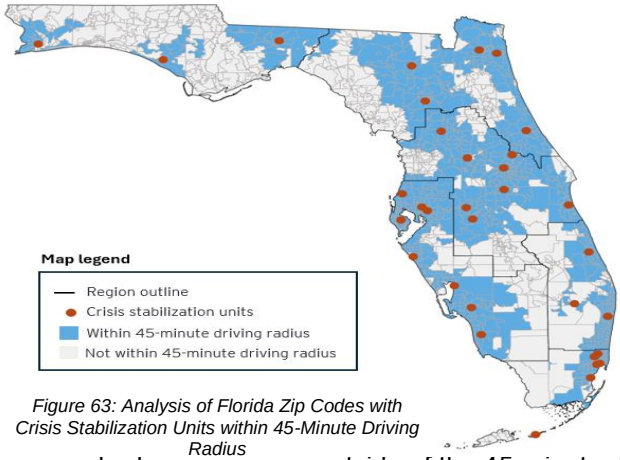


Figure 63: Analysis of Florida Zip Codes with Crisis Stabilization Units within 45-Minute Driving Radius

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and
suburban areas, are outside of the 45-minute driving

Inpatient Treatment Facilities

Currently, 94% of Floridians reside within a 45-minute driving distance of an inpatient treatment facility. Six percent, who primarily reside in rural and suburban areas, live more than a 45-minute driving distance of an inpatient treatment facility.

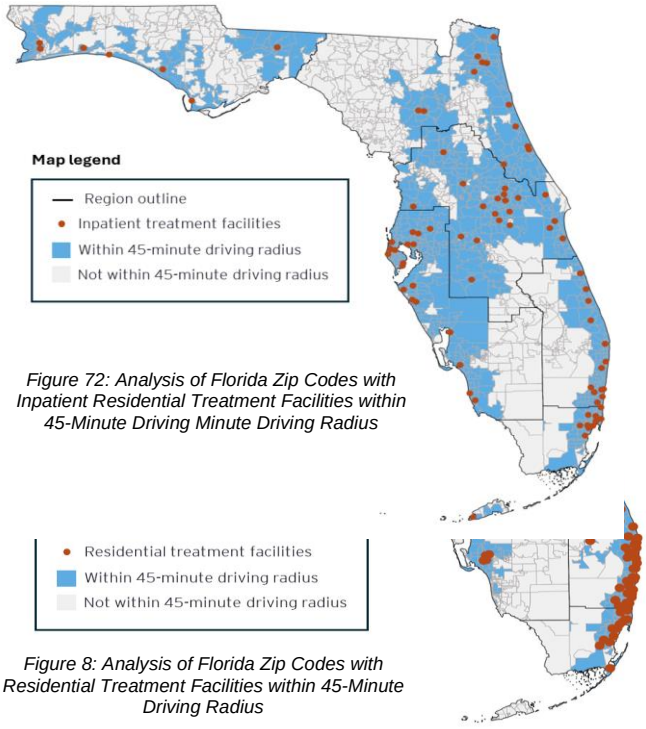

Figure 72: Analysis of Florida Zip Codes with Inpatient Residential Treatment Facilities within 45-Minute Driving Minute Driving Radius

Figure 8: Analysis of Florida Zip Codes with Residential Treatment Facilities within 45-Minute Driving Radius

37 Federal Register, Update To Access Standards Drive Time Calculations

Stakeholder–Identified Gaps in the System of Services and Supports

Interviews with behavioral health providers, state mental health treatment facilities, government agencies, Managing Entities, and partner health organizations were conducted to identify gaps – treatment, recovery, and service administration gaps – in the behavioral health system of care and to inform the quantitative data analyses generated in report. The qualitative findings are organized across the system of care, from the least to most restrictive level of care.

Treatment Gap(s)

- Lack of residential options (e.g., short term residential, assisted living) causes longer lengths of inpatient stay, which subsequently causes longer crisis stabilization unit lengths of stay, and hampers transitions from inpatient levels of care. This shortage has forced patients to remain in inpatient settings longer than necessary, occupying beds that could be used for new admissions.
- Insufficient community–based services – Florida Assertive Community Treatment, or FACT – to meet the needs of all eligible individuals throughout the state, especially in rural areas results in greater demand for higher acuity, and more expensive, services (e.g., crisis stabilization and inpatient hospitalization).
- Limited availability of peer support at all levels of behavioral health treatment to meet the needs of the patient population. Stakeholders identified peer support as an integral component of recovery and expressed that increased funding is needed along with more emphasis on outreach and awareness to educate individuals and the behavioral health community on peer services and supports.
- The current behavioral health system lacks the infrastructure and specialized programs to provide comprehensive, continuous care for older adults, leading to gaps in service delivery and inadequate support for this vulnerable population.
- Limited options for step–down facilities have slowed transition and flow through in residential treatment beds. As such, individuals are unable to step down from more intense levels of short– term residential service (e.g., level 1 or 2) to less intense levels of residential support (e.g., level 3 or 4) because of the unavailability of residential options. This gap has created an increased demand for acute behavioral health services, preventing new patients from accessing the care they need.
- The lack of affordable housing, including assisted living facilities, supported housing, statewide inpatient psychiatric programs, and short–term residential treatment, impedes the stabilization of individuals. This shortage has created a critical gap in the system of care, leaving many individuals without the necessary support to achieve and maintain stability and impeding behavioral health providers from facilitating the step–down of patients into community–based care.
- The long length of stay for some individuals in civil state mental health facilities significantly extends the waitlist for state mental health treatment facility placement, creating a bottleneck that delays access to critical mental health services for new patients. Factors contributing to long lengths of stay include limited residential transition settings into which individuals can be safely discharged in the community and limited resources to sustain independent living once discharged into the community. Patients have remained in higher levels of care longer than necessary, which not only strains facility resources but also impacts the overall efficiency of the mental health care system, leading to prolonged wait times and potentially worsening conditions for those awaiting placement.

Recovery Gap(s)

- There is a need to increase access and implementation of recovery community organizations, Mental Health Clubhouses, peer led warm lines, and other peer supports to provide supportive, structured, and recovery–oriented community–based service for children, adolescents, and adults.

Service Administration Gap(s)

- Reimbursement rates have not kept up with increases in cost of patient care affecting providers' financial sustainability, ability to maintain operations, hire and retain high performing staff, and deliver high–quality care.

- Providers are unable to offer competitive compensation packages, causing difficulty in recruiting and maintaining staff, which subsequently reduces their ability to provide care. The staffing challenges have led to reduced availability of treatment services, both in community and facility–based settings, longer wait times for patients, increased workloads for existing staff, and potential burnout.
- Current reimbursement rates for some services do not adequately cover the increasing costs associated with serving higher acuity individuals or those with specific/special needs e.g., dually diagnosed with behavioral health and intellectual and developmental disabilities, pregnant women, or individuals exhibiting aggressive behaviors that require more intensive supervision).
- There is variance in how care is provisioned for the same services by region and by provider. For example, different community action teams in separate regions serve different segments of the child and adolescent population, resulting in challenges in coordination of care and inconsistent coverage across the state.
- Individuals in need of mental health and or substance use conditions treatment are often unaware of where to obtain help. This lack of awareness impacts access to care and can cause delays in receiving needed services and supports. Providing information and education on behavioral health resources and how to access services and supports further destigmatizes help seeking.

Conclusions

Building on the bed capacity analysis, this section discusses opportunities for enhancement within Florida's behavioral health system of care. By identifying areas where improvements can be made, this section aims to address gaps in behavioral health service provision within the state and optimize the utilization of existing resources.

The following tables include proposed service enhancements, number needed (i.e., units) and estimated costs of implementation. The estimated time to implement service enhancements (e.g., includes operationalization and implementation) will vary based on the types of new services implemented, priority of service needs (i.e., short, medium, or long-term) staffing needs, and facility construction, if applicable. It is anticipated to take at least twelve to twenty-four months accounting for procurement, staff training, and resource acquisition factors and constraints. Construction may increase the timeline to thirty-six months**.** Cost estimates are based on average FY23–24 DCF Catalog of Care listed costs per unit, prior funding requests, and analogues from other states.

Table 23. Estimated Implementation Cost of Proposed Enhancements to Community Based Services

Services	Cost per unit per Year	Total Units	Average Estimated Total Costs per Year
Recovery clubhouse*	$125,000	1	$125,000
Florida Assertive Community Treatment*	$1,401,639	29	$40,647,531
Intermediate Level Florida Assertive Community Treatment*	$1,000,000	3	$3,000,000
Mobile response team*	$647,058	7	$4,529,406
Adults – Additional Beds			
State Mental Health Treatment Facility – Civil**	$268,640	770 – 934	$228,881,280
State Mental Health Treatment Facility – Forensic**	$271,560	1,074 – 1,429	$339,857,340
Hospital with psychiatric beds/inpatient units**	$318,645	53 – 190	$38,715,368
Specialty psychiatric hospital (Class 3)**	$318,645	137 – 177	$50,027,265
Crisis stabilization unit**	$166,440	62 – 369	$35,867,820
Residential treatment**	$71,631	149 – 205	$12,678,687
Short–term residential treatment**	$127,385	46 – 67	$7,197,253
Children and Adolescents – Additional beds			
Juvenile Incompetent to Proceed (JITP)**	$161,695	22 – 37	$4,770,003
Hospital with psychiatric beds/inpatient units**	$187,245	29 – 102	$12,264,548
Specialty psychiatric hospital (Class 3)**	$187,245	57	$10,672,965
Crisis stabilization unit**	$169,360	26 – 48	$6,266,320
Residential treatment**	$96,238	72 – 106	$8,565,182
Short–term residential treatment**	$162,060	80	$12,964,800
Specialized therapeutic group home**	$49,175	17	$835,975
Total	**NA**	**NA**	**$817,866,741**

Notes: Range of additional units are calculated based on projected service demand sensitivity analysis as described in Tables 8 and 17 in addition to estimated number of beds per facility for new facility implementations.
*:Additional unit estimates identified based on current utilization and demand.
**:Additional unit estimates identified based on projected gap in bed availability by 2029.

Increase the Availability of Peer–Led Recovery Resources

Research has shown that individuals with serious mental illness who participate in a recovery clubhouse are less likely to be hospitalized or have encounters with law enforcement.[38] The Northwest region is the only DCF region in Florida that currently lacks a recovery clubhouse. The addition of at least one recovery clubhouse in the Northwest region is expected to increase access to evidence-based, peer-led recovery services. In FY24-25, the approximate cost to operate a recovery clubhouse in Florida was $125,000 per year, excluding increased administrative expenses for the service operator.[39] Expanding the availability of recovery clubhouse services in the Northwest region would cost approximately $125,000 per year.

38 McKay, C., Nugent, K.L., Johnsen, M. *et al.* A Systematic Review of Evidence for the Clubhouse Model of Psychosocial Rehabilitation. *Adm Policy Ment Health* **45**, 28–47 (2018). https://doi.org/10.1007/s10488-016-0760-3

39 Local Funding Initiative Request #1976, Fiscal Year 2024-20025

Increase Coverage of Mobile Response Teams in Underserved Areas

There are currently 55 Mobile Response Teams in operation across Florida, this includes four new teams being implemented during FY 24-25. However, multiple mobile response teams cover multiple counties, especially in the Northwest region where three mobile response teams cover a combined catchment area of 16 counties.[40] Although more populace than the Northwest region, the Northeast is the most similar region as it is comprised of a mix of urban and rural areas, has over 20 counties, and operates an average of 0.6 mobile response teams per county. To provide comparable coverage of mobile response teams across regions, the number of mobile response teams in the Northwest region should be increased by seven in order for the density of teams in the Northwest region to be on par with the density of teams in the Northeast region. In FY23–24, the average expenditure per mobile response team was $647,058.[41] At this rate, the estimated cost to increase the total number of mobile response teams in Florida by seven would be approximately $4.5 million dollars per year.

Expand the Availability of Florida Assertive Community Treatment

Previous research has found that assertive community treatment is both cost effective and provides adequate coverage to the eligible patient population when there is a sufficient number of assertive community treatment teams to serve 0.03% of the given general population.[42] There are 39 Florida Assertive Community Treatment teams serving approximately 0.017% of the total state population per year and four Intermediate Level Florida Assertive Community Teams in operation in the state – one in the Northwest, two in the Northeast, and one in the Southeast region, providing services at a lower level of care. To provide a consistent level of access to this service modality, at least one Intermediate Level Florida Assertive Community Teams should be present in each DCF region. The addition of 29 Florida Assertive Community Treatment teams throughout the state and three Intermediate Level Florida Assertive Community Treatment teams, one team each in the Southern, Suncoast, and Central regions meet the population threshold and will divert individuals from higher acuity levels of care. This increase in the number of Florida Assertive Community Treatment teams would bring Florida closer to parity in this service compared to similarly sized states: New York operates 108 teams for a population of 19.5 million and Pennsylvania operates 43 teams for a population of 13 million.[43,44]

Table 24. Estimated Additional FACT Teams Required and Associated Costs for Region Populations

Region	Current Number of ACT Teams	Minimum Additional ACT Teams Required	Estimated Annual Cost to Increase ACT Teams
Southern	4	4	$5,606,556
Suncoast	13	4	$5,606,556
Southeast	5	8	$11,213,112
Central	8	8	$11,213,112
Northeast	7	4	$5,606,556
Northwest	4	1	$1,401,639
Total	**39**	**29**	**$40,647,531**

[40] Florida Department of Children and Families, Specialty Treatment Team Maps, 2024
[41] Florida Department of Children and Families, DCF Sees Continued Success Supporting Strong and Resilient Families Through Innovation and Impact
[42] Cuddeback GS, Morrissey JP, Meyer PS. How many assertive community treatment teams do we need?. *Psychiatr Serv*. 2006;57(12):1803-1806. doi:10.1176/ps.2006.57.12.1803
[43] New York State, Governor Hochul Announces Funding for Additional Innovative, Effective Community-Based Treatment Teams
[44] Commonwealth of Pennsylvania, ACT in PA

In FY24-25, the annual allocation per Florida Assertive Community Treatment team was $1,401,639 and the annual allocation per Intermediate Level Florida Assertive Community Treatment team was $1,000,000.[45] The estimated cost to provide 29 additional Florida Assertive Community Treatment teams would be $40.1 million per year to operate (not including start–up costs or other expenditures). Similarly, the cost to increase Intermediate Level Florida Assertive Community Treatment teams by three would be $3,000,000. Feedback from providers and stakeholders across the state indicated reimbursement rate for Florida Assertive Community Treatment team services need to be increased.

Expand the Availability of Residential Treatment

There is a projected gap in residential treatment beds ranging from 149–205 for adults, by 2029. The projected gaps for child residential treatment beds, and specialized therapeutic group home beds, are 72–106 and 7, respectively. While the current analysis does not include stratification of additional residential treatment beds by level, expansions of each level of residential treatment should increase access to different acuities of care. Additionally, there is not currently a specialized therapeutic group home in operation in the Northwest region. The addition of at least one of these facilities, which include an average of 10 beds per facility, would increase access.

In FY23–24, the average per unit cost rate for an adult residential treatment bed was $308 for a Level 1 bed, $255 for a Level 2 bed, $157 for L level 3 bed, and $65 for Level 4 bed. Similarly, the average per unit cost rate for a child and adolescent residential treatment bed was $429 for a Level 1 bed, $314 for a Level 2 bed, and $48 for Level 4 bed Using a pooled estimate across the four levels provides an estimate of $197 per adult residential bed per day and $264 per child and adolescent bed per day. Child and adolescent residential Level 3 bed cost rates were not available and were thus excluded from this cost estimate. The average per unit cost rate for a specialized therapeutic group was $135 in FY22–23.[46] Total estimated annual costs to implement these services are displayed in table 21.

Increase the Availability of Adult and Child and Adolescent Crisis Services and Short-Term Residential Treatment

There are currently 726 adult and 237 child and adolescent crisis stabilization unit beds across Florida. To meet the 2029 projected demand for crisis services, between 62 and 369 additional adult crisis stabilization beds and between 15 and 37 additional child and adolescent crisis stabilization beds are required. Additionally, there is no child and adolescent-serving crisis stabilization unit in operation in the Northwest region, indicating a gap in the coverage of crisis services. The addition of one child and adolescent crisis stabilization unit in Northwest region would bring approximately 11 beds (based on average capacity of other facilities) thereby increasing access to crisis services.

The Northeastern and Southern regions do not have any adult short-term treatment facilities currently in operation. Short-term residential treatment for children and adolescents is not available in six regions; currently only available in the Southern region. To provide a consistent level of care throughout Florida, at least one adult and one child and adolescent short-term residential treatment facility should be in operation within each DCF region, with an estimated number of 22 and 16 beds, respectively, based on the average capacity of similar facilities in the state.

[45] Ibid.

[46] Florida Agency for Health Care Administration, Specialized Therapeutic Services Fee Schedule 2022

In FY23–24, the average per unit cost rate for a crisis stabilization bed was $456 for adults and $464 for children and adolescents. The average per unit cost rate for an adult short–term residential bed was $349 and $444 for a child and adolescent short–term residential bed.[47] Total estimated annual costs to implement these services are displayed in table 21.

Increase the Number of Inpatient Psychiatric Beds

There are currently 2,573 adult beds and 406 child and adolescent beds within hospitals with psychiatric beds across Florida. Analysis of the gap between the projected demand for and supply of inpatient psychiatric beds revealed that, to meet the projected demand for these services by 2029, between 53 and 190 estimated additional hospital with psychiatric bed adult units and between 29 and 102 estimated additional child and hospital with psychiatric bed child and adolescent units are required. For specialty psychiatric hospitals, between 137 and 169 for adults and up to 31 for child and adolescent estimated additional beds are needed to meet projected demand. Additionally, there is currently no specialty psychiatric hospital which serves children and adolescents in the Southern region. To provide a consistent level of inpatient care across the state, at least one child and adolescent serving specialty psychiatric hospital should be established in the Southern region, which would operate approximately 26 beds based on the average operating level for similar facilities in the state.

Cost rates for Florida adult psychiatric inpatient bed days were not readily available. Federal FY25 Medicare Inpatient Psychiatric Facilities Prospective Payment System estimates that the cost of adult inpatient psychiatric beds is $873 per unit.[48] The average per unit cost rate for child psychiatric inpatient bed days was $513 in FY22–23 in Florida.[49] Due to a lack of readily available information, these rates are used as estimates for the per unit cost rate for adult and child class 3 psychiatric hospitals. Total estimated annual costs to implement these services are displayed in table 21.

Increase Civil and Forensic State Psychiatric Hospital and Juvenile Incompetent to Proceed Beds

There are currently 1,850 civil and 1,335 forensic state mental health treatment facility beds and 48 Juvenile Incompetent to Proceed beds in Florida. To meet the 2029 projected demand for state mental health treatment facility services between 770 and 934 estimated additional civil beds and between 1,074 and 1,429 estimated additional forensic beds are required (range based on occupancy rates). Similarly, analysis showed that between 22 and 37 estimated additional Juvenile Incompetent to Proceed beds are required to meet the needs of justice–involved children with behavioral health issues.

Costs rates for Florida state mental health treatment facility civil and forensic beds were not readily available. Civil and forensic bed cost rates identified through a cost study in Texas provide usable analogues from a similarly sized state. In Texas, the daily cost per bed is $736 for a civil bed and $744 for a forensic bed.[50] In FY23-24, the per unit cost rate for a Juvenile Incompetent to Proceed bed in Florida was $443 per day.[51] Total estimated annual costs to implement these services are displayed in table 21.

47 DCF Substance Abuse and Mental Health, FY 23-24 Catalog of Care

48 Centers for Medicare and Medicaid Services, Medicare Program; FY 2025 Inpatient Psychiatric Facilities Prospective Payment System – Rate Update

49 Department of Children and Families, Assessment of Behavioral Health Services, 2023

50 Texas Health and Human Services Commission, State Hospital Cost Study

51 DCF Substance Abuse and Mental Health, FY 23-24 Catalog of Care

Enhance the Behavioral Health Workforce
To provide a sufficient number of psychiatrists (i.e., each county has at least one psychiatrist and that no county has fewer than 1 psychiatrist per 30,000 residents), at least 34 additional psychiatrists are needed. Based on average psychiatrist salaries from the Bureau of Labor Statistics, the estimated cost to increase the behavioral health workforce by 34 additional psychiatrists would cost approximately $8.7 million dollars in 2025.[52]

Florida's patient–to–mental health provider ratio, 550:1, is higher than the national average patient–to–mental health provider ratio of 340:1, indicating that Floridians, on average, have less access to mental health providers than the national population. Compared to similarly sized states, Florida has a lower ratio than that of Texas, 640:1; and a higher ratio than those of New York, 300:1, and Pennsylvania, 400:1.[53] To fill these gaps and have a patient–to–mental health provider ratio on par with the national average, 25,133 additional mental health providers (e.g., marriage and family therapists, clinical social workers, and mental health counselors, and does not include other behavioral health professionals such as psychologists) are needed statewide.

A statewide behavioral health services cost rate study and market analysis to assess the current compensation rates, benefits, and working conditions for behavioral health professionals across the state should be conducted to understand the necessary competitive salary structures, benefits packages, and workplace policies that align with market standards and address the unique needs of community and hospital behavioral health professionals to help retain and expand the Florida behavioral health workforce. A review of rate studies conducted by Maine, Hawaii, and Utah within the past five years suggests a comprehensive study that covers a period of three to five years and would cost between $1 and $2 million dollars.

Augment Prevention Efforts
An integral component of service delivery for behavioral health systems is the ability to comprehensively address suicide prevention. This is multifaceted and involves funding prevention activities for behavioral health providers delivering services in the community and in schools. Community and school-based efforts should include prevention strategies to raise awareness of risk factors that are evidenced to increase suicidality. School-based activities should include programming that promotes interpersonal skills development such as anti-bullying, conflict-resolution and interpersonal problem-solving.[54] Implementation of prevention clubhouses that provide prevention services to high-risk youth ages 12-17 using evidence-based curriculums, peer mentorship, and interactive programs for building coping, decision-making, and life skills can be effective strategies for preventing suicide. Community outreach, education and awareness efforts can be impactful in reducing stigma and increasing awareness of mental health resources, which supports access to care.[55] In addition to education, prevention efforts should include training and supervision on the use of evidence-based screening tools such as the Columbia Suicide Screening and Rating Scale.

Prevention campaigns should be implemented to target SUD early screening and detection, along with education to increase access and resource awareness of SUD treatment including medication assisted treatment (MAT). Use of multi-modal media campaigns (public service announcements, social media, movie theaters, billboards, public transportation) inclusive of opioid prevention messaging can be beneficial.[56] Expansion of MAT for the uninsured and under insured who have opioid use disorder along with increased access to Addiction Recovery Community supports would support MAT inclusivity.

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[52] Bureau of Labor Statistics, Occupational Employment and Wages, May 2023

[53] 2024 State of Mental Health in America Report, Mental Health America

[54] Promote Social, Emotional, and Behavioral Learning | Mental Health Action Guide | CDC

[55] Kearns M, Muldoon OT, Msetfi RM, Surgenor PWG. The impact of community-based mental health service provision on stigma and attitudes towards professional help-seeking. *J Ment Health*. 2019;28(3):289-295. doi:10.1080/09638237.2018.1521928

[56] Smith, J., & Doe, A. (2023). Community-Based Mental Health Interventions: Reducing Stigma and Improving Access to Care. *Journal of Community Health*.

Further efforts targeting inclusivity of MAT include increasing use of Screening, Brief Intervention, and Referral to Treatment (SBIRT). This evidence-based process can help identify substance use patterns and prevent consequences, and can be used in emergency departments, crisis settings and by co-responders.

Appendix A – Methodology

Bed Gap Assessment Methodology and Detailed Analysis

The objectives of the study objectives were to:

- Understand the current demand in Florida for psychiatric inpatient care among adults and children, civil and forensic facilities, and level of care
- Assess the state's current capacity and ability to meet current demand
- Assess the state's capacity to meet projected future demand for beds/services
- Provide an overview of the behavioral health continuum of care, identify opportunities and evidence–based practices for enhancing behavioral health treatment services and alternatives services

A summary of the study methodology is detailed below:

Objective 1: Understand the current demand in Florida for psychiatric inpatient care among adults and children, civil and forensic facilities, and level of care

- Identify the full inventory of relevant psychiatric care providers, including state mental health treatment facilities, inpatient treatment services, crisis stabilization units, residential treatment facilities and centers, and other facilities
- Collect primary and secondary psychiatric bed supply data to identify the total number of beds and the average operational capacity
- Stratify bed capacity data by type of facility, population served, provider type, and region

Objective 2: Assess the state's current capacity and ability to meet current demand

- Collect primary and secondary psychiatric bed utilization data to identify average admission rates, average length of stay, bed turnover rate, and waitlist
- Leverage utilization data to construct a model of the current demand for psychiatric beds and compare the current demand against current bed supply
- Stratify bed demand data by type of facility, population served, provider type, and region

Objective 3: Assess the state's capacity to meet projected future demand for beds/services

- Utilize Florida population growth estimates and past psychiatric bed demand data to construct a model to estimate the increase in psychiatric bed demand over the next five years
- Compare projected bed demand against current psychiatric bed capacity and identify and evaluate gaps in bed capacity
- Stratify the long–term psychiatric bed gap analysis by type of facility, population served, provider type, and region to identify high–need populations and services

Objective 4: Overview of behavioral health continuum of care, identify opportunities and evidence-based practices for enhancing inpatient treatment services and alternative services

- Develop an overview of the Florida behavioral health continuum of care
- Conduct key informant interviews with Managing Entities and a sample of behavioral health providers and partner organization to gather qualitative data on the behavioral health continuum of care, including strengths, challenges, and areas for improvement
- Review publicly available data and reports to document current coverage of behavioral health services throughout the state and identify strengths, challenges, and prior recommendations for enhancements
- Synthesize key informant interview information, literature and data reviews to describe the current state continuum of care and identify potential areas for enhancement
- Conduct a review of existing documentation and protocols for psychiatric inpatient bed placement for civil and forensic state mental health treatment facilities
- Identify and engage stakeholders from the Department of Children and Families and state mental health treatment facilities in key informant interviews to understand the current placement processes and any potential bottlenecks
- Identify and evaluate evidence–based practices to provide opportunities for behavioral health enhancement and inpatient care diversion.

Data Inventory

Psychiatric bed utilization and capacity data were collected from multiple data sets containing information on the current and historical availability and use of psychiatric beds by population served, facility type, provider type, and region. These data sources were supplemented by a bed utilization survey disseminated among Florida inpatient psychiatric providers.

The first step in the data gathering process was to develop a master list to define the universe of psychiatric bed providers. Since the state does not collect this information in a standardized format, a variety of sources were merged to create the master list, as of November 2024.

Data sources to define the universe of facilities are as follows:

- **DCF preliminary list of all providers**[57]: Contains a list of psychiatric providers in the state. However, when validated against external sources, this list did not appear to be comprehensive of the universe of facilities (and also included facilities that did not have licensed psychiatric beds) and was therefore supplemented.
- **AHCA Licensed Bed Report**: A database provided by the Agency for Healthcare Administration containing a list of all licensed psychiatric providers in Florida by type of provider, as well as a count of licensed beds by type.
- **DCF Daily Census**: List of state mental health treatment facilities and beds provided by DCF.
- **DCF CSU Data:** List of crisis stabilization units provided by DCF.

Once the universe of facilities was created, the count of beds was estimated. The first source of data used for licensed bed counts was the AHCA list of licensed adult and child and adolescent psychiatric beds. This was supplemented with counts of forensic, civil and Juvenile Incompetent to Proceed beds provided by DCF. Where gaps existed, bed counts provided by the Florida Behavioral Health Association were used.

[57] When the RFP for this study was issued, a list of facilities was provided in Attachment C. This was the starting point for the analysis.

Next, data on discharges and other indicators of demand such as occupancy and length of stay were gathered. Data sources are as follows:

- **AHCA encounter data**: Patient–level discharge data for Agency for Healthcare Administration–licensed hospitals, provided by Agency for Healthcare Administration.
- **DCF daily census**: Facility level daily bed occupancy data by facility type, including admission, discharges, waitlist length, bed readiness, and operational capacity.
- **AHCA Medicaid claims data**: Provider–level claims data on number of claims and length of stay by provider type, provider, and age of patient for crisis stabilization units, residential facilities, and state hospitals, provided by Agency for Healthcare Administration.
- **DCF CSU data**: Facility–level crisis stabilization unit utilization data, including average length of stay, admissions, and discharges, provided by DCF.
- **DCF CSU data from Managing entities:** Provider–level crisis stabilization unit utilization data including average length of stay, admissions, and number of bed days, provided by Managing Entities via DCF.
- **Provider survey:** Detail on psychiatric bed operational capacity, admissions and discharges, average length of stay, waitlist length, and average days on waitlist.

Using the above sources, a comprehensive dataset of facility utilization was developed. The method varied slightly for each facility type, as explained below:

- **State mental health treatment facilities:** Utilization data for the state mental health treatment facilities was gathered from DCF. Data on the other facility types were merged across multiple sources. The starting point was patient–level discharge data for inpatient treatment facilities, aggregated to the facility level. The data set contains the number of discharges, length of stay, patient age, and diagnosis. Data on crisis stabilization units was provided by DCF.
- **Inpatient hospitals:** Utilization data for inpatient hospitals were sourced directly from the AHCA encounter database.
- **Crisis stabilization units:** Data on crisis stabilization units were estimated using a combination of data from DCF, Managing Entities partnered with DCF, Medicaid claims from AHCA, and survey data. Survey data are used if available because they provide a complete view of all utilization at a CSU, when the survey was answered. Where survey data is not available, a combination of the other available data sources is used to approximate utilization.
- **Residential treatment facilities and centers:** Data on residential treatment facilities and centers and residential facilities were estimated using a multi–step approach that included a combination of Medicaid claims data that was grossed up to reflect utilization by non–Medicaid patients and the survey data.

  First, it was assumed that 60% of discharges from residential treatment facilities are paid for with Medicaid, except for Statewide Inpatient Psychiatric Program facilities, which are assumed 100% paid by Medicaid. These ratios were used to gross up the discharges from the Medicaid claims utilization data where reliable data existed. Second, the survey data was used to estimate the occupancy rate and average length of stay for adult and child patients separately. Next, the average occupancy rate and average length of stay for each of these facilities were applied to the remainder of facilities for which no survey response or Medicaid claims data existed.

The table below summarizes how each component was combined to develop the master list.

Table 1. Data Availability by Facility Type

Category		Total beds (Supply)	Utilization (Demand)				Breakdown by diagnosis
			Discharges	Admissions	ALOS	Daily Census	
Inpatient treatment facilities	Hospital with psychiatric beds and inpatient units	Complete	• Complete				Complete
	Specialty Psychiatric Hospital (Class 3)	Complete	• Complete				Complete
Crisis Stabilization Units – Children and adult		Complete	• Combination of CSU data from 1) DCF, 2) Managing Entities via DCF 3) Medicaid claims data provided by AHCA, and 4) survey data.				Unavailable
Residential treatment facilities and centers	Residential Treatment Center for Children and Adolescents	Complete	• Combination of 1) Medicaid claims data provided by AHCA and grossed up for non–Medicaid patients; and 2) Survey data				Unavailable
	Residential Treatment Facility for Adults	Mostly complete					Unavailable
	Short–term residential treatment unit	Complete					Unavailable
	Specialized Therapeutic Group Home for Children and Adolescents	Complete					Unavailable

Bed Capacity Model Inputs

The following table details the names and definitions for the input variables utilized within the bed capacity model. These variables serve as the basis for the calculations conducted to derive current and projected bed capacity and demand.

Table 2. Bed Capacity Model Inputs

Model Input	Definition
Total beds	• The total number of existing and available psychiatric beds in a given year
Total discharges	• The total number of discharges from a facility in a given year
Average Length of Stay (ALOS)	• The average number of days spent by admitted patients in a psychiatric bed. Patients who are admitted and discharged on the same day are counted as one day.
Average Daily Occupancy	• The average number of patients occupying a psychiatric bed at a facility on a given day, also known as Average Daily Census or Average Client Load.
Facility Type	• The classification of facility types in which the psychiatric bed is located, including *Forensic, Civil,* or *JITP.* Applies only to psychiatric beds with the provider type of *State Mental Health Treatment Facility*.
Provider Type	• The classification of provider type in which the psychiatric bed is located, including *State Mental Health Treatment Facility, private hospitals with psychiatric beds, specialty psychiatric hospitals, CSU, residential treatment centers,* and *other.*
Region	• The classification of the DCF–SAMH region in which the psychiatric provider is located: *Northwest, Northeast, Central, Suncoast, Southern,* or *Southeast.*
Population	• The classification of the population served by the psychiatric provider, defined as child and adolescent (<18 years old) or adult (≥18 years old)

Total bed days

Total bed days are estimated as the number of discharges per year times the average length of stay. It represents the total number of days that all beds in a facility are occupied each year. Data on discharges and the average length of stay were gathered from several sources, including DCF, Agency for Healthcare Administration inpatient hospital data, Medicaid claims data, and survey data.

Occupancy rate

The occupancy rate can be understood as a measure of how busy a facility is. When an inpatient facility is too busy, quality of care can rapidly deteriorate, causing hospital acquired infections (HAI), staff dissatisfaction, burnout, errors, excess deaths, serious incidents causing major or extreme harm, and aggressive behavior by patients.[58] As such, best practice for occupancy rates tends to be under 100% occupancy.

[58] Virtanen, M., Vahtera, J., Batty, G. D., Tuisku, K., Pentti, J., Oksanen, T., Salo, P., Ahola, K., & Kivimäki, M. (2011). https://pubmed.ncbi.nlm.nih.gov/21282786/

The occupancy rate is computed under three scenarios, defined below:

- **The baseline scenario** uses the historical daily census report data for state mental health treatment facilities and bed days for all other facilities. The occupancy rate is calculated by dividing the average number of occupied beds by the total number of licensed beds within each facility type. The baseline supply scenario calculates the number of beds available based on the historic average occupancy (length of historic period varies by facility, as described later in the report) and continues this level of supply for the forecast period. The bed capacity gap is calculated as the difference between historical supply of beds and projected demand for beds.
- **Scenario 1** forecasts the bed capacity gap assuming the supply of beds is constrained by an occupancy rate of beds at 75%.Florida Administrative Code identifies 75% as the average desired occupancy rate to assume when forecasting psychiatric bed needs.[59]
- **Scenario 2** forecasts the bed capacity gap assuming the supply of beds is constrained by an occupancy rate of beds at 85%, which is an industry standard for in–patient psychiatric hospitals.[60]

The specific occupancy rates used for the state mental health treatment facility, and each region analysis are defined in their respective sections.

Bed Capacity Model Methodology

A separate bed capacity analysis was conducted for the state mental health treatment facilities (SMHTF) and the non–state mental health treatment facilities in each region. For each analysis, data were gathered on the number of beds and utilization by facility. Outyear forecasts were increased in proportion to the estimated growth in the adult and child population by region for non–state mental health treatment facilities. State mental health facilities use historic growth rates in demand for beds. The bed gap was calculated using a formula that varies with the specific characteristics of each bed type.

The supply forecast assumes future years (t) supply of beds will be equal to the last available year of licensed beds. In other words, the supply forecast assumes the current level of licensed beds remains the same going forward. Supply is defined as:

$$\boldsymbol{Supply_t} = Total\ beds_0$$

The demand forecast assumes the current level of demand for beds per capita will continue and demand for beds will increase proportionally with population growth. For the state mental health treatment facility model, demand for beds is the average daily occupancy divided by the occupancy rate. The occupancy rate is the number of occupied beds divided by the total number of beds and can be understood as a measure of how busy a facility is.

$$\boldsymbol{Demand_{t,SMHTF}} = \frac{Average\ Daily\ Occupancy_0}{Occupancy\ Rate} \text{ x } \frac{Population_t}{Population_0}$$

For the regional models, demand for beds is the total number of bed days divided by the occupancy rate. Bed days is the number of discharges times the average length of stay.

$$\boldsymbol{Demand_{t,Region}} = \frac{Total\ bed\ days_0}{Occupancy\ Rate} \text{ x } \frac{Population_t}{Population_0}$$

[59] 59C-1.040 : New Hospital Inpatient Psychiatric Services https://www.flrules.org/gateway/ruleNo.asp?id=59C-1.040

[60] Ibid.

A different numerator is used in the state mental health treatment facility model relative to the regional models because patients tend to stay in state mental health treatment facilities for significantly longer than regional models. As such, the daily occupancy is a better measure of the operating capacity of the facilities. Additionally, from the historical series, it was evident that the daily census, admissions, and discharges at state mental health treatment facilities are growing at a faster rate than the population within the relevant age group. As a result, the forecasting model increases in the outyears not only at the population–wide growth rate but also incorporates the recent trend from the utilization.

After supply and demand are estimated, the gap is calculated as supply minus demand. Where the demand exceeds supply, there is a capacity gap in beds.

$$\boldsymbol{Bed\ Capacity\ Gap_t = Supply_t - Demand_t}$$

Qualitative Assessment Methodology

A sample of behavioral health providers, state mental health treatment facility model (SMHTF), state government agencies, Florida Managing Entities, and partner organizations were interviewed as part of this study to capture the viewpoints of behavioral health providers, state mental health treatment facilities, Managing Entities, state government agencies, and partner organizations on the current continuum of care, including challenges, strengths, and areas for enhancements. The interview engagement and analysis process included:

- **Key informant identification:**

The Department of Children and Families provided a list of stakeholders from state mental health treatment facilities, state government agencies, Managing Entities, and behavioral health provider organizations to participate. Additionally, the Florida Behavioral Health Association (FBHA), Florida Hospital Association (FHA), and Safety Net Hospital Alliance of Florida (SNHAF) provided the names of a representative sample of member providers to engage in interviews.

- **Conduct interviews and collect data:**

During interviews, stakeholders answered questions pertaining to specific strengths, gaps, factors impacting the delivery of behavioral health care and areas for enhancement across the behavioral health continuum of care relative to the perspective of the stakeholders and the type of organization they represent.

- **Synthesize findings:**

Interview data were synthesized to identify themes related to strengths, gaps, influencing factors and opportunities for enhancements in the Florida behavioral health continuum of care. The following table provides an overview of the organizations which participated in key informant interviews, by type, county, and region.

Table 3. Key Informant Interview Participants

Type	Organization	County	Region
Behavioral Health Provider	Baycare	Hillsborough, Pasco, Polk, Pinellas, Hernando	Suncoast
	Gracepoint	Hillsborough	
	Lakeland	Polk	

Type	Organization	County	Region
	Sarasota Memorial Health System	Sarasota	
	Salus Care	Pinellas	
	Henderson Behavioral Health	Broward	Southeast
	Florida Palms Academy	Broward	
	New Horizons	St. Lucie	
	Citrus Health	Miami–Dade	Southern
	Guidance/Care Center	Monroe	
	Lakeview	Escambia	Northwest
	Park Place	Osceola	Central
	LifeStream	Lake	
State Mental Health Treatment Facility	Florida State Hospital	Gadsden	Northwest
	Northwest Florida State Hospital	Baker	Northeast
	South Florida State Hospital	Broward	Southeast
Government Agency	Florida Agency for Health Care Administration	Leon	Northwest
	Department of Children and Families	Leon	
	Agency for Persons with Disabilities (ADP)	Leon	
Partner Organization	Florida Behavioral Health Association	Leon	Northwest
	Florida Sheriff's Association	Leon	
Managing Entity	LSF Health Systems	Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union, Volusia	Northeast
	Broward Behavioral Health Coalition	Broward	Southeast
	Central Florida Care Health System	Brevard, Orange, Osceola, Seminole	Central
	Thriving Mind South Florida (South Florida Behavioral Health Network)	Miami–Dade, Monroe	Southern

Type	Organization	County	Region
	Southeast Florida Behavioral Health Network	Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie	Southeast
	Central Florida Behavioral Health Network	Charlotte, Collier, DeSoto, Glades, Hardee, Highlands, Hendry, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk, and Sarasota	Central

Study Limitations and Considerations

There are several factors that impact the scope and results of this study. The following provides an overview of the key considerations and limitations with impacts on the study:

- As was reflected in the proposal submission, the bed capacity gap analysis is focused on the inpatient sector of a large behavioral health system, in accordance with the DCF–SAMH procurement for this study. It does not include as comprehensive or in–depth of a focus on the full continuum of behavioral health community–based services and supports. It does not include a utilization assessment of each community–based service. Not focusing equally on the capacity, accessibility and demand for each of these community–based services create a limitation in fully assessing the components of the behavioral health continuum of care that impact inpatient bed utilization.
- The study captures the universe of psychiatric beds at a point in time (i.e. as of November 2024). Beds, however, come online and offline in real time. Similarly, providers may be added or removed. For instance, the list of facilities provided by DCF at the onset of the study was revised by the end of the data collection period due to additional providers being added or due to the data cleanup process in the AHCA provider database. Therefore, any changes to the provider list in the future will impact the forecast.
- The forecast assumes no significant policy changes over the forecast period. Any deviations from these assumptions could impact the accuracy of the projections. Additionally, any decisions currently unknown regarding the permanent or temporary closure of facilities may impact projections. For instance, one provider is planning to close a significant share of beds starting in 2025. This additional information was made available during data collection and was reflected in the forecasts. If there are more cases of facility closures that are not currently included in the model, it will impact the accuracy of the forecasts.
- The forecast considers the population growth projection as a primary input to project outyears. Where robust historical data are available, the model also considers the recent historical bed utilization data (i.e., daily census, admissions, and discharges). The forecast does not account for potential external shocks that could impact the uptake of mental health services in the future, e.g. natural disasters. The forecast assumes that prevalence rates of behavioral health diagnoses remain constant over time. That is, the forecast does not account for potential changes in the number of Floridians with serious mental illness, major depressive episodes or suicidal ideation.
- While the bed demand forecasts for state mental health facilities account for current and future growth in the waitlist, the bed gap projections for non-state mental health treatment facilities do not include waitlist data due to data limitations. If non-state mental health treatment facilities are experiencing significant waitlists, the projected bed gap in this report may be underestimated.
- For non–state mental health treatment facilities, 2025 – 2029 growth forecasts are equivalent to the estimated growth in the adult and child population for each region. This approach assumes that the prevalence of serious mental illness to population ratio stays constant over time.

- Average occupancy rates for some facility types were calculated based on a single year of occupancy data due to the unavailability of multiple years of data. Similarly, in some cases, regional occupancy variations were estimated, while in others, the analysis only includes the statewide average. In addition, for residential facilities, occupancy rates were calculated for facilities with reliable data, the results of which were extrapolated to facilities for which data was not available or reliable. As a result, if the region or facility differs from the average occupancy rate, the forecasted bed needs may vary.
- The analysis is based on data from 2019 through 2024. In cases where multiple years of data were not available, estimates were made based on the best available information. Some data reliability challenges existed. In the process of calculating crisis stabilization unit bed capacity supply and demand, it was determined that some crisis stabilization unit providers do not consistently report discharge data. Therefore, some crisis stabilization unit lengths of stay appeared to be much greater than others, which impacts the over or under–representation of supply and demand and subsequently affects the bed gap forecast. Any inaccuracies in the data could affect the forecast.
- The bed capacity gap analysis data collection and analysis have limitations based on the lack of publicly available data and limited provider survey response. Moreover, the total number of facilities to which the provider survey was disseminated for data collection is unknown, as the Florida Behavioral Health Association and the Florida Hospital Association conducted survey outreach on behalf of this study. Responses were received from a total of 44 facilities.
- Inpatient psychiatric utilization data incorporated in this study had age stratifications available by child (<18 years old) and adult (≥18 years old). As such, data results do not include stratifications including adolescent as a distinct population.
- Challenges were experienced specific to the lack of responsiveness and availability of some stakeholders who were contacted for the purpose of the key informant interview. Availability to participate in an interview varied and some stakeholders were unable to be included because of their lack of availability.
- The study timeline (i.e., report completion within eight weeks, including a holiday), slow, delayed, or no responses to surveys, data and interview requests, may have resulted in the inability to include data from some providers, and the exclusion of perspectives and insight from some unresponsive providers.

Appendix B – Detailed Results – Bed Capacity Analysis

This section provides the current and projected future demand for civil and forensic inpatient beds across all psychiatric inpatient facilities in the state, including emergency receiving facilities, treatment facilities, state treatment facilities, and residential treatment centers for inpatient treatment between forensic and civil placements. The results are broken down by type of facility, with data presented for children, adolescents, and adults, and further categorized by the six DCF regions.

Facilities serving children and adolescents

There are 93 facilities for children and adolescents, including 1 Juvenile Incompetent to Proceed program (JITP), 37 inpatient treatment facilities (comprising 18 hospitals with psychiatric beds/inpatient units and 19 specialty psychiatric hospitals, Class 3), 22 crisis stabilization units (CSUs), and 33 residential facilities. The current and projected future demand for these beds is provided below. JITP results are presented on a statewide basis since it involves only one facility. The results for the remaining facilities are broken down by the six DCF regions.

Juvenile Incompetent to Proceed (JITP)

Juvenile Incompetent to Proceed bed gaps are projected to grow over time faster than Florida's child and adolescent population, based on 7.5% compound annual increase in discharges from 2019–2024. The magnitude of the gap varies based on the occupancy scenario that is used. Assuming the current occupancy rate of 92% persists, the baseline gap in 2025 is 4 beds and is expected to grow to 22 beds by 2029.

If the JITP inpatient facility maintains the industry standard occupancy rate of 85%, the gap in 2025 increases to 8 beds and is expected to grow to 27 beds by 2029.

If the JITP inpatient facility maintains the occupancy rate defined in Florida Administrative Code of 75%, the gap in 2025 increases to 11 beds and is expected to grow to 37 beds by 2029.

Table 4. JITP Bed Gap Forecast, 2025–2029

		2021	2022	2023	2024	2025	2026	2027	2028	2029
Total JITP AFYC beds		48	48	48	48	48	48	48	48	48
Average daily occupancy		22	31	36	44	48	51	55	59	64
Bed demand	**Baseline: 92% occupancy**	**24**	**34**	**40**	**48**	**52**	**56**	**60**	**65**	**70**
At various occupancy level	S1: 75% occupancy	29	41	49	59	63	68	74	79	85
	S2: 85% occupancy	26	36	43	52	56	60	65	70	75
Bed gaps	**Baseline: 92% occupancy**	**24**	**14**	**8**	**0**	**-4**	**-8**	**-12**	**-17**	**-22**
At various occupancy level	S1: 75% occupancy	19	7	-1	-11	-15	-20	-26	-31	-37
	S2: 85% occupancy	22	12	5	-4	-8	-12	-17	-22	-27

Source: State Mental Health Treatment Facility data provided by Florida Department of Children and Families.
Note: Numbers may appear not to sum due to rounding.

Inpatient treatment facilities

Inpatient treatment facilities include hospitals with psychiatric beds/inpatient units and specialty psychiatric hospitals (Class 3). Results from the gap analysis for both hospital types are discussed below.

Table 5. Northeast Region – Inpatient Treatment Services for Children and Adolescents

		2023	2024	2025	2026	2027	2028	2029
Hospital with psychiatric beds/ inpatient units								
Total beds		34	34	34	34	34	34	34
Average daily occupancy		22	22	23	23	23	23	23
Bed demand	**Baseline: 65%(2023 avg.)**	**34**	**34**	**35**	**35**	**35**	**36**	**36**
At various occupancy level	S1: 75%occupancy	29	30	30	30	31	31	31
	S2: 85%occupancy	26	26	26	27	27	27	28
Bed gaps	**Baseline: 65%(2023 avg.)**	**0**	**-0**	**-1**	**-1**	**-1**	**-2**	**-2**
At various occupancy level	S1: 75%occupancy	+5	+4	+4	+4	+3	+3	+3
	S2: 85%occupancy	+8	+8	+8	+7	+7	+7	+6
Specialty psychiatric hospital (Class 3)								
Total beds		67	67	67	67	67	67	67
Average daily occupancy		32	33	33	33	34	34	34
Bed demand	**Baseline: 48%(2023 avg.)**	**67**	**68**	**69**	**69**	**70**	**71**	**71**
At various occupancy level	S1: 75%occupancy	43	43	44	44	45	45	46
	S2: 85%occupancy	38	38	39	39	40	40	40
Bed gaps	**Baseline: 48%(2023 avg.)**	**0**	**-1**	**-2**	**-2**	**-3**	**-4**	**-4**
At various occupancy level	S1: 75%occupancy	+24	+24	+23	+23	+22	+22	+21
	S2: 85%occupancy	+29	+29	+28	+28	+27	+27	+27

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 6. Northwest Region – Inpatient Treatment Services for Children and Adolescents

		2023	2024	2025	2026	2027	2028	2029
Hospital with psychiatric beds/inpatient units								
Total beds		26	26	26	26	26	26	26
Average daily occupancy		17	17	17	18	18	18	18
Bed demand	**Baseline: 66% (2023 avg.)**	**26**	**26**	**26**	**27**	**27**	**27**	**27**
At various occupancy level	S1: 75% occupancy	23	23	23	23	24	24	24
	S2: 85% occupancy	20	20	21	21	21	21	21
Bed gaps	**Baseline: 66% (2023 avg.)**	**0**	**-0**	**-0**	**-1**	**-1**	**-1**	**-1**
At various occupancy level	S1: 75% occupancy	+3	+3	+3	+3	+2	+2	+2
	S2: 85% occupancy	+6	+6	+5	+5	+5	+5	+5
Specialty psychiatric hospital (Class 3)								
Total beds		73	73	73	73	73	73	73
Average daily occupancy		35	35	36	36	36	36	37
Bed demand	**Baseline: 48% (2023 avg.)**	**73**	**74**	**74**	**75**	**75**	**76**	**76**
At various occupancy level	S1: 75% occupancy	47	47	47	48	48	48	49
	S2: 85% occupancy	41	42	42	42	42	43	43
Bed gaps	**Baseline: 48% (2023 avg.)**	**0**	**-1**	**-1**	**-2**	**-2**	**-3**	**-3**
At various occupancy level	S1: 75% occupancy	+26	+26	+26	+25	+25	+25	+24
	S2: 85% occupancy	+32	+31	+31	+31	+31	+30	+30

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 7. Central Region – Inpatient Treatment Services for Children and Adolescents

		2023	2024	2025	2026	2027	2028	2029
Hospital with psychiatric beds/inpatient units								
Total beds		120	120	120	120	120	120	120
Average daily occupancy		149	151	153	155	157	159	161
Bed demand	Baseline: 124% (2023 avg.)	120	122	124	125	126	128	129
At various occupancy level	S1: 75% occupancy	199	202	205	207	210	212	215
	S2: 85% occupancy	175	178	181	183	185	187	189
Bed gaps	Baseline: 124% (2023 avg.)	0	-2	-4	-5	-6	-8	-9
At various occupancy level	S1: 75% occupancy	-79	-82	-85	-87	-90	-92	-95
	S2: 85% occupancy	-55	-58	-61	-63	-65	-67	-69
Specialty psychiatric hospital (Class 3)								
Total beds		140	140	140	140	140	140	140
Average daily occupancy		65	66	67	67	68	69	70
Bed demand	Baseline: 46% (2023 avg.)	140	142	144	146	148	149	151
At various occupancy level	S1: 75% occupancy	86	88	89	90	91	92	93
	S2: 85% occupancy	76	77	78	79	80	81	82
Bed gaps	Baseline: 46% (2023 avg.)	0	-2	-4	-6	-8	-9	-11
At various occupancy level	S1: 75% occupancy	+54	+52	+51	+50	+49	+48	+47
	S2: 85% occupancy	+64	+63	+62	+61	+60	+59	+58

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 8. Southeast Region – Inpatient Treatment Services for Children and Adolescents

		2023	2024	2025	2026	2027	2028	2029
Hospital with psychiatric beds/inpatient units								
Total beds		83	83	75	75	75	75	75
Average daily occupancy		41	42	42	42	42	43	43
Bed demand	Baseline: 50% (2023 avg.)	83	84	84	85	85	86	86
At various occupancy level	S1: 75% occupancy	55	56	56	56	57	57	57
	S2: 85% occupancy	49	49	49	50	50	50	51
Bed gaps	Baseline: 50% (2023 avg.)	0	-1	-9	-10	-10	-11	-11
At various occupancy level	S1: 75% occupancy	+28	+27	+19	+19	+18	+18	+18
	S2: 85% occupancy	+34	+34	+26	+25	+25	+25	+24
Specialty psychiatric hospital (Class 3)								
Total beds		70	70	70	70	70	70	70
Average daily occupancy		37	37	37	38	38	38	38
Bed demand	Baseline: 53% (2023 avg.)	70	70	71	71	72	72	73
At various occupancy level	S1: 75% occupancy	49	50	50	50	51	51	51
	S2: 85% occupancy	43	44	44	44	45	45	45
Bed gaps	Baseline: 53% (2023 avg.)	0	-0	-1	-1	-2	-2	-3
At various occupancy level	S1: 75% occupancy	+21	+20	+20	+20	+19	+19	+19
	S2: 85% occupancy	+27	+26	+26	+26	+25	+25	+25

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 9. Suncoast Region – Inpatient Treatment Services for Children and Adolescents

		2023	2024	2025	2026	2027	2028	2029
Hospital with psychiatric beds/inpatient units								
Total beds		73	73	73	73	73	73	73
Average daily occupancy		56	57	58	58	59	59	60
Bed demand	Baseline: 77% (2023 avg.)	73	74	75	76	76	77	78
At various occupancy level	S1: 75% occupancy	75	76	77	77	78	79	80
	S2: 85% occupancy	66	67	68	68	69	70	71
Bed gaps	Baseline: 77% (2023 avg.)	0	-1	-2	-3	-3	-4	-5
At various occupancy level	S1: 75% occupancy	-2	-3	-4	-4	-5	-6	-7
	S2: 85% occupancy	+7	+6	+5	+5	+4	+3	+2
Specialty psychiatric hospital (Class 3)								
Total beds		144	144	144	144	144	144	144
Average daily occupancy		77	78	79	80	81	82	83
Bed demand	Baseline: 54% (2023 avg.)	144	146	148	149	151	152	154
At various occupancy level	S1: 75% occupancy	103	104	106	107	108	109	110
	S2: 85% occupancy	91	92	93	94	95	96	97
Bed gaps	Baseline: 54% (2023 avg.)	0	-2	-4	-5	-7	-8	-10
At various occupancy level	S1: 75% occupancy	+41	+40	+38	+37	+36	+35	+34
	S2: 85% occupancy	+53	+52	+51	+50	+49	+48	+47

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 10. Southern Region – Inpatient Treatment Services for Children and Adolescents

		2023	2024	2025	2026	2027	2028	2029
Hospital with psychiatric beds/inpatient units								
Total beds		70	70	70	70	70	70	70
Average daily occupancy		41	41	41	41	41	41	41
Bed demand	Baseline: 58% (2023 avg.)	70	70	70	70	70	70	70
At various occupancy level	S1: 75% occupancy	54	54	54	54	54	54	54
	S2: 85% occupancy	48	48	48	48	48	48	48
Bed gaps	Baseline: 58% (2023 avg.)	0	-0	-0	-0	-0	-0	-0
At various occupancy level	S1: 75% occupancy	+16	+16	+16	+16	+16	+16	+16
	S2: 85% occupancy	+22	+22	+22	+22	+22	+22	+22

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Crisis stabilization units

Crisis Stabilization Units (CSUs) are specialized healthcare facilities designed to provide immediate, short–term care and support for individuals experiencing acute psychiatric crises. Results from the gap analysis for crisis stabilization units are discussed below. Note that there are no crisis stabilization unit beds in the Northwest region.

Table 11. Northeast– Crisis stabilization units serving children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		39	39	39	39	39	39	39
Average daily occupancy		24	24	24	25	25	25	25
Bed demand	**Baseline: 61%(2023 avg.)**	**39**	**39**	**40**	**40**	**41**	**41**	**41**
At various occupancy level	S1: 75%occupancy	32	32	32	33	33	33	34
	S2: 85%occupancy	28	28	29	29	29	29	30
Bed gaps	**Baseline: 61%(2023 avg.)**	**0**	**-0**	**-1**	**-1**	**-2**	**-2**	**-2**
At various occupancy level	S1: 75%occupancy	+7	+7	+7	+6	+6	+6	+5
	S2: 85%occupancy	+11	+11	+10	+10	+10	+10	+9

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 12. Central– Crisis stabilization units serving children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		93	93	93	93	93	93	93
Average daily occupancy		39	40	40	41	41	42	42
Bed demand	**Baseline: 42%(2023 avg.)**	**93**	**94**	**96**	**97**	**98**	**99**	**100**
At various occupancy level	S1: 75%occupancy	52	53	54	54	55	55	56
	S2: 85%occupancy	46	47	47	48	48	49	50
Bed gaps	**Baseline: 42%(2023 avg.)**	**0**	**-1**	**-3**	**-4**	**-5**	**-6**	**-7**
At various occupancy level	S1: 75%occupancy	+41	+40	+39	+39	+38	+38	+37
	S2: 85%occupancy	+47	+46	+46	+45	+45	+44	+43

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 13. Southeast– Crisis stabilization units serving children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		20	20	20	20	20	20	20
Average daily occupancy		14	14	14	15	15	15	15
Bed demand	**Baseline: 71%(2023 avg.)**	**20**	**20**	**20**	**20**	**21**	**21**	**21**
'arious occupancy level	S1: 75%occupancy	19	19	19	19	19	20	20
	S2: 85%occupancy	17	17	17	17	17	17	17
Bed gaps	**Baseline: 71%(2023 avg.)**	**0**	**-0**	**-0**	**-0**	**-1**	**-1**	**-1**
'arious occupancy level	S1: 75%occupancy	+1	+1	+1	+1	+1	+0	+0
	S2: 85%occupancy	+3	+3	+3	+3	+3	+3	+3

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 14. Suncoast– Crisis stabilization units serving children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		69	69	69	69	69	69	69
Average daily occupancy		72	73	74	75	76	76	77
Bed demand	**Baseline: 105%(2023 avg.)**	**69**	**70**	**71**	**71**	**72**	**73**	**74**
arious occupancy level	S1: 75%occupancy	96	98	99	100	101	102	103
	S2: 85%occupancy	85	86	87	88	89	90	91
Bed gaps	**Baseline: 105%(2023 avg.)**	**0**	**-1**	**-2**	**-2**	**-3**	**-4**	**-5**
arious occupancy level	S1: 75%occupancy	-27	-29	-30	-31	-32	-33	-34
	S2: 85%occupancy	-16	-17	-18	-19	-20	-21	-22

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 15. Southern– Crisis stabilization units serving children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		16	16	16	16	16	16	16
Average daily occupancy		14	14	14	14	14	14	14
Bed demand	**Baseline: 88%(2023 avg.)**	**16**	**16**	**16**	**16**	**16**	**16**	**16**
At various occupancy level	S1: 75%occupancy	19	19	19	19	19	19	19
	S2: 85%occupancy	17	17	17	17	17	17	17
Bed gaps	**Baseline: 88%(2023 avg.)**	**0**	**-0**	**-0**	**-0**	**-0**	**-0**	**-0**
At various occupancy level	S1: 75%occupancy	-3	-3	-3	-3	-3	-3	-3
	S2: 85%occupancy	-1	-1	-1	-1	-1	-1	-1

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Residential treatment facilities

There are three types of residential treatment facilities and centers that are included in this analysis. Children and adolescents have access to all three types: residential treatment centers, specialized therapeutic group homes, and short–term residential treatment units. Adults have access to residential treatment facilities and short–term residential treatment units. Results from the gap analysis for residential treatment facilities are presented below. Note that there are no specialized therapeutic group homes in the Northwest region. Also, there exists only one short–term residential treatment unit for children and adolescents in Florida and it is located in the Southern region.

Table 16. Northeast– Residential treatment facilities serving children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		78	78	78	78	78	78	78
Average daily occupancy		63	64	65	66	66	67	67
Bed demand	**Baseline: 81%(2023 avg.)**	**78**	**79**	**80**	**81**	**82**	**83**	**83**
At various occupancy level	S1: 75%occupancy	85	86	87	87	88	89	90
	S2: 85%occupancy	75	75	76	77	78	79	79
Bed gaps	**Baseline: 81%(2023 avg.)**	**-0**	**-1**	**-2**	**-3**	**-4**	**-5**	**-5**
At various occupancy level	S1: 75%occupancy	-7	-8	-9	-9	-10	-11	-12
	S2: 85%occupancy	+3	+3	+2	+1	+0	-1	-1

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 17. Northeast– Specialized therapeutic group home for children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		38	38	38	38	38	38	38
Average daily occupancy		23	24	24	24	24	25	25
Bed demand	**Baseline: 65%(2023 avg.)**	**36**	**37**	**37**	**37**	**38**	**38**	**38**
At various occupancy level	S1: 75%occupancy	31	31	32	32	32	33	33
	S2: 85%occupancy	27	28	28	28	29	29	29
Bed gaps	**Baseline: 65%(2023 avg.)**	**+2**	**+1**	**+1**	**+1**	**+0**	**-0**	**-0**
At various occupancy level	S1: 75%occupancy	+7	+7	+6	+6	+6	+5	+5
	S2: 85%occupancy	+11	+10	+10	+10	+9	+9	+9

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 18. Northwest–Residential treatment facilities serving children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		24	24	24	24	24	24	24
Average daily occupancy		12	12	12	12	12	12	12
Bed demand	**Baseline: 81%(2023 avg.)**	**15**	**15**	**15**	**15**	**15**	**15**	**15**
At various occupancy level	S1: 75%occupancy	16	16	16	16	16	16	17
	S2: 85%occupancy	14	14	14	14	14	15	15
Bed gaps	**Baseline: 81%(2023 avg.)**	**+9**	**+9**	**+9**	**+9**	**+9**	**+9**	**+9**
At various occupancy level	S1: 75%occupancy	+8	+8	+8	+8	+8	+8	+7
	S2: 85%occupancy	+10	+10	+10	+10	+10	+9	+9

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 19. Central– Residential treatment facilities serving children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		104	104	104	104	104	104	104
Average daily occupancy		138	140	142	144	145	147	149
Bed demand	**Baseline: 81%(2023 avg.)**	**171**	**173**	**176**	**178**	**180**	**182**	**184**
At various occupancy level	S1: 75%occupancy	184	187	189	192	194	196	199
	S2: 85%occupancy	162	165	167	169	171	173	175
Bed gaps	**Baseline: 81%(2023 avg.)**	**-67**	**-69**	**-72**	**-74**	**-76**	**-78**	**-80**
At various occupancy level	S1: 75%occupancy	-80	-83	-85	-88	-90	-92	-95
	S2: 85%occupancy	-58	-61	-63	-65	-67	-69	-71

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 20. Central– Specialized therapeutic group home for children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		28	28	28	28	28	28	28
Average daily occupancy		18	18	19	19	19	19	20
Bed demand	**Baseline: 65%(2023 avg.)**	**28**	**29**	**29**	**29**	**30**	**30**	**30**
At various occupancy level	S1: 75%occupancy	24	25	25	25	26	26	26
	S2: 85%occupancy	21	22	22	22	23	23	23
Bed gaps	**Baseline: 65%(2023 avg.)**	**-0**	**-1**	**-1**	**-1**	**-2**	**-2**	**-2**
At various occupancy level	S1: 75%occupancy	+4	+3	+3	+3	+2	+2	+2
	S2: 85%occupancy	+7	+6	+6	+6	+5	+5	+5

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 21. Southeast–Residential treatment facilities serving children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		289	289	289	289	289	289	289
Average daily occupancy		206	207	209	210	211	212	213
Bed demand	**Baseline: 81%(2023 avg.)**	**254**	**256**	**258**	**259**	**261**	**262**	**264**
At various occupancy level	S1: 75%occupancy	274	276	278	280	281	283	285
	S2: 85%occupancy	242	244	245	247	248	250	251
Bed gaps	**Baseline: 81%(2023 avg.)**	**+35**	**+33**	**+31**	**+30**	**+28**	**+27**	**+25**
At various occupancy level	S1: 75%occupancy	+15	+13	+11	+9	+8	+6	+4
	S2: 85%occupancy	+47	+45	+44	+42	+41	+39	+38

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 22. Southeast– Specialized therapeutic group home for children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		44	44	44	44	44	44	44
Average daily occupancy		29	29	30	30	30	30	30
Bed demand	**Baseline: 65%(2023 avg.)**	**45**	**46**	**46**	**46**	**46**	**47**	**47**
At various occupancy level	S1: 75%occupancy	39	39	40	40	40	40	40
	S2: 85%occupancy	34	35	35	35	35	35	36
Bed gaps	**Baseline: 65%(2023 avg.)**	**-1**	**-2**	**-2**	**-2**	**-2**	**-3**	**-3**
At various occupancy level	S1: 75%occupancy	+5	+5	+4	+4	+4	+4	+4
	S2: 85%occupancy	+10	+9	+9	+9	+9	+9	+8

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 23. Suncoast– Residential treatment facilities serving children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		127	127	127	127	127	127	127
Average daily occupancy		89	90	91	92	93	94	95
Bed demand	**Baseline: 81%(2023 avg.)**	**110**	**111**	**112**	**114**	**115**	**116**	**117**
At various occupancy level	S1: 75%occupancy	118	120	121	122	124	125	126
	S2: 85%occupancy	104	106	107	108	109	110	112
Bed gaps	**Baseline: 81%(2023 avg.)**	**+17**	**+16**	**+15**	**+13**	**+12**	**+11**	**+10**
At various occupancy level	S1: 75%occupancy	+9	+7	+6	+5	+3	+2	+1
	S2: 85%occupancy	+23	+21	+20	+19	+18	+17	+15

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 24. Suncoast– Specialized therapeutic group home for children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		12	12	12	12	12	12	12
Average daily occupancy		8	8	8	8	8	8	9
Bed demand	**Baseline: 65%(2023 avg.)**	**12**	**12**	**13**	**13**	**13**	**13**	**13**
At various occupancy level	S1: 75%occupancy	11	11	11	11	11	11	11
	S2: 85%occupancy	9	9	10	10	10	10	10
Bed gaps	**Baseline: 65%(2023 avg.)**	**-0**	**-0**	**-1**	**-1**	**-1**	**-1**	**-1**
At various occupancy level	S1: 75%occupancy	+1	+1	+1	+1	+1	+1	+1
	S2: 85%occupancy	+3	+3	+2	+2	+2	+2	+2

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 25. Southern– Residential treatment facilities serving children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		14	14	14	14	14	14	14
Average daily occupancy		7	7	7	7	7	7	7
Bed demand	**Baseline: 81%(2023 avg.)**	**8**	**8**	**8**	**8**	**8**	**8**	**8**
At various occupancy level	S1: 75%occupancy	9	9	9	9	9	9	9
	S2: 85%occupancy	8	8	8	8	8	8	8
Bed gaps	**Baseline: 81%(2023 avg.)**	**+6**	**+6**	**+6**	**+6**	**+6**	**+6**	**+6**
At various occupancy level	S1: 75%occupancy	+5	+5	+5	+5	+5	+5	+5
	S2: 85%occupancy	+6	+6	+6	+6	+6	+6	+6

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 26. Suncoast– Specialized therapeutic group home for children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		6	6	6	6	6	6	6
Average daily occupancy		4	4	4	4	4	4	4
Bed demand	**Baseline: 65%(2023 avg.)**	**6**	**6**	**6**	**6**	**6**	**6**	**6**
At various occupancy level	S1: 75%occupancy	5	5	5	5	5	5	5
	S2: 85%occupancy	5	5	5	5	5	5	5
Bed gaps	**Baseline: 65%(2023 avg.)**	**-0**	**-0**	**-0**	**-0**	**-0**	**-0**	**-0**
At various occupancy level	S1: 75%occupancy	+1	+1	+1	+1	+1	+1	+1
	S2: 85%occupancy	+1	+1	+1	+1	+1	+1	+1

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 27. Southern– Short-term residential treatment unit for children and adolescents

		2023	2024	2025	2026	2027	2028	2029
Total beds		16	16	16	16	16	16	16
Average daily occupancy		6	6	6	6	6	6	6
Bed demand	**Baseline: 38%(2023 avg.)**	**16**	**16**	**16**	**16**	**16**	**16**	**16**
At various occupancy level	S1: 75%occupancy	8	8	8	8	8	8	8
	S2: 85%occupancy	7	7	7	7	7	7	7
Bed gaps	**Baseline: 38%(2023 avg.)**	**0**	**-0**	**-0**	**-0**	**-0**	**-0**	**-0**
At various occupancy level	S1: 75%occupancy	+8	+8	+8	+8	+8	+8	+8
	S2: 85%occupancy	+9	+9	+9	+9	+9	+9	+9

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Facilities serving adults

The 302 facilities for adults include six state mental health facilities, 104 inpatient treatment facilities (including 71 hospitals with psychiatric beds/inpatient units and 33 specialty psychiatric hospitals, Class 3), 42 crisis stabilization units (CSUs), and 150 residential facilities. The Southeast and Suncoast regions have the highest number of facilities, with 86 and 64 respectively, while the Northwest region has the fewest, with 28 facilities.

Statewide Mental Health Treatment Facilities

DCF oversees the state mental health treatment facilities (SMHTF) program, which provides comprehensive mental health care to individuals with severe and persistent mental illnesses. These facilities offer a range of services, including psychiatric treatment. Resources in the public mental health system for adults are focused on people in crisis, people with serious, disabling or potentially disabling mental illnesses who live in the community, those who cannot otherwise access mental health care, and certain people with serious mental illnesses who become involved with the criminal justice system.

Adults in mental health crisis include people who are 18 or older who: 1) Meet criteria under the Baker Act for admission to a mental health receiving facility; or 2) Show evidence of a recent stressful event and significant problems coping with that event. Other individuals in the state mental health treatment facilities system include adults with severe psychiatric disabilities. Finally, those with a serious mental illness and forensic (court) involvement participate in services and supports at state mental health treatment facilities. These include those who: 1) have an "incompetent to proceed (ITP)" court order due to mental illness; 2) have a "not guilty by reason of insanity (NGI)" court order for evaluation of competency or sanity; or 3) are on conditional release due to a mental illness.

Florida has seven statewide mental health treatment facilities distributed throughout the state, as shown on the map below.

Map of SMHTF Facility Locations and Total Population by County

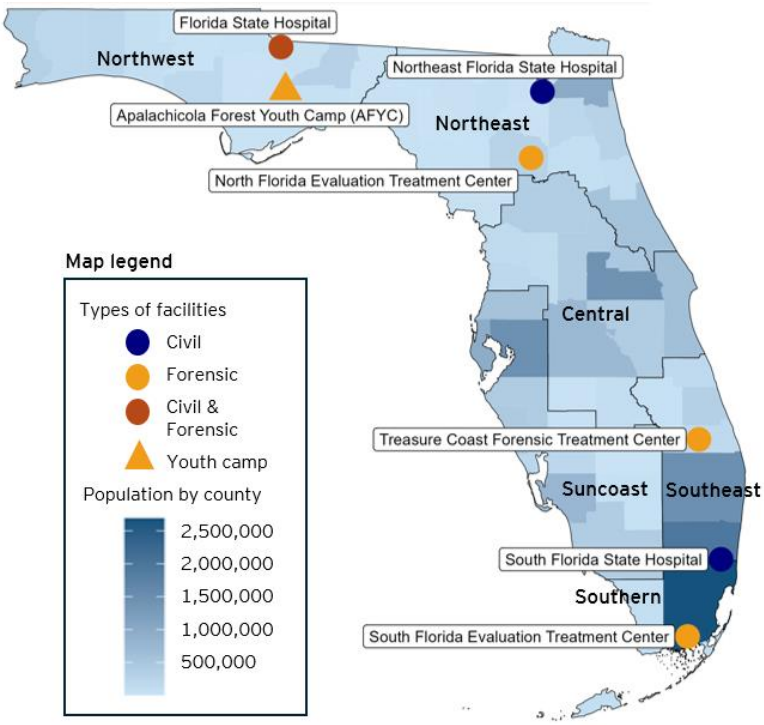

Table 28. SMHTF Facilities, Settings, and Operators

• SMHTF Facility	• Setting	• Operator
Florida State Hospital	Civil and Forensic	DCF
North Florida Evaluation Treatment Center	Forensic	DCF
South Florida Evaluation Treatment Center	Forensic	Wellpath Recovery
Treasure Coast Forensic Treatment Center	Forensic	Wellpath Recovery
Northeast Florida State Hospital	Civil	DCF
South Florida State Hospital	Civil	Wellpath Recovery

Bed forecasts for the state mental health treatment facilities are provided in the Findings Section of the *Office of Substance Abuse and Mental Health 2024 Behavioral Health Gap Analysis* report.

Other inpatient treatment facilities

Inpatient treatment facilities include hospitals with psychiatric beds/inpatient units and specialty psychiatric hospitals (Class 3). Results from the gap analysis for both hospital types are discussed below.

Table 29. Northeast – inpatient treatment facilities serving adults

		2023	2024	2025	2026	2027	2028	2029
Hospital with psychiatric beds/inpatient units								
Total beds		359	359	359	359	359	359	359
Average daily occupancy		196	199	202	205	208	210	213
Bed demand	Baseline: 55% (2023 avg.)	359	365	371	375	380	385	390
At various occupancy level	S1: 75% occupancy	261	265	270	273	277	280	284
	S2: 85% occupancy	230	234	238	241	244	247	251
Bed gaps	Baseline: 55% (2023 avg.)	0	-6	-12	-16	-21	-26	-31
At various occupancy level	S1: 75% occupancy	+98	+94	+89	+86	+82	+79	+75
	S2: 85% occupancy	+129	+125	+121	+118	+115	+112	+108
Specialty psychiatric hospital (Class 3)								
Total beds		190	190	190	190	190	190	190
Average daily occupancy		140	142	144	146	148	150	152
Bed demand	Baseline: 73% (2023 avg.)	190	193	196	199	201	204	207
At various occupancy level	S1: 75% occupancy	186	189	192	195	197	200	202
	S2: 85% occupancy	164	167	169	172	174	176	178
Bed gaps	Baseline: 73% (2023 avg.)	0	-3	-6	-9	-11	-14	-17
At various occupancy level	S1: 75% occupancy	+4	+1	-2	-5	-7	-10	-12
	S2: 85% occupancy	+26	+23	+21	+18	+16	+14	+12

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 30. Northwest – inpatient treatment facilities serving adults

Northwest Region- Inpatient Treatment Services for Adults		2023	2024	2025	2026	2027	2028	2029
Hospital with psychiatric beds/inpatient units								
Total beds		265	265	265	265	265	265	265
Average daily occupancy		112	113	115	116	117	118	119
Bed demand	Baseline: 42% (2023 avg.)	265	268	271	274	276	279	281
At various occupancy level	S1: 75% occupancy	149	151	153	154	156	157	159
	S2: 85% occupancy	132	133	135	136	137	139	140
Bed gaps	Baseline: 42% (2023 avg.)	0	-3	-6	-9	-11	-14	-16
At various occupancy level	S1: 75% occupancy	+116	+114	+112	+111	+109	+108	+106
	S2: 85% occupancy	+133	+132	+130	+129	+128	+126	+125
Specialty psychiatric hospital (Class 3)								
Total beds		149	149	149	149	149	149	149
Average daily occupancy		84	85	86	87	87	88	89
Bed demand	Baseline: 56% (2023 avg.)	149	151	152	154	155	157	158
At various occupancy level	S1: 75% occupancy	112	113	114	115	117	118	119
	S2: 85% occupancy	99	100	101	102	103	104	105
Bed gaps	Baseline: 56% (2023 avg.)	0	-2	-3	-5	-6	-8	-9
At various occupancy level	S1: 75% occupancy	+37	+36	+35	+34	+32	+31	+30
	S2: 85% occupancy	+50	+49	+48	+47	+46	+45	+44

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 31. Central – inpatient treatment facilities serving adults

		2023	2024	2025	2026	2027	2028	2029
Hospital with psychiatric beds/inpatient units								
Total beds		306	306	306	306	306	306	306
Average daily occupancy		235	239	244	247	251	255	259
Bed demand	Baseline: 77% (2023 avg.)	306	312	318	323	328	333	338
At various occupancy level	S1: 75% occupancy	313	319	325	330	335	340	346
	S2: 85% occupancy	276	281	287	291	296	300	305
Bed gaps	Baseline: 77% (2023 avg.)	0	-6	-12	-17	-22	-27	-32
At various occupancy level	S1: 75% occupancy	-7	-13	-19	-24	-29	-34	-40
	S2: 85% occupancy	+30	+25	+19	+15	+10	+6	+1
Specialty psychiatric hospital (Class 3)								
Total beds		586	586	586	586	586	586	586
Average daily occupancy		368	375	383	389	395	401	407
Bed demand	Baseline: 63% (2023 avg.)	586	597	609	618	628	638	648
At various occupancy level	S1: 75% occupancy	491	500	510	518	526	535	543
	S2: 85% occupancy	433	442	450	457	464	472	479
Bed gaps	Baseline: 63% (2023 avg.)	0	-11	-23	-32	-42	-52	-62
At various occupancy level	S1: 75% occupancy	+95	+86	+76	+68	+60	+51	+43
	S2: 85% occupancy	+153	+144	+136	+129	+122	+114	+107

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 32. Southeast – inpatient treatment facilities serving adults

Southeast Region- Inpatient Treatment Services for Adults

		2023	2024	2025	2026	2027	2028	2029
Hospital with psychiatric beds/inpatient units								
Total beds		574	574	574	574	574	574	574
Average daily occupancy		324	327	331	334	337	341	344
Bed demand	Baseline: 56% (2023 avg.)	574	581	587	593	598	604	610
At various occupancy level	S1: 75% occupancy	432	437	442	446	450	454	459
	S2: 85% occupancy	381	385	390	393	397	401	405
Bed gaps	Baseline: 56% (2023 avg.)	0	-7	-13	-19	-24	-30	-36
At various occupancy level	S1: 75% occupancy	+142	+137	+132	+128	+124	+120	+115
	S2: 85% occupancy	+193	+189	+184	+181	+177	+173	+169
Specialty psychiatric hospital (Class 3)								
Total beds		407	407	407	407	407	407	407
Average daily occupancy		269	273	276	278	281	284	286
Bed demand	Baseline: 66% (2023 avg.)	407	412	416	420	424	428	432
At various occupancy level	S1: 75% occupancy	359	363	367	371	375	378	382
	S2: 85% occupancy	317	321	324	327	330	334	337
Bed gaps	Baseline: 66% (2023 avg.)	0	-5	-9	-13	-17	-21	-25
At various occupancy level	S1: 75% occupancy	+48	+44	+40	+36	+32	+29	+25
	S2: 85% occupancy	+90	+86	+83	+80	+77	+73	+70

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 33. Suncoast – inpatient treatment facilities serving adults

Suncoast Region- Inpatient Treatment Services for Adults

		2023	2024	2025	2026	2027	2028	2029
Hospital with psychiatric beds/inpatient units								
Total beds		472	472	472	472	472	472	472
Average daily occupancy		334	340	345	350	354	359	364
Bed demand	Baseline: 71% (2023 avg.)	472	480	487	494	500	507	513
At various occupancy level	S1: 75% occupancy	446	453	460	466	472	479	485
	S2: 85% occupancy	393	400	406	411	417	422	428
Bed gaps	Baseline: 71% (2023 avg.)	-1	-8	-15	-22	-28	-35	-41
At various occupancy level	S1: 75% occupancy	+26	+19	+12	+6	-0	-7	-13
	S2: 85% occupancy	+79	+72	+66	+61	+55	+50	+44
Specialty psychiatric hospital (Class 3)								
Total beds		596	596	596	596	596	596	596
Average daily occupancy		348	353	359	364	369	373	378
Bed demand	Baseline: 58% (2023 avg.)	596	606	615	623	631	640	648
At various occupancy level	S1: 75% occupancy	464	471	479	485	491	498	504
	S2: 85% occupancy	409	416	423	428	434	439	445
Bed gaps	Baseline: 58% (2023 avg.)	0	-10	-19	-27	-35	-44	-52
At various occupancy level	S1: 75% occupancy	+132	+125	+117	+111	+105	+98	+92
	S2: 85% occupancy	+187	+180	+173	+168	+162	+157	+151

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 34. Southern – inpatient treatment facilities serving adults

Southern Region- Inpatient Treatment Services for Adults

		2023	2024	2025	2026	2027	2028	2029
Hospital with psychiatric beds/inpatient units								
Total beds		597	597	597	597	597	597	597
Average daily occupancy		328	331	335	337	340	343	346
Bed demand	Baseline: 55% (2023 avg.)	597	603	609	614	619	625	630
At various occupancy level	S1: 75% occupancy	437	442	446	450	454	458	461
	S2: 85% occupancy	386	390	394	397	400	404	407
Bed gaps	Baseline: 55% (2023 avg.)	0	-6	-12	-17	-22	-28	-33
At various occupancy level	S1: 75% occupancy	+160	+155	+151	+147	+143	+139	+136
	S2: 85% occupancy	+211	+207	+203	+200	+197	+193	+190
Specialty psychiatric hospital (Class 3)								
Total beds		72	72	72	72	72	72	72
Average daily occupancy		169	170	172	173	175	176	178
Bed demand	Baseline: 234% (2023 avg.)	72	73	73	74	75	75	76
At various occupancy level	S1: 75% occupancy	225	227	229	231	233	235	237
	S2: 85% occupancy	198	200	202	204	206	208	209
Bed gaps	Baseline: 234% (2023 avg.)	0	-1	-1	-2	-3	-3	-4
At various occupancy level	S1: 75% occupancy	-153	-155	-157	-159	-161	-163	-165
	S2: 85% occupancy	-126	-128	-130	-132	-134	-136	-137

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Crisis stabilization units

Crisis Stabilization Units (CSUs) are specialized healthcare facilities designed to provide immediate, short–term care and support for individuals experiencing acute psychiatric crises. Results from the gap analysis for CSUs are discussed below.

Table 35. Northeast – crisis stabilization units serving adults

Northeast Region- Crisis Stabilization Unit – Adult

		2023	2024	2025	2026	2027	2028	2029
Total beds		75	75	75	75	75	75	75
Average daily occupancy		80	81	83	84	85	86	87
Bed demand	Baseline: 107%(2023 avg.)	75	76	77	78	79	80	82
At various occupancy level	S1: 75%occupancy	107	109	110	112	113	115	116
	S2: 85%occupancy	94	96	97	99	100	101	102
Bed gaps	Baseline: 107%(2023 avg.)	0	-1	-2	-3	-4	-5	-7
At various occupancy level	S1: 75%occupancy	-32	-34	-35	-37	-38	-40	-41
	S2: 85%occupancy	-19	-21	-22	-24	-25	-26	-27

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 36. Northwest – crisis stabilization units serving adults

Northwest Region- Crisis Stabilization Unit – Adult

		2023	2024	2025	2026	2027	2028	2029
Total beds		60	60	60	60	60	60	60
Average daily occupancy		68	69	70	70	71	72	72
Bed demand	Baseline: 113%(2023 avg.)	60	61	61	62	63	63	64
At various occupancy level	S1: 75%occupancy	91	92	93	94	95	95	96
	S2: 85%occupancy	80	81	82	83	83	84	85
Bed gaps	Baseline: 113%(2023 avg.)	0	-1	-1	-2	-3	-3	-4
At various occupancy level	S1: 75%occupancy	-31	-32	-33	-34	-35	-35	-36
	S2: 85%occupancy	-20	-21	-22	-23	-23	-24	-25

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 37. Central – crisis stabilization units serving adults

Central Region- Crisis Stabilization Unit – Adult

		2023	2024	2025	2026	2027	2028	2029
Total beds		252	252	252	252	252	252	252
Average daily occupancy		212	216	220	223	227	231	234
Bed demand	Baseline: 84%(2023 avg.)	252	257	262	266	270	274	279
rious occupancy level	S1: 75%occupancy	282	288	293	298	303	307	312
	S2: 85%occupancy	249	254	259	263	267	271	275
Bed gaps	Baseline: 84%(2023 avg.)	0	-5	-10	-14	-18	-22	-27
rious occupancy level	S1: 75%occupancy	-30	-36	-41	-46	-51	-55	-60
	S2: 85%occupancy	+3	-2	-7	-11	-15	-19	-23

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 38. Southeast– crisis stabilization units serving adults

Southeast Region- Crisis Stabilization Unit – Adult

		2023	2024	2025	2026	2027	2028	2029
Total beds		98	98	98	98	98	98	98
Average daily occupancy		109	110	111	112	113	114	115
Bed demand	Baseline: 111%(2023 avg.)	98	99	100	101	102	103	104
At various occupancy level	S1: 75%occupancy	145	146	148	149	151	152	154
	S2: 85%occupancy	128	129	131	132	133	134	136
Bed gaps	Baseline: 111%(2023 avg.)	0	-1	-2	-3	-4	-5	-6
At various occupancy level	S1: 75%occupancy	-47	-48	-50	-51	-53	-54	-56
	S2: 85%occupancy	-30	-31	-33	-34	-35	-36	-38

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 39. Suncoast– crisis stabilization units serving adults

Suncoast Region- Crisis Stabilization Unit – Adult

		2023	2024	2025	2026	2027	2028	2029
Total beds		165	165	165	165	165	165	165
Average daily occupancy		216	219	223	226	229	232	235
Bed demand	Baseline: 131%(2023 avg.)	165	168	170	173	175	177	179
arious occupancy level	S1: 75%occupancy	288	293	297	301	305	309	313
	S2: 85%occupancy	254	258	262	266	269	273	276
Bed gaps	Baseline: 131%(2023 avg.)	0	-3	-5	-8	-10	-12	-14
arious occupancy level	S1: 75%occupancy	-123	-128	-132	-136	-140	-144	-148
	S2: 85%occupancy	-89	-93	-97	-101	-104	-108	-111

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 40. Southern – crisis stabilization units serving adults

Southern Region- Crisis Stabilization Unit – Adult

		2023	2024	2025	2026	2027	2028	2029
Total beds		76	76	76	76	76	76	76
Average daily occupancy		74	74	75	76	76	77	78
Bed demand	Baseline: 97%(2023 avg.)	76	77	78	78	79	80	80
\t various occupancy level	S1: 75%occupancy	98	99	100	101	102	103	103
	S2: 85%occupancy	86	87	88	89	90	90	91
Bed gaps	Baseline: 97%(2023 avg.)	0	-1	-2	-2	-3	-4	-4
\t various occupancy level	S1: 75%occupancy	-22	-23	-24	-25	-26	-27	-27
	S2: 85%occupancy	-10	-11	-12	-13	-14	-14	-15

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Residential facilities

There are three types of residential treatment facilities and centers that are included in this analysis. Children and adolescents have access to all three types: residential treatment centers, specialized therapeutic group homes, and short–term residential treatment units. Adults have access to residential treatment facilities and short–term residential treatment units. Results from the gap analysis for residential treatment facilities are presented below. Note that there are no short–term residential treatment facilities in Florida's Southern region.

Table 41. Northeast – residential facilities serving adults

Northeast Region- Residential Treatment Facility for Adults

		2023	2024	2025	2026	2027	2028	2029
Total beds		327	327	327	327	327	327	327
Average daily occupancy		249	253	257	260	263	267	270
Bed demand	Baseline: 73% (2023 avg.)	339	344	349	354	359	363	368
At various occupancy level	S1: 75% occupancy	332	337	342	347	351	356	360
	S2: 85% occupancy	293	297	302	306	310	314	318
Bed gaps	Baseline: 73% (2023 avg.)	-1	-17	-22	-27	-32	-36	-41
At various occupancy level	S1: 75% occupancy	-5	-10	-15	-20	-24	-29	-33
	S2: 85% occupancy	+34	+30	+25	+21	+17	+13	+9

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 42. Northwest– residential facilities serving adults

		2023	2024	2025	2026	2027	2028	2029
Total beds		127	127	127	127	127	127	127
Average daily occupancy		82	83	84	85	85	86	87
Bed demand	Baseline: 73% (2023 avg.)	112	113	114	115	116	117	118
At various occupancy level	S1: 75% occupancy	109	110	112	113	114	115	116
	S2: 85% occupancy	96	97	99	99	100	101	102
Bed gaps	Baseline: 73% (2023 avg.)	+1	+14	+13	+12	+11	+10	+9
At various occupancy level	S1: 75% occupancy	+18	+17	+15	+14	+13	+12	+11
	S2: 85% occupancy	+31	+30	+28	+28	+27	+26	+25

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 43. Northwest– Short-term residential treatment unit serving adults

		2023	2024	2025	2026	2027	2028	2029
Total beds		32	32	32	32	32	32	32
Average daily occupancy		21	21	22	22	22	22	23
Bed demand	Baseline: 53% (2023 avg.)	40	40	41	41	41	42	42
At various occupancy level	S1: 75% occupancy	28	29	29	29	30	30	30
	S2: 85% occupancy	25	25	26	26	26	26	27
Bed gaps	Baseline: 53% (2023 avg.)	-1	-8	-9	-9	-9	-10	-10
At various occupancy level	S1: 75% occupancy	+4	+3	+3	+3	+2	+2	+2
	S2: 85% occupancy	+7	+7	+6	+6	+6	+6	+5

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 44. Central– residential facilities serving adults

		2023	2024	2025	2026	2027	2028	2029
Total beds		358	358	358	358	358	358	358
Average daily occupancy		255	259	264	269	273	277	282
Bed demand	Baseline: 73% (2023 avg.)	347	353	360	366	371	377	383
At various occupancy level	S1: 75% occupancy	339	346	353	358	364	369	375
	S2: 85% occupancy	299	305	311	316	321	326	331
Bed gaps	Baseline: 73% (2023 avg.)	+1	+5	-2	-8	-13	-19	-25
At various occupancy level	S1: 75% occupancy	+19	+12	+5	-0	-6	-11	-17
	S2: 85% occupancy	+59	+53	+47	+42	+37	+32	+27

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 45. Central– Short-term residential treatment unit serving adults

		2023	2024	2025	2026	2027	2028	2029
Total beds		91	91	91	91	91	91	91
Average daily occupancy		41	41	42	43	44	44	45
Bed demand	Baseline: 53% (2023 avg.)	76	77	79	80	81	83	84
At various occupancy level	S1: 75% occupancy	54	55	56	57	58	59	60
	S2: 85% occupancy	48	49	50	50	51	52	53
Bed gaps	Baseline: 53% (2023 avg.)	+1	+14	+12	+11	+10	+8	+7
At various occupancy level	S1: 75% occupancy	+37	+36	+35	+34	+33	+32	+31
	S2: 85% occupancy	+43	+42	+41	+41	+40	+39	+38

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 46. Southeast– residential facilities serving adults

		2023	2024	2025	2026	2027	2028	2029
Total beds		1,032	1,032	1,032	1,032	1,032	1,032	1,032
Average daily occupancy		760	769	778	785	793	800	808
Bed demand	Baseline: 73% (2023 avg.)	1,035	1,047	1,059	1,069	1,079	1,090	1,100
At various occupancy level	S1: 75% occupancy	1,014	1,025	1,037	1,047	1,057	1,067	1,077
	S2: 85% occupancy	895	905	915	924	933	942	950
Bed gaps	Baseline: 73% (2023 avg.)	-1	-15	-27	-37	-47	-58	-68
At various occupancy level	S1: 75% occupancy	+18	+7	-5	-15	-25	-35	-45
	S2: 85% occupancy	+137	+127	+117	+108	+99	+90	+82

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 47. Southeast– Short-term residential treatment unit serving adults

		2023	2024	2025	2026	2027	2028	2029
Total beds		65	65	65	65	65	65	65
Average daily occupancy		34	34	34	35	35	35	36
Bed demand	Baseline: 53% (2023 avg.)	63	64	65	65	66	66	67
At various occupancy level	S1: 75% occupancy	45	45	46	46	47	47	48
	S2: 85% occupancy	40	40	41	41	41	42	42
Bed gaps	Baseline: 53% (2023 avg.)	+1	+1	+0	-0	-1	-1	-2
At various occupancy level	S1: 75% occupancy	+20	+20	+19	+19	+18	+18	+17
	S2: 85% occupancy	+25	+25	+24	+24	+24	+23	+23

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 48. Suncoast– residential facilities serving adults

		2023	2024	2025	2026	2027	2028	2029
Total beds		451	451	451	451	451	451	451
Average daily occupancy		335	340	346	350	355	360	364
Bed demand	Baseline: 73% (2023 avg.)	456	463	471	477	483	490	496
At various occupancy level	S1: 75% occupancy	447	454	461	467	473	479	486
	S2: 85% occupancy	394	400	407	412	417	423	429
Bed gaps	Baseline: 73% (2023 avg.)	-1	-12	-20	-26	-32	-39	-45
At various occupancy level	S1: 75% occupancy	+4	-3	-10	-16	-22	-28	-35
	S2: 85% occupancy	+57	+51	+44	+39	+34	+28	+22

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 49. Suncoast – Short-term residential treatment unit serving adults

		2023	2024	2025	2026	2027	2028	2029
Total beds		12	12	12	12	12	12	12
Average daily occupancy		11	11	12	12	12	12	12
Bed demand	Baseline: 53% (2023 avg.)	21	21	22	22	22	23	23
At various occupancy level	S1: 75% occupancy	15	15	16	16	16	16	16
	S2: 85% occupancy	13	14	14	14	14	14	14
Bed gaps	Baseline: 53% (2023 avg.)	-1	-9	-10	-10	-10	-11	-11
At various occupancy level	S1: 75% occupancy	-3	-3	-4	-4	-4	-4	-4
	S2: 85% occupancy	-1	-2	-2	-2	-2	-2	-2

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.

Table 50. Southern– residential facilities serving adults

		2023	2024	2025	2026	2027	2028	2029
Total beds		339	339	339	339	339	339	339
Average daily occupancy		254	256	259	261	263	266	268
Bed demand *At various occupancy level*	Baseline: 73% (2023 avg.)	346	349	353	356	359	362	365
	S1: 75% occupancy	338	342	345	348	351	354	357
	S2: 85% occupancy	299	302	305	307	310	312	315
Bed gaps *At various occupancy level*	Baseline: 73% (2023 avg.)	-1	-10	-14	-17	-20	-23	-26
	S1: 75% occupancy	+1	-3	-6	-9	-12	-15	-18
	S2: 85% occupancy	+40	+37	+34	+32	+29	+27	+24

Source: Analysis of data provided by AHCA, DCF and the provider survey.
Note: Numbers may appear not to sum due to rounding.