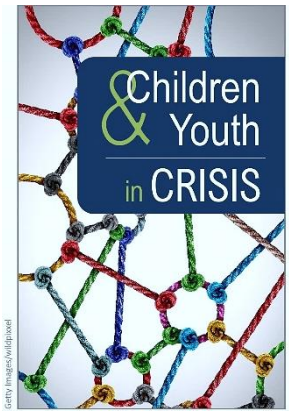

Children and Youth in Crisis Served by the Multiagency Rapid Care Team

January 2024 to June 2025

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This document was prepared for the Washington State Office of the Governor as part of a 2025 Report to the Legislature required by RCW 43.06.535.

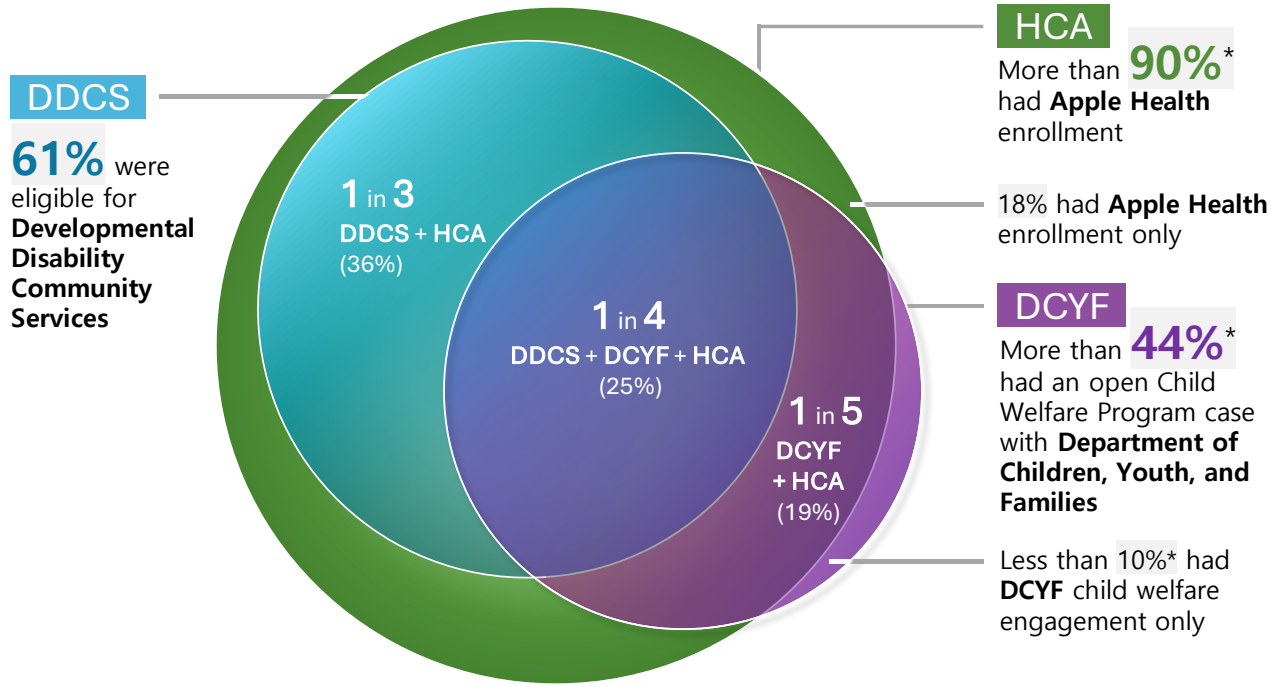
WASHINGTON STATE House Bill 1580 (2023-24) created a multiagency Rapid Care Team to identify supportive services and living arrangements for children and youth in crisis. The Rapid Care Team began accepting referrals in January 2024, and HB 1272 (2025-26) extended this work through June 2027. This report describes characteristics of children and youth referred to the Rapid Care Team from its initiation through SFY 2025 (i.e., January 2024 to June 2025).

Nearly 80 percent of children and youth in crisis had current or recent engagement with more than one state agency (Figure 1); 1 in 4 were engaged with all three Rapid Care Team agencies (HCA, DCYF, and DSHS-DDCS).

FIGURE 1.

Multiagency Engagement among Children and Youth in Crisis

TOTAL (All eligible referrals) = 107



* Fewer than 11 referrals were for children/youth who did not have current or prior Apple Health coverage but did have an open DCYF Child Welfare case. See page 6 for details on medical coverage and system engagement by agency.

Who is a "Child in Crisis"?

A "child in crisis" is defined by RCW 43.06.535 as person under age 18 who is staying in, or at risk of remaining in, a hospital without medical necessity and unable to return to the care of a parent; or who is dependent under chapter 13.34 RCW, experiencing placement instability, and referred to the Rapid Care Team (RCT) by the Department of Children, Youth, and Families (DCYF).

Data Sources

All data summarized in this report were collected by the HCA, DCYF, and DSHS-DDCS members of the RCT. The information is sourced from the RCT referral form, discussions and correspondence that occurred during the case conferencing process, and data gathered by RCT members from agency-specific data systems and case managers.

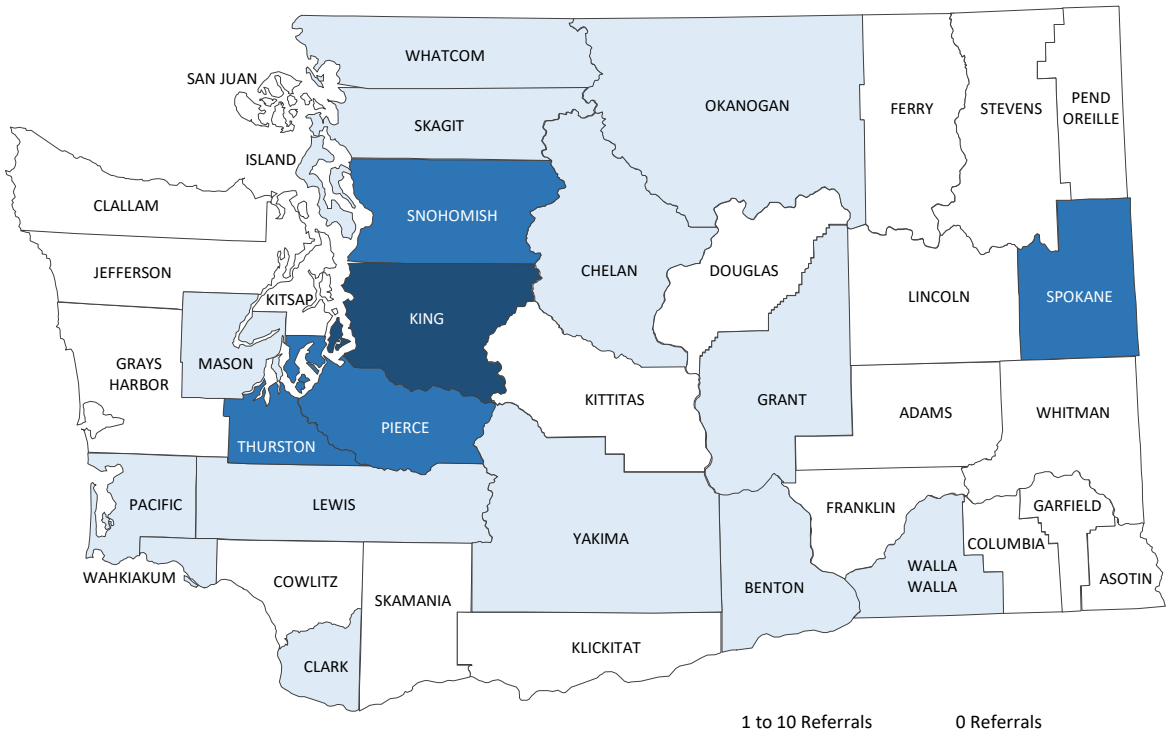
Referrals to the Rapid Care Team

The RCT received 131 referrals from January 2024 through June 2025 for 130 unique children and youth. The average number of referrals received per month was seven. The highest number of monthly referrals received was in May 2025 (n=13). The number of referrals doubled from the first quarter (Jan to Mar 2024, n=15 referrals) to the most recent quarter (Apr to June 2025, n=33 referrals). One quarter of all children/youth referred lived in King County (25 percent) (Figure 2).

FIGURE 2.

Rapid Care Team Referrals by Child's County of Residence

TOTAL (All children/youth referred) = 130



	King	Pierce	Snohomish	Spokane	Thurston	1 to 10 Referrals 14 Counties	0 Referrals 20 Counties
Number of Referrals	32	17	15	12	12	37	0
Percent of Total Referrals	25%	13%	12%	9%	9%	28%	0%
Legend							

NOTES: Four percent of the population (n=5) had no county indicated, or the child/youth was out of state and ineligible. Percentages by county did not vary substantially when the population was limited to eligible children and youth (n=106).

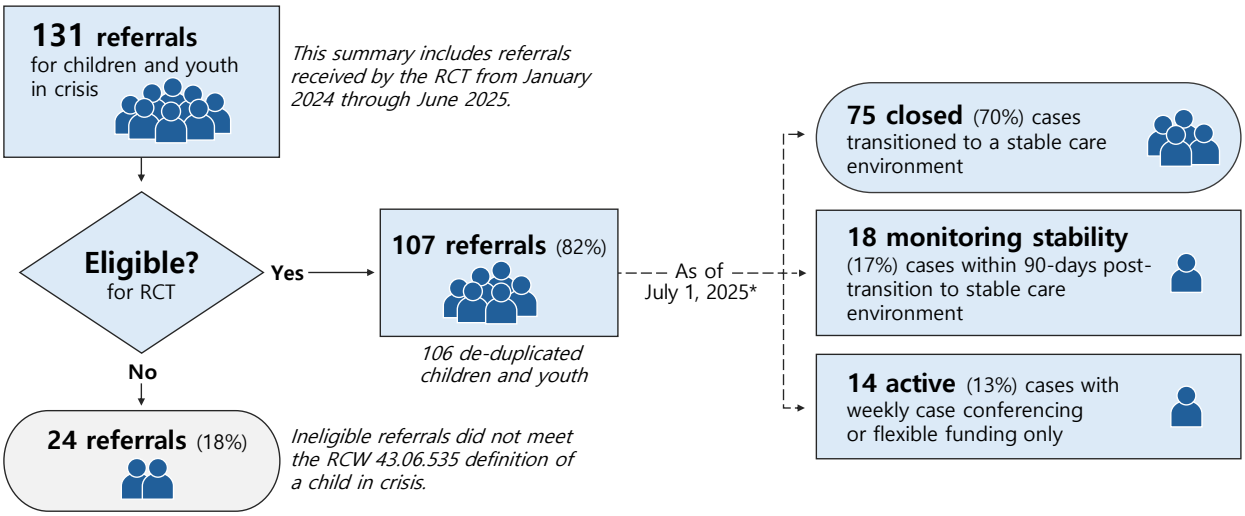
SOURCE: Child/youth county of residence prior to hospitalization from RCT client tracking files.

Case Status

Of the 131 referrals received from January 2024 through June 2025, 82 percent (n=107) met eligibility criteria and were served by the RCT through weekly case conferencing and/or provided flexible funding to support safe discharge from the hospital (Figure 3). After discharge or placement transition, the RCT monitors cases for *at least* 90 days before closing the case. As of July 1, 2025, 70 percent of the eligible referrals (n=75) had been closed because the child/youth either transitioned to a stable care environment or monitoring status was deemed no longer necessary. An additional 18 children and youth had discharged or implemented a transition plan, and they were being monitored. Fourteen children and youth were being actively served by the RCT through weekly case conferencing and/or flexible funding. More detailed information on systems coordination and decision-making practices by the RCT are described in the RCT Actions section of the report (page 8).

FIGURE 3.

Rapid Care Team Referrals Case Status



NOTE: As of October 1, 2025, fewer than 11 of the eligible cases referred from January 2024 through June 2025 had monitoring or active status (i.e., nearly all were closed). The few updated status counts are not displayed to prevent reporting of small numbers.

Nearly 1 in 5 referrals (n=24, 18 percent) did not meet eligibility criteria as defined by RCW 43.06.535. Most of these children and youth were ineligible because they discharged shortly after the referral was received or were not recently in a hospital setting. The RCT referred these children/youth to Kids Mental Health Washington and/or the Youth and Young Adult Housing Response Team when appropriate.

RELATED REPORT

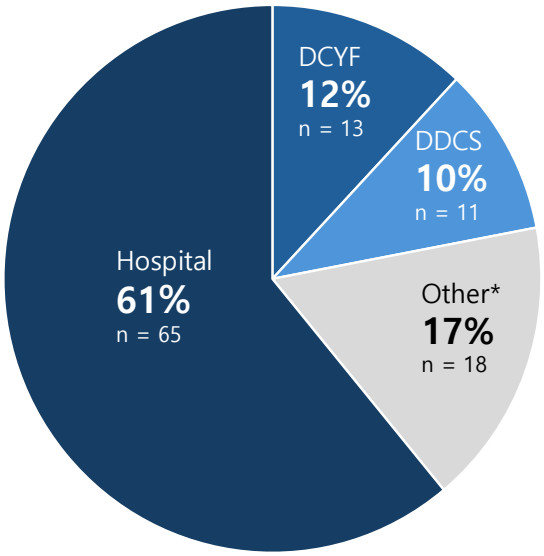
The first report to the Legislature required by RWC 43.06.535 summarized the characteristics of children and youth in crisis served by the RCT from January to November 15th, 2024. The current report builds off this prior work to include cases served through June 2025.

Transforming Washington's Children and Youth System of Care: Report on System Changes and Innovations. Nov 2024. Data Addendum (pages 41-47) added Dec 2024.

FIGURE 4.

Referral Sources

TOTAL = 107



Referral Source

More than half of eligible referrals (n=65; 61 percent) were submitted to the RCT by a hospital (Figure 4). Seattle Children's Hospital submitted the most referrals (n=45, 42 percent), and eight other hospitals submitted one to four eligible referrals. Just over one in five eligible referrals (22 percent) were submitted by a state agency, including 12 percent from DCYF and 10 percent from DSHS-DDCS. Just under one in five eligible referrals (17 percent) were submitted by other sources (see Figure 4 footnote). The sources for ineligible referrals did not differ substantially from the sources for eligible referrals (counts for ineligible referrals by source are not shown because of small numbers).

* Other (chart left) includes the Center of Parent Excellent (COPE) project, parent of the child/youth, Kids Mental Health Washington, Wraparound with Intensive Services, other community providers.

Characteristics of Children/Youth in Crisis

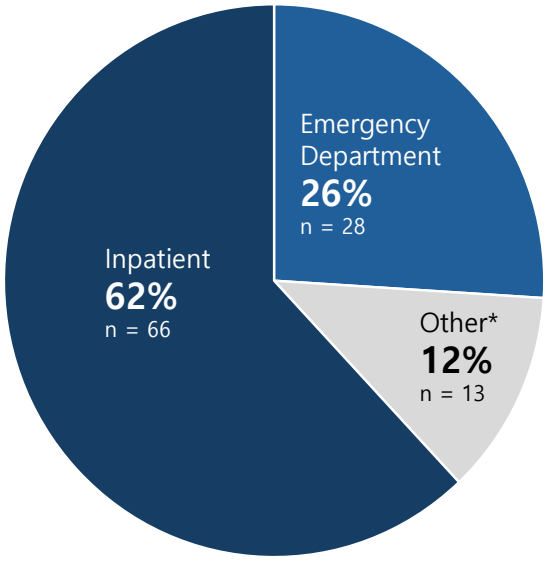
Setting at Time of Referral

At the time of referral, most children and youth in crisis were in a hospital setting (88 percent, n=94), including 62 percent with an inpatient admission and 26 percent at an emergency department (Figure 5). Inpatient stays at the time of referral occurred across 12 different hospitals. Seattle Children's Hospital, including the Psychiatry and Behavioral Medicine Unit (PBMU), was the most common inpatient setting (n=41), and 11 other hospitals each served one to five children and youth in crisis in an inpatient setting at the time of referral (n=25). Among children and youth in an emergency department at the time of referral, Seattle Children's Hospital was the most common emergency department setting (n=13), and eight other hospital emergency departments served one to four children and youth in crisis at the time of referral (n=15). Just over one in ten children and youth in crisis were in a non-hospital setting at the time of referral to the RCT (12 percent, see Figure 5 footnote).

FIGURE 5.

Setting at Time of Referral

TOTAL = 107



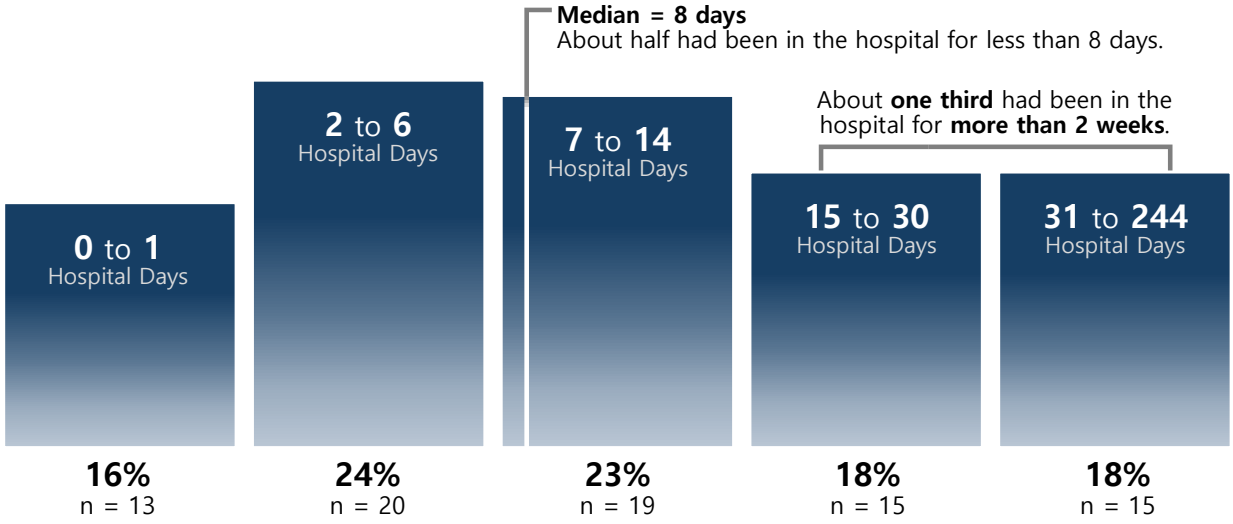
* Other includes DCYF child welfare placement, juvenile detention, community setting, or not specified.

Most children and youth in a hospital setting had an admission date indicated on their referral (n=82). The average number of days from admission to referral was 19, but there was a large range from 0 to 244 days. Half of referrals with an admission date indicated were for children and youth who had been in the hospital for less than 8 days (median) prior to referral (Figure 6). Just over one-third of referrals (35 percent) were for children and youth who had been in the hospital for more than 2 weeks.

FIGURE 6.

Days in Hospital prior to Rapid Care Team Referral

TOTAL = 82 referrals for children and youth in a hospital setting with admission date on referral



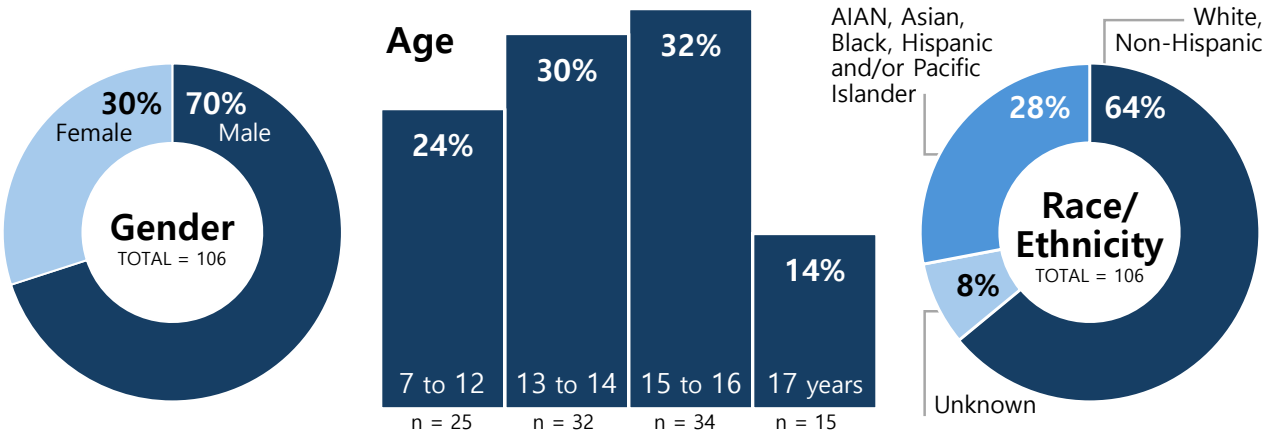
Demographics

Most children and youth in crisis served by the RCT were male (70 percent; Figure 7). The age of children and youth at time of referral ranged from 7 to 17 years old, and the average age was 14 years. Nearly two-thirds of children and youth had White, non-Hispanic race/ethnicity indicated (64 percent). Just over 1 in 4 RCT-eligible cases were for children/youth of color (28 percent) including American Indian or Alaska Native, Black or African American, Asian, Hispanic, and/or Pacific Islander, but counts in each of these groups were less than 11 so cannot be shared separately (see "Small Numbers" in Technical Notes). Fewer than 1 in 10 children/youth (8 percent) had unknown race/ethnicity indicated in RCT tracking files.

FIGURE 7.

Demographics of Children and Youth Served by the Rapid Care Team

All eligible children and youth



NOTES: One child/youth had two referrals and is only counted once in this demographic summary; the denominators represent the 106 unduplicated children/youth served by RCT rather than the 107 total referrals served by the RCT. Fewer than 11 children/youth are transgender. Gender counts are based on the identity of the child/youth as understood by the RCT rather than sex assigned at birth when both were indicated. AIAN=American Indian or Alaksa Native; Black=Black or African American.

State System Engagement

Nearly eighty percent of children and youth in crisis had current or recent engagement with more than one state agency (79 percent; Figure 1). One quarter of children/youth were engaged with all three RCT agencies (HCA, DCYF, and DSHS-DDCS). Nearly all children and youth in crisis (more than 90 percent) had HCA engagement, defined in this context as being currently or historically enrolled in Apple Health coverage at the time of RCT referral. Fewer than 11 children and youth in crisis did not have Apple Health coverage at the time of referral but were historically eligible. A subset of these re-enrolled in Apple Health soon after referral to RCT. Thirteen children and youth in crisis with current Apple Health coverage had additional or dual healthcare coverage indicated, such as private insurance or federally managed insurance (e.g., TRICARE, CHAMPVA). Fewer than 11 children and youth had Fee-for-Service coverage. Just under one in five children and youth in crisis (18 percent) had Apple Health coverage and no current engagement with DCYF child welfare or DSHS-DDCS.

Over half of children and youth in crisis (61 percent) were eligible for DSHS-DDCS at the time of referral. A few additional children and youth (n<11) were determined eligible for DSHS-DDCS after referral to the RCT. Fewer than 11 children and youth had a diagnosis for a qualifying condition (e.g. Autism Spectrum Disorder) but did not meet adaptive test thresholds or were not financially eligible to access waiver services. Among those with DSHS-DDCS eligibility, all children and youth also had Apple Health coverage, and 42 percent also had DCYF child welfare engagement. Thirty-seven children and youth (35 percent) were receiving disability-related waiver services at the time of referral.

More than 44 percent of children and youth in crisis had an open case with a DCYF child welfare program at the time of referral to the RCT. Among the DCYF-engaged children and youth in crisis, nearly all also had Apple Health coverage, and just over half (54 percent) were also eligible for DSHS-DDCS. Fewer than 11 children and youth had only DCYF child welfare engagement and no Apple Health coverage. Sixteen children and youth (15 percent) were in an out-of-home placement at the time of referral to the RCT, but fewer than 11 children and youth had a dependent legal status. Just over one in ten children and youth (n=12; 11 percent) had been adopted through the DCYF adoption program. Fewer than 11 children and youth were adopted from another state or through a private adoption process. Eleven children and youth (10 percent) had an open Child Protective Services (CPS) case, including CPS Investigation or Family Assessment Response (FAR). Fewer than 11 children and youth had an open Family Reconciliation Services (FRS) or Family Voluntary Services (FVS) case. See Technical Notes for descriptions of DCYF child welfare programs.

Health Conditions

All children and youth served by the RCT had a mental health condition and/or intellectual or developmental disability indicated on their referral. Some referrals were submitted by non-clinical sources and may not include complete clinical indicators for children and youth in crisis. Based on available data, nearly all children and youth had a mental health condition (89 percent, Figure 8). The three most common mental health conditions were attention deficit/hyperactivity disorder (ADHD, 59 percent), disruptive, impulse, or conduct disorder (40 percent), and depressive disorder (34 percent). Many children and youth also had an indicated intellectual or developmental disability (I/DD) at the time of referral (72 percent). Of those children and youth, 63 percent had an indication of autism spectrum disorder (ASD) and 38 percent had an indicator of other intellectual or developmental disability diagnosis (e.g., unspecified I/DD, fetal alcohol syndrome). More than one in four children and youth (28 percent) had a communication barrier indicated, such as non-speaking and/or need for a communication device.

Children and youth served by the RCT also experienced complexity in health conditions. Sixty-two percent of children and youth had co-occurring mental health conditions and intellectual or developmental disabilities (e.g., ADHD and ASD), and nearly half of children and youth (47 percent)

had four or more diagnosed conditions, including mental health, intellectual or developmental disability, and/or physical health conditions. Of those children and youth with a physical health condition (28 percent of the population), epilepsy, spinal bifida, and diabetes were among the most frequently indicated conditions.

FIGURE 8.

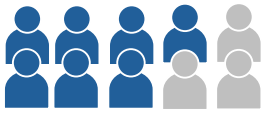
Health Conditions of Children and Youth in Crisis

Among eligible children/youth with diagnosis information reported on RCT referral* (TOTAL = 104)

n = 93 (89%)

Nearly 9 of 10 children (89%) had an indicated mental health condition. Attention deficit/hyperactivity disorder **(ADHD, 59%) was most common.**

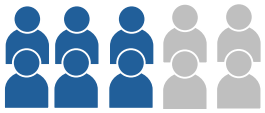
Any Mental Health Condition	93	89%
Attention deficit/hyperactivity disorder (ADHD)	61	59%
Disruptive, impulse, or conduct disorder	42	40%
Depressive disorder**	35	34%
Trauma/stressor disorder	34	33%
Anxiety disorder	32	31%
Disruptive mood dysregulation disorder (DMDD)	15	14%
Other MH disorder (e.g., bipolar, schizoaffective)	12	12%



n = 75 (72%)

More than 7 of 10 children (72%) had an indicated intellectual or developmental disability; **63% had autism spectrum disorder (ASD).**

Intellectual or Developmental Disability	75	72%
Autism spectrum disorder	66	63%
Other I/DD diagnosis (e.g., unspecified I/DD, fetal alcohol syndrome)	39	38%
Communication barriers (e.g., non-speaking and/or communication device needed)	29	28%



n = 64 (62%)

More than 6 of 10 children (62%) had **co-occurring** mental health conditions and intellectual or developmental disabilities.

n = 29 (28%)

Over 1 of 4 children (28%) had a diagnosis of a **physical condition**, such as epilepsy, spina bifida, or diabetes.

n = 49 (47%)

Nearly 1 of 2 children (47%) had **four or more diagnosed conditions**, including mental health, intellectual or developmental disability, and/or physical health conditions.

* Diagnosis information reported on the RCT referral may be reported by either clinical staff or non-clinical staff. Therefore, referrals may include conditions that are not clinically diagnosed.

** Depressive disorder counts only include those with a condition that specified "depression" and do not include other mood disorders, such as bipolar or disruptive mood dysregulation disorder.

Rapid Care Team Actions

The RCT supported children and youth in crisis and their families by convening weekly case conferences with system partners, facilitating care transition planning to stable living arrangements, providing parent peer support, and/or allocating flexible funding. The results in this section include data collected by the RCT through October 1, 2025, but the population of focus for this report remains eligible cases referred from January 2024 through June 2025.

Active Case Conferencing

Active case conferencing for eligible children and youth in crisis begins with a community care planning meeting with the RCT core members and the hospital staff and/or community partners included on the referral. The RCT then convenes weekly meetings with partners, such as Managed Care Organizations, hospital staff, DCYF staff, DSHS-DDCS staff, school district representatives, parent peer supporters, community providers, and other relevant parties to coordinate care and develop discharge or transition plans for each child or youth. The RCT core members meet at least twice weekly to review progress on follow-up actions for involved agencies and partners.

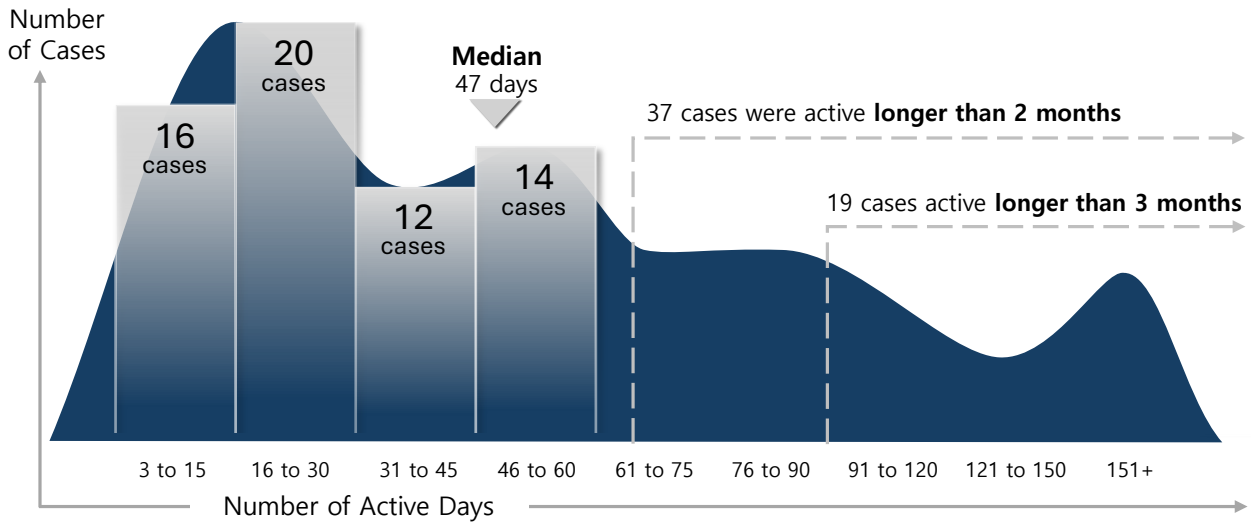
After a discharge or transition plan is implemented for a child or youth, the case is shifted to monitoring status. Monitoring status involves reviewing the child or youth's placement stability after 30 and 90 days. If the child or youth experiences another eligible crisis within the 90-day monitoring period, their RCT case returns to active status. If placement stability is retained for 90 days, their case is considered closed. If a child or youth with a closed case experiences another crisis, a new referral is submitted to the RCT for consideration. One child/youth had a second eligible referral submitted prior to June 30, 2025.

As of October 1, 2025, 99 RCT cases referred from January 2024 through June 2025 had closed or were in monitoring status (See Table 1 in the Supporting Detail section). The median duration for active cases (i.e., days from referral date to discharge or transition plan implementation) was 47 days (Figure 9). The minimum number of days a case remained active was 3, and the maximum was 403 days.

FIGURE 9.

Duration of Active Rapid Care Team Cases

TOTAL = 99 cases; duration calculated as of October 1, 2025

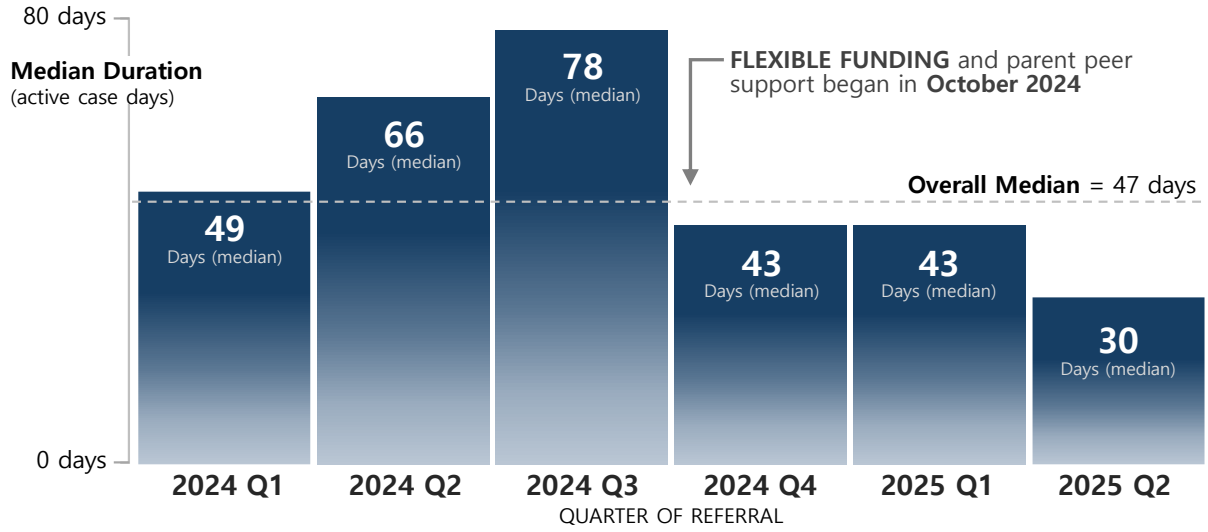


Cases that were referred to the RCT in the first three quarters of 2024 tended to require more days of active case conferencing than cases that were referred from October 2024 onward (Figure 10). The median duration for active case conferencing in the first quarter of 2024 was 49 days, and the median increased to 78 days by the third quarter of 2024. The median active duration declined to 43 days in the fourth quarter of 2024 and remained stable in early 2025 before declining again to 30 days in the last quarter. The RCT attributes the improvements in discharge or transition plan implementation to the initiation of flexible funding disbursements and engagement with parent peer support specialists in October 2024. The descriptive methods used in this report cannot confirm if other factors may have contributed to changes in active case duration over time.

FIGURE 10.

Quarterly Trends in Median Duration of Active Rapid Care Team Cases

TOTAL = 99 cases; duration calculated as of October 1, 2025



NOTE: See Table 1 in the Supporting Detail section for case counts, status, and summary statistics by quarter.

Living Arrangements

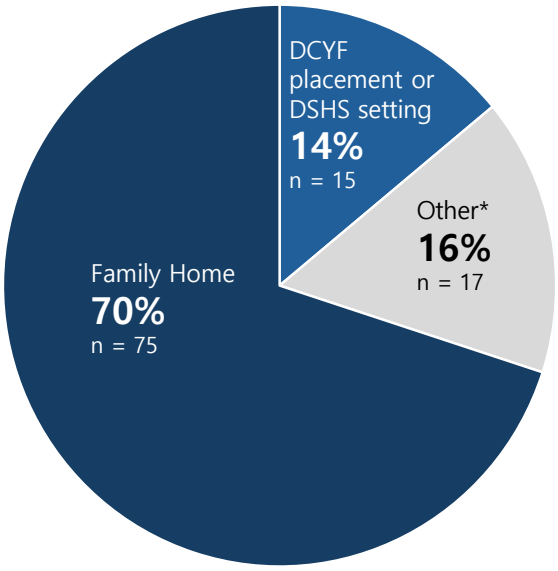
Prior to hospitalization or referral to the RCT, most children and youth in crisis were residing in a family home (70 percent, Figure 11). A smaller proportion (14 percent) were in a DCYF placement or a DSHS setting. The most common type of DCYF placement was Behavior Rehabilitation Services (BRS), and a few children and youth were in a foster home. The most common DSHS setting was Out-of-Home Services (OHS). Sixteen percent of children and youth were in another living situation, including homeless or residential treatment facility, or their prior living arrangement was unknown.

After discharge or crisis stabilization, over a third of children and youth went to a family home (36 percent), including a child/youth's home of origin or with another family member or known caregiver (Figure 12). Just over one in five children and youth (21 percent) went to a residential facility in Washington State, including Children's Long-term Inpatient Program (CLIP) facilities, Lake Burien Transitional Care Facility (LBTCF), Residential Habilitation Centers (RHCs), and Medically Intensive Children's Program (MICP) nursing facility. Sixteen percent of children and youth went to an out-of-state residential treatment facility, which are privately operated facilities across six states. Just over one in eight children and youth went to a DCYF out-of-home placement or DSHS setting in the community (13 percent). DCYF placements were BRS and Emergent Placement Services. DSHS community settings were OHS and a Stabilization, Assessment, and Intervention Facility (SAIF). See Technical Notes for placement descriptions. One in seven children and youth in crisis (14 percent) had another or unknown living arrangement after RCT intervention or were working toward crisis stabilization as of October 1, 2025.

FIGURE 11.

Living Arrangement Prior to Crisis

TOTAL = 107

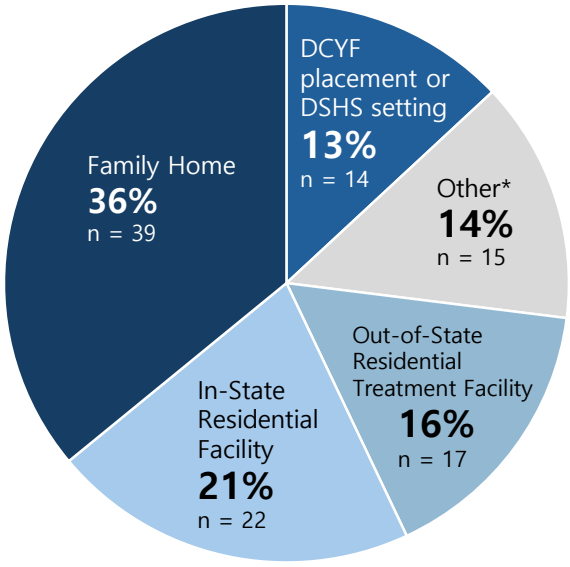


* Other includes homeless, residential treatment facility, or unknown.

FIGURE 12.

Living Arrangement after RCT Intervention

TOTAL = 107



* Other includes active and flexible funding only cases and those with rare outcomes of death, detention, homelessness, or out-of-state child welfare.

Parent Peer Support

In October 2024, the RCT began partnering with certified peer support specialists (CPSS) who have lived experience as a parent or caregiver of a child or youth who experienced a crisis similar to those of the children and youth served by the RCT. Three parent support specialists became core members of the RCT and were the first point of contact with families of eligible children and youth in crisis who did not have a dependent legal status. Forty-nine RCT cases received parent peer support from October 2024 through June 2025. Examples of support include one-on-one meetings and correspondence, connection to local support groups and workshops, parent/caregiver representation at case conferencing meetings, and system navigation.

Flexible Funding

Concurrently with the introduction of parent peer support in October 2024, the RCT began using flexible funding to support safe discharge and transition plan implementation. Requests for flexible funds could be submitted by anyone involved in the case consultation or case conference processes, except RCT members representing state agencies. Requests were reviewed and then approved or denied by RCT core members. Prior to approving flexible funding requests, the RCT explored Medicaid payment options and only authorized funding for goods and services that were either not available or not available in a timely manner.

Fifty-three children and youth received flexible funding from October 2024 through June 2025. The total amount of flexible funding dollars distributed was $1,205,536 (Figure 13). Examples of flexible funding uses included travel and lodging costs (e.g., airfare, ground transportation, short-term hotel stays for families), housing stability (e.g., utilities, rent, repairs, long-term hotel stays to support families), concrete goods (e.g., sensory items, communication devices, safety equipment), hospital contracts, out-of-home support for children and youth in residential settings, and in-home support (e.g., consultation, day camps, supportive supervision, and behavioral support).

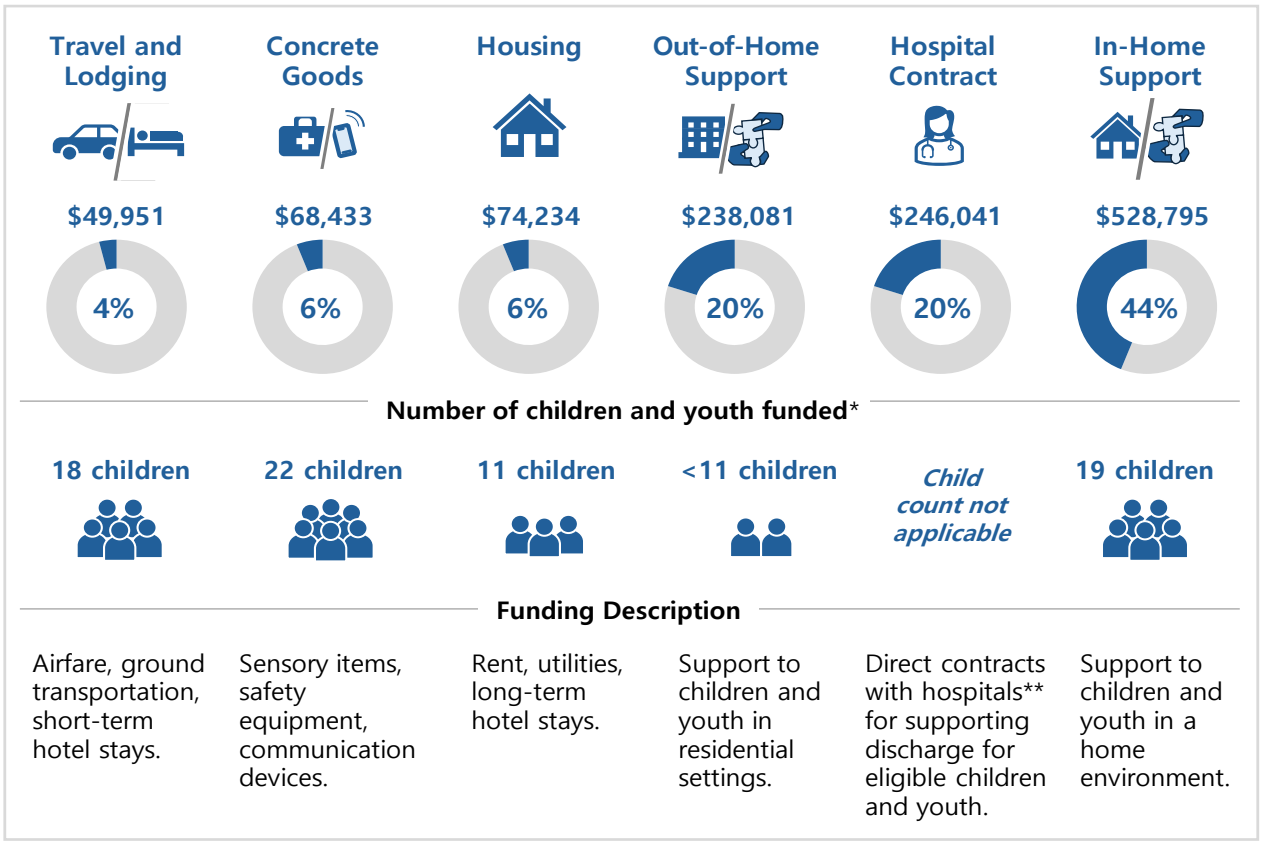
The largest amount of flexible funding (44 percent) went toward in-home support services for children and youth who discharged to a family home. Fewer than 11 children and youth who needed funding support could not be discharged to a family home; costs for out-of-home services per child/youth were much greater compared to the average cost for in-home services (results not shown to suppress small number of children/youth who received support for out-of-home services). Some of the least costly funding categories benefited the most children and youth (e.g., 22 children received flexible funding for concrete goods, which was the second-lowest category of spending).

More than a third of children and youth who needed flexible funding used funds for travel and lodging (n=18, 34 percent) and/or concrete goods (n= 22, 42 percent); 4 percent and 6 percent of all funds were used for travel and lodging or concrete goods, respectively. One in five children and youth who needed flexible funding used funds to support housing stability (n=11, 21 percent); 6 percent of all funds were used for housing support for families.

FIGURE 13.

Flexible Funding by Category

October 2024 to June 2025; Total Population = 53 children/youth



* NOTE: Some children and youth received funds from more than one category.

** Contracts were established with two hospitals. Seattle Children's Hospital used funds to directly support eligible children and youth (n<11), and Mary Bridge Children's Hospital used funds to provide assessment, consultation and trainings and to directly support eligible children and youth. See Tangen, K. (2025). *HB1580 Funding Impact Report: Reducing Youth Hospital Boarding in Perce County.* MultiCare Mary Bridge Children's, which is included as an Appendix in the Transforming Washington's Children & Youth System of Care Report on System Changes and Innovations 2025 Report to the Legislature.

Discussion

This report summarizes the characteristics of children and youth in crisis served by the multiagency RCT from January 2024 through June 2025. Additional data collected through October 1, 2025, was incorporated to provide more complete information on living arrangements after RCT intervention (Figure 12) and active case duration (Figures 9 and 10 and Supporting Detail Table 1).

Compared to the data summary included in the first report to the legislature (see "Related Report" call-out box on page 3), this summary includes more than twice as many referrals (131 in this report compared to 64 in the 2024 report) and a longer follow-up period to more accurately measure active case duration and living arrangements after intervention. More than half of children and youth did not go to a family home after discharge or crisis stabilization (Figure 12), and many of those who went to a family home required in-home support provided by flexible funding (Figure 13). See the Emerging Themes and Strategic Pathways Forward sections of the full report to the legislature for ongoing work and recommendations to expand and strengthen the array of services and supports for children and youth in crisis and their families.

Although this report provides the most complete summary of children and youth in crisis served by the RCT to date, it has notable limitations. First, this report only includes information on the children and youth who were referred to the RCT and does not include all children and youth in Washington State who met "child in crisis" eligibility requirements established in RCW 43.06.535. Analytic work is underway to estimate the statewide population of children and youth in crisis, and results will be shared in a future report. Second, the data included in this report come from a limited number of sources, including RCT referral forms, information that was shared with the RCT through the case conferencing process, and data gathered by RCT members from agency-specific data systems and case managers. The data do not include family and caregiver information that was shared with parent peer support specialists or administrative data such as pre- or post-intervention social and health services indicators. Additional work is needed to document and report on the strengths of children and youth in crisis and their families and identify long-term outcomes and ongoing support needs.

SUPPORTING DETAIL

TABLE 1.

Rapid Care Team Referrals and Active Duration Summary Statistics[1] by Quarter

Calculated as of October 1, 2025

Referral Quarter	Case Counts[2]	Average Days	Median Days	Minimum Days	Maximum Days
2024 Q1	13	87	49	7	285
2024 Q2	15	93	66	17	403
2024 Q3	13	88	78	18	302
2024 Q4	14	56	43	3	203
2025 Q1	22	42	43	5	98
2025 Q2	22	43*	30	7	135*
TOTAL	**99**	**64***	**47**	**3**	**403***

[1] Summary statistics are based on the active case span, which starts at RCT referral date and ends when the discharge or transition plan is implemented for monitoring and closed cases, or the data extract date (October 1, 2025) for active cases.

[2] Excludes cases who only received flexible funding or did not meet eligibility criteria. Nearly all included cases had closed status as of October 1, 2025. Very few cases (<11) had active or monitoring status. All active or monitoring status cases were referred in 2025 Q2.

* The average and maximum days values for 2025 Q2 and the Total may increase once the few remaining active and monitoring cases close. An end date of October 1, 2025, was used to estimate duration for active cases. Values during this time period were greater than 47 days, so median values are unaffected.

TECHNICAL NOTES

This report describes the children and youth referred to the Rapid Care Team (RCT) from its initiation in January 2024 through SFY 2025. Results describing actions of the RCT include data collected through October 1, 2025.

ACRONYMS

DCYF Department of Children, Youth, and Families.

DDCS Developmental Disability Community Services, a division within the Washington State Department of Social and Health Services (DSHS) Home and Community Living Administration (HCLA) (community-based services formerly within the DSHS Developmental Disabilities Administration (DDA)).

DSHS Department of Social and Health Services. Services provided by two DSHS administrations are referenced in this report; the Home and Community Living Administration (HCLA) focuses on coordinating home and community-based services, and the Behavioral Health and Habilitation Administration (BHHA) oversees state-operated settings and manages comprehensive behavioral health and habilitation services. In May 2025, the agency consolidated key functions previously managed by the Behavioral Health, Developmental Disabilities, and Aging and Long-term Support Administrations (BHA, DDA, ALTSA) into two administrations (HCLA and BHHA).

HCA Health Care Authority. The agency is Washington state's Medicaid authority and its behavioral health authority.

RCT Rapid Care Team; a multiagency team initiated by RCW 43.06.535 whose work is managed and directed by the Children and Youth Multisystem Project Director within the Office of the Governor.

POPULATION

Children and youth referred to the RCT from January 2024 through June 2025. Some measures are focused on the population who met eligibility criteria established in RCW 43.06.535 and other measures are further limited to the population with complete data for particular indicators (e.g., admission date, diagnosis information, etc.). See figure notes and report text for complete inclusion and exclusion criteria for each indicator.

DATA SOURCES

All indicators are derived from data collected by the HCA, DCYF, and DSHS-DDCS members of the RCT. The information is sourced from the RCT referral form, discussions and correspondence that occurred during the case conferencing process, and data gathered by RCT members from agency-specific data systems and case managers.

PRIVACY PROTECTION

The presentation of these results follows the Washington State Health Care Authority small number standards to address confidentiality and reliability issues with small numbers. Counts and rates are suppressed when the population is fewer than 11 individuals. Additional statistics based on a population of 11 individuals or greater may also be suppressed (secondary data suppression) to prevent recalculation of primary suppressed values.

STATE PROGRAMS AND SERVICES (grouped by agency)

1. Department of Social and Health Services

Child Study and Treatment Center (CSTC): State-operated psychiatric hospital for children ages 5-17 who have psychological and safety needs that cannot be met in their communities. CSTC is one of four Children's Long-term Inpatient Program (CLIP) facilities (see section 3 below). Youth who are certified for voluntary admission or subject to a 180-ITA are referred to CSTC via the CLIP Administration in coordination with the family or guardian to best determine each child's specific needs. https://www.dshs.wa.gov/bha/division-state-hospitals/child-study-and-treatment-center

DDCS eligibility: To qualify for DDCS, an individual must have a diagnosed condition before age 18 of intellectual disability, cerebral palsy, epilepsy, autism, or another neurological or other condition found by DDCS to be closely related or requiring treatment similar to intellectual disability. The diagnosed condition must be expected to continue indefinitely and result in substantial limitations as defined by DDCS. Once eligible, clients must request services covered under the Home and Community Based waiver. It is important to note that eligibility for DDCS does not automatically mean an individual can receive DDCS services. To access DDCS services, the child or youth must also be Medicaid eligible. Families may request waiver services if they identify supports that would benefit the child or youth. If the waiver request is approved, Medicaid eligibility is typically established following a financial review. https://app.leg.wa.gov/wac/default.aspx?cite=388-823

Disability-related waiver services: DDCS offers five Home and Community-Based Services (HCBS) Waivers that provide an array of services tailored to the specific populations they serve. Waiver services provide additional support when Medicaid state plan services and other supports are not sufficient. For the DDCS population, HCBS waivers are the most common pathway to long-term services and supports, though institutional setting waivers may also apply depending on the child or youth's needs. https://www.dshs.wa.gov/dda/home-and-community-based-waivers-hcbs

Lake Burien Transitional Care Facility (LBTCF): A state-run residential treatment facility providing specialized treatment serving youth ages 13–17 with intellectual and developmental disabilities, autism spectrum disorder, and co-occurring behavioral health needs. The facility primarily supports individuals with severe psychiatric diagnoses who require intensive inpatient psychiatric treatment in a structured and specialized environment. https://app.leg.wa.gov/ReportsToTheLegislature/home/GetPDF?fileName=25-0403%20DDA%20Lk.%20Burien%20Report%20final_242e6d23-6566-4c25-b4e9-bb76b7d83179.pdf

Medically Intensive Children's Program (MICP): A delegated (to DSHS from HCA) State Plan medically necessary service providing private duty nursing to children ages 17 and younger in a family home, foster home, group care facility for medically fragile children, or staffed residential home. To be eligible, a child must have a complex medical need, be enrolled in Apple Health, and require at least 4 hours of continuous skilled nursing care per day. https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-medical-dental-or-vision-care/medically-intensive-childrens-program-micp

Out-of-Home Services (OHS)/State-operated Living Alternatives (SOLA): Children's residential habilitation services provided in licensed and certified community-based settings under DDCS. Parents retain legal rights and responsibilities for their child and work in partnership with the provider through a child and family engagement plan. https://www.dshs.wa.gov/dda/community-residential-services-children

Residential Habilitation Center (RHC): 24/7 residential service that provides comprehensive habilitation and nursing services for individuals needing a high level of skill development, behavior support, and/or intensive nursing care. Each RHC is certified as an Intermediate Care Facility (ICF) for Individuals with Intellectual Disabilities or as a State-Operated Nursing Facility (SONF). ICF services are temporary with the goal of gaining skills to be as independent as possible. Planned respite is also provided at NFs. RHCs typically support adults age 21 years or older, but young adults ages 16-20 may be eligible if services are not available in the community to meet their needs. https://www.dshs.wa.gov/dda/residential-habilitation-centers

Stabilization, Assessment, and Intervention Facility (SAIF): Provides short-term, intensive residential habilitation for up to 90 consecutive days for those age 18 and over with the goal of living in one's own community safely. The program addresses needs for clients who experience a crisis that risks disruption to their residential services or exhibit persistent behavior that prevents continued access to residential service providers. https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/policy_archives/apolicy4.25_071522.pdf

2. DCYF Child Welfare

Adoption Support: Assists in removing barriers for families adopting special needs children by providing financial, medical, and counseling support to families who adopt from Washington State. Benefits include medical and dental services through Medicaid, pre-authorized counseling supports, nonrecurring adoption costs reimbursement, training opportunities, and monthly cash payment. https://dcyf.wa.gov/services/adoption-support-program

Behavior Rehabilitation Services (BRS): A short-term intensive support and treatment program for youth with high-level service needs. Supports and services can include in-home services or placement in a Qualified Residential Treatment Program (QRTP) or Therapeutic Foster Care (TFC) home. In-home BRS are provided in a caregiver's home, QRTPs are a subset of licensed group care facilities, and TFC is a foster family home setting. All BRS are intended to support and safely stabilize youth and support transition to a less intensive service to assist in achieving a permanent plan. BRS overview: https://dcyf.wa.gov/sites/default/files/pdf/reports/BRSUpdate-2025A.pdf

Child Protective Services (CPS): Investigates reports of child abuse and neglect or when children or youth are believed to be at imminent risk of harm. Screened-in CPS intakes meet the Washington State sufficiency screening criteria for CPS investigation, Family Assessment Response (FAR), or Risk Only. CPS investigations include alleged subject(s) of child abuse and/or neglect. FAR is Washington State's differential response for screened-in CPS intakes that do not require an investigation. Risk Only CPS intakes indicate that a child is alleged to be at imminent risk of harm, but there is no allegation that meets the criteria for child abuse or neglect as defined in the Washington Administrative Code. https://dcyf.wa.gov/policies-and-procedures/2200-intake-process-and-response; FAR: https://www.dcyf.wa.gov/sites/default/files/pubs/CWP_0023.pdf; Risk Only: https://depts.washington.edu/acwewa/Intake/Resources/IntrotoIntake/CPSRiskOnlyIntakes.pdf

Dependency: When the State assumes temporary legal custody of a child as a result of a dependency petition to protect the child from harm. A dependency petition is a legal document addressed to the court about concerns that a child has been abused, neglected, or abandoned, or there is no parent able to safely care for the child. Placement could be out-of-home or in-home with services to assist parents in keeping their children safe. https://www.dcyf.wa.gov/sites/default/files/pubs/CWP_0044.pdf

Family Reconciliation Services (FRS): A voluntary program serving runaway adolescents and youth ages 12–17 who are in conflict with their families. Services are meant to resolve crisis situations and prevent unnecessary out-of-home placement and may include short-term family counseling, referrals for substance use treatment and counseling, referrals for mental health services, family assessments for At-Risk Youth and Child in Need of Services petitions, and crisis planning and help. https://dcyf.wa.gov/services/at-risk-youth/frs

Family Voluntary Services (FVS): A program that lets parents and legal guardians choose to participate in services to meet their child(ren)'s safety, health, and well-being needs. Caseworkers work with families to complete an assessment of strengths, needs, and child safety, with the goal of supporting families to engage in services that meet the family's needs while strengthening and keeping the family together. https://www.dcyf.wa.gov/sites/default/files/pubs/CWP_0035.pdf

Out-of-home placement: A placement outside of a child's home of origin, including licensed foster care, kinship care, congregate setting, or a temporary event (e.g., hotel stays, detention, hospital, and missing from care). A child or youth in an out-of-home placement typically has an open CFWS case and may have dependent, protective custody, shelter care, voluntary placement, or other legal status. A placement must meet the child/youth's safety, health, stability, and well-being needs and be in their best interest. https://dcyf.wa.gov/policies-and-procedures/4250-out-home-placements

Child and Family Welfare Services (CFWS): The child welfare program that manages cases for children and youth in out-of-home placement or with an in-home dependency.

Open case with a DCYF child welfare program: Current engagement with any of the above programs.

3. Health Care Authority

Apple Health: Provides full-benefit Medicaid health coverage under Title XIX of the Social Security Act (SSA); full-benefit State Children's Health Insurance Program (SCHIP) under SSA Title XXI; and state-funded Apple Health coverage for non-federally qualifying children (Children's Health Program). Benefits include physical health, behavioral health, and crisis-related services that support stability for children and youth. https://www.hca.wa.gov/about-hca/programs-and-initiatives/apple-health-medicaid

Center of Parent Excellence (COPE Project): Offers support to parents and caregivers who are raising children and youth (ages 2-22) experiencing behavioral and mental health challenges in the home, school, and community. Operated through A Common Voice, a statewide, family-run nonprofit organization, COPE offers navigation assistance, education, and family-centered guidance to support caregivers' ability to maintain their children safely in their homes and communities. https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/center-parent-excellence-cope-project

Children's Long-term Inpatient Program (CLIP): Provides the highest level of inpatient psychiatric care for Washington State residents ages 5–17. With 109 state-funded beds across four facilities, CLIP provides assessment, treatment, and stabilization for youth with the most acute psychiatric needs. Youth may access CLIP through voluntary or involuntary pathways, with admissions coordinated by the CLIP Administration. https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/childrens-long-term-inpatient-program-clip

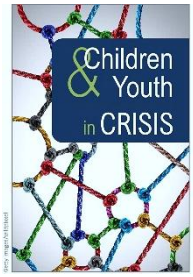
Wraparound with Intensive Services (WISe): Provides intensive home- and community-based behavioral health services for children and youth up to age 20 with complex mental health needs. Using a team-based approach that includes family partners, peers, natural supports, and clinical providers, WISe aims to maintain stability in the home, school, and community and reduce the need for higher levels of care. WISe provides intensive behavioral health in home and community settings to youth who are Apple Health eligible under WAC 182-505-0210 and meet medical necessity criteria for WISe. https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-behavioral-health-support/wraparound-intensive-services-wise

4. Interagency Collaborations

Kids Mental Health Washington: A collaboration between HCA, DSHS-DDCS, and Kids Mental Health Pierce County to establish Youth Regional Behavioral Navigation teams across the state. These regional teams aim to enhance communication, streamline service connections, and establish Multidisciplinary Teams (MDT) to better coordinate support for children and youth facing behavioral health challenges. https://kidsmentalhealthwa.org/ and https://www.hca.wa.gov/assets/program/fact-sheet-youth-behavioral-health-navigators.pdf

HB1580/1272 Rapid Care Team (RCT): A team of representatives from HCA, DSHS-DDCS, DCYF and parent peer support specialists serving "children in crisis" (under age 18) as defined by RCW 43.06.535. The RCT is managed and directed by the Children and Youth Multisystem Project Director within the Office of the Governor.

Youth and Young Adult Housing Response Team (YYAHRT): A partnership between DSHS-DDCS, DCYF, Department of Commerce Office of Homeless Youth (OHY), and HCA that coordinates resources and secures appropriate housing for youth and young adults under age 25 exiting a publicly funded system of care, including behavioral health, juvenile justice, office of homeless youth programs, and child welfare systems. https://dcyf.wa.gov/services/housing-homelessness-prevention/yyahrt



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