Mental Health and Substance Use Report on Expenditures and Services (MHEASURES)
January 2020 (Fiscal Year 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 Health Homes operated by DBH's network and the Mental Health Rehabilitation Services (MHRS) option. Consumers enrolled in MHRS have access to the following services: (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-based mental health services, early childhood services, suicide prevention, forensic services, peer support, and supported employment.

DBH contracts with 50 core service agencies and eight 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 Community Response Team (CRT).

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 29 treatment and recovery providers that provide services for adolescents and adults with substance use disorders (SUD) through Adult Substance Abuse Rehabilitation Services (ASARS) program. Individuals who want to obtain services go through the Access and Referral Center (ARC) and five community intake sites operated by existing treatment providers that were certified in July 2019. During the intake process, clients receive 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, and limited housing (up to 6 months) to help foster a stable recovery environment.

SUD services for adolescents are provided through the Adolescent Substance Abuse Treatment Expansion Program (ASTEP). Three 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:

- Individuals receiving services from both mental health and substance use providers is shown in *Figure 1;*
- Gender and race distribution for individuals receiving services from both mental health and substance use providers is shown in *Figures 2 and 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 shows in *Figures 8 and 9*;
- Mental health cost and utilization data based upon claims expenditures 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.*

MHEASURES contains information regarding MHRS, Health Homes, and ASARS services paid for through Medicaid claims and local dollars

Limitations of the Report

1. **Mental health findings in this report are based solely on the public mental health system's MHRS claims data**. Individuals with mild to moderate levels of mental health needs may receive care from non-MHRS providers such as free-standing mental health clinics, Federally Qualified Health Centers (FQHCs) or independent psychiatrists who bill private insurers. In addition, approximately seventy percent of all Medicaid beneficiaries are enrolled in a managed care plan, through which they may receive behavioral health services outside of the MHRS benefit. These services are not captured in the DBH MHRS claims data. Additionally, the MHRS claims data do not include:

- inpatient psychiatric stays;

- contracted services supported with local dollars such as prevention and intervention services (e.g., school based mental health, early childhood services, forensic services, housing, transition-age youth services, and suicide prevention services).

2. Substance use findings are based solely on the public substance use system's ASARS claims data. As with mental health, individuals receive substance use services outside of ASARS benefit. There are providers certified by DBH that do not have a contract with DBH and therefore do not use the DBH electronic health record, WITS, which is the source of data for this report. Some individuals receive medication assisted treatment (MAT) in the form of Buprenorphine or Naloxone, which are not billable as ASARS services. The only MAT included in MHEASURES is methadone, which is provided in DBH's Opioid Treatment Programs (OTPs).

3. Youth SUD treatment is predominantly covered by Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and/or funded by grants. Since DBH does not collect claims data that qualify for the EPSDT benefit and/or grant data, information on the number of youth served and expenditures understate DBH services for youth.

Summary of Findings

The Department of Behavioral Health provides a robust array of services to meet the mental health and substance use service needs of District residents. Findings based upon the current analysis of data show:

Consumers Served

- DBH served a total of 24,098 mental health consumers in FY19. This is a slight increase from the 23,259 served in FY18.
- DBH served 5,174 clients with substance use disorders in FY19, a slight decrease from the 5,186 served in FY18. This change reflects a small increase in adults served and a decrease in children/adolescents (aged 0-20) served.[1]
- Of the individuals receiving mental health or substance use services, 8 percent (i.e., 2,353) were identified as having both a mental health and substance use disorder.

District Expenditures on Behavioral Health Services

- District Medicaid and local funds paid for $121.9 million on mental health services claims in FY19.
- 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). This is consistent with previous years, as these are services for the highest acuity population.

[1] In FY20, DBH will have access to more comprehensive data from DHCF for substance use services beyond ASARS and will be able to report on a broader universe of people receiving publicly financed SUD services.

- District Medicaid and local funds paid for $17.1 million on substance use services claims in FY19. Residential (inpatient) treatment represented the largest share (53%) of expenditures; 30% of episodes were for this level of care. The second highest percentage of expenditures was for services provided by the Opioid Treatment program (21%).

Types of Services Provided

- About 12 percent (2,619) of adult mental health clients received an intensive community-based service and 10 percent (1,999) of adults obtained a crisis and emergency service in FY19. Among youth aged 17 and younger, about 17 percent (534) received an intensive community-based service and 13 percent obtained a crisis and emergency service in FY19.

- About 37 percent (1,920) of substance use clients received residential (inpatient) treatment in FY19. The second most frequently used substance use service was the opioid treatment program, with 31 percent (1,598) of clients enrolled in FY19.

FY19 data is based on mental health claims submitted and substance use data entered for dates of service between October 1, 2018 and September 30, 2019.

MH Data Source: *iCAMS, DHCF claims data (Run Date: 1/3/2020)*

SUD Data Source: *WITS, (Run Date: 1/2/2020)*

Report prepared by the DBH Data and Performance Management Division

Figure 1. Individuals Who Received Mental Health and Substance Use Services – FY 2019

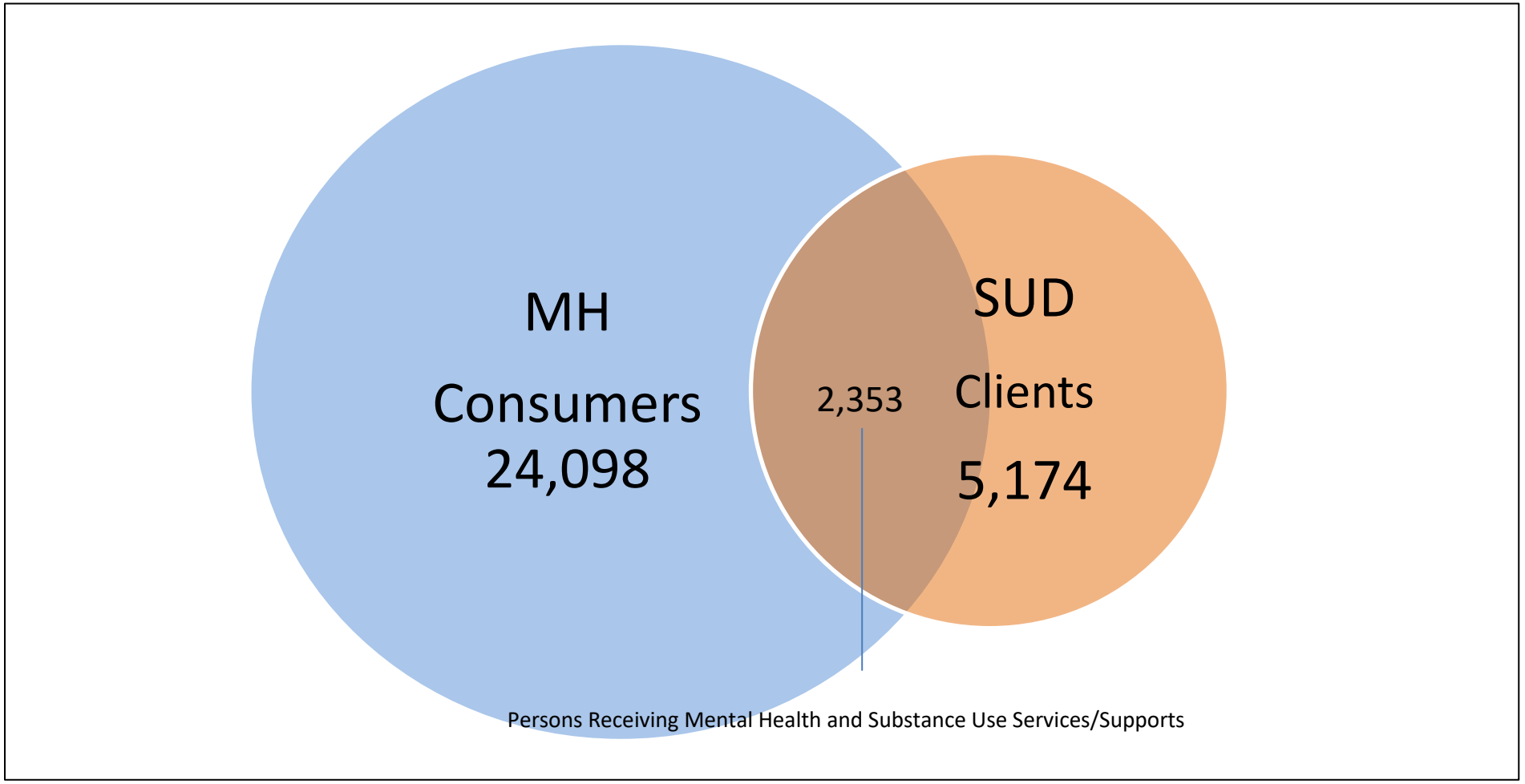


Figure 2. Gender FY19

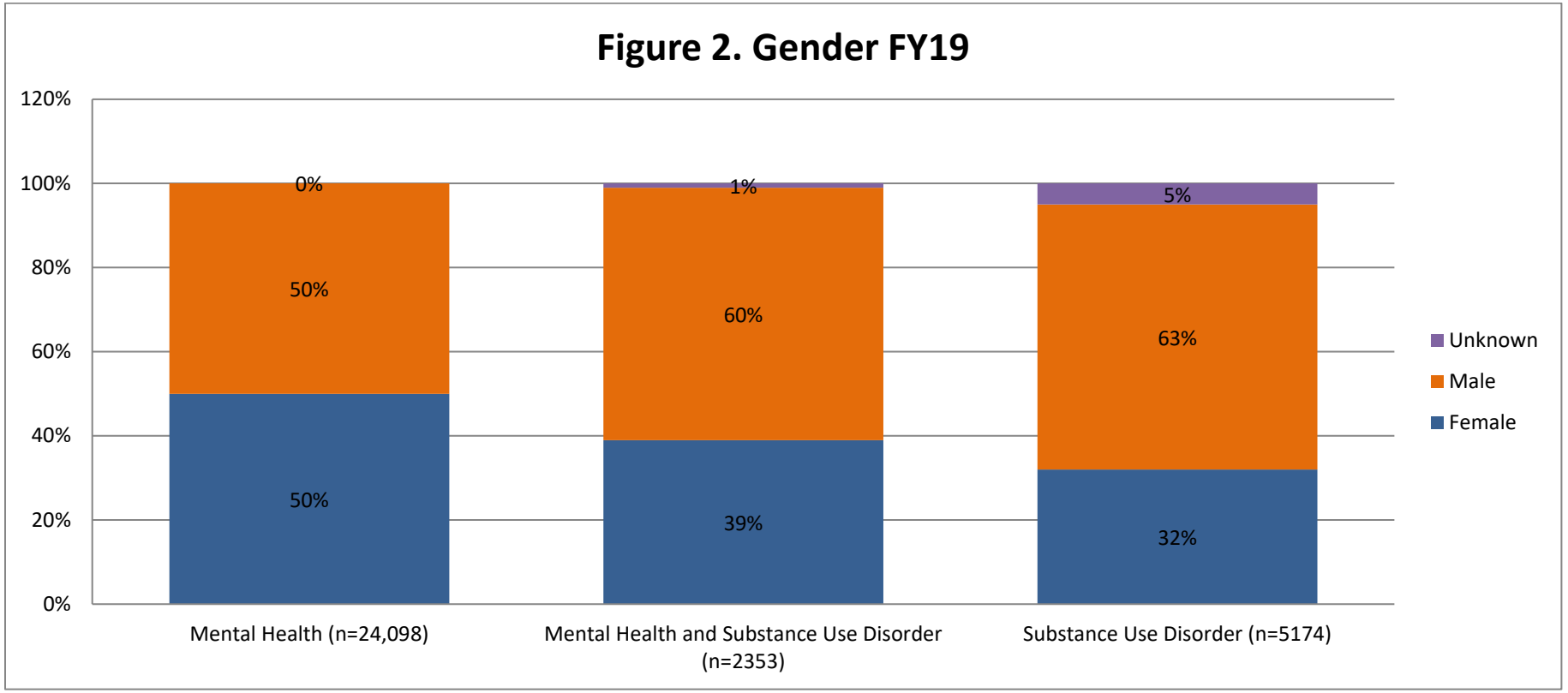


Figure 1 displays the gender of mental health, substance use, and co-occurring consumers and clients. The count of mental health consumers includes those who also received substance use services, and the count of substance use clients includes those who also received mental health services. The count of people who received both mental health and substance use services is a subset of the total mental health consumers and total substance use clients.

Figure 3. Race FY 2019

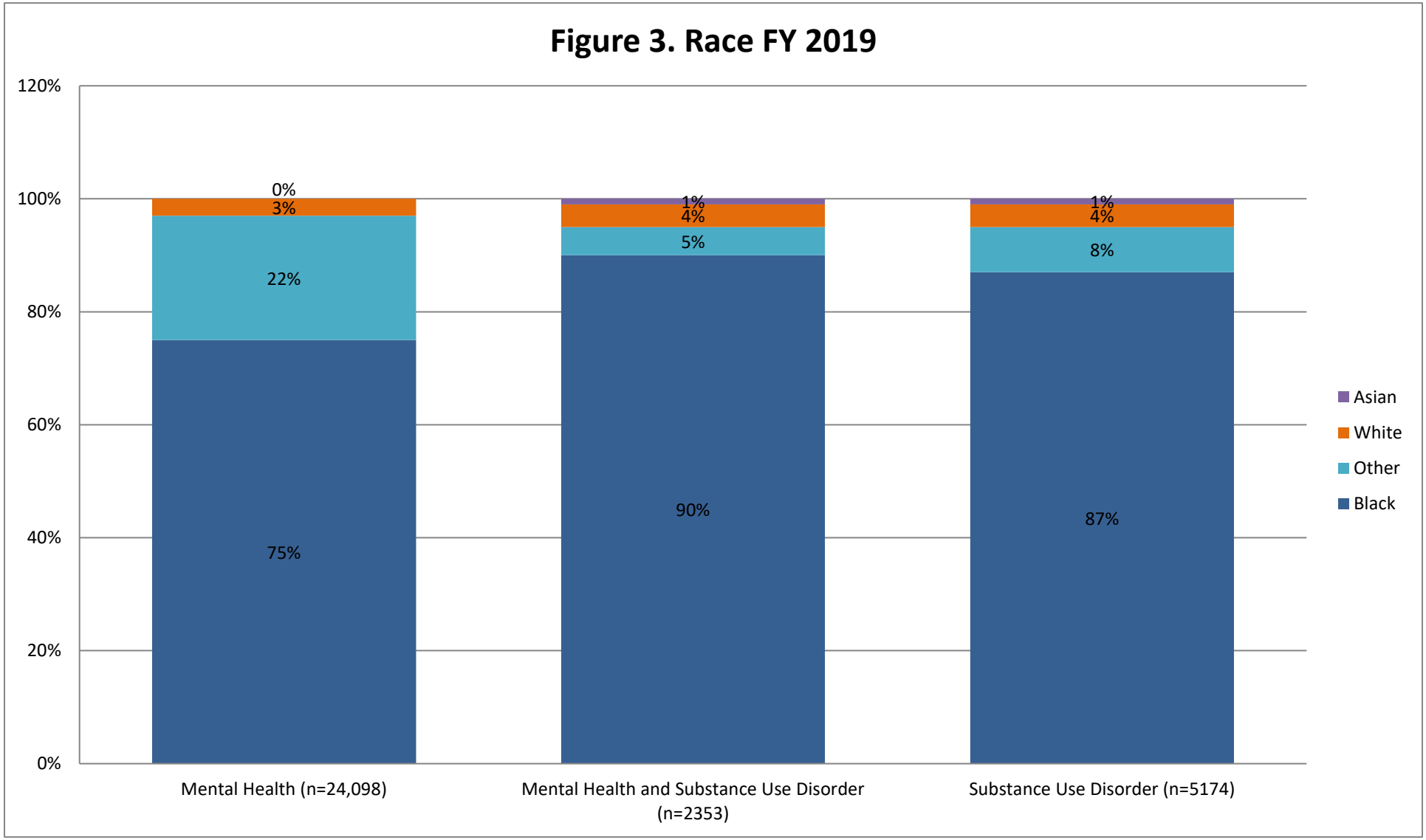
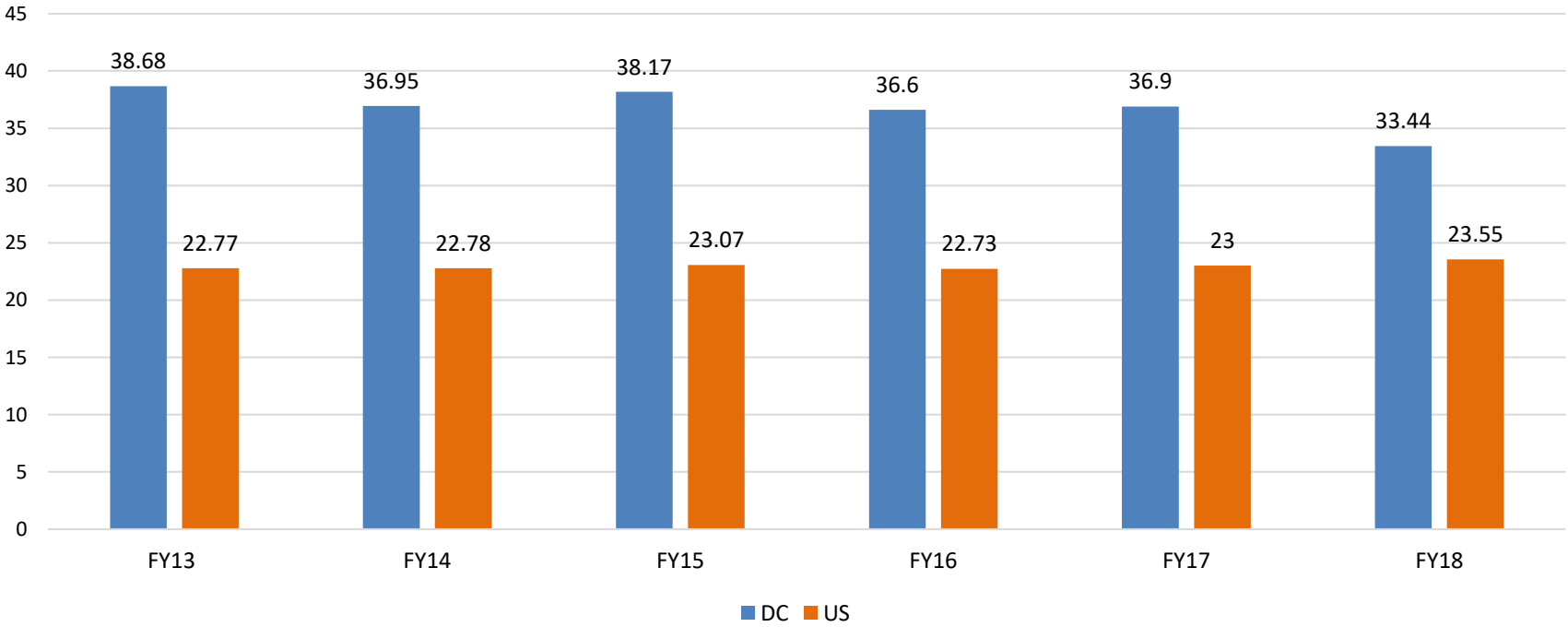
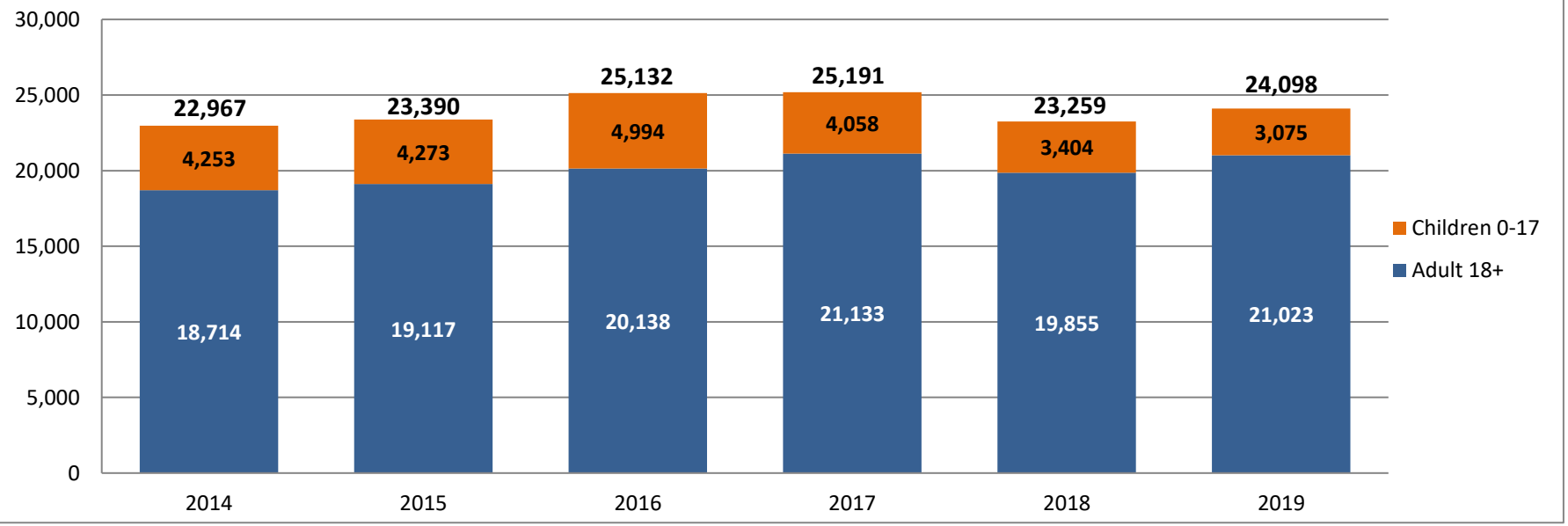


Figure 4. Mental Health Medicaid Penetration Rate



Penetration rate is calculated by the Substance Abuse and Mental Health Services Administration (SAMHSA) and is calculated per 1000 people. FY19 data was not available at the time of publication.
https://www.samhsa.gov/data/report/2018-uniform-reporting-system-urs-output-tables.

Figure 5. Consumers Receiving Mental Health Services by Fiscal Year



Children (Age 0-17)

0% Change from 2014 to 2015
14% Increase from 2015 to 2016
-23% Decrease from 2016 to 2017
-16% Decrease from 2017 to 2018
-10% Decrease from 2018 to 2019

Adults (Age 18+)

2% Increase from 2014 to 2015
5% Increase from 2015 to 2016
5% Increase from 2016 to 2017
-6% Decrease from 2017 to 2018
6% Increase from 2018 to 2019

Children & Adults Combined

2% Increase from 2014 to 2015
7% Increase from 2015 to 2016
0% Change from 2016 to 2017
-8% Decrease from 2017 to 2018
4% Increase from 2018 to 2019

Figure 5 displays the total number of consumers who received mental health services from Fiscal Year 2014 to Fiscal Year 2019. Each number represents an individual consumer who received at least one service within the public mental health system during the specified timeframe.

Two District agencies, Child and Family Services Agency and the Department of Human Services, have increased their direct contracts with mental health providers, thereby reducing the number of children served through DBH's programs.

Figure 6. Adult (18+) Mental Health Consumers Enrolled & Served by Fiscal Year

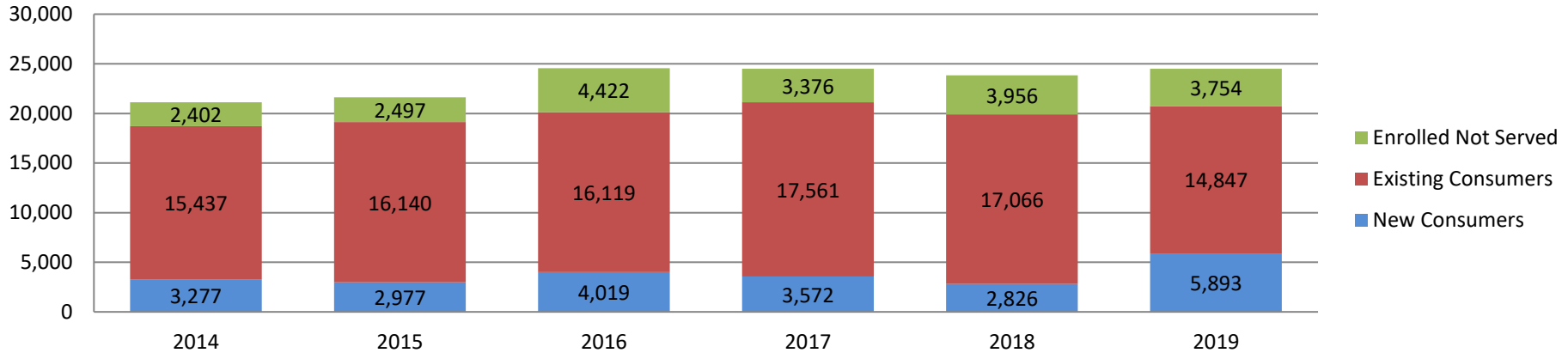
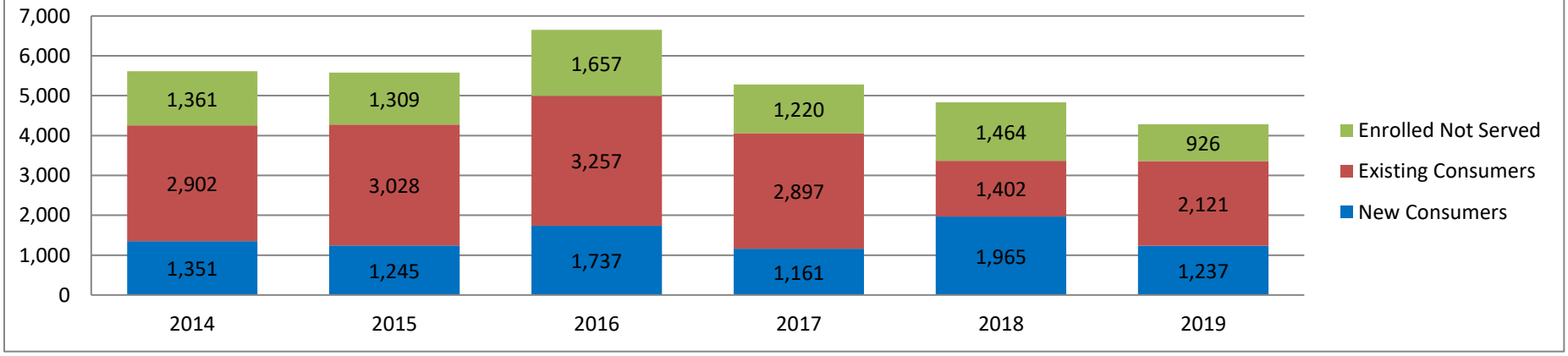


Figure 7. Child (0-17) Mental Health Consumers Enrolled & Served by Fiscal Year



Figures 6 & 7 display the number of consumers who were either: 1) enrolled prior to this reporting period (Existing Consumers), 2) new to the public mental health system (New Consumers), or 3) 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.

Figure 8. Adult (18+) Mental Health Consumers Insurance Type by Fiscal Year

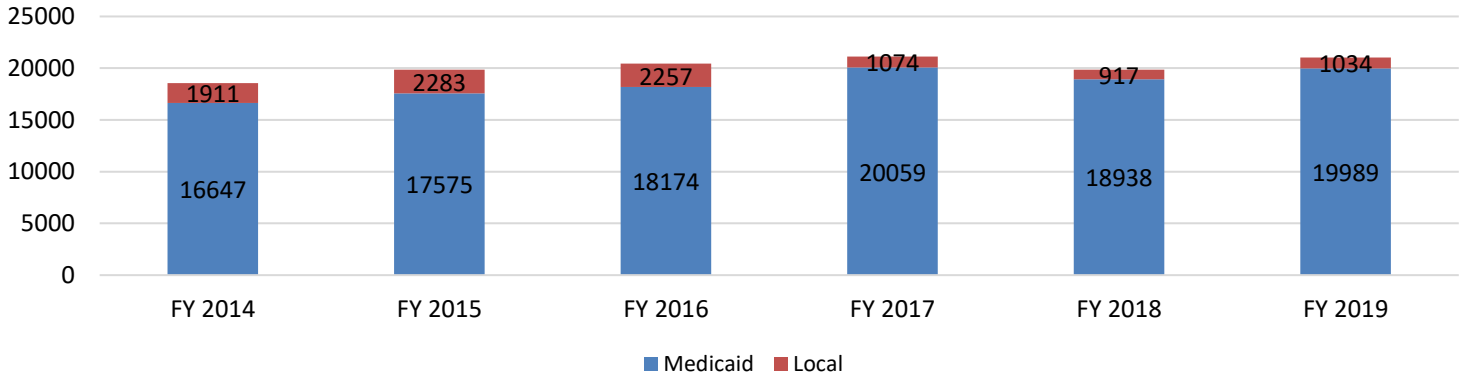
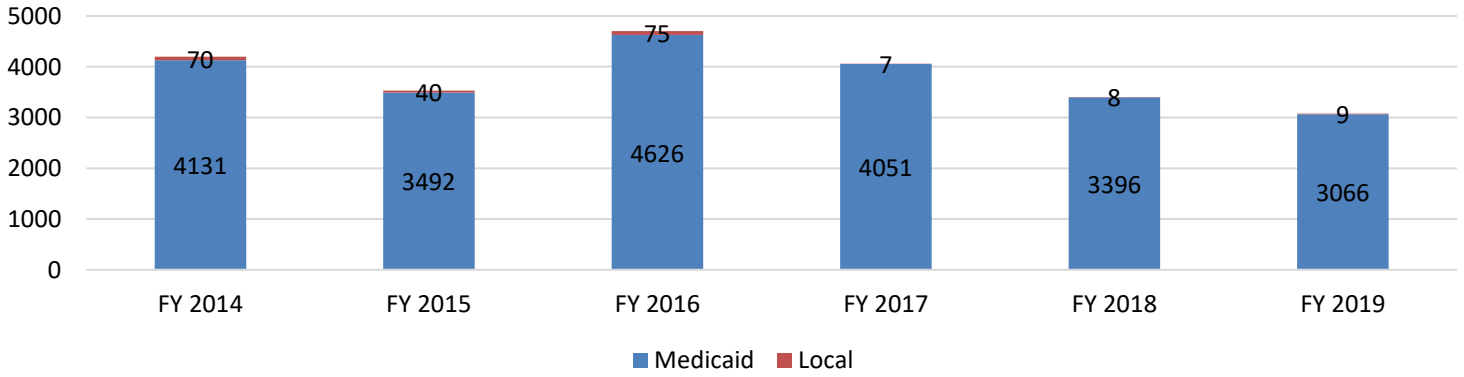


Figure 9. Child (0-17) Mental Health Consumers Insurance Type by Fiscal Year

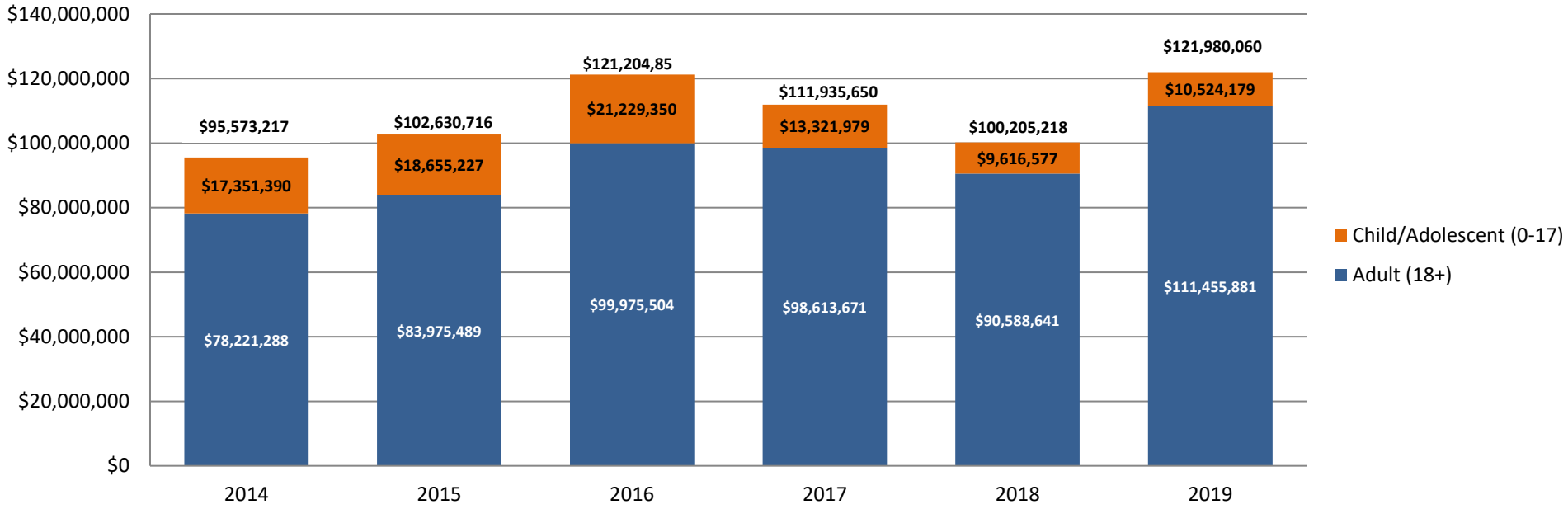


Figures 8 and 9 show the number of consumers who received services that were paid for via Medicaid and those whose services were exclusively paid with local dollars. Consumers who had Medicaid may have had some services paid with local dollars.

Figure 10. FY19 Utilization and Expenditure Details							
Service Group	**Child Total**	**Adult Total**	**Child & Adult Total**	**Average Units**	**Average Cost Per Consumer**	**Paid Amount**	**$ Change from FY18**
ACT	**7**	**2602**	**2609**	**192**	**$10,336**	**$26,967,687**	**$4,720,412**
CBI	**530**	**18**	**548**	**156**	**$8,084**	**$4,430,275**	**$1,340,813**
Level I - MST	41	0	41	129	$6,741	$276,375	$274,710
Level II & III	473	16	489	167	$8,401	$4,108,071	$1,107,897
Level IV - FFT	37	2	39	18	$1,175	$45,829	-$41,794
Community Support	**2483**	**17,313**	**19,796**	**119**	**$3,360**	**$66,517,597**	**$15,166,979**
Counseling	**527**	**3320**	**3847**	**33**	**$715**	**$2,749,954**	**$448,378**
Child Parent Psychotherapy for Family Violence (CPP-FV)	21	0	21	37	$976	$20,501	-$30,451
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	60	5	65	26	$1,232	$80,101	$18,700
Crisis Services	**409**	**1999**	**2408**	**12**	**$753**	**$1,813,182**	**$340,021**
Crisis Stabilization	0	81	81	19	$4,402	$356,568	$86,715
Emergency - Home	7	1401	1408	13	$673	$947,959	$21,662
Emergency – Community MH Facility	124	7	131	8	$435	$56,936	-$64,053
Emergency - Mobile Unit	6	918	924	7	$260	$240,247	$146,280
Emergency - Other/Not Identified	322	8	330	8	$641	$211,473	$149,417
Day Services	**0**	**1164**	**1164**	**170**	**$9,772**	**$11,374,201**	**$794,681**
Diagnostic and Assessment	**594**	**5279**	**5873**	**1**	**$156**	**$914,656**	**$173,617**
Brief	340	3891	4231	1	$93	$394,887	$45,265
Community Based	0	92	92	1	$279	$25,623	$15,679
Comprehensive	268	1436	1704	1	$290	$494,147	$112,672
Medication Somatic	**659**	**9697**	**10,356**	**7**	**$375**	**$3,884,196**	**$634,539**
Supported Employment	**0**	**610**	**610**	**42**	**$739**	**$450,632**	**$174,911**
Therapeutic	0	155	155	14	$352	$54,498	$29,449
Vocational	0	558	558	42	$710	$396,135	$145,462

Figure 10. FY19 Utilization and Expenditure Details							
Service Group	**Child Total**	**Adult Total**	**Child & Adult Total**	**Average Units**	**Average Cost Per Consumer**	**Paid Amount**	**$ Change from FY18**
Transition Support Services	**45**	**820**	**865**	**33**	**$659**	**$569,720**	**$269,751**
Inpatient Discharge Planning ACT	4	270	274	18	$294	$80,537	$33,824
Continuity of Care Tx Planning	13	347	360	18	$358	$129,017	$63,587
Cont. of Care Tx Planning (Non-ACT/CBI)	36	316	352	37	$1,020	$359,203	$171,377
Community Psych Supportive Tx Program	0	8	8	1	$120	$963	$963
Health Homes	**0**	**1366**	**1366**	**8**	**$1,687**	**$2,305,020**	**-$2,290,865**
Team Meeting	**31**	**9**	**40**	**5**	**$74**	**$2,940**	**$1,605**
Total	**3075**	**21,023**	**24,098**	**146**	**$5,062**	**$121,980,060**	**$21,774,842**

Figure 11. Mental Health Claims Expenditures by Age Group and Fiscal Year



7% Increase from 2014 to 2015
18% Increase from 2015 to 2016
-8% Decrease from 2016 to 2017
-12% Decrease from 2017 to 2018
22% Increase from 2018 to 2019

Figure 11 displays the aggregate cost of Medicaid and Non-Medicaid (Locally Funded) services from Fiscal Year 2014 to Fiscal Year 2019. Because of the change in data source in FY19, the increase in expenditures from FY18 should not be considered meaningful.

Figure 12. Mental Health Claims Expenditures by Medicaid & Non-Medicaid Funds and Fiscal Year

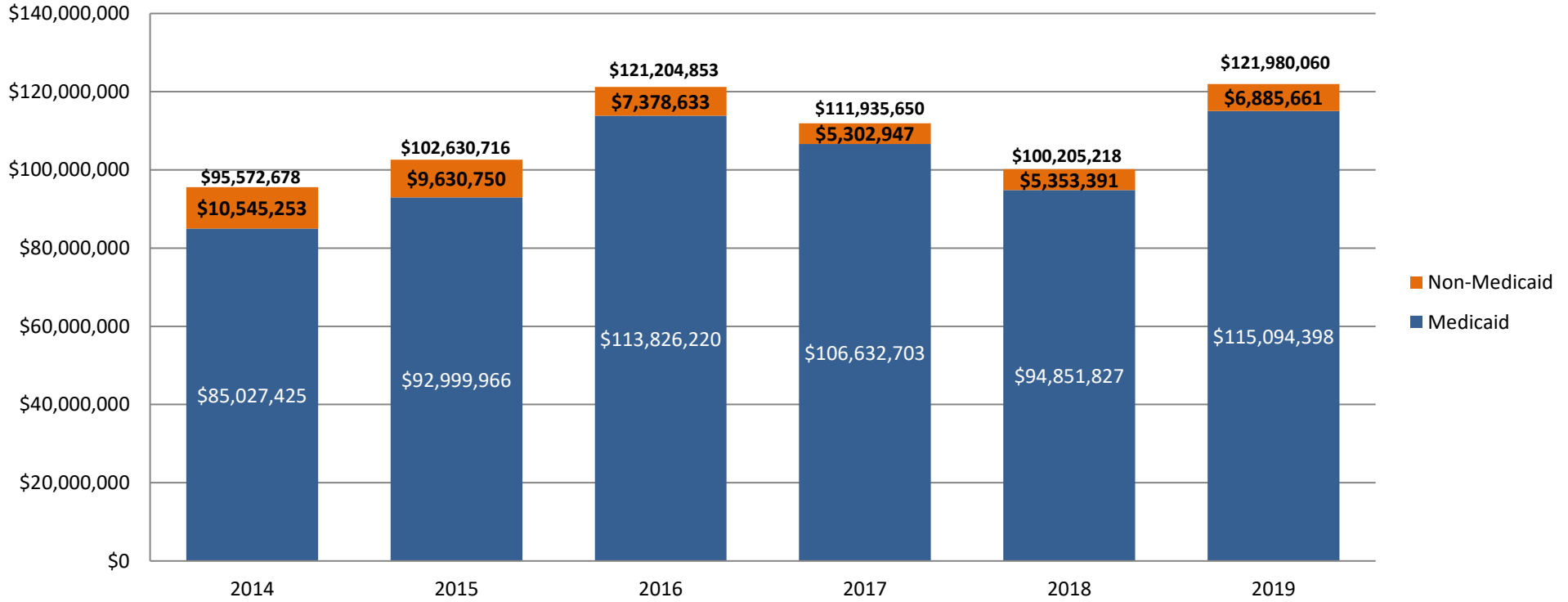
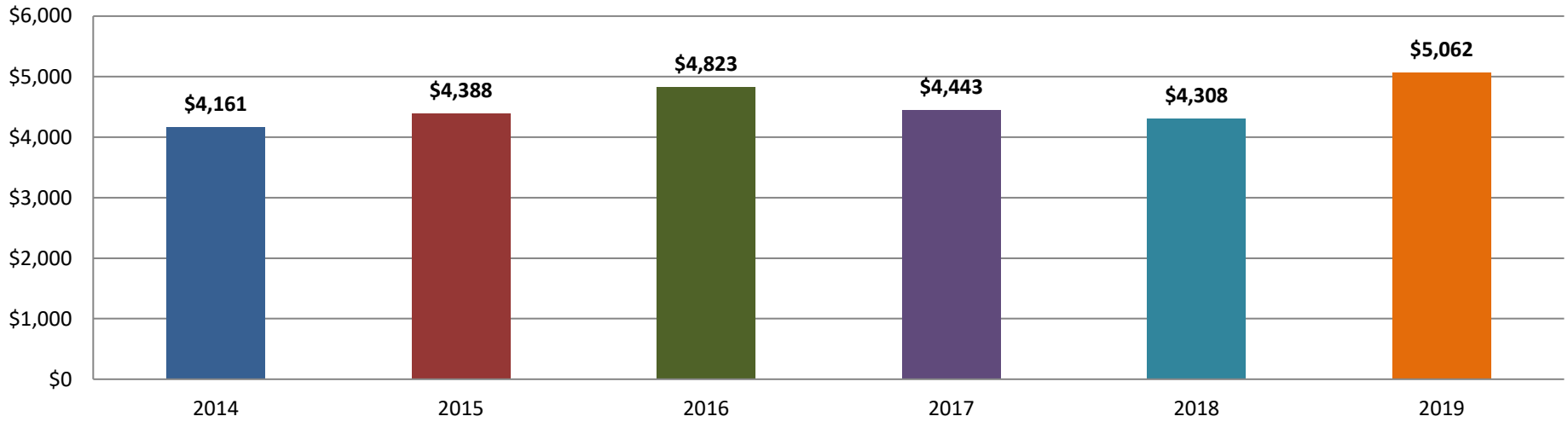


Figure 12 displays the cost of Medicaid and Non-Medicaid (Locally Funded) services from Fiscal Year 2014 to Fiscal Year 2019. Because of the change in data source in FY19, the increase in expenditures from FY18 should not be considered meaningful.

There was a rate change in FY18 that increased rates for some services and decreased them for others. The biggest impact came from the 10% increase in the rate for Community Support ($15 million). The rate for CBI also increased, leading to a $1.3 million increase in expenditures. Despite a 2% decrease in the rate for ACT, expenditures increased by $4.7 million.

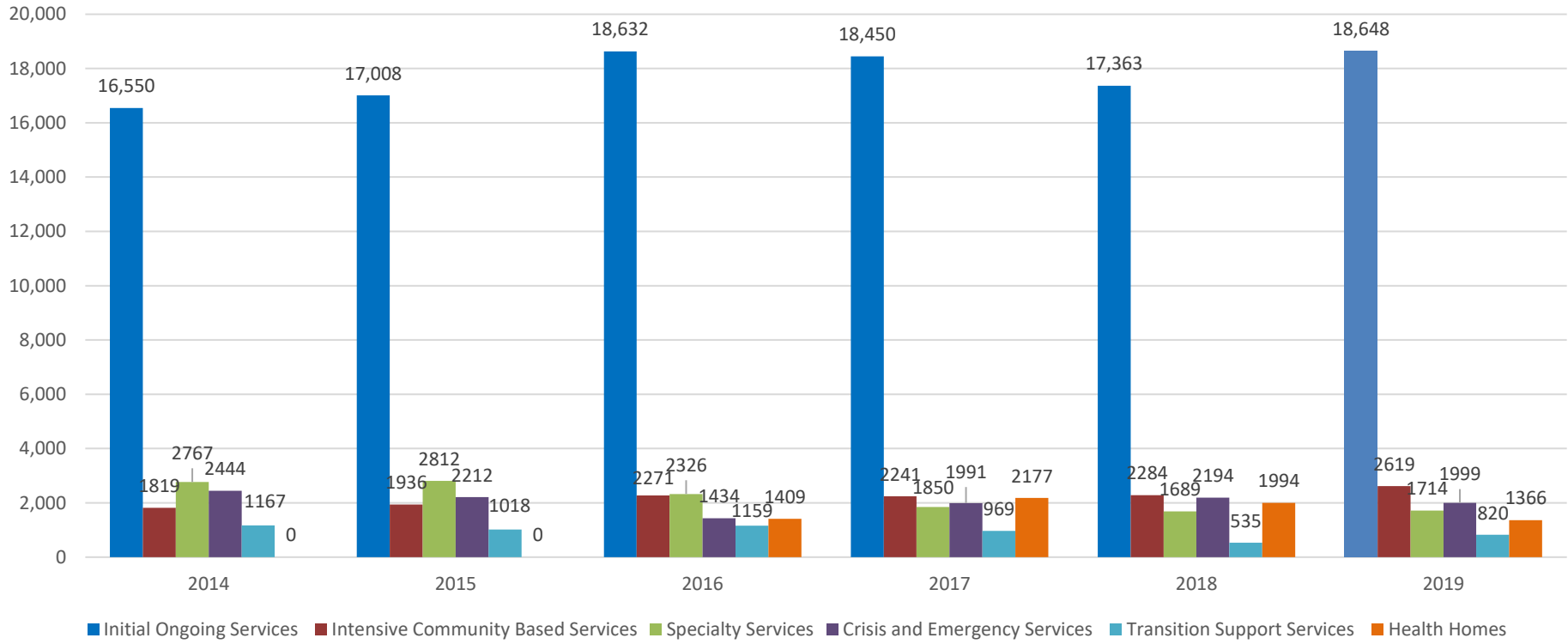
The Health Homes program was significantly changed in FY19. The two acuity levels (high and low) were consolidated into one. In addition, the rate was reduced, but Community Support was unbundled so it could be billed in addition to the monthly Health Homes rate.

Figure 13. Average Cost per Mental Health Consumer by Fiscal Year



Because of the change in data source in FY19, the increase in expenditures from FY18 should not be considered meaningful.

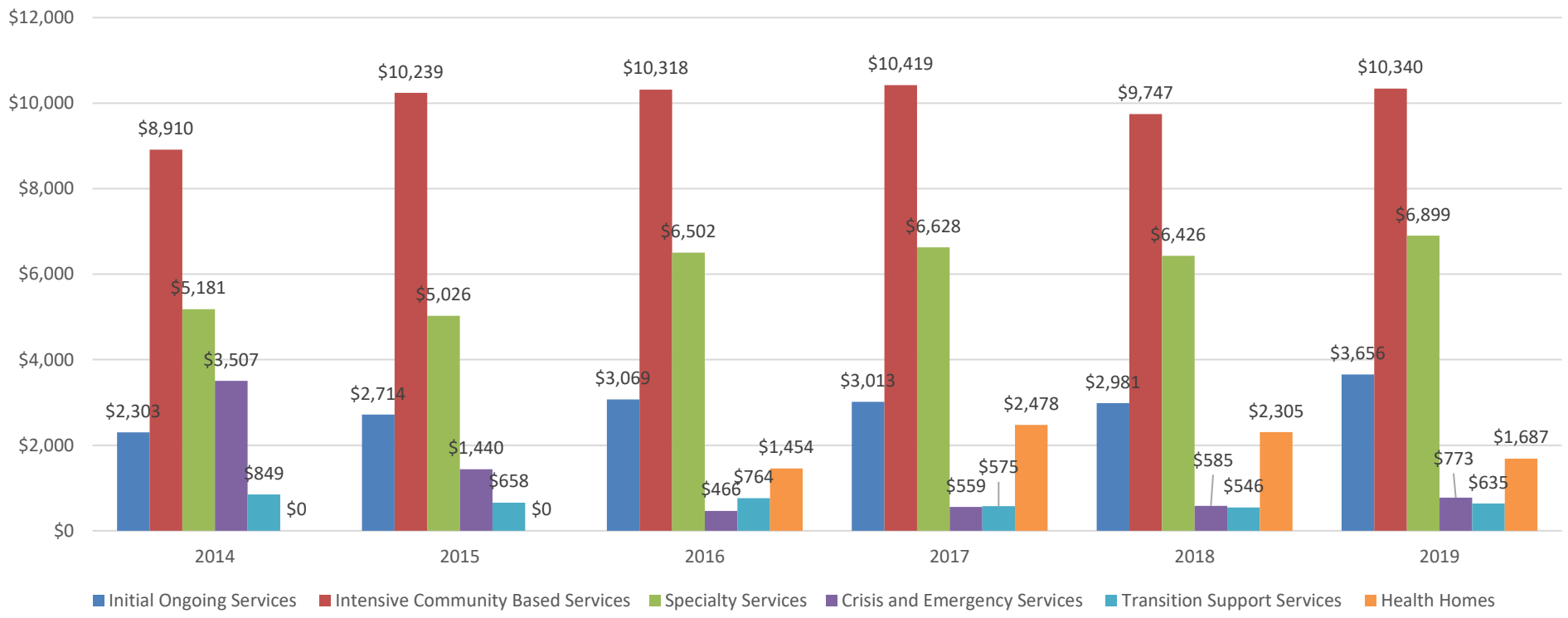
Figure 14. Adult (18+) Mental Health Consumer Counts by Service Cluster and Fiscal Year



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, Integrated Care Community Project, 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 2014 to FY 2019 and the average cost per consumer. Please note that a consumer can be included in multiple service categories. The category of Health Homes was created in FY 2016.

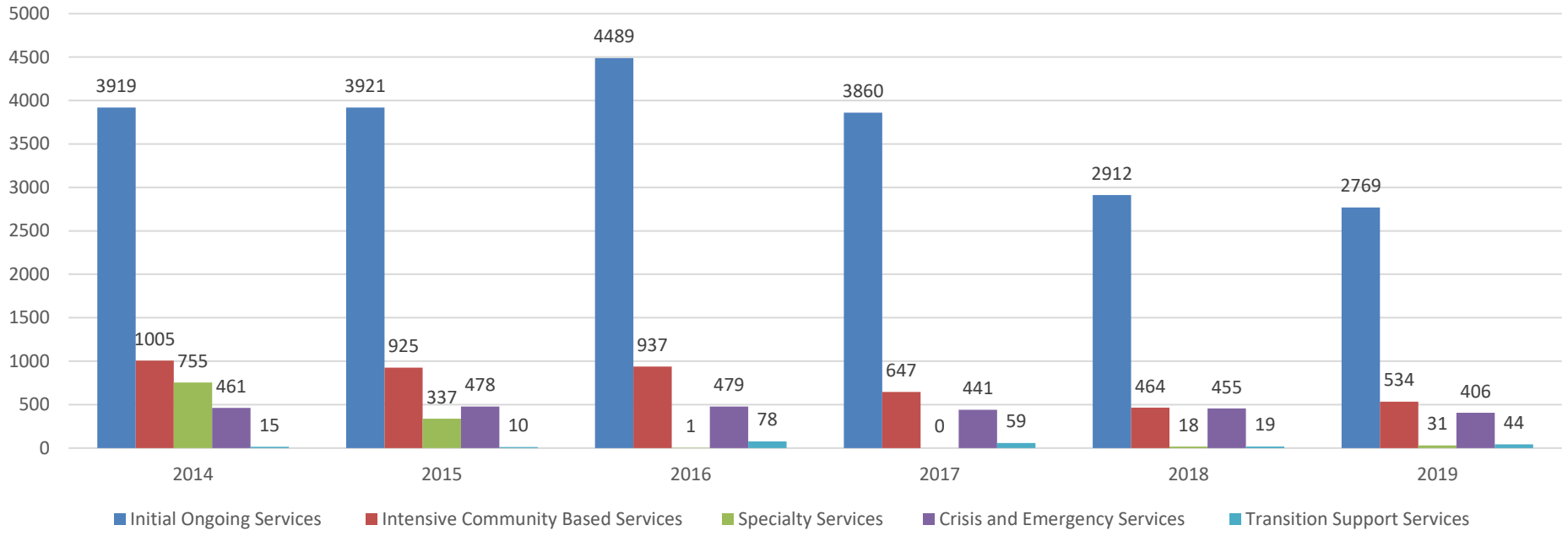
Figure 15. Adult (18+) Average Annual Cost per Mental Health Consumer by Fiscal Year



Initial & Ongoing Services	Intensive Community Based Svc	Specialty Services	Crisis & Emergency Services	Transition Support Services
18% Increase from 2014 to 2015	15% Increase from 2014 to 2015	-3% Decrease from 2014 to 2015	-59% Decrease from 2014 to 2015	-23% Decrease from 2014 to 2015
13% Increase from 2015 to 2016	1% Increase from 2015 to 2016	29% Increase from 2015 to 2016	-68% Decrease from 2015 to 2016	16% Increase from 2015 to 2016
-2% Decrease from 2016 to 2017	1% Increase from 2016 to 2017	2% Increase from 2016 to 2017	20% Increase from 2016 to 2017	-24% Decrease from 2016 to 2017
-1% Decrease from 2017 to 2018	-6% Decrease from 2017 to 2018	-3% Decrease from 2017 to 2018	5% Increase from 2017 to 2018	-5% Decrease from 2017 to 2018
23% Increase from 2018 to 2019	6% Increase from 2018 to 2019	7% Increase from 2018 to 2019	32% Increase from 2018 to 2019	16% Increase from 2018 to 2019

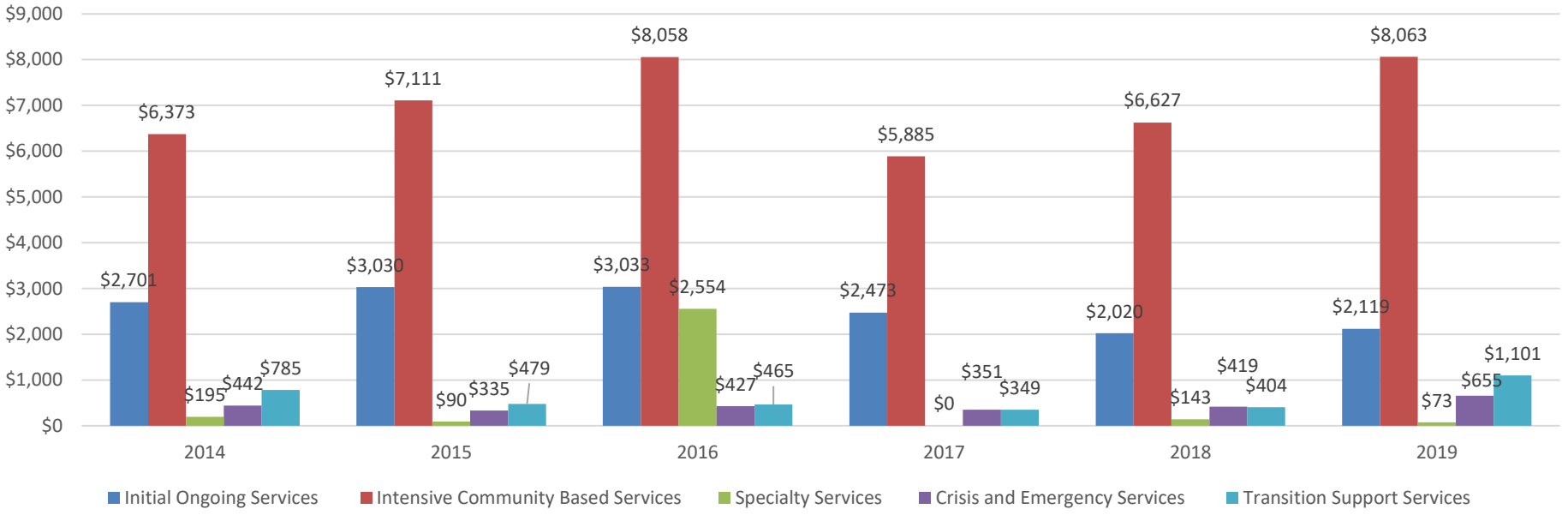
Health Homes average annual cost per consumer increased 70% between 2016 and 2017, then decreased 7% in 2018 and 27% in 2019

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



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, Integrated Care Community Project, 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

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

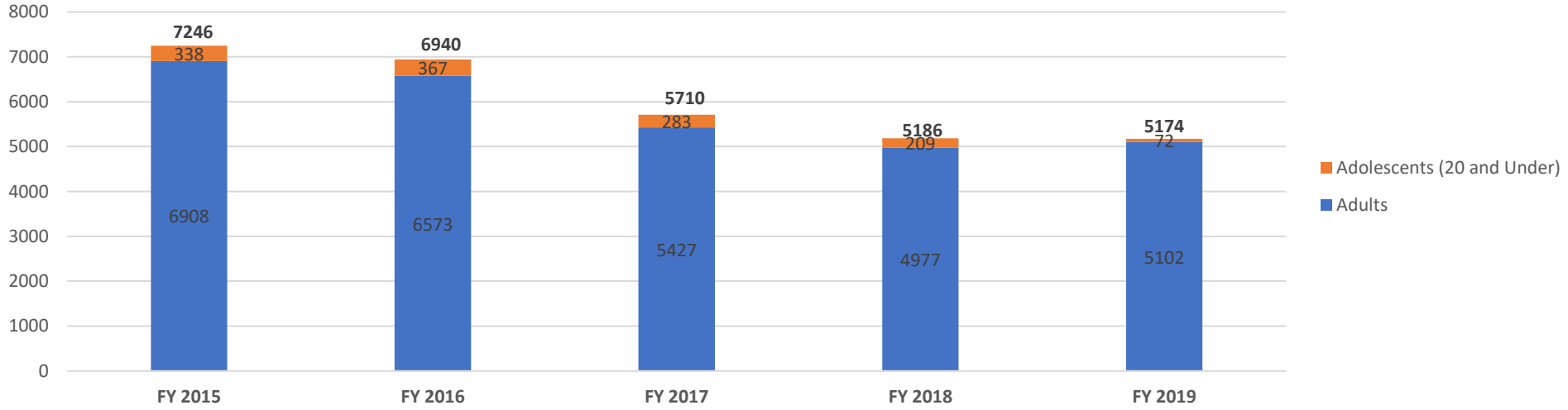


Initial & Ongoing Services	Intensive Community Based Svc	Specialty Services	Crisis & Emergency Services	Transition Support Services
17% Increase from 2014 to 2015	15% Increase from 2014 to 2015	9% Increase from 2014 to 2015	-59% Decrease from 2014 to 2015	-23% Decrease from 2014 to 2015
1% Increase from 2015 to 2016	16% Increase from 2015 to 2016	2738% Increase from 2015 to 2016	26% Increase from 2015 to 2016	0% Change from 2015 to 2016
-19% Decrease from 2016 to 2017	-29% Decrease from 2016 to 2017	-100% Decrease from 2016 to 2017	-16% Decrease from 2016 to 2017	-27% Decrease from 2016 to 2017
-18% Decrease from 2017 to 2018	13% Increase from 2017 to 2018	200% Increase from 2017 to 2018	19% Increase from 2017 to 2018	16% Increase from 2017 to 2018
5% Increase from 2018 to 2019	22% Increase from 2018 to 2019	-49% Decrease from 2018 to 2019	56% Increase from 2018 to 2019	172% Increase from 2018 to 2019

Because of the change in data source in FY19, the increase in expenditures from FY18 should not be considered meaningful

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, Integrated Care Community Project, 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.

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



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

DBH received a grant that funded recovery service that ended in FY16. The decline in clients since then can partially be attributed to the reduction in the number of people who only received recovery services. There were 2371 people who received recovery services in FY15 and 702 in

Children/Adolescents (0-20)

9% Increase from 2015 to 2016
-22% Decrease from 2016 to 2017
-26% Decrease from 2017 to 2018
-66% Decrease from 2018 to 2019

Adults (21+)

-5% Decrease from 2015 to 2016
-17% Decrease from 2016 to 2017
-8% Decrease from 2017 to 2018
3% Increase from 2018 to 2019

All Clients

-4% Decrease from 2015 to 2016
-18% Decrease from 2016 to 2017
-9% Decrease from 2017 to 2018
0% Change from 2018 to 2019

Figure 19. Substance Use Clients Receiving Treatment and Recovery Services in FY2019

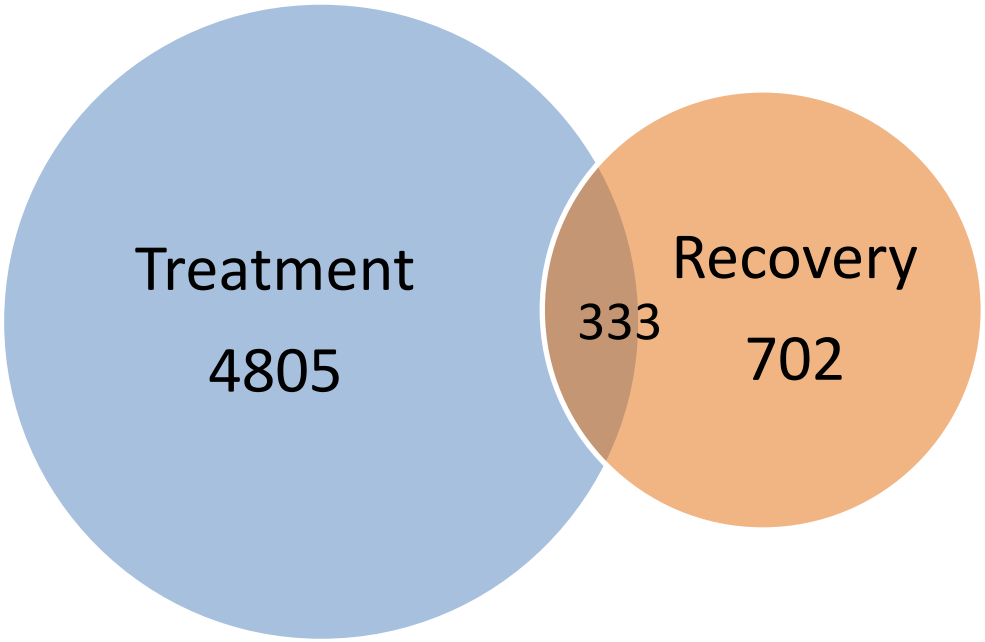
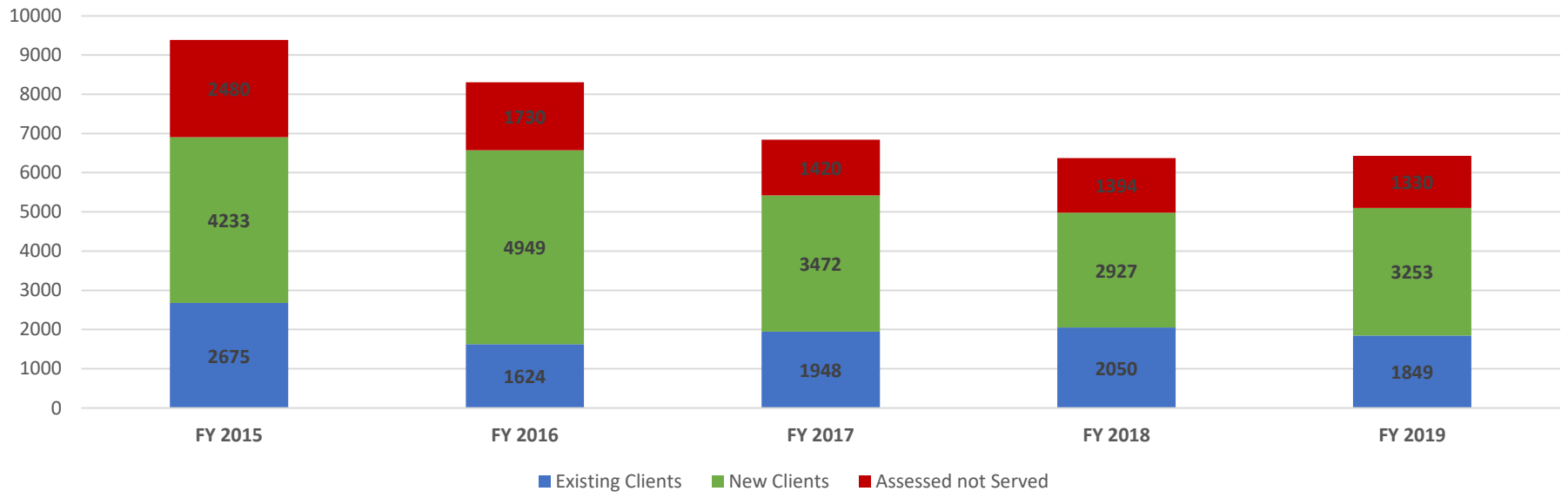


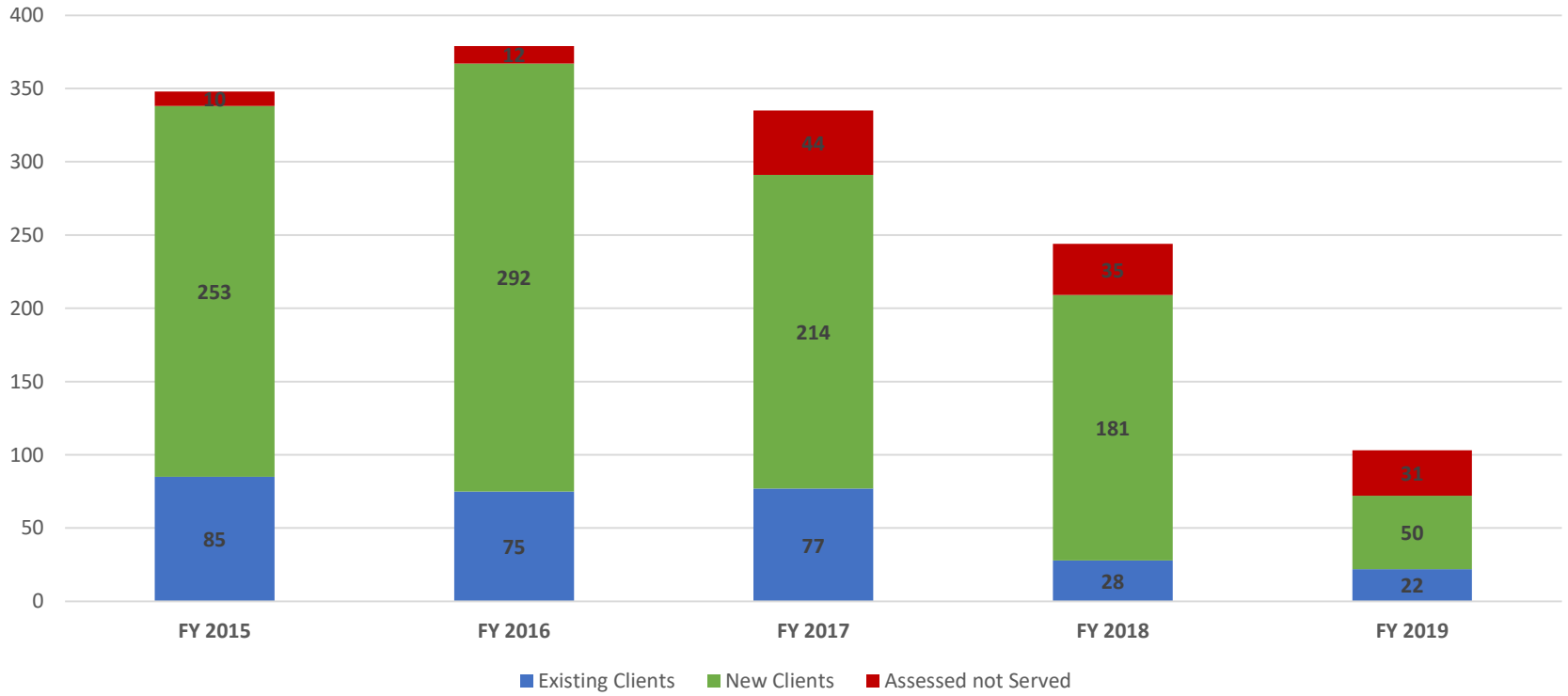
Figure 19 shows the overlap between clients receiving treatment and recovery services in FY 2019. A client can either be admitted directly to recovery services or transition once treatment is completed. Some clients receive treatment and recovery services simultaneously.

Figure 20. Assessed and/or Receiving Substance Use Services by Fiscal Year



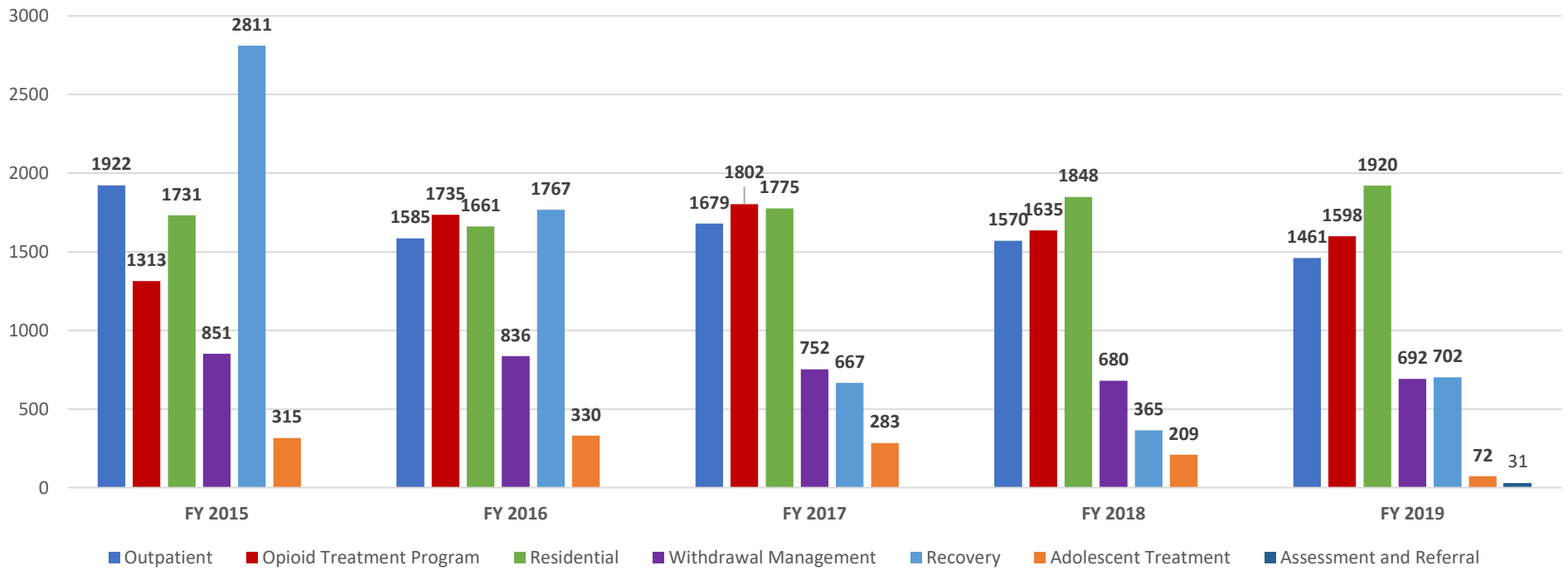
Once clients are assessed at the ARC or another assessment site, the appropriate referrals are made to the network of SUD providers. Those who were assessed but not served were not admitted for various reasons (client did not meet criteria for treatment, client did not agree to participate in services, or client only needed an assessment for legal reasons). Those who are assessed but not admitted fall into the categories of either the program rejecting referral, client refusing treatment, referral rejected, and status pending.

Figure 21. Youth Assessed and Served for Substance Use Services by Fiscal Year



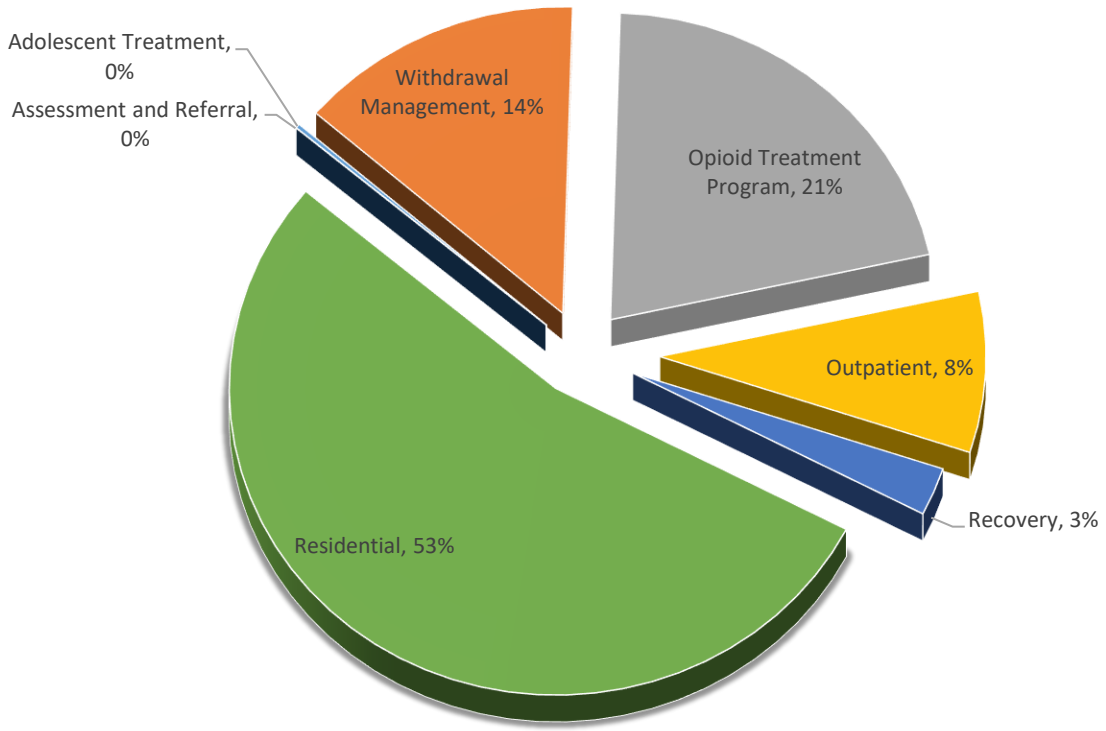
Youth SUD treatment is predominantly provided through Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and services funded by grants. Since DBH does not collect claims data that qualify for the EPSDT benefit and/or grant data, information on the number of youth served and expenditures understate DBH services for youth.

Figure 22. Substance Use Clients by Level of Care and Fiscal Year



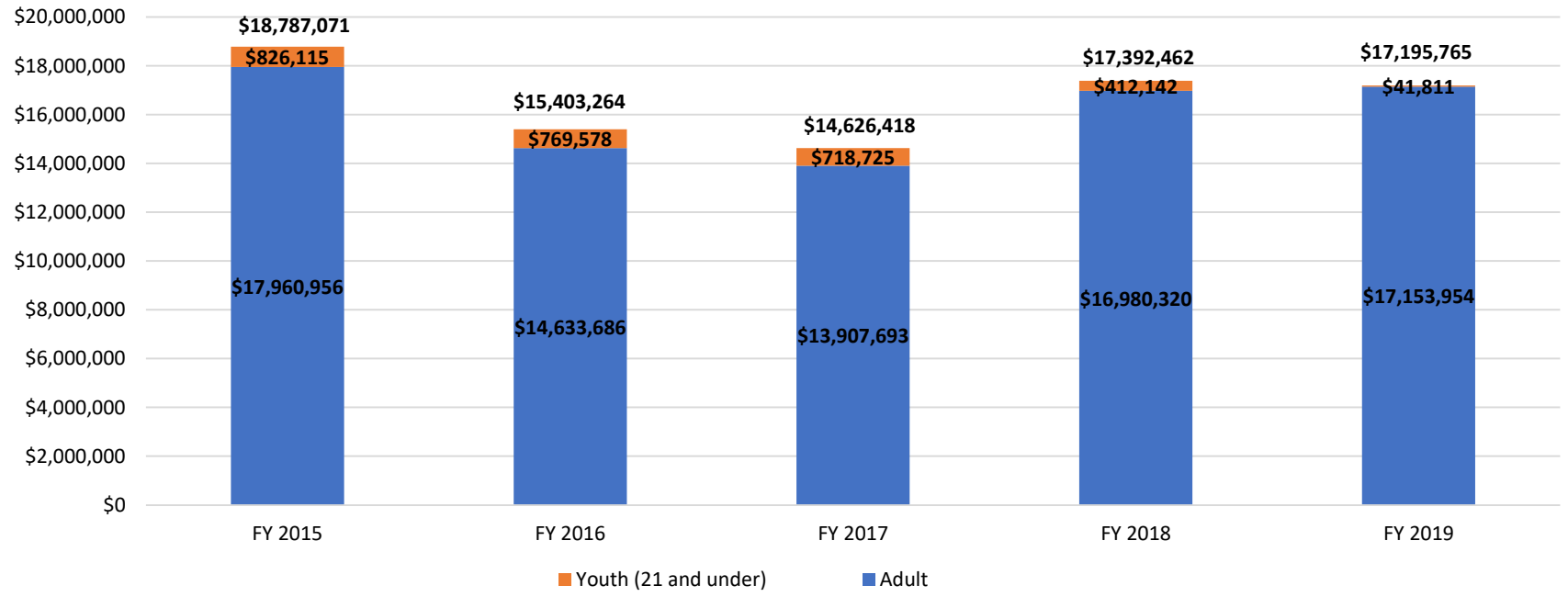
There is a continuum of levels of care for substance use clients. **Assessment and Referral** was added in FY19. In addition to the DBH-run ARC, community providers can now assess clients and maintain them for treatment or refer them to another provider. **Withdrawal Management** (detoxification) is 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. **Opioid Treatment Programs** involve the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Methadone is the medication reported in MHEASURES, as it is part of ASARS services. There is a similar continuum for adolescents as adults. Figure 22 shows the number of episodes at each level. Not only can one client enter multiple levels of care, but the same client may re-enter the same level of care, which explains the higher number of episodes than consumers served.

Figure 23. Percentage of Substance Use Expenditures by Level of Care FY 2019



Level of Care	Expenditures
Assessment and Referral	$391
ASTEP	$41,811
Detox	$2,416,267
Opioid Treatment Program	$3,549,808
Outpatient	$1,434,401
Recovery	$571,934
Residential	$9,181,152
Total	**$17,195,765**

Figure 24. Substance Use Expenditures by Fiscal Year



Children/Adolescents (0-20)

-7% Decrease from 2015 to 2016
-7% Decrease from 2016 to 2017
-43% Decrease from 2017 to 2018
-90% Decrease from 2018 to 2019

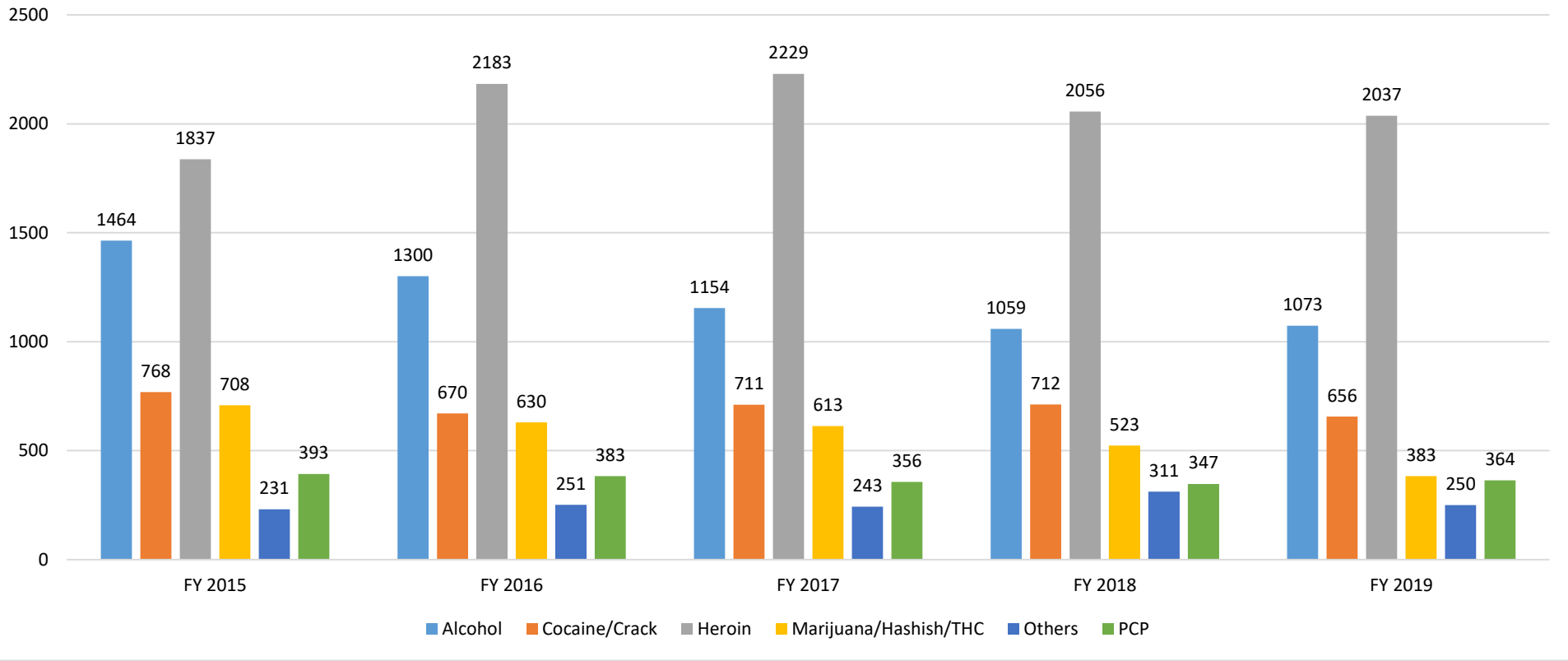
Adults (21+)

-19% Decrease from 2015 to 2016
-5% Decrease from 2016 to 2017
22% Increase from 2017 to 2018
1% Increase from 2018 to 2019

Child/Adolescents & Adults Combined

-18% Decrease from 2015 to 2016
-5% Decrease from 2016 to 2017
19% Increase from 2017 to 2018
-1% Decrease from 2018 to 2019

Figure 25. Primary Drug of Choice by Fiscal Year



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.