# Student Mental Health Outcomes: 2025

Report 25-11

December 2025

OPPAGA

Office of Program Policy Analysis and Government Accountability

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## EXECUTIVE SUMMARY

Mental health conditions can impact children's physical health, academic performance, and educational attainment. In response to the 2018 Marjory Stoneman Douglas High School shooting, the Legislature enacted the Marjory Stoneman Douglas High School Public Safety Act. The act required the creation of threat assessment teams and created the Mental Health Assistance Allocation (MHAA), which provides supplemental funding for school districts to provide mental health supports to students.

As required by s. 1001.212(11), *Florida Statutes*, the Florida Department of Education (FDOE) has implemented all components of the threat management process, including launching a threat management portal. During school year 2024-25, there were 58,983 reported incidents, 26% of which were forwarded to the full school-based threat management team for further review.

Fifty-eight of 60 school districts responding to OPPAGA's survey reported providing information about mental health services to trained staff; however, not all school districts include all statutorily required information in the notification. All 67 school districts' 2024-25 Mental Health Assistance Allocation Plans described the evidence-based mental health programs the school districts used and, 66 of the plans described the school districts' work with community providers. However, OPPAGA could not verify that all school districts had adopted all statutorily required policies and procedures, and no districts met nationally recommended staffing ratios for all mental health professionals.

In school year 2023-24, school districts spent 66% of the state's MHAA on school-based staff and services and 9% on community-based services; the remaining funds were apportioned to charter schools or used for expenses such as printed materials for trainings and professional development. During the same period, districts reported using MHAA funds to provide school-based services to 295,927 students and community-based services to 61,404 students.

Forty-seven school districts reported working with managing entities to provide students mental health and substance abuse services, but some districts identified a need for more service providers. Fifty school districts reported being well-integrated with existing community behavioral health services but managing entity reports provide limited information about such integration. FDOE should ensure that MHAA data are reported consistently over time and collect additional data to improve future evaluations of the MHAA program.

### REPORT SCOPE

As directed by s. 394.4575, *Florida Statutes,* OPPAGA examined school district requirements related to student mental health and threat management, school district integration into community behavioral health systems, and potential approaches to continue evaluating mental health service provision in schools.

OPPAGA is required to complete two reports related to these topics. This first report focuses on compliance and identifying additional data for program evaluation.

# BACKGROUND

Mental health conditions can impact children's lives in various ways, including their physical health, academic performance, educational attainment, involvement with the criminal justice system, and risk of suicide. Although mental health conditions usually start in childhood or adolescence, treatment typically does not occur until years later. Children in Florida experience mental health conditions such as anxiety, depression, attention deficit hyperactivity disorder (ADHD), and behavioral problems; some experience persistent symptoms of stress or feelings of sadness, hopelessness, loneliness, nervousness, worry, or being afraid that prevent them from doing usual activities. School districts have a role in coordinating mental health services for students, including keeping schools safe from behavioral threats and training school personnel to identify students in need of mental or behavioral support.

## Mental health conditions in children can have long-lasting impacts on academic performance, employment, and criminal justice involvement

Mental health conditions in children are often defined as delays or changes in thinking, behaviors, social skills, or control over emotions. Mental health problems usually begin in childhood or adolescence, although treatment typically does not occur until years later.[1] Mental health can affect children's physical health and ability to succeed in school, at work, and in society. For example, depression in children has been associated with obesity, which is linked to increased risk for diseases that include early onset type 2 diabetes.[2,3] Behavioral and emotional problems at age 3 have been associated with performing below grade level at age 12.[4] Similarly, emotional and behavioral problems at ages 6 through 8 significantly decrease the probability of receiving a high school degree.[5] Untreated mental health conditions are associated with poor academic performance, misconduct, school drop-out, unemployment, involvement with the juvenile justice system, and violence. Among children ages 10 through 17, suicide is one of three leading causes of death.

Children who experience trauma—such as life-threatening events, natural disasters, or sudden loss of a loved one—may have increased symptoms of anxiety and depression.[6] After trauma, children who continue to experience difficulties that interfere with day-to-day life (e.g., flashbacks, trouble concentrating) may be diagnosed with post-traumatic stress disorder (PTSD). According to the National Comorbidity Survey Replication-Adolescent Supplement, 5% of adolescents have met criteria for PTSD in their lifetime.[7,8]

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[1] Kessler, Ronald C., et al. "Age of Onset of Mental Disorders: A Review of Recent Literature." *Current Opinion in Psychiatry* 20, no. 4 (July 2007): 359–364. https://doi.org/10.1097/yco.0b013e32816ebc8c.

[2] Kanellopoulou, Aikaterini, et al. "The Association Between Obesity and Depression Among Children and the Role of Family: A Systematic Review." *Children* 9, no. 1244 (August 2022). https://doi.org/10.3390/children9081244.

[3] Oranika, Uchechukwu S., et al. "The Role of Childhood Obesity in Early-Onset Type 2 Diabetes Mellitus: A Scoping Review." *Cureus* 15, no. 10 (October 2023). https://doi.org/10.7759/cureus.48037.

[4] Agnafors, Sara, et al. "Mental Health and Academic Performance: A Study on Selection and Causation Effects From Childhood to Early Adulthood." *Social Psychiatry and Psychiatric Epidemiology* 56, no. 5 (August 2020): 857–866. https://doi.org/10.1007/s00127-020-01934-5.

[5] McLeod, Jane D., et al. "Childhood Emotional and Behavioral Problems and Educational Attainment." *American Sociological Review* 69, no. 5 (October 2004): 636–658. https://doi.org/10.1177/000312240406900502.

[6] Lawrence-Sidebottom, Darian, et al. "Rates of Trauma Exposure and Posttraumatic Stress in a Pediatric Digital Mental Health Intervention: Retrospective Analysis of Associations With Anxiety and Depressive Symptom Improvement Over Time." *JMIR Pediatrics and Parenting* 27, no. 7 (February 2024). https://doi.org/10.2196/55560.

[7] Adolescent is defined as an individual aged 13 to 18.

[8] Merikangas, Kathleen R., et al. "Lifetime Prevalence of Mental Disorders in U.S. Adolescents: Results From the National Comorbidity Study-Adolescent Supplement (NCS-A)." *Journal of the American Academy of Child and Adolescent Psychiatry* 49, no. 10 (October 2010): 980–989. https://doi.org/10.1016/j.jaac.2010.05.017.

## Children in Florida experience a variety of mental health conditions

Anxiety, depression, ADHD, and behavioral disorders are the most diagnosed mental health conditions in children nationwide. Florida ranks 30th among states for the percentage of children who have been diagnosed with anxiety, depression, or ADHD, or have been advised by health care or education professionals that they have a behavior or conduct problem.[9] A 2023 national survey of households with children indicated that 10.3% of children in Florida ages 3 through 17 had received mental health care or counseling in the past 12 months.

The Florida Department of Education (FDOE) developed the Florida-Specific Youth Survey in 2022 and first administered the survey to students throughout the state in 2023. Twenty-two percent of students responding to the 2023 survey reported almost always feeling symptoms of stress, anxiety, or depression. Among respondents who indicated symptoms of stress, anxiety, or depression, 46% had feelings of sadness, hopelessness, loneliness, nervousness, worry, or being afraid that stopped them from doing some usual activities. Thirty-one percent of students reported seeking support or resources when they had a mental health challenge or concern.

## School districts have a role in coordinating mental health services for students, including establishing behavioral threat management processes and training district personnel

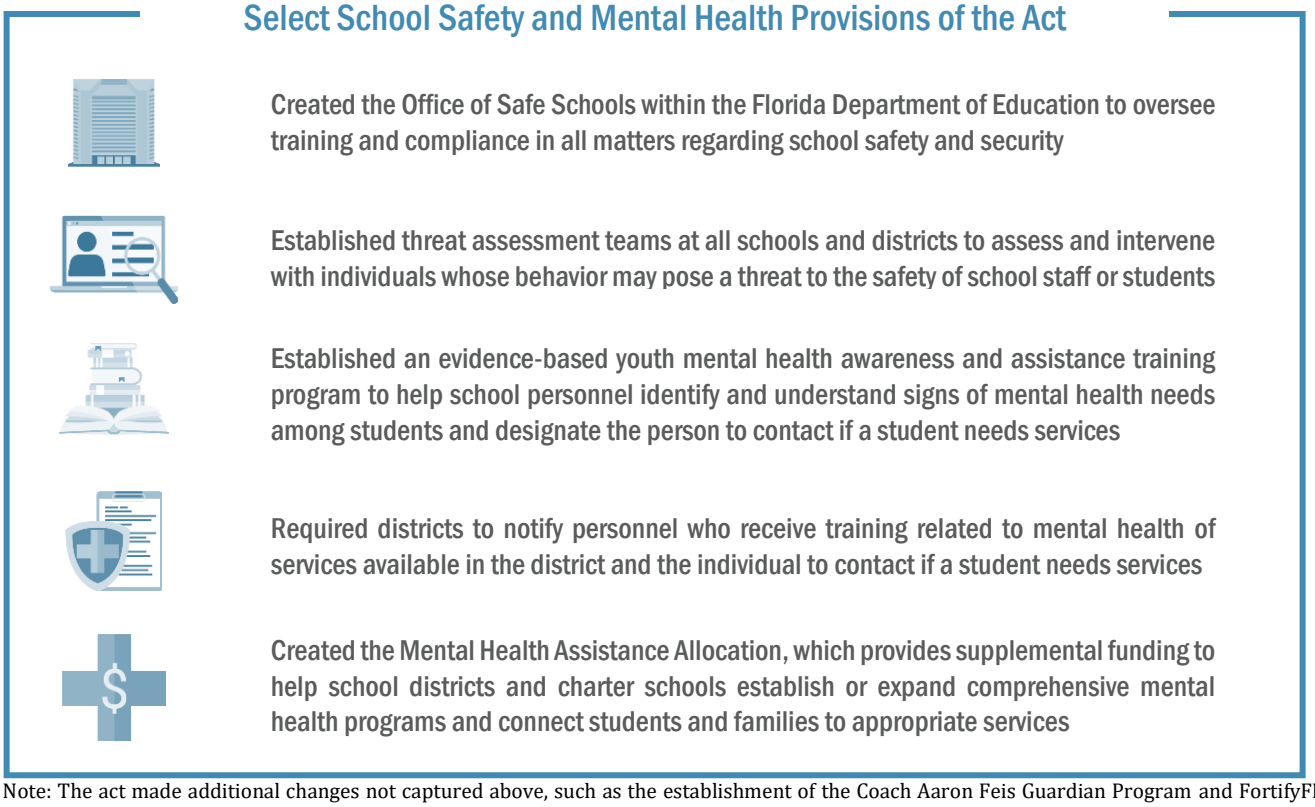
In 2018, Florida experienced one of the deadliest acts of school violence in U.S. history—the mass shooting at Marjory Stoneman Douglas High School.[10] The perpetrator had an extensive history of behavioral issues and had been under the care of mental health professionals since the age of 11. In the aftermath of the shooting, the 2018 Legislature passed the Marjory Stoneman Douglas High School Public Safety Act, which included the creation of the Marjory Stoneman Douglas (MSDHS) Public Safety Commission within the Florida Department of Law Enforcement. The commission's purpose was to investigate system failures in the 2018 shooting and prior mass violence incidents and develop recommendations for school and law enforcement system improvements.[11] The act also made several changes to school safety and mental health supports. (See Exhibit 1.)

[9] In Florida, 22.4% of children have been advised by a health care provider that they have ADHD, depression, or anxiety problems or have been advised by a doctor or educator that they have behavior or conduct problems. Nationwide, 19.9% of children and youth have received such diagnoses or information.

[10] On February 14, 2018, 14 students and 3 staff members at Marjory Stoneman Douglas High School in Parkland, Florida, were fatally shot, and 17 others were wounded.

[11] Chapter 2018-3, *Laws of Florida.*

Exhibit 1
The Marjory Stoneman Douglas High School Public Safety Act Made Several Changes to School Safety and Mental Health Supports




Note: The act made additional changes not captured above, such as the establishment of the Coach Aaron Feis Guardian Program and FortifyFL. Lawmakers subsequently revised the original statutes, including changes to requirements for charter school participation, mental health training, and parental notification and provisions related to how school districts and community behavioral health providers should respond to students in crisis situations. In 2023, the Legislature created the Mental Health Assistance Program with s. 1006.041, *F.S.*, which required districts to submit mental health assistance plans and outcome and expenditures reports.

Source: Chapter 2018-3, *Laws of Florida.*

**As recommended by the MSDHS Public Safety Commission, the 2019 Legislature required the implementation of a behavioral threat assessment instrument.** Threats refer to communication or behavior indicating that an individual poses a danger to the safety of school staff or students through acts of violence or other behavior that would cause harm to self or others. Threat management processes are established to identify threats or other concerning behavior that might lead to violence toward others through mechanisms such as utilizing multidisciplinary teams to investigate the concerns and manage threats based on the level of concern. While the Marjory Stoneman Douglas High School Public Safety Act required districts to adopt policies for establishing school-based threat assessment teams composed of certain individuals to coordinate resources and assess and intervene when a student's behavior poses a threat, the act did not outline a specific threat assessment model or instrument.[12] At the recommendation of the MSDHS Public Safety Commission, the 2019 Legislature amended the act to explicitly require the Office of Safe Schools (OSS) to designate a standardized, statewide behavioral threat assessment instrument for use by all public schools, including charter schools.

[12] The act required that threat assessment teams include persons with expertise in counseling, instruction, school administration, and law enforcement.

OSS initially designated the Comprehensive School Threat Assessment Guidelines (CSTAG) as the statewide standardized threat assessment instrument. CSTAG is an evidence-based model that emphasizes early attention to problems such as bullying, teasing, and other forms of student conflict before such conflicts escalate into violent behavior.[13] The model was developed at the University of Virginia in 2001 and has been widely adopted by schools in Virginia and nationwide. However, in 2022, the MSDHS Public Safety Commission found that CSTAG was not the most appropriate approach to address threats in Florida schools. The commission cited a number of deficiencies with CSTAG including model training limitations and inconsistent model application across districts.[14] Further, the commission found that the CSTAG criteria were too rigid and resulted in some threats being elevated unnecessarily. For example, the commission reported that the CSTAG model requires all threats to *hit*, *fight*, or *beat up* be classified as serious substantive threats and referred to the threat assessment team. This requirement was problematic for younger elementary school students who may use these words but have no intent to cause harm. In addition, the commission identified areas in which CSTAG did not align with Florida law. For example, the commission reported that CSTAG did not require threat assessment teams to consider threats of self-harm a threat, whereas Florida law requires teams to consider threats of self-harm.

In response to recommendations from the MSDHS Public Safety Commission, the 2023 Legislature amended statute to require FDOE to develop a statewide behavioral threat management operational process and transition from CSTAG to a Florida-specific behavioral threat assessment instrument. Together, the behavioral threat management process and instrument are now referred to as Florida's Harm Prevention and Threat Management Model, also known as the Florida Model. In addition, the law established threat management teams to replace threat assessment teams. Threat management teams include members previously included on threat assessment teams and add a requirement that one member of the team be personally familiar with the student the team is evaluating. The law also required FDOE to create and maintain a threat management portal designed to assist school districts and charter schools with the electronic collection and maintenance of information required by the new Florida-specific threat assessment instrument as well as the coordination of interventions and services for students who are the subject of a threat assessment.

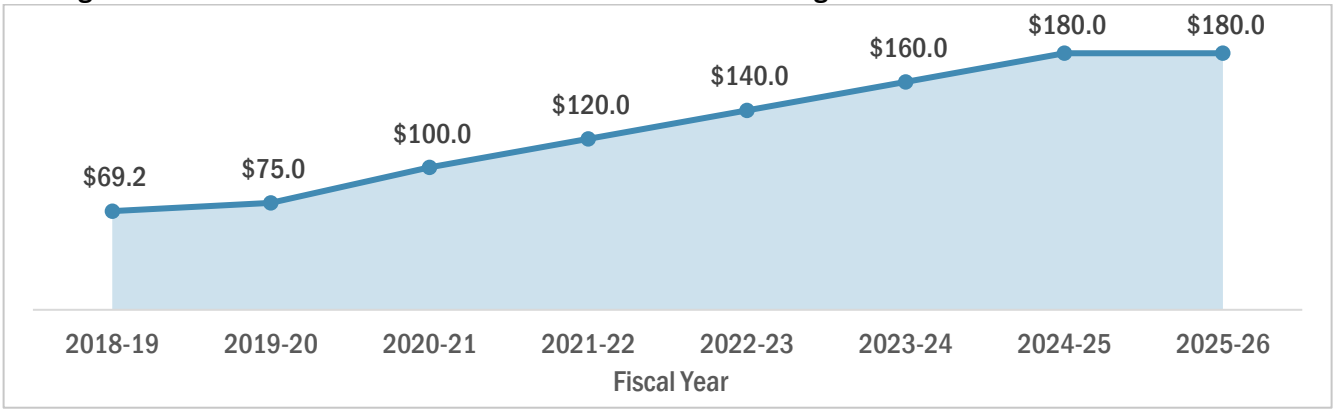
**Since Fiscal Year 2018-19, the Legislature has appropriated funding to school districts through the Mental Health Assistance Allocation to facilitate mental health and substance abuse services for public school students.** The Legislature has increased total funding for the Mental Health Assistance Allocation (MHAA) from $69.2 million in Fiscal Year 2018-19 to $180 million in Fiscal Year 2025-26. (See Exhibit 2.) In Fiscal Year 2025-26, school district MHAAs ranged from $141,772 for Jefferson County School District to $20.1 million for Miami-Dade County School District.

[13] CSTAG includes a decision tree to guide school threat assessment teams through steps such as interviewing witnesses to the threat, using available information to consider the credibility of the threat, and involving law enforcement when necessary, as well as forms for helping schools progress through each step.

[14] The commission reported that districts did not have access to adequate training for CSTAG because only one individual was permitted to train additional CSTAG trainers in Florida, the number of trainers in Florida trained by the CSTAG trainer were inadequate, and available online training was too expensive for districts to afford.

Exhibit 2

The Legislature Increased Mental Health Assistance Allocation Funding to $180 Million in Fiscal Year 2024-25



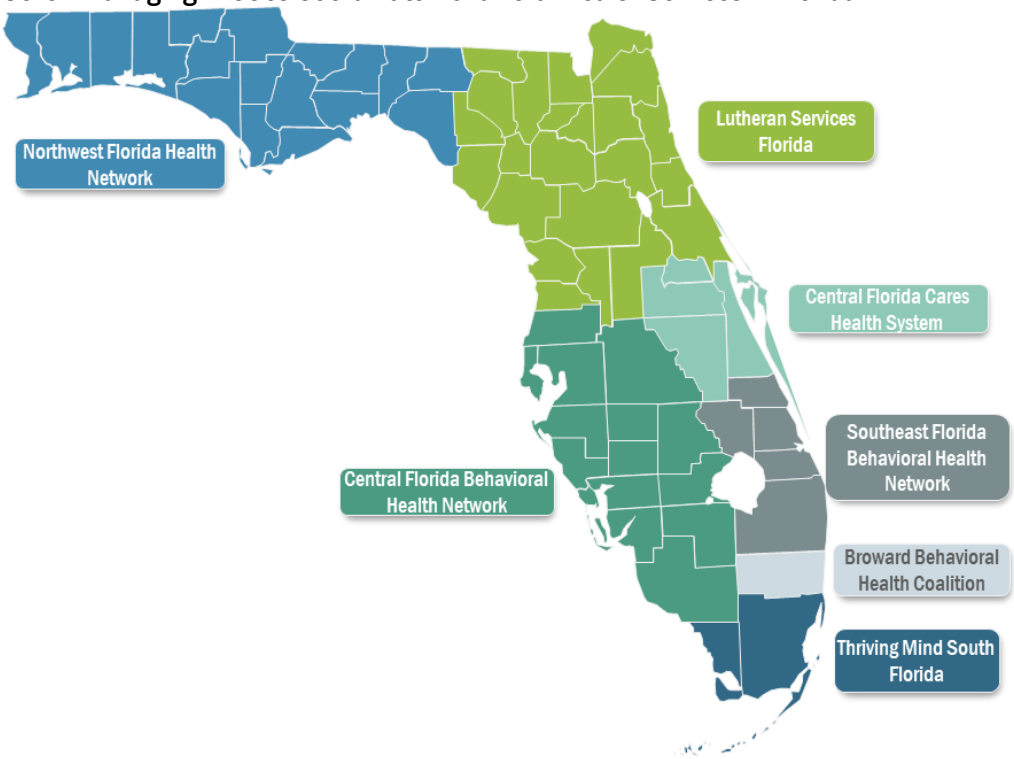

Note: The exhibit shows the dollar amount appropriated in millions for each fiscal year.

Source: Florida Department of Education Mental Health Appropriations Report.

**In addition to receiving funding for school-based services, public schools may also coordinate with the region's managing entity.** Managing entities are corporations that contract with the Florida Department of Children and Families (DCF) to manage the daily operational delivery of behavioral health services through a coordinated system of care. The Legislature created managing entities to plan, coordinate, and contract for the delivery of community mental health and substance abuse services within entities' geographic regions.[15] The state's seven managing entities coordinate a variety of mental health services that students may need, including assessments, outpatient services, case management, care coordination, crisis stabilization services, and mobile response teams. (See Exhibit 3.)

Exhibit 3

Seven Managing Entities Coordinate Behavioral Health Services in Florida




Source: OPPAGA analysis of Florida Department of Children and Families managing entity contact list.

[15] Section 394.9082, *F.S.*

# FINDINGS

## The Florida Department of Education has implemented state-level components of the statewide behavioral threat management operational process

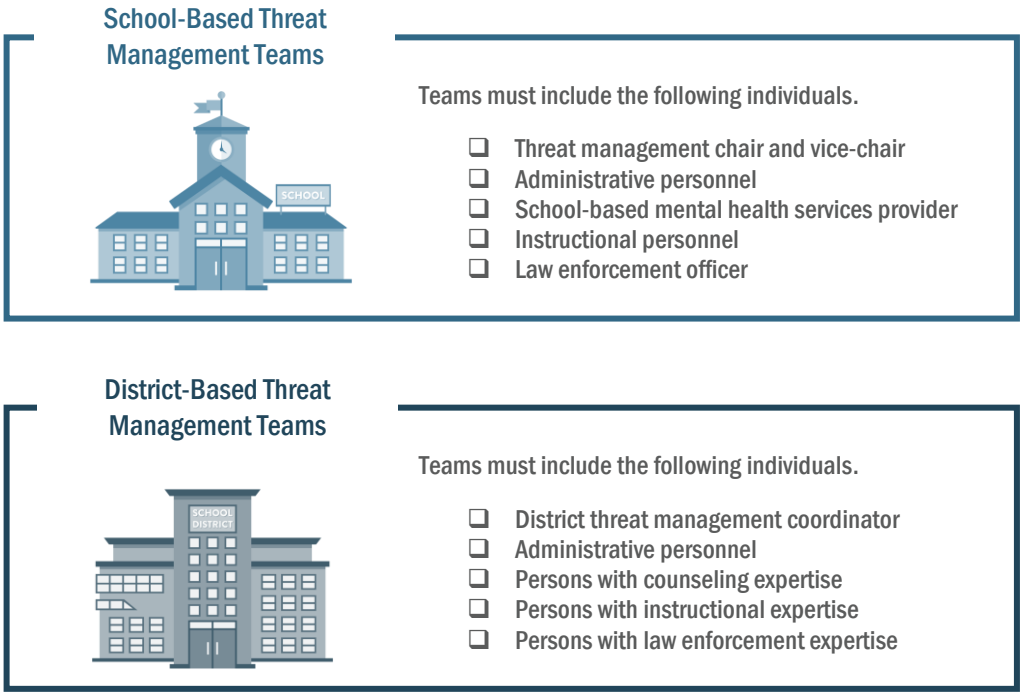
As of August 2025, FDOE had implemented all required components outlined in s. 1001.212(11), *Florida Statutes*, including creating and implementing the Florida Model and launching the threat management portal. The Florida Model identifies students exhibiting threatening or other concerning behavior, gathers information to assess the risk of harm to self or others, and identifies appropriate interventions to prevent violence and promote successful outcomes. In December 2024, FDOE's Office of Safe Schools partnered with a vendor to develop the Safety and Threat Management Portal, which digitizes threat assessment forms including intake disposition, questionnaires, and mental health assessments.

**The Florida Model requires specific district and school roles and processes for responding to concerns that may represent a threat to the community, school, or self.** Rule 6A-1.0019, *Florida Administrative Code*, required all districts to transition to the Florida Model in January 2024 of the 2023-24 school year. According to FDOE staff, there many differences between the Comprehensive School Threat Assessment Guidelines and the Florida Model, but the primary difference is that the CSTAG focuses on threat assessment whereas the Florida Model focuses on threat management. Additionally, the Florida Model introduced mandated timelines for the threat management process and required management of students as deemed necessary by the school-based threat management team (SBTMT).

The Florida Model requires each district superintendent, or lead administrator where there is no superintendent, to designate a district threat management team (DTMT) and each school principal to designate a SBTMT to respond to reports of concerning behavior. The SBTMT is a multidisciplinary team comprised of at least four members with expertise in counseling, school instruction, law enforcement, and school administration; these members are referred to as the core four.[16] The DTMT, also multidisciplinary, receives referrals from SBTMTs, assesses serious situations (e.g., a student acquired weapons to prepare for an attack), and may provide SBTMTs with ongoing assistance. (See Exhibit 4.)

[16] Additional members of the team may be assigned by the school principal, or equivalent, as long as the four required roles are filled.

Exhibit 4
District- and School-Based Threat Management Teams Must Be Composed of Certain Individuals




Source: OPPAGA analysis of Florida Department of Education Florida Harm Prevention and Threat Management Manual.

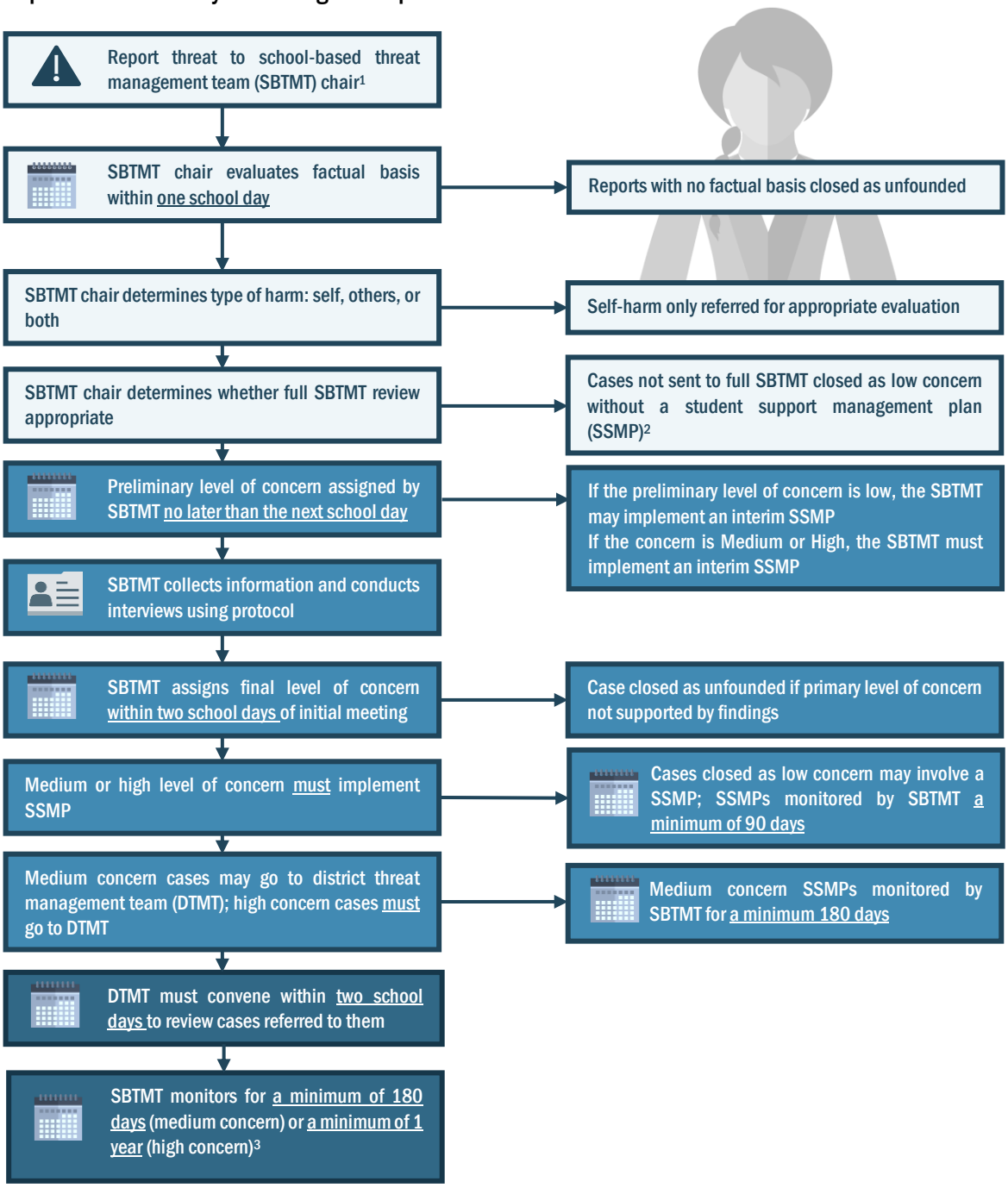
If the chair, the point person at each school for threat management, determines that there is a sufficient factual basis to support an allegation of a threat and refers the matter to the full SBTMT, the team must conduct an assessment and assign a level of concern. Threats are classified in one of three levels of concern.

- Low: The student poses a threat of violence or exhibits other concerning behavior that is minimal, and it appears that any underlying issues can be resolved easily.
- Medium: The student does not appear to pose an immediate threat of violence but exhibits behaviors that indicate a potential intent to harm or exhibits other concerning behavior that requires intervention.
- High: The student poses a threat of violence, exhibits behaviors that indicate both a continuing intent to harm and an effort to acquire the capacity to carry out a plan, and may also exhibit other concerning behavior that requires immediate intervention and protective measures for the target(s) of violence.

If the SBTMT designates the level of concern as medium or high, the SBTMT must develop a student support management plan (SSMP). SSMPs use direct and indirect interventions to help create an environment less likely to produce violence. Such plans can include assigning the student a mentor and regular meetings between the student and a counselor. The SBTMT is required to meet monthly, assess each SSMP for its effectiveness, and modify plans as appropriate. Portions of this process include timeframes for completion. For example, SBTMTs must assign a preliminary level of concern the next school day after the case has been referred by the chair.

The process begins when a student or staff member reports a case of concerning behavior to the SBTMT chair. After referral, the chair determines whether to refer the case to the SBTMT. (See Exhibit 5.)

Exhibit 5
Reported Threats May Go Through Multiple Levels of Review at the School and District




[1] If the threat is imminent, it should be immediately reported to law enforcement.
[2] Students may still be referred to services without a SSMP.
[3] Rule 6A-1.0019, *F.A.C.*, requires DTMTs to meet with SBTMT at least monthly to discuss relevant data, strategies and interventions with collaborative stakeholders, provide ongoing support, and ensure continuous improvement and fidelity in the implementation of the Florida Model.
Source: Florida Harm Prevention and Threat Management Manual (Effective August 2025).

Threat assessment forms are used to document the threat management process. These documents include an intake and disposition form, a student of concern questionnaire, a parent/guardian questionnaire, a witness/target of violence questionnaire, a teacher survey, and mental health assessments used to evaluate threats. Each form is assigned a letter (Forms A through H). Form A is the intake and case disposition form completed for all reported cases. The intake form must be

completed within one school day of receiving the information about the case of concerning behavior. Forms B through H are completed depending on the results of each form. For example, the SBTMT may complete Form F, the mental health parent interview, for cases deemed high or medium level of concern. These forms are completed by the SBTMT during the threat assessment process, and all cases are first reviewed by the school principal followed by the district threat management coordinator. This information is entered into an online portal—the Safety and Threat Management Portal.

The Safety and Threat Management Portal was launched in August 2025 and houses the threat management instrument as well as all completed threat assessments, SSMPs, and monthly SBTMT meeting documentation. The portal is real-time documentation of behavior and can be used to share information across school districts. The portal is intended for use by each school district, school, charter school governing board, and charter school. Portal users provide additional information as needed depending on how forms are completed. OSS officials provided implementation instructions to districts and launched a self-paced training for districts on how to use the portal.

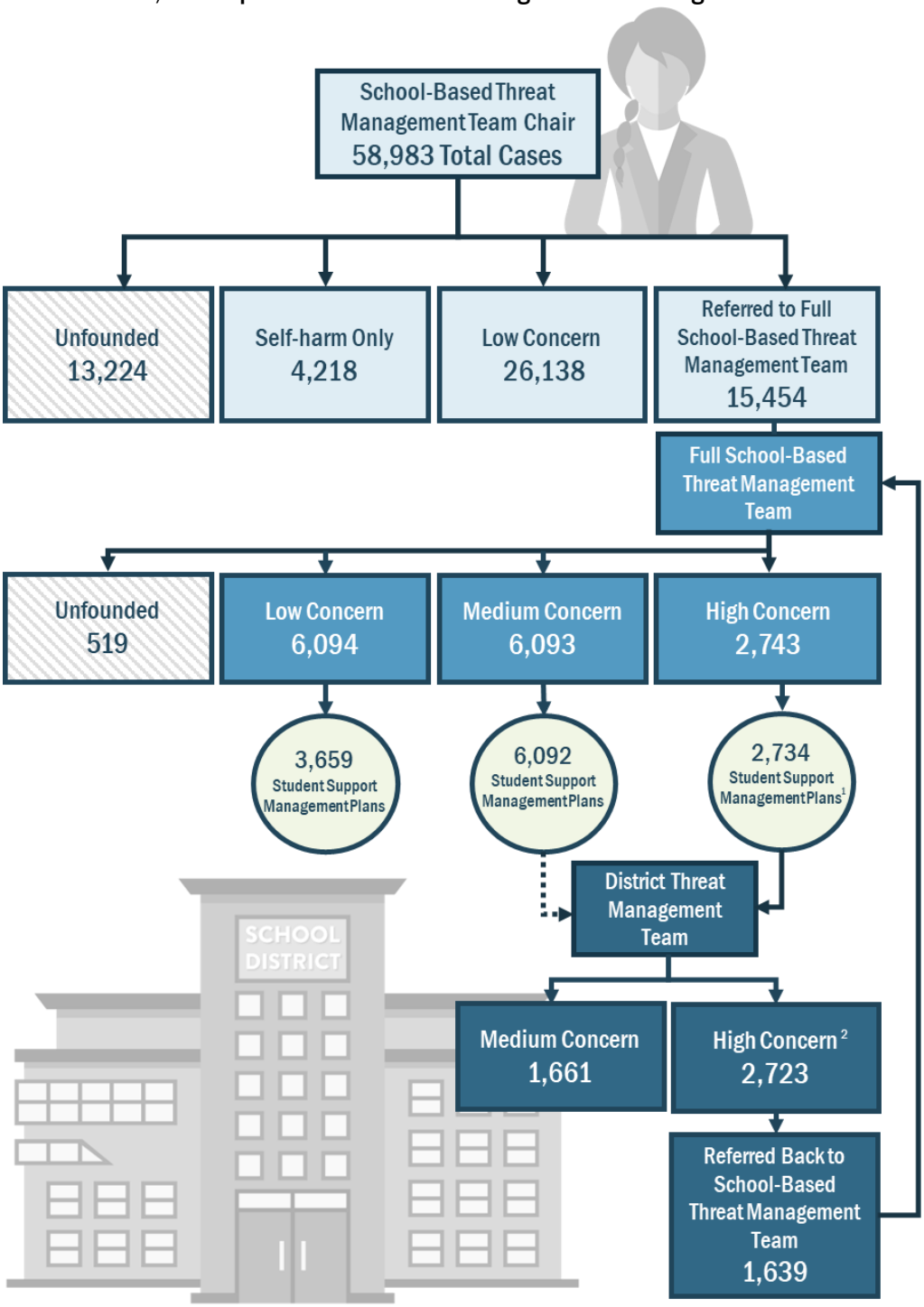
## During the 2024-25 school year, 5% of all reported cases were deemed high-level concerns; districts reported threat management process challenges, with some not fully complying with threat assessment requirements

According to OSS, the Florida Model replaced CSTAG as the approach for Florida school district threat management in January 2024. Of the 58,983 threats reported during the 2024-25 school year, 32,232 were assigned a low level of concern. Districts reported some challenges implementing the Florida Model, particularly with forms, timelines, and technical difficulties with the threat management portal. FDOE reported that in the 2024-25 school year, three districts did not fully comply with the threat management process.

**During the 2024-25 school year, SBTMT chairs forwarded 26% of reported cases to SBTMTs for further review.** OSS reported that school districts began using the Florida Model in January 2024. During the 2024-25 school year, a total of 58,983 cases of concerning behavior were reported to school chairs. Of these, school chairs forwarded 15,454 (26%) to the to the full SBTMT for further review. (See Exhibit 6.) SBTMTs referred 4,384 cases meeting criteria for medium- or high-level concern to DTMTs. DTMTs ultimately referred 1,639 high-level concern cases back to SBTMTs for continued management, such as monitoring via the SSMP.[17]

[17] According to FDOE, in the 2024-25 school year, the DTMT could assist the SBTMTs in providing ongoing threat management, or after assessing the matter, the DTMT could refer the case back to the SBTMT to manage. Beginning in the 2025-26 school year, cases are referred to the DTMT for review and the DTMT may provide ongoing support and recommendations to the SBTMT as needed.

Exhibit 6
There Were 58,983 Reported Cases of Concerning Behavior During the 2024-25 School Year



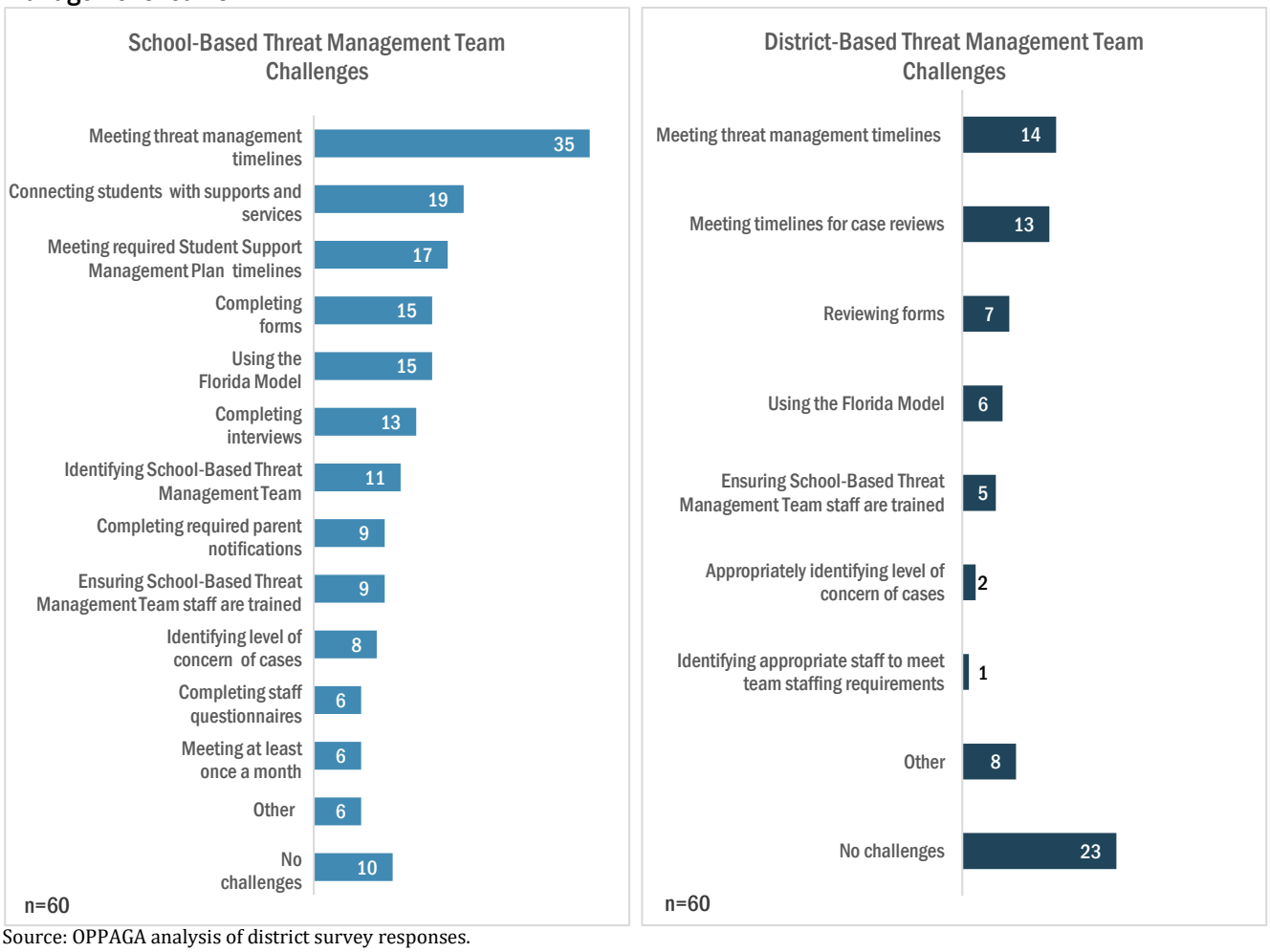

[1] Based on the Florida Harm Prevention and Threat Management Manual, cases deemed medium or high concern must receive a student support management plan. The Office of Safe Schools reported that not all medium and high concern cases include a student support management plan due to data reporting issues from districts.
[2] Based on the Florida Harm Prevention and Threat Management Manual, all cases deemed high level by the school-based threat management team must be referred to the district threat management team. The Office of Safe Schools reported that not all high concern cases were referred to the district threat management team due to data reporting issues from districts.

Source: Florida Department of Education threat management data.

**Districts reported challenges with the threat management process.** One district OPPAGA interviewed reported that some SBTMTs may elevate cases to the DTMT due to liability concerns or school personnel wanting to document cases that are ultimately unfounded. As a result, the district reported offering additional training to chairs and vice chairs on what constitutes a threat.

OPPAGA surveyed Florida's 67 school districts about district experiences with threat management; 60 districts responded to the survey.[18] Overall, more districts reported challenges with the SBTMT (50 districts) than the DTMT (37 districts). For both school and district teams, the top challenge reported was meeting threat management timelines. (See Exhibit 7.)

**Exhibit 7**
**Meeting Threat Management Timelines Posed the Biggest Challenge for School- and District-Based Threat Management Teams**




Source: OPPAGA analysis of district survey responses.

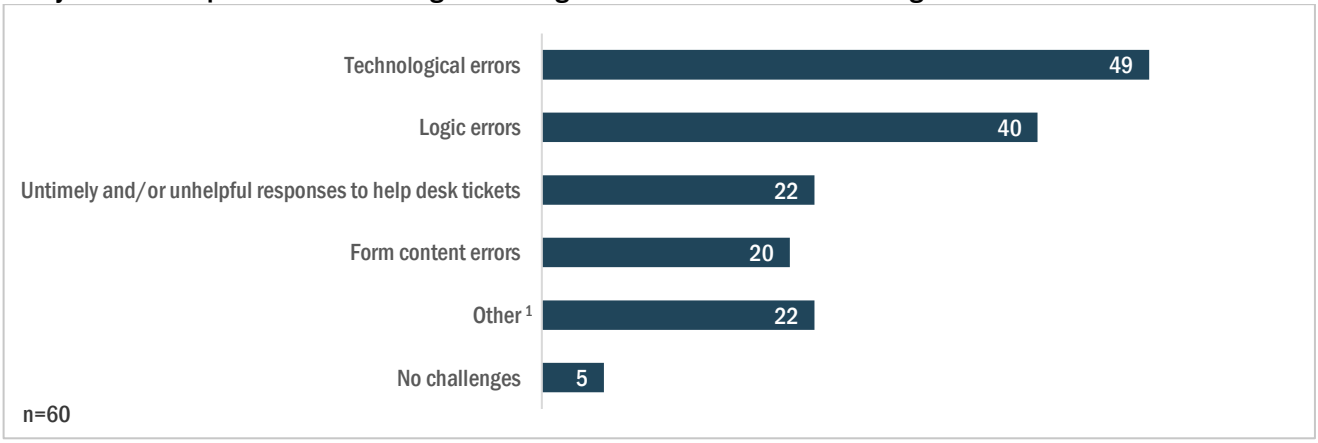
Fifty-five of the 60 districts that responded to OPPAGA's survey reported issues using the threat management portal, such as technological, logic, and content errors. (See Exhibit 8.) Technological errors refer to the portal's failure to save information or other system failures, logic errors include the inability to move on to the next section of the report within the portal, and form content errors refer to errors where the electronic forms in the portal are not consistent with the forms used by FDOE. FDOE reported the forms uploaded in the portal are a direct electronic representation of the forms

[18] OPPAGA sent the surveys to school district mental health coordinators and instructed the coordinators to work with district threat management coordinators to complete the survey. OPPAGA's analysis excluded the state's lab schools, virtual school, and the Florida School for the Deaf and the Blind, which operate separately from school districts.

used by FDOE. FDOE also reported working with the vendor to ensure continued updates to allow for better operability by the end user and addressing several issues through system enhancements and improvements.

Five districts that OPPAGA interviewed provided additional information about portal functionality. For example, one district reported that there are form fields marked as required that should not be required, confusing staff. Another district reported unresponsive buttons that prevent principals from approving assessments and reported difficulty entering information into date fields, preventing staff from finalizing assessments and moving cases forward in the threat management process. The same district explained that the portal is not designed to allow more than one person to enter information for multiple schools, which can be problematic for charter schools that have two physical locations. In addition, districts reported that the portal does not include information about active cases that commenced prior to FDOE's August 2025 launch of the portal. Therefore, staff cannot use the portal to track an SSMP for a student that was created prior to the portal launch, leading staff to simultaneously work in old information system(s) and the new portal to complete assessments. FDOE reported that several identified issues have been addressed through system enhancements and improvements.

**Exhibit 8**
**Many Districts Reported Encountering Technological Errors in the Threat Management Portal**




[1] The Other category includes the portal not being integrated with the Student Information System, and schools receiving alerts for cases even when timelines have been met.

Source: OPPAGA analysis of district survey responses.

**FDOE reported that in the 2024-25 school year, three school districts did not fully comply with the threat management process**. Section 1001.212(11)(d), *Florida Statutes*, requires OSS to evaluate school district compliance with the statewide behavioral threat management operational process, the Florida-specific behavioral threat assessment instrument, and the threat management portal. To monitor school district compliance with the Florida Model, OSS conducts periodic data pulls as well as school and district compliance visits and follow-up visits if compliance concerns are identified. District staff enter security assessment information into the Florida Safe School Assessment Tool (FSSAT), an online platform managed by FDOE that houses compliance reports and district-reported information related to threat management.[19] FSSAT also houses threat management data reported annually by district school safety specialists, in coordination with district threat management coordinators. District-reported data includes the number of cases reported to the SBTMT chair, number of cases evaluated by the SBTMT, student demographic information, and the concern level for cases identified.

[19] The tool is an FDOE online platform that is the primary physical site security assessment tool used by OSS staff; the tool includes information on school emergency and crisis preparedness planning and physical security measures.

In addition to compliance visits, OSS monitors FSSAT threat management data to identify noncompliance with threat management requirements (e.g., comparing data from districts to examine if a district has more or fewer threat management cases than similarly sized districts).

In school year 2024-25, OSS reported sending letters regarding deficiencies related to behavioral threat management compliance to three school districts—Duval, Gadsden, and Indian River county school districts. The districts acknowledged these deficiencies and provided OSS lists of corrective measures.

- Duval County School District: OSS's findings of non-compliance were related to the district threat management coordinator's failure to train threat management team personnel in threat management and on the Florida Model. That coordinator was removed from the position, and the district outlined several other corrective measures in a letter to OSS.
- Gadsden County School District: OSS identified several areas of non-compliance related to implementation of the Florida Model, including the district threat management coordinator's failure to assist SBTMTs, failure to ensure all SBTMTs were meeting at least monthly, and failure to transition from CSTAG to the Florida Model at two schools. The district acknowledged these deficiencies and shared a list of corrective measures with OSS that it planned to implement immediately.
- Indian River County School District: OSS found that SBTMTs were not meeting monthly, as required by rule, and that all required team members were not present when meetings did occur. OSS also found that the district provided inadequate documentation on threat management forms, particularly those related to the team's determination of a final level of concern, and that SBTMTs did not follow the timelines required by the Florida Model. The district reported to OSS that it began to hold monthly SBTMT meetings and conducted additional training with the SBTMTs regarding documentation requirements.

## Fifty-eight school districts reported compliance with required notification of mental health services for trained school personnel; however, the quality of information districts provide varies

Section 1012.584, *Florida Statutes,* requires districts to provide youth mental health awareness and assistance training to school personnel. Districts submit written attestations that the training was completed; all districts completed this attestation in the 2024-25 school year. In addition, statute requires that districts notify trained school personnel about available mental health services and resources as well as who to contact if a student needs services. FDOE is not required to collect information about how these notifications are completed. Based on OPPAGA survey responses, 58 school districts provide a list of resources, but the list does not always include all required information.

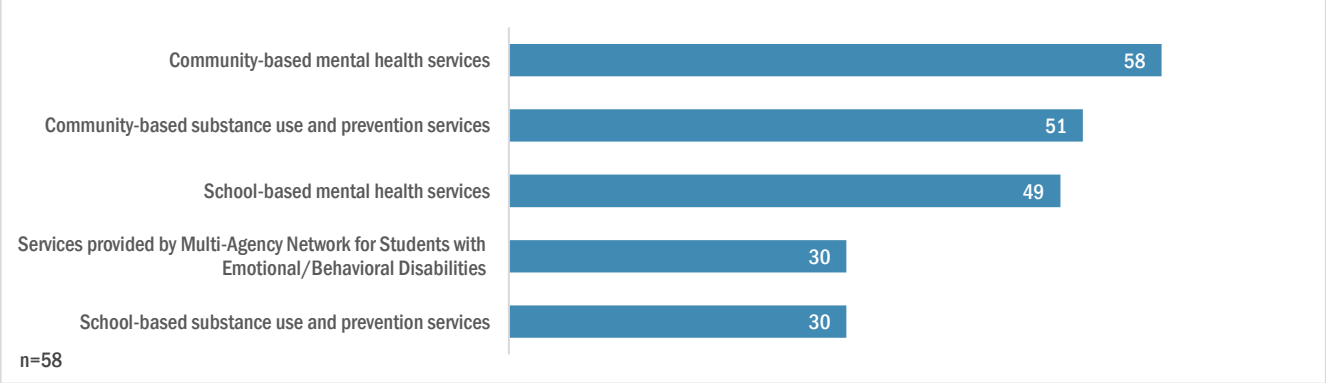
**Districts reported providing required mental health training, and 58 of 60 districts that responded to OPPAGA's survey reported providing required mental health resource information to school personnel.** Section 1012.584, *Florida Statutes,* required FDOE to establish youth mental health awareness and assistance training. The department selected the Youth Mental Health First Aid Program to help school personnel understand the signs of mental health concerns and substance use disorders. The statute further requires that school districts annually certify that at least 80% of school personnel receive this training. In 2024-25, all districts attested to providing training to at least 80% of school personnel. In addition to requiring that school personnel receive youth mental health awareness and assistance training, s. 1012.584(4), *Florida Statutes,* requires districts to notify

personnel who receive the training of the mental health services available in the district and the individual to contact if a student needs services. FDOE does not collect information about notifications provided to school personnel.

OPPAGA surveyed school districts about these notifications. Fifty-eight of the 60 districts that responded to the survey reported providing a list of the mental health services available in the district. Forty-seven of the districts reported providing this information at the time of training, 25 reported providing the information separately from the training, and 25 reported other ways of providing the information, such as during yearly pre-planning or via a website. Two districts reported not providing a list of the mental health services available in the district to trained school personnel. Consequently, school personnel in these two districts may not be equipped to provide necessary resources to students and families in need of mental health assistance.

**District resource lists do not contain all required information and varied widely in form and detail.** Florida law further specifies that districts must provide notification of community mental health services, health care providers, services provided by the Multiagency Network for Students with Emotional/Behavioral Disabilities (SEDNET), and services provided under the district's mental health assistance program.[20,21] However, none of the 58 districts responding to survey questions about the type of resource information provided to school personnel reported that district lists included all services that the statute requires. For example, while all 58 districts reported that community-based mental health services were included in the information provided, only 49 reported that school-based mental health services were included, and only 30 reported providing information about services provided by SEDNET, services provided by health care providers, and school-based substance use and prevention services. (See Exhibit 9.)

**Exhibit 9**
**Districts Providing Mental Health Resources to Personnel Do Not Include All Required Resources**




Note: Responses sum to over 58 because one district could select multiple options. School and community-based services for substance abuse and prevention and mental health are required in school plans under the mental health assistance program.

Source: OPPAGA analysis of district survey responses.

OPPAGA requested documentation of the resources provided to staff from 21 school districts. The documents provided varied in form and detail.[22] For example, one district provided 47 pages of documentation describing available resources, including a flyer about on-campus mental health

[20] Sections 1012.584(4), 1006.04, and 1006.041, *F.S.*

[21] The Legislature established SEDNET to assist students with severe emotional disturbances. SEDNET works within 19 regions to help coordinate services for students and parents.

[22] OPPAGA selected a sample of 20 districts to request documentation from throughout the survey to capture information from small, medium, and large school districts. An additional district provided the requested documentation via email. Therefore, OPPAGA reports information for 21 school districts. One district from which OPPAGA requested this information did not provide a list of resources to staff.

resources, a list of 24-7 crisis resources, an employee resource guide with resources broken out by type (i.e., housing, mental health), and a copy of resources listed on the district's website. In contrast, another district provided an organizational chart with district mental health staff, and another provided a one-page document with names and contacts for four entities. Differences in the number and types of resources within lists may or may not reflect differences in the lists' comprehensiveness (e.g., rural districts may have fewer available resources within the district and hence shorter lists). However, incomplete lists could result in parents being unaware of community mental health and substance abuse resources available to assist families.

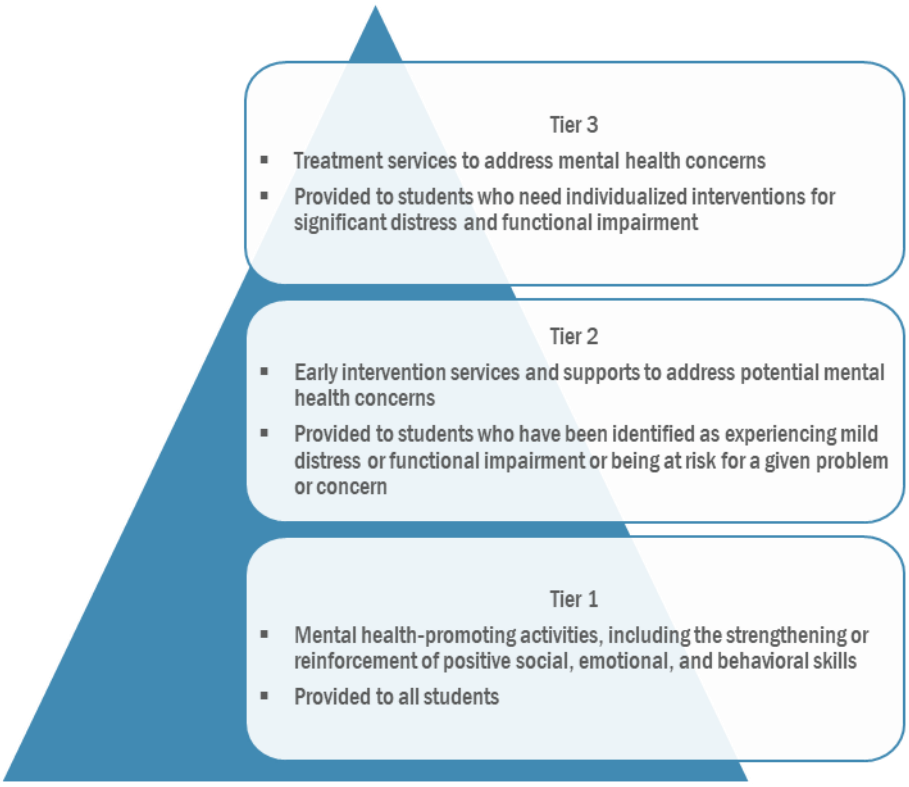
## District Mental Health Assistance Allocation Plans (MHAAPs) contained all statutorily required elements

Florida law provides requirements for annual MHAAPs.[23] All districts provided these plans in 2024-25, and the plans addressed all statutorily required information. However, FDOE requires that districts attest to having required policies and procedures rather than requiring submission of each policy or procedure in the district MHAAPs.

**All districts submitted MHAAPs in 2024-25.** Section 1006.041, *Florida Statutes,* requires districts to annually submit school board-approved MHAAPs to FDOE. The statute further requires that the plans include a description of the multi-tiered system of supports (MTSS) for students, current and prospective employment of mental health professionals, contracts or interagency agreements with community providers, strategies for early identification of mental health issues, strategies to reduce the likelihood of at-risk students developing mental health issues, and policies and procedures related to student service provision. MTSS refers to a tiered structure of interventions that increase in intensity with student needs. (See Exhibit 10.)

[23] Section 1006.041, *F.S.*, refers to the mental health assistance program. However, FDOE titles mental health assistance program plans as Mental Health Assistance Allocation Plans. Therefore, OPPAGA refers to these plans as related to the mental health assistance program as the Mental Health Assistance Allocation Plans.

Exhibit 10
The Multi-Tiered System of Supports Is Designed to Help Students at All Levels of Need




Source: Library of Congress, Congressional Research Service. *School-Based Mental Health: Introduction and Considerations for Congress.* Duff, Johnathan H. and Kyrie E. Dragoo. R48740. November 28, 2025. https://www.congress.gov/crs-product/R48740.

**FDOE does not collect copies of district policies and procedures.** The department provides school districts an MHAAP report template that includes sections for all required statutory elements. FDOE reviews plans using a checklist to ensure that plans include required information and provides feedback to school districts. The template requires district plans to provide detailed descriptions of certain required items, such as the MTSS for students, current and prospective employment of mental health professionals, and contracts or interagency agreements with community providers. However, FDOE only requires that districts attest to having required policies and procedures rather than requiring inclusion of these documents for review in the plans. Therefore, FDOE does not verify that the policies and procedures meet statutory requirements. (See Exhibit 11.)

## Exhibit 11
## School Districts Only Attest to Having Required Policies and Procedures in Mental Health Assistance Allocation Plans

| Required Plan Descriptions | Required Attestations in Plans |
|---|---|
| Multi-tiered system of supports delivered through evidence-based mental health care assessment, diagnosis, intervention, treatment, and recovery services | Policies and procedures to ensure students receive services in a timely manner[2] |
| Direct employment of school-based mental health service providers to better align with nationally recommended ratios of providers to students | Policies and procedures to ensure parents and individuals living in a house with students receiving services are notified about services available |
| Contracts or interagency agreements with local community behavioral health providers or providers of Community Action Treatment Team services | Procedures to assist in attempting to verbally de-escalate a student's crisis before initiating an involuntary examination[3,4] |
| Strategies or programs to reduce the likelihood of at-risk students developing issues[1] | Policies to require that in a student crisis situation, personnel must make a reasonable attempt to contact a mental health prior to involuntary examination[5] |
| Strategies to improve the early identification of issues; to improve the provision of early intervention services; and to assist students in dealing with trauma and violence | |

[1] Section 1006.041(2)(d) and (e), *F.S.,* describes issues as developing social, emotional, or behavioral health problems; depression; anxiety disorders; suicidal tendencies; or substance use disorders.
[2] Section 1006.041(2)(c)1, *F.S.,* states that policies and procedures must ensure that students referred to a school- or community-based mental health service provider for mental health screening for the identification of mental health concerns and students at risk for mental health disorders are assessed within 15 days after referral. School-based mental health services must be initiated within 15 days after identification and assessment, and community-based mental health services must be initiated within 30 days after the school or district makes a referral.
[3] Section 1006.041(2)(f), *F.S.,* specifies procedures are for mental health services providers, behavioral health providers, school resource officers, or school safety officers who have completed mental health crisis intervention training. Such procedures must include strategies to de-escalate a crisis situation for a student with a developmental disability as defined in s. 393.063, *F.S.*
[4] Section 394.463, *F.S.* defines involuntary examination as the process of taking an individual to a receiving facility if there is a reason to believe the individual has a mental illness and because of the mental illness, the individual refused voluntary examinations or the individual is unable to determine whether examination is necessary and without care, the individual will experience substantial harm or there is reason to believe the individual will harm themselves or others.
[5] Section 1006.041(2)(g), *F.S.,* states that school or law enforcement personnel must make a reasonable attempt to contact a mental health professional. Statute states that such contact may be in person or through telehealth. The mental health professional may be available to the school district either by a contract or interagency agreement with the managing entity, one or more local community-based behavioral health providers, or the local mobile response team, or be a direct or contracted school district employee.

Source: OPPAGA analysis of Mental Health Assistance Allocation Plans.

## District MHAAPs describe districts' use of evidence-based programs and collaboration with community providers

OPPAGA reviewed the 2024-25 MHAAPs and surveyed districts to assess compliance with statutory requirements. OPPAGA found that districts use required evidence-based programs, collaborate with community behavioral health providers, and include information on early identification and at-risk assistance strategies for students.

**Districts are using evidenced-based programs and practices to address student mental health needs**. Section 1006.041(2), *Florida Statutes,* requires MHAAPs to focus on a MTSS to deliver evidence-based mental health care assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance abuse diagnoses and to students at high risk of such diagnoses. Evidence-based programs and practices generally are tested approaches that have been shown to benefit recipients.

OPPAGA's review of the 2024-25 MHAAPs found that all the plans included evidence-based practices or programs in the MHAA, though the number and types of programs varied by district. For example, 7 districts each reported using one evidence-based program, while 31 districts each reported using five or more evidence-based programs. Evidence-based programs reported include cognitive behavioral therapy, positive behavioral intervention services, and zones of regulation.[24] District plans indicated the tier of support for which each evidence-based program was intended. For example, districts may designate cognitive behavioral therapy for students receiving Tier 2 or 3 services who need additional support or determine that zone of regulation is appropriate for students in all tiers.

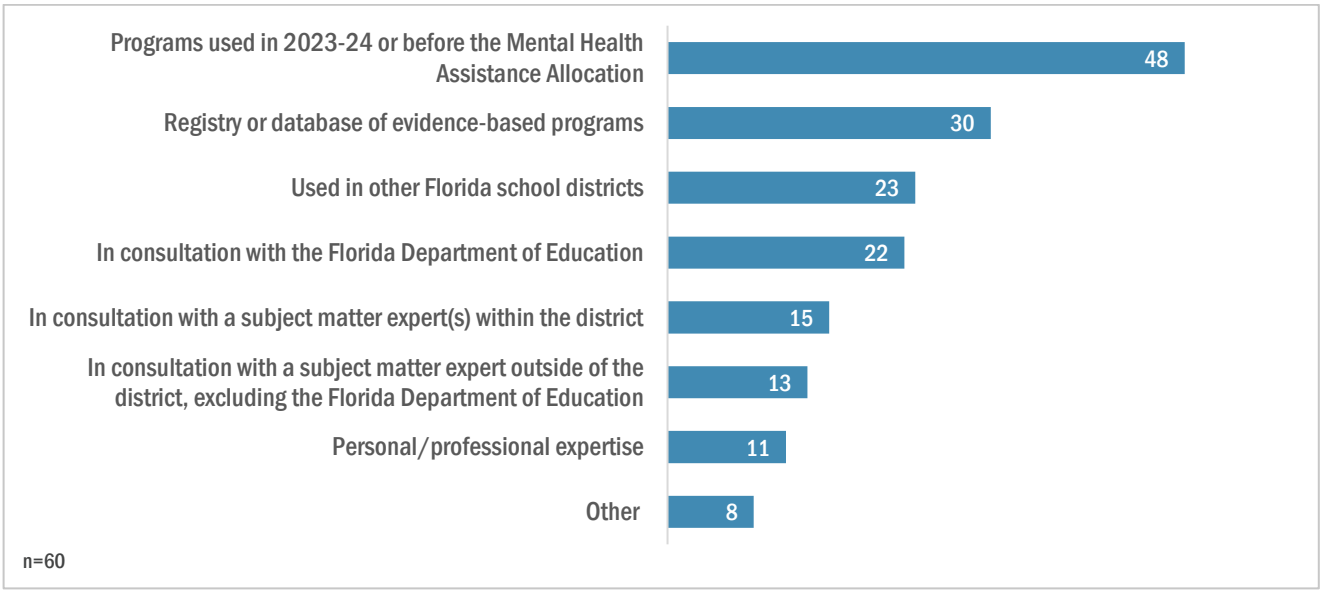
Forty-eight of the 60 districts that responded to OPPAGA's survey reported selecting evidence-based programs that the district used in prior years or before MHAA development. Thirty districts reported selecting programs from a registry or a database of evidence-based programs, such as the What Works Clearinghouse.[25] (See Exhibit 12.)

[24] Cognitive behavioral therapy is a type of talk therapy that helps individuals identify negative thought patterns and learn about the relationship between thoughts, feelings, and behaviors. Positive behavior interventions and supports is a three-tiered system that focuses on identifying, teaching, and reinforcing positive behaviors in students. Zone of regulation is a mental health curriculum that teaches self-regulation.

[25] The What Works Clearinghouse is a source of scientific evidence on education programs, products, practices, and policies. The clearinghouse reviews research, determines which studies meet rigorous standards, and summarizes the findings. The clearinghouse is an investment of the Institute of Education Sciences within the U.S. Department of Education.

Exhibit 12

**Forty-Eight Districts Reported Selecting Evidence-Based Programs by Using Programs Identified in Prior Years or Before the Mental Health Assistance Allocation**



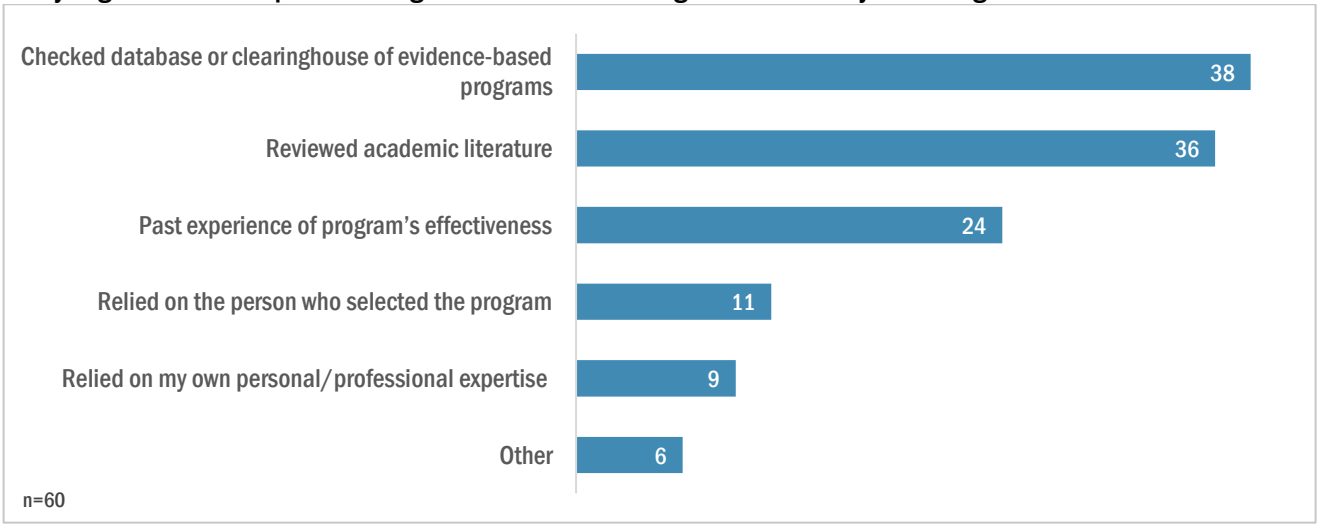

Note: Responses sum to over 60 because a district could select multiple options.

Source: OPPAGA analysis of district survey responses.

OPPAGA asked how districts verified that a program was evidence based. Thirty-eight districts reported reviewing databases or clearinghouses, and 36 districts reported reviewing academic literature to verify that selected programs are evidence based. (See Exhibit 13.)

Exhibit 13

**Thirty-Eight Districts Reported Using Databases or Clearinghouses to Verify That Programs Are Evidence Based**




Note: Responses sum to over 60 because a district could select multiple options.

Source: OPPAGA analysis of district survey responses.

**Districts reported varying early identification strategies and approaches for assisting at-risk students.** Section 1006.041(2)(d), *Florida Statutes,* requires that MHAAPs include strategies or programs to reduce the likelihood of at-risk students developing social, emotional, or behavioral health problems; depression; anxiety disorders; suicidal tendencies; or substance use disorders. Section 1006.041(2)(e), *Florida Statutes,* requires that MHAAPs include strategies to improve the early identification of social, emotional, or behavioral problems or substance use disorders; improve the

provision of early intervention services; and assist students in dealing with trauma and violence. All 67 district MHAAPs included required strategies for early identification of mental health issues and strategies to reduce the likelihood of at-risk students developing mental health issues. Districts report this information for each evidence-based program in the plan rather than providing an overall strategy used at the district or school level to identify students who may benefit from evidence-based programs.

**Districts reported collaborating with community providers via interagency contracts or agreements.** Section 1006.041(2)(b), *Florida Statutes,* requires that MHAAPs include contracts or interagency agreements with one or more local community behavioral health providers or providers of Community Action Treatment (CAT) team services to ensure a behavioral health staff presence and services at district schools.[26] Contracted services include individual counseling or family therapy, addiction support, telehealth mental health services, and mobile response teams.[27] As of October 16, 2025, there were 54 CAT teams and 53 mobile response teams in Florida.[28]

Districts reported 524 interagency contracts in the 2024-25 MHAAPs. All but one district MHAAP included required descriptions of interagency contracts or agreements with community providers.[29] Glades County School District explained the reason it did not report any interagency contracts or agreements with external service providers is because the district is rural and access to mental health providers is limited.[30] For the remaining 66 districts, the number of contracts varied by district from 1 contract to 34 contracts.

## Districts do not meet nationally recommended staffing ratios, and some have not adopted all required policies and procedures

Although MHAAPs included required information on school-based mental health professionals, districts are not meeting nationally recommended staffing ratios, and some districts lack policies and procedures on notification of services for families and service timeframes for students.

**MHAAPs included required information on school-based mental health professionals**. Section 1006.041(2)(a), *Florida Statutes,* requires that MHAAPs include direct employment of school-based mental health services providers (e.g., certified school counselors, school psychologists, school social workers, and other licensed mental health professionals) to expand and enhance school-based student services and reduce the ratio of students to staff to better align with nationally recommended ratio models.[31] The MHAAP templates include sections for reporting district employment, and each school district provided information on direct employment of mental health professionals in the 2024-25 plans. Districts also reported on current and proposed ratios of students to school counselors, school social workers, school psychologists, and other mental health professionals to students.

[26] CAT teams work with eligible children and young adults with behavioral health concerns in their homes by connecting them and their families with local resources. CAT teams provide services such as care coordination, crisis intervention, mental health and substance use treatment, psychoeducation, and therapy.

[27] Mobile response teams provide emergency behavioral health care to eligible individuals and their families to reduce trauma, prevent unnecessary psychiatric hospitalizations, and avoid criminal justice involvement through de-escalation, crisis intervention, and community resource referrals.

[28] Lutheran Services Florida has the most specialty teams, with 17 CAT teams and 19 mobile response teams. Broward Behavioral Health Coalition has the fewest, with two CAT teams and two mobile response teams; however, this managing entity serves one county. Among managing entities serving four or more counties, Southeast Florida Behavioral Health Network has the fewest specialty teams, with three CAT teams and four mobile response teams.

[29] OPPAGA analyzed district information on contracts and inter-agency agreements based on district MHAAPs instead of mental health outcome and expenditure reports because FDOE reported that the plans provide a more comprehensive picture of contracts and agreements whereas the outcome and expenditure reports may provide only those agreements funded by the MHAA.

[30] Glades County School District reported a unique relationship with the managing entity in which the district is a subcontracted service provider for the managing entity.

[31] School counselors, school social workers, and school psychologists are classified as student personnel services and all advise students regarding student abilities and aptitudes, educational and occupational opportunities, and personal and social adjustments. School counselors are often school-employed mental health professionals who promote academic, post-secondary, and social-emotional outcomes for all students.

Stakeholders reported that a key difference between school counselors and other professionals is that school counselors are at the school every day, whereas other professionals may transfer between schools. School social workers coordinate services between families, students, and communities to serve students. School psychologists use expertise in mental health, learning, and behavior to help students succeed. These professionals often have expertise in assessment and evaluation and can assist students struggling with learning disabilities as well as other emotional challenges, like grief.

**Districts do not meet nationally recommended staffing levels for mental health professionals.** Section 1006.041(2)(a), *Florida Statutes* requires districts to directly hire school counselors, school psychologists, school social workers, and other licensed mental health professionals to reduce the ratio of students to staff to better align with nationally recommended ratio models. Organizations such as the American School Counselor Association, the School Social Work Association of America, and the National Association of School Psychologists establish recommended student to staff ratios for these profession types ranging from 1:250 to 1:500. (See Exhibit 14.)

Based on staffing information reported in MHAAPs, OPPAGA determined that in 2024-25, no district met nationally recognized staffing ratios for any of the mental health profession types. Furthermore, one district reported having no school counselors, nine districts had no school social workers, and eight districts had no school psychologists. As a result, school districts may not have adequate staff to meet the mental health needs of students.

**Exhibit 14**
**School Counselors and Social Workers Have the Lowest Recommended Ratios of Professionals to Students**


Note: The School Social Work Association of America recommends a ratio of 1 social worker for every 250 students. However, in 2025 the National Association of Social Workers updated practice standards for school social workers to state that each local education agency should establish and implement a ratio of school social workers to students.

Source: OPPAGA analysis of recommended ratios from the American School Counselor Association, the School Social Work Association of America, and the National Association of School Psychologists.

**Some districts have not enacted all required policies and procedures for notifying families about resources and outlining timeframes for service provision.** Section 1006.041(2), *Florida Statutes*, requires district MHAAPs to include several policies and procedures.

- Policies and procedures related to timeframes for student receipt of mental health services and notification of mental health resources for parents and other individuals residing in the student's home. These policies and procedures must ensure that students referred to a school-based or community-based mental health service provider for screening are assessed within 15 days, students receive school-based services 15 days after identification and assessment, and students receive community-based services within 30 days of referral.
- Procedures to assist a mental health services provider or a behavioral health provider to verbally de-escalate a student's crisis situation before initiating an involuntary examination.[32]

[32] Section 394.463, *F.S.* defines involuntary examination as the process of taking an individual to a receiving facility if there is a reason to believe the individual has a mental illness and because of the mental illness, the individual refused voluntary examinations or the individual is unable to

- Policies that require that in a student crisis situation, school or law enforcement personnel must make a reasonable attempt to contact a mental health professional who may initiate an involuntary examination. All districts report assurances in MHAAPs indicating the district adopted required policies and procedures.

All 60 districts that responded to OPPAGA's survey reported adopting policies and procedures to notify parents of resources and to require contacting a mental health professional before initiating involuntary examination; 59 reported adopting policies and procedures to inform individuals in the household about services available and to assist in crisis de-escalation; and 55 reported adopting policies and procedures related to student assessment and services timeframes.

In addition, OPPAGA requested policy and procedure documents from 21 school districts to determine compliance with statutory requirements. OPPAGA reviewed the documents, which varied widely in detail and specificity, to determine whether documents addressed each statutory requirement. OPPAGA found that 9 of the 21 districts' policies and procedures addressed all five statutory requirements overall. Districts with inadequate policies and procedures cannot ensure that students receive needed services in a timely manner and that parents are notified of services available. (See Exhibit 15.)

**Exhibit 15**
**OPPAGA Verified That Districts Had Documentation Addressing Statutory Requirements**

| Statutory Requirements | Attestation from Mental Health Assistance Allocation Plans (67 Districts) | Survey Responses (60 Districts) | OPPAGA Analysis of Whether Documents Addressed Requirements (21 Districts) |
|---|---|---|---|
| School or law enforcement must attempt to contact a mental health professional to initiate involuntary examination prior to initiating the examination[1] | 67 | 60 | 19 |
| Trained providers or school resource officers must verbally de-escalate a student's crisis situation before initiating involuntary examination[2] | 67 | 59 | 17 |
| Students must be assessed within 15 days after referral, school-based mental health services must be initiated within 15 days after identification and assessment, and community-based mental health services must be initiated within 30 days after referral[3] | 67 | 55 | 16 |
| Parents of students receiving services must be provided information about available behavioral health services[4] | 67 | 60 | 14 |
| Individuals living in a household with students receiving services must be provided information about available behavioral health services[5] | 67 | 59 | 12 |

Note: OPPAGA defined a policy as a document describing the district's goals, standards, or practices (e.g., district policy manual). OPPAGA defined a procedure as any documentation that provides detail on a process. OPPAGA identified a district as having documents that addressed statutory requirements if the district submitted a document that clearly outlined policies or procedures or referenced compliance with policies or procedures. For example, a district submitted a referral form that noted the requirement for a student to receive services within 15 days of referral.

[1] Section 1006.041(2)(g), *F.S.*
[2] Section 1006.041(2)(f), *F.S.*
[3] Section 1006.041(2)(c)1., *F.S.*
[4] Section 1006.041(2)(c)2., *F.S.*
[5] Section 1006.041(2)(c)3., *F.S.*

Source: OPPAGA analysis of Mental Health Assistance Allocation Plans, district survey responses, and reported documentation.

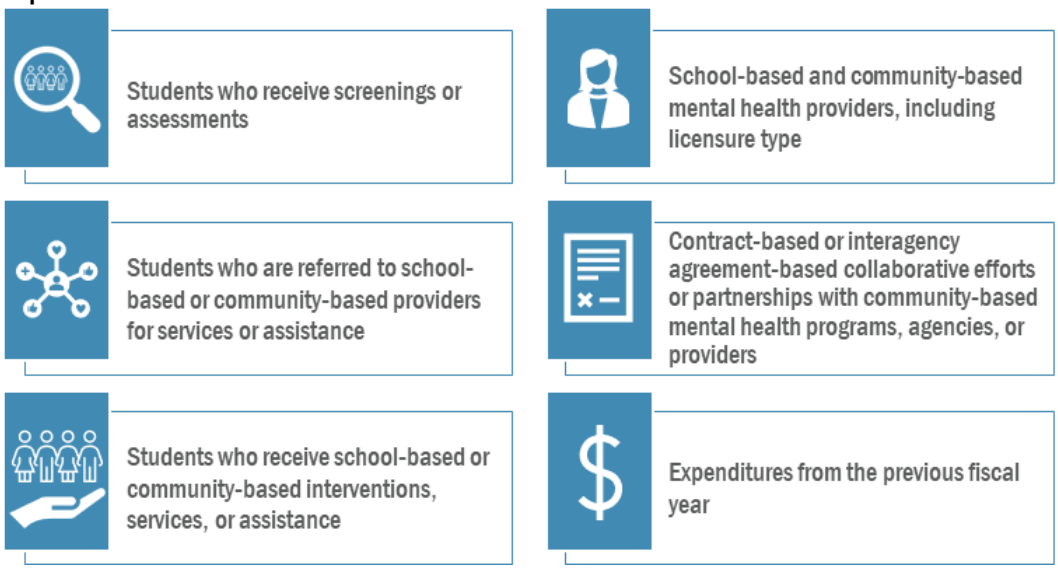
determine whether examination is necessary and without care, the individual will experience substantial harm or there is reason to believe the individual will harm themselves or others.

## MHAA outcome and expenditures reports included required information, but reporting was inconsistent

School districts are meeting the statutory requirement to submit annual MHAA outcome and expenditures reports to FDOE. However, some MHAA expenditures are challenging to evaluate because of changes to FDOE's reporting templates over time. FDOE reported that these changes were made in response to district input and legislative change, and to enhance the ease of use. In addition, district-reported counts of students who receive services and other forms of assistance through the MHAA may be unreliable.

**School districts are meeting the statutory requirement to submit annual MHAA outcome and expenditures reports to FDOE.**[33] Section 1006.041(4), *Florida Statutes*, requires districts to submit annual MHAA outcome and expenditures reports to FDOE. These reports aim to provide information on how districts spent the prior year's MHAA and how many students the program served. Statute specifies outcome information districts are required to include in the reports. However, statute does not specify the types of expenditure information districts must report, stating only that that districts must report annually on expenditures for the prior year. FDOE provides a fillable report template to districts and verbal guidance on completing the report during periodic trainings and upon request. The template requests that districts provide the number of student assessments, screenings, and referrals; information on school-based and community-based providers by licensure type; and information on contractual agreements. (See Exhibit 16.) The template also requests that districts report expenditures by category (e.g., travel, charter). In school year 2023-24, all 67 districts submitted outcome and expenditures reports.

**Exhibit 16**
**Districts Are Required to Report on Students Receiving and Screened for Services, Providers, Agreements, and Expenditures**



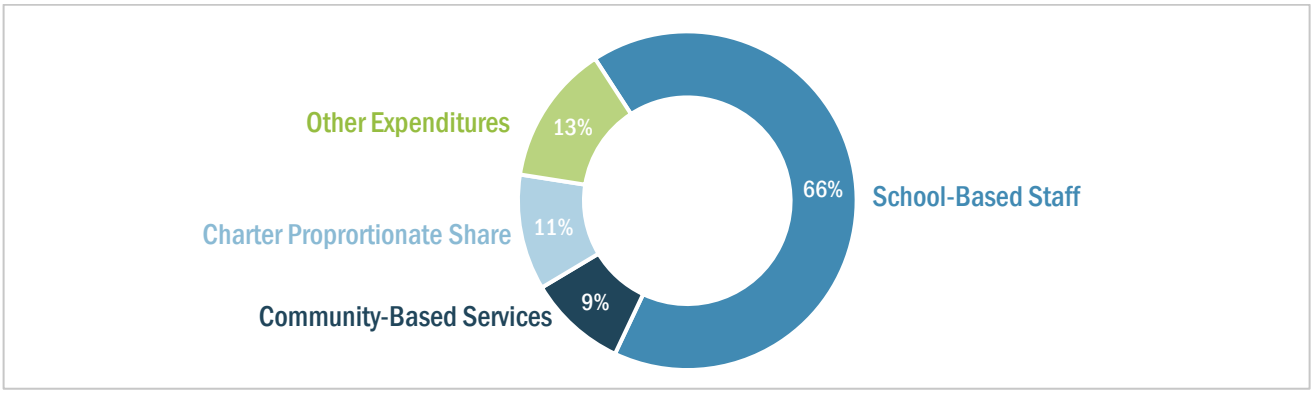

Source: OPPAGA analysis of s. 1006.041(4), *F.S.*

**In 2023-24, districts reported spending over half of MHAA funds on school-based staff and services.** OPPAGA's review of financial data in the outcome and expenditures reports found that

[33] Section 1006.041, *F.S.*, refers to the mental health assistance program. However, FDOE titles mental health assistance program outcome and expenditure reports as MHAA outcome and expenditures reports. Therefore, OPPAGA refers to information related to the mental health assistance program outcome and expenditures reports as the MHAA outcome and expenditures reports.

districts reported spending 66% of MHAA funds on school-based staff and services, including school social workers and other licensed mental health providers; 9% on community-based services; and 11% on charter schools' proportionate share of funds.[34] Districts reported spending 13% of the funds on other items such as printed materials for trainings, technology expenditures such as software, and professional development. (See Exhibit 17.) Examples of school-based interventions, services, or assistance include cognitive behavioral therapy, grief counseling, and suicide prevention efforts. Community-based services include psychiatry outpatient services and case management.

**Exhibit 17**
**In 2023-24, Districts Reported Spending 66% of Mental Health Assistance Allocation Funds on School-Based Staff and Services**

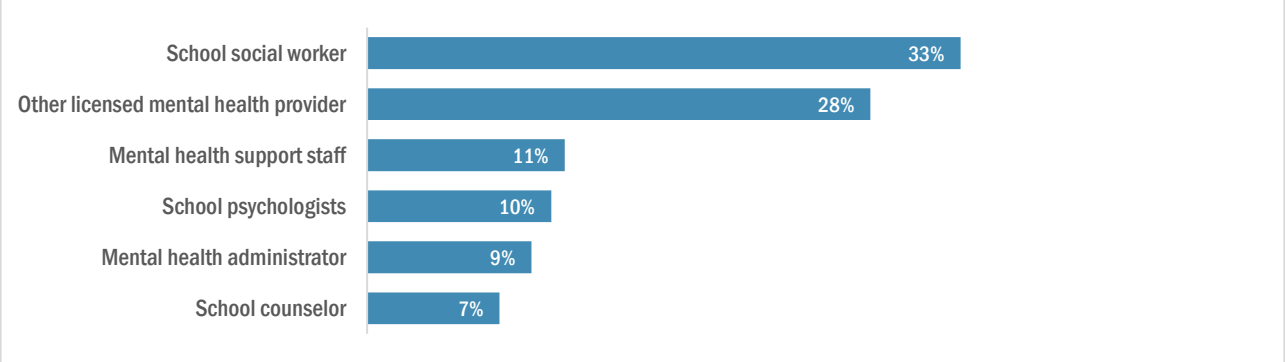



Note: Other expenditures include printed materials for trainings, technology expenditures such as software, and professional development. Percentages sum to less than 100% because of rounding.

Source: OPPAGA analysis of 2023-24 district Mental Health Assistance Allocation outcome and expenditures reports.

Districts reported spending 33% of all staffing expenditures on school social workers and 28% on other licensed mental health providers, such as licensed marriage and family therapists. Districts reported spending the least on school counselors (7% of all staffing expenditures). (See Exhibit 18.)

**Exhibit 18**
**In 2023-24, Districts Reported Spending Most of the Mental Health Assistance Allocation on School Social Workers**




Note: Other licensed mental health provider includes family and marriage therapists and licensed psychologists.

Source: OPPAGA analysis of 2023-24 district Mental Health Assistance Allocation outcome and expenditure reports.

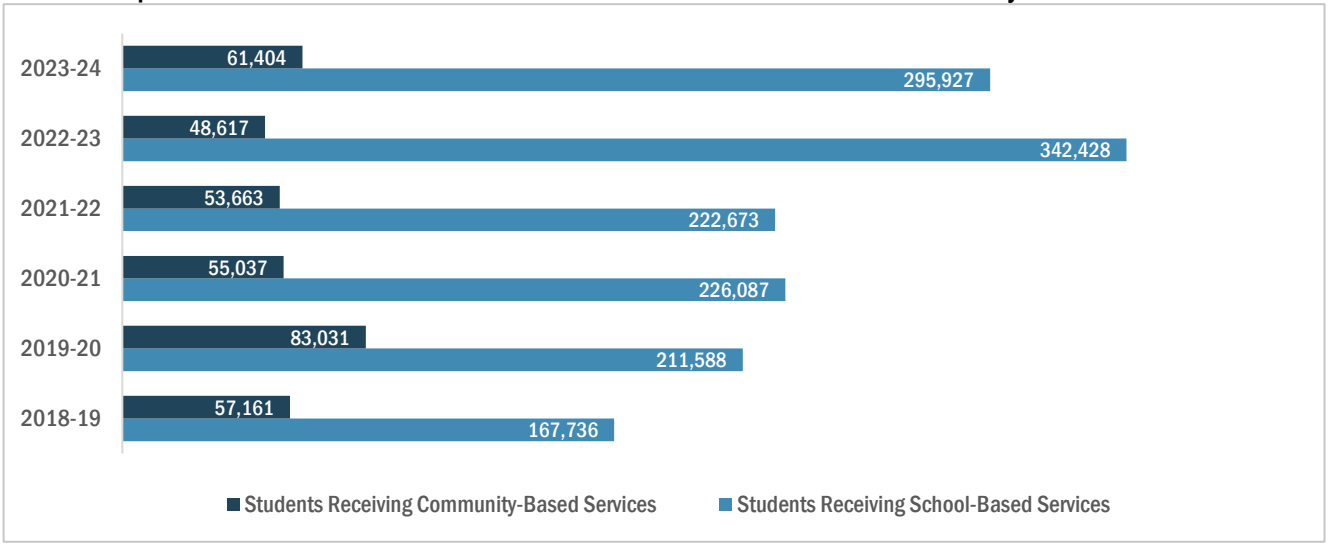
Annual changes to FDOE's outcome and expenditures report template prevent a meaningful analysis of expenditures by category over time. For example, the 2021-22 and 2022-23 templates included a consolidated line item for *expenditures for services provided by community-based mental health*

[34] Proportionate share refers to funds received by charter schools as determined by the Florida Education Finance Program. This funding calculation considers the number of students attending a charter school, total number of students in the district, and the total district operating funds to calculate the funds provided to charter schools.

*program agencies or providers*, but the 2023-24 template did not. Instead, 2023-24 expenditures for community-based services were separately itemized in a section of the form labeled *additional expenditures* that also included training expenses, supplies, additional pay for school staff, furniture, and other items. Other examples of template changes include removing consolidated line items for travel expenses and supplies between 2022-23 and 2023-24. In both cases, the newer version of the template itemizes these expenses. Changes to expenditure columns along with inconsistent use of the *additional expenditures* column means that some expenditure categories cannot be analyzed efficiently or that analysis may produce misleading results. For example, districts report some charter school proportionate share and supplies as *additional expenditures* although the template included space to report such expenses as distinct subcategories.

**In each year since 2018, districts reported more students receiving school-based services than community-based services; however, district-reported service data may be unreliable.** The MHAA outcome and expenditures report template also requires districts to provide information on the services students receive and the associated providers. Students may receive school-based or community-based services. (See Exhibit 19.)

**Exhibit 19**
**Districts Reported That More Students Receive School-Based Services Than Community-Based Services**




Note: The figures presented above present all data reported to the Florida Department of Education, including students served from county-based school districts and students reported by lab schools.

Source: OPPAGA analysis of district Mental Health Assistance Allocation outcome and expenditure reports.

In some instances, outcome reports also show that more students receive services than are referred to services. For example, in 2021-22 districts reported 164,080 students were referred for school-based services and 222,673 students received school-based services. This reporting indicates that 58,593 more students received school-based services in 2021-22 compared to the number of students referred to these services. Districts reported multiple reasons for this result, including that students generally received services without a formal referral (e.g., services by a school counselor). Another reported reason for this discrepancy is that students in crisis may receive services prior to a formal referral due to the urgent need for action.

Further, FDOE does not specify in writing how districts should define the measures requested within the MHAA reporting templates. As a result, districts have not uniformly reported MHAA service-related data and may have provided unreliable counts of students receiving services. For example, districts

have interpreted the meaning of *targeted mental health screenings and assessments* in different ways. In 2023-24, one district included only suicide risk assessments in the total number of students who received targeted mental health screenings or assessments, while another included suicide risk assessments, behavioral threat assessments, and behavioral health screenings. As a result, the total number of students screened or assessed in the second district was nearly five times greater than the first district even though these districts are similar in total student enrollment. FDOE is aware that districts do not have a universal understanding of how to count targeted screenings and assessments and reported that the department addresses the issue with verbal guidance during webinars and safety summits rather than written guidance to all districts.

Districts also reported that students may be counted more than once in total numbers of students assessed, referred to, or receiving services. For example, one district did not begin tracking students with unique identifiers until the 2023-24 school year and stated that this could have resulted in students being counted multiple times. Another district explained that because services and interventions are provided by multiple mental health providers, it is unlikely but possible that students have been counted more than once. FDOE could reduce reporting-related challenges and improve data quality by issuing standard definitions of the measures collected in MHAA reports.

## Additional district reporting could provide more information about MHAA program effectiveness

Information collected through the annual MHAAPs and outcome and expenditures reports includes measures related to treatment, system capacity, performance, and integration with community behavioral health providers. OPPAGA identified 15 additional measures that could be used to evaluate effectiveness and surveyed districts on the feasibility of providing information for each measure. Ten of the 15 measures are already collected by several districts or would be feasible for other districts to collect.

**Information collected through MHAAPs and outcome and expenditure reports is not sufficient to evaluate the effectiveness of services provided through the MHAA program.** Data currently reported by districts through MHAAPs and outcome and expenditures reports describe program outputs related to treatment, system capacity, performance, and integration with community behavioral health services. For example, districts report treatment outputs such as the number of students who receive targeted mental health screenings or assessments and system capacity outputs such as the number of mental health staff hired by districts. (See Exhibit 20.) These measures provide useful information for assessing program implementation but have limited value for evaluating effectiveness or whether a program is achieving intended goals. For example, knowing the number of students who received interventions, services, or assistance does not indicate whether these services resulted in improved behavior or reduced symptoms.

Exhibit 20

Most Mental Health Assistance Allocation Output Measures Currently Reported by Districts Provide Treatment Information

**Treatment**

- Number of students who received targeted mental health screenings or assessments
- Number of students referred to school-based and community-based mental health services providers
- Number of referrals made to school-based and community-based mental health services providers
- Number of students who received school-based and community-based interventions, services, or assistance

**System Capacity**

- Number of school-based and community-based providers by licensure type
- Direct employment ratios for school counselors, psychologists, social workers, and other licensed mental health professionals

**Performance**

- Number of evidence-based mental health intervention and treatment programs

Source: OPPAGA analysis of literature and district Mental Health Assistance Allocation outcome and expenditures reports.

**Many districts do not track information related to the effectiveness of services.** Although evidence-based programs are expected to achieve targeted (i.e., defined) treatment outcomes, only 9 of the 60 districts that responded to OPPAGA's survey reported measuring treatment outcomes for all MHAA programs, and 18 districts reported measuring treatment outcomes for only some MHAA programs. In addition, one district reported not knowing whether targeted treatment outcomes are measured for all MHAA programs, and five provided write-in responses rather than selecting from the response option list. Write-in responses included descriptions of non-targeted pre- or post-outcome measures and measures not associated with individual programs like change in number of school-related involuntary examinations. Some examples of district-reported treatment outcome measures included symptoms of anxiety and depression, level of functioning, improved attendance, and improved grades. In contrast, 27 districts reported not collecting treatment outcomes for any of the evidence-based programs. The most common reasons for not doing so were the lack of a requirement (17 districts), lack of staffing or other resources (8 districts), and lack of information from programs about which data to collect (6 districts).[35]

**OPPAGA identified additional measures that would provide information about MHAA program effectiveness**. OPPAGA's review of relevant literature and interviews with school mental health experts identified additional measures related to treatment, system capacity, and performance that could be used to evaluate MHAA programs within each level of the MTSS.[36] Examples of treatment outcome measures for Tier 1 supports (i.e., supports for all students) are universal mental health screening results and school climate survey results. Examples of treatment outcome measures for Tier 2 and 3 supports and services are targeted treatment outcomes for individual interventions and school-specific measures of student well-being (e.g., attendance, grades, disciplinary actions). MHAA program effectiveness could be evaluated by measuring change over time in the outcomes identified. Four of the treatment outcomes—attendance, days absent, grade point average, and

[35] As of July 1, 2025, districts are required to incorporate the use of the Daily Living Activities-20 functional assessment tool into district mental health assessment procedures.

[36] Twelve of the measures identified by OPPAGA are outcome measures and indicators of program effectiveness. The exceptions are student-level system capacity output measures (i.e., number of hours of Tier 2 and 3 school-based services received, time from assessment to initiation of services by school, and time from referral to initiation of services by outside providers) that would complement the staff-level system capacity output measures currently reported by districts (i.e., staff-to-student ratios). Staff-to-student ratios do not provide insight into the amount of service time provided to students with varying levels of need, a component of system capacity. Staff-to-student ratios also do not provide insight into the timeliness of services provided to students receiving Tier 2 or 3 services. Data on the additional system capacity outputs identified in Exhibit 21 would fill these information gaps.

discipline/resultant action—should be measured for students identified as needing improvement in these areas rather than all students receiving Tier 2 or 3 supports and services. (See Exhibit 21.)

**Exhibit 21**
**OPPAGA Identified 15 Outcome Measures of Treatment, System Capacity, and Performance**

| Measure Category | Measure | Tier Target Population |
|---|---|---|
| Treatment | Universal mental health screening results | 1 |
| | School climate survey results | 1 |
| | Targeted treatment outcomes of programs and interventions delivered to students assessed to have or be at risk of developing specific mental health conditions (e.g., depression, anxiety) | 2 and 3 |
| | Attendance (for students identified as needing to improve attendance) | 2 and 3 |
| | Days absent (for students identified as needing to reduce days absent) | 2 and 3 |
| | Grade promotion | 2 and 3 |
| | Grade point average, by term (for students needing to improve grade point average) | 2 and 3 |
| | Graduation status (when applicable) | 2 and 3 |
| | Student discipline/resultant action (for students identified as needing to improve behavior) | 2 and 3 |
| System Capacity | Teacher/staff well-being self-reports (e.g., well-being survey results) | 1 |
| | Number of hours of Tier 2 and 3 school-based services received | 2 and 3 |
| | Time from assessment to initiation of services by school | 2 and 3 |
| | Time from referral to initiation of services by outside providers | 2 and 3 |
| Performance | Student satisfaction with mental health care received | 2 and 3 |
| | Family satisfaction with mental health care received | 2 and 3 |

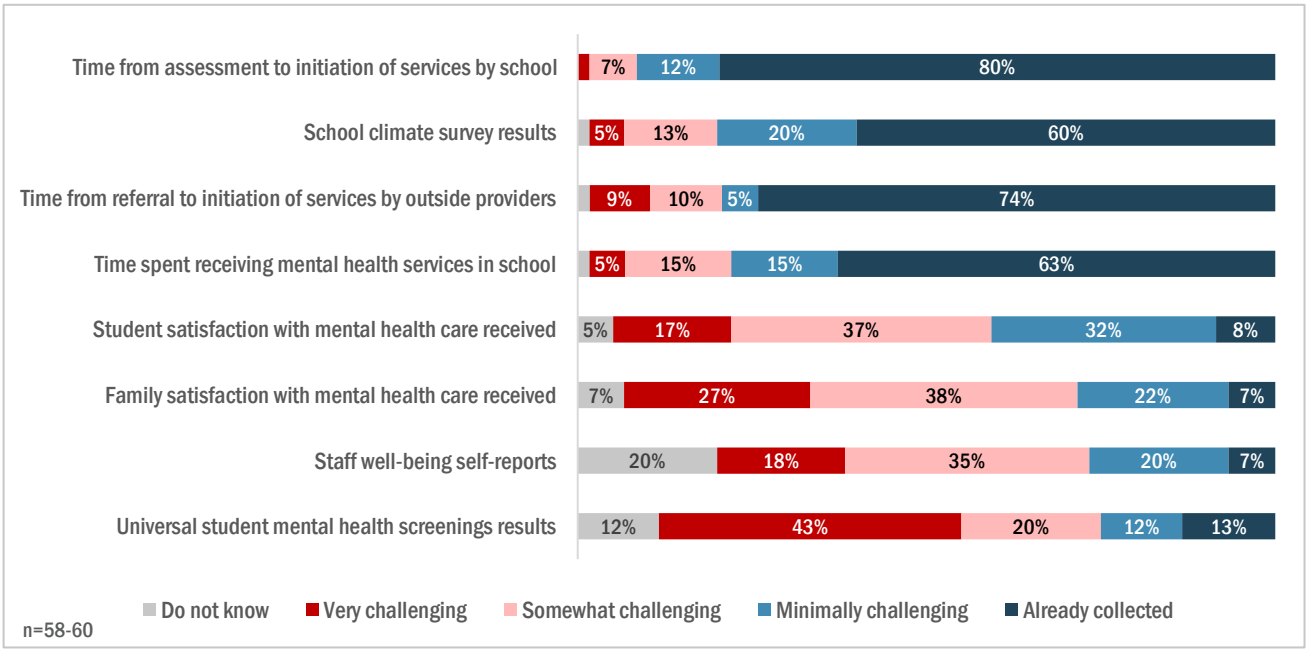
Source: OPPAGA analysis of literature and interviews.

OPPAGA's survey and other field work asked districts which of the 15 measures are currently collected for the indicated target population(s). The survey did not ask how feasible it would be for districts to collect measures that districts already collect for other purposes, including attendance, grade and graduation, and discipline-related information.[37] Over half of the districts reported collecting information on four of the measures—school climate survey results, time from assessment to initiation of services by school, time spent receiving services in school, and time from referral to initiation of services by outside providers. (See Exhibit 22.) Over half of districts reported four potential measures as somewhat or very challenging for districts to collect—family satisfaction with services, student universal mental health screening results, student satisfaction with mental health care received, and staff well-being reports.

[37] OPPAGA interviewed district mental health coordinators about data collection for targeted treatment outcomes of programs and interventions delivered to student receiving Tier 2 and 3 services instead of including this item on the survey. Those results are described in the next section.

Exhibit 22

District Opinions Varied Regarding the Feasibility of Collecting Identified Mental Health Assistance Allocation Evaluation Measures




Note: The number of districts responding to each measure varies because not all districts answered each question. OPPAGA asked districts to indicate the time and effort it would take the district to collect information for each of the measures. Percentages under 5% are not displayed in the chart above.

Source: OPPAGA analysis of district survey responses.

**It may be challenging for districts to aggregate and report targeted treatment outcomes for students receiving Tier 2 or 3 supports and services.** District staff from two districts that OPPAGA interviewed reported collecting treatment outcomes data by mental health condition. For example, a targeted treatment outcome for major depression could be remission or reduction in depressive symptoms, while a targeted treatment outcome for ADHD could be improved behavior. However, different treatment providers may use different instruments to assess the same outcome. For example, depression in children can be measured with at least five different instruments. Thus, reporting targeted treatment outcomes for students receiving Tier 2 or 3 supports and services likely would be very challenging for districts to aggregate and report across mental health conditions, providers, or instruments. However, experts that OPPAGA interviewed indicated that treatment outcomes should be monitored for individual students to ensure treatments are effective. Districts currently report information on attendance, days absent, grade point average, grade promotion, graduation status, and discipline/resultant action. These measures would be useful for students receiving Tier 2 or 3 services who are identified as needing support in these areas. Fifty-two districts reported that the district can identify a list of students receiving Tier 2 or 3 services. Therefore, districts may be able to provide information on these indicators for students receiving Tier 2 and 3 services.

## Most school districts reported working with existing community behavioral health services but often identified a need for more service providers

School staff provide mental health services to students, but districts also contract directly with community-based providers for specialized services or with managing entities that coordinate care for these types of services. Districts reported challenges employing qualified mental health providers in

numbers sufficient to meet student needs and challenges connecting students to community providers despite being satisfied with the services provided by managing entities.

**Districts reported providing students mental health and substance abuse services directly or by collaborating with managing entities.** Although districts hire mental health professionals such as social workers and counselors, districts also refer students to community-based behavioral providers for more specialized services. For example, districts may enter into agreements with psychiatrists to treat students who need psychiatric services (e.g., consultation, medication prescriptions, and medication management). Integration with community behavioral health services helps ensure that students receive necessary services, even when such services are not available at the school district. School districts also may work through managing entities to obtain behavioral health services for students from providers in the behavioral health community. Section 394.9082, *Florida Statutes*, requires the Florida Department of Children and Families to evaluate managing entities' engagement with local systems, such as school districts. Managing entities are also required to promote and support care coordination activities to help improve outcomes among individuals identified as priority populations by DCF, which may include some K-12 students.[38]

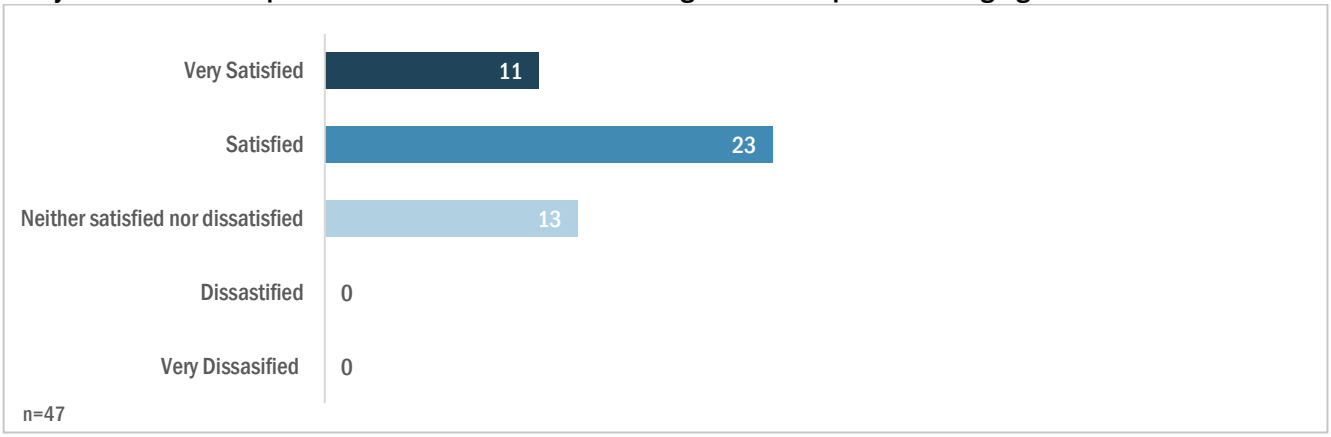
To understand the type and extent of engagement between districts and managing entities, OPPAGA surveyed districts about district relationships with managing entities and reviewed reports issued by managing entities and DCF. Forty-seven districts that responded to OPPAGA's survey reported working with a managing entity to provide services in some capacity. Two districts contract with a managing entity and six districts have a memorandum of understanding (MOU) with a managing entity.[39] The remaining districts have an informal partnership with the region's managing entity. For example, districts with informal partnerships may receive periodic professional development from the managing entity or meet regularly without a formalized agreement. Districts that reported not working with a managing entity stated that the district utilized outside agencies and school-based providers.

Thirty-four districts that reported working with the region's managing entity are satisfied or very satisfied with the working relationship. (See Exhibit 23.) Districts that reported satisfaction with the working relationship also reported that the managing entity had good communication and collaboration with the district. For example, one district reported that the managing entity attends monthly mental health meetings to coordinate services for students receiving Tier 2 or 3 services and their families. Among districts that indicated the district was neither satisfied nor dissatisfied with the managing entity working relationship, one district reported disappointment with the quality of providers funded by the managing entity and another district stated that lack of data prevented comprehensive evaluation of the managing entity performance to adequately support students and families.

[38] DCF program guidance for managing entity contracts outlines priority populations that may benefit from care coordination. These populations include children in the child welfare system with behavioral health needs; children and adolescents diagnosed with a mental health, substance use disorder, or co-occurring disorder; and children on a waitlist to receive services from a Community Action Treatment Team.

[39] Contracts are legally binding agreements that outline specific obligations, services, financial commitments, and enforceable terms. MOUs are a non-binding documents that establish a framework for cooperation, roles, and responsibilities without creating legal liability.

Exhibit 23
Thirty-Four Districts Reported Satisfaction With the Working Relationship With Managing Entities

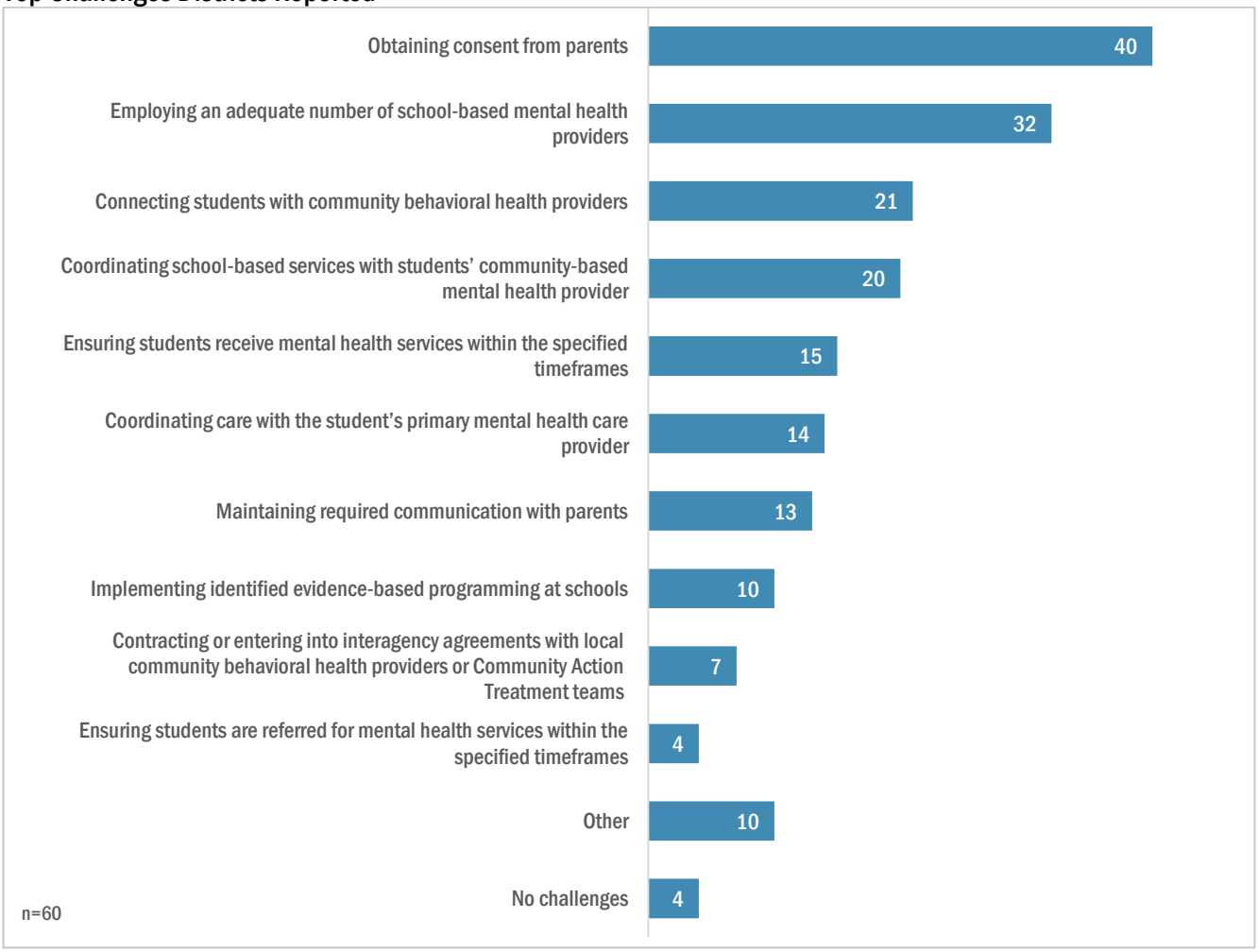



Source: OPPAGA analysis of district survey responses.

Districts also identified several challenges associated with MHAAP implementation. For example, districts most often reported challenges obtaining consent from parents to provide mental health services (40 districts), hiring adequate mental health staff (32 districts), and connecting students with community providers (21 districts). (See Exhibit 24.)

Exhibit 24

Employing School-Based Providers and Connecting Students With Community-Based Providers Are Among the Top Challenges Districts Reported




Note: Other challenges reported included needing additional funding for employment of providers and community-based mental health agencies having a waitlist for services.

Source: OPPAGA analysis of district survey responses.

**More than half of school districts reported a need for more service providers.** Thirty-five districts that responded to OPPAGA's survey reported there are not sufficient community-based providers available in the region, and 30 districts reported that initial wait times for community-based providers did not meet student needs. One district explained that the issue of limited providers is long-standing and impacts the ability for the community's needs to be met. Another district noted that being in a rural area limits the number and quality of community-based behavioral health providers, explaining that if a student is in crisis and needs stabilization, they must be transported 30 minutes away. A third district reported that community providers, such as CAT teams, have waitlists of several months.

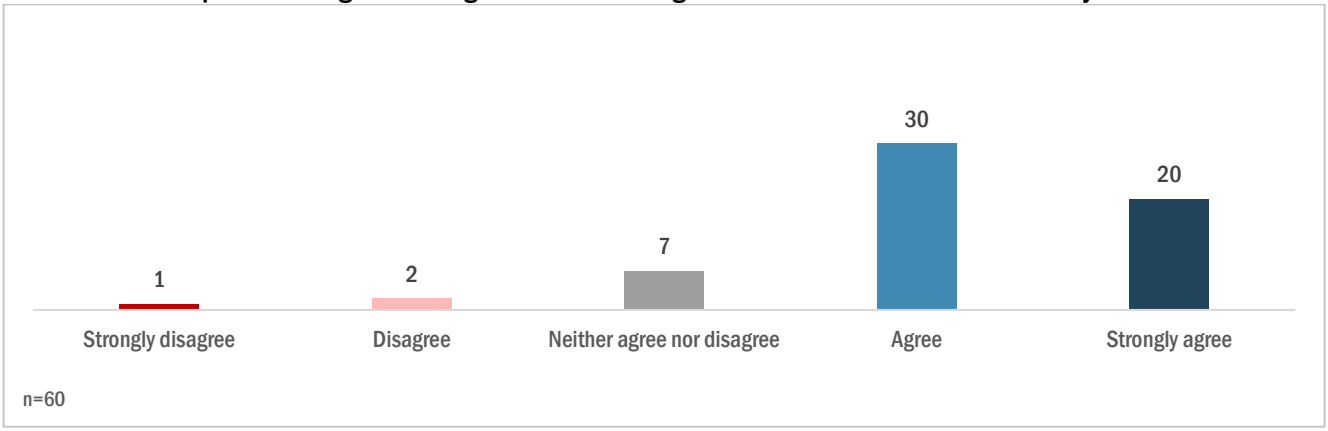
## School districts reported being well integrated with existing community behavioral health services, but more information is needed to evaluate the extent of integration

While districts reported that the school district is well-integrated into the region's behavioral health community, more information about relationships between districts and key stakeholders is needed

to assess these relationships. OPPAGA identified measures that could be used to further evaluate district integration with community behavioral health partners.

**Fifty districts reported being well-integrated into the region's behavioral health community**. Currently, districts report on the number of agreements or MOUs with community partners. However, districts do not provide information related to communication mechanisms, documentation of procedures or systems, routine meetings, or coordination. Information on the number of contracts or agreements a district has with external entities does not provide insight into the quality or functioning of those relationships. OPPAGA's survey asked districts how well-integrated the districts are with the behavioral health community. Fifty districts reported being well-integrated into the region's behavioral health community. (See Exhibit 25.) Districts reported participating in various community meetings and task forces, such as the Mental Health Task Force and Behavioral Health Task Force. Some districts also reported entering into agreements with mental health agencies and community organizations. Districts that reported not being well integrated into the region's behavioral health community explained that the district's community has limited providers.

**Exhibit 25**
**Most Districts Reported Being Well-Integrated Into the Region's Behavioral Health Community**




Source: OPPAGA analysis of district survey responses.

**Managing entity reports provide limited information on the integration of services with school districts.** Managing entities are required to submit multiple reports to DCF to provide information related to entity integration into the communities served, including school districts, such as triennial community behavioral health needs assessments, annual enhancement plans, care coordination plans, and coordinated children's system planning reports. OPPAGA reviewed care coordination plans and the *2024 Annual Assessment of Behavioral Health Services* to identify information pertaining to integration with school systems.[40]

In the care coordination plans, six of seven managing entities identified school-aged children and adolescents with high needs for mental health services as priority populations. Managing entities did not specifically discuss integration with school districts in these reports; however, some reports discuss activities involving schools. For example, two managing entities reported attending meetings that include school systems, one managing entity identified developing partnerships or agreements

[40] Section 394.4573, *F.S.,* requires DCF to submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives an annual assessment of behavioral health services in the state. The annual assessment must, at minimum, consider the needs assessments conducted by the managing entities pursuant to the managing entity duties outlined in s. 394.9082(5), *F.S*

with school districts as a goal, and a fourth managing entity noted receiving referrals from educational systems and providing services at schools through mobile response teams.

DCF's *2024 Annual Assessment of Behavioral Health Services*, which is comprised of various documents that managing entities submit to the department, did not expressly describe integration of behavioral health services into school districts. Rather, the report's references to schools and school districts described school-based programs and services in need of funding as well as interactions with stakeholders associated with school mental health (e.g., attending community education events with schools).

**OPPAGA identified several measures that could be used to evaluate integration of school districts with community behavioral health services.** These include the frequency or extent to which schools ensure coordination across school-community teams and limit duplication of screening, assessment, or survey tool(s). These items might be assessed through data collection or by asking districts to report experiences using a survey. For example, the National Center for School Mental Health recommends asking districts to indicate, for each item, whether the district never, rarely, sometimes, often, almost always, or always completes the action. (See Exhibit 26.)

Exhibit 26
Information Provided by Districts Could Be Used to Assess District and Local Community Behavioral Health System Integration

| Measure | |
|---|---|
| **The extent or frequency with which the district…** | …uses memorandums of understanding or other agreements to detail the terms of the partnership between the district and community partners (e.g., by whom, what, when, where, and how will services or supports be provided)[1] |
| **The extent or frequency with which schools in the district…** | …establish communication mechanisms (e.g., team meetings, email communications, conference calls) to ensure ongoing and effective communication between school staff and community partners |
| | …ensure appropriate documentation procedures and systems are in place to facilitate communication between school staff and relevant community partners. Examples may include release of information forms and consent forms that are compliant with federal privacy laws, such as the Health Insurance Portability and Accountability Act and the Family Education Rights and Privacy Act, as applicable[2,3] |
| | …hold routine referral feedback meetings or use referral feedback forms to let referral sources know the outcome of the referral |
| | …ensure coordination across school-community team and limit duplication of screenings, assessments, and survey tools |

[1] A memorandum of understanding is a non-binding document that establishes a framework for cooperation, roles, and responsibilities without creating legal liability.
[2] The Health Insurance Portability and Accountability Act establishes federal standards protecting sensitive health information from disclosure without a patient's consent.
[3] The Family Education Rights and Privacy Act is a federal law that affords parents the right to have access to their children's education records, the right to seek to have the records amended, and the right to have some control over the disclosure of personally identifiable information from the education records.

Source: OPPAGA analysis of the quality assessment tool from the National Center for School Mental Health.

# RECOMMENDATIONS

The Florida Department of Education should ensure that Mental Health Assistance Allocation program data are reported consistently over time and collect additional data to improve future evaluations of the MHAA program. The Legislature may wish to amend s. 1006.041, *Florida Statutes*, to require FDOE to collect data for specific expenditure categories.

**FDOE should minimize changes to data collection and provide clear, written definitions of the measures to ensure data is consistently reported over time.** FDOE has changed expenditure report templates year-to-year. These template changes complicate MHAA data analysis. For example, FDOE removed a column used to track a specific type of expenditure in 2023-24. Districts itemized these expenditures as *additional expenditures* along with other unrelated expenses; this data cannot be analyzed without first isolating these expenses, a process that would require outreach to individual districts. FDOE should provide clearly written guidance on how districts should report expenditures and remain consistent in expenditure categories requested year-to-year. In addition, the Legislature may want to consider identifying specific expenditure categories of legislative interest for FDOE to request from districts.

FDOE reported that districts do not have a universal understanding of the meaning of *targeted screening or assessment*. To address this issue, FDOE should define it in writing within the outcome and expenditures report template. The department should also include instructions for reporting distinct (i.e., unduplicated) units in unit counts (e.g., number of students who received targeted screenings or assessments) in the templates.

**FDOE should collect additional information to improve future evaluations of the MHAA program.** The measures currently reported by districts in MHAA reports should be supplemented with additional measures including school climate survey results, attendance for specific students, and number of hours students receive services. (See Exhibit 27.)

**Exhibit 27**
**The Florida Department of Education Should Collect School Climate Information and Target Additional Data Collection for Students Receiving Tier 2 or 3 Services**

| Measure | Tier Target population |
|---|---|
| School climate survey results | 1 |
| Attendance | 2 and 3 students identified as needing to improve attendance |
| Days absent | 2 and 3 students identified as needing to reduce days absent |
| Grade promotion | 2 and 3 |
| Grade point average | 2 and 3 students needing to improve grade point average |
| Graduation status (when applicable) | 2 and 3 |
| Student discipline/resultant action | 2 and 3 students identified as needing to improve behavior |
| Number of hours of Tier 2 and 3 school-based services received | 2 and 3 |
| Time from assessment to initiation of services by school | 2 and 3 |
| Time from referral to initiation of services by outside providers | 2 and 3 |

Source: OPPAGA analysis of literature, interviews, and district survey responses.

# OPPAGA

Office of Program Policy Analysis and Government Accountability

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