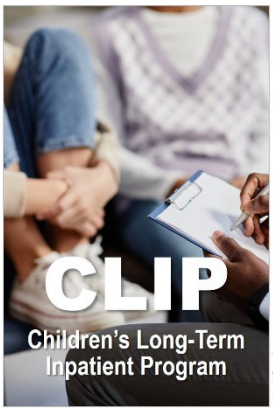

Children's Long-Term Inpatient Program: Patient Characteristics and Outcomes

Children/Youth Discharged in SFY 2013–2018

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THE Children's Long-Term Inpatient Program (CLIP) is Washington State's most intensive inpatient psychiatric treatment program for patients ages 5 through 17. This report describes the characteristics of children and youth with Apple Health coverage who were discharged from CLIP in state fiscal years (SFY) 2013 through 2018 (pre-COVID), compares these patients' characteristics to those in the broader population of children and youth who are Apple Health clients, and documents short- and long-term outcomes for CLIP patients. Designed to assist program and policy leaders, this report quantifies the substantial mental health (MH) needs and compounding risk factors faced by the CLIP patient population, and documents their continued challenges after discharge from CLIP treatment. A targeted analysis of selected subgroups of CLIP patients identifies populations that may need additional supports during CLIP service episodes, during transition back to the community post-discharge, and in the months and years that follow discharge.

Key Findings

1. **CLIP patients have exceptionally high needs in the pre-admission period.** In the year prior to admission, CLIP patients' MH service utilization reflected a period of crisis (e.g., 85 percent used MH crisis services) and their diagnoses reflected substantial needs (e.g., 59 percent had a psychotic disorder, 57 percent were diagnosed with suicidal ideation). Further, two-thirds of patients were recently involved with child welfare, and one-third had previously been arrested.
2. **CLIP patients experience a reduced indication of acute needs immediately post-discharge, indicating that CLIP temporarily stabilizes this population.** Analyses showed notable reductions in utilization of MH inpatient services, MH crisis services, and behavioral health-related emergency department (BH ED) visits in the year post-discharge compared to the year prior to CLIP admission. Rates of suicidal ideation and child welfare involvement were lower post-discharge as well.
3. **A majority of CLIP patients experience an acute behavioral health crisis event within 1 year of discharge.** Though lower than the pre-admission period, the majority (55 percent) of CLIP patients in a recent cohort still experienced a BH ED visit in the year following discharge and more than a third (39 percent) were rehospitalized. Acute behavioral health crisis events were most likely in the first 2 months after discharge.
4. **Long-term outcomes indicate a need for continued intensive supports after CLIP discharge.** Despite the initial reduction in needs following discharge, within 5 years, half of patients (50 percent) returned to psychiatric inpatient care; over half (53 percent) received a diagnosis of

suicidal ideation; over one-third (35 percent) had some type of self-harm event; three-quarters (74 percent) had at least one BH ED visit; one-third (33 percent) experienced homelessness or unstable housing; and nearly half were arrested (47 percent).

5. **The later cohort of CLIP patients had higher pre-admission and post-discharge challenges.** These observations are consistent with national trends of growing mental health problems among children and further highlight the importance of developing strong post-discharge supports.
6. **Subgroups of CLIP patients have different pre-admission characteristics and post-discharge outcomes.** For example, younger CLIP patients (ages 7 to 13 at discharge) were disproportionately male; had higher pre-admission rates of ADHD, disruptive/impulse/conduct disorders, and language and learning disabilities; had longer CLIP stays; and had lower rates of poor behavioral health outcomes post-discharge. Additionally, youth who were in the program for less than 6 months tended to be older, and experienced higher rates of ED visits and mental health inpatient services both pre-admission and post-discharge than youth in CLIP for longer. Subgroup analysis results can help tailor post-discharge supports to individual needs.

CLIP Program

The Children's Long-Term Inpatient Program (CLIP) is an intensive inpatient treatment program for children and youth in Washington State.[1] It is jointly operated by the Health Care Authority (HCA), which manages the privately contracted CLIP facilities, and the Department of Social and Health Services (DSHS), which manages the state-operated Child Study and Treatment Center (CSTC). CLIP is designed to assess, treat, and stabilize children and youth with severe psychiatric disorders. Patients receive individualized treatment using evidence-based practices, with a focus on reintegration into a community setting. Patients typically stay in the CLIP program for several months prior to discharging into the community; the median length of stay for those discharging during SFYs 2013 through 2018 was 7 months. CLIP program staff engage in comprehensive individualized discharge planning, including establishing a stable living arrangement, a crisis plan, and community-based MH services.

Washington's five CLIP facilities are shown in Figure 1, encompassing approximately 116 funded treatment beds statewide as of June 2023. (This number excludes the 10 Navos beds that closed in October 2021, but Navos patients are included in this report's analyses.) Each facility serves a unique patient population differing by age ranges, background characteristics, and geographic locations. CSTC, operated by DSHS in Pierce County, is the largest CLIP facility, with 57 standard beds and 8 forensic beds. It is the only facility that serves younger children (as young as age 5), and it is also the only facility with forensic patients.[2] CSTC is also the only no-refusal facility, where a child cannot be refused treatment for reasons other than capacity or medical necessity.

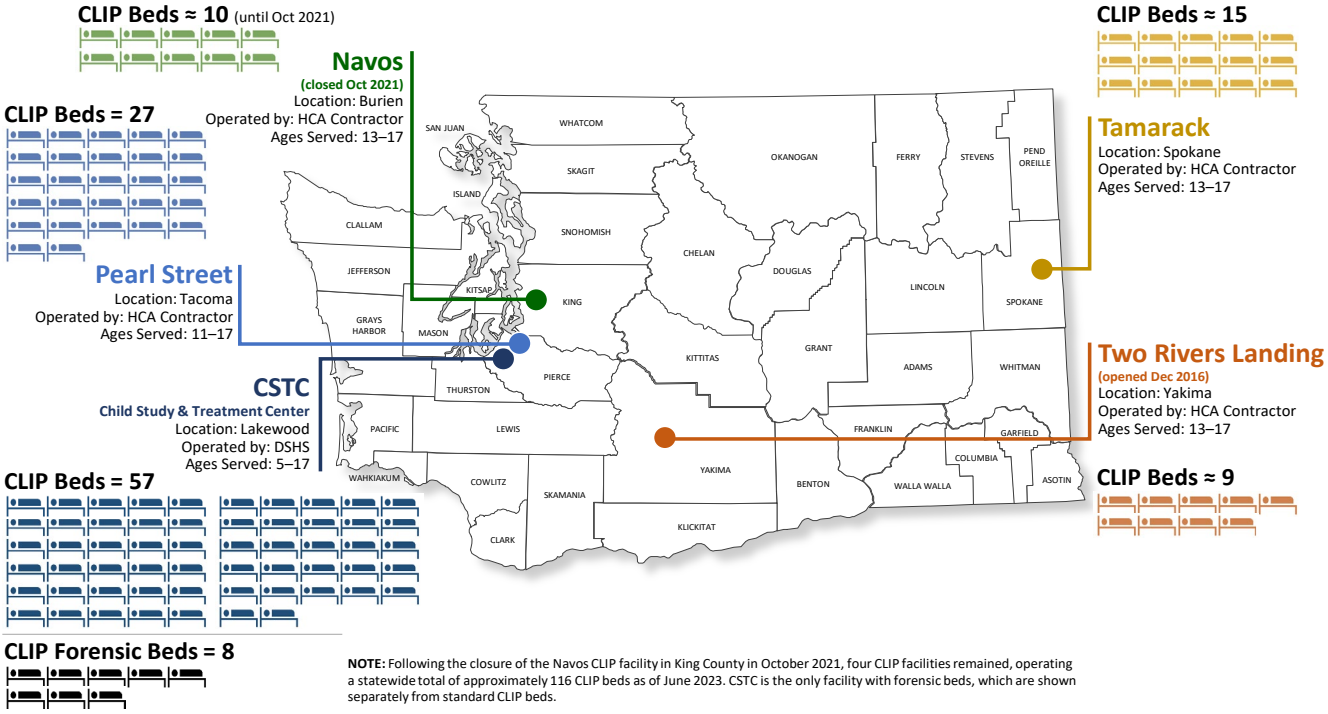
Additional CLIP services are provided by four privately run facilities contracted by HCA. Pearl Street, located in Pierce County, serves children and youth ages 11 to 17 and has a total of 27 CLIP beds. Navos, located in King County, served youth ages 13 to 17 and had approximately 10 CLIP beds until the facility closed in October 2021. Tamarack, located in Spokane County, serves youth ages 13 to 17 with approximately 15 CLIP beds. Two Rivers Landing, located in Yakima County, is the newest CLIP facility and has approximately nine CLIP beds for youth ages 13 to 17. There are several factors that influence where a child is placed, including family preference, bed availability, distance to home, the family's ability to travel, and the individual's treatment needs.

[1] There are two main pathways to admission for CLIP, one via a voluntary application process and the other via court order. More information can be found here: https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/childrens-long-term-inpatient-program-clip

[2] Forensic CLIP beds are for minors charged with a crime who have been committed by court order to CLIP for inpatient forensic MH services.

FIGURE 1.

CLIP Facilities as of October 2021



NOTE: Following the closure of the Navos CLIP facility in King County in October 2021, four CLIP facilities remained, operating a statewide total of approximately 116 CLIP beds as of June 2023. CSTC is the only facility with forensic beds, which are shown separately from standard CLIP beds.

Study Population

CLIP Patients Discharged SFY 2013–2018

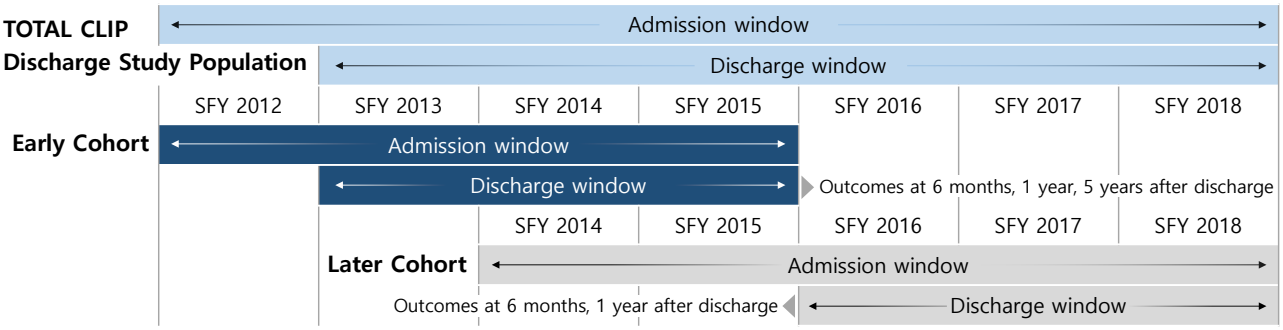
This analysis focuses on **501 children and youth discharged from all CLIP facilities between State Fiscal Years (SFY) 2013 and 2018, excluding forensic and private pay patients** (hereafter "CLIP patients" or "youth"). Private pay patients are those who were not enrolled in Apple Health in any of the 12 months prior to CLIP admission and thus excluding them ensures that all patients in the study population have at least one month of Apple Health in the year prior to CLIP admission. We focus on non-private pay, non-forensic CLIP patients because they are more likely to rely on publicly funded social and health services following discharge (see technical notes for more information on excluded populations). The current study seeks to examine post-discharge outcomes to identify ways to better support this patient population.

A long time period (from July 2012 through June 2018) is used to define the study population in order to ensure a reasonable sample size for this analysis and permit examination of long-term outcomes (up to 5 years). Outcomes were analyzed for two cohorts: 1) the **early cohort** (youth discharged in SFY 2013–2015; N=257) allows outcome measurement over a full 5-year post-discharge period; and 2) the **later cohort** (youth discharged in SFY 2016–2018; N=244) allows analysis of patients served more recently in CLIP. Figure 2 illustrates timeframes for admission and discharge windows for these groups.

The main study population (N=501), comprised of both cohorts, is also compared with a reference population of Apple Health clients in the same timeframe, adjusted to mirror the age profile and year distribution of the CLIP study population (see technical notes for details). The purpose of this **Apple Health reference population** is to see how CLIP patients differ from the broader population of all children and youth ages 6 to 17 enrolled in Apple Health. The Apple Health reference population is not appropriate for use in comparing outcomes, as its baseline characteristics differ dramatically from those of CLIP patients.

FIGURE 2.

Study Timeline

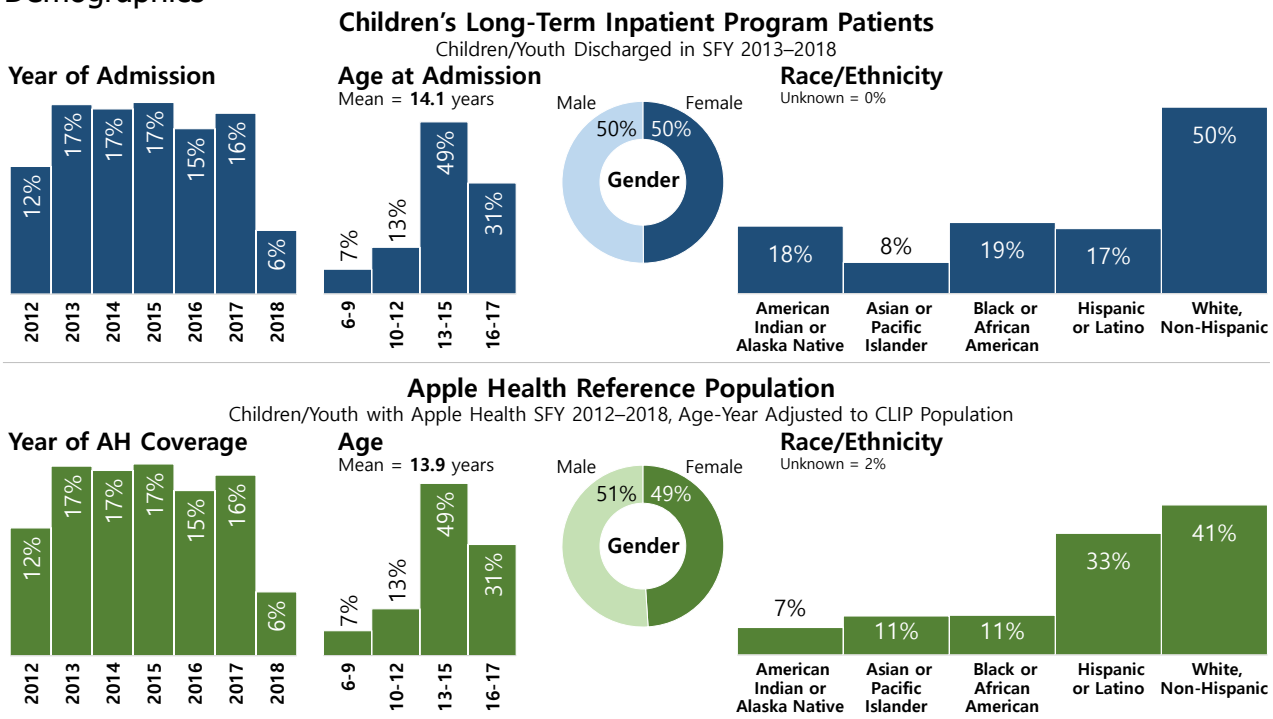


CLIP Demographics

The average age at admission of CLIP patients discharged during SFYs 2013 through SFY 2018 was 14 years, with ages ranging from 6 through 17.[3] Half of CLIP patients in the study sample were female. Half were non-Hispanic White, 19 percent were Black, 18 percent were American Indian or Alaska Native (AIAN), 17 percent were Hispanic or Latino, and 8 percent were Asian or Pacific Islander. Note that race/ethnicity categories are not mutually exclusive except for White, Non-Hispanic. Relative to the distribution of race and ethnicity across the Apple Health reference population, CLIP served a higher percentage of non-Hispanic White, Black, and AIAN youth, and a lower percentage of Asian or Pacific Islander and Hispanic or Latino youth.

FIGURE 3.

Demographics



NOTES: CLIP patients include 501 patients discharged from CLIP SFY 2013–2018, excluding forensic and private pay patients. The Apple Health reference population (N=3.9 million) is a broader population of children and youth receiving Apple Health over the same timeframe, adjusted to mirror the year and age distributions of the CLIP population. Race/ethnicities are not mutually exclusive except for White, Non-Hispanic.

[3] Although the CLIP program officially serves children ages 5 to 17, the youngest CLIP patient in the study sample was 6 years old upon admission. Also, multiple CLIP patients in the study sample were discharged following their 18th birthdays.

An Exceptionally High-Needs Population

CLIP patients demonstrate exceptionally high needs in the pre-admission period, both in absolute terms and in contrast to the Apple Health reference population.

Pre-Admission Behavioral Health Needs

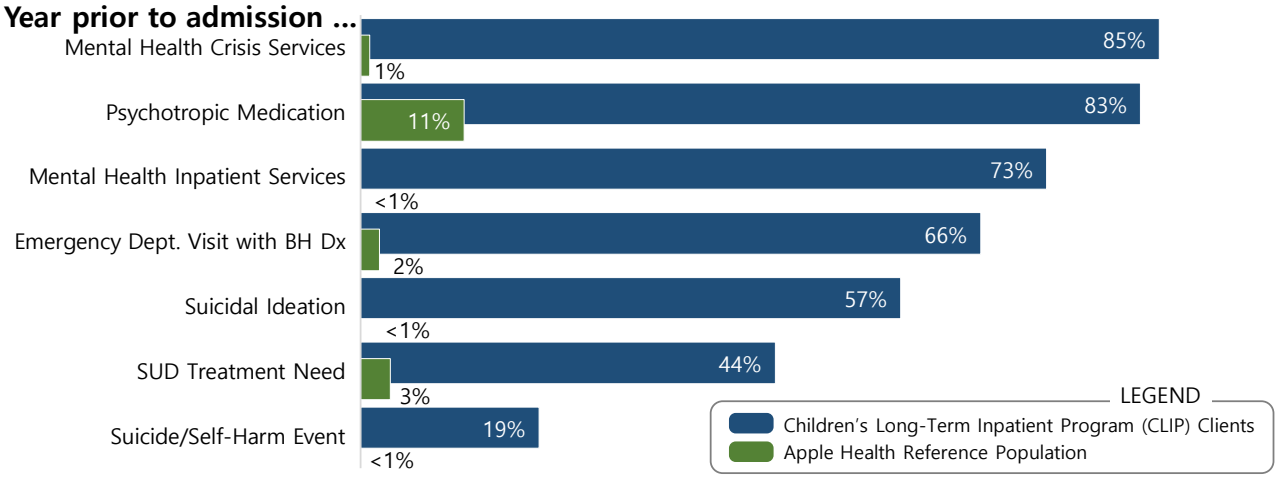
In the year prior to CLIP admission, most patients (85 percent) received MH crisis services, and about three-quarters (73 percent) received MH inpatient services. Most CLIP patients (83 percent) were prescribed psychotropic medications in that year, and two-thirds (66 percent) had an emergency department visit with a behavioral health (BH) diagnosis.

Finally, nearly half of patients (44 percent) had a co-occurring substance use disorder (SUD) treatment need in the year prior to admission. As shown in Figure 4, these BH needs far exceeded those for similarly aged youth in the broader Apple Health reference population.

FIGURE 4.

Pre-Admission Behavioral Health Indicators

Children/Youth Discharged in SFY 2013–2018



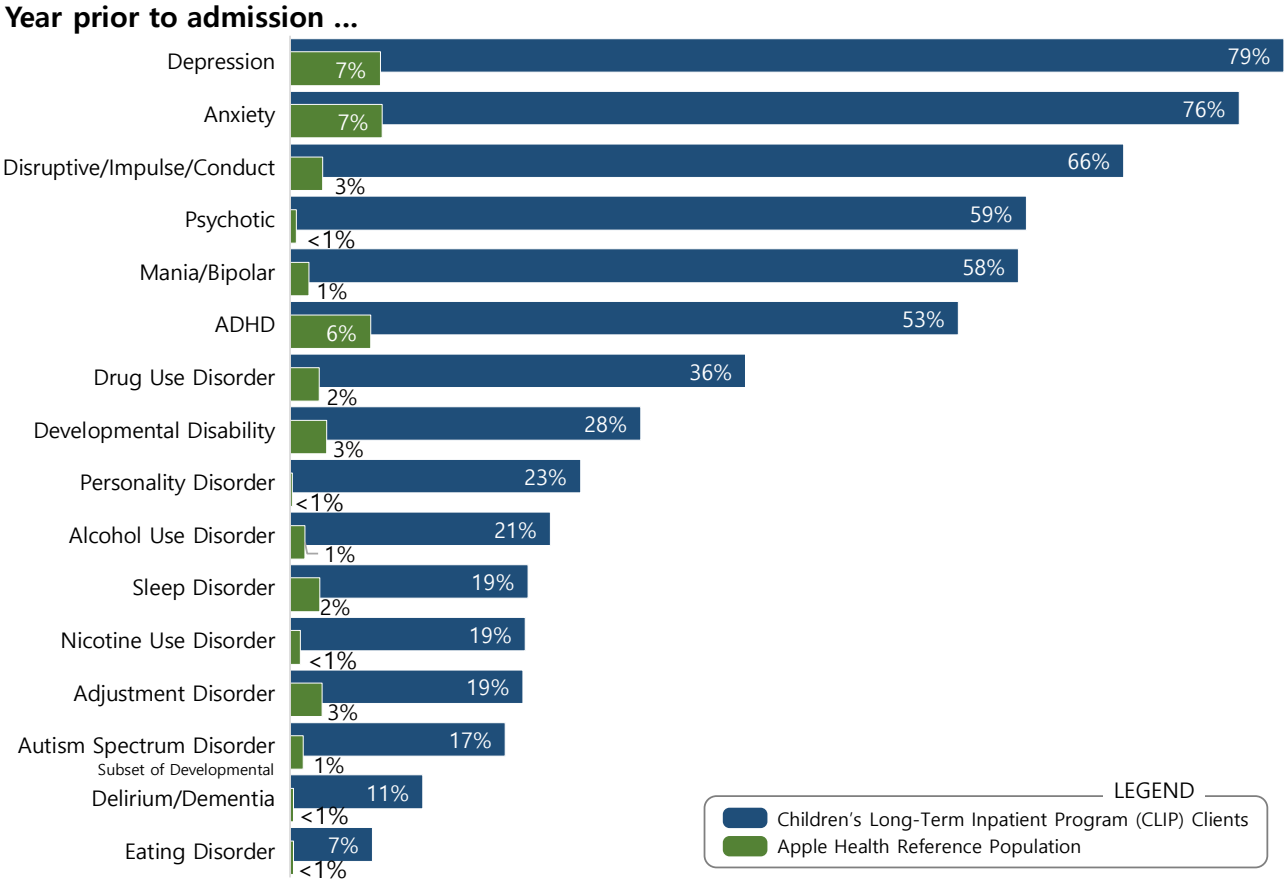
NOTES: CLIP patients include 501 patients discharged from CLIP SFY 2013–2018, excluding forensic and private pay patients. The Apple Health reference population (N=3.9 million) is a broader population of children and youth receiving Apple Health in the same timeframe, adjusted to mirror the year and age distributions of the CLIP population. The Apple Health reference population measures reflect experience in the parallel time period prior to the index month of coverage, rather than in the year prior to CLIP admission.

CLIP patients have substantially higher rates of BH and developmental disability diagnoses than the reference population, with the top five diagnoses for CLIP patients being depression (79 percent of CLIP patients vs. 7 percent in the Apple Health reference population); anxiety (76 percent vs. 7 percent); disruptive/impulse/conduct disorders (66 percent vs. 3 percent); psychotic disorders (59 percent vs. less than 1 percent); and mania/bipolar (58 percent vs. 1 percent). Developmental disabilities and diagnosed drug and alcohol use disorders were also prevalent and more common among CLIP patients compared to the Apple Health reference population (Figure 5).

FIGURE 5.

Pre-Admission Behavioral Health and Developmental Disability Diagnoses

Children/Youth Discharged in SFY 2013–2018



NOTES: CLIP patients include 501 patients discharged from CLIP SFY 2013–2018, excluding forensic and private pay patients. The Apple Health reference population (N=3.9 million) is a broader population of children and youth receiving Apple Health in the same timeframe, adjusted to mirror the year and age distributions of the CLIP population. The Apple Health reference population measures reflect experience in the parallel time period prior to the index month of Apple Health, rather than in the year prior to CLIP admission.

Pre-Admission Social Service and Criminal Legal System Involvement

CLIP patients are frequently involved with the criminal legal system. One-third (33 percent) had ever been arrested and 17 percent had experienced a felony arrest by the time of their CLIP admission compared to 3 percent and 2 percent, respectively, in the Apple Health reference population (Figure 6).

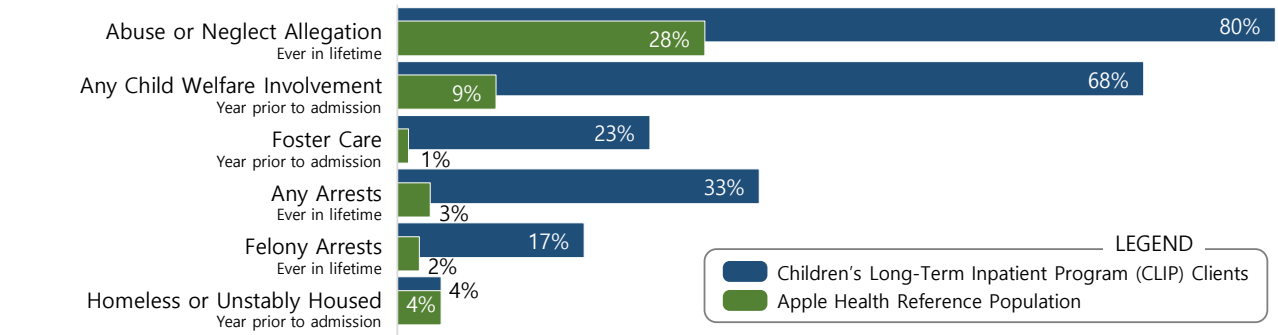
Most CLIP patients also have experience with the child welfare system. The majority of CLIP patients (80 percent) had a screened-in abuse or neglect allegation to Child Protective Services prior to admission versus 28 percent in the Apple Health reference population (Figure 6). Roughly two-thirds (68 percent) had any child welfare involvement and 23 percent were in foster care the year prior to CLIP admission (versus 9 and 1 percent, respectively, in the Apple Health reference population). Eighteen percent of CLIP patients were in foster care when they were admitted to the program.

Homelessness and housing instability, spanning from fully unsheltered to unstable housing such as couch surfing, was experienced by approximately 4 percent of both CLIP patients and the Apple Health reference population in the year prior to admission.

FIGURE 6.

Social Service and System Involvement History

Children/Youth Discharged in SFY 2013–2018



NOTES: CLIP patients include 501 patients discharged from CLIP SFY 2013– 2018, excluding forensic and private pay patients. The Apple Health reference population (N=3.9 million) is a broader population of children and youth receiving Apple Health in the same timeframe, adjusted to mirror the year and age distributions of the CLIP population. The Apple Health reference population measures reflect experience in the parallel time period prior to the index month of coverage, rather than in the year prior to CLIP admission. Foster care includes traditional foster care, kinship care, and congregate care under the authority of DCYF (formerly DSHS).

Outcomes Analysis: Reduction of Immediate Needs, Substantial Long-Term Challenges

Using two cohorts of CLIP patients, we measured several health and other outcomes in the years following discharge. For the "early cohort" (CLIP patients discharged SFY 2013–2015), outcomes were analyzed at 6 months, 1 year, and 5 years post-discharge. For the "later cohort" (CLIP patients discharged SFY 2016–2018), outcomes were analyzed at 6 months and 1 year post-discharge (5-year outcomes were not available for this group). We compared each outcome to pre-admission rates to determine change over time. Across many of the measures examined, patients experienced a reduction of needs following discharge relative to the pre-admission period, as well as a later uptick suggesting continuing long-term challenges for CLIP patients.

Population Sizes for Outcome Analyses

Pre-admission measures for health outcomes, as well as all measures for non-health outcomes, are based on the full cohort. Post-discharge health outcomes, which rely on the availability of administrative medical service data from the ProviderOne system, are measured at each timepoint for the subgroup of CLIP patients enrolled in Apple Health at the specified timepoint (see Table 1).[4] For example, 1-year health outcomes for the early cohort are presented for the 227 youth (88 percent of the full cohort) enrolled in Apple Health at 1 year following discharge. One-year non-health outcomes for the early cohort are presented for all 257 youth in the cohort.

TABLE 1.

Apple Health Enrollment Following CLIP Discharge

	Early Cohort		Later Cohort	
	NUMBER	PERCENT	NUMBER	PERCENT
Full Cohort	257	100%	244	100%
6 Months Post Discharge	232	90%	223	91%
1 Year Post Discharge	227	88%	210	86%
5 Years Post Discharge	174	68%	n/a	n/a

[4] All CLIP patients in the study had Apple Health in the year prior to admission. While many may have retained coverage over the post-discharge period, the sample restriction for post-discharge health outcomes does not imply or require continuous coverage.

Behavioral Health Services

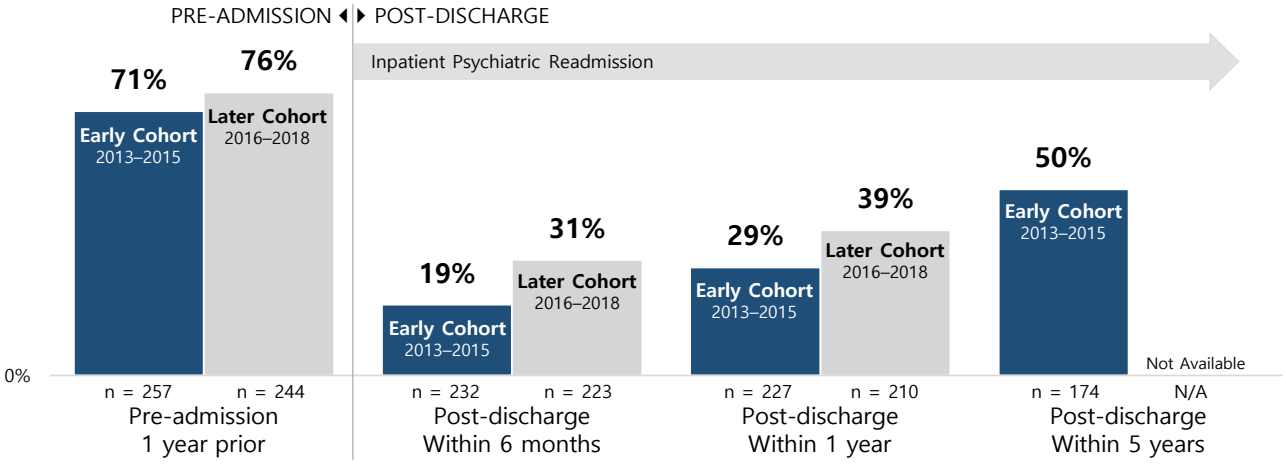
Outpatient MH services are essential for children and youth with MH conditions. The vast majority (94 percent) of CLIP patients in the later cohort received some type of outpatient MH services within 6 months of discharge; this was slightly higher than observed for the early cohort (87 percent).

Wraparound with Intensive Services (WISe) is a specific intensive home- and community-based MH outpatient program for youth with complex MH needs, supplementing therapy sessions with peer supports, care coordination, and 24/7 crisis services. While most CLIP patients in the current study discharged before WISe became available statewide (2018), analyses indicate that more than half (57 percent) of youth in the later cohort (discharged SFY 2016–2018) participated in WISe within 6 months of discharge.

In addition to WISe and other outpatient services, MH inpatient and crisis services are also necessary supports for children and youth with MH conditions. Between CLIP patients' pre-admission year and their first post-discharge year, the early cohort's utilization of MH inpatient services decreased from 71 to 29 percent, while the later cohort's utilization decreased from 76 to 39 percent. Within 5 years following discharge, half (50 percent) of early cohort CLIP patients who were enrolled in Apple Health had been readmitted to a MH inpatient setting. These patterns of utilization are shown in Figure 7, with the left side of the figure showing pre-admission rates and the right side representing readmission to inpatient services following CLIP discharge.

FIGURE 7.

Mental Health Inpatient Utilization

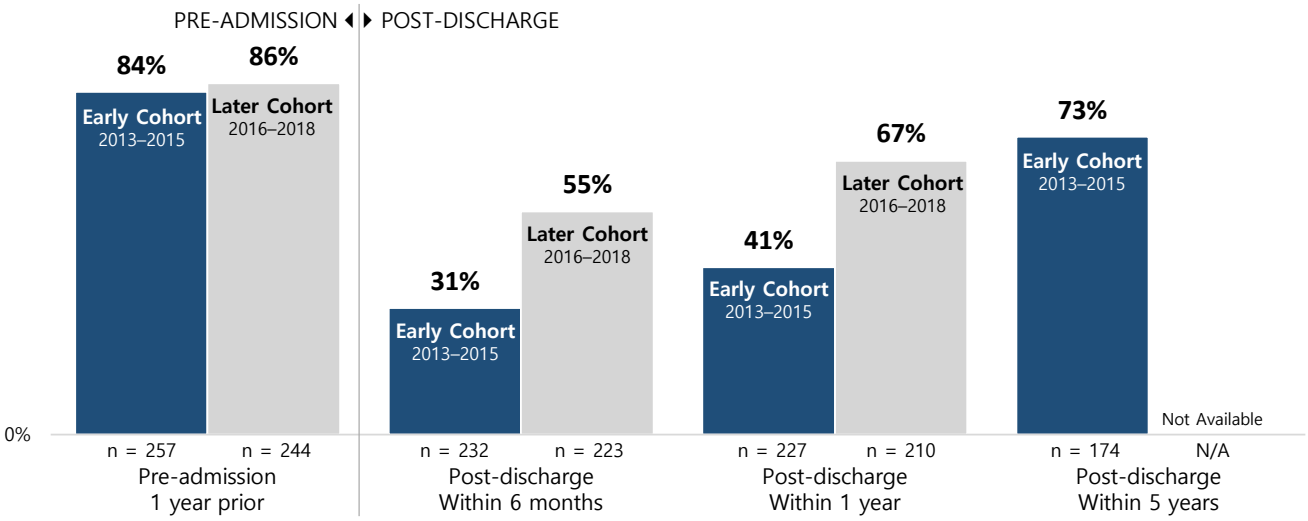


NOTE: This measure includes any type of MH inpatient stays including CLIP, state hospitals, and community psychiatric stays. Post-discharge rates shown are based on the subset of CLIP patients in each cohort who were enrolled in Apple Health at the indicated timepoint. Expanded inpatient capacity could be a contributing factor to the higher readmission rates in the later cohort.

In parallel to MH inpatient services, crisis services showed a reduction of utilization between the pre-admission year and the first-post-discharge year (Figure 8). The early cohort's utilization of MH crisis services decreased from 84 to 41 percent over these periods, while the later cohort's use decreased from 86 percent to 67 percent. The higher crisis services rates in the later cohort as compared to the earlier cohort could reflect increased access to the WISe program, which became statewide in 2018 and includes access to crisis services 24 hours a day, 7 days a week. Within 5 years following discharge, three-quarters (73 percent) of early cohort CLIP patients enrolled in Apple Health received MH crisis services.

FIGURE 8.

Mental Health Crisis Services



NOTE: MH crisis services are a subset of MH outpatient services intended to stabilize a person experiencing a MH crisis event. Post-discharge rates shown are based on the subset of CLIP patients in each discharge cohort who were enrolled in Apple Health at the indicated timepoint.

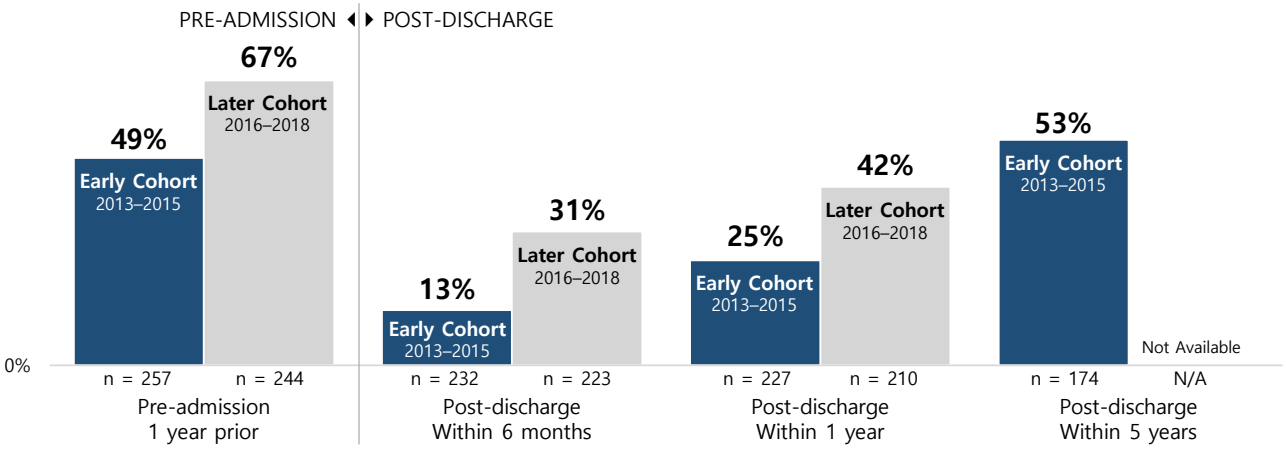
For the subset of CLIP patients with any indication of SUD treatment need in the year prior to CLIP admission (44 percent of all CLIP patients) the rate of receiving SUD treatment services held steady across the pre-admission year and the first post-discharge year, with roughly one-quarter receiving treatment across both periods in each cohort.

Suicidal Ideation and Suicide/Self-Harm Events

A substantial proportion of patients were diagnosed with suicidal ideation in the year prior to CLIP admission (49 percent early cohort; 67 percent later cohort; Figure 9). For both cohorts, a smaller proportion experienced suicidal ideation in the first post-discharge year, a decline to 25 percent for the early cohort and 42 percent for the later cohort. However, within five years following discharge, half (53 percent) of early cohort CLIP patients enrolled in Apple Health were diagnosed with suicidal ideation.

FIGURE 9.

Diagnosis of Suicidal Ideation



NOTE: Post-discharge rates shown are based on the subset of CLIP patients in each discharge cohort who were enrolled in Apple Health at the indicated timepoint.

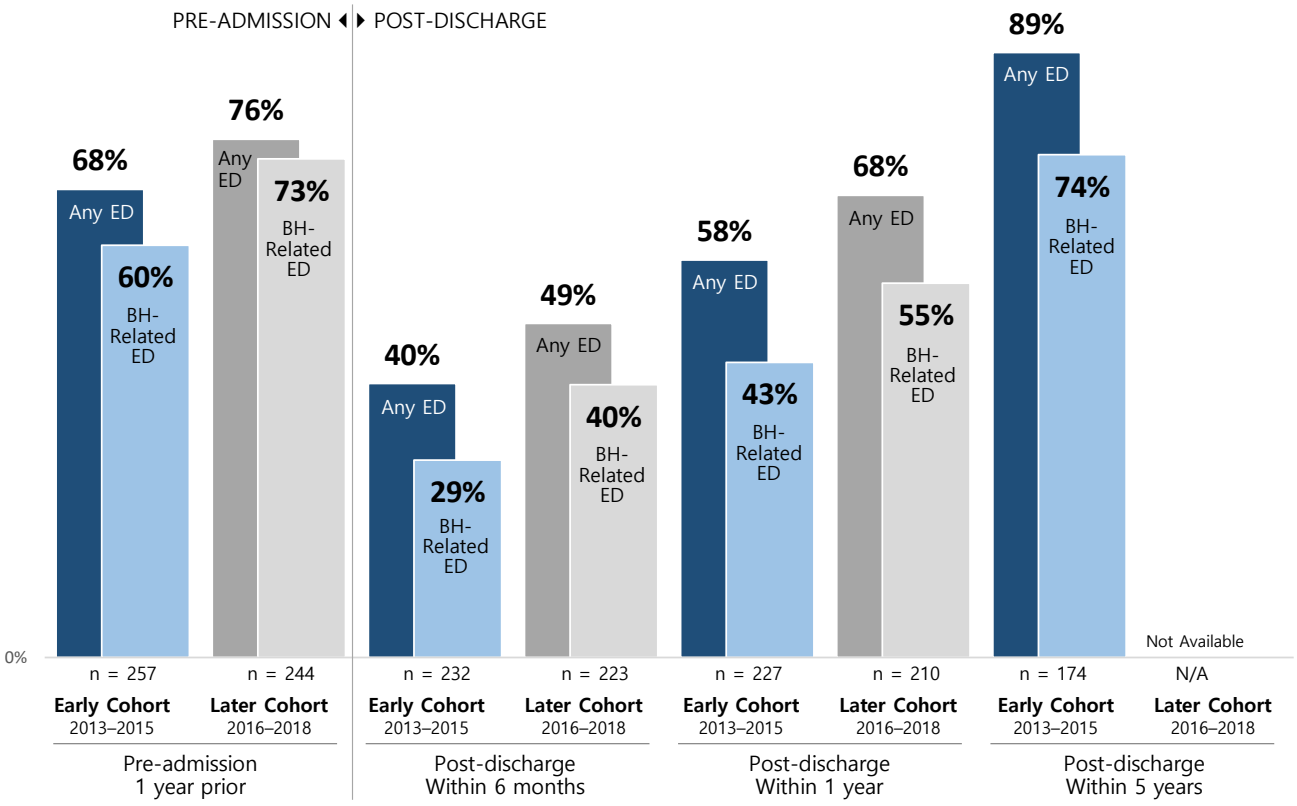
Diagnoses indicating suicide attempts or self-harm events were also examined. However, due to a nationwide change in diagnosis coding standards in October 2015 that substantially changed how self-harm diagnoses are coded, it is not possible to make comparisons between pre-admission and post-discharge diagnostic rates for this diagnosis category. Nevertheless, about one-quarter (24 percent) of the later cohort received a diagnosis of suicide attempt or self-harm in the year following CLIP discharge. In the early cohort, at least one-third (35 percent) received a suicide attempt or self-harm event diagnosis within 5 years of discharge. It is important to note that the 5-year outcome is likely underestimated due to the aforementioned diagnosis coding changes.

Emergency Department Visits

A majority of CLIP participants in both cohorts had an emergency department (ED) visit within the year prior to CLIP admission (68 percent early cohort; 76 percent later cohort; Figure 10). Furthermore, 60 percent of the early cohort and 73 percent of the later cohort had at least one ED visit with a BH diagnosis. After exiting CLIP, participants from both cohorts experienced short-term decreases in ED visits, including BH-related visits. Within 1 year of program discharge, 58 percent of the early cohort and 68 percent of the later cohort had an ED visit. For BH ED visits, this was 43 percent and 55 percent, respectively, at the same timepoint. Within 5 years of CLIP discharge, most (89 percent) of the early cohort CLIP patients enrolled in Apple Health experienced at least one ED visit, with three-quarters (74 percent) experiencing a BH ED visit.

FIGURE 10.

Emergency Department Visits



NOTE: BH ED visits are ED visits where the claim or encounter for the service carries at least one diagnosis reflecting one of these disorder categories: Psychosis, Mania/Bipolar, Depression, Anxiety, ADHD, Disruptive/Impulse/Conduct, Adjustment Disorder, Alcohol Use Disorder, or Drug Use Disorder. Post-discharge rates shown are based on the subset of CLIP patients in each discharge cohort who were enrolled in Apple Health at the indicated timepoint.

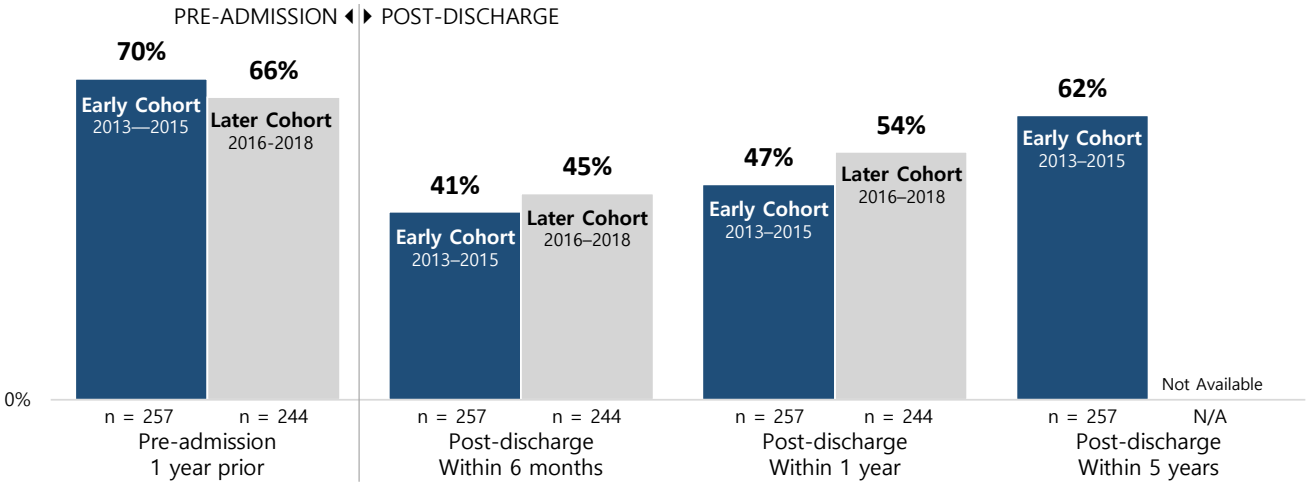
Child Welfare Involvement

Any Involvement

Analyses of CLIP patients' child welfare involvement also demonstrated the near-term reduction of needs after discharge followed by long-term challenges. The majority of CLIP patients were involved with child welfare in the year prior to CLIP admission (70 percent early cohort; 66 percent later cohort; Figure 11). The rate of child welfare involvement was lower in the first post-discharge year relative to the pre-admission year (decreasing to 47 in the first post-discharge year for the early cohort; 54 percent for the later cohort). Nearly two-thirds (62 percent) of early cohort CLIP patients experienced some type of child welfare involvement within 5 years following CLIP treatment. Restricting the population to younger early cohort CLIP patients ages 7 to 13 at discharge, most of whom remain in the typical age range for child welfare involvement for a full 5 years after discharge, indicates that most (80 percent) are child welfare-involved over this period. Note that this measure includes both child protective services intakes as well as supportive family services.

FIGURE 11.

Any Child Welfare Involvement



Foster Care

About one-quarter of CLIP patients (24 percent early cohort; 22 percent later cohort) were in foster care[5] at some point in the year prior to CLIP admission. About 19 percent of the early cohort and 17 percent of the later cohort were in foster care at the time of CLIP admission. Of those who were in foster care at the time of CLIP admission, most remained in care after discharge and about half experienced one or more placement changes within 6 months of discharge. Nearly two-thirds experienced one or more placement changes within 1 year of discharge. Of CLIP patients not in foster care upon admission, about one in ten entered foster care within 1 year of discharge (13 percent early cohort, 10 percent later cohort), and among the early cohort this increased to about 15 percent within the 5 years following CLIP discharge. Behavior Rehabilitation Services (BRS) were common for this population.[6] Of those in foster care in the year prior to CLIP admission, most (77 percent) had been in BRS. Of those not in foster care upon CLIP admission but who entered foster care within 5 years of discharge, most (81 percent) received BRS at some point during that period.

[5] The term "foster care" in this report refers to any child welfare out-of-home placement and includes licensed foster care, kinship care and congregate care.

[6] BRS are temporary intensive wraparound support and treatment services provided by DCYF to youth with extreme, high-level service needs (often due to mental, developmental, emotional, and/or behavioral difficulties) used to safely stabilize youth and assist in achieving a permanent plan or a less intensive service. BRS may be provided in the child's family of origin, in a traditional foster care home with specially trained caregivers, or in a congregate care setting (DCYF, 2023a).

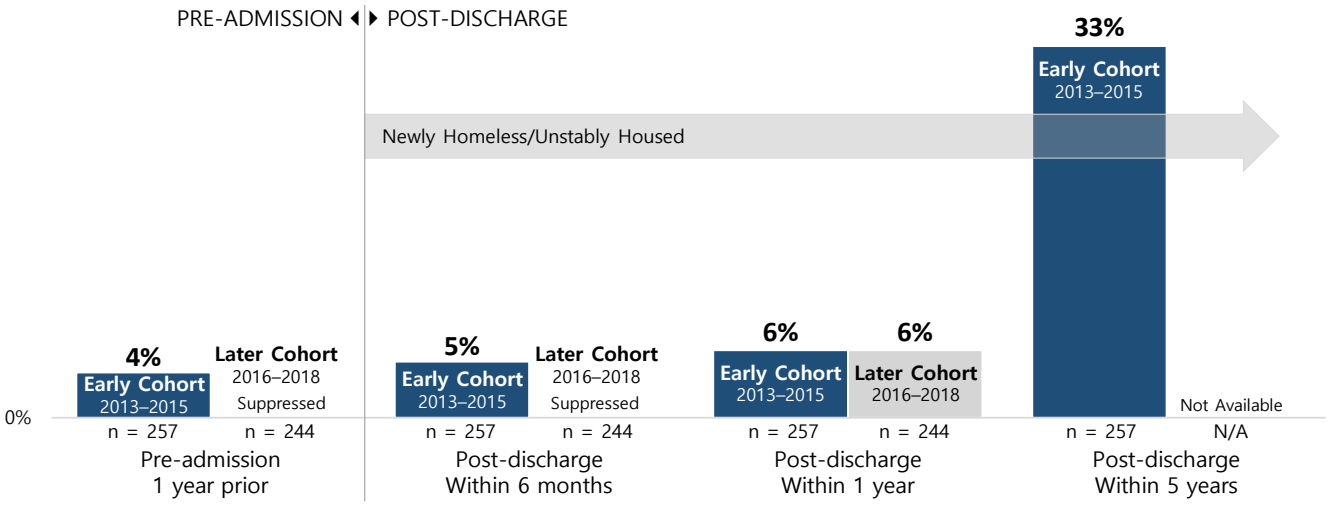
Homelessness or Unstable Housing

A lack of stable and safe housing is a major barrier to well-being (Gultekin et al., 2020) and thus prevalence of homelessness and unstable housing in the year prior to CLIP admission, and in the months and years following discharge, was examined. The combined homelessness/unstable housing measure included unsheltered persons, persons living in homeless shelters, and those housed in unstable situations, such as temporary couch surfing.

Baseline data indicated that roughly 4 percent of early cohort CLIP patients experienced homelessness or unstable housing in the year prior to admission (Figure 12); this percentage was similar across both study cohorts. A slightly higher proportion experienced homelessness or unstable housing in the year following discharge (6 percent of each cohort). One-third (33 percent) of early cohort CLIP patients became homeless or experienced housing instability at some point within 5 years of discharge. The jump in this measure for the long-term follow-up period may be driven by many CLIP patients aging into young adulthood over this period, a riskier life period for homelessness compared to childhood (Morton et al., 2018).

FIGURE 12.

Homelessness or Unstable Housing



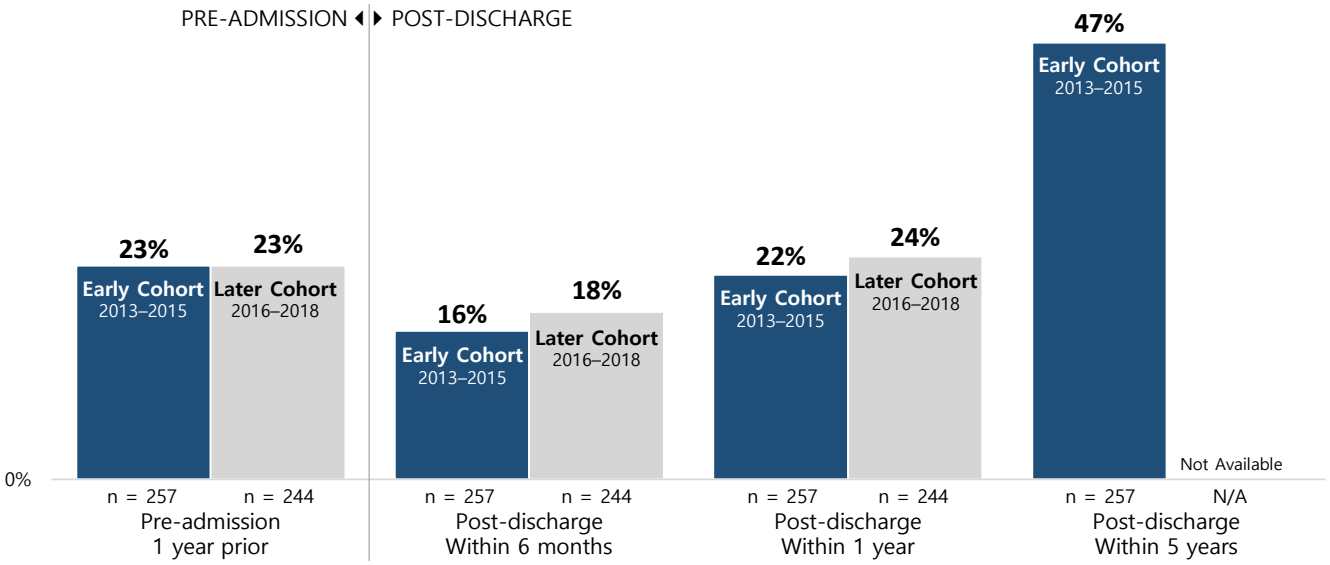
NOTE: CLIP patients who were not reported as homeless in the discharge month and became homeless within the specified time-period month after discharge were considered newly homeless or unstably housed.

Criminal Legal System Involvement

Young people with BH disorders tend to have substantially higher rates of criminal legal involvement than their peers, especially transition-age youth and those with co-occurring MH and substance-related conditions (Iverson et al., 2023). As such, we looked at criminal legal involvement among CLIP patients.

CLIP patients have high arrest rates both before and after discharge. Arrest rates changed little between the pre-admission year and the first post-discharge year for either cohort; just under one quarter of each cohort experienced an arrest in both periods. Within 5 years post-discharge, nearly half (47 percent) of CLIP patients in the early cohort had been arrested (Figure 13).

FIGURE 13.
Arrests



The majority (75 percent) of early cohort CLIP patients arrested within 5 years of discharge were arrested multiple times over this period, with the median time between CLIP discharge to first post-discharge arrest being 15 months (1.25 years) and the median age of first post-discharge arrest being 17. Among those with a post-discharge arrest (47 percent, or 121 of 257), assault was a prominent type of offense (n=98 of early cohort CLIP patients had an arrest for assault within 5 years of discharge), with misdemeanor assaults (n=79) being more common than felony assaults (n=48). Other common offense types were property violations (n=68), harassment or non-contact violations (n=36), failure to comply/probation violations (n=35), alcohol/drug violations (n=24), traffic violations (n=11), and other offenses (n=42). See technical notes for more information on arrest categories.

Acute Behavioral Health Crises: First 12 Months After Discharge

Figure 14 presents a longitudinal portrait of the cumulative occurrence of acute BH crises in the first 12 months after discharge for the later cohort, including emergency department visits with a BH diagnosis and any psychiatric rehospitalization (including CLIP, state hospitals, and community psychiatric stays). Data for the later cohort are presented to provide the most current picture of BH crises over the post-discharge year.

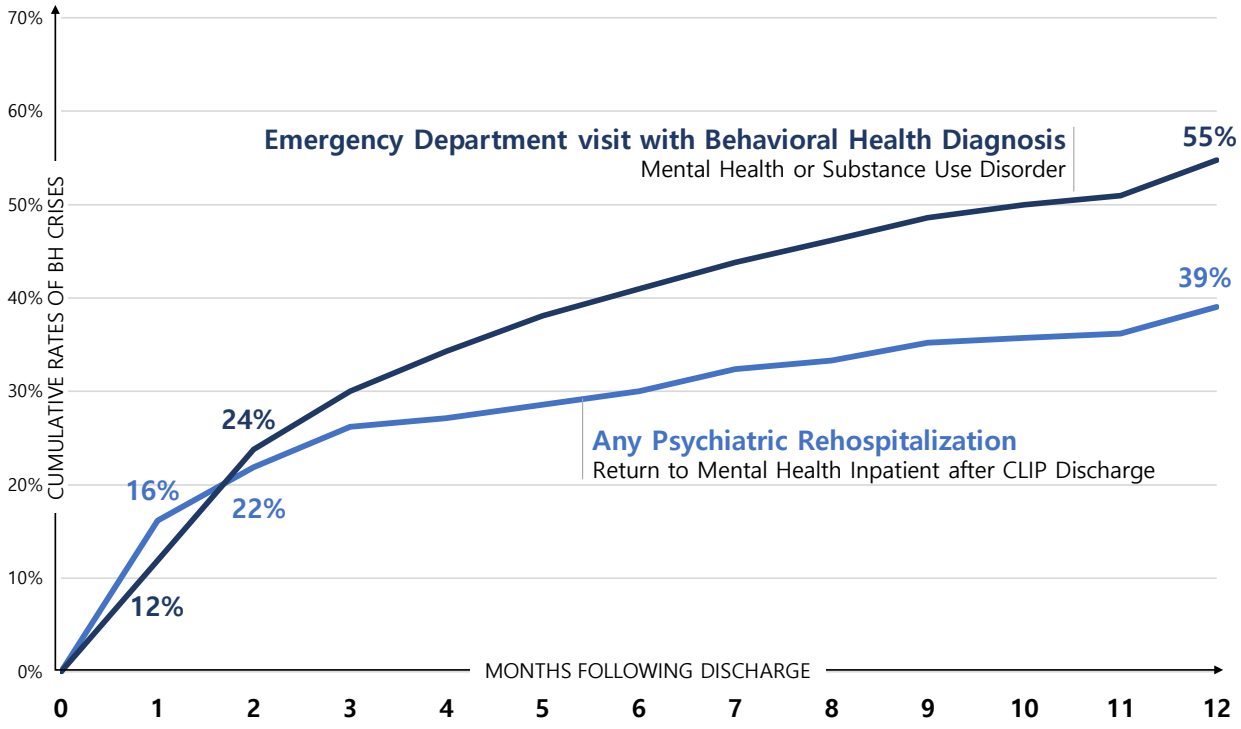
The majority (55 percent) of CLIP patients in the later cohort experienced at least one emergency department visit with a BH diagnosis (i.e., mental health or substance use disorders) within 12 months following discharge (Figure 14, dark blue line). The riskiest period for these emergencies is within the first 2 months following discharge; this is shown by the steepest part of the curve for this outcome occurring between 0 and 2 months. By 2 months after discharge, nearly one-quarter (24 percent) of CLIP patients experienced a BH-related emergency department visit. See also related data in Figure 10.

More than one-third (39 percent) of CLIP patients in the later cohort returned to a MH inpatient program within 12 months of discharge (Figure 14, lighter blue line). Similar to BH-related emergency department visits, the riskiest period for psychiatric readmission is within the first 2 months of discharge. By 2 months after discharge, nearly one-quarter (22 percent) of CLIP patients were readmitted to some type of MH inpatient services. See also related data in Figure 7. The vast majority (nearly 90 percent) of psychiatric readmissions within the first year of discharge were to community-based psychiatric inpatient treatment, rather than to CLIP or another state hospital program.

FIGURE 14.

Cumulative Rates of Acute Behavioral Health Crises within 1 Year of CLIP Discharge

Children/Youth Discharged in SFY 2016–2018 (Later Cohort)



NOTE: Results present acute BH crises in the 12 months after discharge.

Subgroup Differences

This section identifies key differences in baseline characteristics and outcomes across selected subgroups of CLIP patients to identify who may need additional supports during CLIP service episodes, in the transition back to the community, or in the months and years following discharge. Subgroups examined included those by age, gender, race/ethnicity, special populations, and length of stay. Special population subgroups included youth with a developmental disability in the year prior to admission; youth in foster care at time of admission; youth with a psychosis diagnosis in the year prior to admission; and youth with SUD treatment need in the year prior to admission.

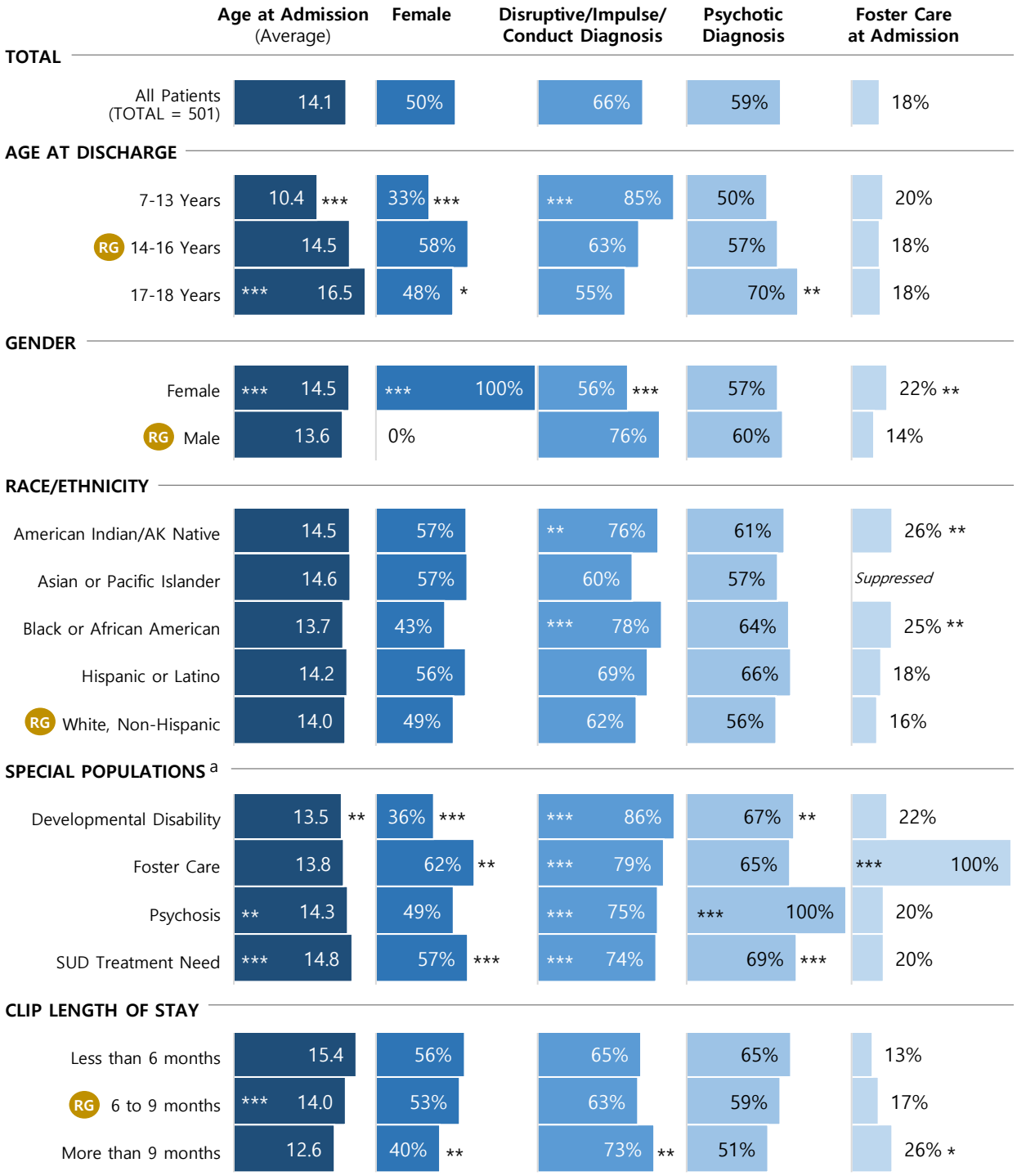
We compared baseline characteristics and outcomes within subgroups using z-tests, with differences interpreted as statistically significant when $p<0.10$. The reader should keep in mind that there may be multiple explanatory factors contributing to differences in outcomes across subgroups, such as: pre-admission subgroup differences, differences in effectiveness of services across subgroups, post-discharge subgroup experiences, life course differences (e.g., groups with older patients are likely to have higher SUD treatment needs).

This analysis does not attempt to unravel the contributions of the various explanatory factors, and **results cannot be interpreted as implying differences in CLIP program effectiveness for the different subgroups** presented here. Figure 15 presents selected baseline differences by subgroups, and Figure 16 presents selected outcome differences by subgroups.

FIGURE 15.

Selected Baseline Characteristics by Subgroup

Children/Youth Discharged in SFY 2013–2018 (combined cohorts)



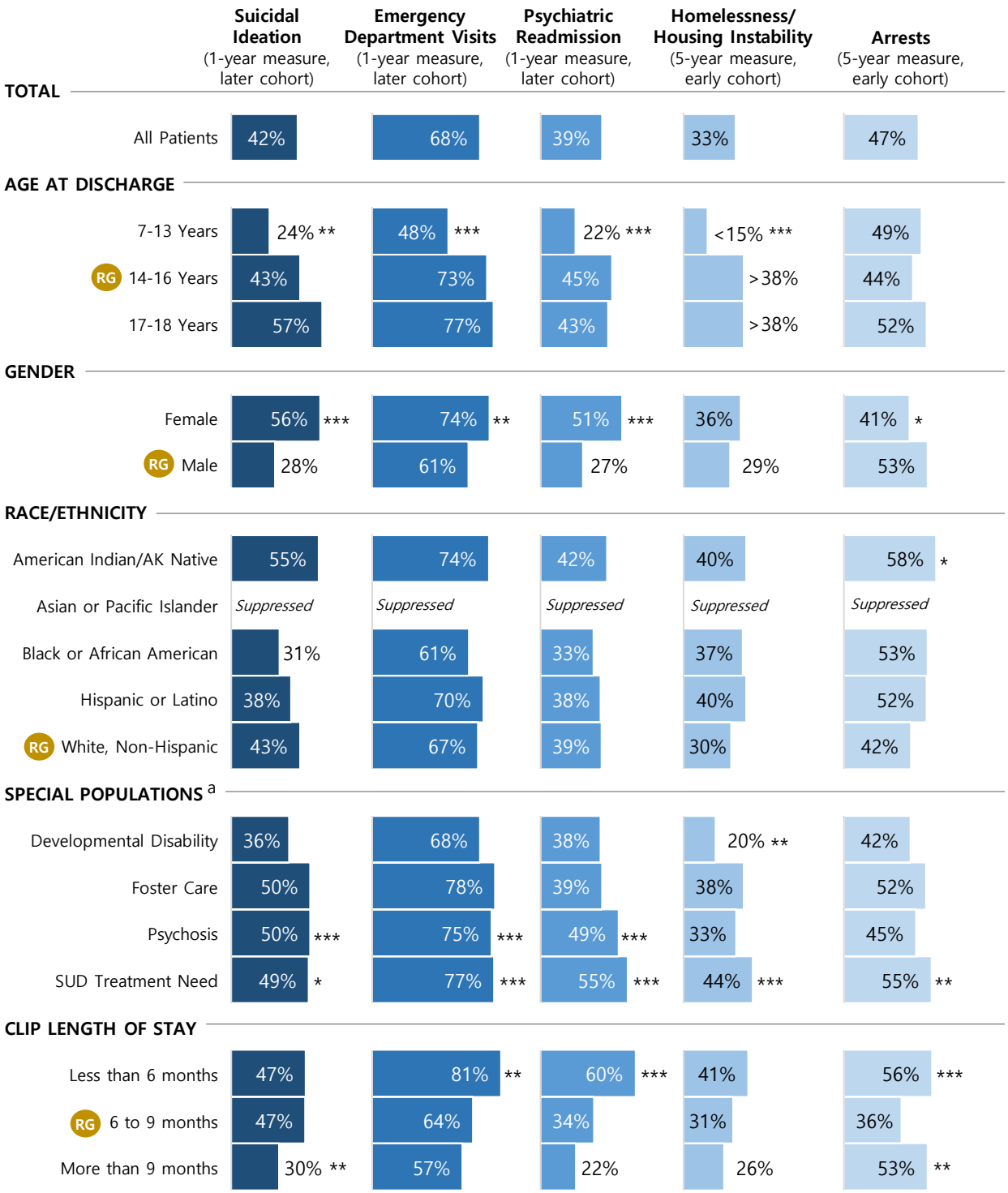
RG = Reference Group | * = Statistically significant at p<.10 | ** = Statistically significant at p<.05 | *** = Statistically significant at p<.01

[a] Reference group for special populations is "not in population." P-values are from t-tests (age) or z-tests (proportions). Diagnoses are measured in the 1 year prior to CLIP admission. *Suppressed* = To protect the privacy of individuals, numbers representing fewer than 11 persons are suppressed.

FIGURE 16.

Selected Outcomes by Subgroup

Children/Youth Discharged in SFY 2013–2015 (early cohort) or SFY 2016–2018 (later cohort)



RG = Reference Group | * = Statistically significant at p<.10 | ** = Statistically significant at p<.05 | *** = Statistically significant at p<.01

[a] Reference group for special populations is "not in population." P-values are from z-tests. *Suppressed* = To protect the privacy of individuals, numbers representing fewer than 11 persons are suppressed. The homelessness/housing instability outcomes are shown with imprecision for age subgroups, to protect the privacy of individuals in these subgroups while also preserving the statistical differences identified between younger and older patients.

Age at Discharge[7]

Younger children (ages 7–13) discharged from CLIP were disproportionately male; had higher pre-admission rates of ADHD, disruptive/impulse/conduct disorders, and language and learning disabilities; had longer CLIP stays (median 10 months, compared to 6–7 months for older age groups); and were at lower risk for poor BH outcomes post discharge (e.g., psychiatric readmission), compared to young teens ages 14 to 16. Older teens (ages 17–18 at discharge) had higher pre-admission rates of psychosis, SUD treatment needs, and legal system involvement compared to young teens; their post-discharge rates of ED visits, psychiatric readmission and homelessness/housing instability were similar to young teens, but higher than younger children.

Gender[8]

Female CLIP patients were older on average at discharge (15.1 years female, 14.3 years male), and had higher rates of depression, anxiety, and SUD treatment need and lower rates of ADHD, disruptive/impulse/conduct disorder, and developmental disabilities compared to male CLIP patients. Female CLIP patients experienced higher rates of poor BH outcomes post discharge, such as suicidal ideation, MH crisis services, emergency department visits, and psychiatric readmission than male patients.

Race/Ethnicity[9]

Black patients had a lower average age at admission (13.7 years) compared to other race/ethnicity groups (14.0–14.6). Compared to other groups, Black and AIAN patients were more likely to be in foster care at the time of admission and had the highest pre-admission rates of disruptive/impulse/ conduct disorder. Hispanic or Latino CLIP patients had the highest rates of anxiety, and Asian or Pacific Islander patients had the highest rates of developmental disabilities. There were few consistent differences in post-discharge BH outcomes across race/ethnic groups. In the early cohort, Black patients showed lower engagement in the MH outpatient services within 6 months of discharge, and higher post-discharge psychiatric readmission compared to non-Hispanic White patients, but these differences were not present in the later cohort. In the later cohort, AIAN patients showed no differences in arrest rates at 1 year post discharge, but had higher arrest rates at 5 years post discharge relative to non-Hispanic White patients.

Special Populations

- *Youth with a developmental disability.* The prevalence of developmental disabilities (DD) was higher for youth in the later cohort (31 percent) than the earlier cohort (25 percent). Across both cohorts, youth with a DD were admitted at a younger average age than other CLIP patients (13.5 years, compared to 14.1 years overall) and were disproportionately male (64 percent). They had elevated pre-admission rates of disruptive/impulse/conduct disorder and ADHD. This group had few consistent differences in post-discharge BH outcomes relative to other CLIP patients but had lower post-discharge rates of homelessness/housing instability.
- *Youth in foster care.* Across both cohorts, 18 percent of CLIP patients were in foster care at the time of admission. Youth in foster care were disproportionately female, AIAN, and Black. This subgroup experienced no significant post-discharge differences in MH services (outpatient, crisis, inpatient readmission), but had higher rates of suicidal ideation and suicide attempts/self-harm events. More than half (60 percent) of foster care youth experience a placement change within 1 year of discharge.

[7] Although The CLIP program serves children as young as 5, the youngest CLIP patient in the study sample was 6 years old at admission and 7 years old at discharge.
[8] More granular categories such as transgender and non-binary are not available in the administrative data used for this study.
[9] Both baseline and outcome differences may be impacted by systemic racism, for example by documented disproportionalities in the child welfare system (e.g., Child Welfare Information Gateway, 2021) and the juvenile legal system (Development Services Group, 2022).

- *Youth with a psychosis diagnosis.* Across both cohorts, 59 percent of CLIP patients had a psychosis diagnosis in the year prior to admission. This group had elevated pre-admission rates of depression, anxiety, mania/bipolar, SUD treatment need, ED visits, and arrests compared to other CLIP patients. Post discharge, they had elevated rates of most negative BH outcomes, including suicidal ideation, suicide attempts or other self-harm events, crisis services, emergency department visits, and psychiatric readmission. Additionally, those in the later cohort had higher rates of post-discharge arrests compared to other patients.
- *Youth with a substance use disorder treatment need.* Across both cohorts, 44 percent of CLIP patients had a pre-admission SUD treatment need. This subgroup had a higher age of admission (14.8 years on average, compared to 14.1 years for all CLIP patients), greater pre-admission MH needs (e.g., MH inpatient, suicide attempt/self-harm events), and greater pre-admission child welfare involvement and criminal legal involvement compared to other CLIP patients. They generally have poorer outcomes compared to other CLIP patients, with higher rates of psychiatric readmission within 1 year of discharge (later cohort only), higher suicidal ideation, more emergency department visits, higher rates of homelessness/housing instability, and more arrests. Of youth with a SUD treatment need identified pre-admission, only about one-quarter received SUD treatment services within the year following CLIP discharge.

CLIP Length of Stay

Patients with a length of stay (LOS) greater than 9 months were younger, and a higher percentage were male and in foster care at admission compared to other CLIP patients. They also had higher pre-admission rates of disruptive, impulse, or conduct disorders, ADHD, and developmental disorders, and lower rates of depression, suicidal ideation, or suicide attempt/self-harm diagnoses. CSTC had the greatest LOS of all facilities, with a median of 10 months, compared to a median of 5 to 6 months for the other facilities. Youth in CLIP for more than 9 months experienced lower suicidal ideation after discharge than youth in CLIP for 6 to 9 months, but had few significant differences for other BH outcomes. Overall, youth who were in the program for less than 6 months experienced higher rates of poor post-discharge BH outcomes (e.g., ED visits, psychiatric readmission) than youth in CLIP for 6 to 9 months. Five-year post-discharge arrest rates were lower for CLIP patients who had stayed in CLIP for 6 to 9 months, as compared to those with longer or shorter lengths of stay.

Summary of Findings

This study examines pre-admission characteristics and post-discharge outcomes for 501 children and youth discharged from CLIP in SFYs 2013 through SFY 2018. Results show that CLIP patients have **extremely high needs at baseline**, and that **admission to CLIP appears to help stabilize this population during the episode of care**. Between their last pre-admission year and their first post-discharge year, CLIP patients in the study showed notable reductions in utilization of MH IP services, MH crisis services, and BH ED visits, as well as declines in suicidal ideation and child welfare involvement.

Nevertheless, substantial challenges remain. **The majority of CLIP patients experienced an acute BH crisis event within the year following discharge**, including a BH ED visit (55 percent; later cohort) and/or psychiatric readmission (39 percent; later cohort). Furthermore, **5-year outcomes suggest substantial long-term challenges.** Within 5 years of discharge, half of patients (50 percent) in the early cohort returned to psychiatric inpatient care; over half (53 percent) received a diagnosis of suicidal ideation; at least one-third (35 percent, conservatively estimated) had some type of self-harm event, such as a suicide attempt; three-quarters (74 percent) had at least one BH ED visit; one-third (33 percent) experienced homelessness or unstable housing; and nearly half were arrested (47 percent). Furthermore, **the later study cohort** (those discharged in SFYs 2016–2018, as compared to

2013-2015) **experienced greater pre- and post-discharge challenges**, consistent with national trends of growing mental health problems among children.

The long-term and growing challenges of discharged CLIP youth highlight the **critical need to develop and enhance more intensive post-discharge cross-system supports and services** for this population. Furthermore, these supports must be in place not only the weeks and months leading up to and following discharge, but also in the subsequent years. Indeed, the MH needs of CLIP patients should not be considered temporary crises that can be addressed through a single episode of inpatient care, but rather as complex chronic health conditions that require multiple modalities of ongoing treatment and support.

Many CLIP patients also are **vulnerable to poor long-term outcomes due to multiple and intersecting needs**; in addition to severe behavioral health needs, they often have pre-admission histories of abuse and neglect, co-occurring developmental disabilities, or involvement with the juvenile legal system. As such, they are frequently involved with multiple state systems. Subgroup analyses in this report demonstrate that youth with different baseline characteristics and needs experience notable differences in outcomes like suicidal ideation, ED visits and psychiatric readmissions.

Post-discharge planning must not only address continued need for intensive behavioral health treatment, but also assistance for youth and families navigating a myriad of other personal and family challenges (e.g., food and housing insecurity, parental health needs), **and multiple complex state systems** (e.g., HCA and DSHS/Behavioral Health, DCYF/Child Welfare, DCYF/Juvenile Rehabilitation, DSHS/Developmental Disabilities Administration).

"Discharging from CLIP can feel like jumping off a ledge."
– Mother of former CLIP patient

Stakeholder Recommendations

With a commitment to "Nothing about us without us", findings of this report were shared with stakeholders and community members with lived experience navigating the CLIP system. Conversations with and feedback from these stakeholders resulted in the following recommendations. These recommendations will be considered in policy discussions; HCA plans to work in partnership with Washington Thriving to learn how outcomes of this report can inform new and ongoing efforts for systemic coordination moving forward.

Facilitate a Seamless Transition to WISe Services

Increasingly, WISe discharge planning includes a plan to enroll a youth in Wraparound with Intensive Services (WISe), an intensive home- and community-based wraparound outpatient program for youth with complex MH needs. While the WISe program became statewide in 2018, after this report's study period, more recent data indicate that about two-thirds (65%) of youth discharged from CLIP in SFY 2023 enrolled in WISe within 1 month of discharge. Follow-up work examining more recent CLIP cohorts should consider how outcomes differ for those engaged in WISe following discharge.

Stakeholder feedback indicates that even when WISe is part of a youth's discharge plan, there is often a gap in time between the CLIP discharge and subsequent WISe enrollment, leaving youth without crucial supports during a very critical time of transition. This study's results suggest that CLIP patients are at greatest risk of recurrence of BH crises within the 2 months following discharge.

Stakeholders recommend that CLIP and WISe program staff could work together to ensure that all CLIP patients **begin regular and intensive engagement by WISe agency staff from their home communities at least 90 days *prior to* CLIP discharge**. During this transitional period, CLIP patients could have ongoing appointments with WISe care coordinators, peers, and therapists, as well as meetings with a child and family team—a group including the child's system supports (e.g., CLIP staff, DDA, DCYF) as well as natural supports (e.g., parents/caregivers, teacher, coach)—who could work collaboratively on the creation of the individualized discharge plan. All of these "WISe-like services" would be facilitated by the community-based WISe agency, billed under procedure code H0023 ("behavioral health care coordination and community integration"), and funded by WISe program dollars.[10]

In addition to laying the foundation for a successful discharge, engaging CLIP patients in WISe-like services prior to discharge also ensures capacity in the community-based WISe program model immediately upon discharge. Implementing this plan would support the CLIP patient and their family with meaningful, intensive cross-service and cross-system collaboration during their time in CLIP, support that would be sustained after discharge. The feasibility of this plan would require increasing WISe capacity in multiple areas of the state, including addressing provider shortages and enhancing communication and coordination across children's MH providers and other child-serving systems.

Offer a Variety of Multi-tiered Step-Down Options

Youth and families have varying needs, and families would benefit from a **system of care offering more multi-tiered options** to individualize post-discharge supports to facilitate timely CLIP discharge and a safe return of patients to their families and communities.

WISe is not a one-size-fits-all program. The WISe program, including the intensity and duration of services, is designed to be individualized to the needs of the youth and families engaged with it. While WISe program standards dictate that the duration of WISe services is to be tailored to the needs of the individual (up to age 20), the median length of stay in WISe was 8 months as of SFY 2023 (RDA, 2020; RDA, 2024). In contrast, this study's findings indicate that many CLIP patients need intensive supports for years following discharge. Like all WISe clients, former CLIP patients should be offered access to WISe for as long as youth and families need this service and at an appropriately calibrated level of service intensity.

Even with individualized service delivery, WISe may not be the solution for all families. Since the study cohort was discharged, discharge supports have expanded to include additional options including partial hospitalization programs, intensive outpatient treatment, Kids Mental Health Washington, etc. Stakeholders recommended that small group homes or facilities in or near home communities, as well as respite services, be added to the existing menu.

For the growing population of CLIP patients with significant co-occurring developmental disabilities, the DSHS Developmental Disabilities Administration (DDA) collaborates closely with the CLIP Administration to facilitate effective communication and transition planning for these youth. Further efforts to strengthen coordination between CLIP staff and specialized DDA regional transition teams could help more consistently identify community-based services or residential supports specific to this population to maintain progress toward stabilizing MH as these youth transition back to their home communities. To support timely and effective coordination, DDA plans to provide targeted training for CLIP staff.

[10] In parallel to traditional WISe services, WISe-like services for current CLIP patients would be billed using the "U8" WISe modifier code, triggering the WISe case payment. Unlike traditional WISe services, they would all be billed under procedure code H0023 ("behavioral health care coordination and community integration"). WISe-like services for current CLIP patients would average 10.5 or more service hours per month over the time period provided, ideally 90 days or more prior to discharge.

Additional Family Supports

The severity of long-term outcomes in this study indicates that CLIP patients may need intensive cross-system services and supports for years following discharge. An additional approach would be to establish a program to assign former CLIP patients **a cross-system service manager to make periodic home visits (e.g., every 3 to 6 months) to assess the changing needs of these vulnerable youth and their families** and help with referrals to and coordination of services. This could include new referrals for MH or SUD services; supports or referrals for parents (e.g., parenting supports, respite care, services for parents' health needs); and educational, employment, or housing supports. Supports tailored to transition-age youth may also be important to consider, given the number of older CLIP patients experiencing homelessness and arrest in the years following discharge. These kinds of supports are similar to those provided in Washington's Health Home program for adults with multiple and complex chronic health conditions.

Lastly, essential supports for families of current and former CLIP patients are **CLIP parent-to-parent supports.** CLIP Parent Advocates provide proactive outreach to families navigating their children's mental health journey before their child's CLIP stay. They provide compassionate support as well as critical information and resources to these families and continue to do so during, and even after, their child's CLIP stay. The CLIP Parent Steering Committee provides consultation and support to the Parent Advocates employed in CLIP facilities. The Committee also provides two CLIP Parent Training Weekends per year which include sharing experiences, key resources, and skill building. The CLIP Parent Training Weekends are described by parents of former CLIP patients as "a lifeline" during an extremely challenging and often traumatic life period for these families as they try to navigate transitions across service systems and cross system-partners, extreme emotions, and extreme behavioral challenges. HCA's Center of Parent Excellence (COPE) project also provides ongoing support groups for parents of children participating in CLIP treatment. These critical parent-to-parent supports should be supported and expanded.

Supporting Children and Families

Each year, the CLIP program discharges roughly 100 of Washington's highest needs children and youth back into the community. This report summarizes their experiences in statistics, but does not reveal their individual stories, their bruises, their trauma, their rock bottoms, and their hopeful recoveries. The families of CLIP patients struggle to support them as best they can and need more scaffolding from an enhanced multi-tiered system of services and supports, bolstered by more robust coordination across HCA, DSHS, and DCYF.

TECHNICAL NOTES

STUDY POPULATION

The study population for this analysis was comprised of 501 children and youth ages 6 to 17 who discharged from CLIP in SFYs 2013 through SFY 2018 (July 2012–June 2018), excluding forensic and "private pay" patients (those who were not enrolled in Apple Health in any of the 12 months prior to CLIP admission). These two excluded populations comprise roughly 8 percent and 13 percent of CLIP patients discharged during this timeframe, respectively; see definitions below. The analysis also excludes patients who could not be reliably linked with RDA's Integrated Client Databases (estimated at roughly 5 percent), and patients discharged during the timeframe but had admissions dates prior to SFY 2012 (less than 1 percent). (Note there may be some overlap across the excluded populations.) In total, the analysis population comprises about 75 percent of all CLIP patients discharged over this timeframe. Two subsets of the study population are used for the outcomes analysis:

- **Early Cohort, SFY 2013–2015:** The early cohort includes children and youth discharged from CLIP in SFY 2013–2015. The purpose of examining this older subset of CLIP patients is to enable measurement of long-term outcomes, up to 5 years after discharge.
- **Later Cohort, SFY 2016–2018:** The later cohort includes children and youth discharged from CLIP in SFY 2016–2018. The purpose of examining this newer subset of CLIP patients is to enable outcomes analyses for patients served more recently.

An analysis of differences in baseline characteristics of the two cohorts relative to the full study population shows that overall, cohort demographics, MH needs, and risk profiles are very similar. Minor differences noted include slightly fewer children ages 6–9 served in the early cohort relative to later cohort and overall study population; and slightly more Asian/Pacific Islander and Hispanic/Latino patients in the early cohort relative to the later cohort and overall study population. The two cohorts also display somewhat different distributions of region of residence (e.g., the earlier cohort had more patients from North Central and fewer from North Sound and Salish relative to the later cohort and overall study sample). Rates of some BH diagnosis categories cannot be directly compared across cohorts or across time because there was a substantial nationwide change to medical diagnosis coding in October 2015, when the United States replaced the International Classification of Diseases, Ninth Edition (ICD-9) with the ICD-10. The ICD-10 transition was particularly impactful on rates of mania/bipolar and suicide attempt/self-harm diagnoses.

APPLE HEALTH REFERENCE POPULATION

The Apple Health reference population consists of children and youth ages 6 to 17 years enrolled in Washington's Apple Health medical assistance program between SFY 2012 and 2018, weighted to mirror the age group-year distribution and baseline Apple Health enrollment of admissions associated with CLIP discharges in the study population. The low-income medical assistance programs referenced, referred to collectively as Apple Health, include full-benefit Medicaid under Title XIX of the Social Security Act (SSA) and full-benefit State Children's Health Insurance Program (SCHIP) under SSA Title XXI, and the Children's Health Program (CHP; state-funded). Note there is no exclusion of CLIP or other MH inpatient patients; as such, CLIP patients in this study are a tiny subset of this much larger reference population. Many baseline characteristics are measured in the 1 year prior to the index month, the selected month of Apple Health coverage for the included client observation. Steps to create the Apple Health sample were as follows:

1. Identify all client-months during SFY 2012–2018 for which: (1) Child is age 6–17; (2) Child has Apple Health in the month and in at least one of the 12 preceding months.
2. Randomly select one client-month per child per year (the index month).
3. Create weights based on the ratio of population proportions in age group (6–9,10–12,13–15,16–17)-admission year cells of the CLIP population and age group-benefit year cells in the Apple Health population.
4. Reweight the Apple Health population such that the age group-Apple Health year distribution is aligned with the age group-admission year distribution in the CLIP population.

HEALTH OUTCOMES

Analyses of post-discharge health outcomes are restricted to persons with Apple Health at the specified post-discharge timepoint.

- **Mental Health Outpatient Services:** MH services delivered in a non-inpatient setting (i.e., not requiring an overnight stay), including services delivered in office or clinical settings, in home or community settings, or via telehealth.
- **Wraparound with Intensive Services (WISe):** Wraparound with Intensive Services (WISe) is an intensive home- and community-based outpatient program that provides wraparound supports and access to 24/7 crisis services, available to Apple Health clients in Washington ages 0–20 years. Washington's WISe program launched in 2014 and became statewide in 2018. As such, this outcome is reported only for the later cohort.
- **Mental Health Inpatient Services (Psychiatric Readmission):** Any type of MH inpatient stays including CLIP, state hospitals, and community psychiatric stays.
- **Mental Health Crisis Services:** MH crisis services are a subset of MH outpatient services that meet the Health Care Authority's guidelines as specified in the Service Encounter Reporting Instructions (SERI) for crisis or stabilization services.
- **Substance Use Disorder Services:** Services delivered to address the needs of persons with a diagnosed substance use disorder. Analysis of this outcome is restricted to the subgroup with an identified SUD treatment need in the year prior to CLIP admission.
- **Diagnosis of Suicidal Ideation:** At least one claim or encounter in administrative data reflecting a diagnosis of suicidal ideation.
- **Diagnosis of Suicide Attempt or Self-Harm Event:** At least one claim or encounter in administrative data reflecting a diagnosis of suicide attempt or another type of self-harm event. The transition from ICD-9 to ICD-10 coding standards in October 2015 overhauled how self-harm diagnoses were recorded, with substantially more detailed categories in ICD-10, leading to higher measured rates of self-harm. As a result, it is not possible to make valid cross-time comparisons for this outcome (e.g., pre-admission vs. post-discharge, early cohort vs. later cohort).
- **Emergency Department Visits:** At least one claim or encounter reflecting an emergency department visit.
- **Behavioral Health-Related Emergency Department Visits:** At least one claim or encounter reflecting an emergency department visit and carrying a MH diagnosis in one of seven key categories (psychotic, mania/bipolar, depression, anxiety, ADHD, disruptive/impulse/conduct, adjustment) and/or an alcohol or drug use disorder (substance use disorder; SUD) diagnosis.

NON-HEALTH OUTCOMES

Analyses of post-discharge non-health outcomes use all CLIP patients in the study population.

- **Child Welfare**
  - **Any Involvement:** Any involvement with Washington's child welfare services administered by the Department Children Youth and Families (DCYF; or formerly by the Children's Administration within DSHS).
  - **Foster Care:** Out-of-home child welfare placement under the care and placement authority of DCYF (formerly DSHS), including licensed foster care, kinship care and congregate care.
  - **Foster Care Placement Changes:** For youth in foster care as of the time of CLIP admission, percent with any foster care placement changes in the outcome time period.
  - **Behavior Rehabilitation Services (BRS):** Temporary intensive wraparound support and treatment services provided by DCYF to youth with extreme, high-level service needs (often due to mental, developmental, emotional, and/or behavioral difficulties) used to safely stabilize youth and assist in achieving a permanent plan or a less intensive service. BRS may be provided in the child's family of origin, in a traditional foster care home with specially trained caregivers, or in a congregate care setting (DCYF, 2023).
- **Homeless or Unstably Housed:** Homeless status is identified using the statewide integrated Homeless Management Information System (HMIS) and, for economic services and Apple Health clients, living arrangement and address information in DSHS' Automated Client Eligibility System (ACES). For homeless status after CLIP discharge, only new homeless episodes are reported. Children and youth who were not reported as homeless in the discharge month AND became homeless within specified time period month after discharge are considered newly homeless or unstably housed.
- **Criminal Legal System Involvement, Any Arrests:** Any arrest, as recorded in administrative data from the Washington State Patrol. This measure does not have an age restriction. Property violations include property destruction, theft, criminal trespassing, and burglary. Harassment/no-contact charges include violation of no-contact/protection/restraining orders, harassment, school property or personnel violation, and bomb threats. Failure to comply/probation violations include failure to comply with court order, probation/supervision violation, escape/bail jump.

OTHER NOTES AND DEFINITIONS

- **Discharge:** A discharge occurred when a youth exited CLIP services sometime between SFY 2013 and SFY 2018. For youth with more than one discharge in this timeframe, only their first discharge is included in the study sample (the first discharge was selected to facilitate conducting the long-term outcomes analysis). A transfer from one CLIP program to another within 24 hours was considered a continuation of the same CLIP episode rather than a discharge. In such cases, the discharge is attributed to the final CLIP program within the episode.
- **CLIP Subpopulations:**
  - **Forensic:** Forensic CLIP patients are minors charged with a crime who have been committed by court order to the state-run CLIP program, Child Study and Treatment Center, for inpatient forensic MH services. They constituted approximately 8 percent of total CLIP discharges between 2013 and 2020; this percentage is estimated to be very similar for the 2013 to 2018 timeframe. This special subpopulation is excluded from this study.
  - **Private Pay:** Private pay CLIP patients are children and youth in CLIP services who have no publicly funded medical assistance in the month prior to CLIP admission. These youth often transition onto Apple Health temporarily during a CLIP stay, as private insurance benefits are usually exhausted and unable to cover the cost of CLIP services. Private pay CLIP patients constituted approximately 13 percent of total CLIP discharges between 2013 and 2020; this percentage is estimated to be very similar for the 2013 to 2018 timeframe. This special subpopulation is excluded from this study.
  - **Study Focal Population (Neither):** The focal population in the current study is CLIP patients who are neither forensic nor private pay patients. This is the patient population most likely to have continued enrollment in Apple Health and access to other public services following CLIP discharge.
- **CLIP Facilities:** There are five CLIP facilities in Washington, CSTC (Lakewood), Navos (Burien), Pearl Street (Tacoma), Tamarack (Spokane), and Two Rivers Landing (Yakima). CSTC is state-run operated by the Behavioral Health Administration (BHA) within the Department of Social and Health Services (DSHS). The other facilities are privately run, as contracted by the Health Care Authority. Two Rivers Landing is included in the main analysis, but excluded from subgroup analyses due to a small number of discharges over the study period.
- **Apple Health/Medical Assistance:** Includes Medicaid (Title XIX full benefit), State Children's Health Insurance Program (SCHIP; Title XXI Full Benefit), and Children's Health Program (CHP; state-funded).
- **Diagnoses:** Diagnoses documented in administrative claim/encounter data, including ProviderOne, during the measurement time period.
- **Other Mental Health Diagnosis**: Includes somatoform, factitious, dissociative/conversion, gender dysphoria, paraphilic, miscellaneous. The most frequent category is miscellaneous, with the most frequent diagnosis code being F99, "mental disorder not otherwise specified."
- **Race/Ethnicity:** All groups shown are alone or in combination with other races or ethnicities (i.e., not mutually exclusive) except for White, Non-Hispanic.
- **Non-age-restricted measures:** This report does not make age restrictions to substance-related measures (e.g., SUD treatment need, alcohol use disorder) or legal system involvement measures (e.g., arrests). Measured rates would be higher if restricted to ages 12 and older. For example, while 44 percent of CLIP patients overall had an indicated SUD treatment need in the year prior to admission, this rate varied by age subgroup: 21 percent for patients 7 to 13 years old at discharge; 48 percent for patients 14 to 16 years old at discharge; 58 percent for patients ages 17 to 18 years old at discharge.

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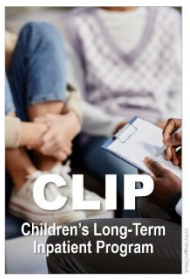

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