



# Mental Health and Substance Use Report on Expenditures and Services

District of Columbia Department of Behavioral Health

LaQuandra Nesbitt, M.D., M.P.H., Interim Director

## Mental Health and Substance Use Report on Expenditures and Services (MHEASURES)

January, 2019

### Overview

The mission of the DBH is to support prevention, treatment, resiliency, and recovery for District residents with mental health and substance use disorders through the delivery of high quality, integrated services. DBH serves children and youth with a diagnosis of severe emotional disturbance (SED) and adults with severe mental illness, as well as youth and adults with substance use disorders. District residents who meet the enrollment criteria are eligible to receive the full range of behavioral health services and supports. Integrated services are available for individuals who have co-occurring disorders.

### Mental Health

DBH provides an array of mental health services and supports through a Mental Health Rehabilitation Services (MHRS) option. This includes: (1) Diagnostic and Assessment, (2) Medication/Somatic Treatment, (3) Counseling, (4) Community Support, (5) Crisis/Emergency, (6) Rehabilitation/Day Services, (7) Intensive Day Treatment, (8) Community Based Intervention, (9) Assertive Community Treatment, (10) Transition Support Services, and (11) Health Homes. In addition, a variety of evidence-based services and promising practices are offered to those enrolled in the system of care. These include wraparound support, trauma-informed care, school mental health services, early childhood services, suicide prevention, forensic services, peer support, and supported employment.

DBH contracts with 33 core service agencies and 11 sub-and specialty providers to carry out the majority of mental health services. In addition, DBH operates adult and child clinics that provide urgent care and crisis emergency services. Outreach and treatment services are also provided through the Homeless Outreach Program.

### Substance Use

The Department supports four Prevention Centers that conduct community education and engagement activities related to substance use prevention across all eight wards. This includes training young people to support the Prevention Centers' capacity-building efforts focused on youth leadership and outreach to the youth population. DBH has developed the Prevention Policy Consortium made up of more than 15 District agencies and national leaders to bolster the substance use prevention infrastructure and system.

DBH also contracts with 33 treatment and recovery providers that provide services for adolescents and adults with substance use disorders (SUD). Individuals who want to obtain services go through the Access and Referral Center (ARC) and other intake sites. During the intake process, clients participate in a comprehensive assessment and evaluation to determine the appropriate level of treatment and maintenance care. A comprehensive continuum of substance abuse treatment services, including outpatient, intensive outpatient, residential, detoxification and stabilization, and medication assisted therapy is available within the system of care. Clients may also receive recovery support services, either concurrently with or subsequent to treatment. Recovery services include care coordination services, recovery coaching/mentoring, education support services, transportation, and limited housing (up to 6 months) to help foster a stable recovery environment.



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SUD services for adolescents are provided through the Adolescent Substance Abuse Treatment Expansion Program (ASTEP). Four certified substance use disorder treatment providers offer these specialized services. Screening, assessment, out-patient and in-patient treatment, and recovery services and supports are provided.

## Contents

The Mental Health and Substance Use Report on Expenditures and Services (MHEASURES) provides a summary of key agency measures related to service cost, utilization and access to the public behavioral health system. Specifically, the following information is contained within this document:

- Gender and race distribution for individuals receiving mental health and substance use services is presented in *Figures 1 and 2*;
- Individuals receiving services from both mental health and substance use providers is shown in *Figure 3*;
- Medicaid penetration information is shown in *Figure 4*;
- Mental health enrollment data is presented in *Figures 5, 6, and 7*;
- Mental health funding sources are shown in *Figures 8 and 9*;
- Mental health cost and utilization data based upon claims expenditures for the first two quarters of Fiscal Year 2015 is presented in *Figures 10-17*;
- Substance use clients served by treatment and recovery programs are shown in *Figure 18*;
- Clients receiving both treatment and recovery substance use services are presented in *Figure 19*;
- Substance use assessment and admissions data is shown in *Figures 20 and 21*;
- Substance use services by Level of Care are shown in *Figure 22*;
- Substance use expenditure breakouts are presented in *Figure 23 and 24*; and
- Primary drug of choice is presented in *Figure 25*.

Reports are published in January of each fiscal year.

MHEASURES contains information regarding mental health services paid for through Medicaid claims and local dollars, and substance use services paid for through the Substance Use Block Grant, Medicaid, and local dollars. This report reflects services provided to individuals participating in the District's public behavioral health system.

## Limitations of the Report

**1. Mental health findings are based solely on the public mental health system's claims data.** Individuals in care receive a wider array of services than what is reflected through DBH claims data. Many of these services are delivered through other arrangements. For example, approximately seventy percent of all Medicaid recipients are enrolled in a managed care plan, through which they may receive mental health or behavioral health services outside of the public mental health system. Individuals who are not enrolled in managed care may also access other mental health or behavioral health services delivered through non-MHRS providers such as free-standing mental health clinics, independent psychiatrists or other qualified professionals that would also not be captured in the DBH mental health claims data set.



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**2. Only those mental health services that are paid through claims are included in the data set of information summarized for this report.** DBH provides a robust array of additional contracted services that are supported with local and grant dollars that enhance the quality of care provided to individuals with mental illness and their families, which are not reflected in this report. This includes prevention and intervention services provided through school based mental health, homeless outreach services, early childhood services, wraparound support, forensic services, housing, transition-age youth services, portions of supported employment services, and suicide prevention services.

**3. Due to the way information is tracked in the electronic data system being used by DBH, there is still a need for data cleanup.** For example, newly enrolled consumers and consumers transferring providers are indistinguishable. When a provider closes, large numbers of consumers are transferred to new providers and enrollment data appears skewed.

## Summary of Findings

The Department of Behavioral Health continues to develop a robust array of services to meet the mental health and substance use service needs of the people receiving care. Findings based upon the current analysis of data shows:

**The Department of Behavioral Health served a total of 23,259 mental health consumers in Fiscal Year 2018.** This is an 8% decrease from the 25,191 served in Fiscal Year 2017. The number of children enrolled with MCOs has increased. For this group of consumers, only a subset of MHRS services are billed through DBH, so any child receiving only non-MHRS mental health services would not be present in DBH's data set.

**DBH served 5,186 substance use clients in FY18,** a 9% decrease from the 5,710 served in FY17. This is the third year in a row the number of clients served has decreased. The decrease in clients who received only recovery services over the past three years accounts for approximately half of the total decrease. The number of individuals receiving buprenorphine, a service implemented outside of DBH's programs, has increased steadily over that timeframe.

**The total expenditures for mental health services decreased by \$11 million between FY17 and FY18.** This is the second year expenditures have declined. Community Support had the largest decrease.

**The highest cost driver per consumer within the mental health system was intensive community based services (Assertive Community Treatment, Community Based Intervention, Multi-systemic Therapy and Functional Family Therapy).** The average annual cost per consumer for this service cluster was slightly lower than FY17 for adults (\$9,760 versus \$10,395) and higher for children (\$6,627 versus \$5,906).

**Proportionally, the most costly substance use service was residential (inpatient) treatment, which represented 54% of all expenditures; 29% of episodes were for this level of care.** The second highest percentage of expenditures was for medication assisted treatment (21%); these episodes made up 26% of the total.

**The most frequently used level of care for substance use clients for FY18 was residential.** In FY17, medication assisted treatment was the most frequently-used level of care.



# **Mental Health and Substance Use Report on Expenditures and Services**

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*FY 18 data is based on mental health claims submitted and substance use data entered for dates of service between October 1, 2017 and September 30, 2018.*

***MH Data Source:*** iCAMS, claims data (Run Date: 12/15/2018)

***SUD Data Source:*** WITS, iCAMS (Run Date: 12/15/2018)

***Report prepared by the DBH Data and Performance Management Division***

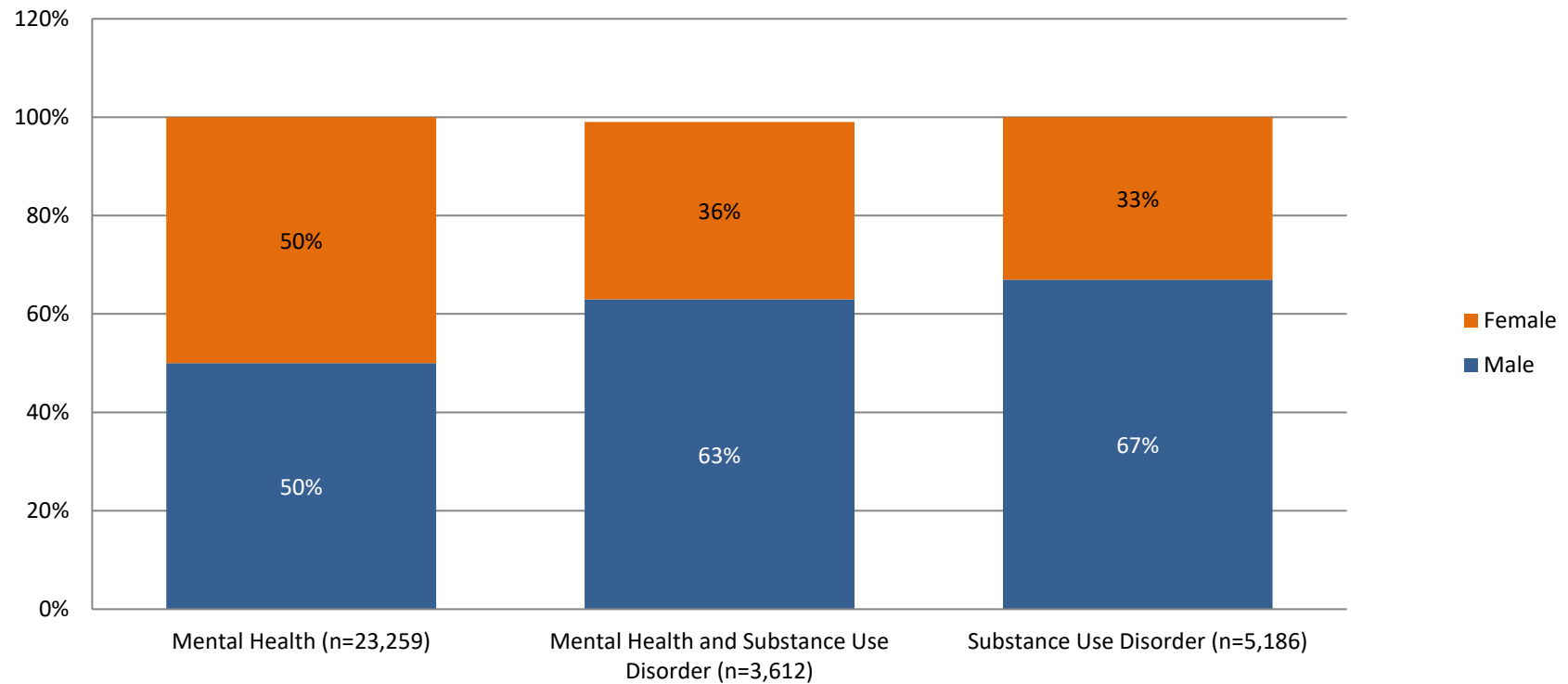


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**Figure 1. Gender FY 2018**

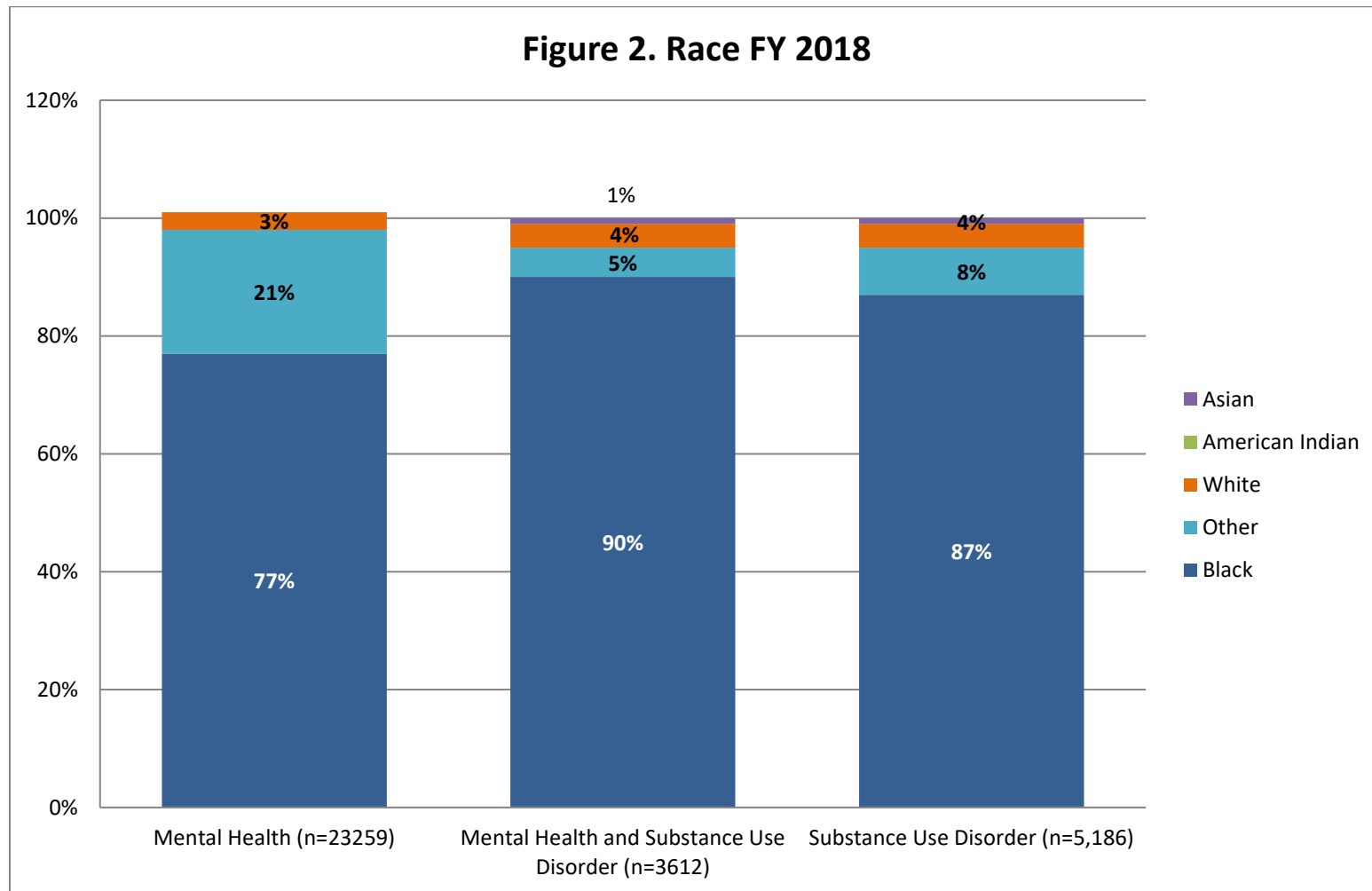




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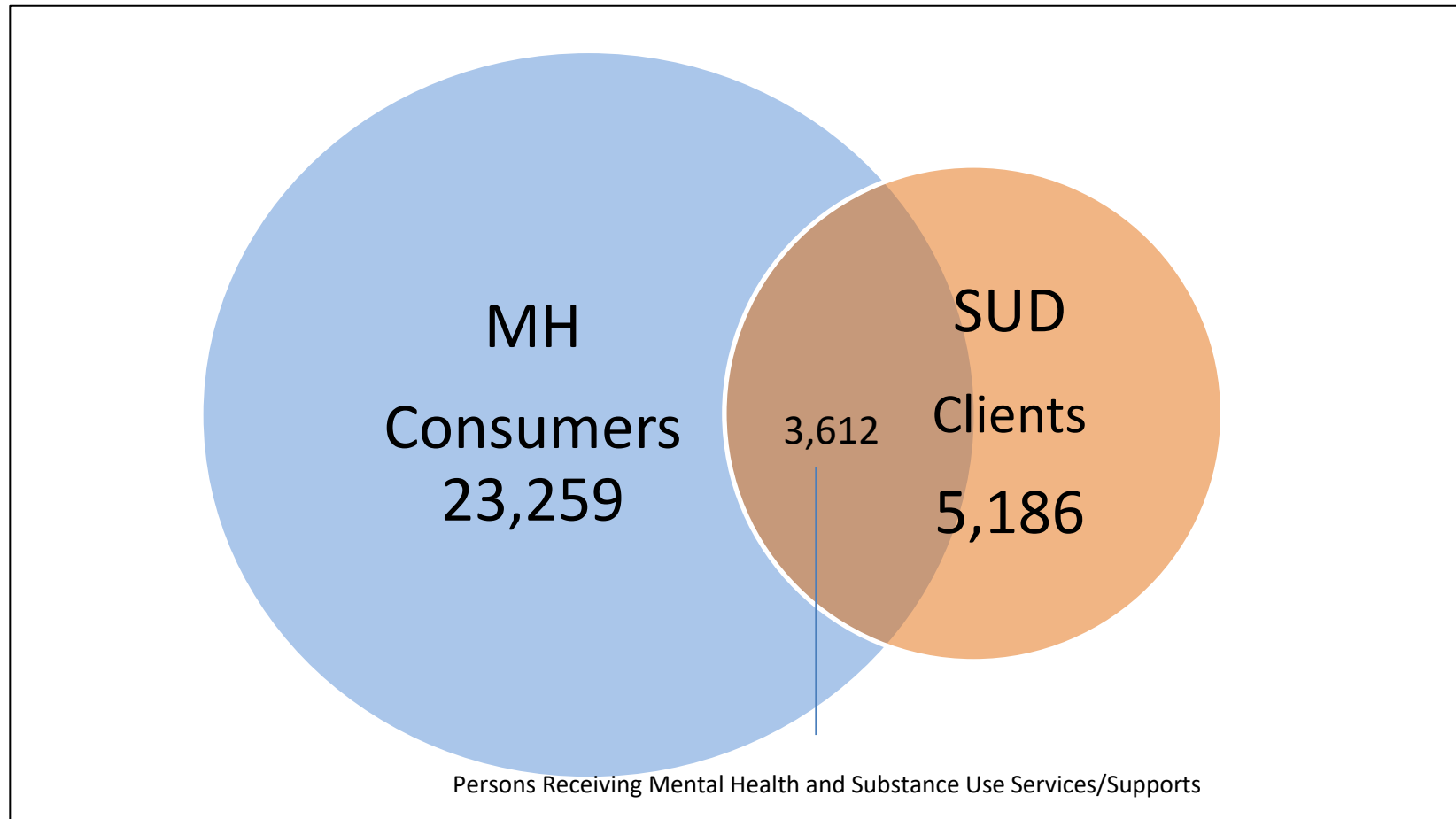


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**Figure 3. Individuals Who Received Mental Health and Substance Use Treatment – FY 18**

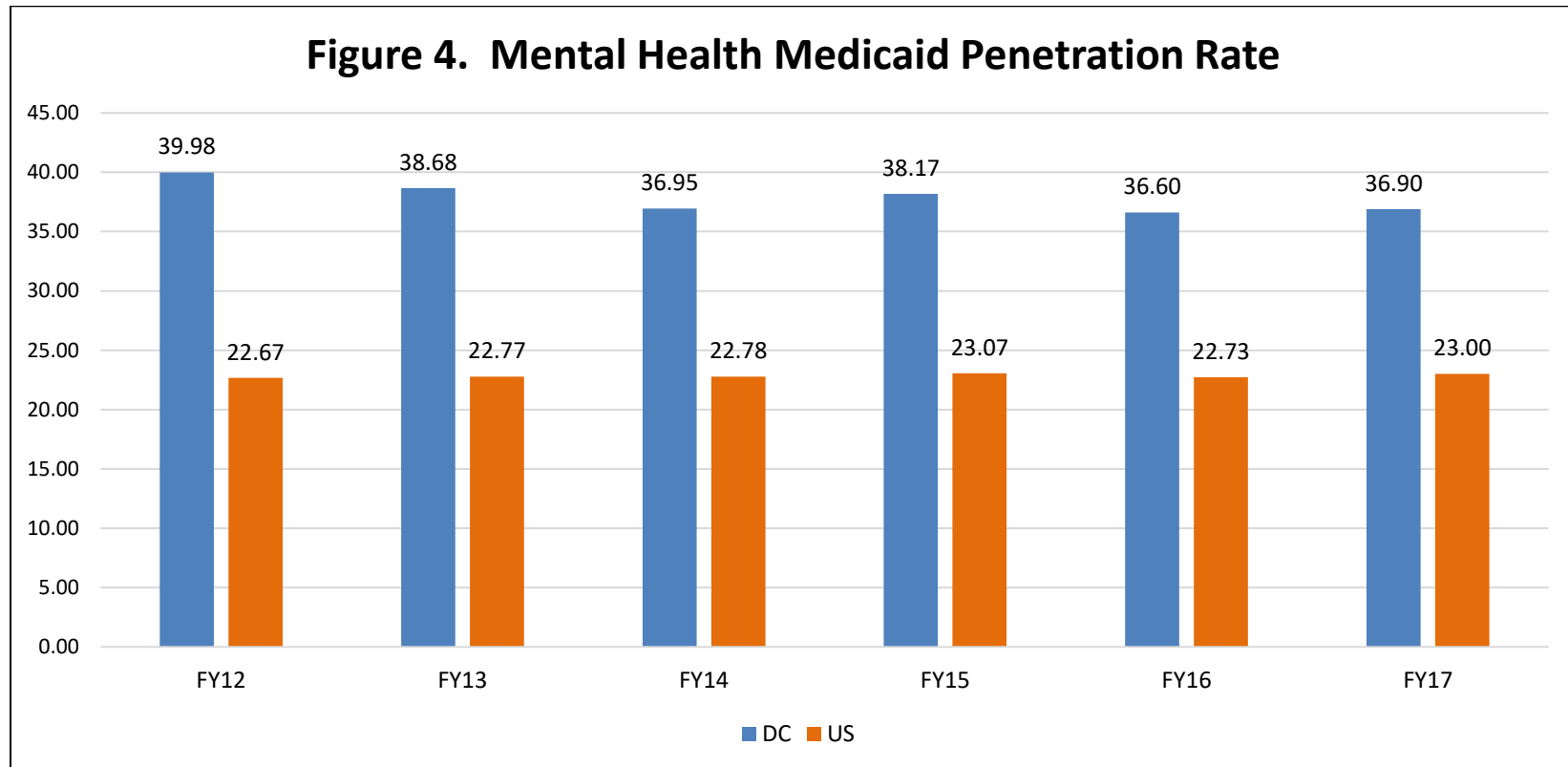




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Penetration rate is calculated by the Substance Abuse and Mental Health Services Administration (SAMHSA).

<https://www.samhsa.gov/data/report/2017-uniform-reporting-system-urs-output-tables>. FY18 data was not available at the time of publication.



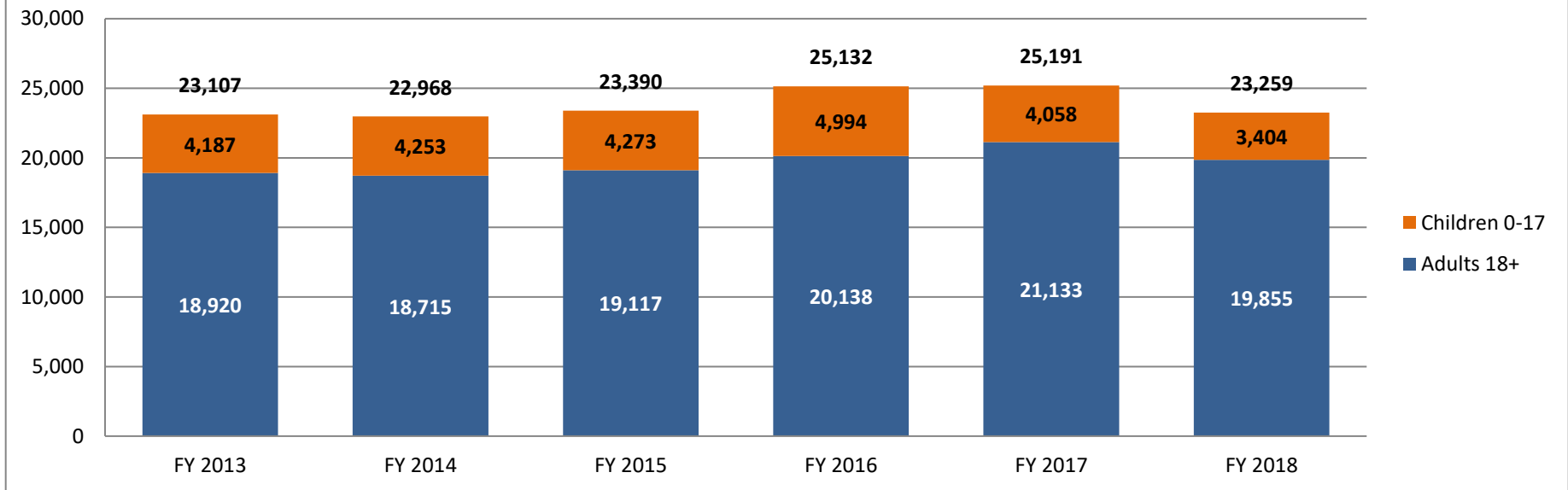


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**Figure 5. Consumers Receiving Mental Health Services by Fiscal Year**



**Children (Age 0-17)**

2% Increase from 2013 to 2014  
0% Change from 2014 to 2015  
14% Increase from 2015 to 2016  
-23% Decrease from 2016 to 2017  
-16% Decrease from 2017 to 2018

**Adults (Age 18+)**

-1% Decrease from 2013 to 2014  
2% Increase from 2014 to 2015  
5% Increase from 2015 to 2016  
5% Increase from 2016 to 2017  
-6% Decrease from 2017 to 2018

**Children & Adults Combined**

-1% Decrease from 2013 to 2014  
2% Increase from 2014 to 2015  
7% Increase from 2015 to 2016  
0% Change from 2016 to 2017  
-8% Decrease from 2017 to 2018

Figure 5 displays the total number of consumers who received mental health services from Fiscal Year 2013 to Fiscal Year 2018. Each number represents an individual consumer who received at least one service within the public mental health system during the specified timeframe.

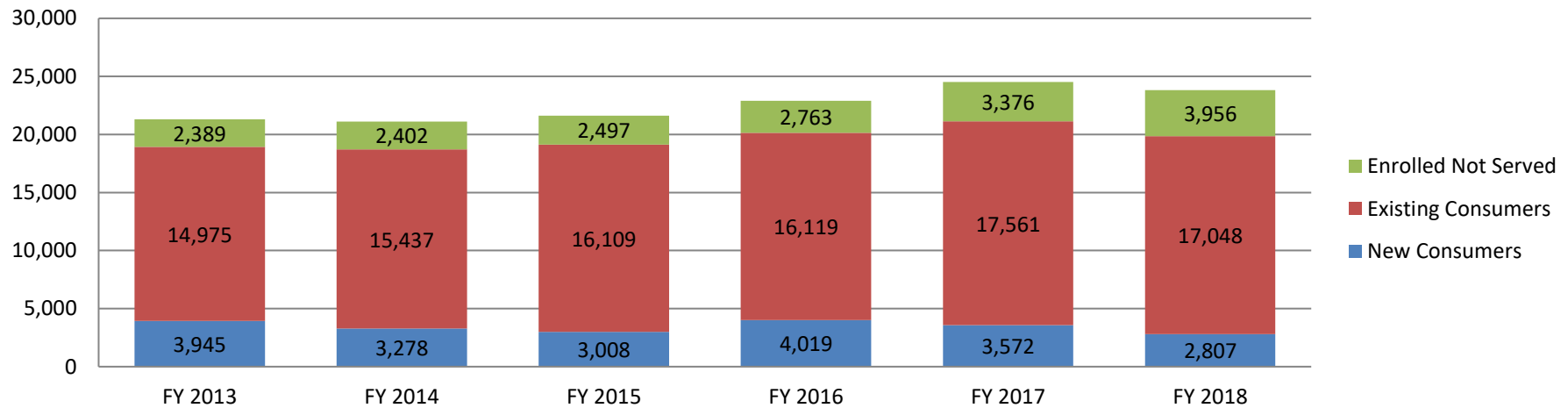


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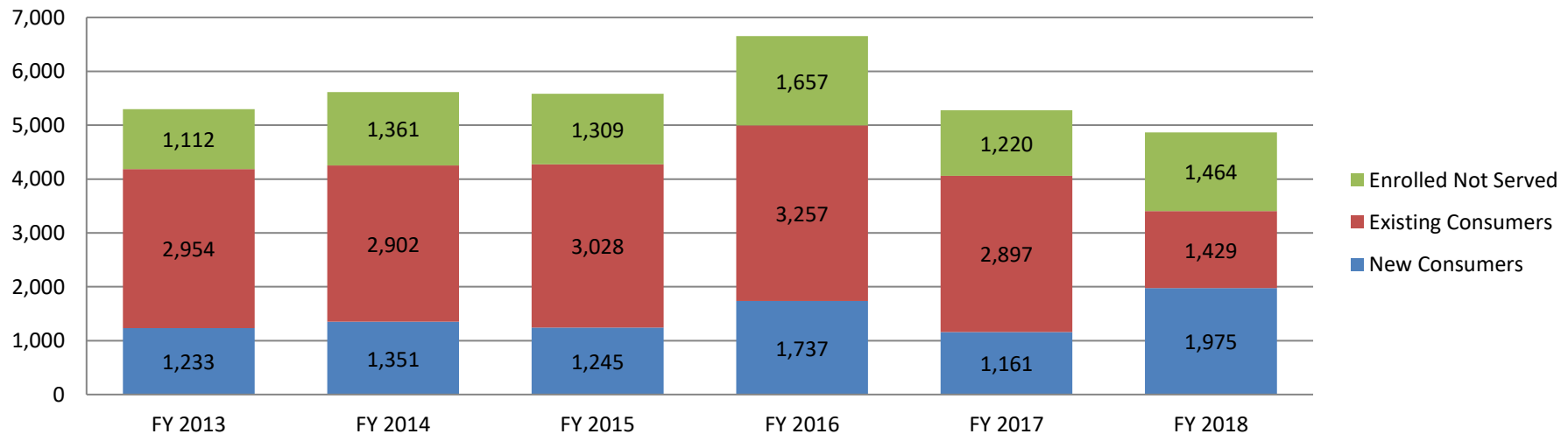
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**Figure 6. Adult (18+) Mental Health Consumers Enrolled & Served**



**Figure 7. Child (0-17) Mental Health Consumers Enrolled & Served**



Figures 6 & 7 display the number of consumers who were either: 1) consumers who were enrolled prior to this reporting period (Existing Consumers), 2) new to the public mental health system (New Consumers), and 3) consumers who were enrolled but did not receive a paid MHRS service during this reporting period (Enrolled Not Served). For the purposes of this report enrollment is defined as linkage to a Core Service Agency (CSA) in the public mental health system.

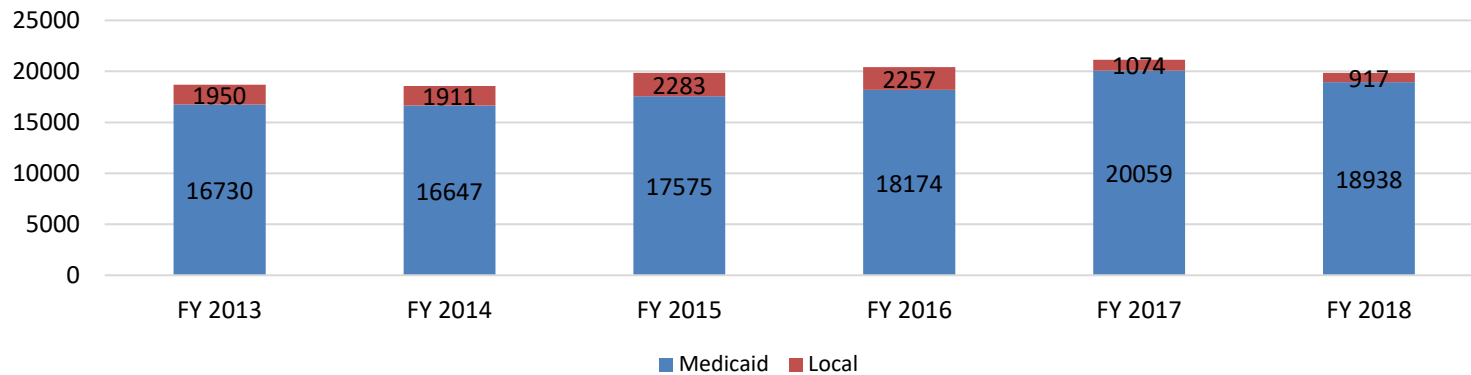


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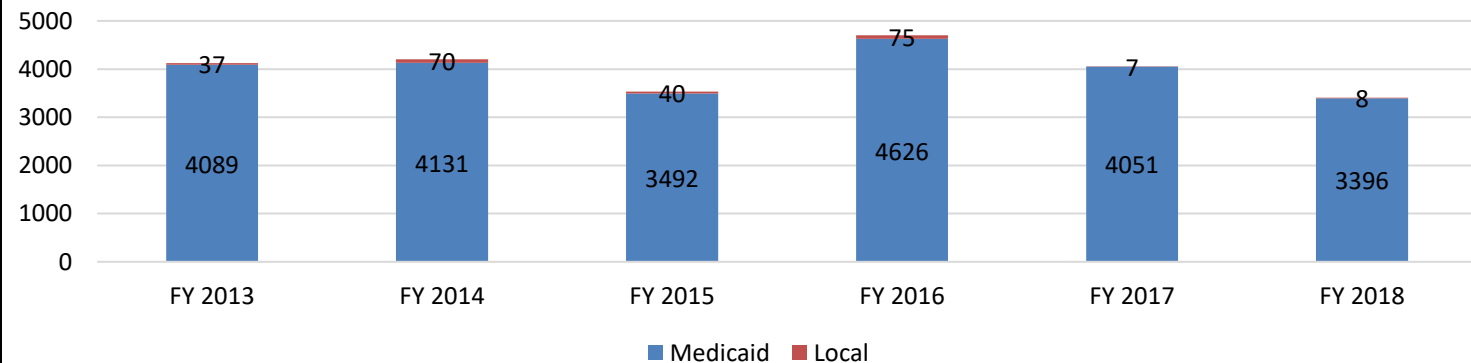
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**Figure 8. Adult (18+) Mental Health Consumers Insurance Type**



**Figure 9. Child (0-17) Mental Health Consumers Insurance Type**



Figures 8 and 9 show the number of consumers who received services that were paid for via Medicaid and those whose services were exclusively paid with local dollars. Consumers who had Medicaid may have had some services paid with local dollars.



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**Figure 10. FY18 Utilization and Expenditure Details**

Service Group	Child Total	Adult Total	Child & Adult Total	Avg Units	Avg Cost Per Consumer	Paid Amount	\$ Change from FY17
<b>ACT</b>	<b>16</b>	<b>2267</b>	<b>2283</b>	<b>272</b>	<b>\$9,745</b>	<b>\$22,247,276</b>	<b>-\$1,006,247</b>
<b>CBI</b>	<b>462</b>	<b>4</b>	<b>466</b>	<b>184</b>	<b>\$6,630</b>	<b>\$3,089,462</b>	<b>-\$814,251</b>
Level I - MST	6	0	6	5	\$278	\$1,665	-\$286,700
Level II & III - 90/180 Day Auth	422	4	426	198	\$7,043	\$3,000,174	-\$441,248
Level IV - FFT	43	0	43	35	\$2,038	\$87,622	-\$86,304
<b>Community Support</b>	<b>2777</b>	<b>15,098</b>	<b>17,875</b>	<b>139</b>	<b>\$2,873</b>	<b>\$51,350,618</b>	<b>-\$7,079,124</b>
<b>Counseling</b>	<b>710</b>	<b>2622</b>	<b>3332</b>	<b>29</b>	<b>\$691</b>	<b>\$2,301,576</b>	<b>-\$137,651</b>
CPP-FV	37	0	37	49	\$1,377	\$50,953	\$28,087
TF-CBT	53	1	54	32	\$1,137	\$61,401	\$27,806
<b>Crisis Services</b>	<b>494</b>	<b>2155</b>	<b>2649</b>	<b>14</b>	<b>\$556</b>	<b>\$1,473,161</b>	<b>\$206,231</b>
Crisis Stabilization	0	69	69	15	\$3,911	\$269,853	-\$136,356
Emergency - Home	48	1979	2027	14	\$457	\$926,297	\$288,682
Emergency - CMHF	350	3	353	9	\$343	\$120,988	\$48,494
Emergency - Mobile Unit	13	376	389	7	\$242	\$93,968	\$32,279
Emergency - Other/Not Identified	198	3	201	8	\$309	\$62,056	-\$26,868
<b>Day Services</b>	<b>0</b>	<b>1229</b>	<b>1229</b>	<b>73</b>	<b>\$8,608</b>	<b>\$10,579,519</b>	<b>-\$1,248,181</b>
<b>D&amp;A</b>	<b>598</b>	<b>4429</b>	<b>5027</b>	<b>1</b>	<b>\$147</b>	<b>\$741,040</b>	<b>-\$127,717</b>
Brief	347	3424	3771	1	\$93	\$349,622	-\$221,274
Community Based	0	59	59	1	\$169	\$9,944	\$9,944
Comprehensive	267	1176	1443	1	\$265	\$381,474	\$84,466
<b>Medication Somatic</b>	<b>603</b>	<b>9158</b>	<b>9761</b>	<b>8</b>	<b>\$333</b>	<b>\$3,249,657</b>	<b>-\$152,881</b>
<b>Supported Employment</b>	<b>0</b>	<b>517</b>	<b>517</b>	<b>31</b>	<b>\$533</b>	<b>\$275,722</b>	<b>-\$157,869</b>
Therapeutic	0	133	133	10	\$188	\$25,049	\$2,776
Vocational	0	473	473	31	\$530	\$250,673	-\$160,646
<b>Transition Support Services</b>	<b>22</b>	<b>532</b>	<b>554</b>	<b>19</b>	<b>\$546</b>	<b>\$299,969</b>	<b>-\$277,938</b>



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**Figure 10. FY18 Utilization and Expenditure Details**

Service Group	Child Total	Adult Total	Child & Adult Total	Avg Units	Avg Cost Per Consumer	Paid Amount	\$ Change from FY17
Cont. of Care Tx Planning (Non-ACT/CBI)	5	101	106	20	\$441	\$46,713	-\$56,405
Continuity of Care Tx Planning	7	255	262	12	\$250	\$65,430	-\$70,760
Inpatient Discharge Planning ACT	10	255	265	20	\$709	\$187,826	-\$150,773
<b>Health Homes</b>	<b>0</b>	<b>1994</b>	<b>1994</b>	<b>6</b>	<b>\$2,305</b>	<b>\$4,595,885</b>	<b>-\$935,211</b>
Low Acuity	0	1908	1908	6	\$2,225	\$4,245,236	-\$384,947
High Acuity	0	194	194	4	\$1,807	\$350,649	-\$550,264
<b>Team Meeting</b>	<b>10</b>	<b>6</b>	<b>16</b>	<b>6</b>	<b>\$83</b>	<b>\$1,335</b>	<b>\$1,305</b>
<b>Total</b>	<b>3404</b>	<b>19,855</b>	<b>23,259</b>	<b>152</b>	<b>\$4,308</b>	<b>\$100,205,218</b>	<b>-\$11,730,432</b>

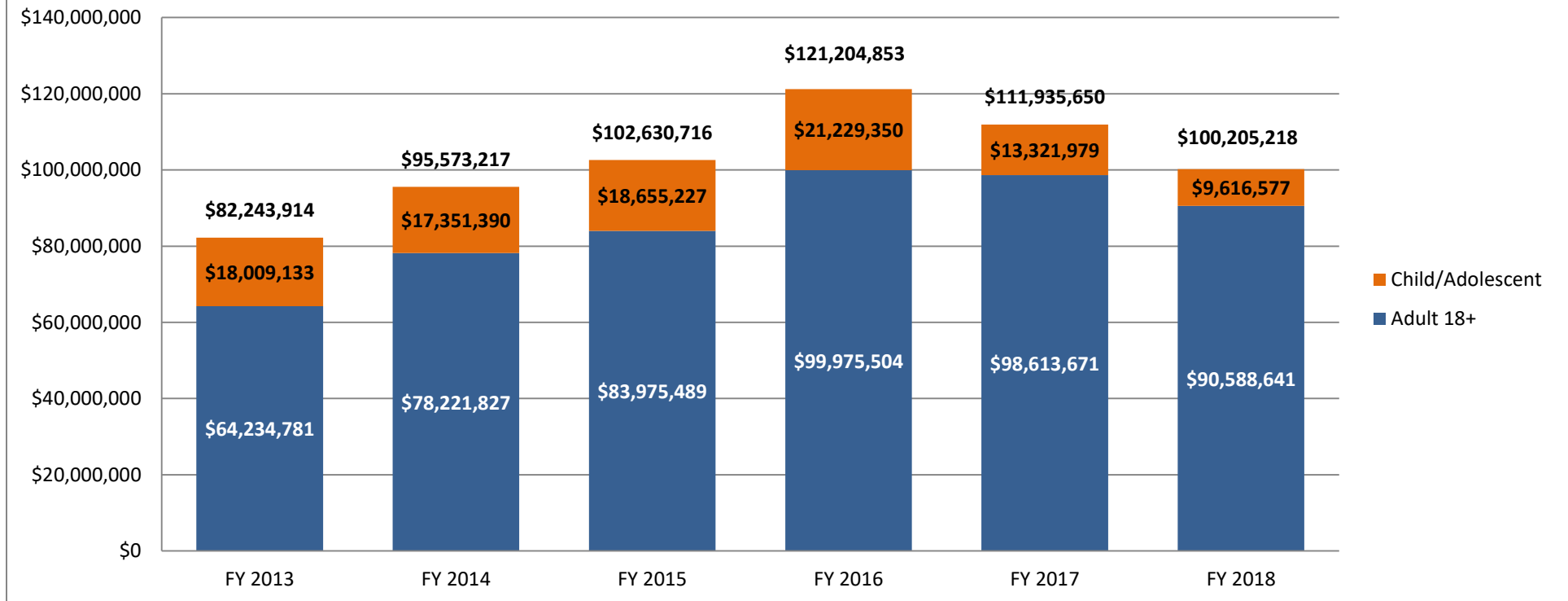


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**Figure 11. Mental Health Claims Expenditures by Age Group**



16% Increase from 2013 to 2014  
7% Increase from 2014 to 2015  
18% Increase from 2015 to 2016  
-8% Decrease from 2016 to 2017  
-10% Decrease from 2017 to 2018

Figure 11 displays the aggregate cost of Medicaid and Non-Medicaid (Locally Funded) services from Fiscal Year 2013 to Fiscal Year 2018.



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**Figure 12 Mental Health Claims Expenditures by Medicaid & Non-Medicaid Funds**

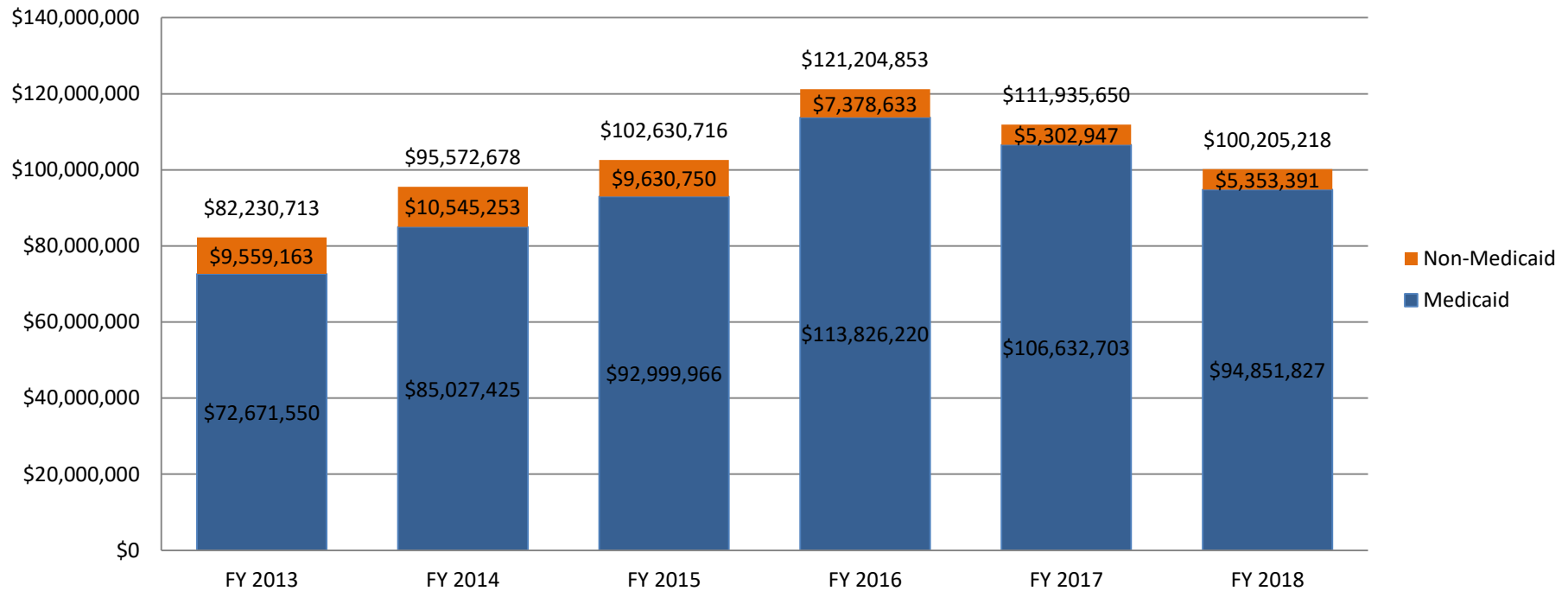


Figure 12 displays the cost of Medicaid and Non-Medicaid (Locally Funded) services from Fiscal Year 2013 to Fiscal Year 2018.

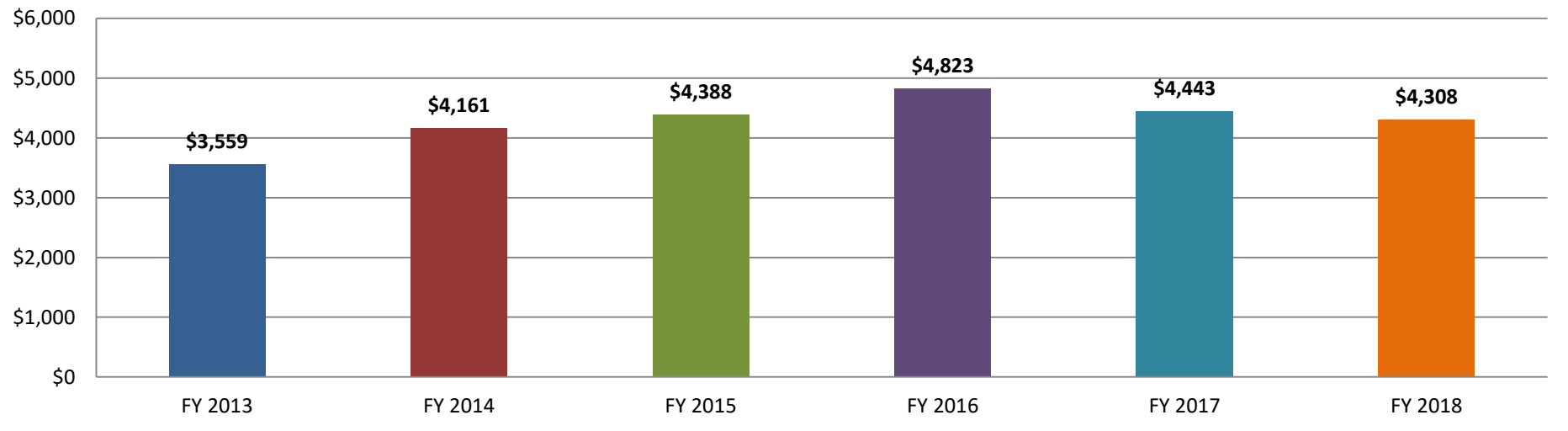


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**Figure 13. Average Cost per Consumer by Fiscal Year**





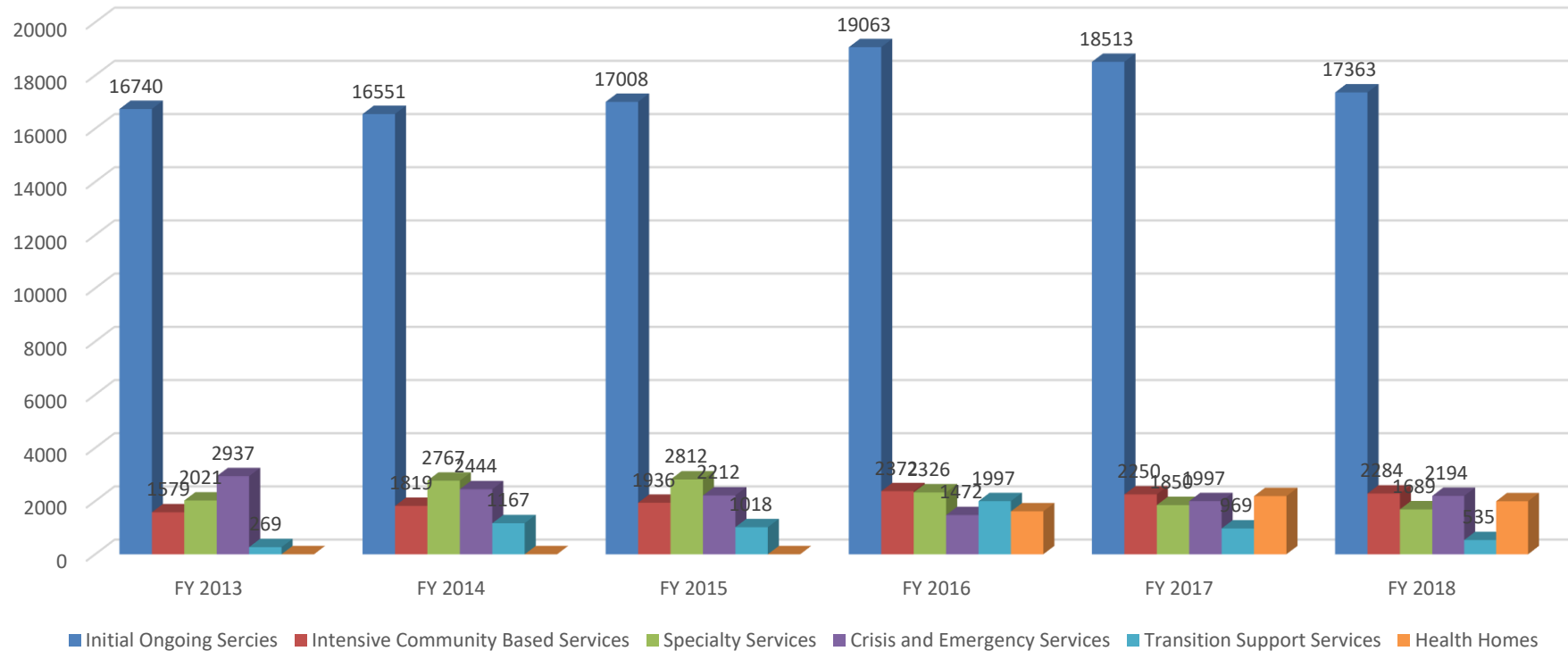


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Figure 14. Adult (18+) Mental Health Consumer Counts by Service Cluster



**Initial and Ongoing Services** include Counseling, Community Support, Diagnostic Assessment and Medication Somatic

**Intensive Community Based Services** include Assertive Community Treatment, Community Based Intervention, Multi Systemic Therapy & Family Functional Therapy

**Specialty Services** include Day, Supported Employment, Team Meeting and Jail Diversion

**Crisis Services** include Non-Authorized Crisis Beds, Psych Beds and Emergency Services

**Transition Support Services** include Inpatient Discharge Planning, Continuity of Care Treatment Planning and Community Psych Supportive Treatment Program

**Health Homes** includes high and low acuity Health Homes services

The DC public mental health system provides a variety of different mental health services to support the needs of the populations it serves. These services are categorized as 1) Initial and On-going Services; 2) Intensive Community-Based Services; 3) Specialty Services, 4) Crisis and Emergency Services, 5) Transition Support Services, and 6) Health Homes. Figures 14 and 15 describe the different services that fall within each category, the number of consumers served within each cluster from FY 2013 to FY 2018 and the average cost per consumer. A consumer can be included in multiple service categories. The category of Transition Support Services was created in FY 2013, and the category of Health Homes was created in FY 2016.

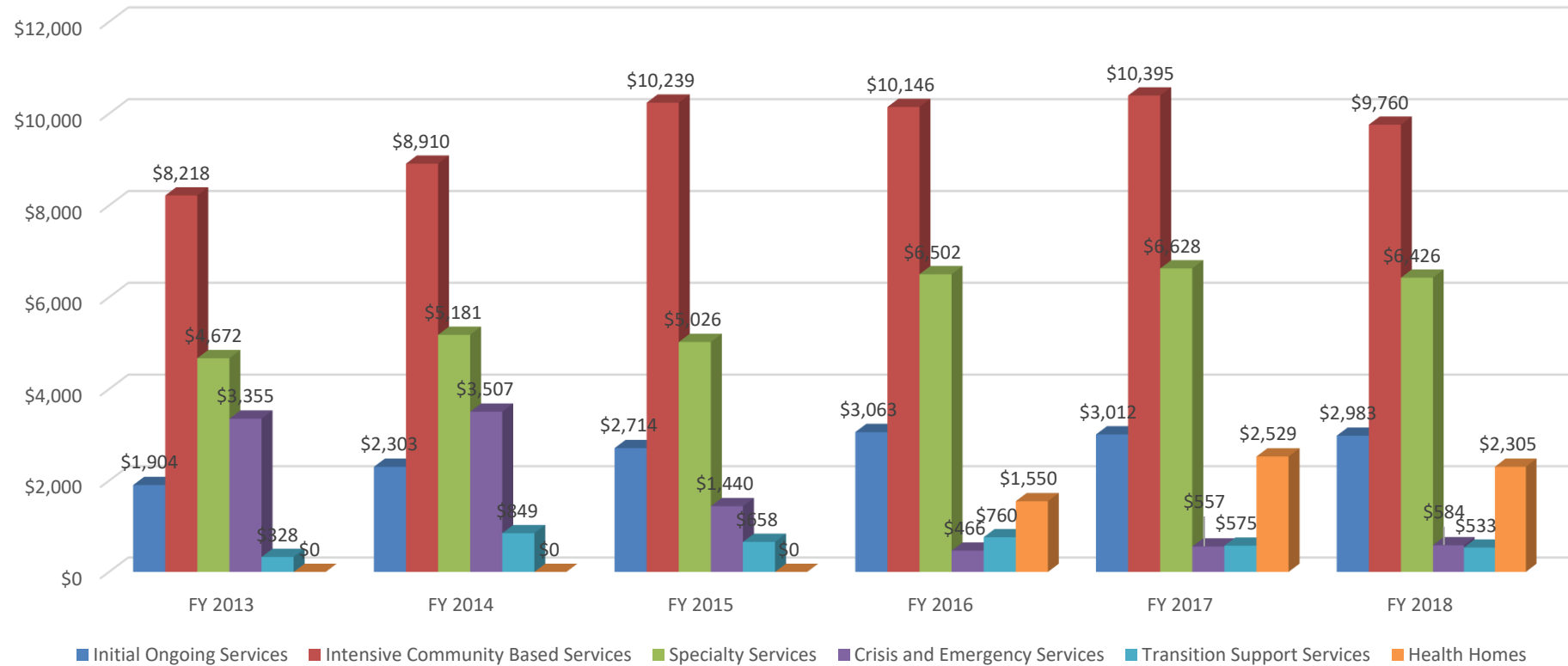


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**Figure 15. Adult (18+) Average Annual Cost per Mental Health Consumer**



**Initial and Ongoing Services** include Counseling, Community Support, Diagnostic Assessment and Medication Somatic

**Intensive Community Based Services** include Assertive Community Treatment, Community Based Intervention, Multi Systemic Therapy & Family Functional Therapy

**Specialty Services** include Day, Supported Employment, Team Meeting and Jail Diversion

**Crisis Services** include Non-Authorized Crisis Beds, Psych Beds and Emergency Services

**Transition Support Services** include Inpatient Discharge Planning, Continuity of Care Treatment Planning and Community Psych Supportive Treatment Program

## Initial & Ongoing Services

21% Increase from 2013 to 2014  
 18% Increase from 2014 to 2015  
 13% Increase from 2015 to 2016  
 -2% Decrease from 2016 to 2017  
 -1% Decrease from 2017 to 2018

## Intensive Community Based Svc

8% Increase from 2013 to 2014  
 15% Increase from 2014 to 2015  
 1% Increase from 2015 to 2016  
 1% Increase from 2016 to 2017  
 -6% Decrease from 2017 to 2018

## Specialty Services

11% Increase from 2013 to 2014  
 -3% Decrease from 2014 to 2015  
 29% Increase from 2015 to 2016  
 2% Increase from 2016 to 2017  
 -3% Decrease from 2017 to 2018

## Crisis & Emergency Services

5% Increase from 2013 to 2014  
 -59% Decrease from 2014 to 2015  
 -68% Decrease from 2015 to 2016  
 20% Increase from 2016 to 2017  
 5% Increase from 2017 to 2018

## Transition Support Services

159% Increase from 2013 to 2014  
 -23% Decrease from 2014 to 2015  
 16% Increase from 2015 to 2016  
 -24% Decrease from 2016 to 2017  
 -9% Decrease from 2017 to 2018

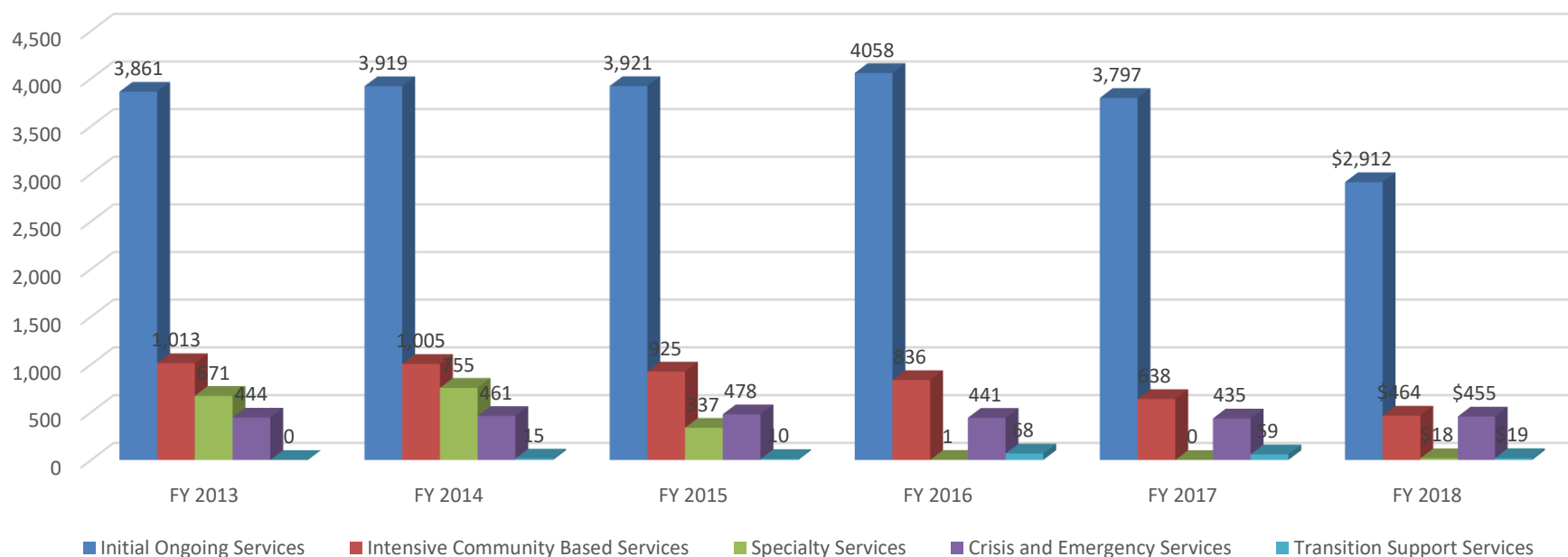


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**Figure 16. Child/Adolescent (0-17) Mental Health Consumer Count by Service Cluster**



**Initial and Ongoing Services** include Counseling, Community Support, Diagnostic Assessment and Medication Somatic

**Intensive Community Based Services** include Assertive Community Treatment, Community Based Intervention, Multi Systemic Therapy & Family Functional Therapy

**Specialty Services** include Day, Supported Employment, Team Meeting and Jail Diversion

**Crisis Services** include Non-Authorized Crisis Beds, Psych Beds and Emergency Services

**Transition Support Services** include Inpatient Discharge Planning, Continuity of Care Treatment Planning and Community Psych Supportive Treatment Program

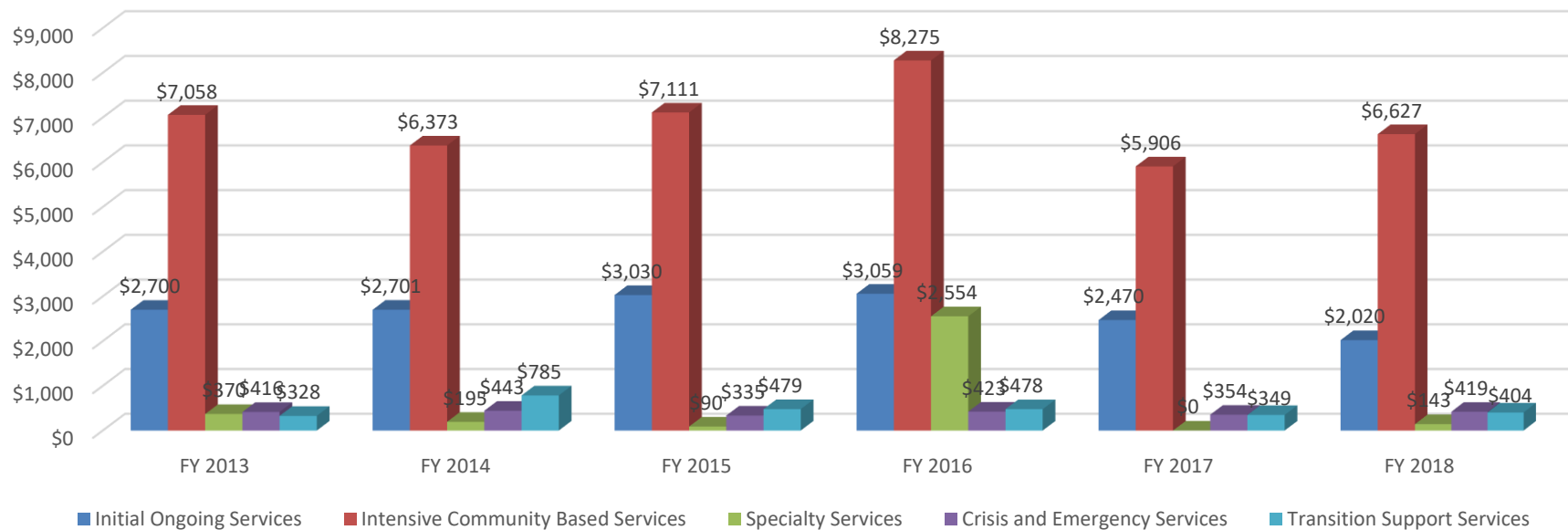


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**Figure 17. Child/Adolescent (0-17) Average Annual Cost per Mental Health Consumer**



**Initial and Ongoing Services** include Counseling, Community Support, Diagnostic Assessment and Medication Somatic

**Intensive Community Based Services** include Assertive Community Treatment, Community Based Intervention, Multi Systemic Therapy & Family Functional Therapy

**Specialty Services** include Day, Supported Employment, Team Meeting and Jail Diversion

**Crisis Services** include Non-Authorized Crisis Beds, Psych Beds and Emergency Services

**Transition Support Services** include Inpatient Discharge Planning, Continuity of Care Treatment Planning and Community Psych Supportive Treatment Program.

## Initial & Ongoing Services

16% Increase from 2013 to 2014

17% Increase from 2014 to 2015

1% Increase from 2015 to 2016

-19% Decrease from 2016 to 2017

-18% Decrease from 2017 to 2018

## Intensive Community Based Svc

3% Increase from 2013 to 2014

15% Increase from 2014 to 2015

16% Increase from 2015 to 2016

-29% Decrease from 2016 to 2017

12% Increase from 2017 to 2018

## Specialty Services

14% Increase from 2013 to 2014

9% Increase from 2014 to 2015

2738% Increase from 2015 to 2016

-100% Decrease from 2016 to 2017

143% Increase from 2017 to 2018

## Crisis & Emergency Services

2% Increase from 2013 to 2014

-59% Decrease from 2014 to 2015

26% Increase from 2015 to 2016

-16% Decrease from 2016 to 2017

18% Increase from 2017 to 2018

## Transition Support Services

-159% Decrease from 2013 to 2014

-23% Decrease from 2014 to 2015

0% Change from 2015 to 2016

-27% Decrease from 2016 to 2017

16% Increase from 2017 to 2018

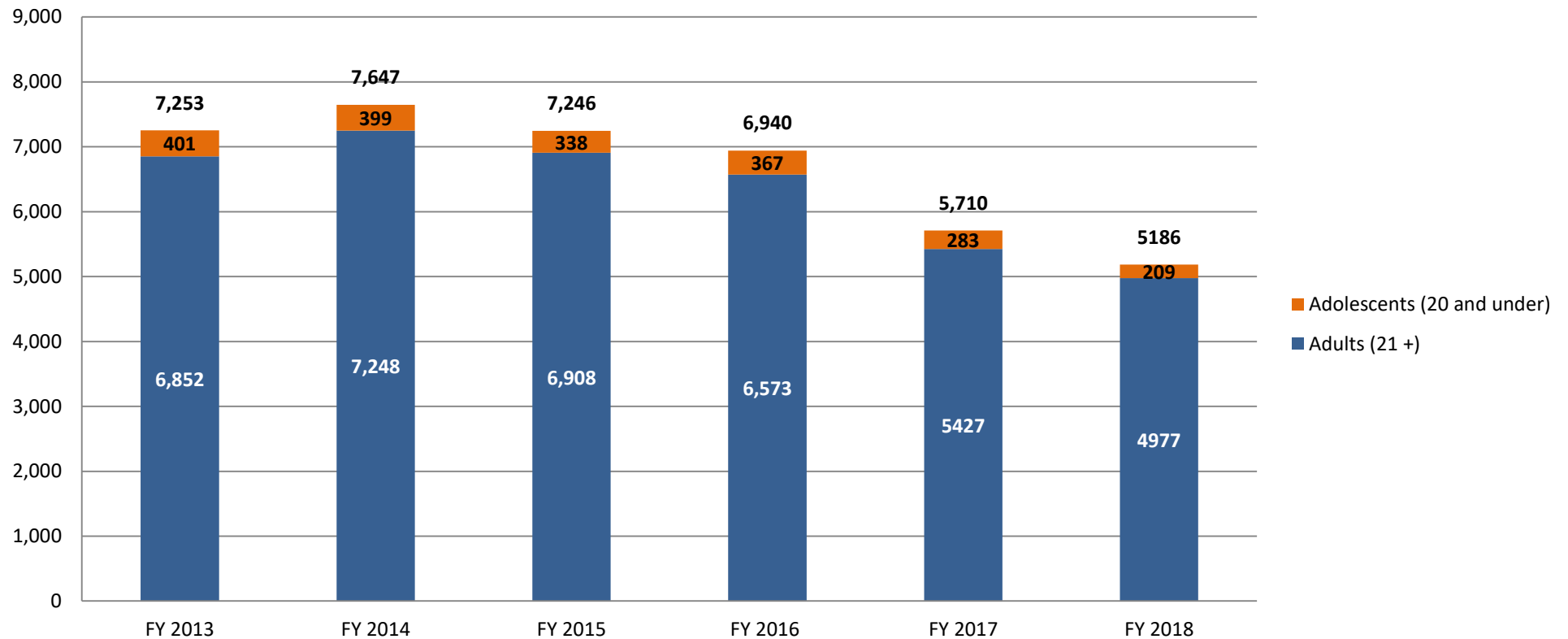


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**Figure 18. Total Number of Substance Use Clients Served**



Substance use clients are individuals who moved from one level of care to another during the fiscal year, those who had a new assessment and referral during the fiscal year, those who remained at the same level of care throughout the fiscal year, and those who received recovery services.



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**Figure 19. Substance Use Clients Receiving Treatment and Recovery Services in FY2018**

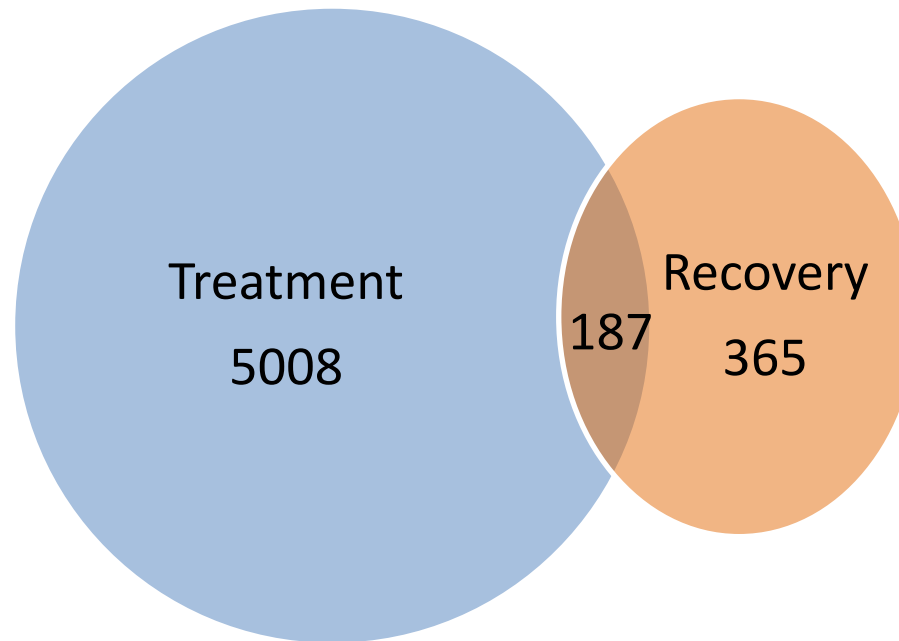


Figure 19 shows the overlap between clients receiving treatment and recovery services in FY 2018. A client can either be admitted directly to recovery services or transition once treatment is completed. Some clients receive treatment and recovery services simultaneously.

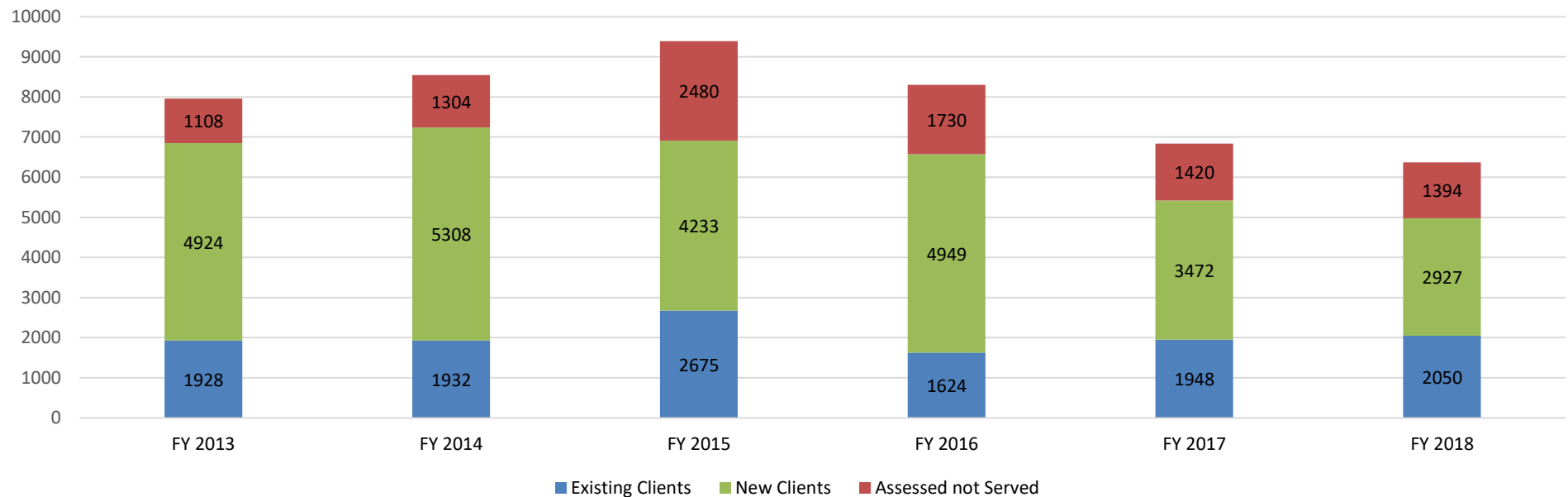


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**Figure 20. Adults Referred and Served for Substance Use Services**



Once clients are assessed at the ARC or another assessment site, the appropriate referrals are made to the network of SUD providers. Those who were assessed but not served were not admitted for various reasons (client did not meet criteria for treatment, client did not agree to participate in services, or client only needed an assessment for legal reasons). After being accepted, the client is then admitted to the facility and their treatment begins. Depending on the initial level of care, a client can be admitted to multiple providers sequentially (i.e. a client is admitted to withdrawal management and then sent to residential treatment and upon completing that program is sent to intensive outpatient). Some clients receive services (predominantly MAT) across multiple years and do not have a referral for that year. Those who are assessed but not served fall into the categories of either the program rejecting referral, client refusing treatment, referral rejected and status pending.

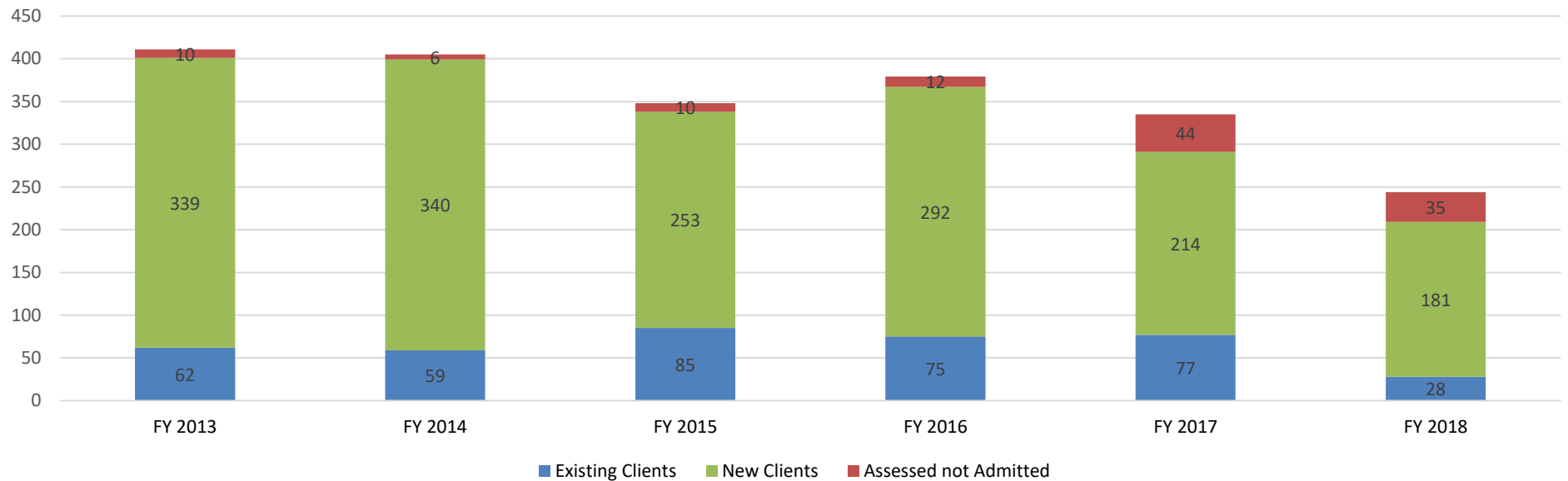


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**Figure 21. Youth Referred and Served for Substance Use Services**





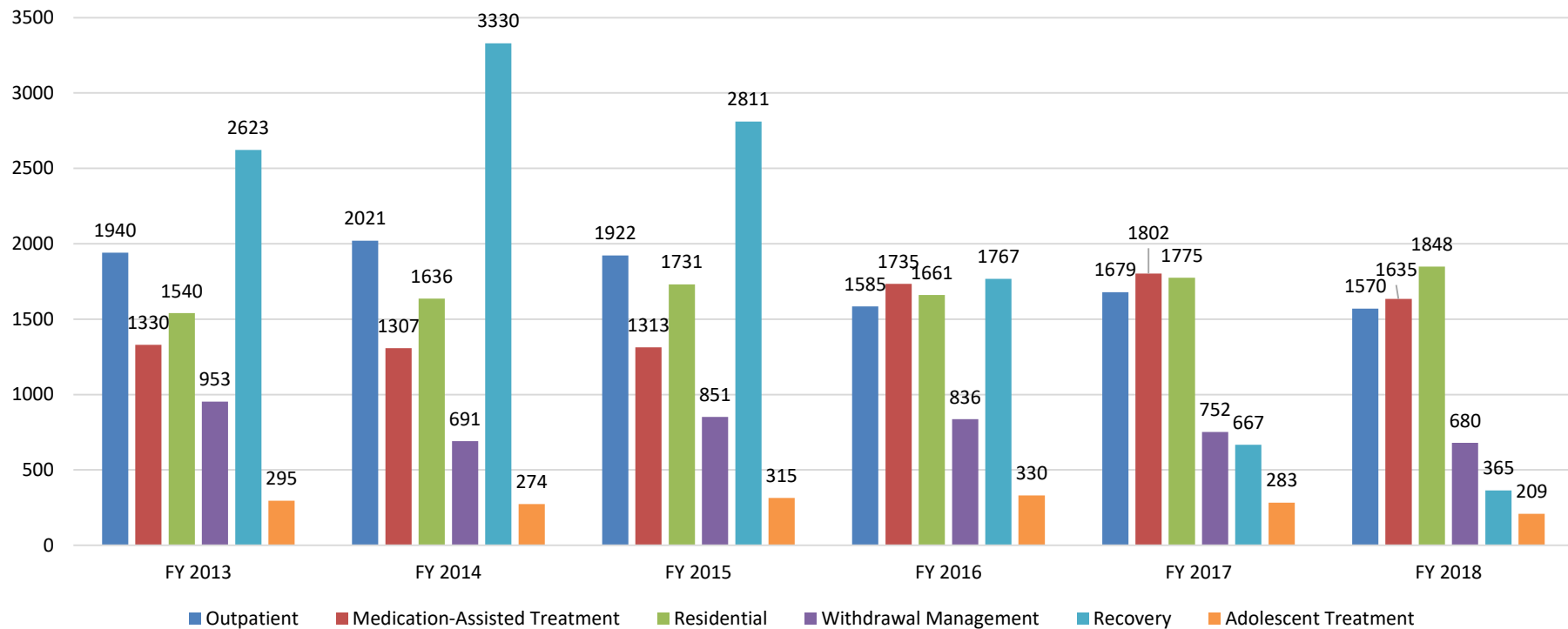


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**Figure 22. Substance Use Clients by Level of Care**



There is a continuum of levels of care for substance use clients. **Withdrawal Management** (detoxification) is the recommended treatment option for clients who struggle withdrawing from substances on their own due to medical complication related to abruptly stopping use. **Residential Treatment** (inpatient) programs focus on helping individuals change their behaviors in a highly structured setting. Shorter term residential treatment is much more common, providing initial intensive treatment, and preparation for a return to community-based settings. **Outpatient** services are designed to meet the needs of individuals who suffer from a substance use disorder and need more than weekly counseling, but do not need residential care. The program provides monitoring several times a week in a supportive group setting. **Medication-Assisted Treatment** involves the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. There is a similar continuum for adolescents as adults. Figure 18 shows the number of clients at each level. Clients who are served in multiple levels of care are counted in each, but the same client is not counted multiple times if they re-enter the same level of care.

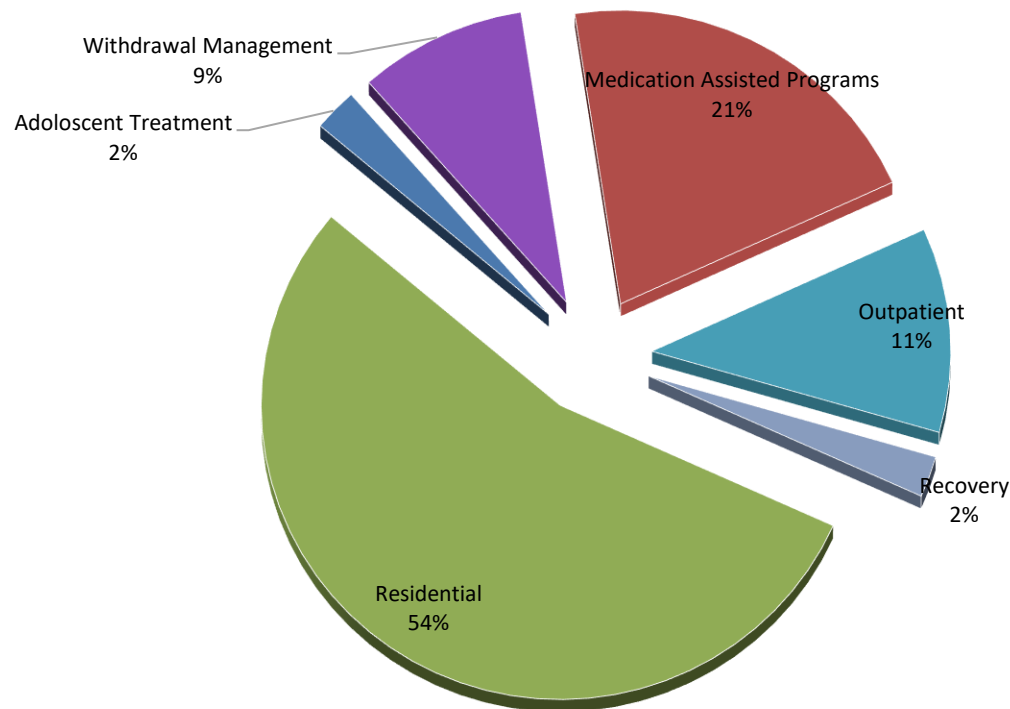


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**Figure 23. Expenditures by Level of Care  
FY 2018**



“Other” spending includes working with veterans (housing and SUD services) and individuals with HIV (education, medical and SUD services).

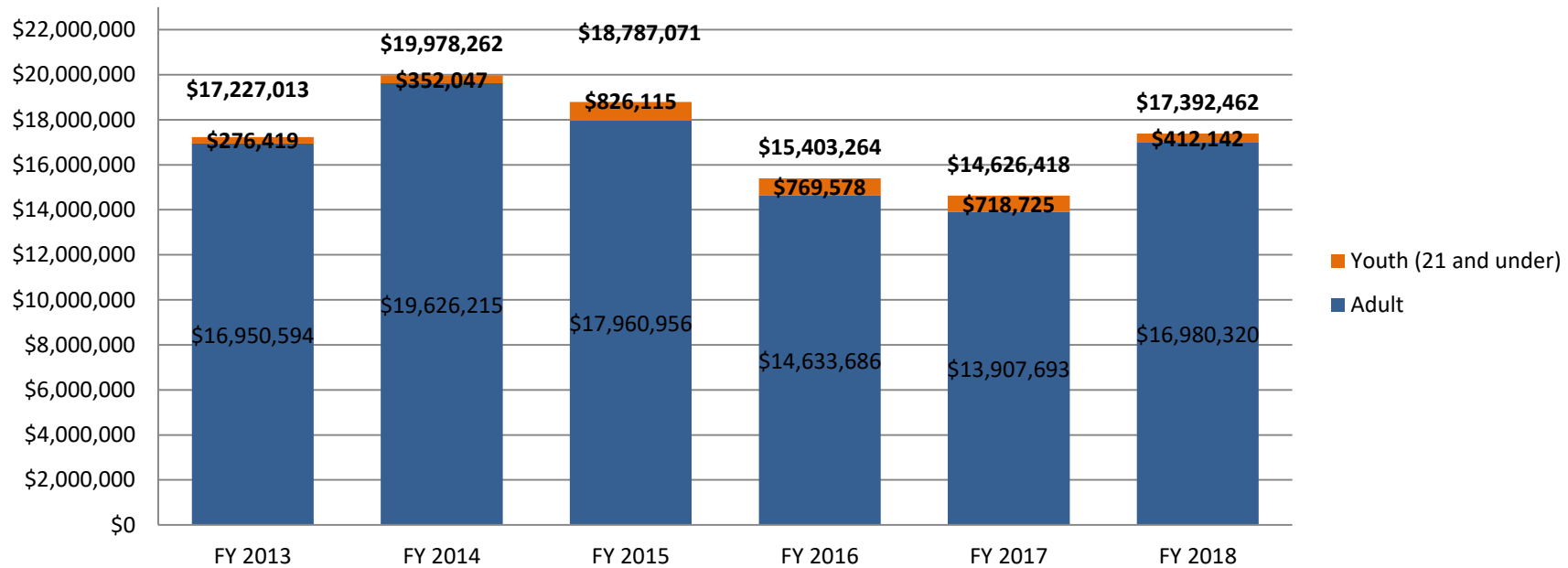


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**Figure 24. Substance Use Expenditures**

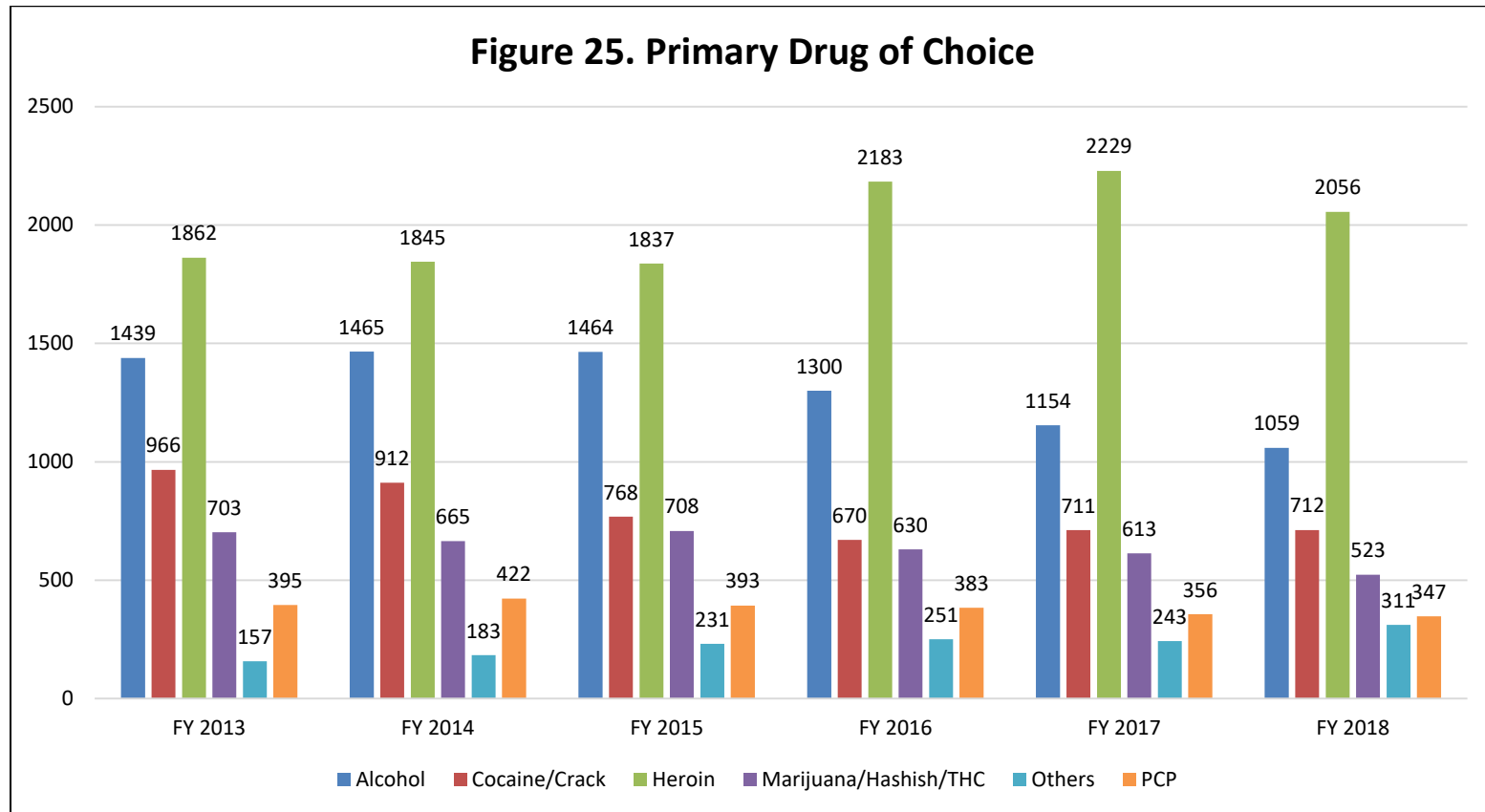




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The counts for each substance come from the most recent admission for each client being served. Not included are the primary substances for clients who only received recovery services. Clients who had more than one admission are only counted once.