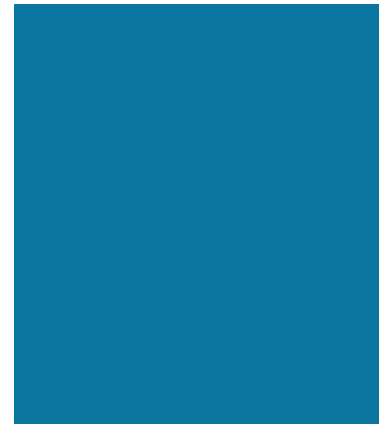




Mental Health and Substance Use Report on Expenditures and Services

MHEASURES

FY 2025 Annual Report



District of Columbia
Department of Behavioral Health
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DC GOVERNMENT OF THE
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MURIEL BOWSER, MAYOR



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Overview

Mission	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.	
Vision	The District of Columbia is a thriving community where prevention and recovery from substance use disorders and mental health conditions is possible and services and supports optimize a resident's potential ability to function effectively within family and community.	

The Department of Behavioral Health (DBH) provides prevention, intervention and treatment services and supports for children, youth and adults with mental and/or substance use disorders (SUD) including emergency psychiatric care and community-based outpatient and residential services. DBH serves eligible adults, children and youth and their families through a network of community-based providers and unique government delivered services. Services are integrated for individuals who have co-occurring disorders; whole person care is the goal. Services are paid via Medicaid- and locally funded claims, as well as contracts and grants. DBH also operates Saint Elizabeths Hospital—the District's inpatient psychiatric facility.

This report contains data on the number of individuals served, their demographics, the types of services used, and expenditures (i.e., based on Medicaid payments and/or DBH locally funded claims) for the period of October 1, 2024 - September 30, 2025 (FY25).

Mental Health

DBH oversees an array of mental health services and support through Mental Health Rehabilitation Services (MHRS) and Free-Standing Mental Health (FSMH) Clinics. DBH also operates adult and child clinics that provide urgent care and crisis emergency services.

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In FY25, DBH had a network of 57 certified providers to deliver community-based mental health services. Thirty-six providers were certified as MHRS-only providers; 19 providers were certified to deliver both MHRS and FSMH services; two providers were certified to deliver FSMH services only; and 13 providers were dually certified to deliver mental health and SUD services.

Substance Use Disorder

In FY25, DBH had 34 certified providers to deliver treatment and recovery services for adolescents and adults with SUD. Thirteen of these providers were dually certified to provide mental health and SUD treatment. Individuals seeking to obtain SUD services must complete an intake and assessment through the Access and Referral Center (ARC) or community intake sites operated by DBH-certified treatment providers. During the intake process, clients receive an assessment to determine the appropriate level of treatment.

DBH providers deliver a comprehensive continuum of SUD recovery and treatment services in accordance with the American Society of Addiction Medicine (ASAM) Levels of Care, including outpatient, intensive outpatient, residential, detoxification and stabilization, and medication assisted treatment. Three SUD providers deliver services for adolescents through the Adolescent Substance Abuse Treatment Expansion Program (ASTEP). Adult and youth SUD providers deliver screening, assessment, outpatient and inpatient treatment, and recovery services and supports.

DBH supports four Prevention Centers that conduct community education and engagement activities related to substance use prevention across all eight wards, including youth empowerment training, social media outreach and Prevention Centers capacity-building efforts. 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 of care. DBH also oversees the District's State Opioid Response (SOR) grant and opioid abatement funds.

Crisis Services

A continuum of behavioral health crisis services is available in the District of Columbia. The Access Helpline (AHL) is a 24/7 resource for residents of Washington, D.C., offering mental health support and information through trained behavioral health professionals. It operates a local crisis line, handles mental health-related calls redirected from 911 and is also the call center for 988. Individuals experiencing a mental health-related crisis can call, chat, or text 988 and reach a trained crisis counselor.

Mental health and substance use outreach and treatment services for adults and youth are also provided through the Community Response Team (CRT), with outreach contractors funded through the District's State Opioid Response (SOR) grant and the locally funded Community

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Engagement Team. Individuals needing stabilization services can go to the Comprehensive Psychiatric Emergency Program (CPEP) or the DC Stabilization Center. Children and adolescents in crisis can also receive support through the Child and Adolescent Mobile Crisis Service (ChAMPS), a mobile psychiatric service aimed at stabilization and avoiding hospitalization, or through the school-based behavioral health program. Crisis stabilization is also available through short-term crisis beds that serve as alternatives to psychiatric hospital stays.

Key Findings

Community Mental Health Services. District Medicaid and local funds paid \$365 million for mental health services claims in FY25. There were more consumers served (2% increase) and fewer expenditures (6% decrease) between FY24 and FY25. The decrease in expenditures was predominantly driven by a reduction in community support services.

Substance Use Treatment. District Medicaid and local funds paid \$51 million for SUD services claims in FY25. There were more youth and adults served (28% and 74% increase, respectively) as well as an increase in expenditures (88% increase). The increase was predominantly driven by recovery support services.

Medication Assisted Treatment. Use of Medication Assisted Treatment (MAT) for opioid use disorder increased by 11% between FY24 and FY25. Use of Methadone increased by 12%; Buprenorphine utilization decreased by 3%; Naltrexone utilization increased by 35%.

Telehealth Expenditures. Twenty-three percent of mental health expenditures were for telehealth in FY25, while telehealth expenditures for SUD were 11% of the total cost of the service. Mental health telehealth expenditures in FY25 decreased by 36% when compared to FY24, while expenditures for SUD telehealth increased significantly (316%). The reduction in mental health telehealth services was largely due to a reduction in the number of billable units allowed for community support. The increase in telehealth for SUD was driven by diagnostic and assessments, prescriber visits, and recovery support services.

Saint Elizabeths Hospital. The average daily census of 266 patients at Saint Elizabeths Hospital in FY25 was relatively unchanged compared to FY24.

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Consumer Feedback

Hearing the voices of the people we serve



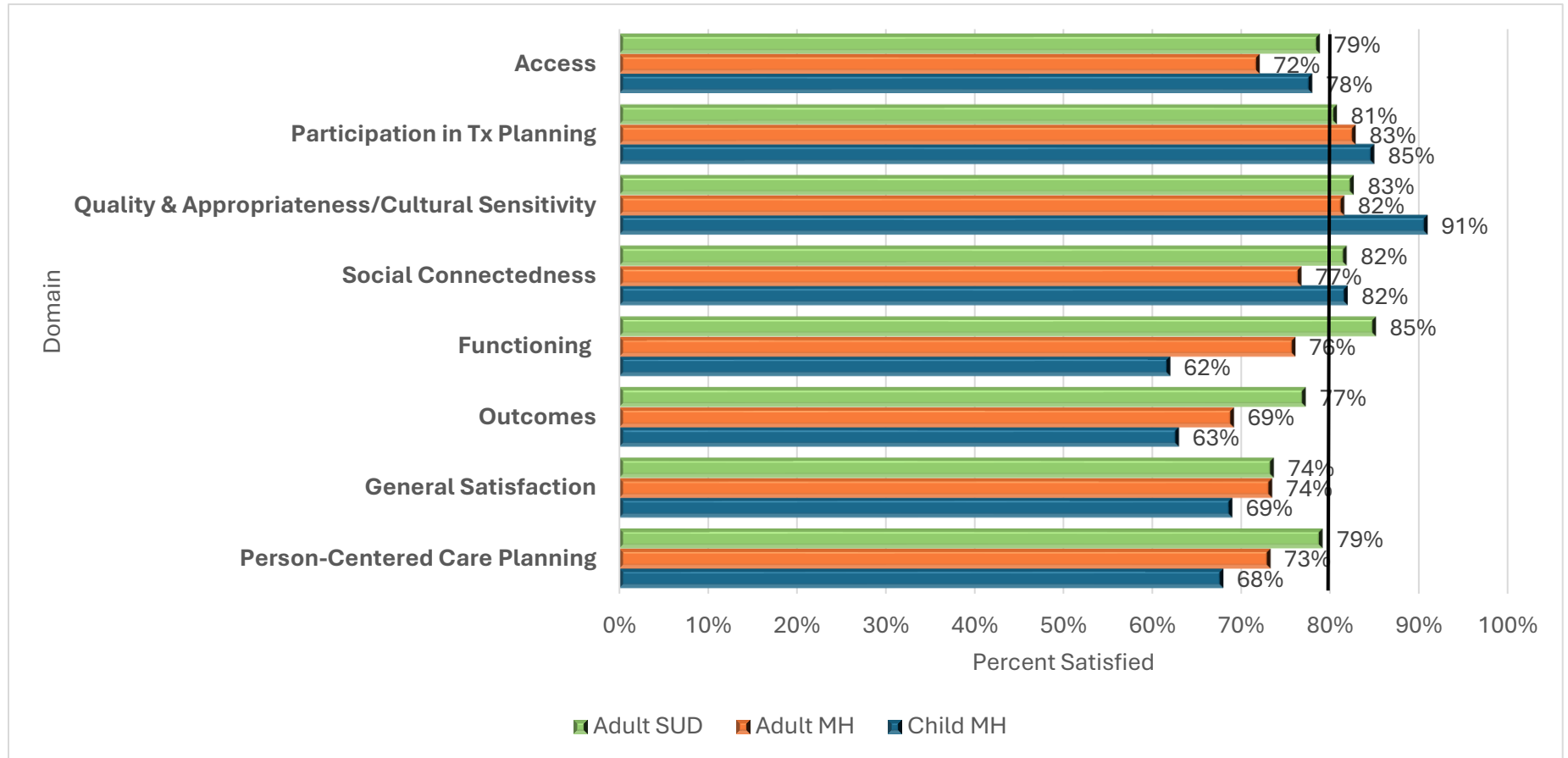
Every year, DBH conducts surveys of consumers, clients, and individuals in care to better understand their satisfaction with services. It is an important opportunity to hear the voices of the people served. The questions in the survey are grouped into domains and scored on a five-point Likert scale, ranging from Strongly Disagree to Strongly Agree.

Figure 1 shows the percentage of respondents satisfied with their experience, broken out by survey domains and type of survey (adult mental health, child/youth caregiver, or adult SUD). Saint Elizabeths Hospital satisfaction survey data are shown in Figure 23.

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Figure 1. Percent of Consumers Satisfied by Survey Domain – FY25



In FY25, 408 adult mental health consumers, 384 parents or caregivers of child/youth mental health consumers, and 133 adult substance use clients responded to the satisfaction survey. The target for each domain is 80% satisfied. Caregivers reported the highest satisfaction in the domain of cultural sensitivity. Among adult mental health and substance use respondents, the lowest scoring domains were access to care and general satisfaction with service delivery. For caregivers of child/youth mental health consumers, the lowest rated domains were improvements in functioning and service outcomes. Nationally, outcomes of care and functioning are typically the lowest scoring domains, in part because many respondents have not yet completed treatment.

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DBH Operated Services



Figure 2. Utilization Data for DBH Operated Children, Adolescent and Family Services – FY25

Program	Metric
<p>Assessment Center (AC). The Assessment Center provides the Superior Court of the District of Columbia with court-ordered, comprehensive mental health consultations, and psychological and psychiatric evaluations for children, adolescents and related adults with child welfare, juvenile justice or family court involvement.</p>	<p>471 Assessments Completed</p>
<p>The Parent Infant Early Childhood Enhancement Program (PIECE) and Physicians Practice Group (PPG). The PIECE program has two components: providing screening, assessment, individual, family, play art therapy, Parent Child Interaction Therapy and Child Parent Psychotherapy for Family Violence; and offering psycho-educational parenting groups, home visits, and maternal mental health services to families with children from birth to eighteen years old. The PPG serves children and youth ages 6-21. Services include clinical assessment of safety, diagnostic evaluations, and recommendations for treatment. Additional services include court ordered evaluations, medication assessments and medication management.</p>	<p>2,920 Visits</p>
<p>School Based Behavioral Health Program (SBBH). Through the School-Based Behavioral Health Program, DBH collaborates with students, families, schools, community-based organizations (CBOs) and other partners to provide behavioral health prevention, early intervention and treatment services that reduce barriers to learning, foster resiliency and maximize students’ potential to become successful learners and responsible residents. Data reported in this document includes children who received treatment (Tier 3) services by DBH and CBO clinicians. CBO data are self-reported by each contracted agency.</p>	<p>2,831 Children Served in Tier 3</p>

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Figure 3. Utilization Data for DBH Operated Adult & Transition Age Youth Services – FY25

Program	Metric
Assessment and Referral Center (ARC). The ARC provides same-day assessments and referrals for individuals seeking treatment for SUD.	759 Intakes Completed
Community Response Team (CRT). The DBH Community Response Team is a twenty-four hour/seven day a week multidisciplinary direct service team that expands our community based service delivery model—including homeless outreach, mobile crisis, and pre-arrest diversion.	2,337 Interventions (Deployments)
Comprehensive Psychiatric Emergency Program (CPEP). CPEP is a twenty-four hour/seven day a week operation that provides emergency psychiatric services and extended observation beds for individuals 18 years of age and older.	4,729 Visits
Forensic Outpatient Department (FOPD). FOPD monitors forensically involved consumers assigned to outpatient mental health providers, to ensure that they receive required treatment in the in the least restrictive environment. FOPD monitors the consumer's psychiatric conditions and compliance with the conditions of release. FOPD also provides psychoeducational training to core service agencies (CSAs) on the best practices for maintaining forensic consumers in an outpatient mental health setting.	24 Consumers Monitored in the Community
Pharmacy (35 K Street). The pharmacy serves as a safety net by filling prescriptions of psychotropic medication to uninsured residents of the District of Columbia, serving as the outpatient pharmacy for CPEP, and filling prescriptions for discharge medication for consumers being released from St. Elizabeths Hospital.	10,299 Prescriptions Filled
Urgent Care (UC). Located at 35 K Street, Urgent Care services include assessment, counseling, psychiatric evaluation and medication management.	8,774 Visits
Saint Elizabeths Hospital. Saint Elizabeths Hospital is the District’s public psychiatric facility for individuals with serious and persistent mental illness who need intensive inpatient care to support their recovery. Saint Elizabeths also provides competency evaluations and care to patients committed to the hospital by the courts.	631 Individuals Served

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Figure 4. Utilization Data for DBH Operated Consumer and Family Services – FY25

Program	Metric
<p>Access HelpLine (AHL). Residents can get immediately connected to services provided by the DBH and its certified behavioral health care providers by calling the AHL, either through 1(888)7WE-HELP or 988. This 24-hour, seven-day-a-week telephone line is staffed by behavioral health professionals who can refer a caller to immediate help to address behavioral health crises or to obtain ongoing care.</p>	<p>44,627 Answered Calls</p>
<p>Consumer and Family Affairs (CFA). CFA promotes and protects the rights of individuals with behavioral health disorders; encourages and facilitates consumer and client and family leadership of treatment and recovery plans and ensures consumer and client voice in the development of the behavioral health system. CFAA also promotes consumer and client leadership, manages the peer certification training, and provides expertise on the consumer and client perspective.</p>	<p>219 Active Certified Peers</p>

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Claims-based Services



This section describes behavioral health services documented and paid through claims. In FY25, 96% of claims were paid by Medicaid. For specific services that are not billable to Medicaid or for people who are not eligible for Medicaid, Medicare, or third-party insurance, local funding is used. Services paid by Medicaid include Fee for Service (FFS) claims and those paid by a Managed Care Organization (MCO). The universe of services included in this section is comprised of those delivered by DBH-certified community-based providers under the regulations governing MHRS, FSMHC, Crisis Services, Adult Substance Abuse Rehabilitative Services (inclusive of methadone), as well as prescriptions for buprenorphine and naltrexone for opioid use disorder.

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Figure 5. Individuals Who Received Mental Health and Substance Use Services – FY25

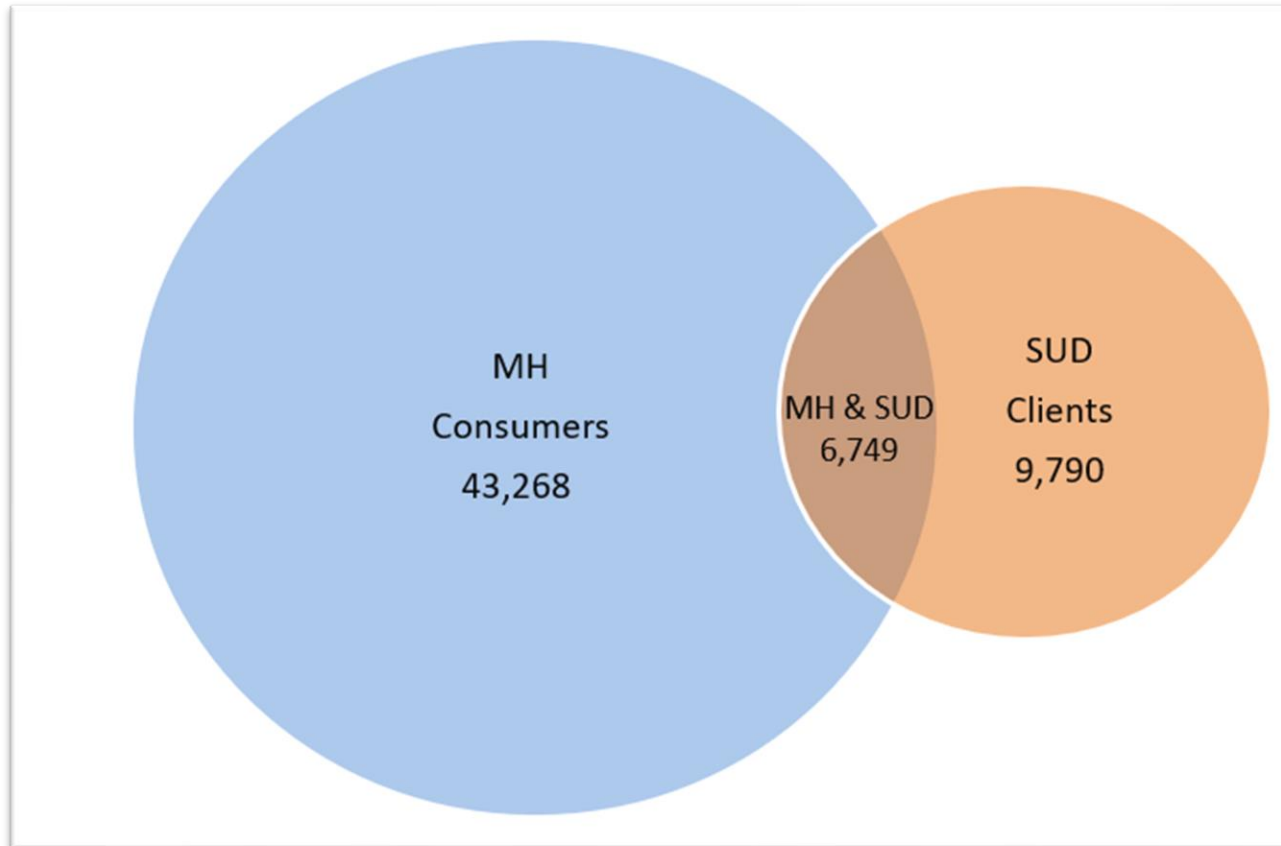


Figure 5 shows a total of 53,058 individuals obtained at least one MH or SUD services in FY25. Of those individuals, 6,749 received both MH and SUD services, which represents 16% of those who received MH and 69% of SUD clients.

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Figure 6. Gender FY25

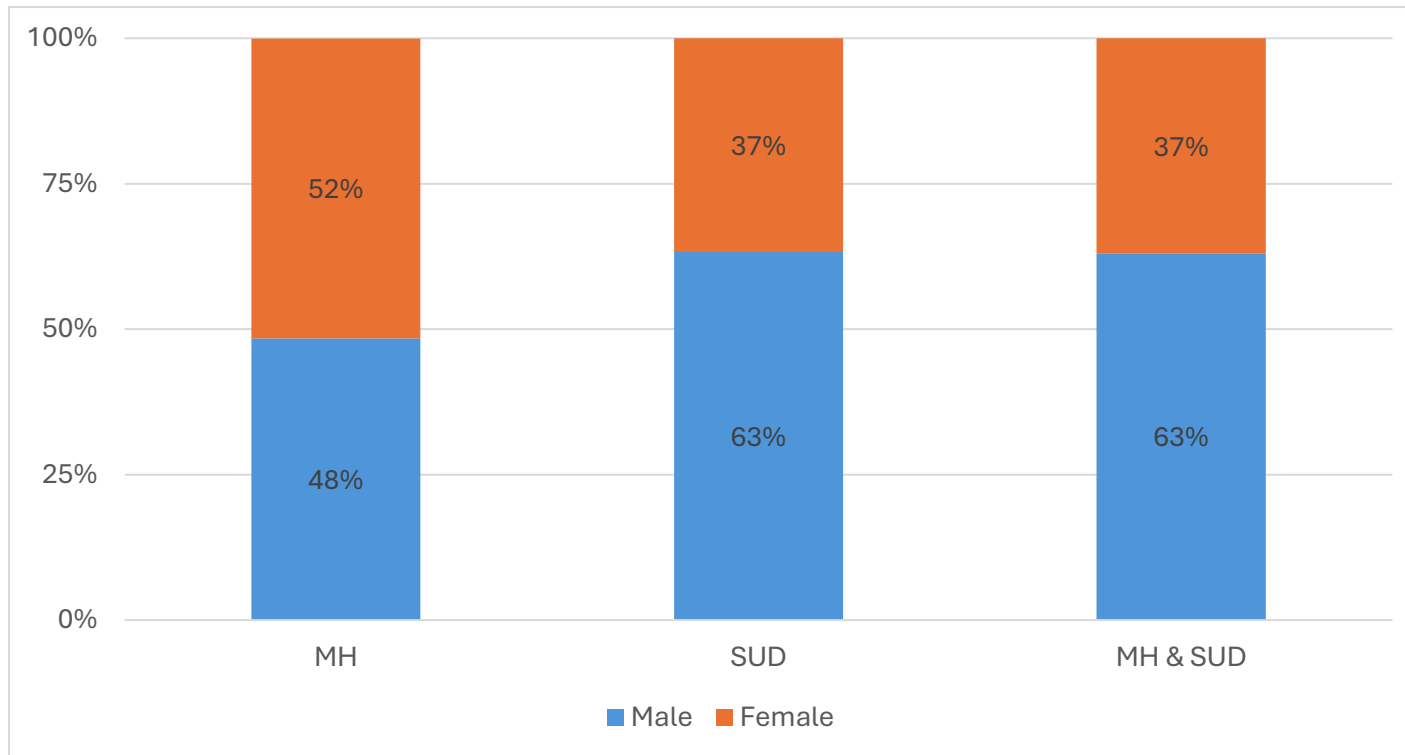


Figure 6 shows a similar proportion of males and females received mental health services in FY25; however, males were a larger share of consumers receiving SUD services and both mental health and SUD services.

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Figure 7. Race FY25

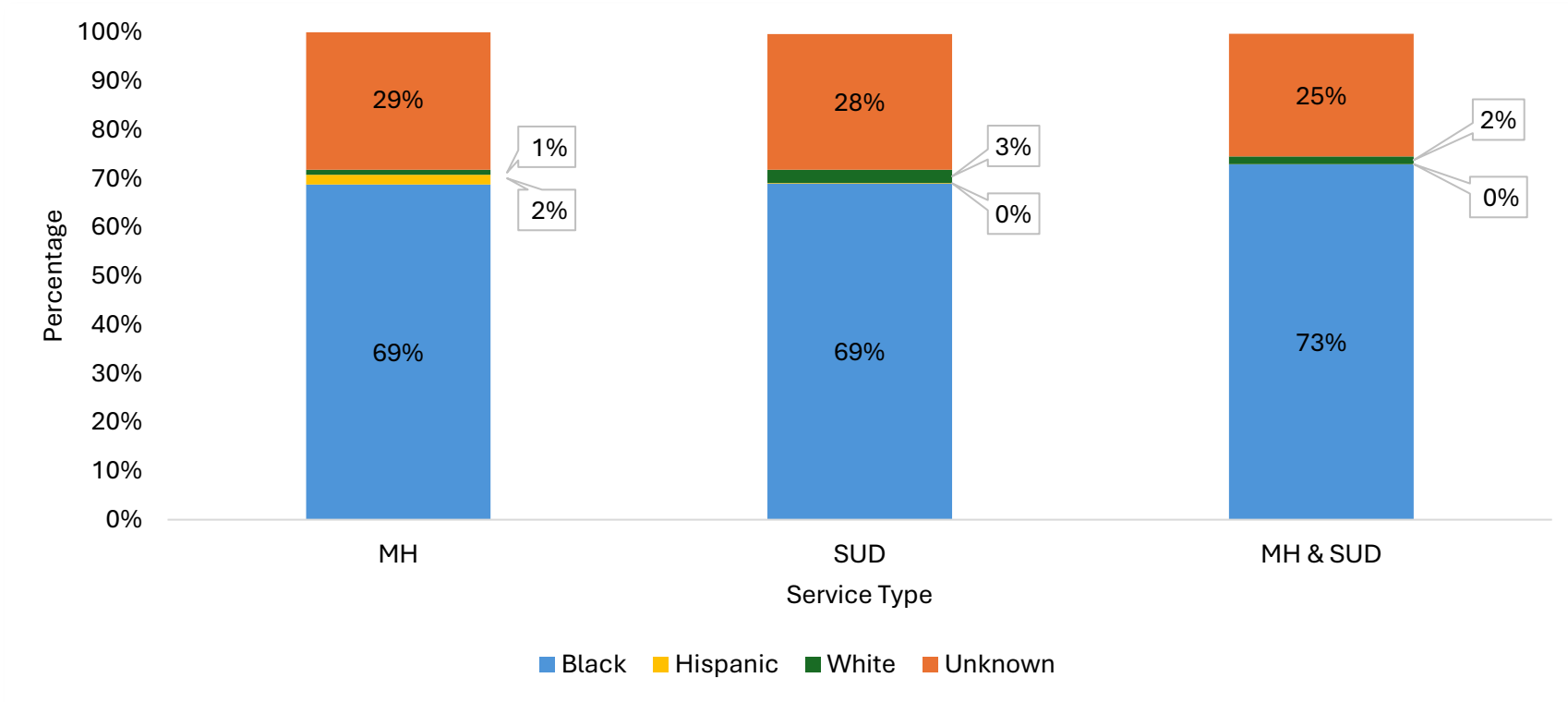


Figure 7 shows that in FY25, most of the residents receiving mental health services, SUD services, or both, self-identify as African American or Black. Race data are received from DHCF as part of claims, and there are data quality issues that lead to a high proportion of unknown races.

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Figure 8. Count of Individuals Served and Provider Locations by Ward – FY25

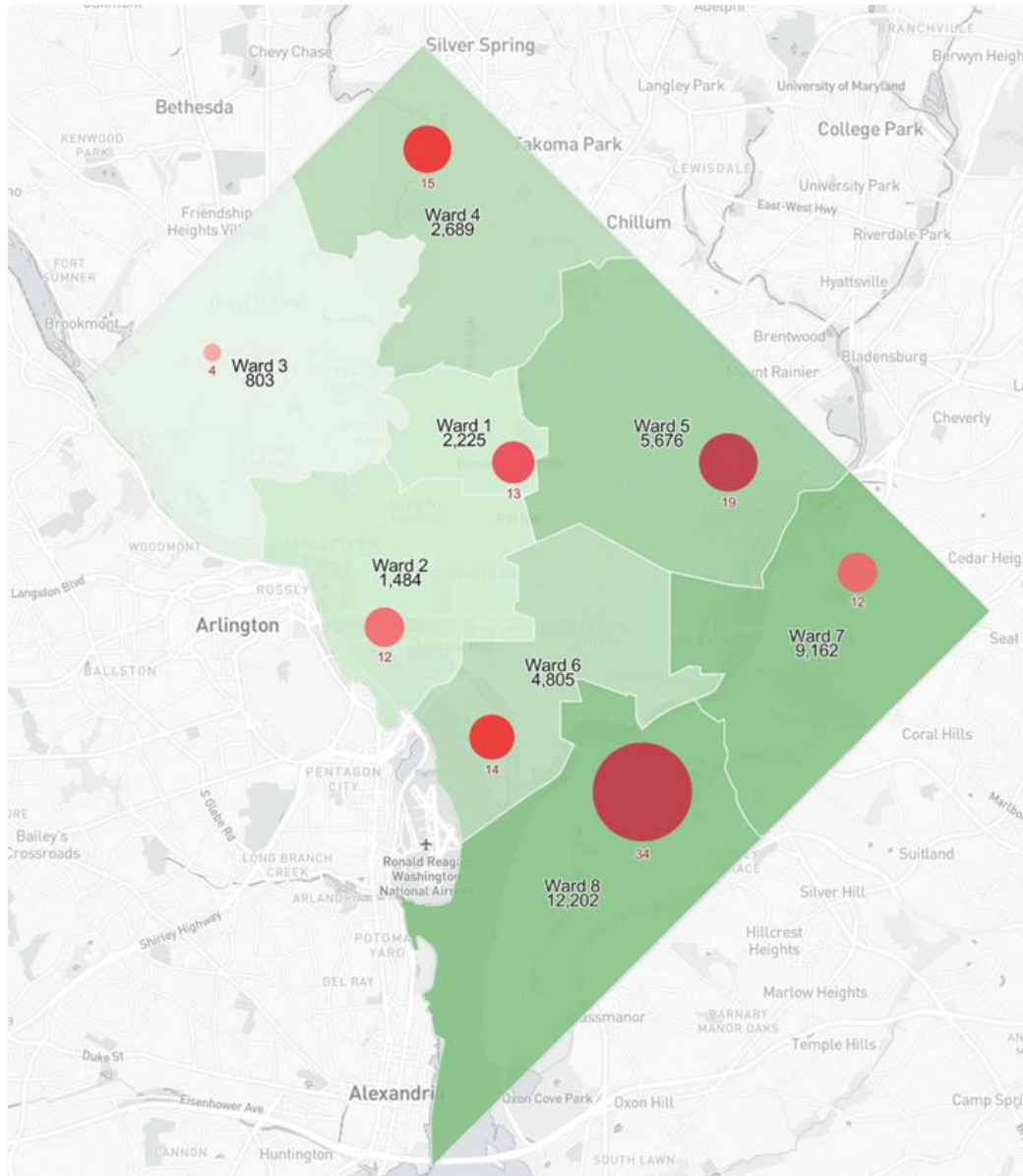


Figure 8 shows the number of provider locations (some providers have more than one location) and the number of people served, according to their address of residence, by Ward. The larger the circle, the more provider locations in the Ward. The darker the color of the Ward, the higher the number of people served in FY25. The total number of people served shown on the map is lower than the total reported throughout this report, as Ward data were not available for all people served.

There were 123 behavioral health providers sites, an average of 1.8 providers per square mile of the District. Most Wards had comparable alignment between the number of people served and provider sites.

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Mental Health Services

Figure 9. Penetration Rate per 1,000 Population

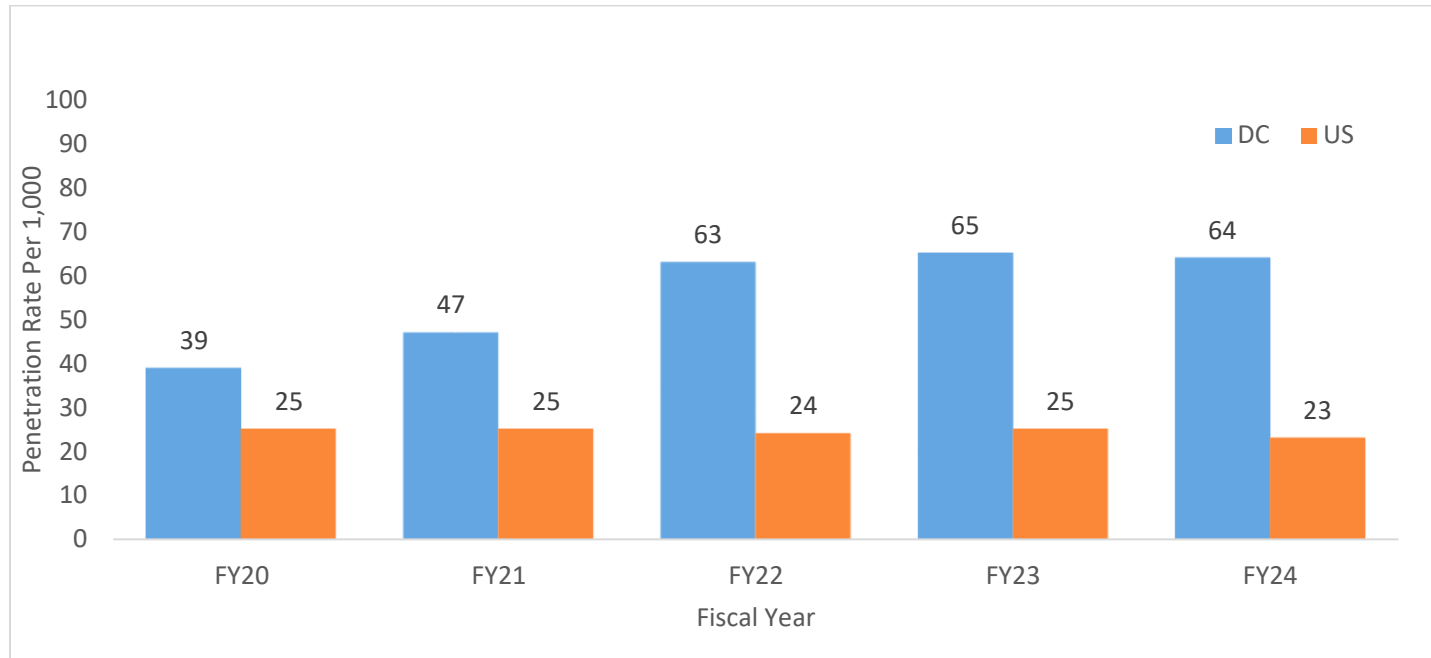


Figure 9. Penetration rate is calculated by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The District’s penetration rate increased significantly between FY20 and FY22 and remained at that level in FY23 and FY24. The national penetration rate has remained essentially the same for the past five years. FY25 data for the District were not available at the time of publication of this report.

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Figure 10. Individuals Who Received Mental Health Rehabilitative and Free-Standing Mental Health Services – FY25

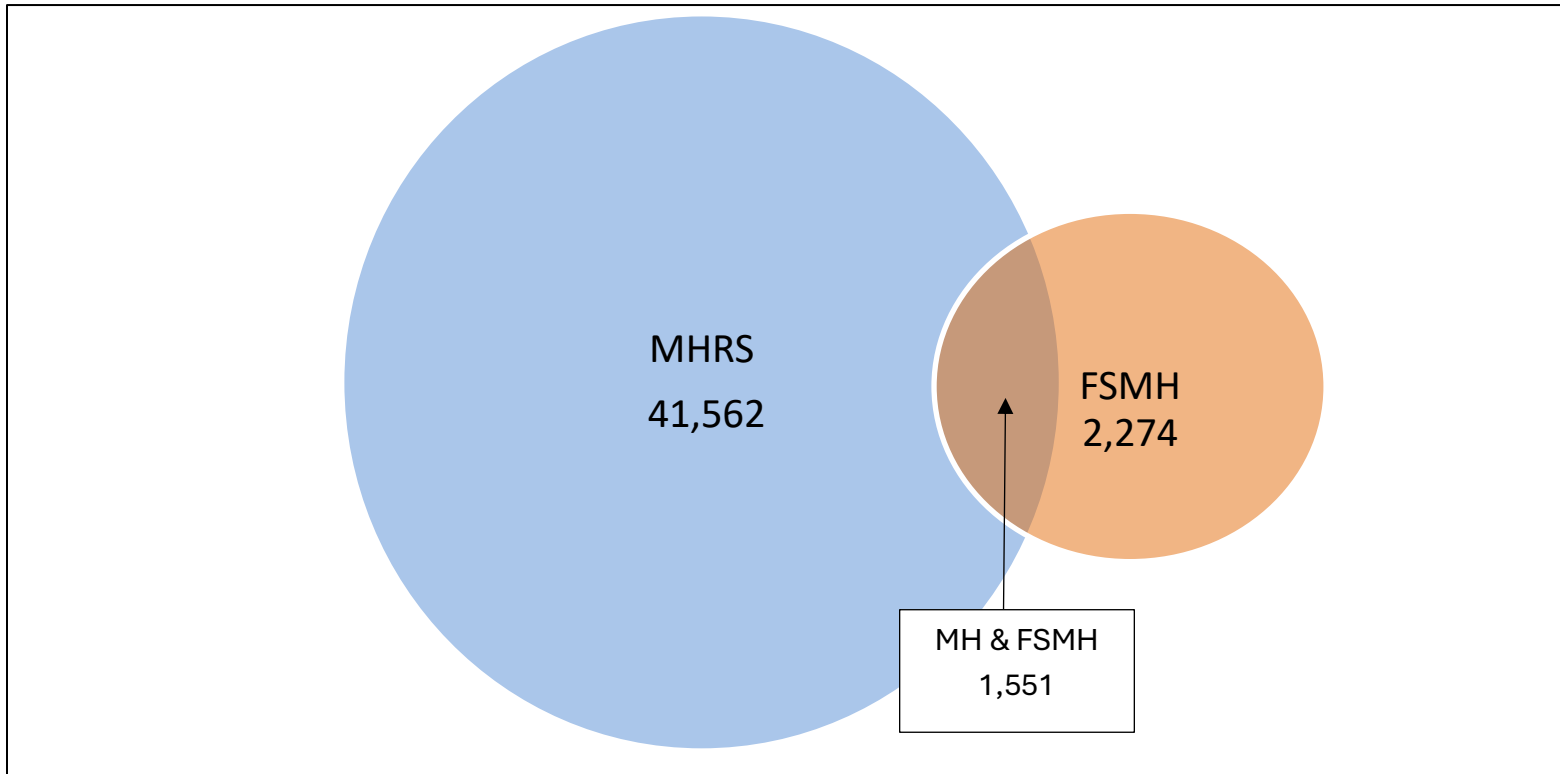


Figure 10 shows a total of 43,836 individuals obtained MHRs or FSMH services in FY25. Of those, 1,551 received services from both. DBH certifies two types of providers to deliver community-based mental health services. FSMH services are provided by behavioral health practitioners within a clinic setting. These services are screenings and assessments, counseling/therapy, and medication management. MHRs offers the same services as FSMH as well as a range of community-based and specialty services, such as Assertive Community Treatment (ACT), Community Behavioral Intervention (CBI), and community support. Providers can be certified as both types, and individuals can receive services from both types at the same time.

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Figure 11. Consumers Receiving Community-based Mental Health Services by Fiscal Year

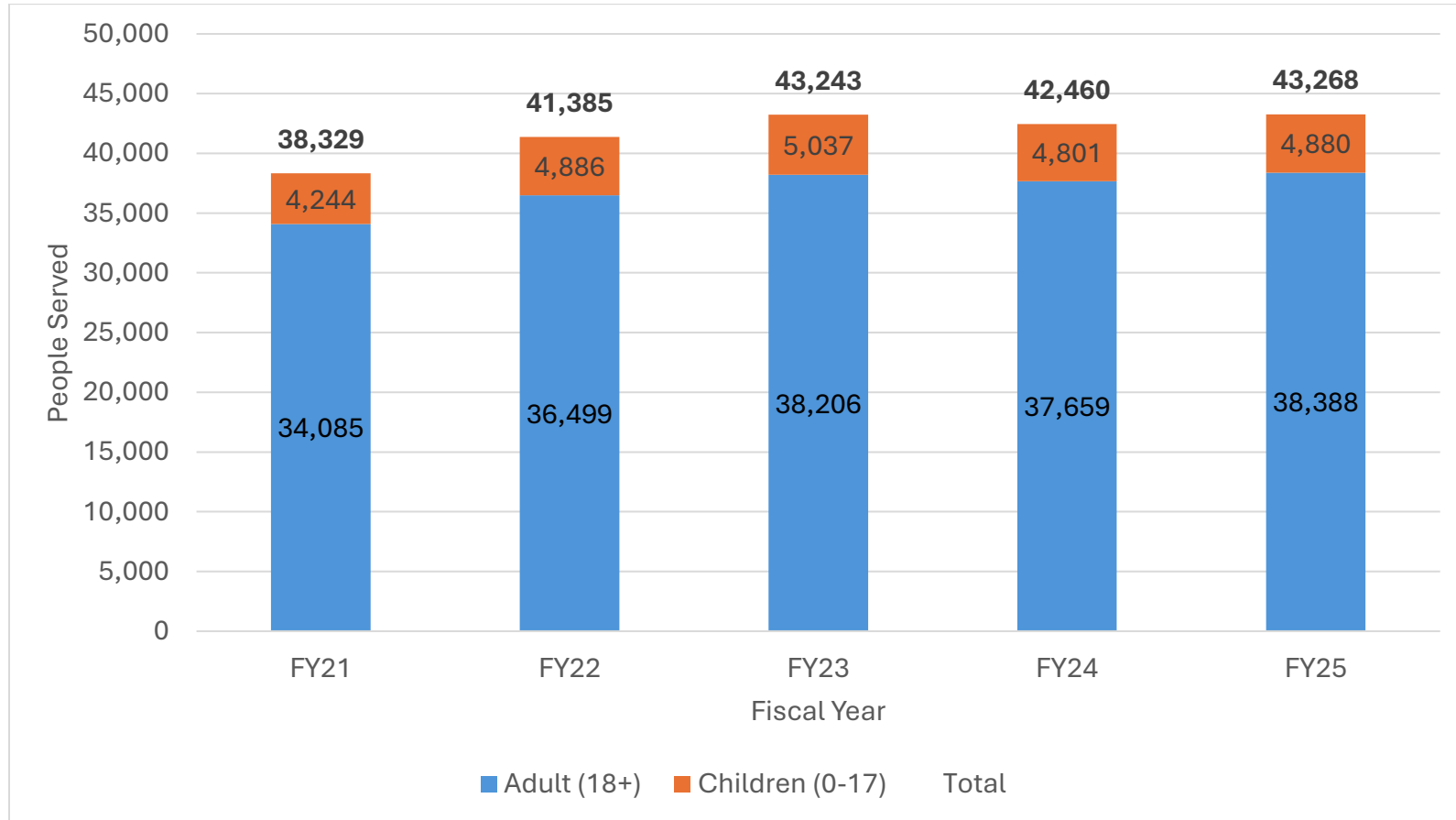


Figure 11 shows the number of adults and children receiving community-based mental health services stayed relatively the same from FY24 to FY25.

MHEASURES FY25



Figure 12. FY25 Utilization & Expenditures for Community-Based Mental Health Services

Service Group	Total Served	Children Served	Adults Served	Average Number of Services per Consumer	Expenditures	Percentage of Total Expenditures
Community Support	37,853	3,729	34,124	63	\$250,670,626	69%
Diagnostic and Assessment Services	30,152	3,078	27,074	2	\$8,735,249	2%
Medication Management	26,889	1,797	25,092	8	\$31,585,399	9%
Therapy (e.g. individual, family, group)	13,652	1,940	11,712	9	\$15,037,235	4%
Coordination Services	11,919	431	11,488	8	\$10,534,974	3%
Assertive Community Treatment (ACT)	1,959	11	1,948	69	\$29,495,750	8%
Day Rehabilitation	1,154	-	1,154	90	\$13,087,734	4%
Community Based Intervention (CBI)	204	167	37	28	\$1,413,576	0%
Supported Employment	170	-	170	4	\$68,777	0%
Inpatient Discharge Planning	85	4	81	2	\$19,718	0%
Psychosocial Rehabilitative (Clubhouse) Services	4	-	4	37	\$29,992	0%

NOTE: FSMHC services were integrated into the service groups of diagnostic and assessment, therapy, and medication management. Therapy is inclusive of evidence-based practices, such as those enumerated in Figure 21. Crisis/Emergency services are delivered by MHRS providers and are distinct from Crisis Services outlined in Figure 14.

Figure 12 shows that the three most frequently used services were community support, diagnostic & assessment, and medication management. Community support accounted for 69% of expenditures. Medication management was the next highest proportion of expenditures at 9%.

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Crisis Services

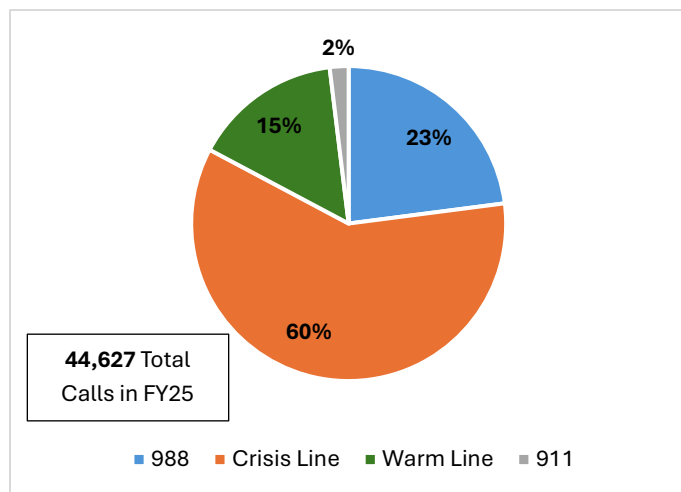
Figure 13. FY25 Utilization of Crisis Services

Service Group	Total Served	Adults Served	Children Served	Average Number of Services per Consumer	Expenditures	Percentage of Total Expenditures
Behavioral Health Outreach	778	515	263	2	\$304,407	8%
Comprehensive Psychiatric Emergency Program (CPEP)	653	653	-	2	\$1,246,953	34%
Crisis Response Team	384	211	173	1	\$267,271	7%
Crisis Beds	208	208	-	27	\$1,865,748	51%

Figure 13 shows the number of people who received each type of crisis service during FY25. The most frequently utilized crisis service by an individual was the crisis response team, and the highest overall expenditures were for crisis bed services.

MHEASURES FY25

Figure 14. FY25 Access HelpLine Call Volume & Line Type



DBH Access HelpLine professionals are trained in crisis response and provide free, confidential support for individuals experiencing suicidal thoughts or emotional distress and connect callers to local resources. AHL answered 44,627 calls in FY25. Calls related to behavioral health issues are diverted from 911 to AHL. Individuals in crisis can call 988 and speak to an AHL counselor. There is a main phone number (1-888-793-4357), and callers can select if they are in crisis or not. Non-crisis calls, categorized as the warm line, are for individuals who are not in immediate crisis but need counseling. The crisis line provides immediate support to individuals experiencing a crisis. Figure 14 shows the majority of calls in FY25 came through the main line and were classified as relating to a crisis (60%).

Figure 15. FY25 988 Volume

988 Calls/Chats/Text Volume	Count
Phone	8,998
Texts	1,352
Chats	1,095

Figure 15 shows the volume for each type of contact available through 988 in FY25. The 988 Lifeline connects call, text, or chat users to DBH counselors.

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Figure 16. FY25 Access HelpLine 988 Call Details

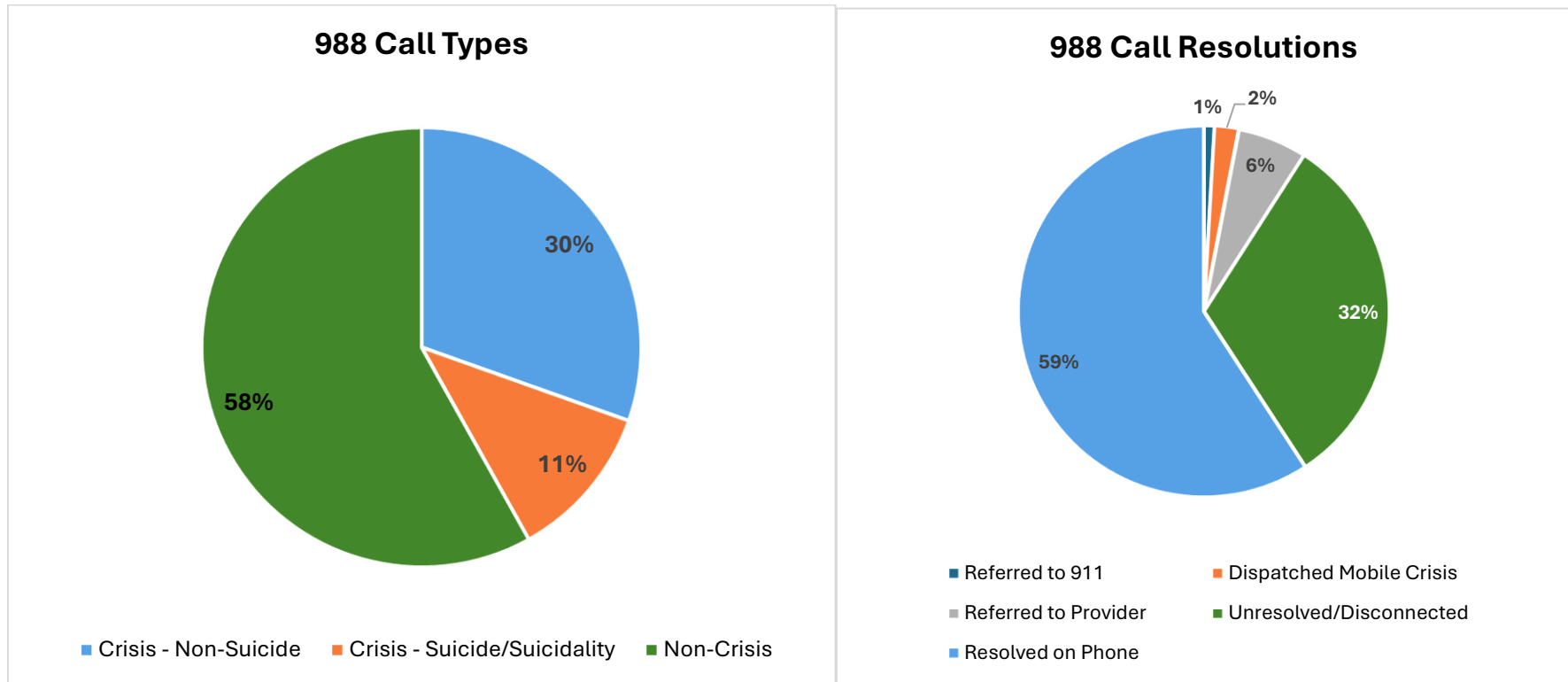
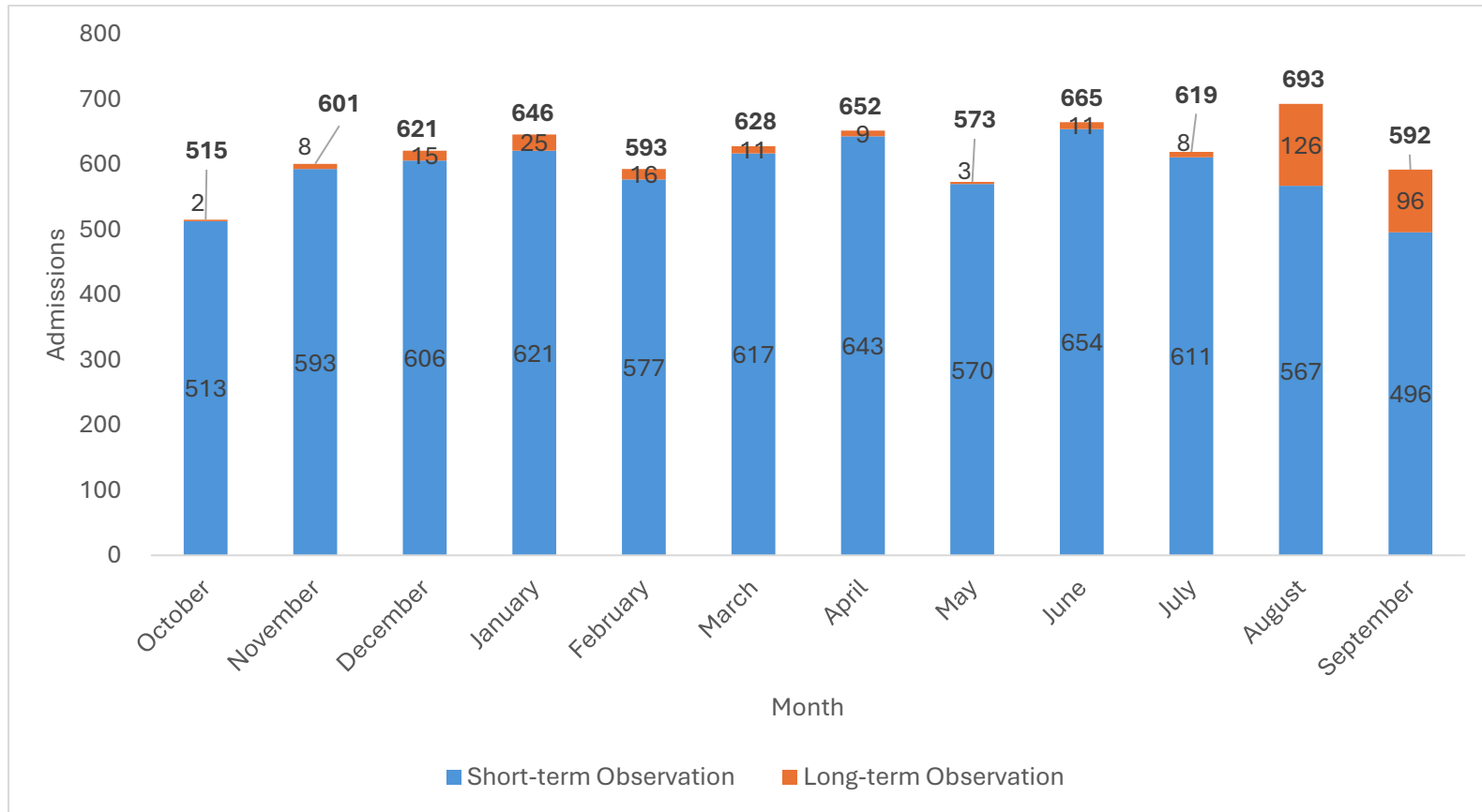


Figure 16 shows the call types and resolutions for 988 calls. Most were non-crisis calls resolved on the phone by DBH counselors. DBH answered 8,998 calls to 988 in FY25.

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Figure 17. FY25 Stabilization Center Utilization



The DC Stabilization Center (DCSC), a partnership between DBH and Community Bridges, Inc., supports adults experiencing an SUD crisis by emphasizing individual safety to reduce potential harms associated with intoxication, including overdoses, injuries, and unnecessary interactions with the criminal justice system. The DCSC accommodates up to 22 individuals simultaneously, with 16 recliners for stays up to 23 hours, and 6 beds for stays up to 72 hours for those needing extended observation. Figure 17 shows throughout FY25, utilization generally increased, from a low of 515 admissions in October to a high of 693 in August.

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Substance Use Services

Figure 18. Total Number of Substance Use Clients Served by Fiscal Year

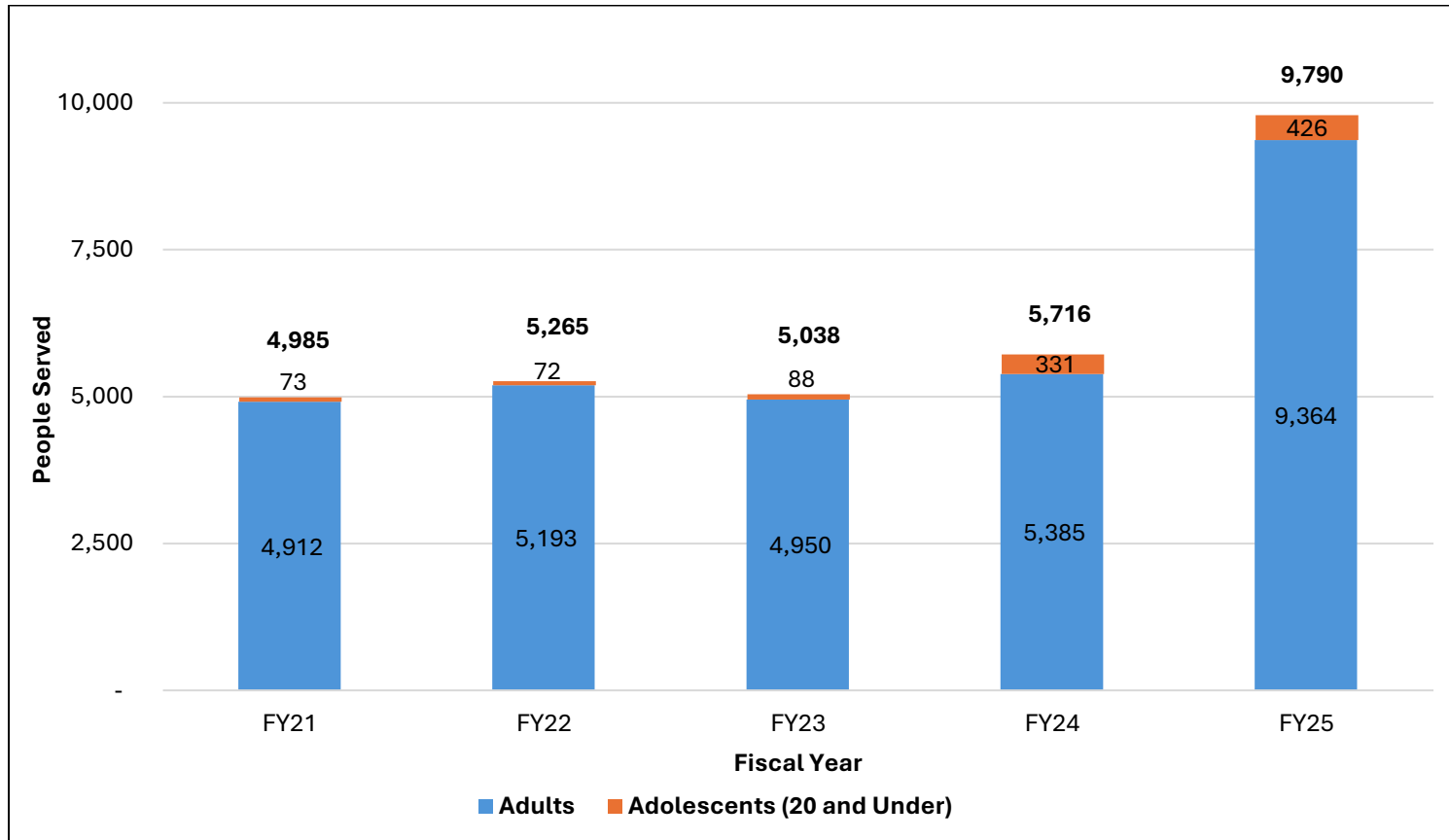


Figure 18 shows a 71% increase in total SUD clients served between FY24 and FY25. This trend was driven by two providers who delivered predominantly recovery support services to adult clients. Youth clients (up to age 20) increased by 29%.

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Figure 19. FY25 SUD Services Utilization

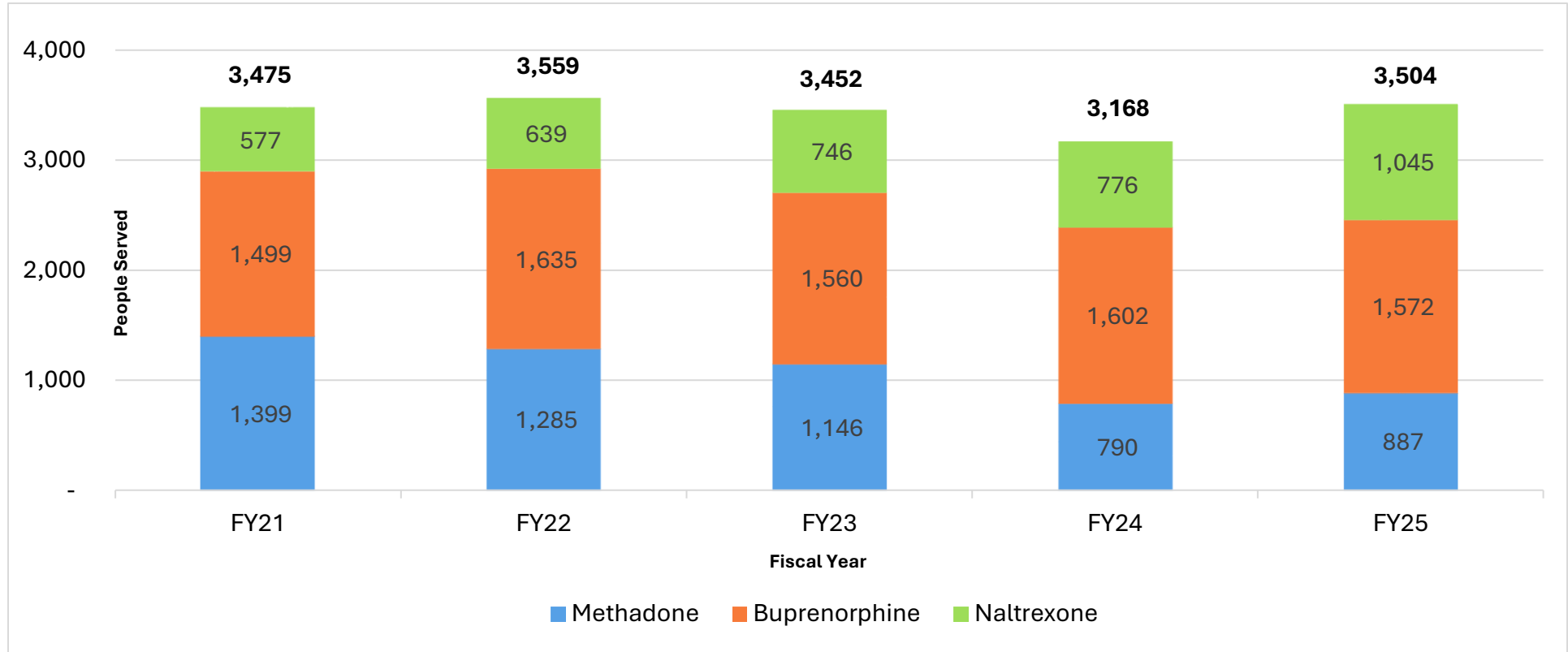
Service Group	Total Served	Children Served	Adults Served	Average Number of Services per Consumer	Expenditures	Percent of Total Expenditures
Diagnostic and Assessment Services	5,901	148	5,753	4	\$1,592,920	3%
Recovery Support	5,567	150	5,417	39	\$21,440,237	42%
Medication Management	3,687	122	3,565	5	\$2,887,069	6%
Medication Assisted Treatment (MAT)	3,419	17	3,402	36	\$9,145,069	18%
Therapy	3,105	155	2,950	21	\$4,262,191	8%
Clinical Care Coordination	2,135	59	2,076	4	\$1,459,008	3%
Residential Services	1,307	-	1,307	31	\$4,174,478	8%
Stabilization Center	618	-	618	7		
Withdrawal Management	357	-	357	4	\$915,213	2%
Crisis/Emergency	278	-	278	1	\$46,950	0%
Supported Employment	2	-	2	3	\$689	0%

Figure 19 shows that the most utilized service was diagnostic and assessment services, followed by recovery support. Assessments completed at DBH’s Assessment and Referral Center are not counted in Figure 19, as they are not billed.

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Figure 20. Medication Assisted Treatment (MAT) by Medication and Fiscal Year



NOTE: Methadone is administered in Opioid Treatment Programs (OTPs), while Buprenorphine and Naltrexone are prescribed in primary care settings. DBH certifies the OTP providers, and the Department of Health Care Finance monitors prescribers of Buprenorphine and Naltrexone.

Figure 20 shows the total number of clients receiving MAT increased by 11%. Clients receiving Methadone increased by 12%; those receiving Buprenorphine decreased by 3%, and those receiving Naltrexone increased by 35%. Use of Naltrexone has increased every year for the past five years, while comparatively, use of Methadone has been decreasing until FY25. Buprenorphine use has varied.

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Children’s Contracted Programs

Figure 21. Utilization Data for Contracted Child/Youth Programs – FY25

Program	Metric
<p>The Children and Adolescent Mobile Psychiatric Service (ChAMPS). ChAMPS provides on-site immediate help to children facing a behavioral or mental health crisis whether in the home, school or community. Services are geared toward children and youth 6-21 years of age with the goal of stabilization to avert inpatient hospitalization or placement disruptions. The mobile crisis teams also make follow up visits and connects families to needed support services. During FY23, the ChAMPS contract was revised to require the vendor to provide support only Monday through Friday from 8:00 a.m. to 8:00 p.m. 24-hour crisis services for youth are provided by the DBH CRT team that answer calls from the dedicated ChAMPS line from 8:00 p.m. to 8:00 a.m. Monday through Friday and on weekends.</p>	279 Deployments
<p>DC Mental Health Access to Pediatrics (DCMAP). DCMAP supports pediatric providers addressing mental health concerns, provides telephone consultation with clinicians, completes community resource referrals and face to face consultations as clinically indicated, and provides mental health education and training for primary care providers. In addition to the emotional and behavioral health screenings completed in FY25, 4,473 screenings were completed to determine whether a child was experiencing developmental delays and 3,025 health screening were completed for caregivers.</p>	21,148 Screenings
<p>Healthy Futures (HF). Healthy Futures is a program wherein clinical specialists provide consultation services to child development centers and home-based facilities to improve outcomes for children, parents, and staff to ultimately eliminate early childhood expulsions and suspensions and provide young children and their families with the behavioral health services required to support functional ability. Services include classroom observations, prevention/early intervention activities, modeling, and consultation with parents, teachers, and center directors.</p>	104 Early Childhood Facilities
<p>Children and Youth Intensive Care Coordination (ICC). ICC, formerly know as High Fidelity Wraparound Support, is a collaborative team-based care coordination service where a family and service team plans, implements, tracks and adapts an individualized plan of care to meet complex needs; address risks of out-of-</p>	184 Children Served

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Program	Metric
<p>home placement, school disruption and high utilization of acute care; and achieve the youth and family’s long-term vision of positive outcomes in the home, school and community.</p>	
<p>HOPE Court. Here Opportunities Prepare you for Excellence (HOPE) Court is a voluntary behavioral health diversion or “treatment” court wherein eligible youth are connected to behavioral health and other community-based supportive services. HOPE Court supports youth who are at risk or are confirmed survivors of commercial sexual exploitation of children (CSEC). Youth may have their charges dismissed or probation shortened through successful completion of the program in the case of a juvenile matter and/or once permanency is achieved in the case of neglect.</p>	58 Children Served
<p>Juvenile Behavior Diversion Program (JBDP). JBDP is a voluntary behavioral health diversion court or “treatment court” wherein eligible youth are connected to behavioral health and other community-based supportive services. Youth may have their charges dismissed or probation shortened through successful completion of the program in the case of a juvenile matter and/or once permanency is achieved in the case of neglect.</p>	49 Children Served
<p>Primary Project (PP). Primary Project is an evidence-based early intervention and prevention program for children in pre-Kindergarten through third grade who have been identified with mild adjustment issues in the classroom. Through one-to-one, non-directive play sessions, the program reduces social, emotional, and school adjustment difficulties to improve school-related competencies in task orientation, behavior control, assertiveness, and peer social skills.</p>	112 Children Served
<p>Psychiatric Residential Treatment Facility (PRTF). A PRTF is an accredited facility that provides inpatient psychiatric services for individuals, typically under the age of 18 who have complex behavioral health needs and meet medical necessity requirements for inpatient rather than community-based services. DBH oversees enrollment and care; and collaborates with PRTFs, families and community-based service providers to ensure youth successfully return to their home and community upon discharge.</p>	32 Children Served

MHEASURES FY25



Figure 22. Evidence Based Practices for Children/Youth

Practice	Number of Children Served in FY25
<p>Attachment and Biobehavioral Catchup (ABC). ABC service is an evidence-based practice that targets key issues among young children who have experienced early maltreatment and/or disruptions in care. ABC is a home visiting program for infants, toddlers, and parents provided by Parent Coaches.</p>	5
<p>Child Parent Psychotherapy (CPP). CPP is a therapeutic intervention for young children with a history of trauma exposure or maltreatment and their caregivers. CPP supports child development, restores the child-parent relationship and the overall feelings of safety, while reducing symptoms associated with the experience of trauma.</p>	16
<p>Functional Family Therapy (FFT). FFT is a family focused intervention for at-risk and juvenile justice involved youth.</p>	56
<p>Multi-Systemic Therapy (MST). CBI level I, MST, is an intensive community-based treatment for families and youth with antisocial behaviors putting them at risk of out of home placement, who are living with or returning to a parent/caregiver with whom the youth have a long-term relationship and who is willing to participate in treatment. Emphasis is on empowering parents/caregivers to assist youth in making and sustaining change in individual, family, peer, and school systems.</p>	17
<p>Parent Child Interaction Therapy (PCIT). PCIT is a supported treatment for young children who are experiencing extreme behavioral difficulties. It places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns.</p>	15
<p>Parent Child Interaction Therapy-Toddler (PCIT-T). PCIT-Toddlers focuses on the decrease of problematic behaviors, improve children’s language, and encourage young children to follow directions.</p>	8
<p>Transition into Independence (TIP). TIP is a practice model which prepares youth and young adults with emotional and behavioral challenges for the transition to adult roles by engaging them in their own futures planning while providing developmentally appropriate support. TIP involves youth/young adults, their families, and other key players in a process that facilitates movement towards greater self-sufficiency and successful achievement of their goals.</p>	355

MHEASURES FY25



Practice	Number of Children Served in FY25
<p>Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT is an intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events and address feelings.</p>	46
<p>Trauma Systems Therapy (TST). TST is a comprehensive model for treating traumatic stress in children and adolescents that adds to individually based approaches by specifically addressing the child’s social environment and/or system of care. TST is designed to provide an integrated and highly coordinated system of services guided by the specific understanding of the nature of child traumatic stress. TST focuses on the interaction between the child’s difficulties regulating their emotions and the deficits within the child’s social environment.</p>	17

MHEASURES FY25



Saint Elizabeths Hospital

The District's public psychiatric facility for individuals with serious and persistent mental illness requiring intensive inpatient care

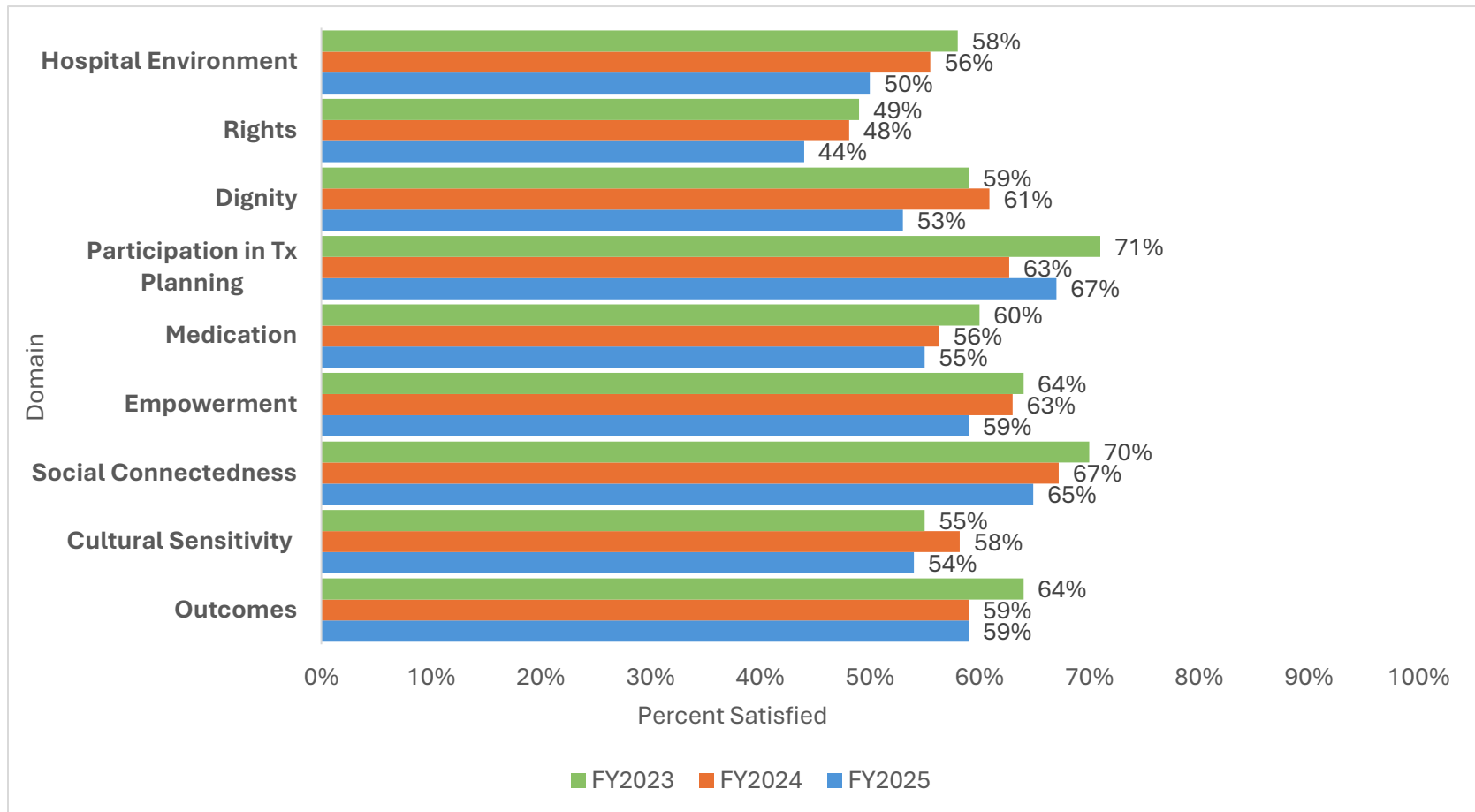


Saint Elizabeths Hospital is the District's public 292 bed psychiatric facility for individuals with serious and persistent mental illness who need intensive inpatient care to support their recovery. Saint Elizabeths also provides mental health evaluations and care to patients committed by the courts. The Hospital develops a personalized treatment plan to help each patient achieve the highest quality mental health outcomes.

MHEASURES FY25



Figure 23. Saint Elizabeths Hospital Satisfaction of Individuals in Care by Domain and Fiscal Year



In FY25, 138 surveys were completed. Satisfaction was highest in the domain of Participation in Treatment Planning (67%), followed by Social Connectedness (65%), Empowerment (59%), and Outcomes (59%). Compared to FY24, Outcomes showed improvement, while the remaining domains experienced either a decrease or no change in satisfaction.

MHEASURES FY25



Figure 24. Saint Elizabeths Hospital Admissions by Fiscal Year and Legal Status

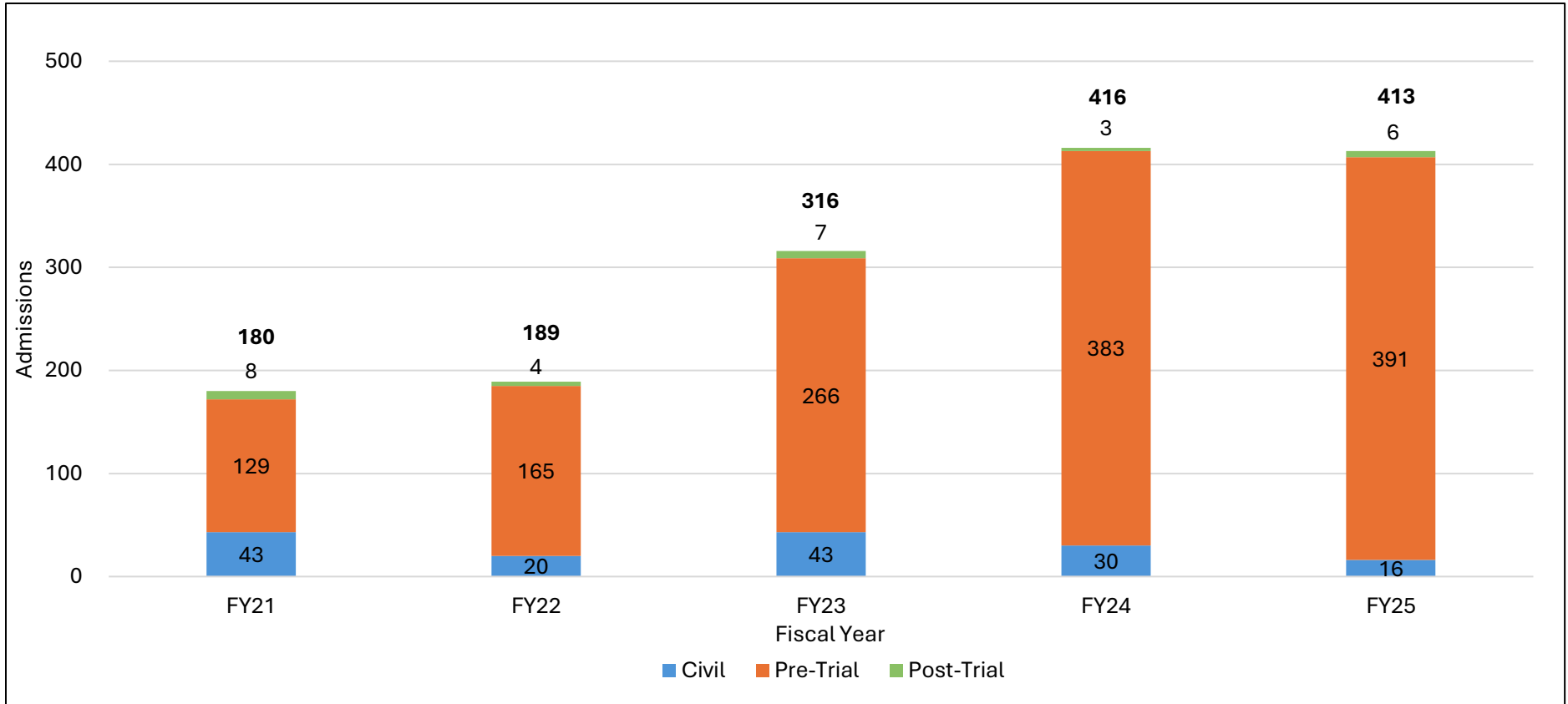


Figure 24 shows the legal status of individuals admitted to Saint Elizabeths Hospital. Civil status indicates individuals whose admissions were mandated by a civil commitment order. Pre-trial status means individuals were mandated by the court to obtain a competency evaluation while awaiting trial. Post-trial status refers to individuals who were found either not competent to stand trial or not guilty by reason of insanity. Most admissions were for forensically involved individuals who had a pre-trial legal status. In general, admissions increased as issues related to COVID-19 decreased. After two years of consistent increases, there was almost no change in admissions between FY24 and FY25.

MHEASURES FY25



Figure 25. Saint Elizabeths Hospital Discharges by Fiscal Year and Legal Status

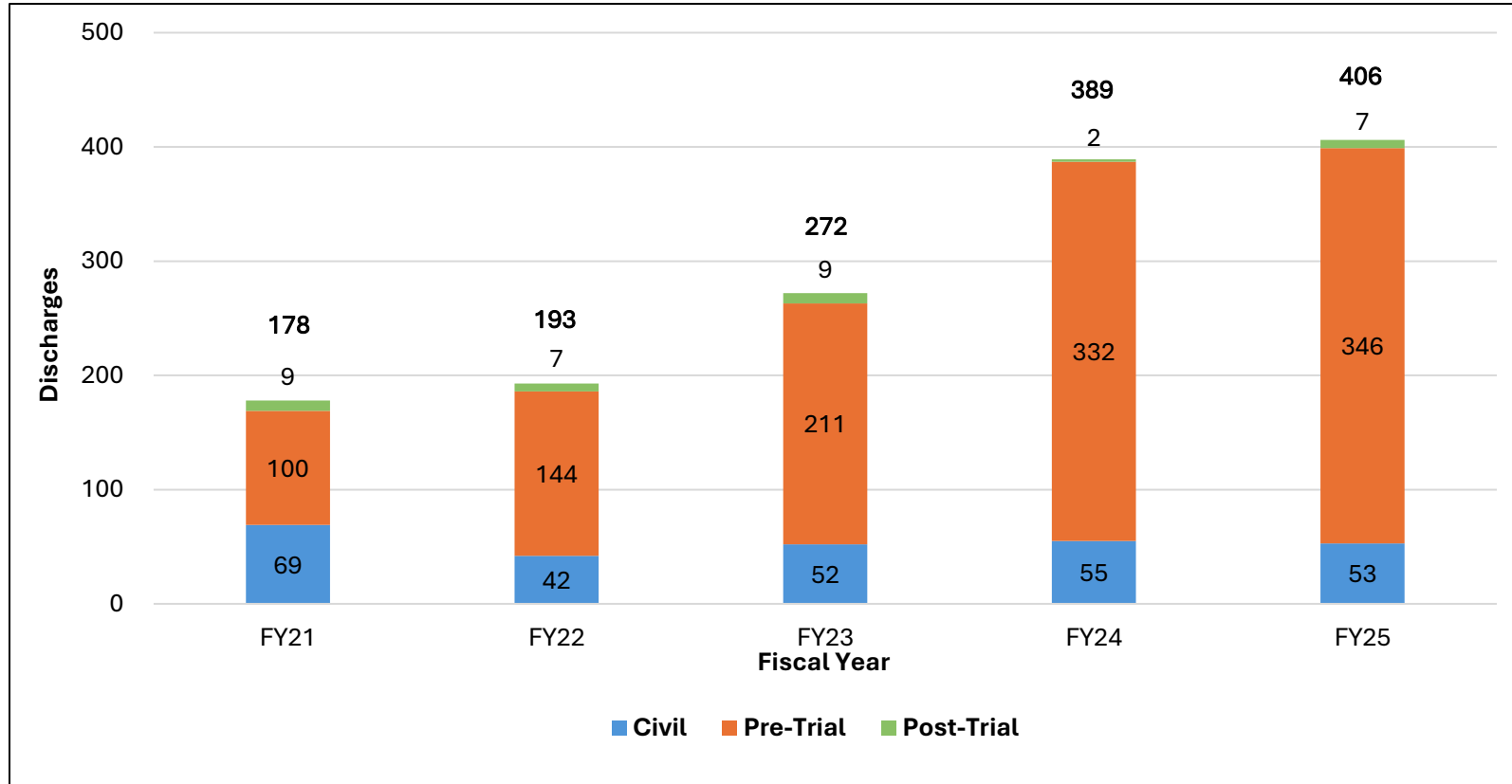


Figure 25 shows discharges from Saint Elizabeths Hospital increased by 4% between FY24 and FY25. The majority of discharges each year were individuals who were of pre-trial legal status.

MHEASURES FY25



Figure 26. Saint Elizabeths Hospital Average Daily Census by Fiscal Year

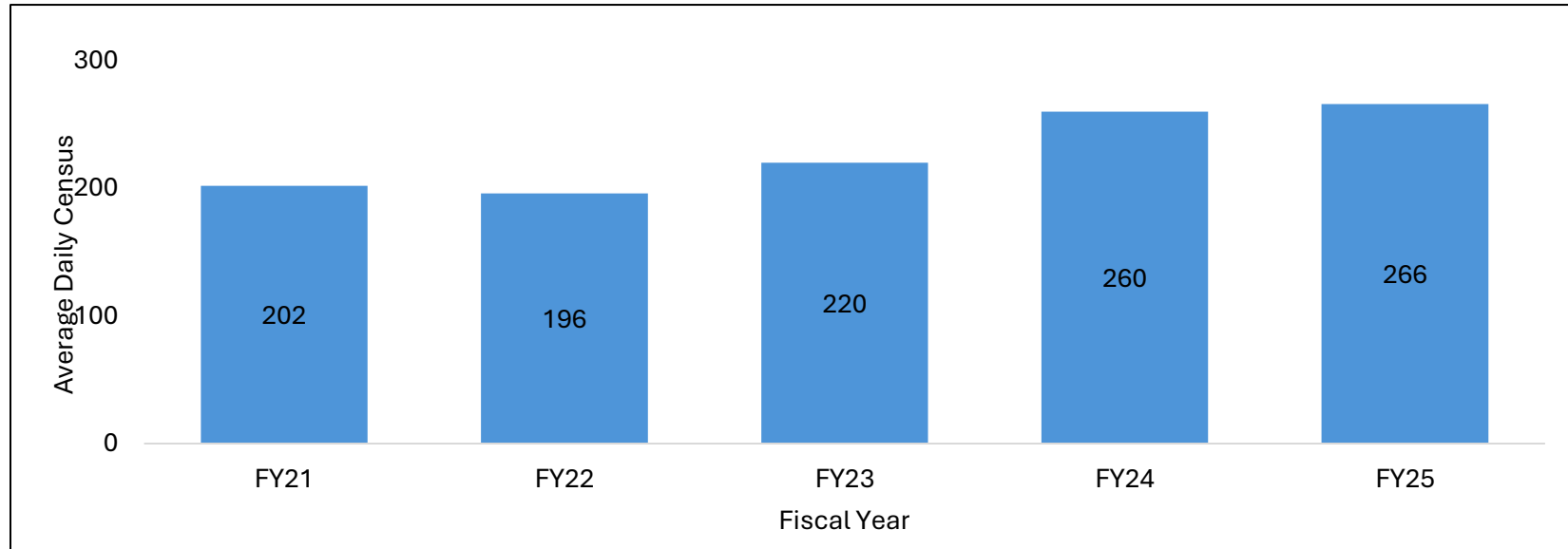


Figure 26 shows the average daily census at Saint Elizabeths Hospital remained steady between FY24 and FY25.

MHEASURES FY25



Expenditures

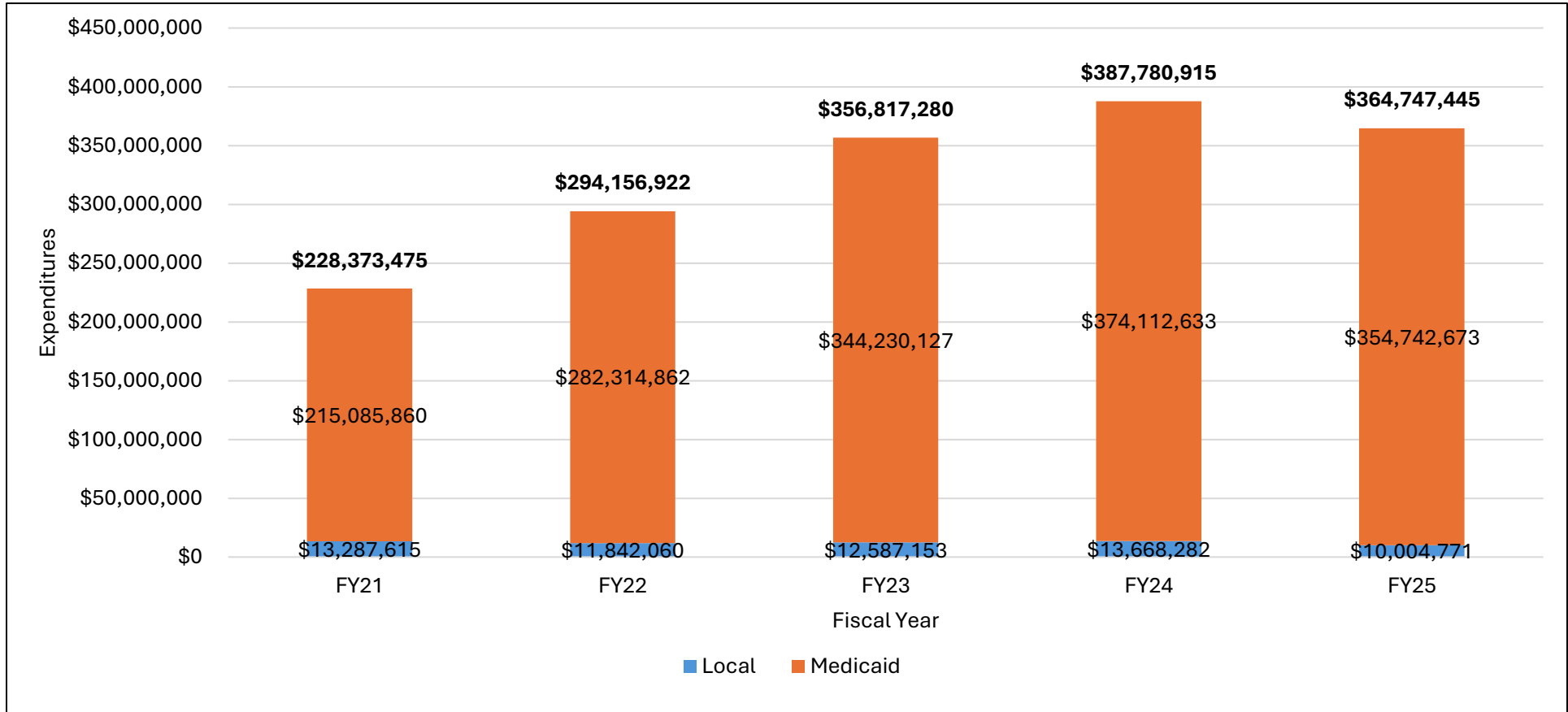


The expenditure data in this report includes behavioral health services delivered by DBH-certified providers. Most services (96%) are paid for by Medicaid (directly by DHCF under FFS or by MCOs on behalf of DHCF). Medicaid services are funded by federal and local dollars. While the federal government pays the majority of claims, DBH pays a percentage of every Medicaid dollar spent using local funds. Fully local funds (4%) are used when either the individual receiving services does not have insurance, or if the service is not reimbursable by Medicaid but is part of the array of services DBH offers.

MHEASURES FY25



Figure 27. Mental Health Claims Expenditures by Payer Type and Fiscal Year



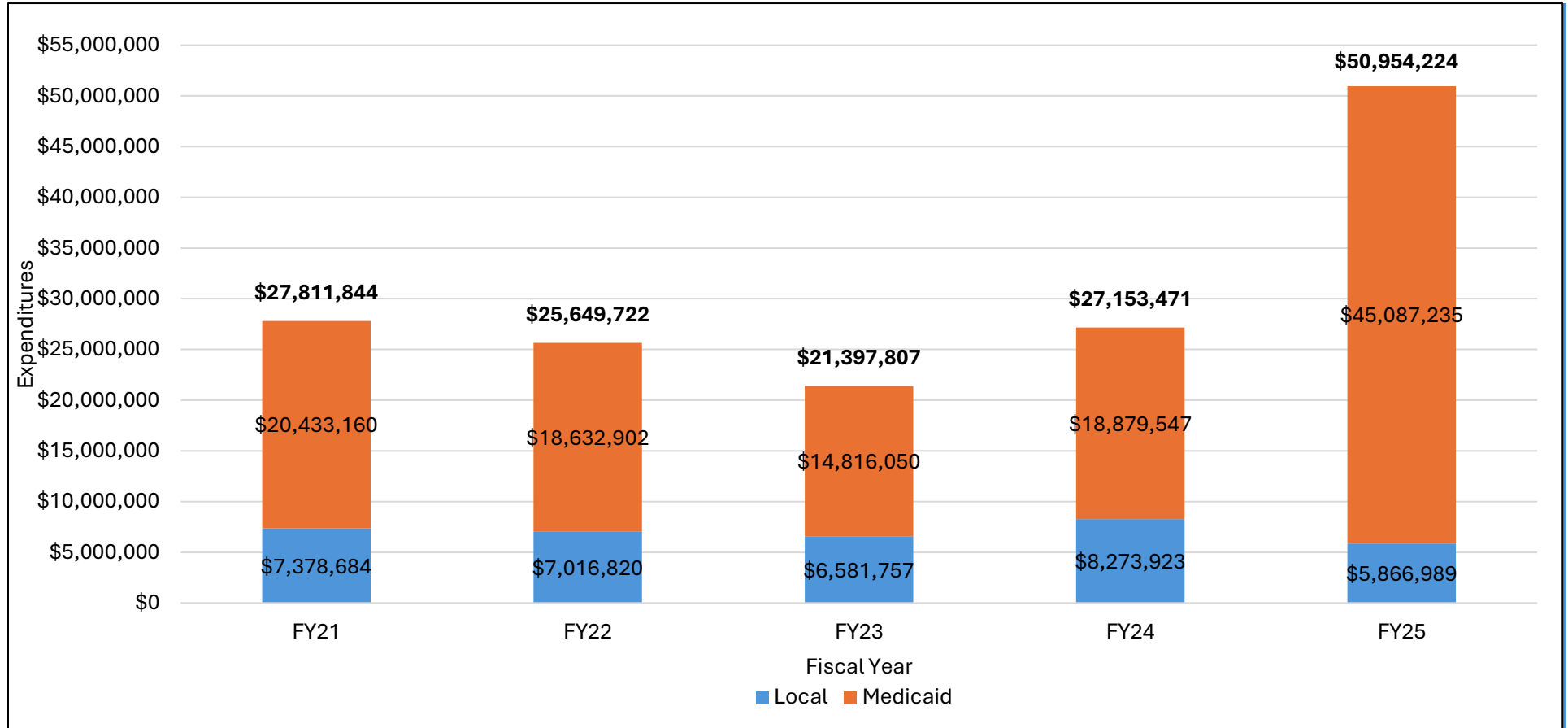
NOTE: Medicaid mental health paid claims data were provided by DHCF. Local paid claims data were extracted from DBH’s Incedo system. Payments to hospitals for mental health inpatient stays are not included in the expenditure data.

Figure 27 shows \$365 million was spent on claims-based mental health services in FY25. This amount reflected a 6% decrease in spending from FY24 to FY25. DBH local funds accounted for about 3% (about \$10 million) of FY25 spending on claims-based mental health services. The decrease in expenditures was largely driven by reductions in community support.

MHEASURES FY25



Figure 28. Substance Use Claims Expenditures by Payer Type and Fiscal Year



NOTE: Medicaid substance use paid claims data, including pharmacy expenditures for MAT, were provided by DHCF. Local paid claims data were extracted from DBH’s Incedo system. Payments to hospitals for withdrawal management services are included in DBH’s local data. There are no payments to hospitals included in the DHCF data.

Figure 28 shows \$51 million was spent on claims-based substance use services in FY25 representing an 88% increase in expenditure as compared to FY24. DBH local funds accounted for 13 % (about \$5.9 million) of FY25 spending on claims-based substance use services. The increase in expenditures was largely driven by two providers delivering predominantly recovery support services.

MHEASURES FY25



Figure 29. Mental Health Telehealth Expenditures – FY23-FY25

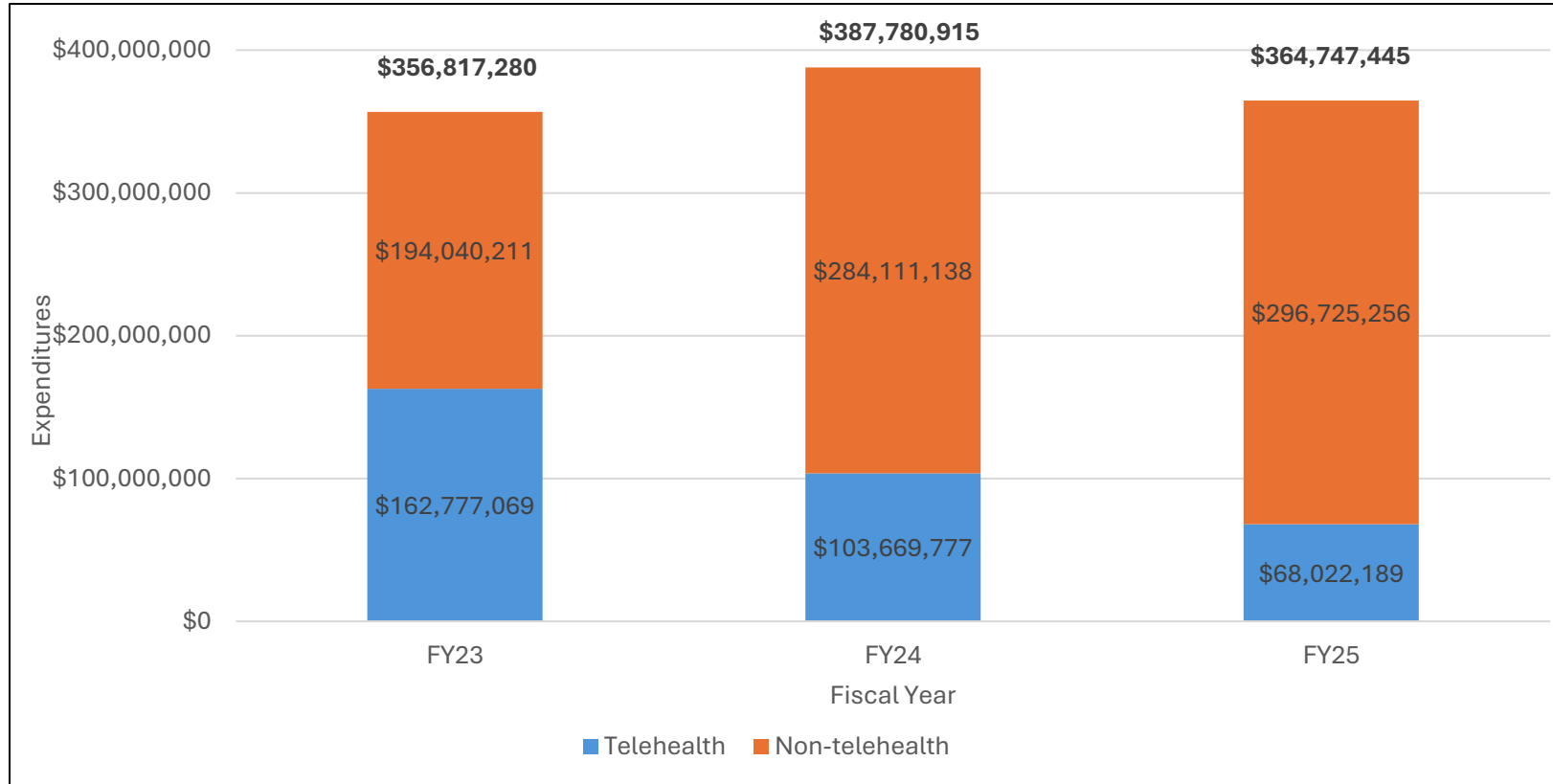


Figure 29 shows the use of telehealth (i.e., telephonic or video telecommunications technology that met required standards of care) for mental health services decreased 34% from FY24 to FY25. This was largely driven by the limitation on providing community support through telehealth.

MHEASURES FY25



Figure 30. SUD Telehealth Expenditures – FY23-FY25

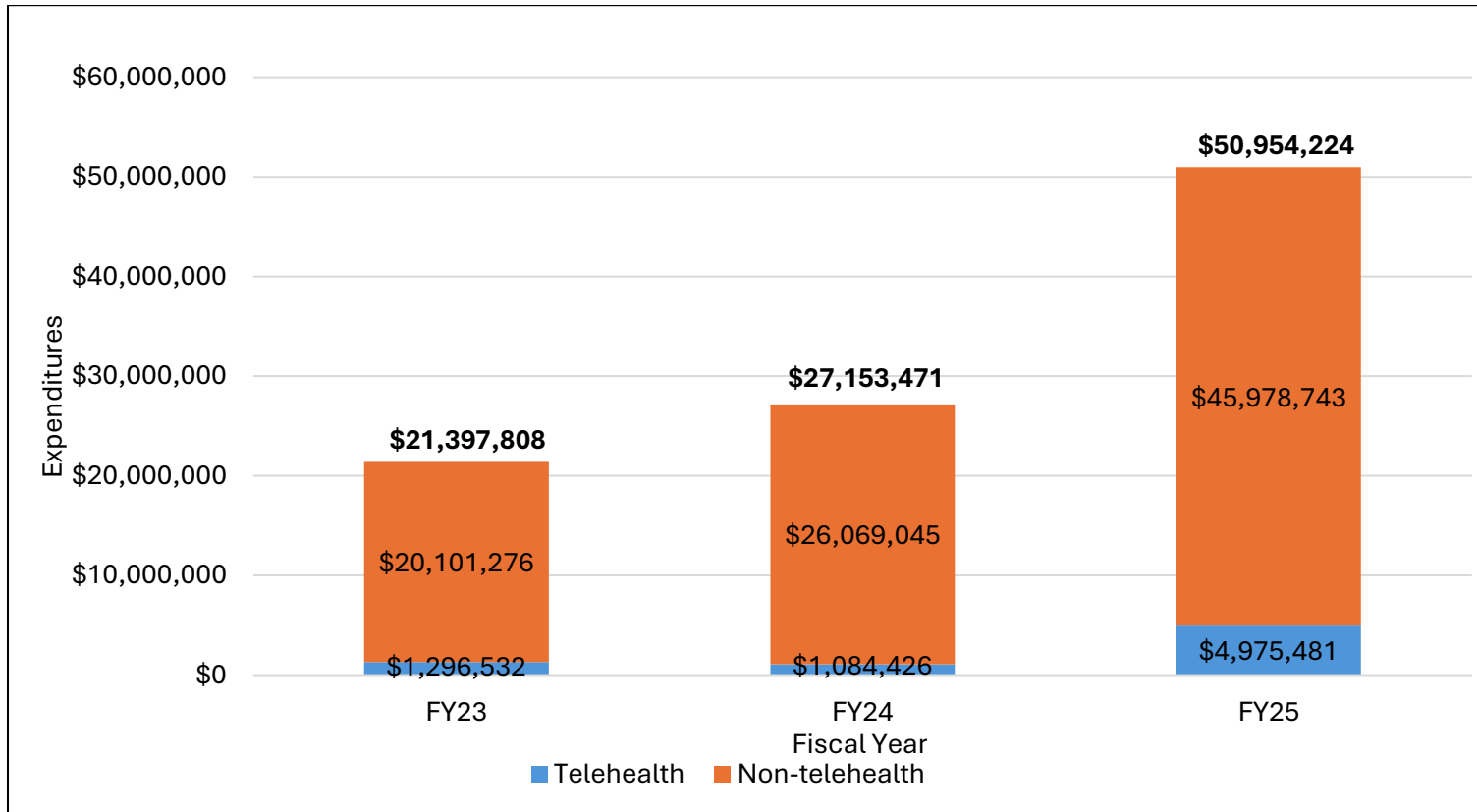


Figure 30 for substance-use disorder services increased 359% from FY24 to FY25. This increase was due to a higher use of telehealth for diagnostic and assessment services, recovery support services, and medication management.

MHEASURES FY25



Figure 31. Mental Health Claims Expenditures by Age Group and Fiscal Year

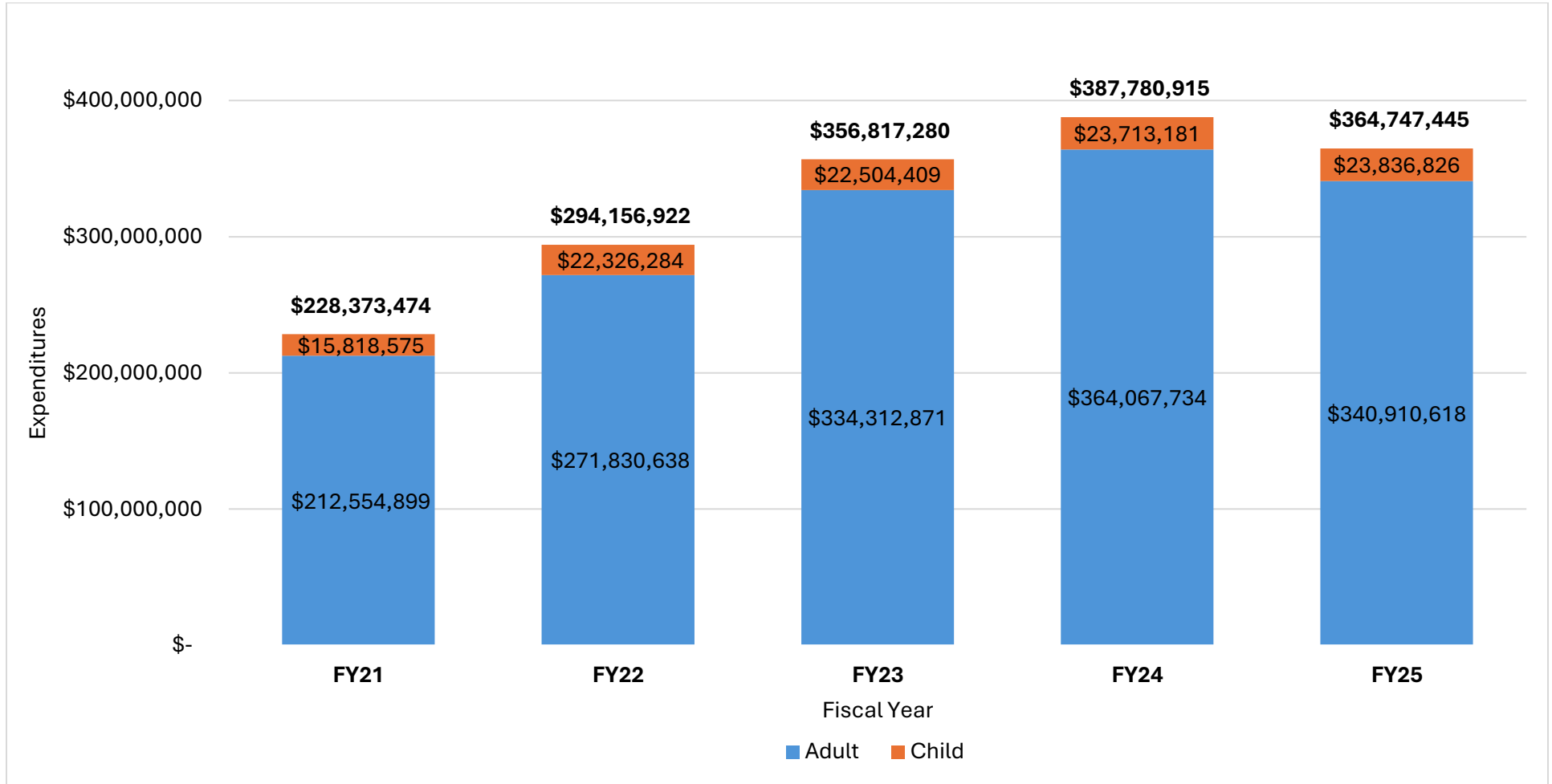


Figure 31 shows mental health claims-based expenditures for both adults and children increased each year from FY20 to FY24. In FY25, adult mental health expenditures decreased by 6%, while expenditures for children remained generally the same as FY24. The decrease in expenditures was driven by limitations on community support.

MHEASURES FY25



Figure 32. Substance Use Claims Expenditures by Age Group and Fiscal Year

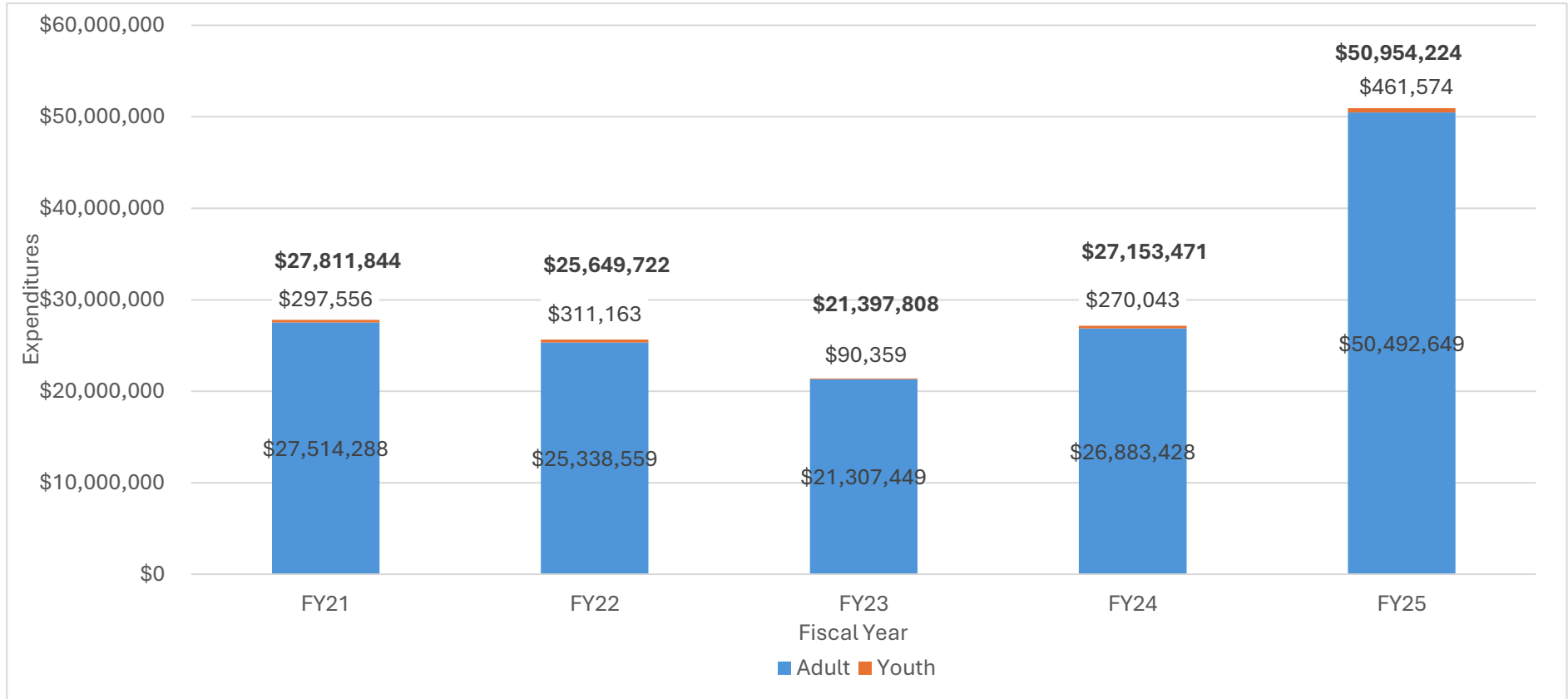


Figure 32 shows a significant increase in adult SUD expenditures in FY25. This was driven by two providers delivering predominantly recovery support services.