PO 2024-0011 – Line Amendment Tracker

Special Regional Policy Committee – May 17, 2024

#	1st Page & Line #	Sponsor	Amendment Description
S1		PvR	• Incorporates technical corrections and clarifying edits to the Plan • Adds language to encourage CCC operators to become a Safe Place Site or Licensed Safe Place Agency. • Adds language stating that individuals treated at a crisis care center shall have access to post-crisis follow-up treatment planning. • Requires CCC's to work with community behavioral health providers, mobile crisis teams, co-responder teams, emergency medical services, or law enforcement to help facilitate transportation to CCC's from provider locations as needed and subject to available resources. • Adds language stating that CCC's with a crisis stabilization unit, a 23-hour crisis relief center, or both shall accept individuals transported by law enforcement, in accordance with state law, to those clinical components. • Requires CCC's to ensure prompt access to substance use disorder treatment on-site. • Requires the competitive procurement process to include an evaluation of how operators will ensure a therapeutic milieu for individuals with different needs such as age disparities, individuals with SUD needs, and people in active psychosis. • Adds DCHS monitorization of CCC utilization rates, and if persistent underutilization is identified at a particular center, requires that DCHS work with the provider to take steps to address the needs of that Center through activities such as increased outreach and use of mobile services; and adds reporting on an overview of this data in the annual report. • Adds a proposal review panel for each of the five competitive procurement process conducted for CCC's. The proposal review panels would have a representative

Last updated 5/16/2024 6:13 PM

			from each of the respective crisis response zones for their respective competitive procurement process, and one representative selected by the City of Seattle and Sound Cities Association (SCA) to review youth crisis care center operator proposals. • Changes the language pertaining to the operator cap from “may operate a maximum of three“ CCC's to “should operate no more than three,“ and revises the associated footnote. • Adds language to allow the Council to reject the Executive's commencement of the alternative siting process by motion within 30 days of the Executive’s transmittal of the alternative siting process notification letter. • Adds jurisdictions within the crisis response zone to the list of entities CCC operators will work with to determine criteria and protocols to manage new admissions when a center is at full capacity. • Adds language stating the Executive will assess the outcome of the investments to Strategy 2 as described in the financial plan, and whether the financial plan remains on target for these investments as part of the annual report. • Adds RPC notification to the annual report, career pathways, substantial financial adjustment, and BHAB members sections. • Adds SCA to Community Partners Consulted for evaluation priorities. • Adds language to have DCHS provide historical and current data in the annual report in a manner that can be used to analyze services and to make year-over-year comparisons. • Requires zip code activity-level data reporting in the annual report. • Adds increased communication to the Council, RPC, and SCA during procurement and siting process. • Adds a list of characteristics of sites with support from the host jurisdiction that will receive preference.

<table>
<tr><td>1 to S1</td><td>Pg. 9, Line 269, of Attachment A dated May 17, 2024</td><td>PvR
Replace missing text</td><td>Replaces missing text in summary regarding the financial plan. This was inadvertently deleted from in the May 17 version of the Plan.</td></tr>
<tr><td>2 to S1</td><td>Pg. 53, Line 1429, of Attachment A dated May 17, 2024</td><td>Perry
Metro Access</td><td>Would add language requiring DCHS to coordinate with the Metro Transit Department to provide support through their security and safety function to people in need of behavioral health crisis services who are on transit, at a transit center, or at a transit stop to access a CCC, which may include fare assistance.</td></tr>
<tr><td>3 to S1</td><td>Pg. 64, Line 1746, of Attachment A dated May 17, 2024</td><td>Perry
Collect and report data on arrival modes</td><td>Would add language to require DCHS to collect and report detailed data about how individuals arrive at a CCC, how DCHS should collaborate to secure data, and description of what the data would look like. The amendment would also add a component to the annual report to report on this data.</td></tr>
<tr><td>4 to S1</td><td>Pg. 72, Line 1900, of Attachment A dated May 17, 2024</td><td>PvR
KC Develops</td><td>On page 72, line 1900, strike Figure 22, and insert:
"***Figure 22. Allowable Crisis Care Center Capital Development Scenarios***
<table>
<tr><th colspan="2">Allowable Crisis Care Center Capital Development Scenarios</th></tr>
<tr><th>Scenario</th><th>Description</th></tr>
<tr><td>Pre-Existing Facility</td><td>Crisis care centers may incorporate a pre-existing facility or program that provides crisis stabilization services if the program’s site, services, and operations are compatible with crisis care center requirements.</td></tr>
<tr><td>Facility Acquisition</td><td>Crisis care centers may be developed by acquiring, renovating, or expanding an existing facility.</td></tr>
<tr><td>New Construction</td><td>Crisis care centers may be developed through new construction.</td></tr>
<tr><td>Multiple Facilities</td><td>In addition to individual facilities, the required crisis care center components may be located within geographically adjacent facilities or non-contiguous facilities if transportation is provided between</td></tr>
</table>
</td></tr>
</table>

			facilities for people seeking and receiving services. Regardless of configuration, King County will prefer development proposals that provide easy access for patients to all crisis care center services. A crisis care center proposal may combine two or more of these scenarios. DCHS will accept proposals from individual organizations and multiple organizations that are interested in forming a multi-organizational partnership or consortium to develop and operate a crisis care center. King County may use CCC levy proceeds to develop one or more crisis care centers through any of the scenarios described in *Figure 22. Allowable Crisis Care Center Capital Development Scenarios* before, during, or after a crisis care center operator procurement process if it has the support of the host jurisdiction.
5 to S1	Pg. 73, Line 1924, of Attachment A dated May 17, 2024	Birney *Scoring SME Rep.*	Would replace the non-scoring representative on the competitive procurement process review board, with a scoring subject matter expert representative that would recuse themselves from scoring for the remainder of the review process if there is an actual or perceived conflict of interest at any stage in the review process.
6 to S1	Pg. 98, Line 2676, of Attachment A dated May 17, 2024	Moore *Good Neighbor Policy*	Would add language stating that crisis care center operators will create a 'Good Neighbor Policy' with the purpose of managing the relationship between the crisis care center and the neighboring community, and state minimum expectations for what the Policy should address.
7 to S1	Pg. 120, Line 3339, of Attachment A dated May 17, 2024	Birney *BHAB Notification*	Would add notification to RPC of BHAB appointments at transmittal.

May 14, 2024

Replaces Attachment A with
version dated May 17, 2024

S1

Sponsor: von Reichbauer

[S. Porter]

Proposed No.: 2024-0011.1

1 **STRIKING AMENDMENT TO PROPOSED ORDINANCE 2024-0011, VERSION**
2 **1**

3 On page 1, beginning on line 9, strike everything through page 8, line 142, and insert:

4 " STATEMENT OF FACTS:

5 1. Federal and state investments in public behavioral health systems have
6 been inadequate for decades. As funding for behavioral health services
7 has remained inadequate, the needs of people in King County who are
8 living with mental health and substance use conditions, collectively
9 referred to as behavioral health conditions, have grown.

10 2. Among people enrolled in Medicaid in King County in 2022, 45,000
11 out of 88,000, which is 51 percent, of adults with an identified mental
12 health need did not receive treatment, and 21,000 of 32,000, which is 66
13 percent, of adults with an identified substance use need did not receive
14 treatment.

15 3. The gap in accessing behavioral health services is not evenly
16 experienced across King County's population. There are significant
17 inequities in service access and utilization among historically and
18 currently underserved communities. Black, Indigenous, and People of

19 Color populations are more frequently placed in involuntary treatment
20 while having the least access to routine behavioral health care.
21 4. The scale of suffering related to mental health conditions and substance
22 use remains persistently elevated. 1,229 people died by suicide in
23 Washington in 2021, equivalent to 15.3 out of every 100,000 people,
24 which is the 27th highest rate nationally. 292 people died by suicide in
25 King County in 2021. Suicide deaths increased nationally by 2.6 percent
26 from 2021 to 2022. Youth are especially impacted. According to the
27 2021 Healthy Youth Survey, 18.6 percent of King County's 8th graders
28 considered suicide in past year, and 8.8 percent made attempts. Among
29 Washington's 10th graders in 2021, 51.6 percent of gender-diverse youth
30 and 42.4 percent of youth identifying as LGBTQIA+ considered suicide,
31 and 22.7 percent and 17.9 percent attempted suicide, respectively.
32 5. Deaths related to drug overdose are increasing at unprecedented rates.
33 The annual number of overdose deaths in King County have nearly
34 doubled in just three years, from 508 deaths in 2020 to 1,001 in 2022, and
35 the number of fatal overdoses in 2023 has already exceeded that total.
36 There are significant disparities in overdose deaths by race and ethnicity.
37 The age-adjusted rate of fatal overdoses in King County is the highest in
38 the American Indian/Alaska Native community and is five times higher
39 than non-Hispanic White King County residents.
40 6. The Federal Substance Abuse and Mental Health Services
41 Administration ("SAMHSA") released its National Guidelines for

42 Behavioral Health Crisis Care in 2020. Those guidelines call for the
43 creation of crisis facilities, referred to by SAMHSA as "somewhere to go"
44 for people in crisis to seek help. SAMHSA's guidelines envision crisis
45 facilities as part of a robust behavioral health crisis system that also
46 includes the 988 Suicide and Crisis Lifeline, referred to as "someone to
47 call," and mobile crisis teams, described as "someone to respond."
48 7. As of December 2023, the Crisis Solutions Center, operated by
49 Downtown Emergency Service Center and requiring mobile team, first
50 responder or hospital referral for entry, is the only voluntary behavioral
51 health crisis facility for the entirety of King County, and a walk-in urgent
52 care behavioral health facility does not exist in King County. For youth in
53 King County, there is not a crisis facility option at all.
54 8. King County's behavioral health crisis service system relies heavily on
55 phone support and outreach services, with very few options of places for
56 persons to go for immediate, life-saving care when in crisis.
57 9. A coalition of community leaders and behavioral health providers
58 issued recommendations to Seattle and King County in an October 13,
59 2021, letter that included recommendations to "expand places for people
60 in crisis to receive immediate support" and "expand crisis response and
61 post-crisis follow up services."
62 10. Multiple behavioral health system needs assessments have identified
63 the addition of crisis facilities as top priorities to improve community-
64 based crisis services in King County. Such assessments include the 2016

65 recommendations of the Community Alternatives to Boarding Task Force
66 called for by Motion 14225, a Washington state Office of Financial
67 Management behavioral health capital funding prioritization and
68 feasibility study in 2018, and a Washington state Health Care Authority
69 crisis triage and stabilization capacity and gaps report in 2019.
70 11. King County is losing mental health residential treatment capacity that
71 is essential for persons who need more intensive supports to live safely in
72 the community due to rising operating costs and aging facilities that need
73 repair or replacement. As of October 2023, King County had a total of
74 240 mental health residential beds for the entire county, down 115 beds, or
75 nearly one third, from the capacity in 2018 of 355 beds.
76 12. As of October 2023, King County residents who need mental health
77 residential services must wait an average of 25 days before they are able to
78 be placed in a residential facility.
79 13. The 2023 King County nonprofit wage and benefits survey found that
80 employee compensation is a key factor contributing to nonprofit
81 employees leaving the sector, even though they are satisfied with their
82 jobs overall.
83 14. A 2023 King County survey of member organizations of the King
84 County Integrated Care Network found that found that there were
85 approximately 600 staff vacancies across the agencies that responded to
86 the survey, a 16-percent total vacancy rate at King County community
87 behavioral health agencies, and there is still a need to hire more behavioral

88 health workers to support the growing behavioral health care needs in the
89 community.
90 15. In September 2022, alongside a broad coalition of elected officials,
91 behavioral health workers and providers, emergency responders, and
92 businesses, the executive announced a plan to address King County's
93 behavioral health crisis and improve the availability and sustainability of
94 behavioral health care in King County through a nine-year property tax
95 levy known as the crisis care centers levy.
96 16. On February 9, 2023, King County adopted Ordinance 19572 to
97 provide for the submission of the crisis care centers levy to the voters of
98 King County.
99 17. King County voters considered the levy as Proposition No. 1 as part
100 of the April 25, 2023, special election, and fifty-seven percent of voters
101 approved it.
102 18. The passage of Proposition No. 1 authorized the crisis care centers
103 levy that will raise proceeds from 2024 to 2032 to create a regional
104 network of five crisis care centers, restore and expand residential
105 treatment capacity, and increase the sustainability and representativeness
106 of the behavioral health workforce in King County.
107 19. Ordinance 19572, Section 7.A., requires the executive to develop and
108 transmit for council review and adoption by ordinance an implementation
109 plan for the crisis care centers levy. The implementation plan, once
110 effective, will govern the expenditure of the levy's proceeds until the crisis

111 care centers levy expires in 2032. The required implementation plan is
112 Attachment A to this ordinance.
113 20. Ordinance 19572, Section 7.C., enumerates specific requirements for
114 the implementation plan. The crisis care centers levy implementation plan
115 2024-2032, dated May 17, 2024, Attachment A to this ordinance, responds
116 to the requirements set out by Ordinance 19572, Section 7.C., by:
117 describing the purposes of the levy; describing the strategies and allowable
118 activities to achieve the levy's purposes; describing the financial plan to
119 direct the use of levy proceeds; describing how the executive will seek and
120 incorporate federal, state, philanthropic and other resources when
121 available; describing the executive's assumptions about the role of
122 Medicaid funding in the financial plan; describing the process by which
123 King County and partner cities will collaborate to support siting of new
124 capital facilities that use proceeds from the levy for such facilities'
125 construction or acquisition; describing a summary and key findings of the
126 community engagement process; describing the process to make
127 adjustments to the financial plan; describing the advisory body for the
128 levy; describing measurable results and a coordinated performance
129 monitoring and reporting framework; describing how the levy's required
130 online annual report will be provided to councilmembers, the regional
131 policy committee or its successor, and the public; and describing how
132 crisis response zones described in the levy will promote geographic
133 distribution of crisis care centers.

134 BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:

135 SECTION 1. The crisis care centers levy implementation plan 2024-2032, dated
136 May 17, 2024, Attachment A to this ordinance, is hereby adopted to govern the
137 expenditure of crisis care centers levy proceeds as authorized under Ordinance 19572."

138

139 Strike Attachment A, Crisis Care Centers Levy Implementation Plan 2024-2032, dated
140 December 31, 2023, and insert Attachment A, Crisis Care Centers Levy Implementation
141 Plan 2024-2032, dated May 17, 2024.

142

143 **EFFECT prepared by S. Porter: Updates the date of the Attachment A in the**
144 **ordinance to match the new Attachment A, and replaces the transmitted**
145 **Attachment A with an updated version dated May 17, 2024, that does the following:**

146 - **Incorporates technical corrections and clarifying edits to the Plan**
147 - **Adds language to encourage CCC operators to become a Safe Place Site or**
148 **Licensed Safe Place Agency**
149 - **Adds language stating that individuals treated at a crisis care center shall**
150 **have access to post-crisis follow-up treatment planning**
151 - **Adds language requiring CCC's to work with community behavioral health**
152 **providers, mobile crisis teams, co-responder teams, emergency medical**
153 **services, or law enforcement to help facilitate transportation to CCC's from**
154 **provider locations as needed**

155 • **Adds language stating that CCC's with a crisis stabilization unit, a 23-hour**
156 **crisis relief center, or both shall accept individuals transported by law**
157 **enforcement to those clinical components in accordance with state law**
158 • **Adds language stating CCC's are required to ensure prompt access to**
159 **substance use disorder treatment on-site**
160 • **Requires that the competitive procurement process include an evaluation of**
161 **how operators will ensure a therapeutic milieu for individuals with different**
162 **needs such as age disparities, individuals with SUD needs, and people in**
163 **active psychosis**
164 • **Adds DCHS monitorization of CCC utilization rates, and if persistent**
165 **underutilization is identified at a particular center, requires that DCHS work**
166 **with the provider to take steps to address the needs of that Center through**
167 **activities such as increased outreach and use of mobile services; and adds**
168 **reporting on an overview of CCC facility utilization data in the annual report**
169 • **Adds a proposal review panel for each competitive procurement process**
170 **conducted for CCC's**
171 • **Changes the operator cap language from "may operate a maximum of three"**
172 **CCC's to "should operate no more than three" CCC's, and revising the**
173 **associated footnote**
174 • **Adds language to the alternative siting process that would allow Council to**
175 **reject the Executive's commencement of the alternative siting process by**
176 **motion within 30 days of the Executive's transmittal of the alternative siting**
177 **process notification letter**

178 • **Adds jurisdictions within the crisis response zone to the list of entities CCC's**
179 **will work with to determine criteria and protocols to manage new admissions**
180 **when a center is at full capacity**
181 • **Adds language stating the Executive will assess the outcome of the**
182 **investments to Strategy 2 as described in the Financial Plan as part of the**
183 **annual report**
184 • **Adds notification of RPC of the annual report, career pathways, substantial**
185 **financial adjustment, and BHAB members sections**
186 • **Adds SCA to Community Partners Consulted for evaluation priorities**
187 • **Adds language to have DCHS provide historical and current data in a**
188 **manner that can be used to analyze services and to make year-over-year**
189 **comparisons**
190 • **Add language requiring zip code activity-level data**
191 • **Adds increased communication to the Council, RPC, and SCA during siting**
192 **process**
193 • **Adds a list of preferential characteristics of sites with support from the host**
194 **jurisdiction**
195

Crisis Care Centers Levy
Implementation Plan 2024-2032

May 17, 2024

King County

22 # I. Contents

23

24 I. Contents 2
25 II. Executive Summary 6
26 Crisis Care Centers Levy Purposes 6
27 Background 6
28 Unmet Behavioral Health Needs in King County 6
29 Need for Crisis Care Centers 7
30 Reduction in Residential Treatment Capacity 7
31 Behavioral Health Workforce Needs 7
32 Crisis Care Centers Levy Implementation Plan Methodology 7
33 Community Engagement Summary 7
34 Behavioral Health Equity Framework 8
35 Crisis Care Centers Levy Strategies 8
36 **Crisis Care Centers Implementation Timeline** 9
37 Restore, Expand, and Sustain Residential Treatment Capacity 9
38 Strengthen the Community Behavioral Health Workforce 9
39 Financial Plan 9
40 Evaluation and Performance Measurement 9
41 Crisis Care Centers Annual Reporting 10
42 Crisis Care Centers Levy Advisory Body 10
43 Conclusion 10
44 III. Background 11
45 A. Department of Community and Human Services 11
46 Department Overview 11
47 Behavioral Health and Recovery Division 11
48 B. The Crisis Care Centers Levy and King County Ordinance 19572 11
49 C. Key Historical and Current Conditions 12
50 Behavioral Health Service Funding Limitations and Opportunities 12
51 Unprecedented Rates of Suicide and Overdose Deaths 16
52 Unmet Behavioral Health Service Needs 17
53 Who Experiences Behavioral Health Inequities 18
54 Need for Places to Go in a Crisis 20
55 Need for Post-Crisis Stabilization Services 22
56 Reduction in Residential Treatment Capacity 24
57 Behavioral Health Workforce Needs 25
58 D. Implementation Plan Methodology 27
59 Crisis Care Center Methodology 27
60 Residential Treatment Methodology 28
61 Workforce Methodology 29
62 E. Community Engagement Summary 29

63 Key Findings of Community Engagement Process 30
64 F. Behavioral Health Equity Framework 38
65 Equitable Access to Behavioral Health Crisis Care 40
66 Culturally and Linguistically Appropriate Services 41
67 Representative Behavioral Health Workforce 43
68 Quality Improvement and Accountability 43
69 IV. Crisis Care Centers Levy Purposes 45
70 Paramount Purpose 45
71 Supporting Purpose 1 45
72 Supporting Purpose 2 45
73 V. Crisis Care Centers Levy Strategies and Allowable Activities 46
74 A. Strategy 1: Create and Operate Five Crisis Care Centers 48
75 Overview 48
76 Crisis Care Center Clinical Program Overview 49
77 Crisis Care Center Operational Activities 58
78 Post-Crisis Stabilization Activities 59
79 Oversight of Crisis Care Center Quality and Operations 63
80 Crisis Care Center Capital Facility Development 66
81 Crisis Care Center Procurement and Siting Process 72
82 Alternative Siting Process 76
83 Sequence and Timing of Planned Expenditures and Activities 77
84 B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity 80
85 Overview 80
86 Activities to Restore, Expand, and Sustain Residential Treatment Capacity 80
87 Residential Treatment Capital Facility Procurement and Siting Process 81
88 2024 Levy Funding Approach for Rapid Initial Progress on Residential Treatment 81
89 C. Strategy 3: Strengthen the Community Behavioral Health Workforce 82
90 Overview 82
91 Community Behavioral Health Career Pathway Activities 83
92 Labor Management Workforce Development Partnership Activities 86
93 Crisis Workforce Development Activities 87
94 2024 Funding Approach for Rapid Initial Progress on Behavioral Health Workforce 88
95 D. Strategy 4: Early Crisis Response Investments 89
96 Increase Community-Based Crisis Response Capacity 90
97 Reduce Fatal Opioid Overdoses by Expanding Low Barrier Opioid Reversal Medication 92
98 Substance Use Facility Investments 92
99 E. Strategy 5: Capacity Building and Technical Assistance 93
100 Facility Operator Capital Development Assistance Activities 93
101 Crisis Care Center Operator Regulatory and Clinical Quality Activities 94
102 Capacity Building for Providers with Expertise in Culturally and Linguistically Appropriate Services
103 95
104 Local Jurisdiction Capital Facility Siting Support Activities 95
105 DCHS Capital Facility Siting Technical Assistance 96

106 F. Strategy 6: Evaluation and Performance Measurement Activities 96
107 G. Strategy 7: Crisis Care Centers Levy Administration 97
108 Community Engagement 98
109 Expertise to Support Oversight of Behavioral Health Equity 98
110 Develop Data Systems Infrastructure and Technology 99
111 Designated Crisis Responder Accessibility 100
112 H. Strategy 8: Crisis Care Centers Levy Reserves 101
113 VI. Financial Plan 102
114 A. Overview 102
115 B. Financial Plan 102
116 CCC Levy Annual Revenue Forecast 102
117 Annual Expenditure Plan 102
118 C. Sequencing and Timing of Planned Expenditures 104
119 D. Seeking and Incorporating Federal, State, and Philanthropic Resources 104
120 E. Health Insurance Assumptions 105
121 Medicaid Health Insurance 105
122 Commercial Health Insurance 106
123 F. Process to Make Substantial Adjustments to the Financial Plan 107
124 Overview 107
125 Process for Communicating and Making a Substantial Adjustment 107
126 Priorities for Reducing Allocations Due to Revenue that is Less than this Plan's Projections 107
127 Priorities for Allocating Revenue in Excess of this Plan's Original Allocations or to Reflect
128 Additional Funding from Other Sources 108
129 VII. Evaluation and Performance Measurement 110
130 A. Evaluation and Performance Measurement Principles 110
131 B. Evaluation and Performance Measurement Framework 111
132 Population Indicators 112
133 Performance Measurement 112
134 In-Depth Evaluation 113
135 C. Aligning CCC Levy Performance Measurement and Reporting with Other Dedicated Human Services
136 Funding Initiatives 114
137 VIII. Crisis Care Centers Levy Annual Reporting 116
138 A. Annual Reporting Process and Requirements 116
139 B. Reporting Methodology to Show Geographic Distribution by ZIP Code 117
140 ZIP Code Reporting Methodology 117
141 ZIP Code Reporting Limitations 118
142 IX. Crisis Care Centers Levy Advisory Body 119
143 A. Overview 119
144 B. BHAB Background and Connection to CCC Levy Purposes 119
145 BHAB Member Recruitment Process 120
146 BHAB Support 120

147 D. Expansion of BHAB's Duties to Include the CCC Levy 120
148 E. Process to Update CCC Levy Advisory Body if Necessary 120
149 X. Conclusion 122
150 XI. Appendices 123
151 Appendix A: Crisis Care Centers Levy Ordinance 19572 Text 123
152 Appendix B: Crosswalk of Implementation Plan Requirements from King County Ordinance 19572 131
153 Appendix C: King County Local Jurisdiction Request for Information (RFI) 135
154 Appendix D: Coordination with State and County Partners 142
155 Appendix E: Site and Field Visits 143
156 Behavioral Health Crisis Facilities 143
157 Mental Health Residential Facilities 143
158 Other Health Care Providers 143
159 Field Visits 143
160 Appendix F: Community Engagement Activities 144
161 Appendix G: Clinical Best Practices in Behavioral Health Crisis Services 147
162 Appendix H: BHRD Capital Improvement Funding for Behavioral Health Facilities Request for
163 Information (RFI) 149
164
165

II. Executive Summary

The Crisis Care Centers (CCC) Levy is a once-in-a-generation opportunity to transform how people experiencing behavioral health crises can access specialized behavioral health care. This nine-year property tax levy will create a countywide network of five crisis care centers, restore residential treatment capacity, and strengthen King County's community behavioral health workforce. The CCC Levy is authorized by King County Ordinance 19572 (see Appendix A and hereinafter referred to as Ordinance 19572).

Crisis Care Centers Levy Purposes

Ordinance 19572 defines the CCC Levy's Paramount Purpose and two Supporting Purposes, which are more fully described in Figure 1.

Figure 1. Summary of Crisis Care Centers Levy Purposes

Summary of Crisis Care Centers Levy Purposes	
Paramount Purpose	**Crisis Care Centers:** Establish and operate a regional network of five crisis care centers in King County, with at least one in each of the four crisis response zones and one serving youth.
Supporting Purpose 1	**Residential Treatment:** Restore the number of mental health residential treatment beds to at least 355 and expand the availability and sustainability of residential treatment in King County.
Supporting Purpose 2	**Community Behavioral Health Workforce**: Increase the sustainability and representativeness of the behavioral health workforce in King County by expanding community behavioral health career pathways, sustaining and expanding labor-management workforce development partnerships, and supporting crisis workforce development.

Background

Unmet Behavioral Health Needs in King County

As more developed at Section III.C. Key Historical and Current Conditions of this CCC Levy Implementation Plan, federal and state investments in public behavioral health systems have been inadequate for decades.[1] As funding for behavioral health services has remained inadequate, the needs of people living with mental health and substance use conditions, generally referred to in this Plan either singularly or collectively as behavioral health conditions, have grown. The gap between behavioral health needs and available services is widening. Importantly, this gap is not evenly experienced across King County's population. There are significant inequities in service access and utilization among historically and currently underserved communities.

The scale of suffering related to behavioral health conditions, remains persistently elevated, with deaths by suicide are on the rise and an increasing risk to youth. Deaths related to drug overdose are increasing at unprecedented rates.

[1] Center for American Progress, The Behavioral Health Care Affordability Problem, May 26, 2022 [LINK]

196 ## Need for Crisis Care Centers
197 The creation of specialized crisis facilities is frequently identified as a key strategy in the crisis service
198 continuum.[2] These facilities facilitate diverting people from emergency department and carceral settings
199 and serving people in higher quality specialized settings that can provide care using trauma-informed,
200 recovery oriented, and cultural humility best practices.[3] Establishing and operating a regional network
201 of five crisis care centers in the County is the paramount purpose to be funded by the CCC Levy.
202
203 ## Reduction in Residential Treatment Capacity
204 Residential treatment is a community-based behavioral health treatment option for people who need a
205 higher level of care than outpatient behavioral health services can provide.[4] As of October 2023, King
206 County had a total of 240 mental health residential treatment beds for the entire county, a decrease of
207 115 beds, down nearly one third from the capacity of 355 beds in 2018.[5] One of the supporting purposes
208 to be funded by the CCC Levy is to restore the number of residential treatment beds to 355.
209
210 ## Behavioral Health Workforce Needs
211 The other supporting purpose to be funded by the CCC levy is to increase the number and diversity of
212 behavioral health workers. There is evidence that improving diversity among behavioral health workers
213 to better reflect the communities they serve may help reduce behavioral health disparities.[6]
214 Concomitant with developing a representative workforce must be the retention of those workers.
215
216 ## Crisis Care Centers Levy Implementation Plan Methodology
217 The CCC Levy Implementation Plan (Plan) is the product of an intensive process that began in June 2023
218 and concluded in December 2023. DCHS's planning activities included engaging community partners,
219 solicitating of formal requests for information (RFIs), engaging with various Washington State
220 departments, consulting with national subject matter experts, coordinating with other County partners,
221 and convening internal workgroups within DCHS.
222
223 ## Community Engagement Summary
224 DCHS staff engaged community partners to inform this Plan, including participation from behavioral
225 health agencies, people with lived experiences of behavioral health crises, and frontline behavioral
226 health workers. See Appendix F: Community Engagement Activities for a complete list of community
227 engagement activities. Engagement activities are summarized in Section III.E. Community Engagement
228 Summary
229

---

[2] Continuum of care is the concept of an integrated system of care that guides and tracks patient over time through a comprehensive array of health services spanning all levels of intensity of care.

[3] ME Balfour and ML Goldman, "Crisis and Emergency Services" in "Textbook of Community Psychiatry: American Association for Community Psychiatry, 2nd edition." Wesley E. Sowers (Editor), Hunter L. McQuistion (Editor), Jules M. Ranz (Editor). Springer 2022, pp. 369-384.

[4] King County Ordinance 19572 defines residential treatment as "a licensed, community-based facility that provides twenty-four-hour on-site care for persons with mental health conditions, substance use disorders, or both, in a residential setting" [LINK].

[5] An additional four mental health residential beds have been lost since the passage of King County Ordinance 19572. BHRD monitors the number of available beds through a bed tracker list.

[6] Chao, P.J., Steffen, J.J., and Heiby, E.M. (2012). The effects of working alliance and client-clinician ethnic match on recovery status. *Community Mental Health Journal* (48), 91-97 [LINK]

230 ## Behavioral Health Equity Framework
231 The success of the CCC Levy hinges not only on increasing access to behavioral health crisis services but
232 also on reducing inequities in who can access that care. Inequities in who can access behavioral health
233 care at the time of this Plan's drafting are described in Section III.C. Who Experiences Behavioral Health
234 Inequities. During this Plan's community engagement process, DCHS received extensive feedback from
235 community partners about the importance of centering health equity in this Plan. In response, this Plan
236 contains a behavioral health equity framework that will guide DCHS's implementation of the CCC Levy.
237 This framework is more fully described at Section III.F. Behavioral Health Equity Framework.
238
239 ## Crisis Care Centers Levy Strategies
240 Ordinance 19572 requires this Plan to define strategies for how CCC Levy funds will be invested between
241 2024 and 2032 to achieve the Levy's purposes. This Plan's strategies reflect Ordinance 19572
242 requirements and input from community partners, subject matter experts, and DCHS staff. Figure 2
243 summarizes the CCC Levy strategies. These strategies are more fully developed in Section V of this Plan.
244
245 ***Figure 2. Summary of the CCC Levy Strategies***

Summary of the CCC Levy Strategies	
Strategy	**Summary Description**
Strategy 1 **Create and Operate Five Crisis Care Centers**	• Capital funding to create and maintain five crisis care centers • Operating funding to support crisis care center personnel costs, operations, services, and quality improvement • Post-crisis follow-up for people after leaving a crisis care center
Strategy 2 **Restore, Expand, and Sustain Residential Treatment Capacity**	• Capital resources to restore mental health residential treatment capacity to at least 355 beds in King County • Capital resources to expand and sustain residential treatment capacity
Strategy 3 **Strengthen the Community Behavioral Health Workforce**	• Resources to expand community behavioral health career pathways, including investments to strengthen and sustain King County's community behavioral health workforce and increase workforce representativeness • Resources to expand and sustain labor-management workforce development partnerships, including support for apprenticeships • Resources to support the development of the region's behavioral health crisis workforce, including crisis care center workers
Strategy 4 **Early Crisis Response Investments**	• Resources to expand community-based crisis service capacity starting in 2024, before crisis care centers are open • Resources starting in 2024 to respond faster to the overdose crisis
Strategy 5 **Capacity Building and Technical Assistance**	• Resources to support the implementation of CCC Levy strategies • Support for capital facility siting • Build capacity for culturally and linguistically appropriate services
Strategy 6 **Evaluation and Performance Measurement**	• Resources to support CCC Levy data collection, evaluation, and performance management • Analyses of the CCC Levy's impact on behavioral health equity

Summary of the CCC Levy Strategies	
Strategy	**Summary Description**
Strategy 7 **CCC Levy Administration**	• Investments in CCC Levy administration, community engagement, information technology systems infrastructure, and designated crisis responder (DCR) accessibility[7]
Strategy 8 **CCC Levy Reserves**	• Provide for and maintain CCC Levy reserves[8,9]

246 **Crisis Care Centers Implementation Timeline**
247 DCHS intends to prioritize opening five crisis care centers as quickly as possible to meet the urgent
248 needs of people experiencing behavioral health crises. DCHS plans to select crisis care center operators
249 through an annual competitive procurement process starting in 2024, The first procurement round in
250 2024 will prefer crisis care center proposals that can be developed and begin serving people rapidly..
251
252 **Restore, Expand, and Sustain Residential Treatment Capacity**
253 Supporting Purpose 1 of the CCC Levy, to restore, expand, and sustain residential treatment capacity
254 will be implemented through Strategy 2. Sustaining residential treatment capacity means investing in
255 existing residential treatment capital facilities to help prevent further facility closures. King County has
256 lost one-third of its mental health residential treatment capacity since 2018. Strategy 2 funds and
257 activities will be prioritized to support existing residential treatment operators to prevent further facility
258 closures and restore King County's mental health residential capacity to at least the 2018 level of 355
259 beds.[10]
260
261 **Strengthen the Community Behavioral Health Workforce**
262 It takes people to treat people. Supporting Purpose 2 will be implemented through Strategy 3, by
263 investing in activities to strengthen King County's community behavioral health workforce. This strategy
264 also directly supports the CCC Levy's Paramount Purpose to establish and operate five crisis care centers
265 by investing in the development of King County's behavioral health crisis workforce, including crisis care
266 center workers. Strategy 3's workforce activities focus on helping more people get hired and make a
267 career in community behavioral health.
268
269 **Financial Plan**
270 **Evaluation and Performance Measurement**
271 The CCC Levy requires evaluation and performance measurements. This Plan focuses on reporting
272 measures relevant to monitoring performance of the CCC Levy, advancing continuous quality
273 improvement, and generating clear and actionable evaluation products for the public. It is critical that
274 the crisis services system can grow and evolve by building on what works well and improving what does
275 not. This process should be continuously informed by performance metrics, outcome data, client
276 experiences, and other relevant information. See Section VII. Evaluation and Performance

---

[7] King County Crisis and Commitment Services offers evaluation of people with behavioral health disorders for involuntary detention in psychiatric and secure withdrawal facilities according to Washington law. The law for adults is RCW 71.05. [LINK] For youth 13 through 17 years of age the law is RCW 71.34. [LINK] Crisis and Commitment staff who perform these duties are referred to as Designated Crisis Responders (DCRs). [LINK]
[8] Ordinance 19704 created the crisis care center fund to account for CCC Levy proceeds. [LINK]
[9] This strategy creates a fund reserve equal to 60 days of budgeted expenditures, less capital expenses, consistent with King County Comprehensive Financial Management Policies (2016). [LINK]

[Measurement](#) for more information about the CCC Levy's evaluation and performance measurement plan.

Crisis Care Centers Annual Reporting

Beginning in 2025, the Executive will make available an online annual report of the CCC Levy that is publicly available to the community and all interested parties, including the King County Council and Regional Policy Committee or its successor. The CCC Levy online annual report will detail each year's annual results. The first year's report, to be provided by August 15, 2025, will report information from calendar year 2024. Subsequent annual reports will continue to be provided by August 15 of the following year until August 15, 2033. In consultation with Cities and the Sound Cities Association, as part of the annual report DCHS will provide historical and current data in a manner that can be used to analyze services and to make year-over-year comparisons. See VIII. Crisis Care Centers Levy Annual Reporting for more information about the annual reporting requirements.

Crisis Care Centers Levy Advisory Body

Ordinance 19572 allows for the CCC Levy's advisory body to be a preexisting King County board that has relevant expertise. This Plan identifies King County Behavioral Health Advisory Board (BHAB) to serve as the advisory body because it has the relevant expertise to advise the Executive and the Council on matters relating to behavioral health care and crisis services in King County. The advisory body ordinance that accompanies this Plan will expand BHAB's membership requirements and duties to include advising the Executive and the Council regarding the CCC Levy once it is enacted.

Conclusion

King County voters approved the Crisis Care Centers Levy on April 25, 2023. The nine-year levy begins on January 1, 2024, starting an ambitious timeline to transform the region's behavioral health crisis response system, restore the region's flagging mental health residential facilities, and reinforce the workforce — the people — upon whom tens of thousands of King County residents depend for their behavioral health. This Plan lays the path that King County, cities and other local jurisdictions, and behavioral health providers must travel with urgency, common purpose, and strong partnership so that future generations will have a safe, accessible, and effective place to go in a moment of mental health or substance use crisis.

The Crisis Care Centers Levy provides the resources. This Plan sets the course. The task is now to King County, cities, and providers to follow the course.

311 # III. Background

312 ## A. Department of Community and Human Services

313 ### Department Overview

314 King County's Department of Community and Human Services (DCHS) is responsible for implementing
315 the Crisis Care Centers (CCC) Levy. DCHS's mission is to provide equitable opportunities for King County
316 residents to be healthy, happy, and connected to community. DCHS's five divisions provide human
317 services for adults; behavioral health care across the lifespan; services supporting children, youth, and
318 young adults to thrive; services for people with developmental disabilities, and affordable housing and
319 homelessness prevention. The department manages more than $1 billion annually in public funds to
320 ensure King County residents can access a broad range of services. DCHS is responsible for oversight and
321 management of five significant local human services plans and dedicated fund sources:

322 - Best Starts for Kids (BSK) voter-approved property tax levy;[11]
323 - Health Through Housing (HTH) initiative funded through a County Council-adopted sales tax;[12]
324 - MIDD behavioral health sales tax fund adopted by the County Council;[13]
325 - Veterans, Seniors, and Human Services Levy (VSHSL) voter approved property tax levy,[14] and,
326 - The Crisis Care Centers (CCC) Levy, a voter approved property tax levy.[15]

327

328 ### Behavioral Health and Recovery Division

329 DCHS's Behavioral Health and Recovery Division (BHRD) is responsible for managing and funding
330 behavioral health services and programs for King County residents enrolled in Medicaid and other
331 people with low incomes,[16] as well as all residents in need of behavioral health crisis services.
332 Approximately 70,000 County residents annually receive services through BHRD programs. BHRD
333 primarily contracts with community behavioral health agencies[17]to provide a full continuum of services.
334 However, in some cases, like involuntary commitment services, BHRD-employed staff provide services
335 directly.[18]

336

337 ## B. The Crisis Care Centers Levy and King County Ordinance 19572

338

---

[11] Best Starts for Kids (BSK) website [LINK]

[12] Health through Housing (HTH) website [LINK]

[13] MIDD is referred to in King County Code and related legislation as the mental illness and drug dependency fund, tax, or levy. KCC 4A.500.300 and 4A.500.309 [LINK]. See also the MIDD Behavioral Health Sales Tax Fund website. [LINK]

[14] Veterans, Seniors and Human Services Levy (VSHSL) website [LINK]

[15] King County Ordinance 19572 [LINK]

[16] King County BHRD Provider Manual [LINK]. People with low incomes are defined as falling below an income benchmark of 220% of the federal poverty level for adults and 300% of the federal poverty level for children.

[17] In the context of this Plan, "community behavioral health agencies" means agencies that meet the requirements defined in the Revised Code of Washington Chapter 71.24 Community Behavioral Health Services Act [LINK], are licensed by the Washington State Department of Health as a community behavioral health agency as defined in Chapter 246-341 Washington Administrative Code [LINK] and are contracted with the King County Behavioral Health Administrative Services Organization or King County Integrated Care Network. Community behavioral health agencies must serve people who are enrolled in Medicaid health insurance to be eligible for CCC Levy funding through Strategy 3.

[18] RCW 71.05 [LINK] and 71.34 [LINK]. King County BHRD Crisis and Commitment Services website [LINK]

339 Ordinance 19572 defines the CCC Levy's paramount and supporting purposes , which are summarized in
340 Figure 3 and further described in Section IV. Crisis Care Centers Levy Purposes. A crosswalk matrix
341 detailing how this Implementation Plan (Plan) addresses each of Ordinance 19572's Plan requirements is
342 included in Appendix B. The background section provides additional context about the CCC Levy,
343 including:
344 - Context about King County's behavioral health system;
345 - The current and historical conditions that created the need for the CCC Levy;
346 - The methodology used to develop this Plan;
347 - The community engagement process that helped inform this Plan's recommendations, and,
348 - Behavioral health equity framework to guide the implementation of this Plan.
349

350 *Figure 3. Summary of Crisis Care Centers Levy Purposes*

Summary of Crisis Care Centers Levy Purposes	
Paramount Purpose	**Crisis Care Centers:** Establish and operate a regional network of five crisis care centers in King County, with at least one in each of the four crisis response zones and one serving youth.
Supporting Purpose 1	**Residential Treatment:** Restore the number of mental health residential treatment beds to at least 355 and expand the availability and sustainability of residential treatment in King County.
Supporting Purpose 2	**Community Behavioral Health Workforce**: Increase the sustainability and representativeness of the behavioral health workforce in King County by expanding community behavioral health career pathways, sustaining and expanding labor-management workforce development partnerships, and supporting crisis workforce development.

351

352
C. Key Historical and Current Conditions

353 DCHS administers King County's publicly funded behavioral health system, which is the primary source
354 of care for people experiencing crises of mental health or substance use, generally referred to in this
355 Plan either singularly or collectively as behavioral health conditions. This section summarizes the
356 structure of King County's behavioral health system, impacts of suicide and overdose deaths, behavioral
357 health service gaps, and recent initiatives to strengthen crisis services.
358

359
Behavioral Health Service Funding Limitations and Opportunities

360 Federal and state investments in public behavioral health systems have been inadequate for decades.[19]
361 There are three primary funding sources, alongside other smaller funding sources, support community-
362 based behavioral health services in King County, as shown in Figure 4. These include Medicaid, through
363 the King County Integrated Care Network (KCICN), state funding, through the Behavioral Health
364 Administrative Services Organization (BH-ASO), and local funding, through the MIDD Behavioral Health
365 Sales Tax Fund.
366

367 Medicaid, which combines state and federal resources and is subject to federal regulations, is
368 administered in Washington by the Health Care Authority (HCA) and locally by the KCICN. Medicaid is an
369 essential funding source, but it features two significant shortcomings:

[19] Center for American Progress, The Behavioral Health Care Affordability Problem, May 26, 2022 [LINK]

370 • Medicaid reimburses less than care costs. King County's analysis of preliminary results from a
371 Washington State rate comparison study conducted by an actuarial firm determined that
372 Medicaid payment rates in King County fall significantly short of provider costs to deliver care.[20]
373 • Medicaid does not reimburse at all for many essential costs. Medicaid is highly regulated and
374 limits how and for whom funds may be used, including restrictions on important types of staff
375 activities and creating new facilities through capital investments.[21]

[20] Behavioral Health Comparison Rate Development – Phase 2: Washington State Health Care Authority, Milliman Client Report, June 30, 2023.

[21] Medicaid generally reimburses only for federally approved direct treatment services provided by licensed and credentialed providers to Medicaid-enrolled clients who earn less than 138 percent of the federal poverty level (FPL), which is $18,700 for a single person or $38,200 for a family of four.

376 *Figure 4. King County Behavioral Health Funding Sources*

	King County Integrated Care Network (KCICN)	Behavioral Health Administrative Services Organization (BH-ASO)	MIDD Behavioral Health Sales Tax	Other Behavioral Health Funding
Funding Source	Medicaid (federal and state)	State general funds; federal mental health and substance abuse block grants, and state funds for specific programs	King County's 0.1 percent MIDD Behavioral Health Sales Tax Fund[22]	Other funds from local and state governments. These include a mix of state grants, levy funds, and local taxes, and contracts with other local governments.
Proportion of Behavioral Health Funding	About 56 percent	About 11 percent	About 20 percent	About 13 percent
Administration	BHRD administers the KCICN and receives funding from HCA via five Medicaid managed care organizations[23]	HCA contracts with BHRD to administer the BH-ASO; HCA mandates investment priorities[24]	BHRD administers funds to complement Medicaid and state funding[25]	BHRD administers funds in compliance with specific grant and contract requirements, as applicable.
Systems and Services Funded	Over 40 behavioral health agencies provide integrated direct services across the behavioral health continuum, and partner with King County to create access to a high-quality, coordinated system of care[26]	Provides for regional crisis services for all residents through mobile crisis and regional crisis lines; covers services for people who are not eligible for Medicaid; staff to carry out the State's involuntary commitment	52 initiatives including prevention and early intervention; crisis diversion including King County's only crisis facility; recovery and reentry services; system improvements to expand access to care, and therapeutic courts.	Other funds primarily provide dedicated support for specific purposes, as identified by the revenue source's grantor or governing authority. A portion of these other funds are flexible and can be used generally for behavioral health programs and services.

[22] MIDD is referred to in King County Code and related legislation as the mental illness and drug dependency fund, tax, or levy. KCC 4A.500.300 and 4A.500.309 [LINK]. See also the MIDD Behavioral Health Sales Tax Fund website [LINK].
[23] The KCICN Improves Access to Behavioral Health Care for Residents Furthest from Care. (2023) [LINK]
[24] Washington State Health Care Authority Behavioral Health Administrative Services Organization (BH-ASO) fact sheet [LINK]
[25] MIDD Implementation Plan [LINK]
[26] King County Integrated Managed Care (IMC) and Integrated Care Network (KCICN) Overview [LINK]

	King County Integrated Care Network (KCICN)	Behavioral Health Administrative Services Organization (BH-ASO)	MIDD Behavioral Health Sales Tax	Other Behavioral Health Funding
		statutes; and additional programs[27]		

377

[27] Overview of The King Behavioral Health Administrative Services Organization (BH-ASO) [LINK]

378 Additional federal block grant and state general funds distributed from HCA to King County through the
379 BH-ASO come with prescriptive requirements. Between 2019 and 2022, Washington State's BH-ASO
380 funding provided approximately $24 million less in total than King County's costs to fulfill its state-
381 mandated crisis service obligations during that period.[28] As a result, the County subsidizes state-
382 required BH-ASO functions with local MIDD Behavioral Health Sales Tax funds.[29]
383
384 Years of consistently paying less in Medicaid and BH-ASO funds than it costs to provide care have
385 created a chronically underfunded behavioral health system that is challenged to meet growing needs or
386 make long term investments. The focus on funding services rather than facilities has been made worse
387 by limited state capital investment in community behavioral health facilities and workforce
388 development.[30,31,32] These factors have combined to cause a loss of facilities and workforce and have
389 inhibited new facility-based capacity at the scale that King County needs. Despite these barriers, King
390 County is leading the state in regional service delivery innovation by creating the KCICN to make care
391 more integrated and effective and by braiding Medicaid, BH-ASO, and MIDD funds.
392

393 ## Unprecedented Rates of Suicide and Overdose Deaths

394 The scale of suffering related to behavioral health conditions remain persistently elevated. A total of
395 1,229 people died by suicide in Washington in 2021, equivalent to 15.3 out of every 100,000 people,
396 which is the 27th highest rate nationally.[33] King County accounted for 292 deaths by suicide in 2021.[34]
397 Suicide deaths increased nationally by 2.6 percent from 2021 to 2022.[35] In the State of Washington,
398 suicide is the seventh leading cause of years of potential life lost, surpassing liver disease, diabetes, and
399 HIV.[36]
400
401 Youth are especially impacted. According to the 2021 Healthy Youth Survey, 18.6 percent of King
402 County's 8th graders considered suicide in past year, and 8.8 percent made attempts.[37] Among
403 Washington's 10th graders in 2021, 51.6 percent of gender-diverse youth and 42.4 percent of youth

---

[28] BH-ASO state-mandated crisis service obligations for include Involuntary Treatment Act (ITA) functions including designated crisis responders (DCRs) to provide evaluations for involuntary treatment as well as related ITA court costs; inpatient hospitalization for people without Medicaid; the region's crisis hotline; and other crisis services that are ineligible for Medicaid reimbursement.

[29] BH-ASO funds only provide for operating investments, and MIDD funding also mainly supports the operation of programs and services, with comparatively little funding used for behavioral health-related capital investments.

[30] Behavioral Health Capital Funding Prioritization and Feasibility Study (2018) [LINK].

[31] Crisis Stabilization Services. Washington State Health Care Authority Report to the Legislature (2019). [LINK]

[32] Crisis Response Improvement Strategy (CRIS) Committee - Initial Assessment of the Behavioral Health Crisis Response and Suicide Prevention Services in Washington and Preliminary Funding Recommendations (2021) [LINK].

[33] Centers for Disease Control - Suicide Rates by State [LINK]

[34] Washington State Vital Statistics (Deaths) – See "More From This Data Source" and select "Suicide" from drop-down list [LINK]

[35] Centers for Disease Control - Provisional Suicide Deaths in the United States, 2022 [LINK]

[36] O'Rourke MC, Jamil RT, Siddiqui W. Washington State Suicide Prevention and Awareness. [Updated 2023 Mar 6]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan. [LINK]

[37] Washington State Healthy Youth Survey fact sheets [LINK]

404 identifying as LGBTQIA+ considered suicide, and 22.7 percent and 17.9 percent attempted suicide,
405 respectively.[38,39]
406
407 Deaths related to drug overdose are increasing at unprecedented rates. The annual number of overdose
408 deaths in King County have nearly doubled in just three years, from 508 deaths in 2020 to 1,001 in 2022,
409 and the number of fatal overdoses in 2023 has already exceeded this total.[40] Additionally, there are
410 significant disparities in overdose deaths by race and ethnicity. The age-adjusted rate of fatal overdoses
411 in King County is the highest in the American Indian/Alaska Native community and is five-times higher
412 than non-Hispanic White King County residents.[41]
413

414 Unmet Behavioral Health Service Needs

415 As funding for behavioral health services has remained inadequate, the needs of people with behavioral
416 health conditions, have only grown. The gap between behavioral health needs and available services is
417 widening. Importantly, this gap is not evenly experienced across King County's population. There are
418 significant inequities in service access and utilization among historically and currently underserved
419 communities, as described in the next subsection (see Section III.C. Who Experiences Behavioral Health
420 Inequities).
421
422 The National Council for Mental Wellbeing's 2022 access to care survey found that 43 percent of U.S.
423 adults who say they need care for behavioral health conditions did not receive that care due to
424 numerous barriers to accessing and receiving needed treatment.[42] According to the 2021 National
425 Survey on Drug Use and Health (NSDUH), 1.06 million of the 1.18 million Washingtonians with substance
426 use disorders (90 percent) needed but did not receive treatment, including 51,000 of the 65,000
427 adolescents (79 percent), respectively.[43] The 2021 NSDUH also found that 1.2 million adults in
428 Washington received mental health services, which is 75 percent of the 1.6 million Washington adults
429 who were living with a mental health condition.[44]
430
431 The national problem exists locally. Among people enrolled in Medicaid in King County in 2022, 45,000
432 out of 88,000 of adults with an identified mental health need did not receive treatment (51 percent),
433 and 21,000 of 32,000 adults with an identified substance use disorder need did not receive treatment
434 (66 percent).[45]
435
436 Among Medicaid-enrolled children in Washington, 87,000 of the 223,000 children with mental health
437 treatment needs do not receive mental health treatment services (39 percent), and 27,000 of the 33,000

---

[38] Washington Department of Health - Adolescent Mental Health: Significant Challenges and Strategies for Improvement in Washington State [LINK]
[39] "LGBTQIA+" is an abbreviation for lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and other sexual orientations or gender identities.
[40] Washington State Department of Health – Opioid Data [LINK]
[41] PHSKC Overdose Death Report (2022) [LINK]
[42] National Council for Mental Wellbeing - 2022 Access to Care Survey - [LINK]
[43] 2021 National Survey on Drug Use and Health (NSDUH): State-Specific Tables [LINK]
[44] 2021 National Survey on Drug Use and Health (NSDUH): State-Specific Tables [LINK]
[45] Washington State Department of Social and Health Services, Cross-System Outcome Measures for Adults Enrolled in Medicaid [LINK]

438 children with substance use disorders (including those with co-occurring mental health disorders) do not
439 receive behavioral health treatment services (81 percent).[46]
440
441 In 2022, there were 25,576 behavioral health crisis interactions with in-person crisis intervention and
442 stabilization programs in King County.[47] This is substantially less than the approximately 63,000
443 estimated crisis episodes that would typically occur in a population of approximately 2.3 million,
444 suggesting a lack of access to these essential services.[48]
445

446 Who Experiences Behavioral Health Inequities

447 Behavioral health inequities include disparities in how mental health and substance use impact specific
448 populations and how well those populations can access behavioral health services.[49] It is also important
449 to consider how those populations that experience such disparities are impacted by social determinants
450 of behavioral health such as homelessness.[50]
451
452 Given the breadth and complexity of these challenges, this section describes "populations experiencing
453 behavioral health inequities," which is the term this Plan uses in subsequent sections. Background
454 research and available literature described in this section highlights behavioral health inequities based
455 on factors that include, but are not limited to, race and ethnicity, sexual orientation, gender identity,
456 language preference, disability, housing status, living in a rural region, and experiential communities
457 such as persons with legal system involvement, military veterans, immigrants, and refugees.
458
459 There are significant racial and ethnic disparities in access to behavioral health services. Black,
460 Indigenous, and People of Color (BIPOC) populations are more frequently placed in involuntary
461 treatment while having the least access to routine behavioral health care.[51] People who identify as being
462 two or more races (24.9 percent) are more likely to report any mental illness within the past year than
463 any other race/ethnic group, followed by American Indian/Alaska Natives (22.7 percent), White (19
464 percent), and Black (16.8 percent).[52] Among adults living with mental illness in 2021, White (52.4
465 percent) or Multiracial adults (52.2 percent) were more likely than Black (39.4 percent), Hispanic (36.1
466 percent), or Asian adults (25.4 percent) to have received any mental health services in the past year.[53]
467
468 Emergency departments exhibit similar disparities, with Black populations waiting longer for care. In jails
469 and prisons, recidivism is significantly more likely among Black populations living with serious mental

---

[46] Washington State Department of Social and Health Services, Behavioral Health Treatment Needs and Outcomes among Medicaid-Enrolled Children in Washington State, November 2023 [LINK]
[47] King County Behavioral Health Crisis Service Utilization Data Sheet, December 2023.
[48] The Crisis Resource Need Calculator [LINK]. The calculator estimates 230 monthly crisis episodes per population of 100,000, based on an analysis that examined national crisis care claims from Truven Commercial, Truven Medicaid, Medicare Limited Data Set 2018, as well as the estimated number of episodes served by first responders that do not lead to care according to the Treatment Advocacy Center's Road Runners report.
[49] American Psychiatric Association - Mental Health Disparities: Diverse Populations [LINK]
[50] Compton, M. T., & Shim, R. S., The Social Determinants of Mental Health, 2015, FOCUS, 13(4), 419–425. [LINK]; Fountain House, From Harm to Health: Centering Racial Equity and Lived Experience in Mental Health Crisis Response, 2021. [LINK]
[51] Shea T, Dotson S, Tyree G, Ogbu-Nwobodo L, Beck S, Shtasel D. Racial and Ethnic Inequities in Inpatient Psychiatric Civil Commitment. Psychiatr Serv. 2022 Dec 1;73(12):1322-1329. [LINK]
[52] American Psychiatric Association - Mental Health Disparities: Diverse Populations, 2017. [LINK]
[53] 2021 National Survey on Drug Use and Health (NSDUH) Annual National Report [LINK]

470 health conditions.[54,55] Nearly one quarter of people killed by police displayed signs of a mental illness,
471 with significantly higher rates among the Black population.[56] People who are involved in the criminal
472 legal system more broadly are also more likely to be living with mental health and substance use
473 conditions, yet they have less access to community behavioral health services.[57]
474
475 Within King County, individuals identifying as Black, African, or African American represented 20 percent
476 of people who received BHRD crisis services and 17 percent of people who died by overdose in 2022,
477 both of which are higher than the seven percent of people identifying as Black, African, or African
478 American in King County.[58,59] In contrast, people identifying as Asian or Asian American represented
479 nine percent of individuals receiving BHRD crisis services and 13 percent of people receiving routine
480 behavioral health care in 2022, both of which are lower than the 21 percent of people in the King
481 County population who identify as Asian or Asian American.[60]
482
483 Immigrants are at higher risk of experiencing mental health conditions, which is due to factors such as
484 higher acculturative stress, pre-migration experiences, discrimination, racism, economic hardship, and
485 stigmatization.[61] Access to care among immigrant populations is also limited, particularly in areas with
486 higher concentration of Latin American immigrants.[62] Similar trends have been observed in refugee
487 populations, with lack of access to mental health services despite higher rates of common mental health
488 conditions such as depression, anxiety, and post-traumatic stress disorder among migrants exposed to
489 adversity and refugees than among host populations.[63] Furthermore, language access has been shown
490 to impede access to mental health services. Among those who were likely to receive specialty mental
491 health services, people who preferred speaking Spanish had a significantly lower rate of mental health
492 care use.[64]
493
494 Among people identifying as lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, or
495 other sexual orientations or gender identities (LGBTQIA+), studies have shown that depression, anxiety,
496 and substance use are two and a half times higher than the general population.[65] Fear of discrimination
497 may lead to some people avoiding care due to common experiences of providers denying care, using

[54] Opoku ST, Apenteng BA, Akowuah EA, Bhuyan S. Disparities in Emergency Department Wait Time Among Patients with Mental Health and Substance-Related Disorders. J Behav Health Serv Res 2018;45(2):204–18. [LINK]
[55] Veeh CA, Tripodi SJ, Pettus-Davis C, Scheyett AM. The interaction of serious mental disorder and race on time to reincarceration. Am J Orthopsych 2018;88(2):125-31. [LINK]
[56] Saleh AZ, Appelbaum PS, Liu X, Scott Stroup T, Wall M. Deaths of people with mental illness during interactions with law enforcement. Int J Law Psychiatry. 2018 May-Jun;58:110-116. [LINK]
[57] Bonfine N, Wilson AB, Munetz MR. Meeting the Needs of Justice-Involved People With Serious Mental Illness Within Community Behavioral Health Systems. Psychiatr Serv. 2020 Apr 1;71(4):355-363. [LINK]
[58] King County Behavioral Health Crisis Service Utilization Data Sheet, December 2023.
[59] Public Health Seattle & King County - Overdose deaths data dashboard [LINK]
[60] King County Department of Community and Human Services - Data Dashboard [LINK]
[61] Markova V, Sandal GM, Pallesen S. Immigration, acculturation, and preferred help-seeking sources for depression: comparison of five ethnic groups. BMC Health Serv Res. 2020 Jul 11;20(1):648. [LINK]
[62] Jing F, Li Z, Qiao S, Ning H, Zhou S, Li X. Association between immigrant concentration and mental health service utilization in the United States over time: A geospatial big data analysis. Health Place. 2023 Sep;83:103055. [LINK]
[63] World Health Organization, "Mental health and forced displacement," 31 August 2021 [LINK]
[64] Byhoff E, Dinh DH, Lucas JA, Marino M, Heintzman J. Mental Health Care Use by Ethnicity and Preferred Language in a National Cohort of Community Health Center Patients. Psychiatr Serv. 2023 Oct 26. [LINK]
[65] Kates, J., Ranji, U., Beamesderfer, A., Salganicoff, A., & Dawson, L. (2016). Health and access to care and coverage for lesbian, gay, bisexual, and transgender individuals in the U.S. [LINK]

498 harsh language, or blaming the patient's sexual orientation or gender identity as the cause for an
499 illness.[66]
500
501 Of the approximately 36,000 people who have severe, chronic intellectual and developmental
502 disabilities (IDD) in King County, an estimated one third have a co-occurring mental health condition.[67]
503 However, in 2022 the Washington State Department of Social and Health Services reported that people
504 with IDD and their families have difficulty accessing behavioral health services due to a lack of resources,
505 communication barriers, and inadequate training among behavioral health providers.[68]
506
507 Access to behavioral health services is also limited among people experiencing homelessness. A recent
508 survey found that only 18 percent of people experiencing homelessness had received either mental
509 health counseling or medications in the prior 30 days despite 66 percent reporting current mental
510 health symptoms.[69] The same survey describes barriers such as lacking access to a phone, needing to
511 stay with belongings to prevent theft, and avoiding services due to past experiences of traumatic or
512 unsupportive interactions with health care providers.
513
514 Among U.S. military veterans who experience depression and PTSD, disparities in access to mental
515 health services have been described as a major factor contributing to the high suicide rates among
516 veterans.[70] People living in rural areas in the U.S. also experience significant disparities in mental health
517 outcomes despite having similar prevalence of mental illness to those living in metropolitan areas.[71]
518

519 Need for Places to Go in a Crisis

520 With so many people unable to access treatment when they need it, crisis care centers and similar
521 facilities can help. The Federal Substance Abuse and Mental Health Services Administration (SAMHSA)
522 released its National Guidelines for Behavioral Health Crisis Care in 2020.[72] These guidelines call for the
523 creation of crisis facilities, referred to by SAMHSA as "somewhere to go," for people in crisis to seek
524 help. SAMHSA's guidelines envision crisis facilities as part of a robust behavioral health crisis system that
525 also includes the 988 Suicide and Crisis Lifeline, referred to as "someone to call," and mobile crisis
526 teams, described as "someone to respond."[73]

---

[66] Kates, J., Ranji, U., Beamesderfer, A., Salganicoff, A., & Dawson, L. (2016). Health and access to care and coverage for lesbian, gay, bisexual, and transgender individuals in the U.S. [LINK]
[67] The Arc of King County – What is IDD? [LINK]
[68] Developmental Disabilities Administration, Washington State Department of Social and Health Services, Best practices for co-occurring conditions: Serving people with intellectual and developmental disabilities and mental health conditions, October 1, 2022. [LINK]
[69] Kushel, M., Moore, T., et al. (2023). Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness. UCSF Benioff Homelessness and Housing Initiative. [LINK]
[70] Hester RD. Lack of access to mental health services contributing to the high suicide rates among veterans. Int J Ment Health Syst. 2017 Aug 18;11:47. [LINK]
[71] Morales DA, Barksdale CL, Beckel-Mitchener AC. A call to action to address rural mental health disparities. J Clin Transl Sci. 2020 May 4;4(5):463-467. [LINK]
[72] Substance Abuse and Mental Health Services Administration. (2020). National Guidelines for Behavioral Health Crisis Care - Best Practice Toolkit. [LINK];
[73] Substance Abuse and Mental Health Services Administration. (2020). National Guidelines for Behavioral Health Crisis Care - Best Practice Toolkit. [LINK]; Substance Abuse and Mental Health Services Administration: National Guidelines for Child and Youth Behavioral Health Crisis Care. Publication No. PEP22-01-02-001 Rockville, MD: Substance Abuse and Mental Health Services Administration, 2022. [LINK]

527
528 King County's behavioral health crisis service system relies heavily on phone support and mobile
529 response, with very few options for people to go for immediate, life-saving care when in crisis. At the
530 time of this Plan's drafting, King County has just one behavioral health crisis facility, called the Crisis
531 Solutions Center (CSC) in Seattle.[74] With a limited capacity of 46 beds across two levels of care, this
532 facility is only able to accept referrals through mobile crisis teams, first responders, and hospitals. For
533 youth in King County, there is no crisis facility option at all.
534
535 With no specialty behavioral health setting in King County to walk in and receive care if a person is
536 experiencing a behavioral health crisis, the front door to crisis services at the time of this Plan's drafting
537 is typically hospital emergency departments, where people seeking help for a behavioral health crisis
538 may often spend hours or even days waiting for care.[75] People experiencing a crisis, especially those in
539 public spaces, are frequently engaged by law enforcement and may end up in jail if they have committed
540 a crime while in distress.[76]
541
542 The creation of specialized crisis facilities is frequently identified as a key strategy in the crisis service
543 continuum. These facilities enable diverting people from emergency department and carceral settings
544 and serving people in a higher quality specialized settings that can provide care using trauma-informed,
545 recovery oriented, and cultural humility best practices.[77, 78, 79] Multiple local behavioral health system
546 needs assessments have arrived at a similar conclusion. The 2016 recommendations of the King County
547 Community Alternatives to Boarding Task Force called for by Motion 14225 included a recommendation
548 to expand crisis diversion capacity.[80] Similar conclusions were reached in needs assessments by the
549 Washington State Office of Financial Management behavioral health capital funding prioritization and
550 feasibility study in 2018, a Washington State Health Care Authority crisis triage and stabilization capacity

[74] Downtown Emergency Services Center (DESC) - Crisis Solutions Center fact sheet [LINK]; the CSC was established in 2011 through a significant ongoing investment from the MIDD behavioral health sales tax fund. Medicaid funds also cover a small portion of the facility's service delivery costs. The Psychiatric Emergency Services program at Harborview Medical Center is part of a hospital-based emergency department and is therefore not considered a stand-alone dedicated behavioral health crisis service setting.

[75] Esmy Jimenez, "King County mental health facilities still reject a quarter of patients, report shows." The Seattle Times, September 5, 2023. [LINK]

[76] Garcia-Grossman I, Kaplan L, Valle K, Guzman D, Williams B, Kushel M. Factors Associated with Incarceration in Older Adults Experiencing Homelessness: Results from the HOPE HOME Study. J Gen Intern Med. 2022 Apr;37(5):1088-1096. [LINK]

[77] ME Balfour and ML Goldman, "Crisis and Emergency Services" in "Textbook of Community Psychiatry: American Association for Community Psychiatry, 2nd edition." Wesley E. Sowers (Editor), Hunter L. McQuistion (Editor), Jules M. Ranz (Editor). Springer 2022, pp. 369-384.

[78] ME Balfour and ML Goldman, "Collaborations Beyond the Emergency Department" in "Primer on Emergency Psychiatry" Tony Thrasher (Editor). Oxford University Press, 2023, pp. 463-478.

[79] Cultural humility is an approach to providing healthcare services in a way that respects a person's cultural identity. The use of this term is intended to align with the U.S. Department of Health and Human Services Office of Minority Health's definition of cultural humility [LINK]

[80] Community Alternatives to Boarding Task Force - King County, Washington [LINK]

551 and gaps report in 2019, and the Initial Assessment of the Behavioral Health Crisis Response and Suicide
552 Prevention Services from the Crisis Response Improvement Strategy (CRIS) Committee in 2021.[81,82,83]
553
554 Federal and state legislation have rapidly advanced the implementation of crisis services across the
555 United States.[84] Expanding access to crisis response services has been a recent focus of the Washington
556 Legislature. This includes its first-in-the-nation support of the implementation and expansion of 988 and
557 other crisis services, with its passage of Engrossed Second Substitute House Bill 1477 in 2021.[85]
558 Additional legislation, including Engrossed Second Substitute House Bill (E2SHB) 1134 in and Second
559 Substitute Senate Bill (2SSB) 5120 in 2023, have further demonstrated the state's commitment to these
560 services.[86,87] The 23-hour Crisis Relief Centers established under 2SSB 5120, which are undergoing
561 Washington State Department of Health and Health Care Authority rulemaking into 2024, will establish
562 important frameworks for licensure and Medicaid payment that will inform the future development of
563 crisis care centers.
564
565 In light of the behavioral health funding crisis, the scale of unmet need, and the opportunity presented
566 by this national and statewide momentum around expanding crisis services, a coalition of community
567 leaders and behavioral health providers issued recommendations to Seattle and King County in a letter
568 on October 13, 2021. The letter included recommendations to "expand places for people in crisis to
569 receive immediate support" and "expand crisis response and post-crisis follow up services."[88] The CCC
570 Levy carries these efforts forward, as outlined in this Plan.
571

572 Need for Post-Crisis Stabilization Services

573 Research studies show the rate of suicide is 15.4 times higher among people immediately after they
574 have been discharged from a psychiatric hospitalization, as compared to the general population.[89] For
575 people exiting inpatient psychiatric care, timely follow-up with outpatient mental health care is
576 associated with a decreased risk for hospital readmission, violence, homelessness, and criminal legal
577 system involvement.[90]
578

---

[81] 2018 Behavioral Health Capital Funding Prioritization and Feasibility Study [LINK];
[82] Crisis Stabilization Services - HCA Report to the Legislature [LINK]
[83] Crisis Response Improvement Strategy (CRIS) Committee - Initial Assessment of the Behavioral Health Crisis Response and Suicide Prevention Services in Washington and Preliminary Funding Recommendations [LINK]
[84] National Alliance for Mental Illness - Reimagine Crisis Response - 988 Crisis Response State Legislation Map [LINK]
[85] 2SSB 1477 (2021). 2SHB 1477's scope included RCW chapters 71.24, 48.43, 43.06, and 82.86. [LINK].
[86] E2SHB 1134 (2023). E2SHB 1134's scope included RCW chapters 71.24, 43.06, 82.86, 43.70, and 38.60. [LINK]
[87] 2SSB 5120 (2023) 2SSB 5120's scope included RCW chapters 71.05, 71.34, 71.24, 10.31, 10.77, and 48.43. [LINK]
[88] 2022 Priority Budget Recommendations to Seattle and King County to Strengthen Continuum of Behavioral Health Crisis Services. October 13, 2021.
[89] Olfson M, Wall M, Wang S, Crystal S, Liu SM, Gerhard T, Blanco C. Short-term Suicide Risk After Psychiatric Hospital Discharge. JAMA Psychiatry. 2016 Nov 1;73(11):1119-1126. [LINK]
[90] Smith TE, Corbeil T, Wall MM, Tang F, Essock SM, Frimpong E, Goldman ML, Mascayano F, Radigan M, Wang R, Rodgers I, Dixon LB, Olfson M, Lewis-Fernández R. Community, Hospital, and Patient Factors Contributing to Ethnoracial Disparities in Follow-Up After Psychiatric Hospitalization. Psychiatr Serv. 2023 Jul 1;74(7):684-694. [LINK]

579 Despite the benefits of follow-up during this high-risk post-crisis period, in 2021 only 58.7 percent of
580 people with Medicaid received follow-up within 30 days of discharge from a psychiatric hospitalization.[91]
581 Among youth and young adults, who visited the emergency room for a mental health reason, the rate is
582 even worse, with only 46.4 percent receiving follow-up care within 30 days.[92] Furthermore, Black
583 populations receive lower rates of outpatient treatment during the 30-day period after discharge
584 compared with White populations. [93]
585
586 SAMHSA considers post-crisis stabilization services to be an essential element of responding to a
587 behavioral health crisis and addressing the person's unmet needs.[94] Studies have shown that prior
588 outpatient engagement is the most important predictor of follow-up after hospitalization, which is
589 indicative of two key factors: the importance of reconnecting people back to prior providers, and the
590 need to dedicate additional resources to connect people to care when they are otherwise without
591 services.[95] Culturally appropriate interventions that link people to outpatient follow-up are also
592 identified as a strategy to reduce racial-ethnic disparities in outpatient mental health treatment
593 following acute treatment.[96]
594
595 A 2017 study of a post-discharge peer support program demonstrated positive outcomes for
596 participants in terms of recovery, wellbeing, and hospital avoidance.[97] The peer approach has been
597 taken up in Washington State through peer bridger programs, which HCA implemented as required by
598 Second Engrossed Substitute House Bill (2ESHB) 2376 from the 2016 Washington State legislative

[91] National Committee for Quality Assurance, HEDIS Measures and Technical Resources, Follow-Up After Hospitalization for Mental Illness [LINK]

[92] Hugunin J, Davis M, Larkin C, Baek J, Skehan B, Lapane KL. Established Outpatient Care and Follow-Up After Acute Psychiatric Service Use Among Youths and Young Adults. Psychiatr Serv. 2023 Jan 1;74(1):2-9. [LINK]

[93] Carson NJ, Vesper A, Chen CN, Lê Cook B. Quality of follow-up after hospitalization for mental illness among patients from racial-ethnic minority groups. Psychiatr Serv. 2014 Jul;65(7):888-96. [LINK]

[94] Substance Abuse and Mental Health Services Administration. (2020). National Guidelines for Behavioral Health Crisis Care - Best Practice Toolkit. [LINK]

[95] Smith TE, Haselden M, Corbeil T, Wall MM, Tang F, Essock SM, Frimpong E, Goldman ML, Mascayano F, Radigan M, Schneider M, Wang R, Rodgers I, Dixon LB, Olfson M. The Effectiveness of Discharge Planning for Psychiatric Inpatients With Varying Levels of Preadmission Engagement in Care. Psychiatr Serv. 2022 Feb 1;73(2):149-157. [LINK]

[96] Smith TE, Haselden M, Corbeil T, Wall MM, Tang F, Essock SM, Frimpong E, Goldman ML, Mascayano F, Radigan M, Schneider M, Wang R, Rodgers I, Dixon LB, Olfson M. The Effectiveness of Discharge Planning for Psychiatric Inpatients with Varying Levels of Preadmission Engagement in Care. Psychiatr Serv. 2022 Feb 1;73(2):149-157. [LINK]

[97] According to this study, "The program involved peer workers (individuals with their own lived experience of mental illness and recovery) providing individualized practical and emotional support to individuals for six to eight weeks following discharge from an inpatient psychiatric unit." This study found: "Participants reported improvements in terms of functional and clinical recovery and in the areas of intellectual, social and psychological wellness. Participants self-report of hospital readmissions suggested that there was a reduction in hospital bed days following engagement with the program." Scanlan JN, Hancock N, Honey A. Evaluation of a peer-delivered, transitional and post-discharge support program following psychiatric hospitalization. BMC Psychiatry. 2017 Aug 24;17(1):307. [LINK]

599 session.[98] Peer bridgers assist with community reintegration planning activities and promote service
600 continuity with the goal of enhancing long-term recovery and reducing hospital readmissions.[99]
601
602 The peer bridger program model is implemented locally in King County for adults who have been
603 hospitalized psychiatrically at two community hospitals. This model is composed of teams of certified
604 peer specialists (paid staff who have lived experience with behavioral health conditions themselves)
605 working in coordination with inpatient treatment teams to develop individualized plans to promote each
606 person's successful transition to the community.[100] However, these post-crisis services are only available
607 in a small number of settings. Most people exiting hospitals, emergency rooms, crisis settings, and other
608 acute behavioral health settings do not receive dedicated services to support these critical care
609 transitions during these high-risk periods.
610

611 Reduction in Residential Treatment Capacity

612 Residential treatment is a community based behavioral health treatment option for people who need a
613 higher level of care than outpatient behavioral health services can provide.[101] Residential treatment
614 programs provide people living with complex behavioral conditions with 24/7 intensive services in a
615 licensed residential treatment facility. These programs are important options for people being
616 discharged from inpatient behavioral health settings when outpatient services are not sufficient to meet
617 their treatment needs. Residential treatment programs help people continue to recover and stabilize in
618 a safe and supportive community-based setting.
619
620 Residential treatment programs provide services for people experiencing severe and persistent mental
621 illness to promote stability, community tenure, and movement toward the least restrictive community
622 housing option.[102] Programs provide residential stabilization and case management services that are
623 strengths-based and promote recovery and resiliency. Such services provide symptom relief to assist
624 clients to find what has been lost in their lives due to their illness, including the opportunity to make
625 friends, use natural supports, make choices about their care, find and maintain employment, and
626 develop personal strategies for coping and regaining independence.[103] Staff help clients to prepare for
627 discharge by providing services that promote community integration and assistance with the transition
628 to the least restrictive community housing option.[104]
629

---

[98] 2ESHB 2376 (2016). 2ESHB 2376's scope included RCW chapters 18.20, 18.43, 18.85, 19.02, 28B.122, 38.52, 41.06, 41.16, 41.26, 41.45, 41.80, 43.09, 43.10, 43.43, 43.79, 43.83B, 43.135, 43.155, 43.185, 43.350, 43.372, 46.08, 50.16, 50.24, 69.50, 70.128, 72.09, 77.12, 79A.80, 90.03, and 90.56 [LINK]

[99] Washington State Health Care Authority - Peer Bridger Program [LINK]

[100] King County Behavioral Health and Recovery Division (BHRD) Provider Manual For the King County Integrated Care Network (KCICN), Behavioral Health Administrative Services Organization (BH-ASO), and Locally-Funded Programs [LINK]

[101] Ordinance 19572 defines residential treatment as "a licensed, community-based facility that provides twenty-four-hour on-site care for persons with mental health conditions, substance use disorders, or both, in a residential setting" [LINK].

[102] "Community tenure" is defined as a person living with a behavioral health condition in a community-based (versus institutional) setting, connected and engaged with the community in which they live.

[103] "Natural supports" is defined as an individual's non-clinical sources of support, such as friends, family, neighbors, and other people in the community who can provide support to a person.

[104] BHRD Provider Manual, pages 119-123 [LINK]

630 Multiple mental health residential treatment facilities, which are a subset of residential treatment
631 facilities, have closed in recent years due to rising operating and maintenance costs, aging
632 infrastructure, and insufficient resources to repair facilities. The lack of resources to pay for capital
633 facility improvements and maintain aging buildings has contributed to facility closures.[105] As of October
634 2023, King County had a total of 240 mental health residential treatment beds for the entire county, a
635 decrease of 115 beds, down nearly one third from the capacity of 355 beds in 2018.[106] The impact of
636 reduced residential treatment facility capacity has impacted residential treatment wait times. For
637 example, King County residents who needed residential treatment services in October 2023 had to wait
638 an average of 25 days before they were admitted to a residential treatment facility.[107] The closing of
639 residential treatment facilities highlights a gap in King County's behavioral health continuum of care for
640 people exiting inpatient behavioral health settings.[108]
641

642 ## Behavioral Health Workforce Needs

643 It takes people to care for people, and King County is experiencing a behavioral health workforce
644 shortage that is impacting people's ability to access behavioral health care when they need it.[109] Similar
645 behavioral health workforce shortages are occurring across the United States, according to the Federal
646 Health Resources and Services Administration (HRSA).[110] By the final year of the CCC Levy in 2032, HRSA
647 projects the national behavioral health workforce will only have 69 percent of the number of mental
648 health counselors, 62 percent of the number of substance use disorder counselors, 73 percent of the
649 number of psychologists, and 54 percent of the number of psychiatrists that are needed to meet the
650 demand for behavioral health care nationally. [111]
651

652 Within King County, a 2021 survey of community behavioral health agencies contracted with the KCICN
653 identified that job vacancies at surveyed agencies were at least double what they were in 2019.[112] The
654 survey also found that master-level licensed mental health clinicians are particularly difficult to
655 recruit.[113] A October 2023 survey of community behavioral health agencies contracted with the KCICN
656 found that there are approximately 600 staff vacancies across the agencies that responded to the
657 survey.[114] This represents a 16 percent total vacancy rate at King County community behavioral health
658 agencies, and there is still a need to hire more behavioral health workers to support the growing
659 behavioral health care needs in the community.[115]

---

[105] Furfaro, Hannah. "Where did King County's mental health beds go?" Seattle Times, February 25, 2023. [LINK]

[106] An additional four mental health residential beds have been lost since the passage of King County Ordinance 19572. BHRD monitors the number of available beds through a bed tracker list.

[107] Executive Dow Constantine. "King County and State acquire behavioral health treatment center in North Seattle, preserving sixty-four treatment beds." September 14, 2022. [LINK] Note: At the time the article was written, the wait for a bed in King County was 44 days. As of October 2023, the waitlist has decreased from 44 days to 25 days since the passage of King County Ordinance 19572. BHRD monitors the waitlist through a bed tracker list.

[108] Sydney Brownstone, "A Belltown residential treatment facility shutters, leaving a hole in King County's mental health system," The Seattle Times, October 11, 2020. [LINK]

[109] King County Community Behavioral Health Provider Survey, 2023.

[110] Health Resources & Services Administration, Behavioral Health Workforce Projections [LINK]

[111] Health Resources & Services Administration, Behavioral Health Workforce Projections [LINK]

[112] KCICN Workforce Survey 2021

[113] KCICN Workforce Survey 2021

[114] KCICN Workforce Survey Data 2023

[115] KCICN Workforce Survey Data 2023

660
661 In addition to staff vacancies, workforce retention is also a challenge for behavioral health providers. A
662 February 2023 poll of members of three labor unions representing health care workers in Washington
663 State, including behavioral health workers, found that 80 percent of health care workers reported
664 feeling burned out by their jobs and 49 percent of workers reported they are likely to leave health care
665 in the next few years. [116] Rising housing and childcare costs are contributing to workers leaving the
666 behavioral health workforce.[117] In addition to high cost of living expenses, behavioral health workers
667 often have student loan debt. For example, a National Council on Social Work Education report found
668 that 73 percent of baccalaureate social work graduates and 76 percent of master's graduates have
669 student loan debt.[118] When community behavioral health agencies are not able to offer competitive
670 wages and benefits, it is more challenging to recruit and retain employees, which contributes to
671 chronically high vacancies and high turnover of staff.[119,120] The KCICN's 2021 survey of King County
672 community behavioral health agencies reinforced this dynamic. Survey respondents identified monetary
673 incentives, loan repayments, professional fees and continuing education assistance, and employee
674 wellbeing, as being impactful activities that could help retain workers.[121]
675
676 Increasing the representativeness of behavioral health workers is a critical component of strengthening
677 King County's community behavioral health workforce.[122] Nationally, the behavioral health workforce
678 does not reflect the demographics and identities of people receiving behavioral health services.[123, 124]
679 There is evidence that improving diversity among behavioral health workers so that workers better
680 reflect the community they serve may help reduce behavioral health disparities.[125] For example,
681 communication and trust is improved between behavioral health workers and people receiving services
682 when there is cultural, linguistic, racial, or ethnic concordance between clinicians and clients.[126]

---

[116] 2023 poll of health care workers represented by SEIU Healthcare 1199NW, UFCW 3000, and WSNA conducted by GBAO [LINK]
[117] 2023 King County Nonprofit Wage and Benefits Survey Report [LINK]
[118] Student Loan Debt Relief for Social Workers [LINK]
[119] Washington State Employment Security Department Supply and Demand Report [LINK]
[120] 2022 Behavioral Health Workforce Assessment [LINK]
[121] KCICN Workforce Survey 2021
[122] A focus of the Plan is to increase accessibility of behavioral health services, including crisis services funded by the CCC Levy, for all King County residents, including populations who experience behavioral health inequities. A consistent theme of community engagement was the importance for people seeking care of culturally and linguistically congruent services, staff with lived experience of behavioral health crises, and demographic representativeness. Establishing a workforce that is representative of King County's population, with particular care to representativeness for populations experiencing behavioral health inequities (see Section III.C. Background: Who Experiences Behavioral Health Inequities), will ensure that more King County residents can choose to receive care from a provider with whom they are comfortable and is one of this Plan's strategies to ensure that all King County residents have meaningful access to CCC Levy-funded facilities and services.
[123] National Academy for State Health Policy State, Strategies to Increase Diversity in the Behavioral Health Workforce [LINK]
[124] Duffy FF, West JC, Wilk J, et al. Mental health practitioners and trainees. In RW Manderschield & MJ Henderson (Eds.), Mental health, United States, 2002 (pp. 327-368; DHHS Publication No. SMA 04-3938). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2004
[125] Chao, P.J., Steffen, J.J., and Heiby, E.M. (2012). The effects of working alliance and client-clinician ethnic match on recovery status. *Community Mental Health Journal* (48), 91-97 [LINK]
[126] The Mental Health Needs and Statistics of the BIPOC Community [LINK]

683 Developing a representative community behavioral health workforce will require intentional training,
684 recruitment, and retention strategies. For example, BIPOC and LGBTQIA+ clinicians are often impacted
685 by a lack of congruent mentorship in higher education, experiences of racism and discrimination.[127]
686
687 At a time when nearly one in five Americans lives with a mental health condition, and more people than
688 ever are interested in seeking behavioral health support, the lack of access to diverse and qualified
689 behavioral health professionals can serve as a barrier for accessing treatment to people and
690 communities across the country and within King County.[128] Creative, local workforce investments are
691 needed to complement Medicaid and state funds to provide for a stable workforce to deliver the high-
692 quality community based behavioral health care that King County residents need and deserve.
693

694 D. Implementation Plan Methodology

695 On April 25, 2023, King County voters approved Proposition No. 1, as called for by Ordinance 19572, to
696 adopt the CCC Levy. Ordinance 19572 requires a CCC Levy Implementation Plan (Plan) be developed and
697 transmitted by the King County Executive to King County Council by the end of December 2023. The
698 Plan's requirements are set out in Ordinance 19572, and Appendix B: Crosswalk of Implementation Plan
699 Requirements from King County Ordinance 19572 describes how this Plan meets these requirements.
700
701 This Plan is the product of an intensive process that began in June 2023 and concluded in December
702 2023. Community engagement was a focus of implementation planning activities and is described in
703 detail in Section III.E. Community Engagement Summary. Planning activities by DCHS also included
704 solicitation of formal requests for information (RFIs), engagement with various Washington State
705 departments, consultation with national subject matter experts, coordination with other County
706 partners, and convenings of internal workgroups within DCHS. These activities are described below and
707 in this Plan's appendices.
708

709 Crisis Care Center Methodology

710 DCHS focused on four major areas to develop strategies in support of the CCC Levy's Paramount Purpose
711 to create a network of five crisis care centers:

712 • Understanding and describing current community needs, service capacity, and system gaps
713 related to behavioral health care (as described in Section III.C. Key Historical and Current
714 Conditions: Unmet Behavioral Health Service Needs);
715 • Developing an approach to integrate substance use treatment services within the crisis care
716 center model;
717 • Defining the related but distinct youth-focused crisis care center model, which addresses the
718 unique needs of children and adolescents, and
719 • Integrating planning for the crisis care centers within regional contexts such as the existing
720 behavioral health crisis system, the behavioral health service continuum more broadly (as
721 described above in Section III.C. Key Historical and Current Conditions), criminal legal systems,
722 health and hospital systems, and additional community resources.
723

[127] Hubbard A, Sudler A, Alves-Bradford JME, Trinh NH, Emmerich AD, Mangurian C. Building a Diverse Psychiatric Workforce for the Future and Helping Them Thrive: Recommendations for Psychiatry Training Directors. Psychiatric Clinics of North America. 2022;45(2):283-295. doi:10.1016/j.psc.2022.03.007

[128] Lack of Access as Root Cause for Mental Health Crisis in America [LINK]

724 DCHS also undertook an in-depth process to establish procurement and siting processes for crisis care
725 centers. DCHS issued an RFI for the capital facility siting process to local jurisdictions, and a copy of the
726 RFI is included in Appendix C: King County Local Jurisdiction Request for Information (RFI).
727
728 Meetings with jurisdictions, behavioral health agencies, and other community partners were held for
729 DCHS to share updates on the CCC Levy planning process with interested parties and to learn about
730 provider, jurisdictional, and community partner needs and challenges. DCHS convened meetings with:

731 • Subject matter experts internal to King County government, such as the Department of Natural
732 Resources and Parks, DCHS, Metro, and Public Health – Seattle & King County (see Appendix D:
733 Coordination with State and County Partners for a list of County partners);
734 • Washington state partners, such as the Health Care Authority, the Department of Health, and
735 the Department of Social and Human Services (see Appendix D: Coordination with State and
736 County Partners for a list of meeting topics); and
737 • Community partners, such as community members, people with lived experience of behavioral
738 health conditions, as well as their families and support systems, community-based
739 organizations, community behavioral health agencies, and others (see Appendix F: Community
740 Engagement Activities for details).
741
742 The DCHS planning team also made site visits to adult and youth crisis facilities in Washington, as well as
743 California and Arizona (see Appendix E: Site and Field Visits). ZiaPartners, a firm with experience
744 planning and implementing local and statewide behavioral health crisis system initiatives, consulted on
745 crisis care center program model development and strategies for crisis system coordination and quality
746 improvement.[129]
747

748 Residential Treatment Methodology

749 Community partner engagement, subject matter expert consultation, and residential treatment
750 operator engagement informed the residential treatment recommendations in this Plan. DCHS BHRD
751 clinical staff with mental health residential subject matter expertise participated in an internal
752 workgroup to provide guidance on preserving and expanding residential treatment capacity. DCHS
753 planning staff met with leadership and frontline workers of agencies operating residential treatment
754 facilities to solicit feedback about residential treatment gaps and how to sustain and increase residential
755 treatment capacity. This included seven site visits to residential treatment facilities in King County,
756 which are listed in Appendix E: Site and Field Visits. It also included an RFI soliciting information from
757 operators about residential treatment facility capital improvement funding needs. The RFI is included in
758 Appendix H: BHRD Capital Improvement Funding for Behavioral Health Facilities Request for Information
759 (RFI). Additionally, residential treatment topics were included in CCC Levy implementation planning
760 community engagement meetings and presentations to solicit feedback from a broader group of
761 community partners beyond the residential treatment sector. Community engagement is highlighted
762 below, and a list of community engagement activities is included in Appendix F: Community Engagement
763 Activities.
764

[129] ZiaPartners, Inc. [LINK]

765 ### Workforce Methodology
766 DCHS planning staff solicited feedback on how the CCC Levy can build, retain, and increase the
767 representativeness of the community behavioral health workforce.[130] Engagement on workforce issues
768 included focus groups with community members and focus groups with subject matter experts;
769 informational interviews with key personnel in community behavioral health agencies; and site visits in
770 San Diego, Arizona and Washington state. DCHS also engaged the University of Washington, Public
771 Health-Seattle and King County, and health care workforce training and apprenticeship programs to
772 inform strategy design. (See Appendix F: Community Engagement Activities for list of key informant
773 interviews and individual engagement meetings.) Community partner meetings included union-
774 represented and non-union represented provider staff.
775
776 ## E. Community Engagement Summary
777 DCHS staff engaged community partners to inform this Plan, including participation from behavioral
778 health agencies, people with lived experiences of behavioral health crises, and frontline behavioral
779 health workers. See Appendix F: Community Engagement Activities for a complete list of community
780 engagement activities. Engagement activities are summarized in Figure 5. In addition to informing the
781 strategies in this Plan, DCHS plans to take the community feedback into account during future
782 procurement and operational phases of the CCC Levy.
783

[130] A focus of the Plan is to increase accessibility of behavioral health services, including crisis services funded by the CCC Levy, for all King County residents, including populations who experience behavioral health inequities. A consistent theme of community engagement conversations was the importance for people seeking care of culturally and linguistically congruent services, staff with lived experience of behavioral health crises, and demographic representativeness. Establishing a workforce that is representative of King County's population, with particular care to representativeness for populations experiencing behavioral health inequities (see Section III.C. Who Experiences Behavioral Health Inequities), will ensure that more King County residents can choose to receive care from a provider with whom they are comfortable and is one of this Plan's strategies to ensure that all King County residents have meaningful access to CCC Levy-funded facilities and services.

784 *Figure 5. Summary of Community Engagement Activities Conducted by DCHS Between June and*
785 *November 2023*

786
787

788 ## Key Findings of Community Engagement Process

789 This section summarizes community input from implementation planning activities, with supporting
790 details provided in the appendices as noted. DCHS organized community feedback into key themes that
791 informed this Plan. Figure 6 summarizes these key themes, with a more detailed description of each
792 theme below the table.
793

794 *Figure 6. Summary of Community Engagement Themes*

Summary of Community Engagement Themes	
Theme	**Description**
Theme A: Implement Clinical Best Practices in Crisis Services	Input on how best to design a crisis care center clinical model most likely to improve the health and wellbeing of people experiencing a behavioral health crisis in King County, including a welcoming and safe environment, person-centered and recovery-oriented care, culturally and linguistically appropriate services, integrated care for people who use substances, promoting least restrictive care, special considerations for serving youth and young adults, and additional clinical considerations.

Theme B: Increase Access to Care for Populations Experiencing Behavioral Health Inequities	Communities voiced the importance of having crisis care centers in desirable locations that are geographically accessible and accessible to transportation, as well as the importance of reaching out to diverse communities.
Theme C: Challenges of Community Resource Limitations	Community partners, including people with lived experience and behavioral health providers, frequently raised important questions about access to ongoing community-based care after a person receives care at a crisis care center as well as emphasizing care coordination and peer engagement.
Theme D: Interim Solutions While Awaiting Crisis Care Centers	Community members advocated for interim solutions to be implemented while awaiting crisis care centers to come online, such as increasing community-based responses and approaches to addressing the overdose crisis.
Theme E: Residential Treatment Facility Preservation and Expansion	Residential treatment providers described the value of residential treatment but identified significant challenges such as a lack of capital resources, and excessive wait times.
Theme F: Behavioral Health Workforce Development	Feedback from community partners, as well as subject matter experts, identified significant obstacles to developing the behavioral health workforce, including low wages, barriers to retention, need for more professional development opportunities, staff burnout, limited collaboration with schools, and lack of workforce representation.
Theme G: Accountability Mechanisms and Ongoing Community Engagement	Community partners expressed a strong preference to continue to be involved in future phases of the CCC Levy, particularly around holding the County accountable, including through defining measures of success and by continuing to engage during future planning phases.

795

796 *Theme A: Implement Clinical Best Practices in Crisis Services*

797 Community partners offered substantial input on the following topics, all focused on how to design a
798 crisis care center clinical model that works as well as possible. These recommendations are reflected in
799 the best practices described in Appendix G: Clinical Best Practices in Behavioral Health Crisis Services
800 that inform the crisis services described in Section V.A. Strategy 1: Create and Operate Five Crisis Care
801 Centers.

802

803 Welcoming and Safe

804 Community members emphasized that people from their communities would only come to crisis
805 care centers if they were confident that they would be helped and not harmed during a crisis.
806 Community members defined safety differently: some people described feeling unsafe around
807 uniformed officers, while others said they prefer or even expect a uniformed officer to be
808 present to feel safe. Some people shared experiences of feeling trapped and unsafe in a locked
809 unit, while others said they would feel safer being in a secured environment. Many described
810 the importance of a comfortable physical space, but that it would be unacceptable to create a
811 superficially attractive space without having a welcoming and safe program to reinforce it.

812

813 ### Person-Centered and Recovery-Oriented Care

814 Community partners described the importance of ensuring that crisis care centers provide
815 person-centered and recovery-oriented care.[131,132] Peer specialists and people with lived
816 experience of a behavioral health conditions emphasized the importance of keeping people in
817 control of their care as much as possible. They also emphasized minimizing care transitions,
818 maximizing continuity of care, and following up after discharge to start ongoing care.
819
820 ### Culturally and Linguistically Appropriate Services

821 Community partners advocated for ensuring that crisis care centers provide culturally and
822 linguistically appropriate services. Such services combine typical clinical best practices with
823 specially trained, often culturally concordant providers who incorporate cultural practices and
824 shared experience into the treatment and relationship with clients.[133] This Plan incorporates this
825 input in:

826 - Section V.A. A. Strategy 1: Create and Operate Five Crisis Care Centers: Clinical Program
827 Overview, which defines the crisis care center clinical model and post-crisis stabilization
828 resources;
829 - Section V. E. Strategy 5: Capacity Building and Technical Assistance: Capacity Building for
830 Providers with Expertise in Culturally and Linguistically Appropriate Services, which will
831 invest in capacity building for crisis care centers operators to further enhance their
832 capacity to deliver culturally and linguistically appropriate services, and
833 - Section VII.A. Evaluation and Performance Measurement Principles, which will measure
834 how well crisis care centers are meeting these needs to hold DCHS accountable for
835 implementing and improving upon culturally and linguistically appropriate services.
836
837 ### Integrate Care for People Who Use Substances

838 Community members identified substance use services as an essential resource to include in
839 crisis care centers because so many people in a mental health crisis have co-occurring substance
840 use or their crisis is primarily related to substance use.[134] Service provider partners emphasized
841 that the model should include medication for opioid use disorder (MOUD), withdrawal
842 management (sometimes referred to as "detox"), substance use counseling, distribution of
843 overdose prevention supplies like naloxone, and testing for HIV and Hepatitis C.
844

[131] According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "person-centered care—also known as patient-centered care—means consumers have control over their services, including the amount, duration, and scope of services, as well as choice of providers. Person-centered care also is respectful and responsive to the cultural, linguistic, and other social and environmental needs of the individual. Family-centered care recognizes the important role of family members and caregivers in the design and implementation of services." [LINK]

[132] SAMHSA's working definition of "recovery-oriented care" defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery signals a dramatic shift in the expectation for positive outcomes for individuals who experience mental and substance use conditions or the co-occurring of the two. [LINK]

[133] National Culturally and Linguistically Appropriate Services (CLAS) Standards. Think Cultural Health, U.S. Department of Health & Human Services [LINK]

[134] Group for the Advancement of Psychiatry. (2021). Roadmap to the Ideal Crisis System: Essential Elements. Measurable Standards and Best Practices for Behavioral Health Crisis Response. National Council for Mental Wellbeing [LINK]

845 ### Least Restrictive Care
846 Community partners, especially peer specialists and people with lived experience of a behavioral
847 health condition, frequently voiced a preference for crisis care center services to be voluntary as
848 much as possible. Some community partners acknowledged that state regulations, as well as
849 rare uncontrollable circumstances, such as when someone is refusing help even when their life
850 is in danger, might require involuntary interventions such as detention by a law enforcement
851 officer, placement of Involuntary Treatment Act (ITA) holds by a designated crisis responder
852 (DCR), involuntary medications, seclusions, and restraints.[135] Most community partners agreed
853 that involuntary interventions should be minimized by proactively engaging someone in
854 treatment decisions whenever possible in the least restrictive setting. Furthermore, community
855 partners expressed consensus that use of involuntary interventions should be a focus of
856 monitoring and accountability for crisis care centers.
857
858 ### Special Considerations for Serving Children, Youth, and Young Adults in Crisis
859 Youth, parents, and providers serving youth clearly stated that behavioral health services for
860 youth differ from adult services in many important ways, and that these differences need to be
861 reflected in the youth crisis care center model. Youth behavioral health service providers
862 explained that adolescents' needs differ from the needs of young children (up to approximately
863 age 12), and very young children (up to age 6) and have their own special needs during a
864 behavioral health crisis. Multiple community partners, including youth, also emphasized the
865 unique needs of transition age youth (ages 18-24), also known as young adults, who may not be
866 well served in a combined crisis care center setting with more mature adults.[136] The needs of
867 families, caregivers, and unaccompanied youth also emerged as important factors. Community
868 members also described the high likelihood that young people with intellectual and
869 developmental disabilities (IDD) will present to crisis care centers. They emphasized the
870 importance of having staff who are specially trained to meet these unique needs. These
871 recommendations were critical to informing the clinical model for the youth crisis care center
872 described in Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers: Clinical Model
873 for Youth Crisis Care Center.
874
875 ### Additional Clinical and Support Considerations
876 Community members discussed the importance of childcare for parents in a behavioral health
877 crisis, care for pets, safe storage of belongings, nutrition and meal services, full-scope
878 medication formulary, basic laboratory testing, and transportation. Though many of these
879 recommendations are beyond the strategic scope of this Plan, DCHS will take this community
880 feedback into account for future procurement and operational phases of crisis care center
881 services.

---

[135] King County Crisis and Commitment Services offers evaluation of people with behavioral health disorders for involuntary detention in psychiatric and secure withdrawal facilities according to Washington law. The law for adults is RCW 71.05. [LINK] For youth 13 through 17 years of age the law is RCW 71.34. [LINK] Crisis and Commitment staff who perform these duties are referred to as Designated Crisis Responders (DCRs). They are mental health professionals who are specially trained to conduct a holistic investigation of risk and to treat the person in need with dignity and respect during their time of Crisis. Crisis and Commitment Services are available 24 hours a day, 365 days a year. [LINK]

[136] "Young adult," also known as "transition age youth" means a person between eighteen and twenty-four years of age, per RCW 43.330.702 – Homeless youth—Definitions. [LINK]

882
883 *Theme B: Increase Access to Care for Populations Experiencing Behavioral Health Inequities*
884 Communities repeatedly voiced an absence of suitable or equitable care access points for when
885 someone is in a behavioral health crisis. The service gaps described previously in Section III.C. Need for
886 Places to Go in a Crisis have real impacts on communities. Community partners reported that existing
887 conditions of limited access to real-time behavioral health crisis services leave people suffering without
888 the care they need and at high risk of their crisis becoming significantly worse. Community members
889 identified that this pattern is particularly prominent among Black, Indigenous, and People of Color
890 (BIPOC) communities.
891
892 Desirable Location Attributes
893 Community members, especially people living in rural areas, shared that a critical need is for
894 facilities to be located in places that are easy to access and close to multiple forms of
895 transportation. Geographic and transportation accessibility are critical both for people who seek
896 services themselves as well as for people who are dropped off by first responders. Community
897 members also identified that County-funded transportation should be flexible with reduced
898 barriers such as having costs covered, so that people can come to crisis care centers with
899 confidence that they'll be able to get back to places such as their home or an appropriate clinical
900 care setting. This input informed the capital facility siting requirements described in Section V.A.
901 Strategy 1: Create and Operate Five Crisis Care Centers: Crisis Care Center Capital Facility
902 Development.
903
904 Community Outreach among Populations Experiencing Behavioral Health Inequities
905 Community partners urged the County to promote the launch of crisis care centers. They said
906 that the County should emphasize conducting outreach about the opening of crisis care centers
907 to promote awareness within populations that experience behavioral health inequities (see
908 Section III.C. Who Experiences Behavioral Health Inequities). Community members advocated
909 for an advertising effort to increase awareness about these new resources, particularly in
910 communities that have historically been marginalized and/or under-served. They also cautioned
911 that word of mouth will be powerful, with the possibility of community members either avoiding
912 services based on negative reports, or greater utilization based on positive experiences. Section
913 V.G. Strategy 7: Crisis Care Centers Levy Administration: Community Engagement includes
914 funding of ongoing community engagement to increase awareness of crisis care center services
915 and associated resources across communities in King County. The goal of this public education
916 work is to increase access to care for populations experiencing behavioral health inequities. To
917 promote equitable access to crisis care centers, there will be a requirement for crisis care center
918 operators to assess the potential equity impacts of their proposed facility as described in Section
919 V.A. Strategy 1: Create and Operate Five Crisis Care Centers: Crisis Care Center Capital Facility
920 Development describing the capital facility siting process.
921
922 *Theme C: Challenges of Community Resource Limitations*
923 Though the CCC Levy is primarily focused on creating capacity for a front door to care, community
924 partners raised important questions about the back door to ongoing community-based services after a
925 person leaves a crisis care center.
926

Need to Build a "Bridge to Somewhere"

People with lived experience and behavioral health providers shared the viewpoint that the period immediately following a crisis episode is a high-risk period for negative outcomes, and that it is important to create pathways so that a crisis service is not a "bridge to nowhere," but instead can link a person to resources to continue to recover, such as primary care services, behavioral health services, social services, and housing resources. Providers with experience operating acute care facilities shared concerns about how limitations of housing resources and outpatient behavioral health services can cause bottlenecks that make it difficult to discharge people from crisis settings, which in turn can impact facility capacity. Community partners also expressed concerns that crisis services that do not bridge to other supports could risk cycling people through crisis systems in a way that is just as problematic as emergency or jail settings. Community members and providers alike advocated to increase access to resources for people in the immediate aftermath of a crisis episode, including access to housing resources. This Plan describes post-crisis stabilization resources in Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers: Post-Crisis Stabilization Activities that were directly informed by this community feedback.

Care Coordination and Peer Engagement

In the aftermath of a behavioral health crisis, people may need to be connected to a range of health and social services such as outpatient care, primary care, housing resources, and public benefits enrollment. However, many barriers exist to successfully connecting with these resources. Community partners described barriers such as distrust of providers, concerns about cost of services, difficulties with transportation and making appointments (especially for those experiencing homelessness or housing instability), and stigma. Providers also described fragmented health records systems that prevent information sharing necessary to transition a person's care, including when trying to re-connect someone with an existing provider. Among the peer-run organizations that participated in the CCC Levy planning process, one solution that was voiced often was the value of peer navigators and peer bridgers who can support people who were recently in crisis to access the resources they need. The post-crisis follow-up program described in Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers: Post-Crisis Stabilization Activities, as well as the care coordination infrastructure investments in Section V.G. Strategy 7: Crisis Care Centers Levy Administration: Develop Data Systems Infrastructure and Technology, both aim to address these needs.

Theme D: Interim Solutions While Awaiting Crisis Care Centers

Throughout the implementation planning process, there was a clear sense of urgency among community partners to invest in resources that can serve people as quickly as possible. Since it can take a long time for facilities to be constructed and initiate operations, community members advocated for expedited resources to be implemented while awaiting crisis care centers to come online.

Importance of Community-Based Response

Some community members, especially parents of young people who had been in crisis, advocated for expanding community-based response resources, such as mobile crisis services. Though crisis facilities may present a front door to care that is not widely available at the time of this Plan's drafting, many people shared during community meetings that they would prefer to be served in their own environment by an outreach or mobile crisis team. Section V.D. Strategy 4: Early Crisis Response Investments: Increase Community-Based Crisis Response Capacity

describes ways that DCHS aims to respond to this community feedback by investing in an expansion of community-based crisis services beginning in 2024.

Urgency of the Opioid Overdose Crisis

Another matter of urgency that community members frequently mentioned during engagement was the opioid overdose crisis. Though there is access to some substance use services and harm reduction approaches, particularly in downtown Seattle, many community members expressed ongoing concern about lack of access to essential resources such as the opioid overdose reversal medication naloxone. An early crisis response investment in Section V.D. Strategy 4: Early Crisis Response Investments: Reduce Fatal Opioid Overdoses by Expanding Low Barrier Opioid Reversal Medication would aim to reduce overdoses beginning in 2024.

Theme E: Residential Treatment Facility Preservation and Expansion

To understand the needs of the residential treatment sector, the CCC Levy planning team engaged in a series of conversations with residential treatment facility operators. These included key personnel informational interviews with leadership and front-line workers and onsite visits to facilities. See Appendix E: Site and Field Visits for a complete list of residential treatment facility site visits. Throughout this engagement, conversations centered around understanding the needs of residential treatment facilities for both adult and youth populations, with an emphasis on the loss of facilities in recent years and the resources needed to preserve existing facilities and to add more. Additionally, operators shared insights regarding the value of providing residential treatment services and impact that facility closures have had on the County's overall behavioral health system.

Residential treatment facility operators shared their challenges operating residential facilities, including historic underinvestment in residential treatment facility capital and maintenance funding. For example, aging facilities require ongoing and often increasing maintenance expenses. Due to inflation and rising costs, operators shared that they do not have enough funding to pay for maintenance and other repairs. Operators expressed that with additional funding, they would be able to address building maintenance to make necessary repairs to facilities. This includes renovations to address health and safety issues, facility improvements such as HVAC repairs, renovations to community spaces, and facility expansion.

Residential treatment facility operator feedback helped to define the allowable activities that are described in Section V.B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity. Activities include both preservation of existing residential treatment facilities and expansion of residential treatment facilities.

Some feedback themes shared by community partners during engagement activities related to residential treatment services, including input about clinical care needs, are not addressed in this Plan because they fall outside of the scope of services that the CCC Levy is designed to address. This feedback will help inform future DCHS quality improvement activities outside of the CCC Levy.

Theme F: Behavioral Health Workforce Development

Community engagement related to behavioral health workforce needs included both systemwide community behavioral health workforce issues and needs specific to the crisis care center workforce. DCHS gathered input from subject matter expert groups, listening sessions, and community engagement events. Feedback highlighted the workforce shortage as a key factor in the success of the crisis care centers. Community members stressed the importance of providing culturally congruent care by having

1021 a workforce reflective of the communities that workforce will serve. Direct line workers provided
1022 feedback regarding workforce challenges such as low wages, lack of opportunities for career
1023 advancement, and burnout. These themes are described in greater detail below and reflected in the
1024 design of Section V.C. Strategy 3: Strengthen the Community Behavioral Health Workforce.
1025

1026 #### Low Wages

1027 Community partners identified that strengthening the behavioral health workforce is important
1028 in increasing behavioral health service access. Behavioral health agencies shared they struggle
1029 to provide care because workers are not entering the behavioral health workforce due to low
1030 wages. Front line workers shared that low wages impact their quality of life, including
1031 preventing workers from being able to afford to live in the communities where they work.
1032 Workers shared that when they are unable to live in the same communities where they work,
1033 they often experience long commutes, which in turn contributes to job dissatisfaction and the
1034 decision to seek employment in jobs that pay a higher wage or are located closer to home.
1035 Workers also identified that low wages are also a constant challenge for people who need to pay
1036 for childcare or family care expenses.
1037

1038 #### Barriers to Entering the Behavioral Health Workforce

1039 Higher education is often a requirement for positions within the behavioral health workforce.
1040 Community partners shared that this is often a barrier for people to enter the behavioral health
1041 workforce, especially for populations that have been disproportionally marginalized and have
1042 faced barriers to accessing higher education. Community members identified activities such as
1043 loan repayment, tuition assistance, assistance with professional licensure fees, and stipends for
1044 books and other supplies as examples of activities that reduce barriers for people to enter and
1045 remain in the behavioral health workforce.
1046

1047 #### Worker Retention and Professional Development

1048 Front line behavioral health workers shared their experiences with work burnout and how it
1049 impacts their longevity in the community behavioral health field. Workers shared they
1050 sometimes experience burnout in their roles, don’t have skills to move into a different role, and
1051 don’t have the resources to access professional development and training to advance their
1052 careers. Workers shared that professional development opportunities, more robust clinical
1053 supervision, and additional support at work would help them feel valued and would help them
1054 grow professionally.
1055

1056 #### Limited Collaboration Between Community Behavioral Health and Schools

1057 During listening sessions, front line behavioral health workers shared feedback about their
1058 professional pathway entering community behavioral health. Workers expressed concerns
1059 about the lack of formal career pathways between schools that train behavioral health
1060 professionals and community behavioral health agencies. Additionally, clinical supervisors
1061 shared the need to increase awareness among students and workers about the various
1062 behavioral health career opportunities and pathways available within community behavioral
1063 health agencies.
1064

1065 #### Importance of Workforce Representation

1066 Community members participating in engagement activities shared that a more diverse
1067 behavioral health workforce is needed, for both future crisis care centers and existing

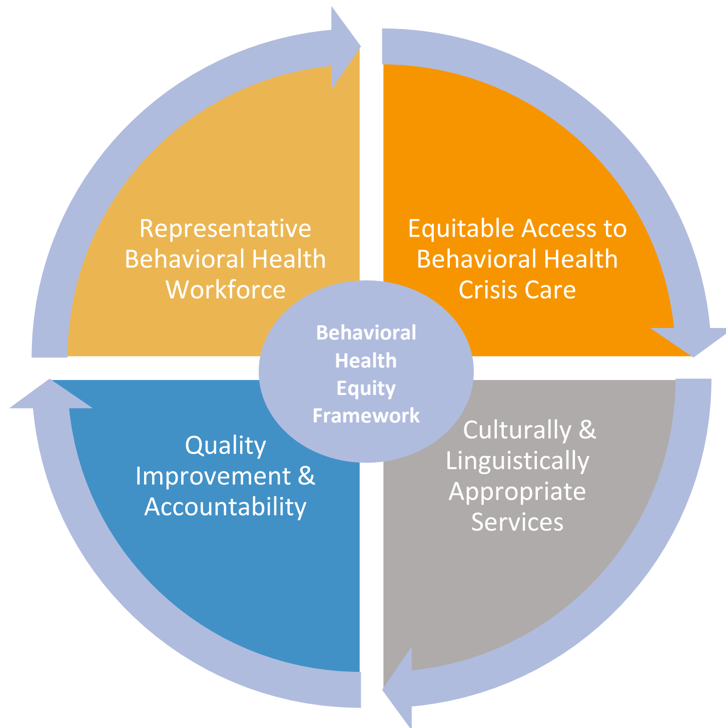
1068 community behavioral health agencies. During focus groups, community members stated that
1069 when someone is seeking care, a behavioral health professional with similar lived experiences
1070 helps to increase the level of comfort for the person accessing care. Community members also
1071 shared that a more representative workforce, at both the frontline and leadership levels, can
1072 influence practices and conditions within behavioral health agencies to be more inclusive of the
1073 different cultures and identities of people seeking behavioral health care.
1074
1075 Feedback solicited through community engagement helped define the allowable funding activities
1076 described in Section V.C. Strategy 3: Strengthen the Community Behavioral Health Workforce. Activities
1077 funded in this Plan address both the workforce at crisis care centers and the systemwide community
1078 behavioral health workforce.
1079
1080 *Theme G: Accountability Mechanisms and Ongoing Community Engagement*
1081 Throughout the implementation planning process, community partners expressed appreciation for being
1082 included in the early planning of the CCC Levy. They also voiced a strong preference to continue to be
1083 involved in future phases of the CCC Levy, including monitoring CCC Levy outcomes.
1084
1085 Defining Measures of Success
1086 Community partners demonstrated an interest in being involved in County processes to define
1087 measures of success of the CCC Levy. Measures of interest include rates of improvement in
1088 regard to a person's behavioral health condition, as well as overall quality of life. Measures of
1089 equity across outcomes were also described as a priority. These topics are addressed in Section
1090 VII. Evaluation and Performance Measurement, which describes the evaluation and
1091 performance management plan for the CCC Levy.
1092
1093 Community Engagement During Future Planning Phases
1094 Community partners voiced strong interest in being included during future planning phases. In
1095 particular, partners expressed interest in providing ongoing input on the clinical implementation
1096 of CCC Levy services and engaging around the opening of each crisis care center. Section V.G.
1097 Strategy 7: Crisis Care Centers Levy Administration: Community Engagement includes activities
1098 related to crisis system administration and includes long-term community engagement as a key
1099 focus.
1100
1101 **F. Behavioral Health Equity Framework**
1102 The CCC Levy will not succeed if it increases access to behavioral health crisis services without also
1103 reducing inequities in who can access that care. Inequities in who can access behavioral health care at
1104 the time of this Plan's drafting are described above in the section on Section III.C. Who Experiences
1105 Behavioral Health Inequities. During this Plan's community engagement process, DCHS received
1106 extensive community feedback from community partners about the importance of centering health
1107 equity in this Plan, as summarized in the previous section, Section III.E. Key Findings of Community
1108 Engagement Process. Ordinance 19572 reinforces this approach by stating that a key function of
1109 behavioral health facilities, including crisis care centers, is to promote equitable and inclusive access to
1110 behavioral health services, including those in racial, ethnic, experiential, and geographic communities,
1111 which experience disparities in mental health and substance use conditions and outcomes.
1112

1113 This section synthesizes findings from research and community engagement into a behavioral health
1114 equity framework for the Plan, depicted in Figure 7, summarized in Figure 8, and described further in
1115 this subsection.
1116
1117

Behavioral Health Equity Highlight

These gold boxes will appear throughout the Plan to emphasize the ways that the behavioral health equity framework described above will be pursued through the Plan's strategies and activities.

1118
1119 *Figure 7. CCC Levy Implementation Plan Behavioral Health Equity Framework*
1120
1121
1122
1123
1124
1125
1126
1127
1128
1129
1130
1131
1132
1133
1134
1135
1136
1137
1138
1139
1140
1141
1142
1143



1144 *Figure 8. CCC Levy Implementation Plan Behavioral Health Equity Framework Summary*

CCC Levy Implementation Plan Behavioral Health Equity Framework Summary		
Behavioral Health Equity Focus	**Background and Community Engagement**	**CCC Levy Strategies and Activities**
Increase equitable access to behavioral health crisis care	• Significant unmet behavioral health service needs in sociodemographic groups • Need to reach out to underserved communities	• Reduce cost/insurance barriers • Increase geographic access 24/7 • Promote awareness and outreach to populations that disproportionately face barriers to access
Expand availability of culturally and linguistically appropriate behavioral health services	• Clinical best practice to offer culturally and linguistically appropriate services (CLAS)[137] • Community demand for increased access to CLAS	• Require and support crisis care center operators to offer CLAS • Invest in providers with expertise in CLAS to expand services
Increase representativeness of the behavioral health workforce	• Culturally concordant care improves outcomes • Community feedback advocating for increased diversity in behavioral health workforce	• Train, recruit and retain a more representative behavioral health workforce
Promote accountability to health equity	• Need to put accountability mechanisms in place • Ongoing community engagement is needed	• Support community engagement throughout the CCC Levy period • Track outcomes within and between demographic subpopulations • Train providers on best practices for gathering demographic information needed to inform equity analyses

1145

1146 This Plan's behavioral health equity framework aligns closely with King County's historic investments in
1147 addressing inequities.[138] In 2016, the Executive released the King County Equity and Social Justice
1148 Strategic Plan.[139] The CCC Levy is highly aligned with the main approaches laid out in the Equity and
1149 Social Justice Strategic Plan and includes investments in upstream resources to: prevent inequities and
1150 injustices, foster community partnerships, support County employees, and develop mechanisms to
1151 ensure transparent and accountable leadership. This Plan describes activities that further the Equity and
1152 Social Justice Strategic Plan's priority domains for pro-equity policies, including leadership, operations
1153 and services; plans, policies and budgets; workforce and workplace; community partnerships;
1154 communication and education; and facility and system improvements.

1155

1156 ## Equitable Access to Behavioral Health Crisis Care

1157 As described in Section III.C. Key Historical and Current Conditions, behavioral health services remain
1158 inaccessible to far too many people who need help. Community members and providers clearly
1159 articulated that people in a behavioral health crisis face many barriers locally, as described in Section

[137] National Culturally and Linguistically Appropriate Services (CLAS) Standards. Think Cultural Health, U.S. Department of Health & Human Services [LINK]

[138] King County Ordinance 16948 [LINK]

[139] King County Equity and Social Justice Strategic Plan [LINK]

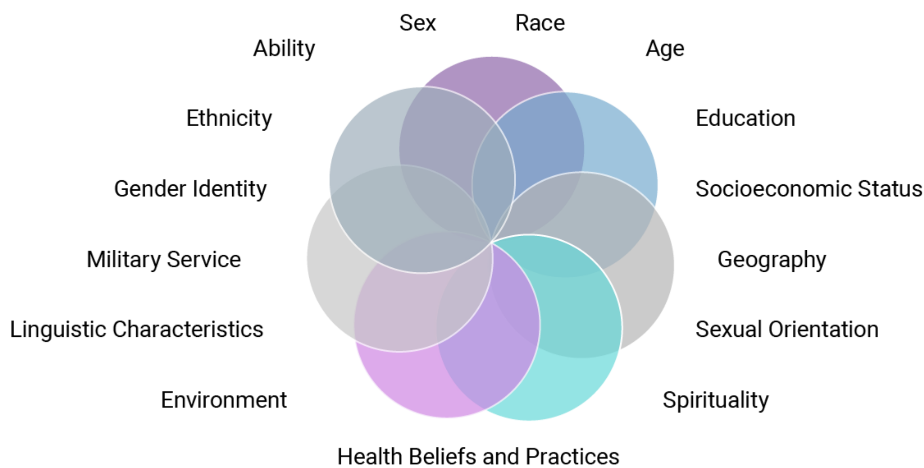
1160 III.E. Community Engagement Summary: Theme B: Increase Access to Care for Populations Experiencing
1161 Behavioral Health Inequities.
1162
1163 Public policies and social norms play a significant role in shaping social determinants of health that result
1164 in behavioral health inequities. Studies have shown that the most significant barriers to accessing
1165 behavioral health care are related to concerns about high costs and lack of health insurance.[140] These
1166 concerns are particularly prevalent among BIPOC communities, in part due to social policies that
1167 impeded generational accrual of wealth.[141] The CCC Levy will increase access to behavioral health crisis
1168 care by making services available regardless of insurance status or ability to pay, as described in Section
1169 V.A. Strategy 1: Create and Operate Five Crisis Care Centers: Crisis Care Center Clinical Model and
1170 Section V.A. Strategy 1: Crisis Care Center Post-Crisis Follow-Up Program. While waiting for the crisis
1171 care centers to open, CCC Levy funds will also be used to invest funds starting in 2024 to expand access
1172 to community-based resources for residents of King County, as described in Section V.D. Strategy 4:
1173 Early Crisis Response Investments: Increase Community-Based Crisis Response Capacity, as well as
1174 substance use services, as described in Section V.D. Strategy 4: Early Crisis Response Investments:
1175 Reduce Fatal Opioid Overdoses by Expanding Low Barrier Opioid Reversal Medication and Section V.D.
1176 Strategy 4: Early Crisis Response Investments: Substance Use Capital Facility Investments.
1177

1178 ## Culturally and Linguistically Appropriate Services

1179 Access to, and engagement in, behavioral health care can also be impeded by a lack of cultural and
1180 linguistic appropriate services among providers,.[142] These challenges are described in Section III.C. Key
1181 Historical and Current Conditions: Behavioral Health Inequities and were also raised by community
1182 members, as described in Section III.E. Community Engagement Summary: Culturally and Linguistically
1183 Appropriate Services.
1184
1185 Culturally and linguistically appropriate services best practices (CLAS) are nationally recognized as a way
1186 to improve the quality of services provided to all individuals, which will ultimately help reduce health
1187 disparities and promote health equity.[143] According to the U.S. Department of Health and Human
1188 Services, which developed the CLAS standards, all aspects of a provider's and a client's cultural identity,
1189 as depicted in Figure 9, influence the therapeutic process and are relevant to the expansion of CLAS as
1190 described throughout this Plan.
1191

[140] Walker ER, Cummings JR, Hockenberry JM, Druss BG. Insurance status, use of mental health services, and unmet need for mental health care in the United States. Psychiatr Serv. 2015 Jun;66(6):578-84. [LINK]
[141] Coombs NC, Meriwether WE, Caringi J, Newcomer SR. Barriers to healthcare access among U.S. adults with mental health challenges: A population-based study. SSM Popul Health. 2021 Jun 15;15:100847. [LINK]
[142] Fountain House, From Harm to Health: Centering Racial Equity and Lived Experience in Mental Health Crisis Response, 2021. [LINK]
[143] National Culturally and Linguistically Appropriate Services (CLAS) Standards. Think Cultural Health, U.S. Department of Health & Human Services [LINK]

1192 *Figure 9. Aspects of Experience and Identity that Impact Behavioral Health*[144]



1193
1194 *Image Source: U.S. Department of Health and Human Services, Think Cultural Health.*
1195
1196 The CCC Levy will increase availability of these clinical best practices by investing in crisis care centers
1197 and post-crisis follow-up services that include CLAS, as described in Section V.A. Strategy 1: Create and
1198 Operate Five Crisis Care Centers: Crisis Care Center Clinical Model and Section V.A. Strategy 1: Culturally
1199 and Linguistically Appropriate Post-Crisis Follow-Up Services. CCC Levy funds will also be used to support
1200 crisis care center operators with capacity building and technical assistance to ensure they are positioned
1201 to meet DCHS's equity goals, as described in Section V.E. Strategy 5: Capacity Building and Technical
1202 Assistance: Crisis Care Center Operator Regulatory and Quality Assurance Activities. Finally, behavioral
1203 health providers with expertise in CLAS will be eligible to receive funds to build their own capacity to
1204 better serve populations experiencing behavioral health inequities, as described in Section V.E. Strategy
1205 5: Capacity Building and Technical Assistance: Building for Providers with Expertise in Culturally and
1206 Linguistically Appropriate Services.
1207

Behavioral Health Equity Highlight

Section III.F. Behavioral Health Equity Framework: Culturally and Linguistically Appropriate Services describes how access to behavioral health care can be impeded by a lack of cultural humility amongst providers and by language barriers.[145] These challenges are described in Section III.C. Key Historical and Current Conditions: Who Experiences Behavioral Health Inequities and were also raised by community members, as described in Section III.E. Community Engagement Summary: Culturally and Linguistically Appropriate Services.

Culturally and linguistically appropriate services (CLAS) are nationally recognized as a way to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and promote health equity.[146] The CCC Levy will increase availability of these clinical best practices by investing in crisis care centers that include CLAS, including interpretation and translation services. CCC

---

[144] Image Source: U.S. Department of Health and Human Services, Think Cultural Health: Improving Cultural Competency for Behavioral Health Professionals [LINK]

Levy funds will be used to support crisis care center operators with capacity building and technical assistance to ensure they are positioned to meet DCHS's equity goals, as described in Section V.E. Strategy 5: Capacity Building and Technical Assistance: Crisis Care Center Operator Regulatory and Quality Assurance Activities.

1208

1209 ### Representative Behavioral Health Workforce

1210 In addition to offering CLAS as part of clinical best practices, there is evidence that improving diversity
1211 among behavioral health workers to better reflect the communities they serve may help improve
1212 communication and trust while reducing behavioral health disparities.[147,148] Based on both the
1213 background in Section III.C. Key Historical and Current Conditions: Behavioral Health Workforce
1214 Shortages and the community engagement described in Section III.E. Community Engagement Summary:
1215 Importance of Workforce Representation, there are investments to improve the representativeness of
1216 the community behavioral health workforce, as described in Section V.C. Strategy 3: Strengthen the
1217 Community Behavioral Health Workforce: Community Behavioral Health Workforce Representation.

1218

1219 ### Quality Improvement and Accountability

1220 The final behavioral health equity focus in this Plan relates to ensuring that equity objectives are realized
1221 to both improve quality of care and hold the County and behavioral health providers accountable.
1222 Community members provided this feedback prominently, as described in Section III.E. Community
1223 Engagement Summary: Theme G: Accountability Mechanisms and Ongoing Community Engagement.
1224 The CCC Levy's operations funding for crisis care center operators includes funds to collect high quality
1225 data about client characteristics, as described in Section V.A. Strategy 1: Collect and Report High Quality
1226 Data, and then to use this information to implement continuous quality improvement activities that
1227 monitor and concertedly aim to reduce observed disparities, as described in Section V.A. Strategy 1:
1228 Continuous Quality Improvement. The CCC Levy will further invest in community-based organizations or
1229 behavioral health providers with expertise in CLAS to provide subject matter expertise to the County to
1230 ensure that quality improvement activities are appropriately monitoring and advancing these equity
1231 goals, as described in Section V.G. Strategy 7: Crisis Care Centers Levy Administration: Expertise to
1232 Support Oversight of Behavioral Health Equity. Additional accountability will occur through the formal
1233 evaluation of the CCC Levy, whose funded activities are described in Section V.F. Strategy 6: Evaluation
1234 and Performance Measurement Activities and details are provided in Section VII. Evaluation and
1235 Performance Measurement. The annual reports will include information about these equity analyses,
1236 including information on geographic variations that may provide insights into serving rural communities,
1237 as described in Section VIII.B. Reporting Methodology to Show Geographic Distribution by ZIP Code.

1238

1239 In addition to collecting, analyzing, and reporting on data and metrics in a way that accounts for this
1240 Plan's behavioral health equity framework, DCHS will engage community partners in an ongoing
1241 manner, as described in Section V.G. Strategy 7: Crisis Care Centers Levy Administration: Community
1242 Engagement. The Behavioral Health Advisory Board, the advisory body of the CCC Levy, will also play an
1243 important role by providing a forum for people with demographics representative of King County, as

---

[147] Shen MJ, Peterson EB, Costas-Muñiz R, Hernandez MH, Jewell ST, Matsoukas K, Bylund CL. The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature. J Racial Ethn Health Disparities. 2018 Feb;5(1):117-140. [LINK]

[148] Chao, P.J., Steffen, J.J., and Heiby, E.M. (2012). The effects of working alliance and client-clinician ethnic match on recovery status. *Community Mental Health Journal* (48), 91-97 [LINK]

1244 well as lived experience of mental health and substance use conditions to advise DCHS on the CCC Levy
1245 implementation, as described in Section IX. Crisis Care Centers Levy Advisory Body.
1246
1247

IV. Crisis Care Centers Levy Purposes

Ordinance 19572 defines the Crisis Care Centers (CCC) Levy's Paramount Purpose and two Supporting Purposes. The Paramount Purpose is to establish and operate a network of five crisis care centers in King County. Supporting Purpose 1 is to restore and expand mental health residential treatment capacity and Supporting Purpose 2 is to strengthen King County's community behavioral health workforce. The Levy's purposes will significantly support King County residents' behavioral health. However, the CCC Levy cannot transform or repair the region's entire system of behavioral health care. Attempting to do so without first fulfilling the CCC Levy's required purposes risks dissipation of the CCC Levy's resources. To promote focused and high-quality implementation of this initiative, this Plan prioritizes the three mandatory, voter-approved purposes of the CCC Levy.

Paramount Purpose

The Paramount Purpose of the CCC Levy is to create and support operations of a regional network of five crisis care centers across King County, including at least one that specializes in serving youth. These crisis care centers will strengthen this region's community behavioral health system by creating safe and welcoming places for people experiencing an urgent behavioral health need to quickly access behavioral health care, as described in detail in Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers. Crisis care centers will promote continuity of care by connecting people to behavioral health and social service resources to support ongoing recovery.

Supporting Purpose 1

Supporting Purpose 1 will restore mental health residential beds lost in King County since 2018. During this brief period, King County's mental health residential bed capacity has dropped by 115 beds, or nearly one third. To restore this bed capacity to 355 beds as King County had in 2018, the CCC Levy will fund capital and maintenance expenses to preserve existing and build new mental health residential treatment beds in King County, as described in detail in Section V.B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity.

Supporting Purpose 2

Supporting Purpose 2 addresses community behavioral health workforce shortages and the need to grow and sustain the behavioral health workforce, including but not limited to the workforce at the region's new crisis care centers. Investments related to this purpose are intended to increase the sustainability and representativeness of the behavioral health workforce by expanding community behavioral health career pathways, sustaining and expanding labor-management workforce development partnerships, and supporting crisis workforce development.[149] These activities are described in detail in Section V.C. Strategy 3: Community Behavioral Health Workforce.

[149] A focus of the Plan is to increase accessibility of behavioral health services, including crisis services funded by the CCC Levy, for all King County residents, including populations who experience behavioral health inequities. A consistent theme of community engagement was the importance for people seeking care of culturally and linguistically congruent services, staff with lived experience of behavioral health crises, and demographic representativeness. Establishing a workforce that is representative of King County's population, with particular care to representativeness for populations experiencing behavioral health inequities (see Section III.C. Who Experiences Behavioral Health Inequities), will ensure that more King County residents can choose to receive care from a provider with whom they are comfortable and is one of this Plan's strategies to ensure that all King County residents have meaningful access to CCC Levy-funded facilities and services.

1285
V. Crisis Care Centers Levy Strategies and Allowable Activities

1286 Ordinance 19572 requires this Plan to define strategies for how CCC Levy funds will be invested between
1287 2024 and 2032 to achieve the Levy's purposes. This Plan's strategies reflect Ordinance 19572
1288 requirements and input from community partners, subject matter experts, and DCHS staff, as described
1289 in Section III.D. Background: Implementation Plan Methodology.
1290
1291 Figure 10 summarizes the strategies, and Figure 11 illustrates which strategies directly and indirectly
1292 support each of the CCC Levy's purposes. Descriptions of each strategy and its allowable expenditures
1293 and activities follow the summary figures.
1294

1295 *Figure 10. Summary of the CCC Levy Strategies*

Summary of the CCC Levy Strategies	
Strategy	**Summary Description**
Strategy 1 **Create and Operate Five Crisis Care Centers**	• Capital funding to create and maintain five crisis care centers • Operating funding to support crisis care center personnel costs, operations, services, and quality improvement • Post-crisis follow-up for people after leaving a crisis care center
Strategy 2 **Restore, Expand, and Sustain Residential Treatment Capacity**	• Capital resources to restore mental health residential treatment capacity to at least 355 beds in King County • Capital resources to expand and sustain residential treatment capacity
Strategy 3 **Strengthen the Community Behavioral Health Workforce**	• Resources to expand community behavioral health career pathways, including investments to stabilize and sustain King County's community behavioral health workforce and increase workforce representativeness • Resources to expand and sustain labor management workforce development partnerships, including support for apprenticeships • Resources to support the development of the region's behavioral health crisis workforce, including crisis care center workers
Strategy 4 **Early Crisis Response Investments**	• Resources to expand community-based crisis service capacity starting in 2024, before crisis care centers are open • Resources starting in 2024 to respond faster to the overdose crisis
Strategy 5 **Capacity Building and Technical Assistance**	• Resources to support the implementation of CCC Levy strategies • Support for capital facility siting • Build capacity for culturally and linguistically appropriate services
Strategy 6 **Evaluation and Performance Measurement**	• Resources to support CCC Levy data collection, evaluation, and performance management • Analyses of the CCC Levy's impact on behavioral health equity
Strategy 7 **CCC Levy Administration**	• Investments in CCC Levy administration, community engagement, information technology systems infrastructure, and designated crisis responder (DCR) accessibility[150]
Strategy 8 **CCC Levy Reserves**	• Provide for and maintain CCC Levy reserves[151,152]

1296

[150] King County Crisis and Commitment Services offers evaluation of people with behavioral health disorders for involuntary detention in psychiatric and secure withdrawal facilities according to Washington law. The law for adults is RCW 71.05. [LINK] For youth 13 through 17 years of age the law is RCW 71.34. [LINK] Crisis and Commitment staff who perform these duties are referred to as Designated Crisis Responders (DCRs). They are mental health professionals who are specially trained to conduct a holistic investigation of risk and to treat the person in need with dignity and respect during their time of crisis. Crisis and Commitment Services are available 24 hours a day, 365 days a year. [LINK]

[151] Ordinance 19704 created the crisis care center fund to account for CCC Levy proceeds. [LINK]

[152] This strategy creates a fund reserve equal to 60 days of budgeted expenditures, less capital expenses, consistent with King County Comprehensive Financial Management Policies (2016). [LINK]

1297 *Figure11. How Each Strategy Advances the CCC Levy's Purposes*

How Each Strategy Advances the CCC Levy's Purposes			
Strategy	**Paramount Purpose** Crisis Care Centers	**Supporting Purpose 1** Residential Treatment	**Supporting Purpose 2** Community Behavioral Health Workforce
Strategy 1 Create and Operate Five Crisis Care Centers	Direct Link		
Strategy 2 Restore, Expand, and Sustain Residential Treatment Capacity		Direct Link	
Strategy 3 Strengthen the Community Behavioral Health Workforce	Direct Link		Direct Link
Strategy 4 Early Crisis Response Investments	Indirect Link		
Strategy 5 Capacity Building and Technical Assistance	Direct Link	Direct Link	Indirect Link
Strategy 6 Evaluation and Performance Measurement	Indirect Link	Indirect Link	Indirect Link
Strategy 7 CCC Levy Administration	Indirect Link	Indirect Link	Indirect Link
Strategy 8 CCC Levy Reserves	Indirect Link	Indirect Link	Indirect Link

1298

1299 **A. Strategy 1: Create and Operate Five Crisis Care Centers**

1300 Overview

1301 The Paramount Purpose of the CCC Levy is to create and operate a regional network of five crisis care
1302 centers across King County. The CCC Levy's network of crisis care centers will create a new front door for
1303 people in crisis who need behavioral health services. Crisis care centers will help people by:

1304 - Providing in-person behavioral health services tailored to the needs of people in a behavioral
1305 health crisis;
1306 - Creating a dedicated place for people in crisis to receive effective care from specialized
1307 behavioral health providers;
1308 - Serving as a destination for first responders, including law enforcement, to bring people who
1309 need behavioral health care;
1310 - Expanding King County's behavioral health continuum of care as a complement to services
1311 funded through the KCICN, BH-ASO, and MIDD (see Section III.C. Key Historical and Current
1312 Conditions: Behavioral Health Service Funding Limitations and Opportunities), and

- Reducing reliance on hospital emergency departments, hospitals, and jails as places that people go when in a behavioral health crisis.

This section provides an overview of the CCC Levy's crisis care center program and the allowable activities within Strategy 1, including descriptions of:

- The clinical model for the five crisis care centers, including the one dedicated to serving youth;
- Post-crisis stabilization activities to support people after a crisis care center visit;
- DCHS's role to oversee and improve the quality of the crisis care centers;
- Allowable operational and capital funding activities for crisis care centers;
- Crisis care center capital facility requirements, and
- The crisis care centers procurement and siting process.

Crisis Care Center Clinical Program Overview

The purpose of this Plan is to guide DCHS in its administration and implementation of the CCC Levy. This section of the Plan describes the initial vision for crisis care centers operations to inform appropriate County-level guidance for levy-level administration activities such as procurements, contracting, performance measurement, and communications with communities. This Plan does not preempt relevant state or federal laws or regulations. It also is not intended to interfere with patient-level care decisions that are more appropriately governed outside of a County-level implementation plan.

DCHS will refine this clinical program and model during procurement and implementation phases based on improved understanding of community needs. Refinements are expected to incorporate rapid advancements in the evidence base for effective behavioral health care, satisfy future federal and state regulatory guidance and licensing rules, and use continuous quality improvement practices that respond to performance data and community accountability. (See more on Section V.A. Strategy 1 Create and Operate Five Crisis Care Clinics: Oversight of Crisis Care Center Quality and Operations later in this subsection).

The crisis care center clinical program model has four parts:

1. **Clinical components**,
2. **Services**,
3. A **facility**, and
4. An **operator**.

Specifically, the crisis care center clinical program has three **clinical components** (24/7 Behavioral Health Urgent Care, 23-Hour Observation Unit, and Crisis Stabilization Unit), in which **services** (assessment, triage, interventions, referrals) are provided at a sited **facility** (see Section V.A. Strategy 1:Created and Operated Five Crisis Care Centers: Crisis Care Center Capital Facility Development) by an **operator** that has been competitively selected by DCHS (see Section V.A. Strategy 1: Created and Operated Five Crisis Care Centers: Crisis Care Center Procurement and Siting Process).

This clinical program model is based on multiple inputs, including:

- The core elements of crisis care centers as defined in Ordinance 19572 (see Figure 12).
- SAMHSA's National Guidelines for Behavioral Health Crisis Care, which call for the creation of crisis facilities ("somewhere to go") for people in crisis to seek help as part of a robust

behavioral health crisis system (see Section III.C. Key Historical and Current Conditions: Need for Places to Go When in Crisis);[153,154]

- The CCC Levy community engagement process, which identified several clinical best practices that helped inform many of the clinical model components (see Section III.E. Community Engagement Summary: Theme A: Implement Clinical Best Practices in Crisis Services);
  Informational interviews with subject matter experts and other community partners, which helped tailor crisis care center services to local contexts and needs (see Section III.D. Implementation Plan Methodology: Crisis Care Center Methodology); and
- Site visits to 10 adult or youth behavioral health crisis facilities in Washington, California, and Arizona (see Appendix E: Site and Field Visits).

Figure 12. Crisis Care Center Definition as Defined in Ordinance 19572

Crisis Care Center Definition
"Crisis care center" means a single facility or a group of facilities that provide same-day access to multiple types of behavioral health crisis stabilization services, which may include, but are not limited to, those described in RCW 71.24.025(20), as amended.[155] A crisis care center shall endeavor to accept at least for initial screening and triage any person who seeks behavioral health crisis care. Among the types of behavioral health crisis stabilization services that a crisis care center shall provide are: • A behavioral health urgent care clinic that offers walk-in and drop-off client screening and triage 24 hours per day, seven days per week; • Access to onsite assessment by a designated crisis responder; • A 23-hour observation unit or similar facility and service that allows for short-term, onsite stabilization of a person experiencing a behavioral health crisis; and • A crisis stabilization unit that provides short-term, onsite behavioral health treatment for up to 14 days or a similar short-term behavioral health treatment facility and service. A crisis care center shall be staffed by a multidisciplinary team that includes peer counselors. A crisis care center may incorporate pre-existing facilities that provide crisis stabilization services so long as their services and operations are compatible with this definition. Where a crisis care center is composed of more than one facility, those facilities shall either be geographically adjacent or shall have transportation provided between them to allow persons using or seeking service to conveniently move between facilities.

DCHS intends for crisis care centers to incorporate clinical best practices, as described throughout the clinical model below. These best practices are summarized in Appendix G: Clinical Best Practices in Behavioral Health Crisis Services and include care that is trauma-informed, recovery-oriented, person-centered, culturally and linguistically appropriate, integrated, and delivered in the least restrictive setting. This Plan includes support for providers to implement these best practices through Section V.E.

---

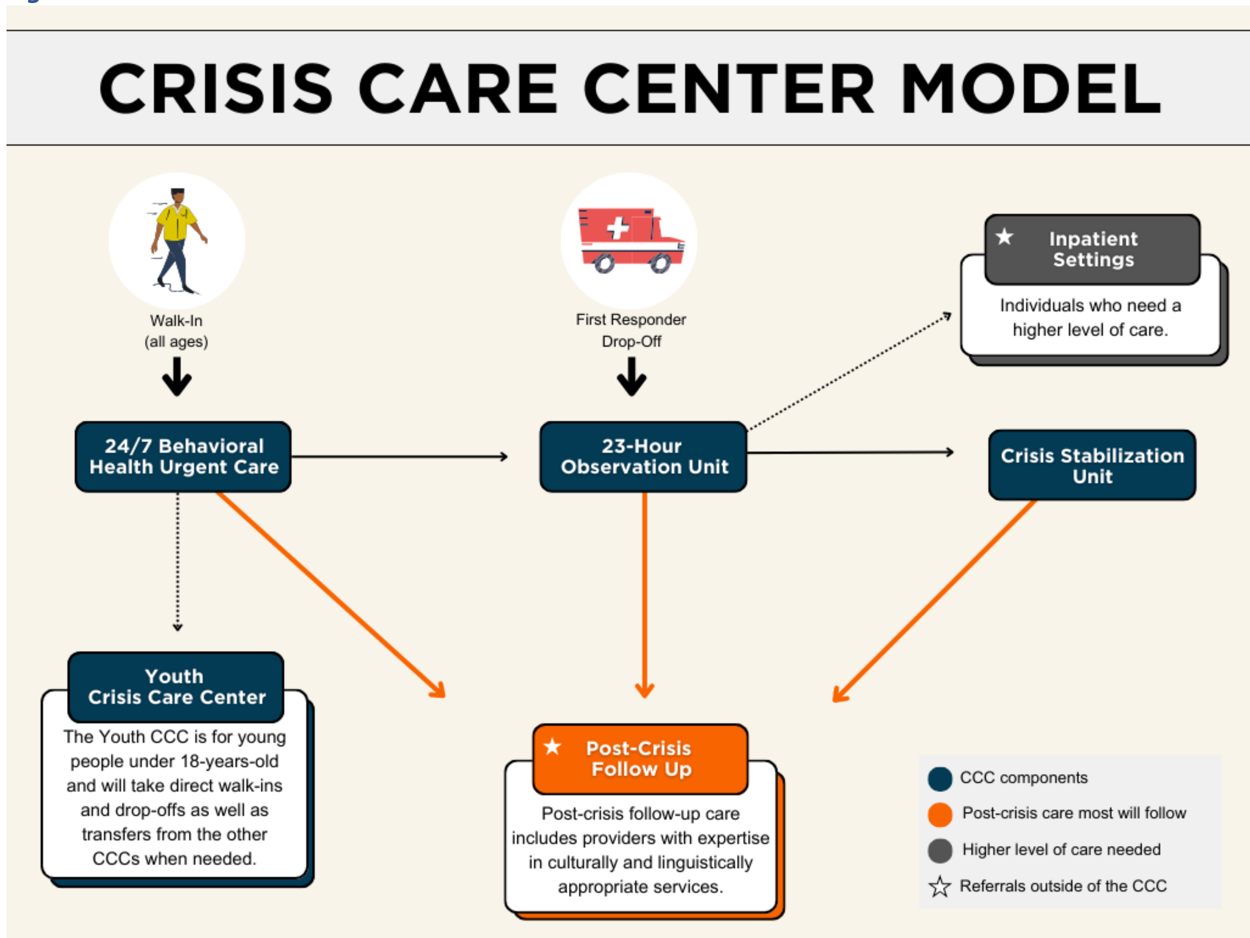
[153] Substance Abuse and Mental Health Services Administration. (2020). National Guidelines for Behavioral Health Crisis Care - Best Practice Toolkit. [LINK]
[154] Substance Abuse and Mental Health Services Administration: National Guidelines for Child and Youth Behavioral Health Crisis Care. Publication No. PEP22-01-02-001 Rockville, MD: Substance Abuse and Mental Health Services Administration, 2022. [LINK]
[155] RCW 71.24.025. [LINK]

1376 [Strategy 5: Capacity Building and Technical Assistance](). This model reflects high quality standards of
1377 compassionate and effective care in crisis settings.[156]
1378

1379 *Crisis Care Center Clinical Model*

1380 The crisis care center clinical model described in this subsection applies to the four crisis care centers
1381 that will primarily serve adults. Figure 13 depicts the model and Figure 14 describes the model in greater
1382 detail. This clinical model describes how at the time of this Plan's transmittal, DCHS expects crisis care
1383 centers will operate. All of the crisis care centers will offer the three clinical components (24/7
1384 behavioral health urgent care, 23-hour observation, and crisis stabilization), which will provide different
1385 levels of care depending on each person's needs. The centers will primarily provide accessible and
1386 efficient assessment, short-term stabilization, and triage to subsequent services and supports. The youth
1387 crisis care center clinical model is described in the next section.
1388

1389 ***Figure 13. Crisis Care Center Clinical Model***



1390
1391
1392 DCHS, in partnership with community behavioral health providers, will create crisis care centers that
1393 operate according to the clinical model depicted in Figure 13 above and described in Figure 14 below.

[156] Group for the Advancement of Psychiatry. (2021). Roadmap to the Ideal Crisis System: Essential Elements. Measurable Standards and Best Practices for Behavioral Health Crisis Response. National Council for Mental Wellbeing. [[LINK]()]

1394 *Figure14. Summary of the Crisis Care Center Clinical Model*

Crisis Care Center Clinical Model				
		Clinical Model Components		
		24/7 Behavioral Health Urgent Care	**23-Hour Observation Unit**	**Crisis Stabilization Unit**
How can a person access care?	*Specific to the clinical component*	Walk-in (no referral needed) or referred/brought in by provider/support system; adults and children	Triaged from 24/7 behavioral health urgent care; first responder direct drop-off	Triaged from 23-hour observation or other settings
	Across all components	"No wrong door" access for all behavioral health needs; all welcome regardless of insurance or ability to pay; meets medically stability criteria		
What services are available?	*Specific to the clinical component*	Initial screening and triage; access to basic needs; mental health and substance use evaluation; brief interventions; medication refills	Up to 23 hours and 59 minutes (with exceptions); full-scope acute psychiatric care; crisis stabilization services; treat basic medical needs; initiate withdrawal management	Up to 14 days; group therapy; substance use counseling; withdrawal management; complex care coordination
	Across all components	Peer engagement; care that is person-centered, trauma-informed, and culturally and linguistically appropriate; medications for opioid use disorder; care coordination to health and social services, including basic housing resources; discharge planning		
Where can a person go next?	*Specific to the clinical component*	If medically unstable, to emergency room; if severe behavioral health symptoms and likely to benefit, to 23-hour observation (≥18 years) or youth crisis care center (<18 years)	If needs more time for stabilization, to crisis stabilization unit; if placed on hold by Designated Crisis Responder, transferred out to involuntary treatment setting	If longer-term supports needed, care transition to appropriate setting such as a higher level of care or a mental health or substance use residential treatment setting
	Across all components	If none of the above, most referred to post-crisis follow-up programs and, if available, existing community-based providers; transportation provided to off-site settings		
What is the physical space like?	*Specific to the clinical component*	Living room model with office space; separate section for youth	Recliner chairs; safety features; dedicated first-responder entrance; outdoor space	Beds in comfortable configuration; outdoor space
	Across all components	Safe and welcoming; comfortable furniture; balance between private and group spaces; areas for outside providers and families/caregivers		

1395

1396 ### Access to Crisis Care Centers

1397 Crisis care centers are places to go in a crisis. People will primarily access care by self-presenting to the
1398 behavioral health urgent care clinic, which may include having another person like a service provider or
1399 family member bring the person. Just like a physical health urgent care clinic, people seeking same-day
1400 behavioral health care outside the traditional outpatient clinic setting should be able to access the
1401 behavioral health urgent care clinic as a "front door" to services.
1402
1403 Crisis care center operators shall work with relevant parties including community behavioral health
1404 providers, mobile crisis teams, co-responder teams, emergency medical services, or law enforcement to
1405 help facilitate transportation to crisis care center facilities from behavioral health provider locations as
1406 needed and subject to available resources.
1407
1408 Crisis care centers that operate either a crisis stabilization unit as defined in RCW 71.05.020, a 23-hour
1409 crisis relief center as defined in RCW 71.24.025, or both, shall accept individuals transported by law
1410 enforcement, in accordance with RCW 10.31.110, to those clinical components.
1411
1412 Crisis care centers will also receive drop-offs by first responders, which include, but are not limited to,
1413 mobile crisis teams, co-responder teams, emergency medical services, and law enforcement. First
1414 responder drop-offs will be made directly into the 23-hour observation unit through a dedicated first
1415 responder entrance. These drop-offs are expected be completed in an efficient manner so that first
1416 responders can return to their duties as quickly as possible.
1417
1418 Youth under age 18, including those who are unaccompanied by parents or caregivers as permitted by
1419 state law, will be able to seek behavioral health urgent care services in any of the crisis care centers,
1420 though the youth crisis care center detailed a later subsection will be tailored best to their needs (see
1421 Section V.A. Strategy 1:Created and Operated Five Crisis Care Centers: Clinical Model for Youth Crisis
1422 Care Center). Crisis care centers will follow the "no wrong door" approach, meaning individuals will be
1423 able to receive at least an initial screening and triage for all clinical needs.[157] Examples of "no wrong
1424 door" may include an individual facing their first behavioral health crisis episode, someone without
1425 regular access to behavioral health care, or an established client seeking services outside their
1426 outpatient clinic's standard hours. Services will be available regardless of ability to pay and without an
1427 appointment.[158] DCHS will work with crisis care center operators, jurisdictions within the crisis response
1428 zone, and other crisis system partners to determine criteria and protocols to manage new admissions
1429 when a center is at full capacity.
1430
1431 Crisis care center operators are encouraged to become a Safe Place Site or Licensed Safe Place Agency.
1432

Behavioral Health Equity Highlight

By increasing access to specialty behavioral health care as an alternative to emergency departments and jails, and by accepting all people regardless of insurance status or ability to pay, King County intends for crisis care centers to be structural solutions that can address these inequities at the root cause.

---

[157] Substance Abuse and Mental Health Services Administration. (2020). National Guidelines for Behavioral Health Crisis Care - Best Practice Toolkit. [LINK]
[158] King County Ordinance 19572 [LINK]

1433

1434 ### Initial Screening and Triage

1435 People coming to a crisis care center will receive an initial screening for mental health and substance use
1436 service needs, social service needs, and medical stability. Peer specialists will engage with each person,
1437 if appropriate, to help them feel welcome and safe. Based on feedback from community partners (see
1438 Section III.E. Community Engagement Summary: Theme A: Implement Clinical Best Practices in Crisis
1439 Services), all team members engaging with people experiencing a behavioral health crisis will be trained
1440 and supervised to use trauma-informed, recovery-oriented, and culturally and linguistically appropriate
1441 approaches (see Appendix G: Clinical Best Practices in Behavioral Health Crisis Services).
1442

1443 The goal of the initial screening is for the clinical team to work with the person in crisis to make shared
1444 decisions about what services and supports they may need. People who come to a crisis care center may
1445 be triaged to a more appropriate setting when they do not meet criteria for medical stability or do not
1446 have an active behavioral health crisis need, which DCHS will define with input from community
1447 partners including first responders.[159] People who decline services will be treated respectfully so their
1448 experience increases their likelihood of accepting services in the future.
1449

1450 ### Services Available at Crisis Care Centers

1451 Some services will be available throughout a crisis care center, while others will be specific to certain
1452 components identified in Figure 14. Regardless of how a person in a behavioral health crisis enters a
1453 crisis care center or which component they are in, crisis care center operators may first address each
1454 person's basic needs by providing resources such as food and water, clean clothes, and a safe place to
1455 rest. Peer specialists will work across the components to engage and support people to take steps
1456 towards their recovery goals and access the services they need. Whenever possible, DCHS expects the
1457 crisis care center operator to collaborate with outside service providers to promote continuity of care
1458 and observe clinical best practices.
1459

1460 Psychiatric providers will be available 24/7 to provide services that include, but are not limited to,
1461 medication refills, administration of long-acting injectable medications, and initiation of medications for
1462 psychiatric symptoms, opioid use disorder and substance use withdrawal.[160] Crisis care centers shall
1463 ensure prompt access to substance use disorder treatment on-site. Social service providers will be
1464 available to help access benefits and existing housing resources (see more on Housing Stability
1465 Resources later in this subsection). Supports for people with co-occurring behavioral health needs and
1466 intellectual and developmental disabilities will also be available at the centers.
1467

1468 Crisis stabilization services will be offered only in the 23-hour observation units (up to 23 hours and 59
1469 minutes, with possible exceptions depending on Washington State Department of Health regulations)
1470 and crisis stabilization units.[161] Services and methodologies in these components will include, but are

[159] First responders include, but are not limited to, mobile crisis teams, co-responder teams, emergency medical services, and law enforcement.
[160] Psychiatric providers include but are not limited to psychiatrists, psychiatric nurse practitioners, and psychiatric physician assistants.
[161] Washington State Department of Health Proposal Statement of Inquiry CR-101 regarding WSR 23-13-017, to implement 2SSB 5120 (2023). [LINK]

1471 not limited to, maintaining a safe and healing environment, using de-escalation techniques, creating
1472 safety plans and crisis plans, and providing evidence-based therapies and substance use counseling.
1473 DCHS expects that the 23-hour observation unit to be equivalent to a psychiatric emergency service in
1474 its ability to serve the full scope of mental health and substance use crises that people will present with
1475 at the crisis care centers. This clinical component will also have the most staff working at any given time
1476 compared to the other components of a crisis care center, including staff to implement a significant
1477 focus on maintaining a safe and healing environment. In contrast, DCHS expects the crisis stabilization
1478 unit to be a lower level of care, with a focus on problem solving around complex health and social
1479 service needs and engaging in short-term counseling within a maximum stay of 14 days. Stabilization
1480 beds may be dual licensed to also provide medically monitored withdrawal management services.[162]
1481
1482 In addition to services, the physical space of a crisis care center affects its function.[163] Though the
1483 Section V.A. Strategy 1: Created and Operated Five Crisis Care Centers: Site and Facility Requirements
1484 subsection later in address the detailed regulatory requirements for these facilities, this subsection
1485 briefly describes the clinical importance of the physical space based on the community feedback
1486 described in Section III.E: Community Engagement Summary: Welcoming and Safe.
1487
1488 DCHS envisions that the crisis care centers will have design features that include, but are not limited to:
1489 - a space that is both open and has flexible rooms to protect privacy when needed;
1490 - comfortable, private, and calming spaces;
1491 - a designated "swing" space to safely separate youth and other vulnerable populations;
1492 - spaces to accommodate outside service providers as well as family and caregivers;
1493 - sound suppression features to prevent echoes and minimize over-stimulation for people living
1494 with intellectual or developmental disabilities;
1495 - a dedicated entrance for first responders for discrete and efficient drop-offs, and
1496 - accessible outdoor space.
1497
1498 DCHS will provide technical assistance and oversight of crisis care center operators to design facilities
1499 that support the clinical model described above.
1500
1501 ### Triage to the Next Level of Care
1502 DCHS anticipates that most people who come in through the behavioral health 24/7urgent care clinic
1503 will have their needs addressed in that setting with potential follow-up care (see Section V. A. Post-Crisis
1504 Stabilization Activities), based on similar care models.[164] DCHS will establish triage criteria, with input
1505 from crisis care center operators and other community partners, for entry to the 23-hour crisis
1506 observation or crisis stabilization units, which will be consistent for adult centers and tailored for
1507 children (see Clinical Model for Youth Crisis Care Center later in this subsection). The criteria will include
1508 with factors that may assess risk of suicide or violence, behavioral distress, withdrawal from substances,
1509 and likelihood of benefitting from a higher level of care. Anyone under age 18 who needs a higher level
1510 of care may be transferred to the youth crisis care center, as capacity allows. If someone needs longer-
1511 term services, the crisis care center team may initiate a referral to an appropriate care setting, such as a
1512 mental health or substance use residential treatment setting.

[162] Washington State Health Care Authority - Adult Withdrawal Management Services [LINK]
[163] Based on crisis center clinical leadership's report during a DCHS staff site visit to crisis facilities listed in Appendix E: Site and Field Visits
[164] Based on crisis center clinical leadership's report during a DCHS staff site visit to a crisis facility in Phoenix, AZ.

1513

1514 It is a priority of King County for behavioral health crisis care to be delivered in the least restrictive
1515 way.[165] This means that the person receiving services remains in control of their own care as much as
1516 possible. Community members provided clear support for this approach, as described in Section III.E.
1517 Community Engagement Summary: Least Restrictive Care.
1518

1519 Only when a significant concern exists that a person meets statutory criteria for involuntary treatment
1520 and the person declines treatment, despite every effort to engage them in care voluntarily, DCHS
1521 anticipates that the crisis care center clinical staff will request an evaluation for potential involuntary
1522 treatment by a designated crisis responder (DCR), as required by the Involuntary Treatment Act.[166] A
1523 DCR would conduct a timely onsite evaluation at a crisis care center, as required by Ordinance 19572.,[167]
1524 Section V.G. Strategy 7: Crisis Care Centers Levy Administration: Designated Crisis Responder
1525 Accessibility provides resources to help expedite designated crisis responder response times.
1526

1527 If a DCR determines that someone requires involuntary treatment in accordance with the Involuntary
1528 Treatment Act, then the crisis care center may continue to provide services up until transfer to the most
1529 appropriate alternative setting, such as a psychiatric hospital or evaluation and treatment (E&T) bed.[168]
1530 DCHS will work with crisis care center operators to develop policies and procedures that minimize the
1531 use of involuntary interventions while remaining compliant with Washington State law. DCHS will
1532 require crisis care center operators to monitor and report on the use of involuntary interventions,
1533 including assessing for potential disparities by race and other demographics. Crisis care center operators
1534 will also be required to use widely recognized national best practices such as the Six Core Strategies to
1535 Reduce Seclusion and Restraint Use, which promotes alternative interventions such as prevention of
1536 escalation, trauma-informed and person-centered approaches, and de-escalation techniques like
1537 affording the person ample space and time.[169]
1538

1539 DCHS expects that, when someone is ready for discharge from a crisis care center, crisis care center
1540 team members will work with each person to determine appropriate transitions to engage with

[165] Least restrictive care refers to care provided in settings that least interfere with a person's civil rights and freedom to participate in society. The practice of care in least restrictive settings supports the key values of self-determination in behavioral health care: that people should be able to disagree with clinician recommendations for care; that people should be informed participants in defining their care plan; and that state laws and agency policies are applied only as a last resort for people who are unable to act in their own self-interests. Detoxification and Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2006. (Treatment Improvement Protocol (TIP) Series, No. 45.) 2 Settings, Levels of Care, and Patient Placement. [LINK]

[166] The Involuntary Treatment Act (ITA) law for adults is RCW 71.05. [LINK] For youth 13 through 17 years of age the ITA law is RCW 71.34. [LINK]

[167] King County Crisis and Commitment Services offers evaluation of people with behavioral health disorders for involuntary detention in psychiatric and secure withdrawal facilities according to Washington law. The law for adults is RCW 71.05. For youth 13 through 17 years of age the law is RCW 71.34. Crisis and Commitment staff who perform these duties are referred to as Designated Crisis Responders (DCRs) They are mental health professionals who are specially trained to conduct a holistic investigation of risk and to treat the person in need with dignity and respect during their time of Crisis. Crisis and Commitment Services are available 24 hours a day, 365 days a year [LINK]

[168] RCW 71.05. [LINK]

[169] National Association of State Mental Health Program Directors (2008). Six Core Strategies to Reduce Seclusion and Restraint Use. [LINK]

1541 community-based health and social service resources. Resources include, but are not limited to,
1542 reconnecting people with their existing providers, initiating new outpatient referrals, providing
1543 prescription refills and medications for opioid use disorder, and linking people to post-crisis follow-up
1544 care. (See more on Section V.A. Strategy 1:Created and Operated Five Crisis Care Centers: Post-Crisis
1545 Stabilization Activities) To provide the clinical best practice of integrating behavioral health with physical
1546 health care, as described in Appendix G: Clinical Best Practices in Behavioral Health Crisis Services, crisis
1547 care center operators may partner with primary care providers, including federally qualified health
1548 centers (FQHCs) or similar programs, to facilitate referrals to primary care and access to low-cost
1549 medications.[170]
1550

1551 *Clinical Model for Youth Crisis Care Center*

1552 The youth crisis care center will be a specialized clinical setting designed to serve young people, as well
1553 as their families and caregivers, in coordination with other youth behavioral health services available in
1554 King County. This youth clinical model describes how at the time of this Plan's transmittal DCHS expects
1555 crisis care centers will operate, providing a level of detail beyond what is included in Ordinance 19572.
1556

1557 The County intends for the youth crisis care center to be like the other four centers in most ways,
1558 including its three clinical components, approach to screening and triage, available services, and physical
1559 environment. However, youth crisis care centers will be a specialized child and adolescent behavioral
1560 health setting. At a minimum, the youth crisis care center will:

1561 - Offer services to and collaborate with the youth in a behavioral health crisis as well as their
1562 families and caregivers.
1563 - Employ team members specially trained in youth behavioral health services and co-occurring
1564 intellectual and developmental disabilities.
1565 - Employ peer specialists that include both young people and parent advocates with lived
1566 experience of navigating youth behavioral health services.
1567 - Accommodate the unique needs of younger children and adolescents, such as the use of age-
1568 specific stabilization units (for example, separate units for children 12 and under and for youth
1569 ages 13 to 17), rather than distinct 23-hour observation and crisis stabilization units as in the
1570 adult centers.[171]
1571 - Accept transfers when a young person seen at one of the other crisis care centers is determined
1572 to meet criteria for facility-based care for reasons such as having a high risk of suicide, violence,
1573 or behavioral distress.
1574 - Coordinate with the young person's existing support systems such as school wellness centers,
1575 child protective services, foster care, and juvenile justice systems.
1576 - Include spaces for youth service providers, family and caregivers to facilitate coordination and
1577 engagement in care.

---

[170] Health centers are community-based and patient-directed organizations that provide affordable, accessible, high-quality primary health care services to individuals and families. Health centers integrate access to pharmacy, mental health, substance use disorder, and oral health services in areas where economic, geographic, or cultural barriers limit access to affordable health care. Federally Qualified Health Centers and look alike health centers are eligible for increased reimbursement for services provided to Medicare and Medicaid beneficiaries. Health Resources and Services Administration (HRSA) - What is a Health Center? [LINK]

[171] In order to qualify as the CCC youth facility, these age-specific units may be licensed to provide either 23-hour crisis observation or its equivalent, short-term onsite crisis stabilization for up to 14 days, or both.

1578 • Provide youth in need of community-based services with specialized short-term post-crisis
1579 wraparound services as the youth is transitioning to ongoing care.
1580

1581
Crisis Care Center Operational Activities

1582 Allowable activities under Strategy 1 include crisis care center operating and service costs. Allowable
1583 crisis care center operating activities are described below in Figure 15.
1584 Crisis care centers will be funded to operate 24/7. DCHS anticipates that many of the services provided
1585 at crisis care centers will be covered by health insurance as described in Section VI.E. Health Insurance
1586 Assumptions. CCC Levy proceeds will pay for crisis care center operating and service costs that are not
1587 covered by health insurance or other sources, including the costs of services for people who are
1588 uninsured. Crisis care centers will welcome and serve people regardless of their insurance or
1589 immigration status and will also serve persons for whom confidentiality is important to their safety or
1590 willingness to seek care.[172] Crisis care center operators will be eligible for workforce investments as
1591 described in Section V.C. Strategy 3: Strengthen the Community Behavioral Health Workforce.
1592

Behavioral Health Equity Highlight

Immigrants and refugees are at higher risk of both experiencing mental health conditions and lacking access to behavioral health care. Because the CCC Levy is a County initiative, levy resources can be used to pay for crisis care center services for people who are uninsured, regardless of immigration or citizenship status. This promotes a "no wrong door" approach by ensuring the cost of care or lack of insurance is not a barrier to accessing crisis care when a person needs it. These investments are in support of Section III.F. Behavioral Health Equity Framework: Equitable Access to Behavioral Health Crisis Care.

1593
1594

[172] Examples of people for whom confidentiality may be important to their safety or willingness to seek care include, but are not limited to, survivors of gender-based violence, undocumented immigrants, and young adults who are covered by their parents' health insurance but do not want to use it to protect their confidentiality.

1595 *Figure 15. Allowable Crisis Care Center Operations Activities*

Allowable Crisis Care Center Operations Activities	
Activity	**Description**
Personnel Costs	Funding for staff salaries, benefits, payroll taxes, and other personnel costs that are part of staffing, operating, and maintaining a crisis care center facility and it services.[173]
Pharmacy Costs	Funding for pharmacy services, such as the cost of medications for people who are uninsured, including immigrants who are unable to access Medicaid because of federal rules. Also included is the cost of pharmacy equipment and other resources needed for regulatory compliance and to ensure that medications are available and can be safely stored and managed onsite at crisis care centers.
Language Access and other Accessibility Costs	Funding for interpretation and translation services, equipment to support these services, other costs to promote language access and provide linguistically appropriate services, and to promote universal access at crisis care centers.
Health Information Technology Costs	Funding to support health information technology at crisis care centers, such as electronic health record infrastructure.
Client Transportation Costs	Funding for transportation assistance for people who receive services at crisis care centers, such as drivers and vehicles, bus passes, taxi vouchers, and other assistance.
Other Operating Costs	Other costs to operate a crisis care center, such as janitorial and environmental management, maintaining a safe and healing environment, operational start-up, supplies, resources to cover the operators' indirect and administrative costs that support high-quality operations, and other eligible expenditures authorized by Ordinance 19572 that promote high quality operations.

1596

1597 Post-Crisis Stabilization Activities

1598 In addition to crisis care center operations, CCC Levy Strategy 1 funds will support people after they
1599 have received services at a crisis care center. Community partners state that many people will likely
1600 need additional community-based behavioral health services, health care, and social services after they
1601 leave a crisis care center, to support their ongoing recovery and wellbeing. Community partners also
1602 shared during implementation planning process engagement that significant supports are needed by
1603 people exiting the crisis care centers in the period immediately following a crisis episode (see Section
1604 III.E. Community Engagement Summary: Need to Build a "Bridge to Somewhere").
1605

[173] Strategy 3 also includes resources for competitive wages in the crisis workforce, including at crisis care centers, that are better aligned with other sectors. See Section V.C. Strategy 3: Community Behavioral Health Workforce for more information about these CCC Levy workforce investments. See Section III.C. Key Historical and Current Conditions: Behavioral Health Workforce Shortages for further discussion of historic underinvestment in behavioral health workers.

1606 Participants in community meetings and focus groups, including people who have experienced
1607 behavioral health crises, discussed the profound benefits of having someone, especially a peer specialist,
1608 continue to offer support and help connect to community-based care (see Section III.E. Community
1609 Engagement Summary: Care Coordination and Peer Engagement). Evidence and research also identify
1610 the need for post-crisis stabilization services, as discussed in Section III.C. Key Historical and Current
1611 Conditions: Need for Post-Crisis Stabilization Services. Despite their importance, existing post-crisis
1612 follow up services in King County are inadequate to meet the need.
1613
1614 Strategy 1 resources will be used to fund the activities described in Figure 16 to create a post-crisis
1615 follow-up program that serves all five of the crisis care centers. These services may address three
1616 important and interrelated objectives:
1617 1. Provide brief behavioral health interventions during the high-risk period immediately following a
1618 discharge from a crisis care center;
1619 2. Engage people proactively to help them connect with community-based behavioral health,
1620 health care, and social service resources that meet their needs and preferences, including
1621 culturally and linguistically appropriate services and housing services; and
1622 3. Manage the capacity of crisis care centers by helping people connect to the intensity of services
1623 that best meets their needs, including less intensive community-based services.
1624
1625 ***Figure 16. Allowable Crisis Care Center Post-Crisis Stabilization Activities***

Allowable Crisis Care Center Post-Crisis Stabilization Activities	
Activity	**Description**
Post-Crisis Follow-Up Services Based at Crisis Care Centers	DCHS will fund a program staffed with clinicians and peer specialists to engage people served at crisis care centers and link them to community-based services and supports. Teams will provide outreach specially tailored for people experiencing homelessness. This activity authorizes expenditures for limited housing stability resources necessary to support post-crisis stabilization.
Post-Crisis Follow-Up by Providers with Expertise in Culturally and Linguistically Appropriate Services	DCHS will fund behavioral health agencies that demonstrate significant experience in providing culturally and linguistically appropriate and accessible post-crisis follow-up services for populations experiencing behavioral health inequities.[174]

1626
1627 DCHS anticipates that the post-crisis stabilization resources within this strategy will be inadequate to
1628 meet the behavioral health needs of all people who access King County's crisis care centers.
1629 Complementary investments from philanthropic partners and the state or federal governments will be
1630 needed to bring the services to scale. Washington State must continue to be a primary funder of post-
1631 crisis services, including through state funding for the Behavioral Health Administrative Services
1632 Organizations (BHASOs), and enhanced Medicaid reimbursement for eligible clinical services. Section

[174] Culturally and linguistically appropriate services (CLAS) are a way to improve the quality of services provided to all individuals, including populations experiencing behavioral health inequities (see Section III.C. Key Historical and Current Conditions: Who Experiences Behavioral Health Inequities), which will ultimately help reduce health disparities and promote health equity. See Section III.F. Behavioral Health Equity Framework: Culturally and Linguistically Appropriate Services and Appendix G: Clinical Best Practices in Behavioral Health Crisis Services for additional information.

1633 VI.D. Financial Plan Seeking and Incorporating Federal, State, and Philanthropic Resources describes how
1634 the Executive intends to seek complementary funding opportunities to augment the impact of the CCC
1635 Levy.
1636
1637 *Crisis Care Center Post-Crisis Follow-Up Program*
1638 Strategy 1 will create a post-crisis follow-up program that serves people after they receive care at the
1639 five crisis care centers. During this high-risk period, post-crisis follow-up services are essential to serving
1640 as a bridge from crisis care centers to the next level of care. Services may include proactive contacts
1641 after discharge, care coordination with new and existing providers, brief interventions to address acute
1642 needs while awaiting linkage to additional services, and peer support to enhance engagement and
1643 support people to access the services they need, similar to the promising but limited Peer Bridging
1644 programs described in Section III.C. Key Historical and Current Conditions: Need for Post-Crisis
1645 Stabilization Services. Services will address both mental health and substance use needs, as well as
1646 referrals to social services, including housing resources when needed. Special considerations may be
1647 needed to tailor post-crisis follow-up services for youth and their families and caregivers. Care should
1648 continue to be trauma-informed, recovery-oriented, person-centered, culturally and linguistically
1649 appropriate, and aim to maintain people in the least restrictive level of care possible, according to the
1650 crisis care center clinical best practices reviewed the Clinical Program Overview in Appendix G: Clinical
1651 Best Practices in Behavioral Health Crisis Services.
1652
1653 DCHS expects that these services will be provided by a multidisciplinary care team that includes peer
1654 specialists and should be initiated in-person at a crisis care center prior to discharge before transitioning
1655 to outpatient offices, outreach in community-based settings, or virtually through telehealth visits. All
1656 individuals treated at a crisis care center shall have access to post-crisis follow-up treatment planning,
1657 subject to available resources. Because demand for post-crisis stabilization services is likely to exceed
1658 the capacity available through this strategy, DCHS may need to establish prioritization criteria in
1659 partnership with post-crisis follow-up providers. For example, post-crisis stabilization resources may be
1660 prioritized to support people who have the highest risk of not engaging in follow-up care, including
1661 populations experiencing behavioral health inequities (see Section III.C. Key Historical and Current
1662 Conditions: Who Experiences Behavioral Health Inequities).[175]
1663
1664 A specific focus of the post-crisis follow-up program will be to reach people who are experiencing
1665 homelessness or are at risk of homelessness, given the significant barriers to accessing behavioral health
1666 services described in Section III.C. Key Historical and Current Conditions: Unmet Behavioral Health
1667 Service Needs. Tailored approaches are often needed to meet people in the community and create
1668 lower threshold entry points for people experiencing homelessness to engage in care.[176] Therefore, the
1669 post-crisis follow-up program is expected to provide outreach-based follow-up and linkages to existing

[175]Risks of not engaging in follow-up care include suicide, violence, homelessness, hospital readmission, and criminal legal system involvement. These risks are more common among people insured by Medicaid, youth and young adults, BIPOC communities, people experiencing homelessness, and people who were not previously engaged in services, as explained in Section III.C. Key Historical and Current Conditions: Need for Post-Crisis Stabilization Services.

[176] Erickson, B. R., Ehrie, J., Murray, S., Dougherty, R. J., Wainberg, M. L., Dixon, L. B., & Goldman, M. L. (2022). A Rapid Review of "Low-Threshold" Psychiatric Medication Prescribing: Considerations for Street Medicine and Beyond. Psychiatric Services. [LINK]

1670 housing and social service resources. This strategy's activities may include short-term housing stability
1671 resources like hotel vouchers.
1672

1673 *Culturally and Linguistically Appropriate Post-Crisis Follow-Up Services*

1674 The availability of culturally and linguistically appropriate services during high-risk periods is essential, as
1675 demonstrated in community feedback, research showing disparities in behavioral health services
1676 following a crisis, and the value of culturally congruent care. (See Section III.F. Behavioral Health Equity
1677 Framework: Culturally and Linguistically Appropriate Services.) Lack of culturally congruent care reduces
1678 engagement in behavioral health care, which this strategy aims to address. (See Section III.C. Key
1679 Historical and Current Conditions: Behavioral Health Workforce Needs.)
1680

1681 For these reasons, providers with expertise in offering culturally and linguistically appropriate services
1682 are well positioned to offer post-crisis follow-up services. DCHS will make funding available specifically
1683 for behavioral health agencies that demonstrate significant experience in providing culturally and
1684 linguistically appropriate services to provide post-crisis follow-up services. These post-crisis services will
1685 be prioritized for people who were seen in crisis care centers. These providers may support care
1686 continuity through longer-term services when appropriate so long as capacity is maintained for new
1687 post-crisis follow-up services.
1688

1689 The Strategy 1 investment activities described in Figure 16 are intended to increase the capacity of
1690 culturally and linguistically specialized service providers to provide post-crisis follow-up services. These
1691 funds will be made available prior to opening of the crisis care centers so that these providers can build
1692 capacity in time to receive referrals when the crisis care centers open. These investments will increase
1693 over time as crisis care centers become operational so that organizations have additional financial
1694 resources to serve new people who are referred from crisis care centers. DCHS intends to award funding
1695 for these activities to organizations that have expertise in providing culturally and linguistically
1696 appropriate or concordant behavioral health services through a competitive procurement process. Prior
1697 to the competitive procurement process, DCHS intends to solicit additional information from providers
1698 and community partners to inform how best to identify and select providers with expertise in culturally
1699 and linguistically appropriate services.
1700

Behavioral Health Equity Highlight

In the aftermath of a behavioral health crisis, multiple factors frequently intersect to decrease access to care in populations experiencing behavioral health inequities. Strategy 1's culturally and linguistically appropriate post-crisis follow-up services component aims to reduce these inequities by designating post-crisis follow-up services funds specifically to expand the capacity of community providers that have expertise in culturally and linguistically appropriate and congruent services.

1701

Housing Stability Resources

Safe, healthy, and affordable housing is a critical resource and social determinant of health for people living with behavioral health conditions.[177, 178] Housing stability is both a protective factor against future crises and an important component of post-crisis care and recovery.[179] Homelessness and housing instability can contribute to crises and undermine the care in settings like a crisis care center.[180] (See Section III.C. Key Historical and Current Conditions: Who Experiences Behavioral Health Inequities.)

Understanding housing stability's importance, crisis care center operators and post-crisis follow-up providers will connect clients with existing housing resources whenever possible. The CCC Levy's regional network of crisis care centers and increased residential treatment capacity will also present housing providers with new resources to reinforce and complement existing housing services.

DCHS will collaborate with other governments and philanthropy to increase housing resources for King County residents, including people receiving CCC Levy-funded care (See Section VI.D. Financial Plan: Seeking and Incorporating Federal, State, and Philanthropic Resources.) DCHS will also coordinate its divisions' work when possible to increase housing supports for people experiencing homelessness who receive care at crisis care centers.

In addition to the limited housing stability expenditures that this Plan authorizes, when necessary and available as part of post-crisis follow up activities, CCC Levy funds may be used for housing resources in accordance with this Plan's priorities for increasing allocations due to additional funding. (See Section VI. Financial Plan: Process to Make Substantial Adjustments to the Financial Plan). These investments may include permanent and emergency housing stability resources like hotel vouchers, rapid rehousing funds, rental assistance, housing vouchers, other housing subsidies, and housing capital or housing operations costs that are otherwise eligible under Ordinance 19572.

Oversight of Crisis Care Center Quality and Operations

The CCC Levy will establish an entirely new class of behavioral health facility in King County. DCHS will be responsible for ensuring that crisis care centers and related programs are functioning as described above in this Section V.A. Strategy 1:Created and Operated Five Crisis Care Centers: Crisis Care Center Clinical Program Overview and Post-Crisis Stabilization Activities.

Ordinance 19572 directs this Plan to include "levy administration activities and activities that monitor and promote coordination, more effective crisis response, and quality of care within and amongst crisis care centers, other behavioral health crisis response services in King County, and first responders." These activities of the CCC Levy are aligned with the "accountable entity" concept defined by the

---

[177] The World Health Organization defines social determinants of health as "the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems," [LINK]

[178] Washington State Health Care Authority Social Determinants of Health-Housing Fact Sheet. [LINK]

[179] Kushel, M., Moore, T., et al. (2023). Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness. UCSF Benioff Homelessness and Housing Initiative. [LINK]

[180] Arienti, F., Mann-McLellan, A., Martone, K., & Post, R. (2020). Effective Behavioral Health Crisis Care for Individuals Experiencing Homelessness. Alexandria, VA: National Association of State Mental Health Program Directors. [LINK]

National Council for Mental Wellbeing's *Roadmap to the Ideal Crisis System* report as "a structure that holds the behavioral health crisis system accountable to the community for meeting performance standards and the needs of the population."[181] The CCC Levy provides a unique opportunity for DCHS to assume this critical oversight role within the scope of the crisis care centers and other related programs funded by the CCC Levy.

This subsection describes how DCHS will support crisis care center operators to engage with first responders and other behavioral health crisis service providers to coordinate policies and procedures, improve quality of services, and collect and report high quality data, as directed by Ordinance 19572.[182]

Funding for DCHS to conduct this oversight is described in Section V.G. Strategy 7: Crisis Care Centers Levy Administration. Additional related CCC Levy investments include:

- Crisis care center personnel costs, Health Information Technology, and other operating costs described in Section V.A. Strategy 1:Created and Operated Five Crisis Care Centers: Crisis Care Center Operations Activities;
- Support for crisis care centers to implement continuous quality improvement practices, as described in Section V.E. Strategy 5: Capacity Building and Technical Assistance: Crisis Care Center Operator Regulatory and Quality Assurance Activities;
- Resources for DCHS to engage community members in quality improvement processes, as described in Section V.G. Strategy 7: Crisis Care Centers Levy Administration: Community Engagement;
- Resources for DCHS to contract with community-based organizations and behavioral health providers to inform quality improvement related to improving equity, as described in Section V.G. Strategy 7: Crisis Care Centers Levy Administration: Expertise to Support Oversight of Behavioral Health Equity; and
- Investments to enhance DCHS data systems and information technology needed to monitor and promote coordination across crisis care centers, as described in Section V.G. Strategy 7: Crisis Care Centers Levy Administration: Develop Data Systems Infrastructure and Technology.

Coordination Between Crisis Care Centers and Crisis System Partners

DCHS expects crisis care center operators to coordinate with regional partners including, but not limited to, community-based organizations, behavioral health providers, hospital systems, first responders, behavioral health co-responders, and the regional behavioral health crisis system coordinated by the King County BH-ASO. DCHS will support operators to coordinate effectively. DCHS will collaborate with first responders and other crisis system partners to develop policies and procedures for referrals from outside facilities like hospitals and emergency departments, first responder drop-offs and medical stability criteria at crisis care centers. DCHS anticipates developing protocols in collaboration with crisis care center operators for when transfers between the centers are needed due to scenarios such as reaching maximum occupancy or needing to transfer a child or adolescent to the youth crisis care center. DCHS plans to further engage crisis care centers along with other crisis providers and first

[181] Group for the Advancement of Psychiatry. (2021). Roadmap to the Ideal Crisis System: Essential Elements. Measurable Standards and Best Practices for Behavioral Health Crisis Response. National Council for Mental Wellbeing [LINK]

[182] First responders include, but are not limited to, mobile crisis teams, co-responder teams, emergency medical services, and law enforcement.

1778 responder agencies, such as crisis call lines, mobile crisis teams, co-responder programs, emergency
1779 medical services, and law enforcement agencies, to develop protocols, workflows, clinical convenings
1780 about shared treatment plans, and other coordination activities.
1781
1782 *Outreach to Increase Awareness*
1783 In addition to working with regional partners within crisis systems, DCHS expects and will support crisis
1784 care center operators to promote awareness and outreach about crisis care center services to
1785 populations experiencing behavioral health inequities (see Section III.C. Key Historical and Current
1786 Conditions: Who Experiences Behavioral Health Inequities) to be responsive to community feedback
1787 described in Section III.E. Community Engagement Summary: Community Outreach Among Populations
1788 Experiencing Behavioral Health Inequities.
1789
1790 *Continuous Quality Improvement and Quality Assurance*
1791 For a crisis system to function well, it must grow, evolve, and continuously improve by building on what
1792 works well and strengthening what does not work well.[183] Continuous quality improvement is the
1793 process by which performance metrics, outcomes data, individual experiences, and other relevant
1794 information are regularly reviewed and analyzed to directly inform policies and procedures, with the
1795 goal of improving outcomes in an ongoing, iterative manner. [184] Quality assurance includes functions
1796 such as internal or external case review and compliance with licensing requirements.[185] Both quality
1797 improvement and assurance are essential to advancing this Plan's Behavioral Health Equity found at
1798 Section III. Background: F. Behavioral Health Equity Framework.[186] DCHS expects and will support crisis
1799 care center operators to monitor and promote quality of care and to develop continuous quality
1800 improvement practices. Contracts with crisis care center operators may include provisions that tie
1801 payment to performance on quality measurements. CCC Levy funds will be used to support crisis care
1802 centers to implement continuous quality improvement practices, as described in Section V.E. Strategy 5:
1803 Capacity Building and Technical Assistance: Crisis Care Center Operator Regulatory and Quality
1804 Assurance Activities.
1805
1806 Ensuring that people efficiently move through the clinical components of a crisis care center will be an
1807 important focus of continuous quality improvement and quality assurance activities. DCHS expects crisis
1808 care center operators to facilitate timely access to behavioral health services while also meeting a wide
1809 range of clinical and psychosocial needs as a "no wrong door" entry point for all. While it may be a sign
1810 of a successful program for crisis care centers to operate at full capacity, crisis care center operators will
1811 need to maintain available capacity for new people to be able to enter. DCHS intends to require and
1812 support crisis care center operators to report near-real-time data on wait times, length of stay,
1813 occupancy, and other measures of capacity and throughput to inform policies that can be adjusted to
1814 ensure that crisis care centers are consistently accessible.

[183] Group for the Advancement of Psychiatry. (2021). Roadmap to the Ideal Crisis System: Essential Elements. Measurable Standards and Best Practices for Behavioral Health Crisis Response. National Council for Mental Wellbeing [LINK]
[184] The National Learning Consortium (2013). Continuous Quality Improvement (CQI) Strategies to Optimize your Practice: Primer. [LINK]
[185] Sherman, L. J., Lynch, S. E., Greeno, C. G. and Hoeffel, E. M. Behavioral health workforce: Quality assurance practices in mental health treatment facilities. The CBHSQ Report: July 11, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD. [LINK]
[186] Dzau VJ, Mate K, O'Kane M. Equity and Quality—Improving Health Care Delivery Requires Both. JAMA. 2022;327(6):519–520. [LINK]

1815
1816 DCHS will monitor utilization rates of crisis care centers and, if persistent underutilization is identified at
1817 a particular center, DCHS will work with the provider to take appropriate steps, including but not limited
1818 to, increased outreach and use of mobile services to address the needs of that particular center.
1819
1820 *Collect and Report High Quality Data*
1821 Accurate and updated clinical records are essential for outcome metrics and quality improvement
1822 activities to be accurate and meaningful. DCHS expects crisis care center operators to develop and
1823 maintain high quality data collection practices and will support their efforts to do so. Crisis care center
1824 operators should develop certified electronic health record systems that track standardized information,
1825 automatically update and interface with care coordination and quality improvement platforms, and
1826 utilize best practices for documentation, including approaches to gathering demographic information
1827 needed to inform equity analyses.[187] Ensuring the reliability of data is necessary for the quality
1828 improvement activities described above, as well as for meaningful evaluation and reporting as described
1829 in Section VII. Evaluation and Performance Measurement and Section VIII. Crisis Care Centers Levy
1830 Annual Reporting.
1831

Behavioral Health Equity Highlight

To address behavioral health inequities, it is necessary to measure disparities prior to and after implementation of interventions aimed at reducing inequities.[188]

The quality assurance and quality improvement practices required by this Plan are how the findings from the evaluation and performance measurement activities will be operationalized and implemented (see Section VII. Evaluation and Performance Measurement).

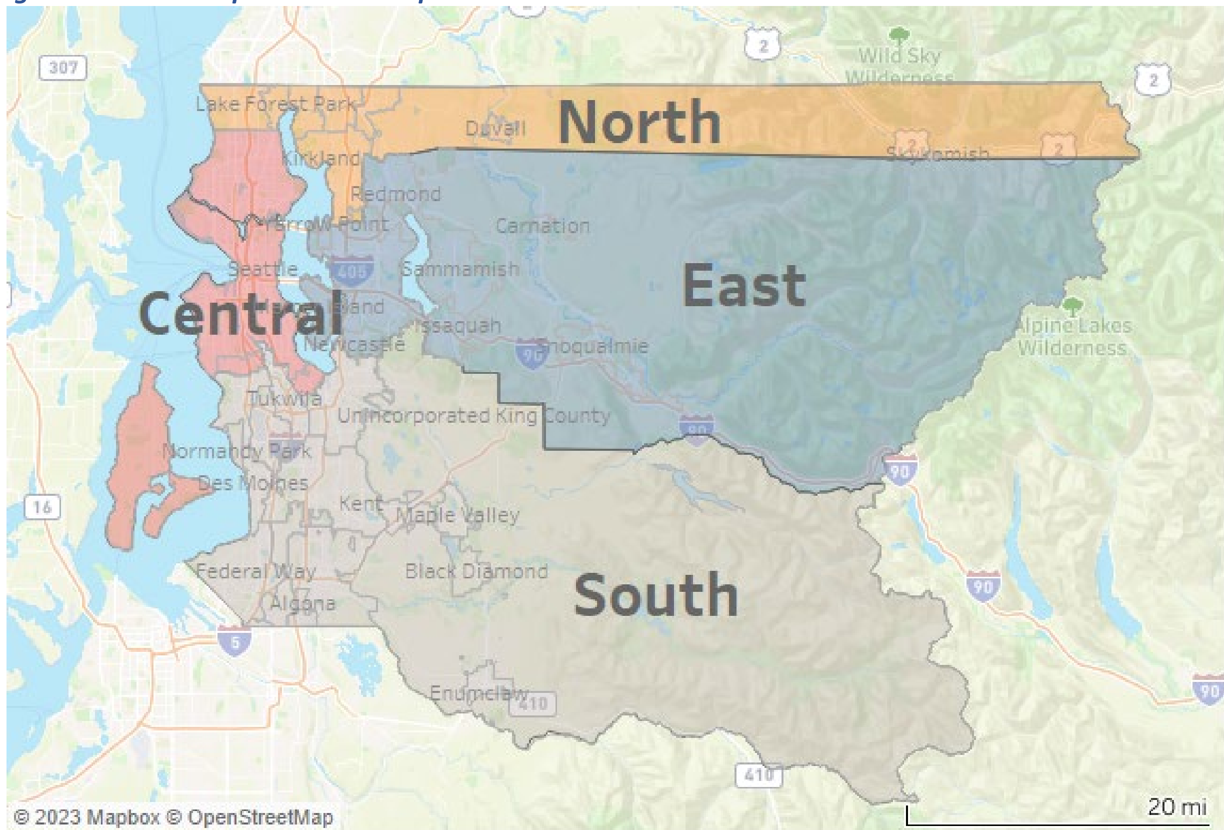
1832
1833 ## Crisis Care Center Capital Facility Development
1834 *Crisis Care Center Capital Activities*
1835 Strategy 1 investments will create a regional network of five crisis care centers in King County, including
1836 one center specializing in serving children and youth, to fulfill the CCC Levy's paramount purpose. King
1837 County intends to contract with operators to develop, maintain, and operate crisis care centers. Crisis
1838 care center operators will be selected through a competitive procurement process, which will begin in
1839 2024 and is described in Section V.A. Strategy 1:Created and Operated Five Crisis Care Centers: Crisis
1840 Care Center Procurement and Siting Process. Once selected, operators will lead crisis care center capital
1841 facility development in coordination with the County, the applicable local jurisdiction or jurisdictions,
1842 and community partners. Strategy 1 investments that will be used to support crisis care center facility
1843 capital development and maintenance activities are described in Figure 17.
1844
1845 ***Figure 17. Allowable Crisis Care Center Capital Development and Maintenance Activities***

Allowable Crisis Care Center Capital Development and Maintenance Activities	
Activity	**Description**

[187] Goldman, M. L., & Vinson, S. Y. (2022). Centering equity in mental health crisis services. World Psychiatry, 21(2), 243–244. [LINK]
[188] Goldman, M. L., & Vinson, S. Y. (2022). Centering equity in mental health crisis services. World Psychiatry, 21(2), 243–244. [LINK]

Crisis Care Center Capital Facility Development	Costs to develop and construct crisis care center facilities, such as but not limited to purchasing land, acquiring an existing facility, planning, design, building renovation or expansion, new construction, or other capital pre-development and development costs.
Crisis Care Center Capital Facility Maintenance	Ongoing crisis care center capital facility maintenance costs.

1846
1847 Crisis care center capital facilities funded with CCC Levy proceeds will be subject to the requirements
1848 defined in this Plan, future procurement processes, and contracts. Procurements of crisis care centers
1849 under Strategy 1 are intended to result in the combined characteristics and requirements described in
1850 this section when the network of five crisis care centers are considered together.
1851
1852 *Crisis Response Zone Requirements*
1853 At least one crisis care center must be located within each of the four crisis response zones defined in
1854 Ordinance 19572. Crisis response zone boundaries are depicted in Figure 18, and the cities and
1855 unincorporated regions of King County located within each zone are listed in Figure 19. The purpose of
1856 crisis response zones is to promote access by geographically distributing crisis care centers across King
1857 County. Crisis response zones do not restrict who can access crisis care centers. A person seeking
1858 services, or a first responder seeking to transport a person to receive services, can access a crisis care
1859 center in any zone.
1860
1861 ***Figure 18. Crisis Response Zone Map***



1862
1863

1864

1865 *Figure 19. Cities and Unincorporated Parts of King County Located Within Each Crisis Response Zone*

Cities and Unincorporated Parts of King County Located Within Each Crisis Response Zone			
Central CRZ	**North CRZ**	**East CRZ**	**South CRZ**
Seattle Unincorporated areas within King County Council District 2 Unincorporated areas within King County Council District 8	Bothell Duvall Kenmore Kirkland Lake Forest Park Shoreline Skykomish Woodinville Unincorporated areas within King County Council District 3 that are north or northeast of Redmond	Beaux Arts Bellevue Carnation Clyde Hill Hunts Point Issaquah Medina Mercer Island Newcastle North Bend Redmond Sammamish Snoqualmie Yarrow Point Unincorporated areas within King County Council District 3 that are east or southeast of Redmond Unincorporated areas within King County Council District 6	Algona Auburn Black Diamond Burien Covington Des Moines Enumclaw Federal Way Kent Maple Valley Milton Normandy Park Pacific Renton SeaTac Tukwila Unincorporated areas within King County Council District 5 Unincorporated areas within King County Council District 7 Unincorporated areas within King County Council District 9

1866

1867 *Public Interest Requirements*

1868 Crisis care center facilities will create long term crisis service capacity in King County. Any crisis care
1869 center facility that receives CCC Levy proceeds for capital development activities must meet the public
1870 interest requirements described in Figure 20 and requirements in future procurement processes and
1871 contracts. The purpose of these requirements is to ensure facilities receiving public capital resources are
1872 dedicated as crisis care centers for the life of the building or construction investments and that their
1873 development complies with County priorities.

1874

1875

1876 *Figure 20. Crisis Care Center Capital Facility Public Interest Requirements*

Crisis Care Center Capital Facility Public Interest Requirements	
Requirement	**Description**
1. 50 Year Minimum Use	Crisis care center capital facilities acquired or constructed with CCC Levy proceeds must remain dedicated to providing crisis care center services for a minimum of 50 years.
2. Operator Cap	A single operator should operate no more than three crisis care center facilities funded by CCC Levy proceeds. The purpose of this requirement is to ensure the CCC Levy is not overly reliant on a single operator.[189]
3. Leased Facility Restrictions	If a crisis care center operates in a leased facility, the operator must pursue ownership of the leased facility when possible. CCC Levy proceeds shall not be used to make capital improvements in leased facilities if the operator does not have an agreement to purchase the facility. The DCHS department director may authorize exceptions to this restriction if the exception is not inconsistent with the Levy's paramount purpose. The DCHS director must describe the rationale and terms of any exception to this restriction in a letter to the Chair of the King County Council to be sent within 90 days of approving the exception.
4. Environmental Sustainability Standards	Crisis care center facilities should align with environmental sustainability standards for building design and operations that King County will define in contracts. These standards and requirements will be informed by King County's Strategic Climate Action Plan, Green Building Ordinance, and Equity and Social Justice strategies for capital projects.[190,191]
5. Equity Impact	Crisis care centers should promote behavioral health equity. DCHS plans to include within Phase 2 of the Crisis Care Center Procurement and Siting Process, described in Figure 23, a requirement for potential crisis care center operators to assess the potential equity impacts of their proposal, and DCHS intends to consider those impacts when selecting crisis care center operators. DCHS also intends to include within a crisis care center operator's ongoing contract a requirement to periodically offer opportunities for persons receiving care at the crisis care center and persons living or working in the immediate area near a crisis care center to provide feedback on the crisis care center facility's equity impacts, and then propose to DCHS how that feedback will influence the operator's future operations within or near the facility.

1877

1878 *Site and Facility Requirements*

1879 Crisis care center sites must meet the minimum requirements described in Figure 21. Minimum
1880 requirements include sufficient size to deliver the crisis care center model's clinical components,

[189] Limiting the number of crisis care center facilities a single operator should operate will help ensure the stability of King County's future network of five crisis care centers in case an operator goes out of business, opts to terminate crisis care center operations, ceases to comply with contractual or licensing requirements, is acquired by or merges with another organization, or is otherwise compromised in a way that impacts the ongoing operations of crisis care center facilities or the quality of crisis care center services.

[190] King County 2020 Strategic Climate Action Plan (SCAP) [LINK]

[191] Green Building Ordinance - King County Code Chapter 18.17 [LINK]

1881 meaningful transportation access, accessibility and zoning requirements, and the ability to meet state
1882 behavioral health facility licensure requirements. Additional requirements may be included in future
1883 procurement processes and contracts to promote the goals and values described in this Plan.
1884
1885 ***Figure 21. Crisis Care Center Site Requirements***

Crisis Care Center Site Requirements	
Requirement	**Description**
1. Sufficient Size	Crisis care center sites must have sufficient space to deliver the crisis care center model's required clinical components. Sites should be able to accommodate a facility with approximately 30,000 to 50,000 square feet of licensed clinical space within one building, multiple adjacent buildings, or buildings that are connected by transportation for people accessing services.[192]
2. Meaningful Transportation Access	Crisis care center sites must be accessible to transportation. King County will prefer sites that have meaningful access to public transportation, convenient access for ambulances and first responders, proximity to major transportation arterials, and free public access for any person.
3. Accessibility Requirements	Crisis care center sites and buildings must be accessible for people with disabilities and comply with the Americans with Disabilities Act.[193] DCHS will prefer facility designs that incorporate the principles of universal design, meaning they are accessible to all people to the greatest extent possible without the need for adaption or specialized design.[194]
4. Zoning Requirements	Crisis care center operators must adhere to the relevant zoning and permitting laws and regulations of the jurisdiction within which a crisis care center facility is sited.
5. Licensure Feasibility	Crisis care center operators must propose sites that can satisfy state licensure requirements that apply to the types of behavioral health facilities that will occupy the site.

1886
1887 Crisis care center facility capital development may occur through a variety of potential scenarios,
1888 described in Figure 22, that are each eligible for CCC Levy funding under Strategy 1. These scenarios
1889 reflect the varied ways a facility could be developed while meeting all the crisis care center
1890 requirements. Crisis care center sites and facilities must be able to accommodate the crisis care center
1891 clinical model described in Section V.A. Strategy 1: Created and Operated Five Crisis Care Centers: Crisis
1892 Care Center Clinical Program Overview, modifications to that model that the County may make during
1893 the levy period, and additional requirements described in future procurement processes and contracts.
1894 This development model flexibility is allowed by Ordinance 19572. The purpose of this flexibility is to
1895 accelerate creation of high-quality crisis care centers, further discussed in Section V.A. Strategy
1896 1:Created and Operated Five Crisis Care Centers: Sequence and Timing of Planned Expenditures and
1897 Activities.
1898
1899

[192] Ordinance 19572
[193] U.S. Department of Justice Civil Rights Division, The Americans with Disabilities Act [LINK]
[194] U.S. General Services Administration, Universal Design and Accessibility [LINK]

1900 *Figure 22. Allowable Crisis Care Center Capital Development Scenarios*

Allowable Crisis Care Center Capital Development Scenarios	
Scenario	**Description**
Pre-Existing Facility	Crisis care centers may incorporate a pre-existing facility or program that provides behavioral health crisis stabilization services if the program's site, services, and operations are compatible with crisis care center requirements.
Facility Acquisition	Crisis care centers may be developed by acquiring, renovating, or expanding an existing facility.
New Construction	Crisis care centers may be developed through new construction.
Multiple Facilities	In addition to individual facilities, the required crisis care center clinical components may be located within geographically adjacent facilities or non-contiguous facilities if transportation is provided between facilities for people seeking and receiving services. Regardless of configuration, King County will prefer development proposals that provide easy access for patients to all crisis care center services.
A crisis care center proposal may combine two or more of these scenarios. DCHS will accept proposals from individual organizations and multiple organizations that are interested in forming a multi-organizational partnership or consortium to develop and operate a crisis care center.	

1901
1902 Facility operators may co-locate within a crisis care center ancillary services or programs that
1903 complement the crisis care center service model. Examples of such services or programs include, but are
1904 not limited to:
1905 - Community health clinics;
1906 - Outpatient behavioral health clinics;
1907 - Sobering, metabolizing[195], and post-overdose recovery centers;
1908 - Substance use treatment programs;
1909 - Affordable housing and permanent supportive housing, and
1910 - Other services that support the health and wellbeing of people accessing crisis care center
1911 services, their families, and their caregivers.

1912
1913 DCHS may prefer in procurements proposals that promote co-locations of complementary programs or
1914 services.
1915
1916 ## Crisis Care Center Procurement and Siting Process
1917 This subsection describes the crisis care center procurement and capital facility siting process,
1918 summarized in Figure 23.
1919
1920 Throughout the phases detailed in Figure 23, King County intends to support jurisdictions located within
1921 specific crisis response zones to coordinate with potential facility operators and to identify and

[195] Metabolizing services refers to the biological process of a person metabolizing a psychoactive substance to eliminate it from their body. Metabolizing services ("sobering") provide a safe environment for adults to recover from the acute effects of a psychoactive substance. Metabolizing services also serve as an access point for case management services and substance use services to support their self-determined health and recovery goals.

recommend crisis care center facility sites.[196] DCHS will ensure that activities King County may undertake to facilitate a potential crisis care center proposal do not inappropriately factor into consideration of crisis care center procurement.

Each competitive procurement process conducted for crisis care centers shall include non-scoring representatives on the proposal review panel to foster collaboration and understanding of local factors between King County and cities within each crisis response zone, to ensure individual cities and each per-zone group have a voice in the decision processes. The proposal review panel for each competitive procurement process shall include representatives as follows:

The proposal review panel for each competitive procurement process shall include representatives as follows:

1. A North King County crisis response zone representative selected by the Sound Cities Association from cities as defined in Section 1.C.1 of Ordinance 19572 to review crisis care center operator proposals for the north King County crisis response zone.
2. A Central King County crisis response zone representative selected by the Mayor and the Council of the City of Seattle to review crisis care center operator proposals for the central King County crisis response.
3. A South King County crisis response zone representative selected by the Sound Cities Association from cities as defined in Section 1.C.3 of Ordinance 19572 to review crisis care center operator proposals for the south King County crisis response zone.
4. An East King County crisis response zone representative selected by the Sound Cities Association from cities as defined in Section 1.C.4 of Ordinance 19572 to review crisis care center operator proposals for the east King County crisis response zone.
5. One representative selected by the City of Seattle and Sound Cities Association to review youth crisis care center operator proposals.

The City of Seattle and Sound Cities Association shall send the names of their representatives to the Director of the Department of Community and Human Services and the Director of the Behavioral Health and Recovery Division no later than September 1, 2024, for competitive procurements occurring in 2024, and by January 1 every year thereafter in which competitive procurements for crisis care center operators will take place. If the City of Seattle or Sound Cities Association has not yet sent the Department of Community and Human Services representatives for the proposal review panel by the dates identified in this section, then the Department may proceed with the procurement process without the representatives in order to avoid crisis care center timeline delays and the representative may join the review panel once selected.

When selecting a crisis care center site, each selected crisis care center operator shall work with the crisis response zone representative of the relevant jurisdiction in the site selection process.

Figure 23. Summary of Crisis Care Center Procurement and Siting Process

Summary of Crisis Care Center Procurement and Siting Process	
Siting Phase	**Description**

[196] In this section, "jurisdictions" means cities, tribes and other jurisdictional entities with siting authority that are physically located within King County.

Phase 1: Pre-Procurement	This is the period before DCHS procures crisis care center operators. Jurisdictions and potential crisis care center operators may form siting partnerships prior to the procurement process. DCHS provides technical support to potential host jurisdictions and facility operators to advance interjurisdictional alignment and partnerships between potential facility operators and jurisdictions.
Phase 2: Procurement	DCHS selects crisis care center operators through a competitive procurement process. DCHS will prefer operators that can demonstrate support from jurisdictions located within the crisis response zone where the crisis care center is proposed, with a focus on the host jurisdiction.
Phase 3: Siting	The period from DCHS executing contracts with a crisis care center operator to develop a facility and when a crisis care center facility opens. DCHS will support selected operators and host jurisdictions with community engagement and communications as described in Section V.E. Strategy 5: Capacity Building and Technical Assistance: Local Jurisdiction Capital Facility Siting Support Activities.
DCHS may be in different phases for each Crisis Response Zone and/or the youth-focused crisis care center at the same time, depending on how rapidly development of each crisis care center progresses.	

1962
1963 The competitive procurement process shall include an evaluation of how operators will ensure a
1964 therapeutic milieu for individuals with disparate and often conflicting needs, especially age disparities
1965 between youth in the youth facility, age disparities between seniors and adults in the adult facilities,
1966 individuals with substance use needs, and people in active psychosis.
1967
1968 DCHS will prefer crisis care center procurement proposals that demonstrate support from a jurisdiction
1969 located within the crisis response zone where the facility is proposed. Jurisdictions can demonstrate
1970 support for a proposed site by providing a written statement as part of the procurement process that
1971 includes, but is not limited to, the following criteria:

1972 • Support for a crisis care center to be developed and operated by the proposed operator.
1973 • Support for the proposed crisis care center facility site and confirmation that the site meets or is
1974 likely to meet the jurisdiction's zoning and other relevant local development requirements.[197]
1975 • If a specific site is not yet identified, willingness to support the proposed operator in identifying
1976 a site that complies with the jurisdiction's zoning and other local development requirements.
1977 • Commitment to supporting the proposed operator in engaging community members regarding
1978 the siting, development, and ongoing operations of a crisis care center facility.
1979
1980 Preference will be given to potential sites for crisis care centers with support from the host jurisdiction
1981 that also include, but are not limited to, the following:

1982 1. Existing facility or facilities that with retrofitting or remodeling will cost less than constructing a
1983 new facility.

[197] Nothing in this requirement shall be interpreted to require a jurisdiction to inappropriately preempt, influence, interfere with, or pre-judge a ministerial or administrative determination.

1984 2. Sites that are bounded on all sides by rights-of-way and do not have any shared lot lines with
1985 adjacent properties or otherwise consistent with jurisdictional zoning and land use
1986 requirements.
1987 3. Sites with larger facilities that include potential expansion space and/or additional space for
1988 supporting service providers.
1989 4. Locations central to the community it will serve.
1990 5. Locations close to, or co-located with, existing community health facilities and hospitals for easy
1991 access and referral capabilities.
1992 6. Locations that provide easy access to bus, streetcar, light rail, and other forms of public transit.
1993 7. Facilities that have or would allow ample available onsite parking.
1994 8. Facilities that include existing infrastructure necessary to host a variety of medical related
1995 services.
1996 9. Facilities with multiple entrances that can be used to segregate portions of the facility into
1997 independent facilities.

1998 DCHS will support the crisis care center facility siting process through CCC Levy funding as described in
1999 Section V.E. Strategy 5: Capacity Building and Technical Assistance. DCHS will also support the siting
2000 process by providing technical advice to jurisdictions and facility operators, supporting interjurisdictional
2001 partnerships, supporting partnerships between facility operators and jurisdictions, supporting
2002 community engagement, and creating and deploying communication content.
2003
2004 **Siting a crisis care center will be a complex process involving review and approval by at least three**
2005 **separate units of government** that only begins with Phases 1 and 2 in Figure 23. Once the King County-
2006 administered procurement is complete and contracts with the selected crisis care center operators are
2007 executed, Figure 23's Phase 3 requires an operator to complete at least two additional steps:
2008 • *Local Jurisdiction Zoning and Permitting:* First, an operator must satisfy land use, zoning, and
2009 permitting requirements of the host jurisdiction or jurisdictions. Each local jurisdiction defines
2010 its own land use, zoning, and permitting requirements and processes in accordance with state
2011 law. Historically, land use, zoning, and permitting decisions have often taken years, especially in
2012 conjunction with new construction or substantial capital rehabilitation for which some permits
2013 require a building or system to be built and then inspected while other types of permits must be
2014 acquired before or during construction.
2015 • *State-Level Facility and/or Operator Licensing:* Second, an operator must satisfy state-level
2016 Department of Health licensing requirements before a facility or its operator can begin providing
2017 certain types of behavioral health care that are required in the crisis care center clinical
2018 program. Other state-level licenses may also be necessary. It is common for Department of
2019 Health licensing requirements to take months, and they could take a year or more in some
2020 circumstances.
2021
2022 This Plan recognizes the necessity of:
2023 • County-level procurement and contracting;
2024 • City or other local jurisdiction-level land use, zoning, and permitting; and
2025 • State-level licensing and their attendant requirements for public notice and potential review.
2026
2027 **While recognizing the importance of these processes for effective facilities and operations, this Plan**
2028 **also acknowledges that in combination they have the potential to last for multiple years and**

constitute a substantial risk to the crisis care center capital development timelines that this Plan describes.

Alternative Siting Process

Ordinance 19572 requires a network of five crisis care centers by the end of 2032. Strong partnership between King County and cities or other local jurisdictions will produce the most rapid and effective accomplishment of this voter approved requirement. King County will encourage jurisdictions located within crisis response zones to coordinate with potential facility operators to identify and recommend crisis care center facility sites that meet the requirements defined in Ordinance 19572, this Plan, and future crisis care center procurement processes.

If, by December 31, 2026, King County does not yet have for any crisis response zone a viable proposal, with local jurisdiction support for an adult-focused crisis care center that meets the requirements defined in Ordinance 19572, this Plan, and future procurement processes, King County reserves all available rights, authorities, means, and abilities to proactively site and open an adult focused crisis care center within that crisis response zone.

If, by December 31, 2026, King County does not yet have a viable proposal that has host jurisdiction support for a youth-focused crisis care center that meets the requirements defined in King County Ordinance 19572, this Plan, and future procurement processes, King County reserves all available rights, authorities, means, and abilities to proactively site and open a youth focused crisis care center within King County.

The purpose of this alternative siting process is to prefer local jurisdiction supported crisis care center siting early in the CCC Levy period while ensuring that King County can fulfill the requirements of Ordinance 19572 as it was approved by a majority of King County voters in the April 2023 Special Election.

To best position crisis care centers for successful and timely siting in local jurisdictions, DCHS will maintain regular communications with stakeholders, including but not limited to the following:

- Provide email updates to all King County Council offices, members and alternate members of the King County Regional Policy Committee or its successor, and Sound Cities Association when planning and releasing annual procurements and when announcing procurement results.
- Incorporate updates on crisis care center operator awards and progress in each annual report.
- For any crisis response zone that does not yet have a supported crisis care center operator after the 2024 and 2025 procurements, convene relevant jurisdictions to coordinate partnerships, provide technical assistance funding, and any other resources to help promote a successful procurement prior to 2027.
- Create a list of steps needed to achieve a viable adult and youth crisis care center proposal, and by December 31, 2025, and prior to the release of the 2026 crisis care center operator procurement, and also at 30, 60, and 90 days prior to December 31, 2026, email an update to all King County Council offices, members and alternates of the King County Council Regional Policy Committee or its successor, and Sound Cities Association that summarizes steps remaining to achieve a viable proposal for each remaining unsited adult focused crisis care center or youth focused crisis care center, along with a red, yellow, or green milestone assessment of whether progress is on schedule to avoid an executive alternative siting process.

2075
2076 The Executive may only commence an alternative siting process authorized in this subsection after
2077 transmitting a notification letter to the King County Council describing the decision, issued no earlier
2078 than January 1, 2027. The Executive will electronically file the letter with the clerk of the Council, who
2079 will retain an electronic copy and provide an electronic copy to all councilmembers and all members of
2080 the Regional Policy Committee or its successor. Unless the Council passes a motion rejecting the
2081 commencement of the alternative siting process within 30 days of the Executive's transmittal, the
2082 Executive may proceed with the use of the alternative siting process.
2083

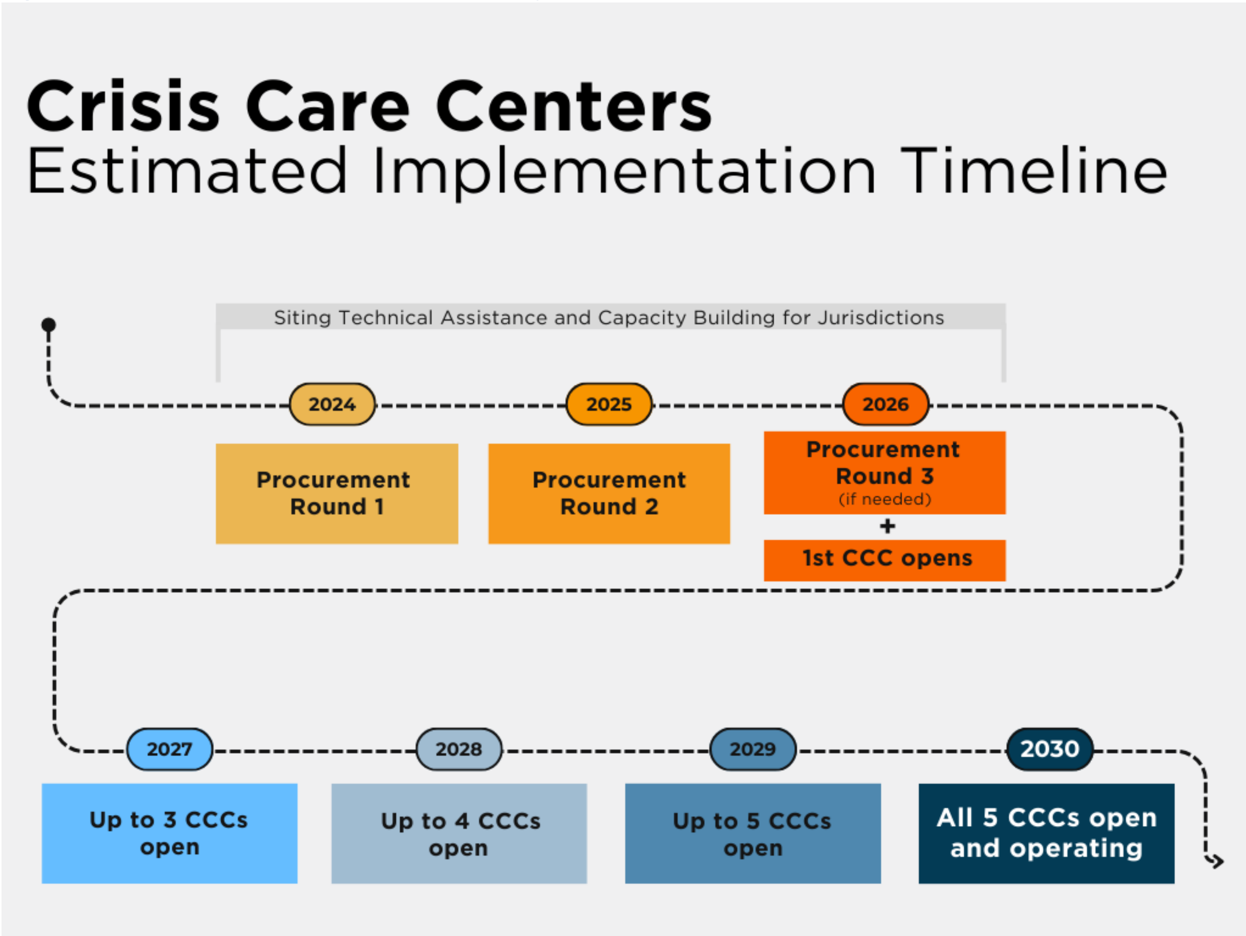
2084 Sequence and Timing of Planned Expenditures and Activities

2085 The process of developing and opening a crisis care center includes multiple parties and steps that have
2086 variable timelines. Before being able to open, any crisis care center would have had to satisfy at least
2087 the County-administered procurement and contracting process; a city or other local-jurisdiction defined
2088 land use, zoning, and/or permitting process; and a state department-defined licensing process. These
2089 necessary processes, administered by at least three separate levels of government, introduce
2090 substantial potential variability to the capital development timeline for a crisis care center.
2091
2092 This subsection describes the sequence and timing of expenditures and activities related to developing
2093 crisis care centers. It also describes when timelines may vary and how DCHS intends to work to mitigate
2094 these variables.
2095

2096 *Crisis Care Centers Implementation Timeline*

2097 DCHS intends to prioritize opening five crisis care centers as quickly as possible to meet the urgent
2098 needs of people experiencing behavioral health crises. DCHS plans to select crisis care center operators
2099 through an annual competitive procurement process starting in 2024, as depicted in Figure 24. The first
2100 procurement round in 2024 will prefer crisis care center proposals that can be developed and begin
2101 serving people rapidly. The 2024 round may include a single review deadline, multiple review deadlines,
2102 or a rolling review of applications, with the ability to make awards at different times within the round.
2103 The 2024 round will award contracts for a maximum of three centers. The purpose of this cap is twofold.
2104 First, it provides additional planning time for organizations that are interested in submitting a
2105 procurement proposal in 2025. The second purpose is to manage the timeline of expenditures against
2106 when CCC Levy proceeds are available. The 2025 procurement round will not have a cap on the number
2107 of awards, and a 2026 procurement round will only be held if operators for all five crisis care centers
2108 have not yet been selected.
2109
2110

2111 *Figure 24. Planned Crisis Care Center Development Timeline*



2112
2113
2114 CCC Levy funding to support crisis care centers' capital facility development and operating costs are
2115 planned to begin in 2025 and increase over time as crisis care centers are developed and become
2116 operational. Figure 24depicts the estimated opening timeline for the five crisis care centers that will be
2117 funded with proceeds from the CCC Levy and described in this Plan. Strategy 1 funding levels as
2118 described above in Section V.A. Strategy 1:Created and Operated Five Crisis Care Centers: Crisis Care
2119 Center Operational Activities support this timeline.
2120
2121 *Managing Development Timeline Variability*
2122 The crisis care center development timeline for individual facilities will likely differ due to the variability
2123 in capital facility development approaches depicted in Figure 22, and potential external factors that
2124 could impact the development timeline for a crisis care center during its siting, design, construction, or
2125 facility activation phases. Examples of such factors are summarized in Figure 25. This Plan identifies the
2126 factors and variety of responsible parties within Figure 25 to enable shared understanding between the
2127 King County Executive, King County Council, Regional Policy Committee, and King County residents
2128 about the importance of alignment to rapidly open crisis care centers, and about the substantial delays
2129 that are possible if various responsible parties are misaligned on the development of a crisis care center.
2130
2131

2132 *Figure 25. Examples of Potential Factors that Could Impact Crisis Care Centers' Development Timeline*

Examples of Potential Factors that Could Impact Crisis Care Centers' Development Timeline		
Development Phase	**Potential Factors Impacting Timeline**	**Responsible Parties**
Siting	• Site identification and feasibility analysis • Community engagement • Environmental impact review • Zoning and permitting	• Crisis care center operator • Local jurisdictions • DCHS supports community engagement
Design	• Programming and clinical processes • Schematic design and design development • WA Department of Health licensing review • Construction and permit documents • Design review process	• Design team • Crisis care center operator • Local jurisdictions • King County • WA Department of Health
Construction	• Supply chains • Macroeconomic conditions • Certificate of occupancy inspections • Labor availability	• Vendors and contractors • Crisis care center operator • Local jurisdictions
Facility Activation	• Equipment and furniture installation • IT installation and stocking supplies • Facility licensing • Labor supply • Staff onboarding and training	• Crisis care center operator • Local jurisdictions • WA Department of Health • Other licensing entities

2133
2134 DCHS will work to mitigate potential timeline delays by:
2135 • Accelerating the development steps managed by DCHS, including expediting the release of the
2136 crisis care centers procurement in 2024 after this Plan is adopted.
2137 • Striving to provide clear and transparent communication about CCC Levy implementation to
2138 support coordination and planning among parties involved in the development process;
2139 • Providing siting support to jurisdictions and crisis care center operators as described in Section
2140 V.E. Strategy 5: Capacity Building and Technical Assistance: Local Jurisdiction Capital Facility
2141 Siting Support Activities;
2142 • Allowing existing facilities or facilities under development that are already sited and require
2143 minimal construction to be eligible to respond to crisis care center procurements, and,
2144 • Reviewing facility development plans during the crisis care centers procurement and giving
2145 preference to proposals that can be developed and operated more rapidly while still meeting
2146 crisis care center requirements defined in this Plan and future procurements and contracts.
2147
2148 To ensure that five crisis care centers open by 2032, DCHS may choose to redistribute capital
2149 development funds, alter the siting location, and release additional procurements if DCHS determines
2150 that the development and opening timeline proposed by the selected crisis care center operator is no
2151 longer viable. Before exercising this option, DCHS will work closely with the selected operator and host
2152 jurisdiction to explore other paths to expedite the crisis care center development and opening.
2153
2154

2155 ## B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity

2156 ### Overview

2157 The CCC Levy's Strategy 2 resources will restore, expand, and sustain residential treatment capacity in
2158 furtherance of a CCC levy Supporting Purpose 1. Sustaining residential treatment capacity means
2159 investing in existing residential treatment capital facilities to help prevent further facility closures. King
2160 County has lost one-third of its mental health residential treatment capacity since 2018. This loss of
2161 capacity has increased residential treatment wait times, made it more challenging for people to be
2162 discharged from higher-intensity levels of care, and has impacted the capacity of other behavioral health
2163 care settings because people cannot access the level of care that they need. Strategy 2 funds and
2164 activities will be prioritized to support existing residential treatment operators to prevent further facility
2165 closures and to restore King County's mental health residential capacity to at least the 2018 level of 355
2166 beds.[198]
2167
2168 Residential treatment provides important community-based treatment options for people who do not
2169 need behavioral health inpatient care, but who need a higher level of care than behavioral health
2170 outpatient services. Activities in Strategy 2 were developed as described in Section III.D. Implementation
2171 Plan Methodology: Residential Treatment Methodology based on the background included in Section
2172 III.C. Key Historical and Current Conditions: Reduction in Residential Treatment Capacity and community
2173 engagement described in Section III.E. Community Engagement Summary: Theme E: Residential
2174 Treatment Expansion.
2175

2176 ### Activities to Restore, Expand, and Sustain Residential Treatment Capacity

2177 Strategy 2 will fund residential treatment capital facility development and maintenance activities. These
2178 activities are described in Figure 26. DCHS intends to distribute these resources to residential treatment
2179 facility operators through competitive procurement processes. Funding from this strategy may also be
2180 used to build additional residential treatment capacity beyond 355 beds.
2181

2182 ***Figure 26. Allowable Residential Treatment Facility Capital Development and Maintenance Activities***

Allowable Residential Treatment Facility Capital Development and Maintenance Activities	
Activity	**Description**
Residential Treatment Capital Facility Development	Costs to develop and construct residential treatment facilities, such as, but not limited to, purchasing land, acquiring an existing facility, planning and design, building renovation or expansion, new construction, and other capital pre-development and development costs.
Residential Treatment Capital Facility Improvements	Costs to make capital improvements to existing residential facilities, such as, but not limited to, facility repairs, renovations, and expansions or enhancements of existing facilities to maintain or improve operations.

[198] Mental health residential treatment facilities are a subset of residential treatment facilities, which are defined in King County Ordinance 19572 as "licensed, community-based facility that provides twenty-four-hour on-site care for persons with mental health conditions, substance use disorders, or both, in a residential setting" [LINK] This Plan prioritizes restoring mental health residential treatment capacity and preventing further residential treatment facility closures and may also expand other types of residential treatment facilities as allowed by Ordinance 19572 [LINK].

Residential Treatment Facility Maintenance	Residential treatment capital facility maintenance costs.

2183
2184 ## Residential Treatment Capital Facility Procurement and Siting Process
2185 This subsection describes the procurement and siting process for residential treatment facilities that
2186 receive capital funding from the CCC Levy proceeds described in this Plan. CCC Levy proceeds dedicated
2187 to residential facility capital development will be awarded through competitive procurement processes
2188 beginning in 2024. The factors that DCHS may consider when awarding Strategy 2 funds include:
2189 • Whether a proposal increases local access to residential treatment beds throughout King County
2190 by opening or expanding new residential treatment capacity in areas where few or no similar
2191 residential treatment facilities exist;
2192 • Whether a proposal leverages a proposer's sited or licensed facility, thereby decreasing the cost
2193 or time necessary for starting new operations or continuing improved operations by proposing
2194 restoration, rehabilitation, or otherwise using a facility that is already licensed, already sited, or
2195 otherwise already meets regulatory requirements, or
2196 • Whether a proposal to increase residential treatment capacity also increases equity in
2197 behavioral health system access by proposing funding for an organization with expertise and
2198 experience providing culturally and linguistically appropriate services for populations
2199 experiencing behavioral health inequities (see Section III.C. Key Historical and Current
2200 Conditions: Who Experiences Behavioral Health Inequities).
2201
2202 Organizations that are awarded capital resources to expand residential treatment facilities and thereby
2203 increase the number of treatment beds, must adhere to the relevant zoning and permitting laws and
2204 regulations of the jurisdiction within which residential treatment facilities are sited. These organizations
2205 must also satisfy licensing requirements from the state and additional requirements that King County
2206 may impose through contract.
2207
2208 ## 2024 Levy Funding Approach for Rapid Initial Progress on Residential Treatment
2209 Strategy 2's 2024 allocation will support capital improvement and maintenance costs of existing
2210 residential treatment facilities and the development of new residential treatment facilities. DCHS
2211 intends to accelerate the distribution of resources to support existing residential treatment facilities by
2212 leveraging a broader behavioral health capital facility improvement procurement process that is planned
2213 for early 2024 and incorporates other funding sources, most notably MIDD.[199] The combined
2214 procurement process will begin in early 2024 to expedite awarding of these resources soon after this
2215 Plan is adopted. DCHS also plans to open a procurement in 2024 to distribute funds to support the
2216 capital development of new residential treatment facilities. Procurement awards will not be made until
2217 after this Plan is adopted. Figure 27 describes the anticipated timeline to distribute capital funding for
2218 residential treatment facilities in 2024.
2219

[199] King County Ordinance 19712 appropriated MIDD funding for this purpose. [LINK] DCHS is planning to open a behavioral health capital procurement in early 2024. DCHS intends to also procure proposals to support capital improvement and maintenance costs of existing residential treatment facilities to accelerate to distribution of CCC Levy resources once this Plan is adopted.

2220 *Figure 27. Timeline to Distribute CCC Levy Proceeds to Support Residential Treatment Facilities in 2024*

Timeline to Distribute CCC Levy Proceeds to Support Residential Treatment Facilities in 2024		
Mid-2023	Early 2024	As Early as Mid-2024
Request for Information: DCHS solicited information from residential treatment facility operators about capital maintenance and improvement funding needs to help inform this Plan and procurement process.	**Competitive Procurement:** DCHS plans to conduct a behavioral health capital facility procurement process that includes 2024 CCC Levy proceeds for residential treatment facilities preservation and development of new residential treatment facilities.	**Funds Distribution:** DCHS plans to award funding to residential treatment facility operators after this Plan is adopted.

2221

2222 ### Initial Prioritization of Residential Treatment Capacity

2223 The financial plan as described in Figure 35 contains an approximate allocation for Strategy 2: Restore,
2224 Expand, and Sustain Residential Treatment Capacity of $48,575,000 in 2027 and $1,464,000 in 2028,
2225 with similar amounts thereafter. The Executive will assess the outcome of these investments and report
2226 whether the financial plan remains on target for these investments as part of the annual report.

2227

2228 ## C. Strategy 3: Strengthen the Community Behavioral Health Workforce

2229 ### Overview

2230 It takes people to treat people. Strategy 3 directly supports the CCC Levy's Supporting Purpose 2 by
2231 investing in activities to strengthen the community behavioral health[200] workforce in King County. This
2232 strategy also directly supports the CCC Levy's Paramount Purpose to establish and operate five crisis
2233 care centers by investing in the development of King County's behavioral health crisis workforce,
2234 including crisis care center workers.

2235

2236 Strategy 3's workforce activities focus on helping more people join and make a career in community
2237 behavioral health. Allowable activities within Strategy 3 fall into three broad categories:

2238 - Career pathways for the broader community behavioral health workforce (called **community**
2239 **behavioral health career pathways**): Resources such as training and paying licensing fees that
2240 help workers join and progress within the community behavioral health workforce;
2241 - Labor-management partnerships on shared workforce development efforts for the broader
2242 community behavioral health workforce (called **labor-management workforce development**
2243 **partnerships**): Programs like apprenticeships and training funds, and
2244 - Workforce development efforts that are specific to the crisis response behavioral health
2245 workforce (called **crisis workforce development**): Specialized training for crisis workers and
2246 crisis settings.

2247

[200] As noted in footnote 58, in the context of this Plan, "community behavioral health" are those agencies that: meet the requirements defined in RCW Chapter 71.24, are licensed by the Washington State Department of Health as a community behavioral health agency as defined in WAC Chapter 246-341, and are contracted with the County's BH-ASO or KCICN. Community behavioral health agencies must serve people who are enrolled in Medicaid health insurance to be eligible for CCC Levy funding through Strategy 3

2248 Figure 28 provides additional summary descriptions for each of Strategy 3's broad categories, and each
2249 is described in detail later in this section.
2250
2251 *Figure 28. Allowable Community Behavioral Health Workforce Activities*

Allowable Community Behavioral Health Workforce Activities	
Activity	**Description**
Community Behavioral Health Career Pathways	Resources to stabilize King County's community behavioral health workforce from 2024-2026 through investments such as financial assistance with license and other professional fees, training and supporting the professional development of staff, and retaining and supporting the wellbeing of workers through activities that promote the physical, mental, and emotional health of employees. At least 25 percent of funding for this activity will be used to increase the representativeness of community behavioral health workers. DCHS will assess the outcomes of these stabilization investments and will propose a refined investment approach to King County Council for 2027 to 2032.
Labor-Management Workforce Development Partnerships	Funding to sustain and expand labor-management workforce development partnerships, including Washington State registered apprenticeship programs and labor-management partnership training funds.
Crisis Workforce Development	Funding to build King County's crisis behavioral health workforce, including recruiting and retaining crisis care center workers and post-crisis follow-up workers and investing in specialty crisis training for community behavioral health workers serving King County.[201]

2252

2253 ### Community Behavioral Health Career Pathway Activities

2254 Strategy 3 will fund career pathway activities to support the development of King County's community
2255 behavioral health workforce, as described in Figure 29 and Figure 30.[202] Career pathway resources will
2256 support the recruitment, training, retention, and wellbeing of community behavioral health workers
2257 through activities such as:
2258 - Tuition assistance;
2259 - Stipends for paid internships;
2260 - Clinical supervision costs;
2261 - Professional licensure fees;
2262 - Grants for community behavioral health agencies to promote the wellbeing of workers,[203] and

[201] Post-crisis follow-up workers are behavioral health workers who provide post-crisis follow-up services for people who receive services at crisis care centers and are employed by agencies that are contracted to provide post-crisis follow-up services defined in Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers.
[202] Within the context of this Plan, "career pathways" means activities like training and recruiting that promote existing behavioral health workers' professional development and support and incentivize new and existing workers to start and pursue long-term careers in community behavioral health.
[203] Examples of activities that promote the wellbeing of community behavioral health workers include supervision and mentorship, covering staff time for self-directed program development and quality improvement initiatives, and access to mental health benefits.

2263 • Clinical training, including evidence-based practice training.

2264 DCHS will use at least 25 percent of the resources dedicated for community behavioral health career
2265 pathway activities for investments that are directly related to increasing the representativeness of King
2266 County's community behavioral health workforce.[204]
2267

2268 DCHS intends to support community behavioral health agencies contracted with the King County
2269 Integrated Care Network (KCICN) for career pathway activities through the expansion of existing
2270 contracts, reimbursement for eligible activities through existing payment mechanisms, and possible
2271 competitive procurements. These investment approaches will be consistent with DCHS's strategic
2272 community behavioral health workforce development plan, which will be approved by the County-
2273 provider Executive Committee of the KCICN and will be informed by significant and broad community
2274 engagement.
2275

2276 *Initial Prioritization and Assessment of Career Pathway Activities*

2277 Between 2024 and the end of 2026, as depicted in Figure 29, DCHS will fund career pathway activities to
2278 strengthen, support the development, and increase the representativeness of King County's community
2279 behavioral health workforce. During 2024 and 2025, DCHS will assess the impact of activities by
2280 researching best and emerging community behavioral health workforce development practices and
2281 soliciting input from community partners, behavioral health workers, and community behavioral health
2282 agency leaders. This assessment will allow DCHS to refine the initial funding approach and improve
2283 activities to strengthen the community behavioral health workforce, increase the representativeness of
2284 behavioral health workers, and build the community behavioral health workforce pipeline.
2285

2286 As part of this assessment, DCHS will convene a workgroup with community partners that have subject
2287 matter expertise in behavioral health workforce development to inform proposed refinements and
2288 adjustments to the initial funding approach. The assessment will include reviewing the impact of career
2289 pathway activities on increasing the representativeness of community behavioral health workers.
2290 Workgroup membership will include, but is not limited to:

2291 • Representatives of workers, including representatives of labor-management workforce
2292 development partnerships;
2293 • Higher education training programs, including a community and technical college;
2294 • Community behavioral health agencies, including representation from both an agency that
2295 provides mental health services and an agency that provides substance use services, and
2296 • People with expertise in improving the representativeness of the behavioral health workforce,
2297 including workers who identify as members of populations experiencing behavioral health
2298 inequities (see Section III.C. Key Historical and Current Conditions: Who Experiences Behavioral
2299 Health Inequities).
2300

2301 In 2026, prior to releasing funding for career pathway activities for 2027 to 2032, the Executive will
2302 transmit a notification letter to Council proposing refinements to career pathway activities and
2303 describing the community engagement process that informed the proposal. The Executive will
2304 electronically file the letter with the Clerk of the Council, who will retain an electronic copy and provide
2305 an electronic copy to all councilmembers, and members of the Regional Policy Committee. Unless the

[204] See Section III.F. Behavioral Health Equity Framework.

2306 Council passes a motion rejecting the contemplated change within 30 days of the Executive's transmittal
2307 or funding has not yet been sufficiently appropriated, the Executive may proceed with the use of funds
2308 allocated for 2027 to 2032 as set forth in the notification letter. All CCC Levy proceeds will remain
2309 subject to Council appropriation.
2310
2311 ***Figure 29. Community Behavioral Health Career Pathway Activities Timeline***

2312
2313
2314 Section VII. Evaluation and Performance Measurement outlines DCHS's expected performance
2315 measurement for workforce investments. Where feasible, DCHS plans to use collected data to assess the
2316 representativeness of workforce and effect of investments to increase the representativeness of
2317 workers to better reflect the demographics of the people receiving community behavioral health
2318 services.
2319
2320

Behavioral Health Equity Highlight

There is evidence that improving diversity among behavioral health workers to better reflect the communities they serve may help improve communication and trust while reducing behavioral health disparities. Community engagement further endorsed the importance of workforce representativeness. The activities referenced in this strategy to increase representativeness of the

behavioral health workforce are central to meeting the goals described in Section III.F. Behavioral Health Equity Framework: Representative Behavioral Health Workforce.

2321
2322 While not Strategy 3's focus, King County recognizes behavioral health wages as an important factor in
2323 both recruitment and retention activities. CCC Levy resources are insufficient to increase wages
2324 meaningfully and consistently across the region's entire community behavioral health workforce. Even if
2325 this were possible, doing so would substantially commit local funding where federal and state funding
2326 should increase instead. Specifically, investing local funds to raise wages for the region's entire
2327 community behavioral health workforce could inhibit efforts to raise Medicaid rates that would
2328 sustainably raise wages for the region's behavioral health workforce with federal and state funds. One
2329 exception to this general principle is that this Plan's Strategy 3 authorizes and allocates funds to support
2330 appropriate wages for the crisis care center workforce because these investments support the CCC
2331 Levy's Paramount Purpose. If funds become available through this Plan's provisions to allocate
2332 additional funds (see Section VI. Financial Plan: Process to Make Substantial Adjustments to the
2333 Financial Plan), this strategy authorizes DCHS to develop and administer activities to increase wages for
2334 the broader behavioral health workforce.
2335

2336 Labor Management Workforce Development Partnership Activities

2337 Labor management workforce development partnerships are activities that are supported by both
2338 management and front-line workers, in this case community behavioral health agencies and workers,
2339 including agencies that are represented by labor unions and agencies that are not represented.[205,206]
2340 Strategy 3 funds labor management workforce development partnership activities, including behavioral
2341 health apprenticeships and other behavioral health worker training opportunities. These investments
2342 are intended to help build a skilled and diverse community behavioral health care workforce in King
2343 County in a way that incorporates workers' voices in workforce development.
2344

2345 *Behavioral Health Apprenticeship Program Activities*

2346 Strategy 3 includes funding to sustain and expand a Washington State registered apprenticeship
2347 program that offers behavioral health apprenticeships. Behavioral health apprenticeship programs are
2348 paid on the job training programs paired with technical instruction to train workers for behavioral health
2349 careers. These careers include but are not limited to peer counselors, substance use disorder
2350 professionals, and behavioral health technicians.
2351
2352 Apprenticeship programs provide access to education and training for people who may be unable to
2353 afford college or significant classroom instruction time while working. The flexibility of apprenticeship
2354 programs can aid in recruitment of individuals from diverse backgrounds that historically have not had
2355 access to traditional higher education programs.[207]
2356
2357 Apprenticeships help workers and employers: Apprenticeship programs benefit workers by providing
2358 pay and benefits while pursuing a certification to advance their behavioral health careers.

---

[205] Labor management partnerships are relationships between front line workers and management. It is a collaborative effort focused on common goals, relationship with unified mission, improve organizational performance and employee wellbeing. [LINK]
[206] SEIU Healthcare 1199NW Multi-Employer Training Fund. [LINK]
[207] Health Care Apprenticeship Consortium [LINK]

2359 Apprenticeship programs benefit employers by building a skilled behavioral health workforce,
2360 promoting employee retention through professional development, and promoting increased workforce
2361 representation by reducing professional development barriers such as training costs.[208]
2362
2363 The apprenticeship programs funded by Strategy 3 will be available to community behavioral health
2364 agencies in King County and workers they employ to participate in behavioral health apprenticeships.
2365 Crisis care center operators funded with CCC Levy proceeds are among the eligible providers.
2366 Apprenticeships are managed by Washington State registered apprenticeship programs, and employers
2367 are responsible for hiring apprentices and mentors. Strategy 3 will sustain and expand DCHS's existing
2368 contract with a Washington State registered apprenticeship program. Eligible activities include, but are
2369 not limited to, apprenticeship program costs, eligible apprentice salary and benefit costs, employer and
2370 apprentice incentives, and program planning and recruitment costs.
2371
2372 *Labor Management Partnership Training Activities*
2373 Strategy 3 will also sustain and expand access to labor management partnership training activities for
2374 community behavioral health agencies in King County, including CCC levy-funded crisis care centers
2375 operators. Labor-management partnership training activities are developed in partnership between
2376 community behavioral health agency employers and frontline workers. DCHS intends to procure labor
2377 management training proposals and contract with community behavioral health agencies to pay for
2378 eligible activities. Eligible activities may include, but are not limited to, tuition assistance, professional
2379 development costs, professional certification fees, student supports, and career counseling. Community
2380 behavioral health agencies may use training resources for a labor-management partnership training
2381 fund in which they participate, or they may manage the training resources directly.[209]
2382
2383 ## Crisis Workforce Development Activities
2384 King County will need more people to join the region's community behavioral health workforce to staff
2385 CCC Levy-funded crisis care centers. Specific roles that crisis care centers need include, but are not
2386 limited to, peer specialists, substance use disorder professionals, mental health professionals,
2387 behavioral health technicians, nurses, nurse practitioners, and physicians. In addition to training and
2388 recruiting additional behavioral health workers, building a crisis workforce will require training existing
2389 workers to provide crisis services. Crisis services are unique clinical services that require specialized skills
2390 in de-escalation, risk assessment, triage decision-making, and motivational interviewing. Strategy 3
2391 invests resources to develop a crisis workforce in King County, which is described in the subsections
2392 below.
2393
2394 *Crisis Care Center and Post-Crisis Follow-Up Workforce Development Activities*
2395 Crisis care centers and post-crisis follow-up programs funded by CCC Levy proceeds, including
2396 organizations with expertise in delivering culturally and linguistically appropriate services (see Section
2397 V.A. Strategy 1: Create and Operate Five Crisis Care Centers: Post-Crisis Stabilization Activities), will need

[208] Health Care Apprenticeship Consortium [LINK]
[209] Labor management partnership training funds are structures that support health care entities, including community behavioral health agencies, in investing in direct education and training benefits at no cost for their employees.

2398 to hire hundreds of behavioral workers to operate at their full capacity.[210] Eligible activities under this
2399 component of Strategy 3 will invest in these organizations to recruit, train, retain, develop, and support
2400 the wellbeing of behavioral health crisis workers. Funds for these activities will be distributed to both
2401 crisis care center operators and post-crisis follow-up providers through a competitive procurement
2402 process and may be used to:

2403 - Increase wages for workers;
2404 - Improve benefits for workers;
2405 - Reduce the cost of living for workers, such as housing, education, or childcare;
2406 - Support the professional development of workers to improve service quality, and
2407 - Support worker wellbeing through activities such as supervision and mentorship, covering staff
2408 time for self-directed program development and quality improvement initiatives, and access to
2409 behavioral health benefits.

2410

2411 *Crisis Workforce Training Activities*

2412 Strategy 3 also includes activities to strengthen King County's community behavioral health crisis
2413 workforce, including, but not limited to, crisis care centers funded by CCC Levy proceeds. DCHS will
2414 procure one or more entities to develop crisis specialty training resources that will be made available for
2415 behavioral health workers serving King County. Training resources will aim to build behavioral health
2416 workers' knowledge and skill of how to assess, triage, and provide behavioral health crisis stabilization
2417 and treatment services for clients by using evidence-based and promising practices, culturally and
2418 linguistically appropriate approaches, trauma-informed care, and care coordination best practices.
2419 These training resources are intended to support behavioral health workers who work in specialty crisis
2420 settings as well as behavioral health workers who work in other settings, such as outpatient settings,
2421 who may benefit from developing their skills related to supporting a person experiencing a behavioral
2422 health crisis.[211] DCHS may invest in training opportunities that build the crisis skills of specific behavioral
2423 health professions, such as specialty crisis internships, practicums, residencies, and fellowships for
2424 behavioral health students and workers pursuing careers in behavioral health crisis services.

2425

2426 ### 2024 Funding Approach for Rapid Initial Progress on Behavioral Health Workforce

2427 DCHS intends to make rapid initial progress towards fulfilling Supporting Purpose 2 by allocating CCC
2428 Levy proceeds through Strategy 3 in 2024. Early workforce investments planned for 2024 and depicted
2429 in Figure 30 will help strengthen King County's community behavioral health workforce, support the
2430 development of the behavioral health worker pipeline, and prepare to build the crisis specialty skills of
2431 behavioral health workers in King County. DCHS plans to begin the procurement and contract processes
2432 for these activities in early 2024 to expedite the distribution of these resources soon after this Plan is
2433 adopted. In this scenario, procurement awards will not be made until after the Plan is adopted.

2434

2435

---

[210] For the purposes of being eligible for workforce investments under Strategy 3, providers with expertise in delivering culturally and linguistically appropriate services will be exempted from the requirements described in the definition of "community behavioral health" described in the footnote above.

[211] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Crisis Services and the Behavioral Health Workforce Issue Brief [LINK].

2436 *Figure 30. Strategy 3 Plans in 2024 to Make Rapid Progress Towards Fulfilling Supporting Purpose 2*

Strategy 3 Plans in 2024 to Make Rapid Progress Toward Fulfilling Supporting Purpose 2	
Activity	**2024 Plans**
Community Behavioral Health Career Pathways	DCHS will provide resources to strengthen King County's community behavioral health workforces through existing King County Integrated Care Network contracts, reimbursing allowable expenses, and possible procurements.[212] At least 25 percent of funding for this activity will be used to increase the representativeness of community behavioral health workers.
Labor-Management Workforce Development Partnerships	DCHS will expand its contract with a Washington State registered apprenticeship program to sustain and expand behavioral health apprenticeships. DCHS will procure proposals for labor-management partnership training activities.
Crisis Workforce Development	DCHS will procure one or more entities to develop crisis specialty training resources for community behavioral health workers serving King County.

2437

2438 **D. Strategy 4: Early Crisis Response Investments**

2439 Crisis care centers are major capital facility projects that will take time to develop and will not open
2440 immediately. The anticipated crisis care center opening timeline is described in Section V.A. Strategy 1:
2441 Create and Operate 5 Crisis Care Centers: Sequence and Timing of Planned Expenditures and Activities.
2442 Strategy 4's early crisis system activities will bring additional behavioral health crisis services and
2443 resources to King County beginning in 2024, particularly to increase community-based crisis response
2444 capacity, reduce fatal opioid overdoses, and invest in substance use capital facilities. Allowable activities
2445 are described in this section and are summarized in Figure 31.
2446
2447

[212] When possible, procurements will be combined to expedite the allocation of resources and to simplify the process for respondents. Funding will not be awarded until after this Plan is adopted.

2448 *Figure 31. Summary of Allowable Crisis Response Investment Activities Beginning in 2024*

Summary of Allowable Crisis Response Investment Activities Beginning in 2024	
Activity	**Description**
Increase Community-Based Crisis Response Capacity	Investments to expand community-based crisis response capacity, including expansion of adult and youth mobile crisis services and expansion of a pilot program that redirects 911 calls to behavioral health counselors.
Reduce Fatal Opioid Overdoses by Expanding Access to Low Barrier Opioid Overdose Reversal Medication	Investments to expand low-barrier access to medications and other public health supplies to reduce opioid overdose deaths, including naloxone and fentanyl testing strips. A portion of funds may be used for King County to administer the resources funded by this strategy and provide overdose prevention education.
Substance Use Facility Investments	Investments include capital funding for one or more behavioral health facilities that can create faster in-person access to substance use crisis services, for costs such as facility renovation or expansion, new construction, and other capital development or capital improvement costs.[213] This may include funding for operations of an eligible client engagement team to support people with behavioral health, health care, and social service needs in the immediate area surrounding a capital facility funded by this strategy.[214]

2449

2450 ## Increase Community-Based Crisis Response Capacity

2451 Strategy 4 includes activities to increase the capacity of community-based crisis response programs.
2452 Community-based crisis response programs are services that can support a person experiencing a
2453 behavioral health crisis in a community-based setting. DCHS intends to expand the capacity of mobile
2454 crisis teams and a pilot program that redirects 911 calls to behavioral health specialists. These programs,
2455 which are described in more detail in the subsections below, will expand access to community-based
2456 crisis resources starting in 2024 before crisis care centers open. In addition, these investments will
2457 complement crisis care centers by increasing capacity to resolve a person's crisis in community-based
2458 settings whenever possible without a transfer to facility-based care at a crisis care center. These
2459 investments may help manage crisis care centers' capacity and client flow, which is further discussed in
2460 Section V.A. Create and Operate Five Crisis Care Centers: Examples of Continuous Quality Improvement
2461 Activities.

2462

2463 ### *Expand Mobile Crisis Services*

2464 Mobile crisis services are provided by teams of behavioral health clinicians and peers who travel to
2465 community-based settings to support people experiencing behavioral health crises. Mobile crisis
2466 responders work to resolve a person's behavioral health crisis in the community by providing crisis
2467 assessments, brief clinical interventions, and immediate basic need supports. Mobile crisis services also
2468 provide referrals and arrange transportation to appropriate care settings when a crisis cannot be
2469 resolved in the community. Strategy 4 will expand the capacity of mobile crisis services in King County,

[213] Eligible site-based behavioral health facilities are defined in the Section V.D. Strategy 4: Early Crisis Response Investments: Substance Use Capital Facility Investments.

[214] Eligible client engagement teams are defined in the subsection within this section titled Section V.D. Strategy 4: Early Crisis Response Investments: Substance Use Capital Facility Investments.

2470 including services for adults and youth, starting in 2024. DCHS intends to distribute these funds through
2471 contract expansions with existing mobile crisis service providers and through a competitive procurement
2472 process. This expansion will create additional crisis service capacity before crisis care centers open. It
2473 will also complement crisis care centers once they open by addressing crises in community settings
2474 whenever possible and serving as a key referral source when people need facility-based crisis care.
2475
2476 Mobile crisis service funding is an investment area that the state has an opportunity to increase and
2477 complement the CCC Levy. The state is responsible for funding mobile crisis services, including in King
2478 County, but the level of state investment is not yet adequate to provide the scale of mobile crisis
2479 services that is needed in King County. This means that people who could benefit from mobile crisis
2480 services are unable to access care. If the state increases mobile crisis funding during the CCC Levy period
2481 to a level that is better able to meet the needs of people living in King County, then DCHS may redirect
2482 Strategy 4 funds for this activity to another use, according to the funding prioritization described in
2483 Section VI. Financial Plan: Process to Make Substantial Adjustments to the Financial Plan.
2484
2485 *Embed Behavioral Health Counselors in 911 Call Centers*
2486 When a person in King County is experiencing a behavioral health crisis and calls 911 seeking help, the
2487 main ways to access behavioral health care are through first responders transporting the person to
2488 emergency departments, or in limited cases, the Crisis Solution Center described in Section III.C. Key
2489 Historical and Current Conditions: Need for Places to Go When in Crisis. An innovative national program
2490 model is being piloted in King County to co-locate trained behavioral health counselors in 911 call
2491 centers.[215,216] This model makes it possible to redirect behavioral health crisis calls to specialized
2492 behavioral health counselors in lieu of law enforcement dispatch.[217] Once the call is redirected to a
2493 behavioral health counselor, the counselor works to support the person over the phone or dispatches a
2494 mobile crisis team to respond to the person. Given the limited first responder resources available, law
2495 enforcement agencies have supported this model to reduce strain on emergency services.[218] Strategy 4
2496 invests funding to expand this King County pilot starting in 2024.
2497
2498

[215] The Council of State Governments Justice Center, Tips for Successfully Implementing a 911 Dispatch Diversion Program, October 2021. [LINK]
[216] The Washington State Department of Health (DOH) is collaborating with Washington's 988 Lifeline crisis centers and 911 call centers, including in King County, to pilot this model on a small scale. The Mental Health Crisis Call Diversion Initiative is funded by the Washington State Department of Health and is described in RCW 71.24.890(2)(a). [LINK]
[217] National Association of State Mental Health Program Directors, 988 Convening Playbook – Public Safety Answering Points (PSAPs). [LINK]
[218] Police Executive Research Forum, Rethinking the Police Response to Mental Health-Related Calls Promising Models, October 2023. [LINK]

Behavioral Health Equity Highlight

Populations experiencing behavioral health inequities are more likely to be placed into involuntary treatment and be victims of police violence. DCHS aims to reduce these inequities by increasing access to community-based services as alternatives to law enforcement.

2499

2500 ## Reduce Fatal Opioid Overdoses by Expanding Low Barrier Opioid Reversal Medication

2501 King County is experiencing an unprecedented number of opioid overdoses, as discussed in Section III.C.
2502 Key Historical and Current Conditions: Unprecedented Rates of Suicide and Overdose Deaths. Naloxone
2503 is a lifesaving opioid overdose reversal medication that can be safely administered in community-based
2504 settings to prevent opioid overdose deaths.[219] Expanding access to naloxone and other public health
2505 resources in community-based settings can help prevent fatal opioid overdoses and other negative
2506 health outcomes. Beginning in 2024, Strategy 4 will fund activities that aim to reduce fatal opioid
2507 overdoses, including expanding access to naloxone and other relevant public health supplies through
2508 vending machines and other community-based distribution mechanisms.[220] The medication and public
2509 health supplies distributed through vending machines and other mechanisms will be provided at no cost
2510 to community members and may be managed by King County. A portion of these funds may be used for
2511 King County to administer the resources funded by this strategy and provide overdose prevention
2512 education. King County will prioritize increasing access to naloxone and other relevant public health
2513 supplies in settings and communities that are experiencing the highest opioid overdose rates and the
2514 greatest opioid overdose disparities. Public Health Seattle and King County (PHSKC) online overdose
2515 data dashboards provide information about communities in the greatest need.[221]

2516

2517 ## Substance Use Facility Investments

2518 Strategy 4 also includes capital facility funding for one or more site-based behavioral health facilities,
2519 especially those that are already permitted and can create faster in-person access to substance use crisis
2520 services, such as post-overdose recovery services, sobering services, and metabolizing services. Capital
2521 development activities may include, but are not limited to, facility renovation or expansion costs, new
2522 construction costs, and other capital development or capital improvement costs. One facility funded by
2523 Strategy 4 will include the 3rd Avenue post-overdose recovery center in Seattle. Strategy 4 may also
2524 include funding for the operations of a client engagement team to support people with behavioral
2525 health , health care, and social service needs in the immediate area surrounding a capital facility funded
2526 by this strategy if that client engagement team is operated by the same organization, or a subcontractor,
2527 providing services within a capital facility funded by this strategy for the purpose of engaging persons in
2528 services or promoting a healthy environment in which to seek or receive services.

2529

[219] Washington State Department of Health Naloxone Instructions [LINK]

[220] Other public health resources may include resources that help prevent the death of people who use substances, reduce the risk of disease transmission, and support the health of people who use substances. An example of such a resource could include, but is not limited to, fentanyl testing strips. Other distribution mechanisms may include, but are not limited to, naloxone distribution boxes and other distribution mechanisms that make naloxone available for focused populations and the public.

[221] Seattle and King County Public Health online overdose data dashboards. [LINK]

2530 ## E. Strategy 5: Capacity Building and Technical Assistance

2531 The investments made by the CCC Levy represent a significant expansion in King County's behavioral
2532 health services. Strategy 5 will provide funding for capacity building and technical assistance activities to
2533 support the implementation of the CCC Levy's strategies described in this Plan. The allowable activities
2534 funded by Strategy 5 are summarized in Figure 32 and described in the subsections below.
2535
2536 *Figure 32. Strategy 5 Capacity Building and Technical Assistance Activities*

Strategy 5 Capacity Building and Technical Assistance Activities	
Activity	**Description**
Facility Operator Capital Development Assistance	Technical assistance and capacity building to support crisis care center and residential treatment facility operators in developing capital facilities funded by CCC Levy proceeds including, but not limited to, capital facility predevelopment planning, capital financial planning, facility siting, facility design, facility construction, and post-construction facility activation.
Crisis Care Center Operator Regulatory and Quality Assurance	Technical assistance and capacity building to support crisis care center operators to comply with regulatory requirements, deliver high quality crisis clinical services including for young adults and people living with intellectual and developmental disabilities, and provide inclusive care. [222]
Capacity Building for Providers with Expertise in Culturally and Linguistically Appropriate Services	Investments to build the organizational capacity of providers with expertise in providing culturally and linguistically appropriate services[223] including, but not limited to, administrative infrastructure investments; enhancing data and information technology systems; developing Medicaid and other health insurance billing infrastructure, and investing in workforce development, training, and worker wellbeing.
Local Jurisdiction Capital Facility Siting Support[224]	Grants to local jurisdictions to offset a portion of jurisdictions' costs directly related to siting behavioral health capital facilities funded by CCC Levy proceeds. Funding will be prioritized for purposes that expedite opening of crisis care center facilities. Funding may not be used to offset siting costs incurred by other parties nor other jurisdiction costs that cannot be directly attributed to facility siting.
DCHS Capital Facility Siting Technical Assistance	Funding for DCHS to provide siting technical assistance such as creating and deploying communication content, supporting siting community engagement, supporting interjurisdictional partnerships, and supporting facility operator and jurisdictional partnerships.

2537
2538 ### Facility Operator Capital Development Assistance Activities

2539 Strategy 5 will support technical assistance and capacity building activities to support organizations in
2540 developing behavioral health facilities funded by CCC Levy proceeds. Organizations that are applying for
2541 or receiving CCC Levy capital funding will be eligible to apply for capacity building and technical
2542 assistance funding during CCC Levy procurement processes related to developing residential treatment

[222] "Young adult," also known as "transition age youth" means a person between eighteen and twenty-four years of age, per RCW 43.330.702 – Homeless youth—Definitions. [LINK]

[223] National Culturally and Linguistically Appropriate Services (CLAS) Standards. Think Cultural Health, U.S. Department of Health & Human Services. [LINK]

[224] In this section, "jurisdictions" means cities, Tribes and other jurisdictional entities with siting authority that are physically located within King County.

2543 facilities or crisis care center facilities. Activities funded by Strategy 5 include, but are not limited to,
2544 capital facility predevelopment planning, capital financial planning, facility siting, facility design, facility
2545 construction, and post-construction facility activation. DCHS may use a portion of these resources to
2546 hire organizations or consultants with relevant subject matter expertise to provide capacity building and
2547 technical assistance directly to individual facility operators or through learning collaboratives for
2548 multiple facility operators to support the development of capital facilities funded by this Plan.
2549

2550 ### Crisis Care Center Operator Regulatory and Clinical Quality Activities

2551 Crisis care centers are a new type of behavioral health facility in King County, and operators may need
2552 support to comply with regulations and provide high quality services. Strategy 5 will provide resources
2553 for technical assistance and capacity building activities to:

2554 - Support crisis care center operators to deliver high quality clinical services;
2555 - Provide inclusive care for populations experiencing behavioral health inequities (see Section
2556 III.C. Key Historical and Current Conditions: Who Experiences Behavioral Health Inequities), and
2557 - Comply with regulatory requirements.[225]

2558 Activities related to assisting crisis care center operators to deliver high quality clinical services include,
2559 but are not limited to:

2560 - Developing clinical policies and procedures;
2561 - Implementing care coordination clinical workflows and technology;
2562 - Implementing evidence-based and promising clinical practices;
2563 - Adopting de-escalation and least restrictive care best practices;
2564 - Building capacity for clinical quality improvement activities;
2565 - Increasing specialization in serving youth and people living with intellectual and developmental
2566 disabilities, and
2567 - Implementing best practices to support workforce development and staff wellbeing.[226]
2568

2569 Activities related to providing inclusive care to populations experiencing behavioral health inequities
2570 include, but are not limited to:

2571 - Assisting crisis care center operators to institute CLAS best practices for providing culturally and
2572 linguistically appropriate services;
2573 - Providing cultural humility and health equity training for crisis care center staff[227];
2574 - Providing organizational leadership training on best practices to advance health equity at an
2575 organizational level, and
2576 - Consulting with organizations with expertise in serving populations that experience behavioral
2577 health inequities (see Section III.C. Key Historical and Current Conditions: Who Experiences

[225] Examples of "experiential communities" include persons who have been incarcerated, persons who are survivors of gender-based violence, persons who have been subject to involuntary treatment under Washington's involuntary Treatment Act, military veterans, immigrants, and refugees.

[226] Supporting worker wellbeing includes providing supervision and mentorship, covering staff time for self-directed program development and quality improvement initiatives, and access to mental health benefits.

[227] Cultural humility is an approach to providing healthcare services in a way that respects a person's cultural identity. The use of this term is intended to align with the U.S. Department of Health and Human Services Office of Minority Health's definition of cultural humility [LINK]

2578 Behavioral Health Inequities) around adopting clinical best practices and supporting individual
2579 client case consultations when appropriate.[228]
2580
2581 Activities related to regulatory technical assistance and capacity building include, but are not limited to,
2582 assisting crisis care center operators to comply with applicable local, state, and federal regulatory rules,
2583 and licensing, auditing, and accreditation requirements.
2584
2585 Crisis care center operators will be able to apply for technical and capacity building support related to
2586 regulatory and quality assurance during crisis care center procurement processes. DCHS may use a
2587 portion of these resources to hire organizations or consultants with relevant subject matter expertise to
2588 provide the capacity building and technical assistance described in this subsection. Consultation may be
2589 provided to individual crisis care centers or through learning collaboratives for multiple crisis care
2590 centers.
2591

2592 ### Capacity Building for Providers with Expertise in Culturally and Linguistically Appropriate
2593 ### Services

2594 Funding through Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers: Culturally and
2595 Linguistically Appropriate Post-Crisis Follow-Up Services is expected to increase the number of
2596 behavioral health organizations with expertise in culturally and linguistically appropriate services to be
2597 well positioned to provide post-crisis follow-up services for people who receive care at crisis care
2598 centers. Strategy 5 funding will support organizations with expertise in culturally and linguistically
2599 appropriate services described under Strategy 1 to:

2600 - Build their organizational capacity to provide and secure payment for delivering post-crisis
2601 follow-up and related services;
2602 - Strengthen organizational administrative infrastructure;
2603 - Enhance data and information technology systems;
2604 - Develop Medicaid and other health insurance billing infrastructure, and
2605 - Invest in workforce development, staff training, and worker wellbeing.[229]

2606

Behavioral Health Equity Highlight
The CLAS capacity building described in this section is an essential investment to advance behavioral health equity in the behavioral health crisis system and will have wider community impacts.

2607

2608 ### Local Jurisdiction Capital Facility Siting Support Activities

2609 DCHS also plans to award grants under Strategy 5 to local jurisdictions to help offset a portion of
2610 jurisdictions' costs that are directly related to siting behavioral health capital facilities funded by CCC
2611 Levy proceeds and that are not recoverable under the jurisdiction's permitting process, such as meeting
2612 facilitation, production of communication materials, and event costs and other expenses to complete
2613 outreach and engagement. Grants will be prioritized for uses that expedite the opening of crisis care
2614 center facilities funded in 2024, 2025, and 2026, which aligns with the preferred crisis care center siting

---

[228] National Culturally and Linguistically Appropriate Services (CLAS) Standards. Think Cultural Health, U.S. Department of Health & Human Services. [LINK]

[229] Supporting worker wellbeing includes providing supervision and mentorship, covering staff time for self-directed program development and quality improvement initiatives, and access to mental health benefits.

2615 timeline and process described in Section V.A. Strategy 1: Create and Operate 5 Crisis Care Centers:
2616 Crisis Care Center Procurement and Siting Process. Funding for jurisdiction siting support activities may
2617 not be used to offset siting costs incurred by other parties or other jurisdiction costs that cannot be
2618 directly attributed to siting capital facilities funded by CCC Levy proceeds.
2619

2620 ### DCHS Capital Facility Siting Technical Assistance

2621 Strategy 5 also includes resources for DCHS to provide capital facility siting technical assistance to local
2622 jurisdictions and operators of capital behavioral health facilities funded by CCC Levy proceeds. DCHS
2623 technical assistance activities funded through Strategy 5 include, but are not limited to, creating and
2624 deploying communication content and supporting siting community engagement, interjurisdictional
2625 collaboration, and facility operator and jurisdictional partnerships. The community engagement
2626 activities funded by Strategy 5 are intended to augment the community engagement activities funded in
2627 Section V.G. Strategy 7: Crisis Care Centers Levy Administration. They include, but are not limited to,
2628 costs related to engaging community members in capital facility siting processes and soliciting
2629 community input, communication costs, translation and interpretation costs, community engagement
2630 event costs, and costs to reduce barriers for community members to participate in related community
2631 engagement activities. DCHS may use a portion of these resources to fund organizations or consultants
2632 with relevant subject matter expertise to provide technical assistance directly to jurisdictions or capital
2633 facility operators to support the siting of capital facilities funded by this Plan.[230]
2634

2635 ## F. Strategy 6: Evaluation and Performance Measurement Activities

2636 DCHS will assess the impact of the CCC Levy through evaluation and performance measurement
2637 activities. Section VII. Evaluation and Performance Measurement details how DCHS will conduct
2638 evaluation and performance activities. Section VIII. Crisis Care Centers Levy Annual Reporting describes
2639 how the CCC Levy's results will be reported to the public and policymakers annually. This subsection
2640 describes what activities will be funded with CCC Levy proceeds, which are summarized in Figure 33.
2641 DCHS will measure and evaluate data to assess the CCC Levy's impact, report its results, and inform
2642 efforts to improve the quality of CCC Levy funded services. DCHS may also engage in more in-depth
2643 evaluation activities to complement regular performance measurement and deepen learnings about the
2644 effect of the CCC Levy and the services the CCC Levy funds.
2645
2646

[230] DCHS staff costs to support capital facility siting, including providing technical advice, are funded by Section V.G. Strategy 7: Crisis Care Centers Levy Administration.

2647 *Figure 33. Evaluation and Performance Measurement Activities*

Evaluation and Performance Measurement Activities	
Activity	**Description**
Routine Reporting and Performance Measurement	DCHS's costs to measure, analyze, evaluate, and report the impact of the CCC Levy to inform quality improvement initiatives and report the CCC Levy's results to the public and policymakers.
In-Depth Evaluation	DCHS's costs to conduct in-depth evaluations of the CCC Levy, which may include costs to contract with third parties.

2648

2649 ## G. Strategy 7: Crisis Care Centers Levy Administration

2650 Strategy 7 supports DCHS costs to manage the implementation of the CCC Levy over the nine-year Levy
2651 period. These investments include using DCHS staff to support the implementation of this Plan, promote
2652 accountability to the community, provide sufficient quality assurance and improvement oversight
2653 infrastructure, and integrate CCC Levy services into existing continuums of care to improve how people
2654 are able to access behavioral health services at crisis care centers and other community behavioral
2655 health settings. Strategy 7 also funds costs related to community engagement, developing data systems
2656 infrastructure and technology, and supporting the ability of designated crisis responders (DCRs) to serve
2657 crisis care centers, which are further described later in this subsection.[231] These allowable activities
2658 within Strategy 7 are described in Figure 34.

2659

2660 *Figure 34. CCC Levy Administration Activities*

CCC Levy Administration Activities	
Activity	**Description**
DCHS Administration Costs	DCHS's costs to manage the implementation of the CCC Levy and oversee quality assurance and improvement activities, including but not limited to, DCHS staff costs, third party consulting and technical assistance, and indirect administrative costs.
Community Engagement	Community engagement activities include, but are not limited to, costs to reduce barriers to community member participation, translation and interpretation, costs to partner with community-based organizations to engage community members, and costs to organize community engagement events.
Data Systems Infrastructure and Technology	Investments in data systems infrastructure and technology to improve care coordination and ensure accurate and timely payment of contractors, and collect necessary data for performance measurement and evaluation. This will include, but may not be limited to, strengthening existing King County Information Technology systems, electronic health record interoperability improvements, and care coordination technical support for behavioral health providers.
DCR Accessibility	Activities that can help expedite DCRs' ability to access crisis care centers, including but not limited to, satellite offices and transportation costs to reduce response times.

[231] King County Crisis and Commitment Services offers evaluation of people with behavioral health disorders for involuntary detention in psychiatric and secure withdrawal facilities according to Washington law. The law for adults is RCW 71.05. [LINK] For youth 13 through 17 years of age the law is RCW 71.34. [LINK] Crisis and Commitment staff who perform these duties are referred to as Designated Crisis Responders (DCRs). They are mental health professionals who are specially trained to conduct a holistic investigation of risk and to treat the person in need with dignity and respect during their time of crisis. [LINK]

2661

2662 Community Engagement

2663 DCHS intends to prioritize community engagement throughout the term of the CCC Levy to help inform
2664 the ongoing implementation, quality improvement, evaluation and performance measurement, and
2665 accountability of the Levy. In addition to its engagement related to ongoing implementation activities,
2666 DCHS plans to engage community members around the opening of crisis care centers to raise awareness
2667 about these new services, including sharing information that is accessible in multiple languages and
2668 formats. The importance of community engagement in an ongoing and meaningful way was a consistent
2669 theme during implementation planning activities (see Section III.E. Community Engagement Summary:
2670 Community Engagement During Future Planning Phases). DCHS will engage community partners and
2671 community members impacted by the CCC Levy, including populations experiencing behavioral health
2672 inequities (see Section III.C. Key Historical and Current Conditions: Who Experiences Behavioral Health
2673 Inequities).[232] Community partners also include, but are not limited to, people who have received CCC
2674 Levy funded services, community-based organizations, contracted service providers, and elected officials
2675 and policy makers. DCHS intends to conduct listening sessions at least annually to solicit community
2676 feedback about the CCC Levy implementation. DCHS also intends to engage community partners in the
2677 CCC Levy's performance measurement and evaluation activities by publicly sharing and disseminating its
2678 annual reporting, and by soliciting provider feedback on performance measurement to foster
2679 accountability and collaboration in the measurement of the CCC Levy's progress.
2680

2681 Expertise to Support Oversight of Behavioral Health Equity

2682 Measuring behavioral health equity is a complex and nuanced task, as described in Section III.F.
2683 Behavioral Health Equity Framework: Quality Improvement Accountability. Convening community
2684 partners is important to helping inform a quality metric selection process.[233] DCHS plans to contract with
2685 community-based organizations or behavioral health agencies with expertise in culturally and
2686 linguistically appropriate services to help DCHS define quality standards and quality improvement
2687 activities to better serve people identified in this Plan's Background Section as populations experiencing
2688 behavioral health inequities (see Section III.C. Key Historical and Current Conditions: Who Experiences
2689 Behavioral Health Inequities). This investment will help inform quality improvement priorities for crisis
2690 care center operators and post-crisis follow-up providers.
2691
2692

[232] Examples of "experiential communities" include persons who have been incarcerated, persons who are survivors of gender-based violence, persons who have been subject to involuntary treatment under Washington's involuntary Treatment Act, military veterans, immigrants, and refugees.

[233] Goldman, M. L., Shoyinka, S., Allender, B., Balfour, M., Eisen, J., Hopper, K., Minkoff, K., Parks, J., Pinheiro, A., Rosa, D., & Shaw, B. (2023). Quality Measurement in Crisis Services. National Council for Mental Wellbeing. [LINK]

Behavioral Health Equity Highlight

DCHS will make equity a key focus of CCC Levy administration activities. The community engagement investments described in this section are key to respond to community feedback about the importance of accountability and oversight of the CCC Levy, as well as ongoing community engagement. The investments of CCC Levy funds in expert consultations will be critical to ensuring that DCHS is overseeing its behavioral health equity framework using the best standards that are reflective of King County's communities and local context.

2693

2694 Develop Data Systems Infrastructure and Technology

2695 To advance the purposes of the CCC Levy, DCHS needs to have access to timely and accurate
2696 information and secure and reliable data systems. The CCC Levy will invest in data systems infrastructure
2697 and technology to improve service providers' ability to coordinate care for people experiencing a
2698 behavioral health crisis and to support providers' and DCHS's operational and administrative activities
2699 associated with implementing this Plan. These enhancements would have the added benefit of
2700 strengthening the administration of the entire public behavioral health system in King County, in line
2701 with the activities described in Section V.A. Strategy 1: Create and Operate 5 Crisis Care Centers:
2702 Oversight of Crisis Care Center Operations and Quality. Furthermore, these enhancements would
2703 provide more robust data to support DCHS's performance measurement and evaluation activities,
2704 including internal and external-facing dashboards and annual reporting, as described in Section VIII.
2705 Crisis Care Centers Levy Annual Reporting. CCC Levy investments in data systems infrastructure and
2706 technology may include upgrading outdated technology, redesigning databases to make them more
2707 efficient, and automating more data processing tasks and reports.
2708
2709 Care coordination is essential during a crisis encounter. Crisis service providers need to be able to
2710 efficiently access clinical information, such as a client's prior use of clinical services, their responses to
2711 prior treatments, and their current active services. This kind of information is critical for informing the
2712 initial risk assessment and triage, discharge planning, and engagement in post-crisis follow-up services.
2713 It is equally as important for crisis service providers to communicate with other providers, including
2714 automated alerts when someone has entered an acute care setting and information sharing to inform
2715 warm handoffs as a client begins to transition to longer-term care.
2716
2717 At the time of this Plan's drafting, providers in King County currently have limited access to relevant
2718 clinical and social services data, which is a common problem across the United States.[234] The
2719 Washington State Health Care Authority and Department of Health are developing statewide crisis
2720 system data sharing platforms to support implementation of the 988 Suicide and Crisis Line and related
2721 crisis services, as required under E2SHB 1477.[235] DCHS intends to coordinate with the state in these
2722 efforts to maximize the local benefits of these state investments. While these state activities are
2723 promising, there may remain a need for local investments in data systems and technology infrastructure
2724 if there is not full alignment with King County's local needs or timelines. DCHS will assess its progress
2725 toward data system and technology infrastructure and technology goals periodically to determine if
2726 there is a need to focus also on data system improvements solely within King County government.

---

[234] Goldman, M. L., Shoyinka, S., Allender, B., Balfour, M., Eisen, J., Hopper, K., Minkoff, K., Parks, J., Pinheiro, A., Rosa, D., & Shaw, B. (2023). Quality Measurement in Crisis Services. National Council for Mental Wellbeing. [LINK]
[235] 2SSB 1477 (2021). 2SHB 1477's scope included RCW chapters 71.24, 48.43, 43.06, and 82.86. [LINK]

2727
2728 In addition to supporting clinical crisis care coordination, DCHS and crisis care center operators will need
2729 robust data systems for operational and administrative functions. As the administrator of King County's
2730 Integrated Care Network (KCICN) and Behavioral Health Administrative Service Organization (BH-ASO),
2731 DCHS already maintains a core administrative processing system to facilitate payments to providers,
2732 reporting to the state and managed care organizations, and monitoring of provider and overall system
2733 performance. However, the addition of CCC Levy-funded programs will further add to the demands on
2734 the system. The CCC Levy presents a unique opportunity to expand and strengthen DCHS's backbone
2735 technologies to securely and reliably manage data that are essential to the success of the CCC Levy.
2736

2737 ## Designated Crisis Responder Accessibility

2738 Ordinance 19572 requires crisis care centers to provide access to onsite assessment by a designated
2739 crisis responder (DCR) when needed.[236] A persistent feature of King County's pre-CCC Levy behavioral
2740 health system has been that wait times for a DCR evaluation in community settings have too often been
2741 measured in days and weeks instead of minutes and hours.[237,238] While immediately seeking an
2742 involuntary commitment hold may, in rare cases, be appropriate, DCRs' primary responsibility is to
2743 conduct a DCR evaluation and make an initial legal determination about whether a person meets legal
2744 criteria for detention under Washington's Involuntary Treatment Act.[239] DCRs are mental health
2745 clinicians, but they do not provide treatment. DCRs are an essential part of the region's behavioral
2746 health crisis response system, but they should rarely be the first or only call a community member
2747 makes in a crisis.
2748
2749 The CCC Levy will create a regional network of crisis care centers that will enable treatment to become
2750 the first response to a behavioral health crisis. The creation of 24/7 walk-in facilities that provide
2751 specialized treatment for crises as they happen is central to the CCC Levy proposal. In addition to
2752 increasing access to care, crisis care centers are a key part of DCHS's strategy to reduce DCR response
2753 times in community settings by reducing the number of calls that DCRs receive.
2754
2755 During the implementation planning process, DCHS received feedback from community members that
2756 timely access to a DCR evaluation is critical when needed, but that DCR access should be held in balance
2757 with trying treatment first, promoting least restrictive care, and prioritizing voluntary services. DCHS will
2758 address this feedback by investing in activities to expedite DCR assessments of a person who is
2759 experiencing a behavioral health crisis at a crisis care center when clinically appropriate. These activities
2760 are described in Figure 34 and include costs such as satellite DCR offices and transportation costs to
2761 reduce response times. DCHS will work with crisis care center operators to prioritize least restrictive

[236] King County Crisis and Commitment Services offers evaluation of people with behavioral health disorders for involuntary detention in psychiatric and secure withdrawal facilities according to Washington law. The law for adults is RCW 71.05. For youth 13 through 17 years of age the law is RCW 71.34. Crisis and Commitment staff who perform these duties are referred to as Designated Crisis Responders (DCRs) They are mental health professionals who are specially trained to conduct a holistic investigation of risk and to treat the person in need with dignity and respect during their time of crisis. Crisis and Commitment Services are available 24 hours a day, 365 days a year [LINK].

[237] Washington Post (2022) Fixing the broken lovelies: As American cities deteriorate, a psychiatric nurse reckons with the high price of compassion [LINK].

[238] Seattle Times (2022) Washington's designated crisis responders, a 'last resort' in mental health care, face overwhelming demand. [LINK]

[239] RCW Chapters71.05 [LINK] and 71.34 [LINK]. King County BHRD Crisis and Commitment Services website. [LINK]

2762 care options whenever possible, thereby allowing DCRs to respond faster in crisis care centers and
2763 community settings to less frequent cases that have already exhausted less restrictive options for care.
2764

2765 H. Strategy 8: Crisis Care Centers Levy Reserves

2766 The CCC Levy will maintain fund reserves as directed by Ordinance 19572. The expenditure plan
2767 described in Section VI.B. Financial Plan: Annual Expenditure Plan includes a fund reserve equal to 60
2768 days of budgeted expenditures, less capital expenses, consistent with King County Comprehensive
2769 Financial Management Policies.[240] The purpose of the reserve is to ensure continuity of levy-funded
2770 operating activities for 60 days if the CCC Levy is not renewed after 2032. The 60-day operating reserve
2771 will also help promote continuity of levy-funded activities in the event of fluctuations in CCC Levy
2772 revenue or strategy costs.
2773
2774 In addition, Section V. A. Strategy 1: Create and Operate Five Crisis Care Centers and Section V. A.
2775 Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity each reserve a portion of CCC
2776 Levy funding to help pay for ongoing capital maintenance costs of behavioral health capital facilities
2777 funded by Levy proceeds. These capital resources will promote the future sustainability of behavioral
2778 health capital facilities funded by this Plan.
2779

[240] King County Comprehensive Financial Management Policies (2016) [LINK]

VI. Financial Plan

A. Overview

This section describes the CCC Levy's financial plan and other related financial considerations. These considerations include the CCC Levy's approach to incorporating additional financial resources to complement and augment CCC Levy proceeds, the role of health insurance funding, and the process to makes substantial adjustments to the financial plan. The strategy to establish and maintain CCC Levy reserves is described in Section V.H. Strategy 8: Crisis Care Centers Levy Reserves.

B. Financial Plan

CCC Levy Annual Revenue Forecast

Figure 35 illustrates the CCC Levy's annual revenue forecast from January 1, 2024, to December 31, 2032. During 2024, the first year of the CCC Levy, the levy rate will be 14.5 cents per $1,000 in assessed property value. From 2025 to 2032, total levy collections may increase in accordance with Washington State's levy limit, which at the time of this Plan's drafting was one percent annually plus the value of new construction as determined by the King County Assessor.[241] The revenue forecast incorporated into this Plan is from the King County OEFA August 2023 revenue forecast.[242] The revenue forecast depicted in Figure 35 assumes a 99 percent revenue collection rate and an assumption that the CCC Levy's proceeds will generate annual interest revenue at a rate of 0.5 percent.[243,244]

Annual Expenditure Plan

The CCC Levy's annual expenditure plan between 2024 and 2032 is described in Figure 35. The expenditure plan includes annual investment amounts for each of the CCC Levy's strategies, which are described in Section V. Crisis Care Centers Levy Strategies and Allowable Activities. The expenditure plan also includes one-time costs such as the election costs for King County Proposition 1 in April 2023 and initial planning costs permitted under Ordinance 19572.[245,] In addition to costs, the expenditure plan also includes health insurance funding assumptions, which account for the share of crisis care center expenses that are projected to be paid for by health insurance, including Medicaid. Additional information about the expenditure plan's health insurance assumptions is described Section VI. Financial Plan: Health Insurance Assumptions. CCC Levy reserves are also depicted in the expenditure plan, and additional reserve information is described in Section V.H. Strategy 8: Crisis Care Centers Levy Reserves.

[241] Municipal Research and Services Center (MRSC). *Levy Lid Lift*. [LINK]
[242] King County Office of Economic and Financial Analysis' (OEFA) economic forecasts [LINK]
[243] King County Office of Economic and Financial Analysis' (OEFA) economic forecasts [LINK]
[244] Fund revenues and corresponding cash balances accrue interest and County investment pool earnings, which are conservatively estimated at 0.5% of total collected revenues annually.
[245] King County Elections. Ballot Measures: April 25, 2023 Special Election. King County Proposition No. 1: Crisis Care Centers Levy. [LINK]

2812 *Figure 35. Crisis Care Centers Levy Projected Revenue and Approximate Annual Allocations by Strategy, 2024-2032* [246]
2813

Crisis Care Centers Levy Projected Revenue (2024 - 2032)										
	2024	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**Total**
Projected CCC Levy Revenue	$117,304,000	$119,829,000	$122,449,000	$125,130,000	$127,866,000	$130,654,000	$133,489,000	$136,384,000	$139,346,000	**$1,152,451,000**
Projected Annual Interest	$587,000	$599,000	$612,000	$626,000	$639,000	$653,000	$667,000	$682,000	$697,000	**$5,762,000**
Total Revenue [247]	**$117,891,000**	**$120,428,000**	**$123,062,000**	**$125,755,000**	**128,505,000**	**$131,307,000**	**$134,156,000**	**$137,066,000**	**$140,042,000**	**$1,158,213,000**

Crisis Care Centers Levy Approximate Allocation by Strategy (2024 - 2032)										
	2024	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**Total**
Strategy 1: Create and Operate Five Crisis Care Centers	$16,150,000	$59,888,000	$54,816,000	$72,640,000	$97,865,000	$73,069,000	$82,146,000	$84,094,000	$86,147,000	**$626,815,000**
Projected Additional Medicaid Funding	*$-*	*$-*	*$3,801,000*	*$15,426,000*	*$27,388,000*	*$35,723,000*	*$40,268,000*	*$40,852,000*	*$41,444,000*	***$204,904,000***
Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity	$42,000,000	$33,340,000	$40,148,000	$48,575,000	$1,464,000	$1,611,000	$1,772,000	$1,949,000	$2,144,000	**$173,001,000**
Strategy 3: Strengthen the Community Behavioral Health Workforce	$7,500,000	$11,849,000	$13,030,000	$16,352,000	$19,894,000	$22,418,000	$23,877,000	$24,199,000	$24,574,000	**$163,693,000**
Strategy 4: Early Crisis Response Investments	$8,200,000	$6,290,000	$7,410,000	$7,518,000	$7,627,000	$7,737,000	$7,522,000	$7,632,000	$7,742,000	**$67,678,000**
Strategy 5: Capacity Building and Technical Assistance	$1,750,000	$2,029,000	$2,058,000	$1,357,000	$1,748,000	$2,203,000	$2,071,000	$1,659,000	$1,683,000	**$16,559,000**
Strategy 6: Evaluation and Performance Measurement Activities	$771,000	$1,099,000	$1,127,000	$1,156,000	$1,239,000	$1,270,000	$1,302,000	$1,335,000	$1,369,000	**$10,667,000**
Strategy 7: CCC Levy Administration	$5,065,000	$7,581,000	$9,025,000	$9,373,000	$9,626,000	$9,756,000	$9,825,000	$9,763,000	$9,979,000	**$79,993,000**
Election Costs	$3,500,000									**$3,500,000**
Planning Costs	$1,000,000									**$1,000,000**
Total CCC Levy Costs	**$85,936,000**	**$122,077,000**	**$127,613,000**	**$156,971,000**	**$139,462,000**	**$118,064,000**	**$128,515,000**	**$130,631,000**	**$133,638,000**	**$1,142,908,000**
Strategy 8: CCC Levy Reserves	$4,354,000	$2,050,000	$1,833,000	$3,506,000	$5,330,000	$6,573,000	$7,281,000	$7,445,000	$15,285,000	

2814

246 The dollar amounts in this table are approximate and are rounded to the nearest thousand dollars.
247 The revenue forecast incorporated into this Plan is from the King County Office of Economic and Financial Analysis' August 2023 revenue forecast. [LINK] The revenue forecast assumes a 99 percent revenue collection rate and an assumption that the CCC Levy's proceeds will generate annual interest revenue at a rate of 0.5 percent.

C. Sequencing and Timing of Planned Expenditures

Ordinance 19572 requires this Plan describe the sequence and timing of planned expenditures and activities necessary to establish and operate a regional network of five crisis care centers. This requirement is addressed in Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers: Sequence and Timing of Planned Expenditures and Activities. DCHS plans to open competitive procurement rounds in 2024, 2025, and 2026 if needed to select five crisis care center operators.

Ordinance 19572 also requires this Plan to describe how a portion of first year levy proceeds will be allocated to make rapid initial progress towards fulfilling the CCC Levy's Supporting Purposes One and Two. Section V.B. Restore, Expand, and Sustain Residential Treatment Capacity: 2024 Funding Approach for Rapid Initial Progress on Residential Treatment describes how progress will be made in 2024 towards fulfilling Supporting Purpose 1. DCHS plans to open a competitive procurement in 2024 to award capital improvement funding for resident treatment facility operators to help stabilize the sector and prevent additional closures and to award capital funding for new residential treatment facility development. Section V.C. Strategy 3: Strengthen the Community Behavioral Health Workforce: 2024 Funding Approach for Rapid Initial Progress on Behavioral Health Workforce describes how progress will be made in 2024 towards fulfilling Supporting Purpose 2. DCHS plans to distribute resources to help strengthen and support the development of King County's community behavioral health workforce through existing contracts with organizations and new procurement processes.

D. Seeking and Incorporating Federal, State, and Philanthropic Resources

The CCC Levy's financial plan is designed to advance the Paramount Purpose, Supporting Purpose 1, and Supporting Purpose 2, within forecasted resources. Forecasted resources include projected CCC Levy proceeds and health insurance funding. These funding assumptions are described in Section VI. B. Financial Plan: CCC Levy Annual Revenue Forecast and Section VI.E Health Insurance Assumptions.

In this Plan's financial plan, the Executive has not assumed federal, state, or philanthropic resources will contribute to achieving the CCC Levy's purposes except for state and federal Medicaid funding based on information available at the time of this Plan's drafting. While this Plan does not depend upon it, government and philanthropic partners have a significant opportunity to bolster the impact of the CCC Levy.

Additional philanthropic and government investments in CCC Levy purposes could reduce the amount of CCC Levy proceeds that are needed to fulfill this Plan's strategies. CCC Levy proceeds could then expand funding for strategies through the uses described in Section VI. F. Process to Make Substantial Adjustments to the Financial Plan. Government and philanthropic partners could also augment the impact of the CCC Levy by investing in other parts of the behavioral health system or in other areas that impact social determinants of health. For example, if federal and state partners invest in affordable housing resources to meet the scale of housing needs of people living with behavioral health conditions and housing instability in King County, individual experiences of behavioral health crises may be reduced. The Executive will seek investments from government and philanthropic partners to augment CCC Levy proceeds. Figure 36 describes examples of government and philanthropic investments that could complement this Plan.

Figure 36. Federal, State, and Philanthropic Opportunities to Augment CCC Levy Proceeds

Federal, State, and Philanthropic Opportunities to Augment CCC Levy Proceeds

Investment Area	Federal Government	State Government	Philanthropy
Medicaid Rates: Increase Medicaid rates to reduce the CCC Levy proceeds needed to subsidize services.	x	x	
Non-Medicaid Rates: Increase non-Medicaid funding for state and federal behavioral health services to reduce CCC Levy proceeds needed to subsidize costs for services and populations ineligible for Medicaid.	x	x	
Mobile Crisis Services: Increase funding for adult, youth, and specialty population mobile crisis services.	x	x	x
Capital Resources: Contribute capital resources to land and capital facilities funded by CCC Levy proceeds.	x	x	x
Transition Age Youth: Dedicate resources to create a specialized crisis care setting and services for transition age youth.[248]	x	x	x
Housing Resources: Increase housing resources for people living with behavioral health conditions.	x	x	x
Workforce: Strengthen behavioral health workforce through training, recruitment, and retention funding.	x	x	x
Opioid Overdose Crisis: Address the opioid crisis by expanding naloxone, MOUD, and other services.[249]	x	x	x
Care Coordination Technology: Invest in health informatics infrastructure to support crisis system.	x	x	x

2860
2861 Through King County's annual legislative agenda and policymaker engagement activities, such as but not
2862 limited to briefings, work sessions, and public meetings, the Executive intends to seek federal and state
2863 government funding to complement the CCC Levy . DCHS will strive to coordinate the CCC Levy with
2864 federal and state crisis service initiatives and investments to maximize resource coordination and crisis
2865 system integration. As the state makes ongoing, state-wide investments in crisis facilities and programs,
2866 the Executive will continue to seek funds to augment the CCC Levy.
2867
2868 The Executive and DCHS also plan to seek philanthropic funding by sharing opportunities for
2869 philanthropic partners to amplify the impact of the CCC Levy proceeds with targeted funding support.
2870 Similar to state and federal initiatives, DCHS will strive to coordinate with existing philanthropic
2871 initiatives related to crisis services whenever feasible to maximize resource coordination across
2872 initiatives.
2873

2874
E. Health Insurance Assumptions

2875
Medicaid Health Insurance

2876 The CCC Levy financial plan assumes that Medicaid health insurance ("Medicaid") will pay for
2877 approximately 40 percent of the crisis care centers' operating and service activities and approximately

[248] "Young adult," also known as "transition age youth" means a person between eighteen and twenty-four years of age, per RCW 43.330.702 – Homeless youth—Definitions. [LINK]
[249] Naloxone is a lifesaving opioid overdose reversal medication that can be safely administered in community-based settings. "MOUD" means medication for opioid use disorder and includes medications that are used to support people receiving treatment for opioid use.

2878 40 percent of the post-crisis follow-up program's operating and service activities that are described in
2879 Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers. CCC Levy proceeds will be used to
2880 pay for the remaining 60 percent of these activities' operating and service costs that are expected not to
2881 be covered by Medicaid.
2882
2883 DCHS developed the 40 percent Medicaid assumption by analyzing King County's historic crisis service
2884 health insurance billing codes and utilization data, estimating the likely health insurance coverage payer
2885 mix of people who may access crisis care centers, and reviewing Medicaid funding rates at comparable
2886 facilities in Washington State. A review of crisis service health care billing codes and utilization rates
2887 showed a range of 29 percent to 50 percent of the client population was covered by Medicaid,
2888 depending on the service type, with a 34 percent average rate of people accessing behavioral health
2889 crisis services. The crisis care centers' payer mix will likely be higher than this 34 percent average rate
2890 because crisis care centers are anticipated to disproportionally serve people who are eligible for
2891 Medicaid. King County reviewed the share of costs Medicaid covered at two comparable crisis facilities
2892 in Washington. Medicaid covered 24 percent of the operating and service costs at one facility and 86.5
2893 percent of the operating and service costs at the second facility.[250] This analysis, along with King
2894 County's commitment to maximize Medicaid billing through supporting Medicaid enrollment and billing
2895 infrastructure, resulted in this Plan's funding assumption reflecting a modest increase from Medicaid
2896 utilization rates for crisis services that existed at the time of this Plan's drafting, up to 40 percent
2897 Medicaid funding.
2898
2899 The actual Medicaid reimbursement amount, which may vary annually, may be higher or lower than this
2900 40 percent projection based on the implementation of state law directing the state to maximize the use
2901 of Medicaid for behavioral health services, including crisis services.[251] Section VI. F. Process to Make
2902 Substantial Adjustments to the Financial Plan describes how excess funding or reduced funding,
2903 including funding changes resulting from Medicaid assumptions, will be prioritized.
2904

2905 Commercial Health Insurance

2906 Recent state legislation regarding emergency health insurance coverage requires commercial health
2907 insurance plans ("commercial plans") to cover behavioral health crisis services at the same level as
2908 physical health emergency services.[252] As a result of this legislation, beginning in 2024, commercial plans
2909 will pay for the types of behavioral health crisis services that will be delivered at crisis care centers as
2910 described in Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers. At the time of this
2911 Plan's transmittal, commercial plan payment rates were being negotiated and were unknown. Due to
2912 the uncertainty regarding commercial plan rates, the CCC Levy's financial plan does not assume any
2913 commercial plan funding. The actual commercial plan funding will likely be higher than zero dollars. The
2914 real amount will be determined by the insurance coverage payer mix of people who receive services at
2915 crisis care centers and the final negotiated commercial plan rates. Any future commercial insurance
2916 payments will offset CCC Levy expenses and will allow for CCC Levy proceeds to be prioritized for uses

---

[250] The Crisis Solutions Centers in Seattle, WA has a 24 percent Medicaid reimbursement experience. The Spokane Regional Stabilization Center in Spokane, WA has an 86.5 percent Medicaid reimbursement experience.
[251] E2SSHB 1515 [LINK] and SSSB 5120 [LINK] both passed during the 2023 state legislative session and direct the Washington State Health Care Authority to maximize Medicaid billing for crisis services.
[252] Engrossed Second Substitute House Bill 1688 passed during the 2022 state legislative session and requires health insurance carriers to cover emergency services, including services provided at out-of-network facilities, up until the point of stabilization. [LINK]

described in the next section, Section VI. F. Process to Make Substantial Adjustments to the Financial Plan.

F. Process to Make Substantial Adjustments to the Financial Plan

Overview

This section describes the process to communicate and make substantial adjustments to the CCC Levy's financial plan. A substantial adjustment is a change or series of changes within the same calendar year to a strategy's annual funding allocation by the greater of five percent or $500,000.

A change is not considered a substantial adjustment if it is due to additional CCC Levy revenue or other funding sources becoming available. In this scenario, the additional CCC Levy revenue must be allocated according to the priorities described later in this section and cannot reduce another strategy's allocation. In addition, CCC Levy proceeds that are not spent within a strategy may be retained within the same strategy for use in a subsequent year without being considered a substantial adjustment for the purpose of this Plan.

Potential causes for substantial adjustments to the financial plan may include, but are not limited to:

- Macroeconomic conditions such as inflation being higher than expected;
- CCC Levy generating less revenue than forecasted;
- Health insurance funding being lower than projected; [253]
- Additional funding contributions allowing CCC Levy proceeds to be reprioritized;
- Unanticipated fluctuations or variations in program costs, and
- Evolving needs, such as workforce conditions and capital project timeline changes.

Expenditure of CCC Levy proceeds in any year remains subject to Council appropriation. Annual reporting requirements directed by Ordinance 19572 and this Plan include annual financial reporting.

Process for Communicating and Making a Substantial Adjustment

Substantial adjustments to the CCC Levy's financial plan will be communicated according to the process defined in this subsection. If, without Council direction or concurrence, the Executive determines a substantive adjustment to the funding allocations specified in the CCC Levy's financial plan is needed, then the Executive will transmit a notification letter to Council detailing the scope of and rationale for the changes. The Executive may only send such notification letters as frequently as twice per year when needed. The Executive will electronically file the letter with the Clerk of the Council, who will retain an electronic copy and provide an electronic copy to all councilmembers, the Council Chief of Staff, the lead staff for the Committee of the Whole, or its successor, and the Regional Policy Committee. Unless the Council passes a motion rejecting the contemplated change within 30 days of the Executive's transmittal, the Executive may proceed with the change as set forth in the notification letter.

Priorities for Reducing Allocations Due to Revenue that is Less than this Plan's Projections

This subsection describes the process for prioritizing substantial adjustments that reduce this Plan's annual allocations to one or more strategies. If the projected CCC Levy revenue or health insurance funding assumptions are less than this Plan's projections in any year, then it may be necessary to make a

[253] In this context, health insurance includes Medicaid and commercial health insurance.

2960 substantial adjustment to an allocation amount in one or more strategies. If this occurs, the Executive
2961 will identify necessary substantial adjustments according to the priorities described in Figure 37.
2962
2963 ***Figure 37. Funding Priorities if CCC Levy Proceed Allocations Must be Reduced Due to Funding that is***
2964 ***Less than Projected***

Funding Priorities if CCC Levy Allocations Must be Reduced Due to Funding that is Less than Projected	
Priority	**Description**
First Priority	Maintain funding or minimize reductions to strategies with a direct link to accomplishing the Paramount Purpose to establish and operate a regional network of five crisis care centers in King County.[254]
Second Priority	Maintain funding or minimize reductions to strategies with a direct link to accomplishing Supporting Purpose 2 to increase the sustainability and representativeness of the community behavioral health workforce in King County through recruitment, retention, and training activities.[255]
Third Priority	Maintain or minimize reductions to strategies with a direct link to accomplishing Supporting Purpose 1 to restore the number of mental health residential treatment beds to at least 355 and expand the availability and sustainability of residential treatment in King County.[256]

2965

2966 ## Priorities for Allocating Revenue in Excess of this Plan's Original Allocations or to Reflect
2967 ## Additional Funding from Other Sources

2968 This subsection describes the process for prioritizing allocations of CCC Levy revenue that exceed this
2969 Plan's revenue projections, or CCC Levy revenue that becomes available because other funding sources
2970 are contributing funding toward this Plan's strategies at a higher level than anticipated. Examples of
2971 other funding sources could include but are not limited to higher than assumed health insurance
2972 funding[257] or complementary investments made by federal, state, and philanthropic partners to
2973 augment the impact of the CCC Levy. Increases to a strategy's allocation due to additional CCC Levy
2974 revenue or funding secured for CCC Levy purposes from other sources that do not reduce another
2975 strategy's allocation and that comport with this subsection's priorities do not constitute a substantial
2976 adjustment for the purposes of this Plan. Expenditures of CCC Levy proceeds allocated through this
2977 prioritization remain subject to Council appropriation. The Executive will apply the priorities described in
2978 Figure 38 to allocate additional funding that becomes available because of higher CCC Levy revenue
2979 projections or newly available funding from other sources.
2980

[254] Strategies with a direct link to accomplishing the CCC Levy's paramount purpose include Strategy 1: Create and Operate Five Crisis Care Centers, Strategy 3: Strengthen the Community Behavioral Health Workforce, and Strategy 5: Capacity Building and Technical Assistance.
[255] Strategy 3: Strengthen the Community Behavioral Health Workforce has a direct link to accomplishing the CCC Levy's Supporting Purpose 2.
[256] Strategies with a direct link to accomplishing Supporting Purpose 1 include Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity and Strategy 5: Capacity Building and Technical Assistance.
[257] In this context, health insurance includes Medicaid and commercial health insurance.

2981 *Figure 38. Priorities for Increasing Allocations Due to Additional Funding*

Priorities for Increasing Allocations Due to Additional Funding	
Priority	**Description**
1st Priority	Ensure at least 60 days of operating reserves are funded.
2nd Priority	Increase funding to *Strategy 1: Create and Operate Five Crisis Care Centers* up to the amount needed to satisfy the Paramount Purpose if it has not been satisfied, including funding unanticipated strategy costs due to inflation and providing up to $25 million in any single year for housing stability resources for people who receive services at crisis care centers and are experiencing homelessness.
3rd Priority	Increase funding to *Strategy 3: Strengthen the Community Behavioral Health Workforce* up to $25 million in any single year.
4th Priority	Increase funding to *Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity* up to the amount needed to restore the number of mental health treatment beds in King County to at least 355 beds, including funding unanticipated strategy costs due to inflation.
5th Priority	Fund the creation and operation of additional crisis care center facilities, components of facilities, or other facilities that CCC Levy data shows would benefit crisis care center clients and are allowed under Ordinance 19572. An example of such a facility could include an additional crisis care center, beyond the five specified in Ordinance 19572, specializing in serving transition age youth.[258]

2982
2983
2984

[258] "Young adult," also known as "transition age youth" means a person between eighteen and twenty-four years of age, per RCW 43.330.702 – Homeless youth—Definitions. [LINK]

2985 # VII. Evaluation and Performance Measurement

2986 This section describes how DCHS will approach evaluating and measuring the performance of the CCC
2987 Levy. This includes a description of the principles and framework that will guide evaluation and
2988 performance measurement activities. A description of how CCC Levy proceeds will be used to support
2989 evaluation and performance measurement activities is included in Section V.F. Strategy 6: Evaluation
2990 and Performance Measurement Activities. A description of how community partners may be engaged in
2991 evaluation and performance measurement activities is included in Section V.G. Strategy 7: Crisis Care
2992 Centers Levy Administration. Lastly, DCHS will create and maintain an online annual report so the public
2993 and policymakers can review the performance of the CCC Levy. The CCC Levy's annual report
2994 requirements and process are described in Section VIII. Crisis Care Centers Levy Annual Reporting.
2995

2996 ## A. Evaluation and Performance Measurement Principles

2997 The evaluation and performance measurement of the CCC Levy will be guided by the principles
2998 described in Figure 39. Community engagement feedback and DCHS subject matter experts informed
2999 these principles during the implementation planning process.
3000

3001 *Figure 39. CCC Levy Evaluation and Performance Measurement Principles*

CCC Levy Evaluation and Performance Measurement Principles	
Principle	**Description**
Transparent and Community Informed	King County will transparently share evaluation and performance measurement findings via public annual reporting detailed in Section VIII. Crisis Care Centers Levy Annual Reporting, with clearly described methods and reliable data sources that are made available on a regular basis through public platforms. Community partners will be given opportunities to collaborate on approaches and information gathering related to evaluation and performance measurement activities.
Person-Centered	Throughout performance measurement and evaluation activities, King County plans to center the voices of people engaged with the crisis system to understand their experiences, preferences, and motivations.
Continuously Improving	DCHS plans to use data to make evidence-informed decisions to improve program quality and service effectiveness in its system oversight role of the CCC Levy. Whenever possible, measurement and evaluation findings and products will be used to engage service providers in continuous quality improvement initiatives. Performance measurement and evaluation approaches may also change over time to be responsive to emergent data needs and implementation factors.
Equitable	Performance measurement frameworks and evaluations will be grounded in King County's Equity and Social Justice principles.[259] Whenever possible, DCHS plans to measure and document demographic data, including race and ethnicity data, to identify potential disparities and to measure equity impacts on the effectiveness of services.

3002
3003

[259] King County Equity and Social Justice Strategic Plan (2016-2022). [LINK]

Behavioral Health Equity Highlight

To address behavioral health inequities, it is necessary to measure disparities prior to and after implementation of interventions aimed at reducing inequities.). The CCC Levy's evaluation and performance measurement plan will measure by race, ethnicity, or other demographic characteristics at both the program level and across programs to analyze the effectiveness strategies at reducing inequities. These analyses will yield critical information to advance the behavioral health equity framework.

3004

3005 B. Evaluation and Performance Measurement Framework

3006 The CCC Levy evaluation and performance measurement framework will focus on reporting measures
3007 relevant to monitoring performance of the CCC Levy, advancing continuous quality improvement, and
3008 generating clear and actionable evaluation products for the public. It is critical that the crisis services
3009 system can grow and evolve by building on what works well and improving what does not. This process
3010 should be continuously informed by performance metrics, outcome data, client experiences, and other
3011 relevant information, as described in Section V.A. Strategy 1: Create and Operate Five Crisis Care
3012 Centers: Continuous Quality Improvement and Quality Assurance.
3013
3014 Evaluation of the CCC Levy will aim to inform strategic learning and accountability. Strategic learning is
3015 using data to understand which strategies are effective and why they are effective to inform continuous
3016 quality improvement activities.[260] Data from evaluation also supports shared responsibility and
3017 accountability for CCC Levy activities between the County and community agencies. Providers are
3018 accountable for the activities they are funded to do, while the County is accountable for the overall
3019 results of the CCC Levy.
3020
3021 The scale and complexity of the CCC Levy requires an evaluation approach that encompasses a range of
3022 measurement techniques. The evaluation framework will therefore include three overall approaches:
3023 1. **Population Indicators:** DCHS will use population level measures to identify needs, characterize
3024 baseline conditions, and track trends.
3025 2. **Performance Measurement:** Performance measures are regularly generated and collected
3026 descriptors of program processes and outcomes that can be used to assess how well a strategy
3027 is working.
3028 3. **In-Depth Evaluation:** Additional evaluation activities will complement performance
3029 measurement to deepen learnings and understand selected CCC Levy investments'
3030 effectiveness. Approaches may include piloting new programs, developing new evaluation tools,
3031 and identifying areas that may benefit from new or deeper community supports. DCHS may
3032 contract with one or more third party, independent organization(s), or engage in public private
3033 partnerships to conduct in depth evaluations.
3034
3035 These three approaches are described in more in the following subsections.
3036

[260] Center for Evaluation Innovation. Evaluation for Strategic Learning: Assessing Readiness and Results. [LINK]

3037 ## Population Indicators

3038 The CCC Levy will impact two priority populations, detailed in the list below, which reflect the two
3039 facility-focused purposes of the CCC Levy. DCHS will focus on measuring how these populations change
3040 over time in size and demographics. Where feasible, DCHS will disaggregate population indicator data by
3041 demographic characteristics to advance King County's equity goals, including evaluating
3042 representativeness of services by comparing priority population demographics to regional population
3043 demographics (see Section III. F. Behavioral Health Equity Framework: Quality Improvement and
3044 Accountability). DCHS will also measure how the CCC Levy, as a part of the King County behavioral
3045 health system, provides services to these two priority populations. Building on the King County
3046 Behavioral Health Data System, DCHS plans to use the following definitions to provide estimates for
3047 following population indicators, which reflect the purposes of the CCC Levy as noted in parentheses:

3048 1. People seeking immediate and in person crisis care through intervention and stabilization
3049 services provided by County-contracted crisis services (Paramount Purpose); and
3050 2. People seeking residential treatment care and who have an open authorization to receive
3051 residential treatment with County-contracted residential treatment providers (Supporting
3052 Purpose 1).

3053

3054 While the goal is for the CCC Levy to contribute to population level outcomes in the long term, there are
3055 multiple other sectors and community factors that are also responsible for countywide conditions and,
3056 as a result, influence these measures. It is therefore difficult to attribute changes in population
3057 indicators — positive or negative — to the CCC Levy itself.

3058

3059 ## Performance Measurement

3060 DCHS will measure and report on the impact of the CCC Levy in the three domains defined by Results
3061 Based Accountability (RBA) framework, as appropriate.[261] The RBA framework describes performance
3062 measurement by asking three key questions: how much did we do, how well did we do it, and is anyone
3063 better off? The measurement framework will focus on reporting measures relevant to continuous
3064 quality improvement and generating clear and actionable evaluation products to the public.

3065

3066 This approach to performance measurement will promote strategic learning and accountability through
3067 transparency and collaboration with service providers funded through the CCC Levy. The RBA framework
3068 also helps reduce data collection burden for providers and ensures that measurement reflects both
3069 program and community definitions of progress. Consistent with standard practice for the department,
3070 DCHS will give service providers the opportunity to inform final plans for performance measurement to
3071 ensure they include meaningful measures and feasible reporting requirements.

3072

3073 For every strategy of the CCC Levy that is competitively procured, procurement materials such as
3074 requests for proposal (RFPs) will include proposed performance measures to transparently
3075 communicate contract expectations based on the CCC Levy's intended impact and likely reporting
3076 requirements. During the contract negotiation process, DCHS will engage with selected service providers
3077 to finalize a performance measurement plan. The finalized performance measurement plan will capture
3078 the individual program model's unique aspects, while also adopting standardized measures to facilitate
3079 measuring the CCC Levy's collective impact.

3080

[261] Clear Impact. What is Results Based Accountability? [LINK]

Performance measures across programs will vary based on the populations served, duration of services, type of investment and activity, and funding duration. These measures can be quantitative or qualitative. DCHS intends to require contracted service providers to regularly report data for CCC Levy funded programs and strategies and will collect performance measurement data in a consistent manner. The timeline for developing and reporting measures will be distinct for each program and will depend on its implementation stage and data collection requirements. Specific measures will be finalized in consultation with providers and refined periodically.

For strategies that are investing in directly providing behavioral health services to clients, DCHS plans to collect and monitor performance measures on individuals served, the nature of services provided, and associated outcomes to support the implementation of Strategy 1: Create and Operate Five Crisis Care Centers and Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity. Individual level data may be collected on people receiving services to disaggregate measures by race, ethnicity, or other demographic characteristics at both the program level and across programs for analysis within strategies and result areas.

For strategies that are investing in workforce or systems infrastructure, DCHS plans to collect and monitor performance measures among community behavioral health providers that describe agency attributes such as workforce characteristics, activities conducted, and associated outcomes to support the implementation of Section V.C. Strategy 3: Community Behavioral Health Workforce. Individual-level data may be collected on a community behavioral health agency's staff to disaggregate measures by race, ethnicity, or other demographic characteristics at both the program level and across programs for analysis within strategies and result areas.

Across all strategies, DCHS intends to continue expanding the ways in which populations experiencing behavioral health inequities (see Section III.C. Background: Who Experiences Behavioral Health Inequities) are visible in data and are involved in decisions about what data are gathered and how it is interpreted. This may include expanding the ways existing systems disaggregate data by race and ethnicity, developing new methods for data collection, continuing to report on both numbers and stories to value participants' experiences, increasing opportunities for community reflection and feedback on data analysis, and evaluating representativeness by comparing demographics of people reached by CCC Levy strategies to regional population demographics. A description of how community partners will be engaged in evaluation and performance measurement activities is included in Section V.G. Strategy 7: Crisis Care Centers Levy Administration.

In-Depth Evaluation

Performance measurement and evaluation activities may also include additional in-depth evaluations that are more focused in scope, time, or substance to inform program decision making and to ensure that the CCC Levy is functioning as intended. To conduct such evaluations for the CCC Levy, DCHS may contract with external research partners or engage in public-private partnerships to augment its own data collection, measurement, and evaluation work. Where feasible, DCHS will disaggregate in-depth evaluation data by demographic characteristics to advance King County's equity goals.

In collaboration with community partners, the CCC Levy plans to use the following criteria for selecting priority areas for evaluation:

1. **High interest from community partners**. Evaluations identified as being of critical need or interest to King County Council, Cities and the Sound Cities Association, community-based

organizations, providers, the King County Behavioral Health Advisory Board, and others community partners as applicable.

2. **High potential to improve equity**. Evaluations that focus on identifying disproportionalities in services, or identifying whether there is improvement in servicing historically underserved communities.
3. **High potential to improve quality of services**. Evaluation of programs or processes that are integral to quality of care, and where findings can be used with partners for continuous quality improvement.
4. **Provide new evidence**. Evaluation of new or existing programs that can fill a gap in the scientific evidence base and enhance program learning and adaptation.
5. **High quality data**. Evaluations will be selected to leverage available robust, rigorous, and sustainable data sources; results may also inform where further data infrastructure investments are needed.

The design of potential evaluations will be based on what is appropriate for the program's stage of implementation, and the existing evidence base for effectiveness of the selected program models. Options include, but are not limited to:

- **Formative evaluation** to support innovation and decision making for a new program;
- **Process evaluation** to support program implementation and improvements, and,
- **Outcomes evaluation** to demonstrate whether the program is leading to the desired results.

The timeline for completing in-depth evaluations will depend on when baseline data are available; the point at which a sufficient number of individuals have reached the outcome to generate a statistically reliable result; and the time needed for data collection, analyses, and interpretation of data.

C. Aligning CCC Levy Performance Measurement and Reporting with Other Dedicated Human Services Funding Initiatives

DCHS intends to align CCC Levy performance measurement and reporting with other dedicated human services funding initiatives where possible. Alignment is important because King County residents' health and human services needs span the boundaries of federal, state, and local funding. Revenue from the CCC Levy, along with the MIDD, Best Starts for Kids (BSK), the Veterans, Seniors, and Human Services Levy (VSHSL), and Health Through Housing (HTH) constitutes a substantial portion of King County's local health and human service investments. Many of the County's dedicated human services funding streams are time-limited, requiring periodic renewal. MIDD (expires after 2025), BSK (expires after 2027), and VSHSL (expires after 2029) will require renewal during the CCC Levy period to continue; and the County's updated implementation plan for HTH is due in 2027 also during the CCC Levy period. In the development of this Plan, DCHS staff engaged across initiatives to coordinate planning efforts. These overlapping funding timelines offer opportunities over the course of the CCC Levy to innovate, adapt, and tune performance measurement and reporting in response to community needs.

In response to a proviso included in King County's 2017-2018 adopted budget, DCHS has invested heavily in data systems and infrastructure to responsibly collect, manage, and share information, with the goal to make data widely accessible and used to animate conversations, spark innovation, and direct programming and policy decisions to benefit King County residents.[262] These investments have made

[262] Motion 15081 accepts DCHS's report on consolidated human services reporting, as required by Ordinance 18409, Section 66, Proviso P2. [LINK]

3172 possible new data products, including online dashboards, that provide insight on participants in
3173 programs and activities and how they access services, as well as how investments and services are
3174 geographically distributed. This information supports monitoring and evaluating the collective impact in
3175 communities and informs continuous improvement of service delivery. Using these tools, DCHS
3176 collaborates with program participants, contracted service providers, and its own direct services staff to
3177 collect high-quality data, review program performance, and develop and monitor quality improvement
3178 initiatives.
3179
3180 In July 2022, DCHS released a consolidated dashboard to report data on BSK, MIDD, and VSHSL funded
3181 services.[263] In 2023, the dashboard added data for all programs and activities, including those that were
3182 federally funded, in the Behavioral Health and Recovery Division and the Developmental Disabilities and
3183 Early Childhood Supports Division. By 2025, expansion of this dashboard will include further information
3184 from all DCHS divisions to transparently share how the department works to help strengthen the
3185 communities of King County. By 2026, CCC Levy data will be included in this dashboard to transparently
3186 show how this initiative works to help strengthen the communities of King County.
3187
3188

[263] The consolidated dashboard is titled *Measuring DCHS' Impact.* [LINK]

3189 # VIII. Crisis Care Centers Levy Annual Reporting
3190 ## A. Annual Reporting Process and Requirements
3191 Beginning in 2025, and until 2033, DCHS staff will generate an annual report in alignment with reporting
3192 requirements of this Plan and Ordinance 19572. The report will then be reviewed and certified by the
3193 CCC Levy advisory body.[264] By no later than August 15 of each year, the certified annual report will be
3194 made available online so that the community and all interested parties, including the King County
3195 Council and Regional Policy Committee or its successor, will have unfettered access.
3196
3197 The first year's report will report on information from calendar year 2024. Subsequent certified, annual
3198 reports will report on the previous year, including updating the previous year's data. In consultation
3199 with Cities and the Sound Cities Association, as part of the annual report, DCHS will provide historical
3200 and current data in a manner that can be used to analyze services and to make year-over-year
3201 comparisons.
3202
3203 Recognizing that the annual report reflects a collaborative commitment from DCHS to provide useful
3204 data at the local level for local jurisdiction partners in support of levy purpose outcomes, , each CCC Levy
3205 online annual report will, consistent with Ordinance 19572, include:
3206 1. Total expenditure of CCC Levy proceeds by crisis response zone, crisis care center, purpose,
3207 strategy, activities related to crisis care center post-crisis stabilization, and activities related to
3208 expanding mobile crisis services, reported by King County ZIP code where the services were
3209 received, and
3210 2. The number of individuals receiving CCC Levy funded behavioral health care services by crisis
3211 response zone, crisis care center, purpose, strategy, , activities related to crisis care center post-
3212 crisis stabilization, and activities related to expanding mobile crisis services, reported by the ZIP
3213 code where the individuals resided at the time of services and by the King County ZIP code
3214 where the services were received, provided that individually protected information is not
3215 disclosed.
3216
3217 In addition, DCHS will, in consultation with Cities, develop strategies for ZIP code reporting for the CCC
3218 Levy's Supporting Purpose Two, workforce development, informed by evolving career pathways
3219 programming and data availability, and include in the Executive's 2026 career pathways notification
3220 letter a plan for annual reporting of this ZIP code data.
3221
3222 Additionally, each CCC Levy online annual report will include:
3223 3. An overview of CCC facility utilization data as described in the Continuous Quality Improvement
3224 and Quality Assurance subsection of Strategy 1 in this Plan;
3225 4. Crisis care center operator awards made and progress on each awarded operator contract
3226 during the reporting period as required in the Alternative Siting Process section of Strategy 1 in
3227 this Plan;
3228 5. An overview of CCC Levy accomplishments during the previous calendar year, and changes DCHS
3229 intends to make or direct to improve performance in the following year, when applicable;
3230 6. The assessment and reporting required by the Initial Prioritization of Residential Treatment
3231 Capacity of this Plan;
3232 7. The CCC Levy's fiscal and performance measurement during the applicable calendar year, and

[264] Described in Section IX. Crisis Care Centers Levy Advisory Body

3233 8. A map or summary describing the CCC Levy's geographic distribution.
3234
3235 No later than by August 15 of each year, the Executive will transmit directly to the Council, with a copy
3236 sent to the Regional Policy Committee, a summary of the online annual reporting in the form of a letter
3237 that:
3238 • Confirms availability of the online annual report and includes a web link or links;
3239 • Identifies how the online annual report meets the requirements of Ordinance 19572, and
3240 • Summarizes key data and conclusions in the five areas above, including an overview of
3241 accomplishments; fiscal and performance management; expenditure of levy proceeds by crisis
3242 response zone, strategy, and levy purpose by King County ZIP code; the number of individuals
3243 receiving levy-supported services by crisis response zone, strategy, and levy purpose by King
3244 County ZIP code; and a map or summary describing CCC Levy's geographic distribution. This
3245 information will be described in greater detail within the online annual reporting.
3246
3247 The Executive will transmit with the summary letter a motion acknowledging receipt of the summary
3248 letter and completion of the online annual report requirement. The Executive will be prepared to
3249 present a briefing at the invitation of the King County Council or its committees, including the Regional
3250 Policy Committee, on the contents of the online annual report, to inform the Council's consideration of
3251 this motion.
3252
3253 **B. Reporting Methodology to Show Geographic Distribution by ZIP Code**
3254 Consistent with Ordinance 19572, each annual report shall provide total expenditures of CCC Levy
3255 proceeds by crisis response zone, purpose, and strategy by ZIP code in King County, reflecting the
3256 methodology and limitations described in this subsection. DCHS will also report the number of
3257 individuals receiving CCC Levy funded services by crisis response zone, purpose, and strategy by the ZIP
3258 code in King County where the individuals resided at the time of service, also reflecting the methodology
3259 and limitations described in this subsection. ZIP code data will be reported using maps or other
3260 visualizations to aid interpretation of the data.
3261
3262 ZIP Code Reporting Methodology
3263 DCHS intends to report expenditures by ZIP code data for all services that operate from a fixed brick and
3264 mortar location in each CCC Levy annual report, beginning with the inaugural 2025 report. DCHS intends
3265 to align methodology and dissemination practices for reporting program expenditures by ZIP code based
3266 on available data or modeling with approaches implemented in 2023 for Best Starts for Kids, and that
3267 are planned for the Veterans, Seniors, and Human Services Levy consistent with the adopted Veterans,
3268 Seniors, and Human Services Levy Implementation Plan for 2024-2029.[265]
3269
3270 DCHS evaluators may calculate expenditures by ZIP code through service provider location and program
3271 participant residence. Both approaches provide an understanding on the spread of expenditures across
3272 King County. For example, CCC Levy service providers may provide a mix of virtual, mobile, and in-
3273 person programs and services. Reporting by service provider location may not fully capture the service
3274 reach. Alternatively, reporting by program participant residence may not capture difficulties participants
3275 may have accessing services, including transportation. Many program participants access programs in
3276 more than one way. Using more than one methodology to assess expenditures by ZIP code can help
3277 deepen understanding of how programs are accessible to people throughout the County.

[265] Best Starts for Kids Implementation Plan: 2022-2027. [LINK]

3278

ZIP Code Reporting Limitations

3279
3280 Collection of program participant ZIP code data may be limited for some programs in the following
3281 strategies found in Section V. A. Strategy 1: Create and Operate Five Crisis Care Centers, B. Strategy 2:
3282 Restore, Expand, and Sustain Residential Treatment Capacity, C. Strategy 3: Strengthen the Community
3283 Behavioral Health Workforce, D. Strategy 4: Early Crisis Response Investments, and E. Strategy 5:
3284 Capacity Building and Technical Assistance. The limitations include activities associated with, but not
3285 limited to, mobile programs or programs serving people experiencing homelessness, refugees, people
3286 experiencing acute behavioral health crisis, or people who are survivors of domestic violence.
3287 Geographic information may not be available or relevant for programs and strategies that invest in
3288 systems and environment change and strategies that support systemwide workforce capacity building.
3289 ZIP code collection may also not be possible for programs that are required to use an existing data
3290 system that the CCC Levy cannot revise, or when a legal framework prevents the sharing of these data.
3291 All reporting by ZIP code will continue to abide by privacy and confidentiality guidelines.
3292
3293

3294 # IX. Crisis Care Centers Levy Advisory Body

3295 ## A. Overview

3296 This section describes the composition, duties of, and process to establish the CCC Levy's advisory body,
3297 consistent with Ordinance 19572, which allows for the CCC Levy's advisory body to be a preexisting King
3298 County board that has relevant expertise. This Plan identifies the King County Behavioral Health
3299 Advisory Board (BHAB) to serve as the advisory body because it has the relevant expertise to advise the
3300 Executive and the Council on matters relating to behavioral health care and crisis services in King
3301 County.[266] Ordinance XXXXX (Proposed Ordinance 2024-0013) that accompanies this Plan will expand
3302 BHAB's membership requirements and duties to include those set forth in Ordinance 19572.
3303

3304 ## B. BHAB Background and Connection to CCC Levy Purposes

3305 Integrating the CCC Levy's advisory body duties into the BHAB will help promote the coordination and
3306 integration of crisis services across the continuum of behavioral health care managed by King County.
3307 BHAB is the advisory body of the King County BH-ASO. The BH-ASO is the administrative entity within
3308 King County BHRD that contracts with the Washington State HCA to manage non-Medicaid behavioral
3309 health services, behavioral health block grants, and other behavioral health funds, with a significant
3310 focus on crisis services. A significant portion of King County's existing behavioral health crisis services are
3311 administratively organized under the BH-ASO. As the advisory body of the BH-ASO, BHAB has relevant
3312 expertise related to King County crisis services and is well positioned to advise the Executive and Council
3313 regarding the CCC Levy. In addition to having the relevant expertise, centralizing advisory duties within
3314 BHAB will ensure there is a single advisory body for King County's continuum of crisis services. This
3315 approach is intended to help avoid system fragmentation and to promote an integrated approach to
3316 managing crisis services at the system level.
3317

3318 Ordinance 19572 defines the CCC Levy advisory body's membership requirements and duties, which
3319 complement BHAB's existing statutory and contractual requirements. BHAB membership requirements
3320 and duties are established in the Revised Code of Washington (RCW) 71.24.300, Washington State
3321 Administrative Code (WAC) 182-538C-252, King County's BHASO contract with the HCA, and King County
3322 Code 2A.300.050.[267,268,269,270] Thus, an expansion of the BHAB's board member composition
3323 requirements and advisory duties to include advising on the CCC Levy will not conflict with its state
3324 requirements.
3325 To reduce the potential of conflicts, the reader is directed to Ordinance XXXXX (Proposed
3326 Ordinance 2024-0013), for the composition and duties to be fulfilled the BHAB serving as the CCC Levy
3327 advisory body.
3328

[266] King County Behavioral Health Advisory Board [LINK]
[267] RCW 71.24.300 [LINK]
[268] WAC 182-538C-230 [LINK]
[269] King County Code 2A.300.050 [LINK]
[270] The 2023 HCA BH-ASO contract can be obtained from DCHS.

Behavioral Health Equity Highlight

The Behavioral Health Advisory Board serving as the CCC Levy advisory body will play an important role by providing a forum for people with demographics representative of King County as well as lived experience of mental health and substance use conditions to inform DCHS on the CCC Levy's impacts, which will help advance the equity goal described in Section III. F. Behavioral Health Equity Framework: Quality Improvement Accountability.

3329

3330 ### BHAB Member Recruitment Process

3331 Members of the BHAB serving at the time of this Plan's drafting will continue to serve their advisory
3332 board terms after the Plan and its accompanying advisory board ordinance are enacted. Upon adoption
3333 of Ordinance XXXXX (Proposed Ordinance 2024-0013), as necessary to meet the membership
3334 requirements for the CCC Levy advisory body, the Executive shall undertake a recruitment process to
3335 select for appointment new members that satisfy the CCC Levy advisory body qualifications, and subject
3336 to confirmation by the Council, in accordance with K.C.C. chapter 2.28. When BHAB seats become
3337 vacant, the Executive will appoint new BHAB members, informed by the composition requirements of
3338 Ordinance XXXXX (Proposed Ordinance 2024-0013), and subject to confirmation by the Council, in
3339 accordance with K.C.C. chapter 2.28..

3340

3341 ### BHAB Support

3342 DCHS will provide staff support to BHAB and, in consultation with BHAB, will help BHAB fulfill its
3343 required CCC Levy duties described in this section. DCHS will work to remove barriers that may dissuade
3344 persons from seeking to join BHAB. Included in those strategies will be per diem compensation.

3345

3346 ## D. Expansion of BHAB's Duties to Include the CCC Levy

3347 BHAB is responsible for advising the King County BH-ASO on the design and implementation of publicly
3348 funded behavioral health services.[271] This Plan and the accompanying of Ordinance XXXXX (Proposed
3349 Ordinance 2024-0013), expand the duties of BHAB to include the CCC Levy's advisory body duties
3350 required in Ordinance 19572. These additional required duties include:

3351 - Advise the King County Executive and Council on matters affecting the CCC Levy;
3352 - Visit each existing crisis care center annually to better understand the perspectives and
3353 priorities of crisis care center operators, staff, and clients, and
3354 - Report on the CCC Levy to the Council and the community through annual online reports
3355 beginning in 2025, as described in Section VIII. Crisis Care Centers Levy Annual Reporting.

3356

3357 BHAB's additional duties related to advising the CCC Levy will go into effect on the effective date of the
3358 of Ordinance XXXXX (Proposed Ordinance 2024-0013).

3359

3360 ## E. Process to Update CCC Levy Advisory Body if Necessary

3361 Existing BHAB membership requirements and duties defined by state law and state contracts may be
3362 updated during this Plan's term. These potential changes could require adjustment of BHAB's
3363 membership composition or duties that are described in this Plan and the accompanying of Ordinance
3364 XXXXX (Proposed Ordinance 2024-0013). If BHAB's requirements are updated by the state in a way that

[271] King County Behavioral Health Advisory Board Bylaws [LINK]

3365 is no longer compatible with the CCC Levy or if the Executive determines that a different CCC advisory
3366 body will better serve effective administration of the CCC Levy, then the Executive may propose an
3367 ordinance to the Council to update the CCC Levy's advisory body structure, that will not require an
3368 amendment to this Plan. If the Executive proposes an ordinance to Council to update the CCC Levy's
3369 advisory board structure, the Executive will notify the Regional Policy Committee.
3370
3371

X. Conclusion

King County voters approved the Crisis Care Centers Levy on April 25, 2023. The nine-year levy begins on January 1, 2024, starting an ambitious timeline to transform the region's behavioral health crisis response system, restore the region's flagging mental health residential facilities, and reinforce the workforce — the people — upon whom tens of thousands of King County residents depend for their behavioral health. This Plan lays the path that King County, cities and other local jurisdictions, and behavioral health providers must travel with urgency, common purpose, and strong partnership so that future generations will have a safe, accessible, and effective place to go in a moment of mental health or substance use crisis.

King County begins this levy at a critical moment. The other systems upon which society depends — schools, the legal system, housing providers, first responders, hospitals, employers, and so many more — newly recognize that they cannot fully function if the people they serve cannot get behavioral health care. Federal and state funding for behavioral health have not kept pace with needs, and local communities, families, and individuals bear the results. Without better options, too many King County residents experiencing a crisis have languished in a jail, emergency room, on the street, or alone in their home when what they needed was a place they could get same-day care from a trained and supportive professional in a setting that helps, instead of making symptoms or underlying conditions worse.

The Crisis Care Centers Levy also comes at a moment of new opportunity. Other communities have tested and proven models of care and facility types that help people get better. Mental health and substance use treatments work when they are accessible and properly administered with dignity. The new 988 crisis line gives people in crisis someone they can call. Governments at all levels are investing in new teams and approaches that respond to more emergency calls with behavioral health clinicians.

At this moment when long-forming needs meet new attitudes and infrastructures, people in crisis increasingly have *someone they can call* and *someone to respond* to those calls. This Plan describes how King County will focus new resources and efforts to create *somewhere for people to go* — and to know that there will be providers there to help.

But plans do not by themselves make change. Creating a regional network of crisis care centers, restoring the region's recently lost residential treatment capacity, and growing and better supporting a more representative workforce in nine years will require King County, cities and other local jurisdictions, and providers to work together in new ways. King County must fully resource and staff this Plan's strategies, maintaining disciplined prioritization — and avoiding diffusion — of the Levy's proceeds and staff capacity. Cities, other local jurisdictions, and communities must embrace and support development of new behavioral health facilities. Providers will need to incorporate new practices, integrate services, and coordinate care with new partners. All must communicate, collaborate, and be accountable with a new commitment to creating a behavioral health system and model of cooperation that future generations will be proud of and depend on.

The Crisis Care Centers Levy provides the resources. This Plan lays the path. The task is now to King County, cities, and providers to make it happen.

3416 # XI. Appendices

3417 ## Appendix A: Crisis Care Centers Levy Ordinance 19572 Text

3418 AN ORDINANCE providing for the submission to the qualified electors of King County at a special election
3419 to be held in King County on April 25, 2023, of a proposition authorizing a property tax levy in excess of
3420 the levy limitation contained in chapter 84.55 RCW, for a consecutive nine-year period, at a first year
3421 rate of not more than $0.145 per one thousand dollars of assessed valuation for collection beginning in
3422 2024, with the 2024 levy amount being the base for calculating increases in years two through nine
3423 (2025 - 2032) by the limit factor in chapter 84.55 RCW, as amended, for regional behavioral health
3424 services and capital facilities to establish and operate a regional network of behavioral health crisis care
3425 centers; to preserve, expand and maintain residential treatment facilities; to provide behavioral health
3426 workforce supports; to provide mobile crisis care and post-discharge stabilization; to pay, finance or
3427 refinance costs of those projects; and for administration, coordination, implementation and evaluation
3428 of levy activities.

3429

3430 STATEMENT OF FACTS:
3431 1. King County's behavioral health crisis service system relies heavily on phone support and outreach
3432 services, with very few options of places for persons to go for immediate, life-saving care when in crisis.
3433 2. As of September 2022, the Crisis Solutions Center, operated by Downtown Emergency Service Center
3434 and requiring mobile team, first responder or hospital referral for entry, is the only voluntary behavioral
3435 health crisis facility for the entirety of King County, and no walk-in urgent care behavioral health facility
3436 exists in King County.
3437 3. A coalition of community leaders and behavioral health providers issued recommendations to Seattle
3438 and King County in an October 13, 2021, letter that included recommendations to "expand places for
3439 people in crisis to receive immediate support" and "expand crisis response and post-crisis follow up
3440 services."
3441 4. Call volume to King County's regional behavioral health crisis line increased by 25 percent between
3442 2019 and 2021, from 82,523 calls in 2019 to 102,754 calls in 2021.
3443 5. The number of persons per year who received community-based behavioral health crisis response
3444 services in King County increased 146 percent between 2012 and 2021, from 1,764 persons served in
3445 2012 to 4,336 persons served in 2021.
3446 6. Referrals for mobile crisis outreach in King County grew 15 percent between 2019 and 2021, from
3447 4,030 referrals in 2019 to 4,648 referrals in 2021.
3448 7. King County's designated crisis responders conducted 14 percent more investigations for involuntary
3449 behavioral health treatment in 2021, when they investigated 9,189 cases, than in 2017 when they
3450 investigated 8,066 cases. There was a 10 percent increase in detentions or revocations for involuntary
3451 hospitalization during that same period, from 4,387 in 2017 to 4,806 in 2021.
3452 8. The wait time for a King County resident in behavioral health crisis in a community setting to be
3453 evaluated for involuntary behavioral health treatment tripled between January 2019 and June 2022,
3454 from 4 days to 12 days.
3455 9. The U.S. Department of Health and Human Services reported that in August 2022, the first full month
3456 that the new national 988 Suicide and Crisis Lifeline was operational, the overall volume of calls, texts
3457 and chats to the Lifeline increased by 152,000 contacts, or 45 percent, compared to the number of
3458 contacts to the National Suicide Prevention Lifeline in August 2021.
3459 10. The federal Substance Abuse and Mental Health Services Administration's ("SAMHSA's") National
3460 Guidelines for Behavioral Health Crisis Care, and its vision for the implementation of the new national

3461 988 Suicide and Crisis Lifeline, call for the development of safe places for persons in crisis to go for help
3462 as part of a robust behavioral health crisis system.
3463 11. In 2021, the Washington state Legislature passed Engrossed Second Substitute House Bill 1477,
3464 which became Chapter 302, Laws of Washington 2021, to support implementation of 988 in
3465 Washington, to further SAMHSA's overall vision and build on the crisis phone line change by expanding
3466 and transforming crisis services.
3467 12. RCW 71.24.025 defines crisis stabilization services to mean services such as 23-hour crisis
3468 stabilization units based on the living room model, crisis stabilization centers, short-term respite
3469 facilities, peer-operated respite services, and behavioral health urgent care walk-in centers, including
3470 within the overall crisis system components that operate like hospital emergency departments and
3471 accept all walk-ins, and ambulance, fire, and police drop-offs. Chapter 302, Laws of Washington 2021
3472 further expressed the state legislature's intent to expand the behavioral health crisis delivery system to
3473 include these components.
3474 13. Multiple behavioral health system needs assessments have identified the addition of crisis facilities
3475 as top priorities to improve community-based crisis services in King County. Such assessments include
3476 the 2016 recommendations of the Community Alternatives to Boarding Task Force called for by Motion
3477 14225, a Washington state Office of Financial Management behavioral health capital funding
3478 prioritization and feasibility study in 2018, and a Washington state Health Care Authority crisis triage
3479 and stabilization capacity and gaps report in 2019.
3480 14. King County is losing mental health residential treatment capacity that is essential for persons who
3481 need more intensive supports to live safely in the community due to rising operating costs and aging
3482 facilities that need repair or replacement. As of August 2022, King County had a total of 244 mental
3483 health residential beds for the entire county, down 111 beds, or nearly one third, from the capacity in
3484 2018 of 355 beds.
3485 15. As of July 2022, King County residents who need mental health residential services must wait an
3486 average of 44 days before they are able to be placed in a residential facility.
3487 16. Data from the U.S. Centers for Disease Control and Prevention, the U.S. Census Bureau and the
3488 Kaiser Family Foundation show that about three in ten adults in the United States reported symptoms of
3489 anxiety or depressive disorder in June 2022, up from one in ten adults who reported these symptoms in
3490 2019.
3491 17. The National Council for Mental Wellbeing's 2022 access to care survey found that 43 percent of
3492 U.S. adults who say they need mental health or substance use care did not receive that care, and they
3493 face numerous barriers to accessing and receiving needed treatment.
3494 18. According to the Washington state Department of Social and Health Services, the number of
3495 Medicaid enrollees in King County with an identified mental health need increased by approximately 34
3496 percent for adults and nine percent for youth between 2019 and 2021.
3497 19. The Washington state Department of Social and Health Services reports that in 2021, among those
3498 enrolled in Medicaid in King County, nearly half of adults and over a third of youth with an identified
3499 mental health need did not receive treatment.
3500 20. The Washington state Department of Social Health Services reports that in 2021, among those
3501 enrolled in Medicaid in King County, approximately 62 percent of adults and 80 percent of youth with an
3502 identified substance use disorder need did not receive treatment.
3503 21. SAMHSA's National Guidelines for Behavioral Health Crisis Care recommend including peers with
3504 lived experience of mental health conditions or substance use disorders on crisis response teams. Those
3505 guidelines also feature the living room model as an example of crisis service delivery innovation
3506 featuring peers.

3507 22. The 2021 King County nonprofit wage and benefits survey showed that many nonprofit employees
3508 delivering critical services earn wages at levels that make it difficult to sustain a career doing
3509 community-based work in this region.
3510 23. A 2021 King County survey of member organizations of the King County Integrated Care Network
3511 found that job vacancies at these community behavioral health agencies were at least double what they
3512 were in 2019. Providers cited professionals' ability to earn more in medical systems or private practice,
3513 and the high cost of living in the King County region, as the top reasons their workers were leaving
3514 community behavioral healthcare.
3515 24. The behavioral health workforce advisory committee to the state of Washington's Workforce
3516 Training and Education Coordinating Board found in 2021 that Washington continues to face a shortage
3517 of behavioral health professionals, while demand for services, and qualified workers to deliver them,
3518 continues to grow. The advisory committee also found that workers need increased financial support
3519 and incentives to remain in community behavioral health care.
3520
3521 BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:
3522 SECTION 1. **Definitions.** The definitions in this section apply throughout this ordinance unless the
3523 context clearly requires otherwise.
3524 A. "Crisis care center" means a single facility or a group of facilities that provide same-day access to
3525 multiple types of behavioral health crisis stabilization services, which may include, but are not limited to,
3526 those described in RCW 71.24.025(20), as amended. A crisis care center shall endeavor to accept at
3527 least for initial screening and triage any person who seeks behavioral health crisis care. Among the
3528 types of behavioral health crisis stabilization services that a crisis care center shall provide are a
3529 behavioral health urgent care clinic that offers walk-in and drop-off client screening and triage twenty-
3530 four hours per day, seven days per week; access to onsite assessment by a designated crisis responder; a
3531 twenty-three-hour observation unit or similar facility and service that allows for short-term, onsite
3532 stabilization of a person experiencing a behavioral health crisis; and a crisis stabilization unit that
3533 provides short-term, onsite behavioral health treatment for up to fourteen days or a similar short-term
3534 behavioral health treatment facility and service. A crisis care center shall be staffed by a
3535 multidisciplinary team that includes peer counselors. A crisis care center may incorporate pre-existing
3536 facilities that provide crisis stabilization services so long as their services and operations are compatible
3537 with this definition. Where a crisis care center is composed of more than one facility, those facilities
3538 shall either be geographically adjacent or shall have transportation provided between them to allow
3539 persons using or seeking service to conveniently move between facilities.
3540 B. "Designated crisis responder" has the same meaning as in RCW 71.05.020, as amended.
3541 C. "King County crisis response zone" means each of four geographic subregions of King County:
3542 1. North King County crisis response zone, which is the portion of King County within the boundaries of
3543 the cities of Bothell, Duvall, Kenmore, Kirkland, Lake Forest Park, Shoreline, Skykomish and Woodinville,
3544 plus the unincorporated areas within King County council district three as it is drawn on the effective
3545 date of this ordinance that are north or northeast of the city of Redmond;
3546 2. Central King County crisis response zone, which is the portion of King County within the boundaries
3547 of the city of Seattle, plus all unincorporated areas within King County council districts two and eight as
3548 they are drawn on the effective date of this ordinance;
3549 3. South King County crisis response zone, which is the portion of King County within the boundaries of
3550 the cities of Algona, Auburn, Black Diamond, Burien, Covington, Des Moines, Enumclaw, Federal Way,
3551 Kent, Maple Valley, Milton, Normandy Park, Pacific, Renton, SeaTac and Tukwila, plus all unincorporated
3552 areas within King County council districts five, seven and nine as they are drawn on the effective date of
3553 this ordinance; and

3554 4. East King County crisis response zone, which is the portion of King County within the boundaries of
3555 the cities of Beaux Arts, Bellevue, Carnation, Clyde Hill, Hunts Point, Issaquah, Medina, Mercer Island,
3556 Newcastle, North Bend, Redmond, Sammamish, Snoqualmie and Yarrow Point, plus the unincorporated
3557 areas within King County council district three as it is drawn on the effective date of this ordinance that
3558 are east or southeast of the city of Redmond, plus all unincorporated areas within King County council
3559 district six as it is drawn on the effective date of this ordinance.
3560 D. "Levy" means the levy of regular property taxes for the specific purposes and term provided in this
3561 ordinance and authorized by the electorate in accordance with state law.
3562 E. "Levy proceeds" means the principal amount of moneys raised by the levy and any interest earnings
3563 on the moneys and the proceeds of any interim or other financing following authorization of the levy.
3564 F. "Regional behavioral health services and capital facilities" means programs, services, activities,
3565 operations, staffing and capital facilities that: promote mental health and wellbeing and that treat
3566 substance use disorders and mental health conditions; promote integrated physical and behavioral
3567 health; promote and provide therapeutic responses to behavioral health crises; promote equitable and
3568 inclusive access to mental health and substance use disorder services and capital facilities for those
3569 racial, ethnic, experiential and geographic communities that experience disparities in mental health and
3570 substance use disorder conditions and outcomes; build the capacity of mental health and substance use
3571 disorder service providers to improve the effectiveness, efficiency, and equity, of their services and
3572 operations; provide transportation to care for persons receiving, seeking, or in need, of mental health or
3573 substance use disorder services; promote housing stability for persons receiving or leaving care from a
3574 facility providing mental health or substance use disorder services; promote service and response
3575 coordination, data sharing, and data integration amongst first responders, mental health and substance
3576 use disorder providers, and King County staff; promote community participation in levy activities,
3577 including payment of stipends to persons with relevant lived experience who participate in levy activities
3578 whose employment does not already compensate them for such participation; administer, coordinate
3579 and evaluate levy activities; apply for federal, state and philanthropic moneys and assistance to
3580 supplement levy proceeds; and promote stability and sustainability of the behavioral health workforce.
3581 G. "Residential treatment" means a licensed, community-based facility that provides twenty-four-hour
3582 on-site care for persons with mental health conditions, substance use disorders, or both, in a residential
3583 setting.
3584 H. "Strategy" means a program, service, activity, initiative or capital investment intended to achieve the
3585 purposes described in section 4 of this ordinance.
3586 I. "Technical assistance and capacity building" means assisting organizations in applying for grants
3587 funded by the levy and in implementing and improving delivery of a strategy or strategies for which levy
3588 moneys are eligible, and includes assisting community-based organizations in delivery of strategies to
3589 persons and communities that are disproportionately impacted by behavioral health conditions.
3590 SECTION 2. **Levy submittal.** To provide necessary moneys to fund, finance or refinance the purposes
3591 identified in section 4 of this ordinance, the King County council shall submit to the qualified electors of
3592 the county a proposition authorizing a regular property tax levy in excess of the levy limitation contained
3593 in chapter 84.55 RCW for nine consecutive years, with collection commencing in 2024, at a rate not to
3594 exceed $0.145 per one thousand dollars of assessed value in the first year of the levy period. The dollar
3595 amount of the levy in the first year shall be the base upon which the maximum allowable levy amounts
3596 in years two through nine (2025-2032) shall be calculated using the limit factor in chapter 84.55 RCW, as
3597 amended.
3598 SECTION 3. **Deposit of levy proceeds.** The levy proceeds shall be deposited into the crisis care centers
3599 fund, or its successor.
3600 SECTION 4. **Levy purposes.**

3601 A. The paramount purpose of the levy shall be to establish and operate a regional network of five crisis
3602 care centers in King County, with each of the four King County crisis response zones containing at least
3603 one crisis care center and at least one of the five crisis care centers specializing in serving persons
3604 younger than nineteen years old.
3605 B. The levy's supporting purpose one shall be to restore the number of mental health residential
3606 treatment beds in King County to at least three hundred fifty-five beds and to expand the availability
3607 and sustainability of residential treatment in King County.
3608 C. The levy's supporting purpose two shall be to increase the sustainability and representativeness of
3609 the behavioral health workforce in King County by increasing recruitment and retention, and by
3610 improving financial sustainability for the behavioral health workforce through increased wages,
3611 apprenticeship programming and, where possible, reduction of costs such as costs of insurance, child
3612 care, caregiving and fees or tuition associated with behavioral health training and certification. This
3613 purpose shall promote workforce recruitment and retention for the region's behavioral health
3614 workforce while prioritizing increased wages and reduction of costs for the behavioral health workforce
3615 who are providing regional behavioral health services and capital facilities as a part of the levy's
3616 paramount purpose.
3617 D. The levy implementation plan required by section 7 of this ordinance may specify additional
3618 supporting purposes so long as those additional supporting purposes are not inconsistent with and are
3619 subordinate to the paramount purpose and supporting purposes one and two described in subsections
3620 A. through C. of this section.
3621 SECTION 5. **Eligible expenditures.**
3622 A. If approved by the qualified electors of the county, such sums from the first year's levy proceeds as
3623 are necessary may be used to provide for the costs and charges incurred by the county that are
3624 attributable to the election, and an amount from the first year's levy proceeds not to exceed one million
3625 dollars may be used for initial levy implementation planning activities.
3626 B. After the amounts authorized in subsection A. of this section, the remaining levy proceeds shall not
3627 be expended until King County enacts an ordinance adopting the implementation plan required by
3628 section 7 of this ordinance. The council's process to consider and adopt the levy implementation plan
3629 and any amendments shall include mandatory referral to the regional policy committee or its
3630 successor. After King County enacts an ordinance adopting the levy implementation plan, levy proceeds
3631 shall be expended in accordance with the implementation plan, as amended, and with this ordinance.
3632 C. Levy proceeds described in subsection B. of this section shall only be used to fund, finance or
3633 refinance costs to:
3634 1. Plan, site, construct, acquire, restore, maintain, operate, implement, staff, coordinate, administer
3635 and evaluate regional behavioral health services and capital facilities that achieve and maintain the
3636 paramount purpose, supporting purpose one, and supporting purpose two of the levy that are described
3637 in section 4. and as they may be further described in the implementation plan;
3638 2. Plan, site, construct, acquire, restore, maintain, operate, implement, staff, coordinate, administer
3639 and evaluate regional behavioral health services and capital facilities that achieve additional levy
3640 purposes that are included in the implementation plan, so long as those purposes are subordinate to
3641 and not inconsistent with the paramount purpose and supporting purposes one and two; and
3642 3. Provide for regional behavioral health services and capital facilities provided by metropolitan park
3643 districts, fire districts or local public hospital districts in King County in an amount up to the lost
3644 revenues to the individual district resulting from prorationing, as mandated by RCW 84.52.010, to the
3645 extent the levy was a demonstrable cause of the prorationing and only if the county council has
3646 authorized the expenditure by ordinance.

3647 D. Unless made otherwise eligible in subsection C. of this section, levy proceeds shall not be used to
3648 provide, supplant, replace or expand funding for non-behavioral health purposes including, but not
3649 limited to, jails, prisons, courts of law, criminal prosecution, criminal defense or law enforcement,
3650 except for costs that provide or coordinate regional behavioral health services and capital facilities
3651 within or between crisis care centers and other health care settings or that remove or reduce a barrier
3652 to receiving behavioral health services such as quashing a warrant. Nothing in this subsection shall be
3653 interpreted or construed to limit, discourage, or impede law enforcement agencies' or other first
3654 responders' coordination with, use of and access to crisis care centers for persons they encounter in the
3655 conduct of their duties.
3656 SECTION 6. **Call for special election.** In accordance with RCW 29A.04.321, the King County council
3657 hereby calls for a special election to be held on April 25, 2023, to consider a proposition authorizing a
3658 regular property tax levy for the purposes described in this ordinance. The King County director of
3659 elections shall cause notice to be given of this ordinance in accordance with the state constitution and
3660 general law and to submit to the qualified electors of the county, at the said special county election, the
3661 proposition hereinafter set forth. The clerk of the council shall certify that proposition to the director of
3662 elections in substantially the following form:
3663 PROPOSITION___: The King County Council passed Ordinance ____ concerning funding for
3664 mental health and substance use disorder services. If approved, this proposition would fund
3665 behavioral health services and capital facilities, including a countywide crisis care centers
3666 network, increased residential treatment; mobile crisis care; post-discharge stabilization; and
3667 workforce supports. It would authorize an additional nine-year property tax levy for collection
3668 beginning in 2024 at $0.145 per $1,000 of assessed valuation, with the 2024 levy amount being
3669 the base for calculating annual increases in 2025-2032 under chapter 84.55 RCW, and exempt
3670 eligible seniors, veterans, and disabled persons under RCW 84.36.381. Should this proposition
3671 be:
3672 Approved? _____
3673 Rejected? _____
3674 SECTION 7. **Implementation plan.**
3675 A. If voters approve the levy, the executive shall transmit by December 31, 2023, a proposed levy
3676 implementation plan for council review and adoption by ordinance. The proposed implementation plan
3677 shall direct levy expenditures from 2024 through 2032.
3678 B. The executive shall electronically file the implementation plan required in subsection A. of this
3679 section with the clerk of the council, who shall retain the original and provide an electronic copy to all
3680 councilmembers, the council chief of staff, the policy staff director and the lead staff for the law, justice,
3681 health and human services committee and the regional policy committee, or their successors. The
3682 implementation plan shall be accompanied by proposed ordinances that adopt the implementation plan
3683 and that establish or empower the advisory body, the description of which is set forth in subsection C.9.
3684 of this section.
3685 C. The implementation plan required in subsection A. shall include:
3686 1. A list and descriptions of the purposes of the levy, which must at least include and may not materially
3687 impede accomplishment of the paramount purpose and supporting purposes one and two described in
3688 section 4 of this ordinance;
3689 2. A list and descriptions of strategies and allowable activities to achieve the purposes described in
3690 subsection C.1. of this section, which strategies shall at least include:
3691 a. planning, capital, operations and services investments for crisis care centers, which may include
3692 construction of new or acquisition, renovation, updating or expanding existing buildings in whole or in
3693 part;

3694 b. capital and maintenance investments for mental health residential treatment capacity;
3695 c. investments to increase attraction to, retention in, and sustainability of the behavioral health
3696 workforce;
3697 d. establishment and maintenance of levy and capital reserves to promote continuity of levy-funded
3698 activities and prioritization of the paramount purpose and then supporting purposes one and two in the
3699 event of fluctuations in levy revenue or strategy costs;
3700 e. activities that promote post-crisis stabilization, including housing stability, for persons receiving or
3701 discharging from levy-funded services;
3702 f. a plan for the initial period of the levy prior to initiation of operations of the first crisis care center for
3703 the provision of mobile and site-based behavioral health activities that promote access to behavioral
3704 health services for persons experiencing or at risk of a behavioral health crisis;
3705 g. technical assistance and capacity building for organizations applying for or receiving levy funding,
3706 including a strategy or strategies to promote inclusive care at levy-funded facilities for racial, ethnic and
3707 other demographic groups that experience disproportionate rates of behavioral health conditions in
3708 King County;
3709 h. capital facility siting support, communication and city partnership activities;
3710 i. levy administration activities and activities that monitor and promote coordination, more effective
3711 crisis response, and quality of care within and amongst crisis care centers, other behavioral health crisis
3712 response services in King County, and first responders; and
3713 j. performance measurement and evaluation activities;
3714 3. A financial plan to direct the use of the proceeds for regional behavioral health services and capital
3715 facilities that achieve the purposes and strategies described in subsection C.1. and 2. of this section,
3716 which must at a minimum include:
3717 a. the forecast of annual revenue for each year of the levy;
3718 b. an annual expenditure plan for each year of the levy that allocates forecasted levy proceeds among
3719 the levy's strategies;
3720 c. a description of the sequence and timing of planned expenditures and activities to establish and
3721 operate the regional network of five crisis care centers required to satisfy the levy's paramount purpose;
3722 and
3723 d. a description of how a portion of first-year levy proceeds will be allocated to make rapid initial
3724 progress towards fulfilling supporting purposes one and two;
3725 4. A description of how the executive will seek and incorporate when available federal, state,
3726 philanthropic and other moneys that are not proceeds of the levy to accelerate, enhance, compliment or
3727 sustain accomplishment the levy's paramount purpose and supporting purposes one and two;
3728 5. A description of the executive's assumptions about the role of Medicaid funding in the financial plan
3729 and the executive's planned approach to billing eligible crisis care services to Medicaid or other sources
3730 of potential payment such as private insurance;
3731 6. A description of the process by which King County and partner cities shall collaborate to support
3732 siting of new capital facilities that use proceeds from the levy for such facilities' construction or
3733 acquisition;
3734 7. A summary of the process and key findings of the community and stakeholder engagement process
3735 that informs the proposed implementation plan;
3736 8. A process to make substantial adjustments to the financial plan required in subsection C.3. of this
3737 section, which process shall require notice to the council and provide for the council the ability to stop
3738 any substantial adjustment that the council does not support;
3739 9. A description of the composition, duties of, and process to establish the advisory body for the
3740 levy. The advisory body may be a preexisting King County board or commission that has relevant

3741 expertise or a new advisory body. The composition of the advisory body shall be demographically
3742 representative of the population of King County and shall include at least one resident of each King
3743 County crisis response zone, persons who have previously received crisis stabilization services, and
3744 persons with professional training and experience in the provision of behavioral health crisis care. The
3745 duties of the advisory body shall include advising the executive and council on matters pertaining to
3746 implementation of the levy, annually visiting each existing crisis care center and reporting annually to
3747 the council and community, through online annual reports beginning in 2025, on the levy's progress
3748 over the previous year towards accomplishing the levy purposes described in section 4 of this ordinance
3749 and on the levy's actual financial expenditures in the previous year relative to the financial plan required
3750 in subsection C.3. of this section that shall include, but not be limited to, the following:
3751 a. total expenditure of levy proceeds by crisis response zone, strategy, and levy purpose by ZIP Code in
3752 King County; and
3753 b. the number of individuals receiving levy-funded services by crisis response zone, strategy, and levy
3754 purpose by ZIP Code in King County of where the individuals reside at the time of service;
3755 10. A description of how the executive shall provide each online annual report described in subsection
3756 C.9. of this section to the clerk of the council, to all councilmembers and all members and alternate
3757 members of the regional policy committee, or its successor, including confirmation that the executive
3758 shall electronically file a proposed motion that shall acknowledge receipt of the report; and
3759 11. A description of how the purpose of the crisis response zones described in this levy will promote
3760 geographic distribution of crisis care centers so that they are accessible for walk-in and drop-off crisis
3761 care throughout King County, but that the crisis care zones shall not be used to limit the ability of any
3762 person in King County to use any particular crisis care center.
3763 SECTION 8. **Updating the definition of crisis care center.** If new research, changing best practices,
3764 updated federal or state regulations or other evidence-based factors cause this ordinance's definition of
3765 "crisis care center" to become infeasible, impracticable or inconsistent with the levy's paramount
3766 purpose, King County may, upon recommendation of the advisory body described in section 7.C.9. of
3767 this ordinance and with mandatory referral to the regional policy committee, update the definition of
3768 "crisis care center" through adoption of an ordinance to a definition substantially similar to what is
3769 recommended by the advisory body.
3770 SECTION 9. **Exemption.** The additional regular property taxes authorized by this ordinance shall be
3771 included in any real property tax exemption authorized by RCW 84.36.381.
3772 SECTION 10. **Ratification and confirmation.** Certification of the proposition by the clerk of the county
3773 council to the director of elections in accordance with law before the special election on April 25, 2023,
3774 and any other act consistent with the authority and before the effective date of this ordinance are
3775 hereby ratified and confirmed.
3776 SECTION 11. **Severability.** If any provision of this ordinance or its application
3777 to any person or circumstance is held invalid, the remainder of the ordinance or the application of the
3778 provision to other persons or circumstances is not affected.
3779

3780
3781 **Appendix B: Crosswalk of Implementation Plan Requirements from King County Ordinance**
3782 **19572**
3783

Crosswalk of Implementation Plan Requirements from King County Ordinance 19572[272]	
King County Ordinance 19572 Requirements	**Implementation Plan Section(s)**
List and Descriptions of Purposes of the Levy	See Section(s)
1. A list and descriptions of the purposes of the levy, which must at least include and may not materially impede accomplishment of the paramount purpose and supporting purposes one and two described in section 4 of this ordinance;	• Section IV. Crisis Care Centers Levy Purposes
List and Descriptions of Strategies and Allowable Activities	See Section(s)
2. A list and descriptions of strategies and allowable activities to achieve the purposes described in subsection C.1. of this section, which strategies shall at least include:	• Section V. Crisis Care Centers Levy Strategies and Allowable Activities
Crisis Care Centers	*See Section(s)*
a. planning, capital, operations and services investments for crisis care centers, which may include construction of new or acquisition, renovation, updating or expanding existing buildings in whole or in part;	• Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers
Mental Health Residential	*See Section(s)*
b. capital and maintenance investments for mental health residential treatment capacity;	• Section V.B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity
Behavioral Health Workforce	*See Section(s)*
c. investments to increase attraction to, retention in, and sustainability of the behavioral health workforce;	• Section V.C. Strategy 3: Strengthen the Community Behavioral Health Workforce
Reserves	*See Section(s)*
d. establishment and maintenance of levy and capital reserves to promote continuity of levy-funded activities and prioritization of the paramount purpose and then supporting purposes one and two in the event of fluctuations in levy revenue or strategy costs;	• Section V.H. Strategy 8: Crisis Care Centers Levy Reserves
Post-Crisis Stabilization/Discharge Resources incl Housing Stability	*See Section(s)*
e. activities that promote post-crisis stabilization, including housing stability, for persons receiving or discharging from levy-funded services;	• Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers
Plan for Initial Levy Period: Mobile and Site-Based BH Activities	*See Section(s)*
f. a plan for the initial period of the levy prior to initiation of operations of the first crisis care center for the provision of mobile and site-based behavioral health activities that promote access to	• Section V.D. Strategy 4: Early Crisis System Investments

[272] King County Ordinance 19572 [LINK].

behavioral health services for persons experiencing or at risk of a behavioral health crisis;	
Technical Assistance and Capacity-Building	*See Section(s)*
g. technical assistance and capacity building for organizations applying for or receiving levy funding, including …	• Section V.E. Strategy 5: Capacity Building and Technical Assistance
… a strategy or strategies to promote inclusive care at levy-funded facilities for racial, ethnic and other demographic groups that experience disproportionate rates of behavioral health conditions in King County;	• Section V.E. Strategy 5: Capacity Building and Technical Assistance
Capital Facility Siting Support, Communication, City Partnership	*See Section(s)*
h. capital facility siting support, communication and city partnership activities;	• Section V.E. Strategy 5: Capacity Building and Technical Assistance
Administration, Coordination, and Quality	*See Section(s)*
i. levy administration activities and activities that monitor and promote coordination, more effective crisis response, and quality of care within and amongst crisis care centers, other behavioral health crisis response services in King County, and first responders, and	• Section V.G. Strategy 7: Crisis Care Centers Levy Administration
Performance Measurement and Evaluation	*See Section(s)*
j. performance measurement and evaluation activities;	• Section V.F. Strategy 6: Evaluation and Performance Measurement Activities
Financial Plan: Revenue Forecast and Expenditures by Strategy	See Section(s)
3. A financial plan to direct the use of the proceeds for regional behavioral health services and capital facilities that achieve the purposes and strategies described in subsection C.1. and 2. of this section, which must at a minimum include:	• Section VI. Financial Plan
a. the forecast of annual revenue for each year of the levy;	• Section VI. Financial Plan
b. an annual expenditure plan for each year of the levy that allocates forecasted levy proceeds among the levy's strategies;	• Section VI. Financial Plan
Sequence and Timing of Planned Expenditures/Activities to establish CCCs	*See Section(s)*
c. a description of the sequence and timing of planned expenditures and activities to establish and operate the regional network of five crisis care centers required to satisfy the levy's paramount purpose; and	• Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers
Description of Use of Portion of First-Year Revenue for Rapid Progress on MH Residential and Workforce	*See Section(s)*
d. a description of how a portion of first-year levy proceeds will be allocated to make rapid initial progress towards fulfilling supporting purposes one and two;	• Section V.B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity

	• Section V.C. Strategy 3: Strengthen the Community Behavioral Health Workforce
Plan to Seek Other Funds to Accelerate/Enhance Levy Purposes	*See Section(s)*
4. A description of how the executive will seek and incorporate when available federal, state, philanthropic and other moneys that are not proceeds of the levy to accelerate, enhance, compliment or sustain accomplishment the levy's paramount purpose and supporting purposes one and two;	• Section VI. Financial Plan
Description of Medicaid and Private Insurance Assumptions	See Section(s)
5. A description of the executive's assumptions about the role of Medicaid funding in the financial plan and the executive's planned approach to billing eligible crisis care services to Medicaid or other sources of potential payment such as private insurance;	• Section VI. Financial Plan
Description of Collaboration with Cities in Siting	See Section(s)
6. A description of the process by which King County and partner cities shall collaborate to support siting of new capital facilities that use proceeds from the levy for such facilities' construction or acquisition;	• Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers • Section V.B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity
Community and Stakeholder Engagement Summary	See Section(s)
7. A summary of the process and key findings of the community and stakeholder engagement process that informs the proposed implementation plan;	• Section III. Background
Process for Substantial Adjustments to Financial Plan	See Section(s)
8. A process to make substantial adjustments to the financial plan required in subsection C.3. of this section, which process shall require notice to the council and provide for the council the ability to stop any substantial adjustment that the council does not support;	• Section VI. Financial Plan
Advisory Body (New or Preexisting)	See Section(s)
9. A description of the composition, duties of, and process to establish the advisory body for the levy. …	• Section IX. Crisis Care Centers Levy Advisory Body
…The advisory body may be a preexisting King County board or commission that has relevant expertise or a new advisory body. …	• Section IX. Crisis Care Centers Levy Advisory Body
Advisory Body Composition	*See Section(s)*
… The composition of the advisory body shall be … …	• Section IX. Crisis Care Centers Levy Advisory Body
… demographically representative of the population of King County and shall include …	• Section IX. Crisis Care Centers Levy Advisory Body
… at least one resident of each King County crisis response zone, …	• Section IX. Crisis Care Centers Levy Advisory Body

… persons who have previously received crisis stabilization services, and …	• Section IX. Crisis Care Centers Levy Advisory Body
… persons with professional training and experience in the provision of behavioral health crisis care. …	• Section IX. Crisis Care Centers Levy Advisory Body
Advisory Body Duties	*See Section(s)*
… The duties of the advisory body shall include …	• Section IX. Crisis Care Centers Levy Advisory Body
… advising the executive and council on matters pertaining to implementation of the levy, …	• Section IX. Crisis Care Centers Levy Advisory Body
… annually visiting each existing crisis care center …	• Section IX. Crisis Care Centers Levy Advisory Body
Annual Reporting (framed as an advisory body role)	*See Section(s)*
… and reporting annually to the council and community, through online annual reports beginning in 2025, on …	• Section VIII. Crisis Care Centers Levy Annual Reporting
… the levy's progress over the previous year towards accomplishing the levy purposes described in section 4 of this ordinance and …	• Section VIII. Crisis Care Centers Levy Annual Reporting
… on the levy's actual financial expenditures in the previous year relative to the financial plan required in subsection C.3. of this section …	• Section VIII. Crisis Care Centers Levy Annual Reporting
… that shall include, but not be limited to, the following:	• Section VIII. Crisis Care Centers Levy Annual Reporting
a. total expenditure of levy proceeds by crisis response zone, strategy, and levy purpose by ZIP Code in King County; and	• Section VIII. Crisis Care Centers Levy Annual Reporting
b. the number of individuals receiving levy-funded services by crisis response zone, strategy, and levy purpose by ZIP Code in King County of where the individuals reside at the time of service;	• Section VIII. Crisis Care Centers Levy Annual Reporting
10. A description of how the executive shall provide each online annual report described in subsection C.9. of this section to the clerk of the council, to all councilmembers and all members and alternate members of the regional policy committee, or its successor, including confirmation that the executive shall electronically file a proposed motion that shall acknowledge receipt of the report; and	• Section VIII. Crisis Care Centers Levy Annual Reporting
Geographic Distribution/Crisis Response Zone Description	See Section(s)
11. A description of how the purpose of the crisis response zones described in this levy will promote geographic distribution of crisis care centers so that they are accessible for walk-in and drop-off crisis care throughout King County, but that the crisis care zones shall not be used to limit the ability of any person in King County to use any particular crisis care center.	• Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers

3784
3785

3786 ## Appendix C: King County Local Jurisdiction Request for Information (RFI)

3787

3788 The purpose of this RFI was to solicit information from jurisdictions located within King County to help
3789 inform this Plan and future CCC siting and procurement processes. The RFI was open from September
3790 29, 2023, to October 27, 2023 and was extended to November 15, 2023.

3791

3792 **CRISIS CARE CENTERS INITIATIVE REQUEST FOR INFORMATION (RFI)**
3793 **for**
3794 **KING COUNTY LOCAL JURISDICTIONS**

3795

Release Date	Friday, September 29, 2023
Information Session	Thursday, October 12, 2023 3:00 – 4:30pm Pacific Time Please register at this link
Due Date	Friday, October 27, 2023
Purpose	The purpose of this RFI is to solicit information from **Jurisdictions located within King County** to help inform the Crisis Care Centers Initiative's Implementation Plan and future Crisis Care Center siting and Procurement processes. This RFI is optional for Jurisdictions to respond to and is for informational purposes only. Responses will not be a commitment to action. The decision to respond or not respond to this RFI will not give Jurisdictions preferential nor disadvantageous treatment during any future Crisis Care Center site selection or siting processes.
Who Should Respond	Jurisdictions physically located within King County, including cities, tribes, and other jurisdictional entities with siting authority.
How to Respond	Responses are hereby solicited and will be received via survey no later than 11:59 p.m. Pacific Time on the due date noted above. Please submit your response at the following survey link: https://forms.office.com/g/vmeUMAhMZd
RFI Lead	Joanna Armstrong DCHScontracts@kingcounty.gov

3796

3797 **PLEASE NOTE:**
3798 This RFI is informational only and will help inform the Crisis Care Centers Initiative planning,
3799 including future Crisis Care Center siting processes and Procurement processes to select
3800 organizations to develop and operate Crisis Care Centers. Responses will not be a commitment
3801 to action. The decision to respond or not respond to this RFI will not give Jurisdictions
3802 preferential nor disadvantageous treatment during any future Crisis Care Center site selection
3803 or siting processes.

3804

3805 ## RFI Overview

A. **PURPOSE**

The purpose of this RFI is to solicit information from Jurisdictions located within King County to help inform the Crisis Care Centers Initiative's Implementation Plan and future Crisis Care Center siting and Procurement processes. This RFI is optional for Jurisdictions to respond to and is for informational purposes only. Responses will not be a commitment to action. The decision to respond or not respond to this RFI will not give Jurisdictions preferential nor disadvantageous treatment during any future Crisis Care Center site selection or siting processes.

B. **BACKGROUND**

King County voters approved a nine-year property tax Crisis Care Centers Levy in April 2023 to fund the Crisis Care Centers Initiative (Initiative) from 2024 to 2032. The Initiative will create a countywide network of five Crisis Care Centers, restore and expand mental health residential treatment beds in the region, and invest in the recruitment and retention of the community behavioral health workforce.

Crisis Care Centers are a type of behavioral health facility that will have three core components: a 24/7 Behavioral Health Urgent Care Clinic, a 23-hour Crisis Observation Unit, and a Crisis Stabilization Unit. Crisis Care Centers will use a "no-wrong door approach" and will endeavor to accept, at least for initial screening and triage, any person who seeks behavioral health crisis care. Crisis Care Centers will also be expected to provide a Post-Crisis Follow-Up Program to promote post-crisis stabilization for people who receive services at Crisis Care Centers.

The site requirements for Crisis Care Centers are still being developed and are subject to change. Requirements will likely include:

1. The capacity to accommodate approximately 30,000 - 50,000 square feet of clinical space within one or multiple adjacent buildings;
2. Zoning that allows for the construction and ongoing operations of a Crisis Care Center;
3. Proximity to arterials, public transportation, and other transportation infrastructure to ensure ease of access for community members seeking care and their families, mobile crisis teams, first responders, and other community partners.

Components of a Crisis Care Center may incorporate pre-existing facilities that are compatible with the model's required clinical components. Crisis Care Centers may be located in a single facility or more than one facility as long as they are geographically adjacent or have transportation provided between them so that people seeking services can easily move between facilities. Additional program components may be co-located with Crisis Care Centers. Each Crisis Care Center may be operated by a single provider or by multiple providers that work together to meet all required clinical components.

The Crisis Care Center siting process will be informed by responses to this Request for Information, as well as additional community partner feedback, and will be defined in the Crisis Care Centers Initiative Implementation Plan as adopted by King County Council. Crisis Response Zones, described and depicted below, will determine the geographic distribution of Crisis Care Centers across King County.

[King County Ordinance 19572](#) created four geographic Crisis Response Zones in King County (see Figure 1). Each of the four Crisis Response Zones will contain at least one Crisis Care Center and at least one of the five Crisis Care Centers will specialize in serving youth.

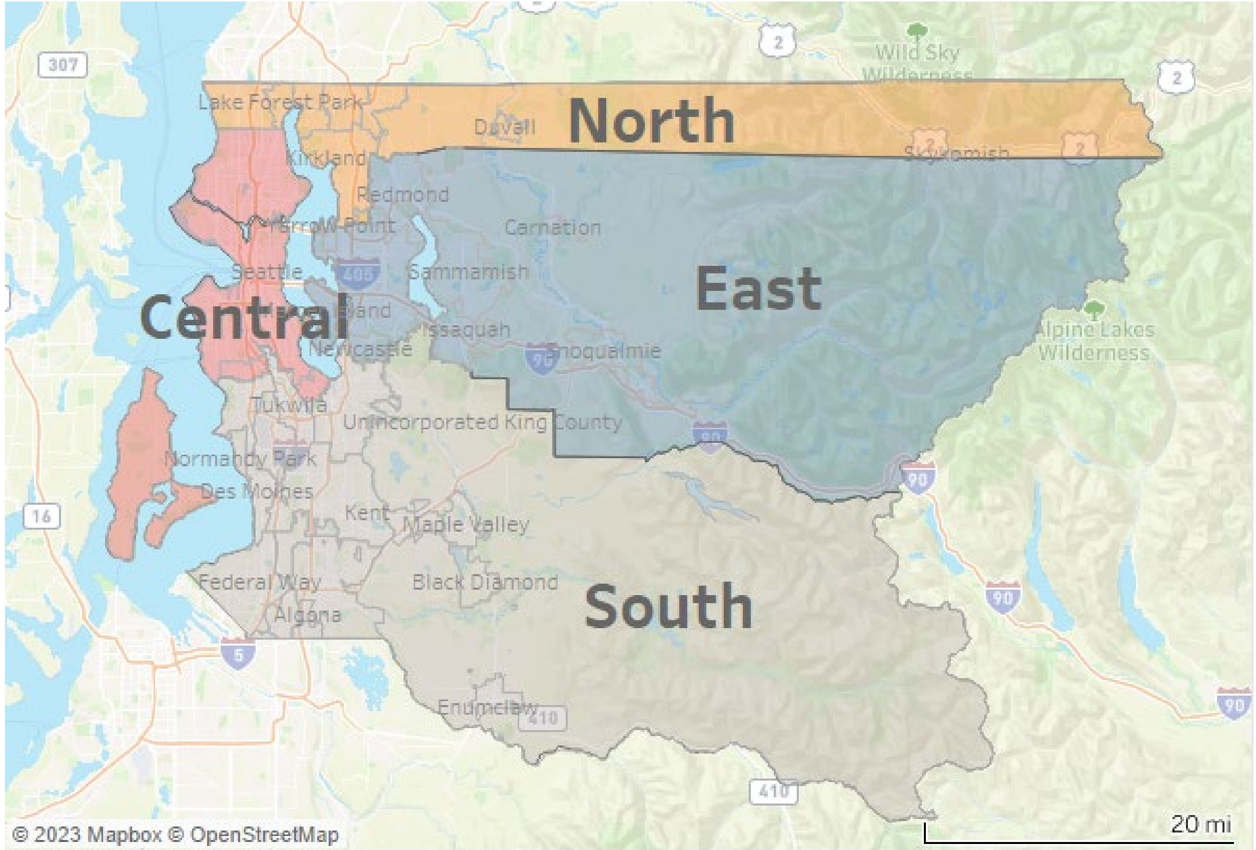


Figure 1: Map of Crisis Response Zones

King County intends to release one or more Procurements in 2024 to begin to select organizations to develop and operate Crisis Care Centers. Local Jurisdictions will be key partners in siting Crisis Care Centers within the designated Crisis Response Zones. King County is seeking information from Jurisdictions through this RFI to help inform the Crisis Care Centers Initiative's Implementation Plan and the future planning of Crisis Care Center siting processes and Procurement processes.

C. **WHO SHOULD RESPOND**

All Jurisdictions located within King County are invited to respond to this RFI. Elected mayors or similar elected leadership, city managers, or their designee may submit a response on behalf of the Jurisdiction that they represent.

D. **HOW TO RESPOND**

Jurisdictions can respond to this RFI by submitting responses to the questions listed below through an online survey located at the following link: https://forms.office.com/g/vmeUMAhMZd.
Responses will be accepted between Friday, September 29 and Friday, October 27 at 11:59pm Pacific Time. King County's Department of Community and Human Services will hold an RFI information session for local government officials and staff on Thursday,

October 12, 3:00 – 4:30pm via Zoom; please register at this link. This is an optional meeting, and its purpose is to provide background about the Crisis Care Centers Initiative and answer questions about the RFI.

Glossary

"**23-Hour Crisis Observation Unit**" means a behavioral health facility where people experiencing an acute mental health and/or substance use crisis can receive psychiatric services for up to twenty-three hours and fifty-nine minutes. 23-Hour Crisis Observation Units serve people triaged as having higher clinical acuity as well as people dropped off by first responders such as mobile crisis, emergency medical services, and law enforcement.

"24/7" means open twenty-four hours per day, seven days per week.

"Behavioral Health Agency" means an organization licensed by the Washington State Department of Health to provide behavioral health services under Chapter 246-341 Washington Administrative Code.

"**Behavioral Health Urgent Care Clinic**" means a behavioral health clinic that is open twenty-four hours per day, seven days per week (24/7) and can triage and assess people who walk-in seeking mental health and/or substance use services.

"Crisis Care Center" means a behavioral health facility defined in King County Ordinance 19572 as "a single facility or a group of facilities that provide same-day access to multiple types of behavioral health crisis stabilization services, which may include, but are not limited to, those described in RCW 71.24.025(20), as amended. A Crisis Care Center shall endeavor to accept at least for initial screening and triage any person who seeks behavioral health crisis care. Among the types of behavioral health crisis stabilization services that a Crisis Care Center shall provide are a Behavioral Health Urgent Care clinic that offers walk-in and drop-off client screening and triage 24/7; access to onsite assessment by a designated crisis responder; a 23-Hour Crisis Observation Unit or similar facility and service that allows for short-term, onsite stabilization of a person experiencing a behavioral health crisis; and a Crisis Stabilization Unit that provides short-term, onsite behavioral health treatment for up to fourteen days or a similar short-term behavioral health treatment facility and service. A Crisis Care Center shall be staffed by a multidisciplinary team that includes peer counselors. A Crisis Care Center may incorporate pre-existing facilities that provide crisis stabilization services so long as their services and operations are compatible with this definition. Where a Crisis Care Center is composed of more than one facility, those facilities shall either be geographically adjacent or shall have transportation provided between them to allow persons using or seeking service to conveniently move between facilities."

"Crisis Care Centers Initiative" means the purposes defined in King County Ordinance 19572, which include creating a countywide network of five Crisis Care Centers, restoring and expanding mental health residential treatment beds in the region, and growing the community behavioral health workforce.

"Crisis Care Centers Levy" means the nine-year property tax levy described in King County Ordinance 19572 that was approved by King County voters in April 2023 and will raise revenue between 2024 and 2032 to fund the Crisis Care Centers Initiative.

"**Crisis Response Zone**" means a geographic subregion of King County defined in King County Ordinance 19572 where at least one Crisis Care Center will be located. The four Crisis Response Zones are depicted in Figure 1 and defined in King County Ordinance 19572 as follows:

1. "**North King County Crisis Response Zone**, which is the portion of King County within the boundaries of the cities of Bothell, Duvall, Kenmore, Kirkland, Lake Forest Park, Shoreline, Skykomish and Woodinville, plus the unincorporated areas within King

3927 County council district three as it is drawn on the effective date of this ordinance that are
3928 north or northeast of the city of Redmond;
3929 2. **Central King County Crisis Response Zone**, which is the portion of King County
3930 within the boundaries of the city of Seattle, plus all unincorporated areas within King
3931 County council districts two and eight as they are drawn on the effective date of this
3932 ordinance;
3933 3. **South King County Crisis Response Zone**, which is the portion of King County
3934 within the boundaries of the cities of Algona, Auburn, Black Diamond, Burien, Covington,
3935 Des Moines, Enumclaw, Federal Way, Kent, Maple Valley, Milton, Normandy Park,
3936 Pacific, Renton, SeaTac and Tukwila, plus all unincorporated areas within King County
3937 council districts five, seven and nine as they are drawn on the effective date of this
3938 ordinance; and
3939 4. **East King County Crisis Response Zone**, which is the portion of King County
3940 within the boundaries of the cities of Beaux Arts, Bellevue, Carnation, Clyde Hill, Hunts
3941 Point, Issaquah, Medina, Mercer Island, Newcastle, North Bend, Redmond,
3942 Sammamish, Snoqualmie and Yarrow Point, plus the unincorporated areas within King
3943 County council district three as it is drawn on the effective date of this ordinance that are
3944 east or southeast of the city of Redmond, plus all unincorporated areas within King
3945 County council district six as it is drawn on the effective date of this ordinance."
3946 "**Crisis Stabilization Unit**" means a behavioral health facility where people recovering from an
3947 acute mental health and/or substance use crisis can receive continued behavioral health
3948 stabilization services for up to 14 days.
3949 "**Implementation Plan**" means a plan required by King County Ordinance 19572 that will direct
3950 Crisis Care Centers Levy expenditures from 2024 through 2032.
3951 "**Jurisdictions**" means cities, tribes and other jurisdictional entities with siting authority that are
3952 physically located within King County.
3953 "**King County Ordinance 19572**" means the ballot measure ordinance that was enacted by
3954 King County Council on February 9, 2023 and passed by King County voters on April 25, 2023
3955 to create the Crisis Care Centers Levy.
3956 "**Post-Crisis Follow-Up Program**" means short-term case management and peer engagement
3957 services to connect people to care after they leave a Crisis Care Center.
3958 "**Procurement"** means a future solicitation to determine who will be contracted to develop, own,
3959 and operate Crisis Care Centers.
3960 **"RFI"** means this Request for Information plus all written amendments, addenda, or
3961 attachments hereto, and all terms and conditions incorporated herein.
3962

3963
Upcoming Procurement Description

3964 A. **UPCOMING PROCUREMENT FUNDING AMOUNT AND OBJECTIVES**
3965 King County intends to release one or more Procurements beginning in 2024. Funding will
3966 include resources to construct and operate Crisis Care Centers, and the funding amount
3967 that will be available is not yet determined. The siting of Crisis Care Centers will be
3968 coordinated in partnership with local Jurisdictions and King County.
3969 B. **ANTICIPATED TIMELINE**
3970 One or more rounds of Procurement processes will be released in 2024. The timeline will
3971 be determined in 2024 after the King County Council passes the Crisis Care Centers
3972 Initiative Implementation Plan.
3973 C. **PROGRAM DESCRIPTION**

Crisis Care Centers are behavioral health facilities defined by King County Ordinance 19572 that will provide same-day access to mental health and substance use crisis services. Crisis Care Centers will have three programmatic components:

1. 24/7 Behavioral Health Urgent Care Clinic;
2. 23-Hour Crisis Observation Unit; and
3. Crisis Stabilization Unit.

Crisis Care Centers will also be expected to provide a Post-Crisis Follow-Up Program to promote post-crisis stabilization for people who receive services at Crisis Care Centers. Crisis Care Centers will strive for a "no-wrong door" approach and will endeavor to accept, at least for initial screen and triage, any person who seeks behavioral health crisis care. Crisis Care Centers will strive to create and foster a safe and welcoming environment that provides care that is trauma-informed, recovery-oriented, person-centered, integrated, and supports people in the least restrictive environment possible.

RFI Questions

A. **QUESTIONS**

Please submit responses to each of the following questions (* indicates response is required; respondents are not required to answer all questions to submit a response).

Contact Information

1. *Name of Jurisdiction responding to RFI.
2. *Name of person submitting response.
3. *Title of person submitting response.
4. *Email address of person submitting response.
5. *Phone number of person submitting response.
6. What other points of contact from your Jurisdiction should receive communication about this RFI and the Crisis Care Centers Initiative? Please share their name, title, and contact information.

Crisis Care Center Information

7. What communities or populations in your Jurisdiction have historically been, or are at greatest risk of being, underserved in their behavioral health needs?
8. Is your Jurisdiction interested in siting an adult or youth Crisis Care Center, or both? Why or why not?
9. How would siting a Crisis Care Center in or adjacent to your Jurisdiction benefit your Jurisdiction and region of King County?
10. What additional information would you need from the County to help determine if your Jurisdiction is interested in siting a Crisis Care Center?
11. What are important attributes of a Crisis Care Center and its location from your Jurisdiction's perspective?
12. What are potential geographic features, transportation infrastructure, or other factors in your Jurisdiction that may impact access to a Crisis Care Center?
13. What obstacles would deter your Jurisdiction from siting a Crisis Care Center?

4020 14. Does your Jurisdiction have any facilities that are like a Crisis Care Center? If
4021 yes, do you have recommendations of siting best practices based on your
4022 experience with existing facilities?
4023 15. What ideas do you have for how Jurisdictions and the County can work
4024 together to site Crisis Care Centers?
4025 16. If your Jurisdiction decided to site a Crisis Care Center, what type of capital
4026 facility siting support, communication, and Jurisdiction partnership activities
4027 would be helpful?
4028 17. Do you have one or more potential site(s) that may be suitable for a Crisis
4029 Care Center site(s) identified in your Jurisdiction? If yes, please share the
4030 location and a brief description. Alternatively, would you be interested in
4031 scheduling a meeting with the County to discuss possible locations?
4032 18. Does your Jurisdiction own one or more parcels of land or properties that
4033 could be rehabilitated to become a Crisis Care Center that your Jurisdiction
4034 would be willing to donate? If yes, please briefly describe the property.
4035 Alternatively, would you be interested in scheduling a meeting with the
4036 County to discuss possible properties?
4037 19. Does your Jurisdiction have any capital or operating resources it would be
4038 willing to contribute to a Crisis Care Center property or facility? If yes, please
4039 briefly describe the resource. Alternatively, would you be interested in
4040 scheduling a meeting with the County to discuss possible resources?
4041 20. Does your Jurisdiction have feedback regarding the types of entities that
4042 should be eligible to apply to the eventual Crisis Care Center
4043 Procurement(s)? Examples of entities could include Behavioral Health
4044 Agencies (Agencies), Agencies with letters of support from host Jurisdictions,
4045 formal partnerships between Jurisdictions and Agencies, or a Jurisdiction by
4046 itself?
4047 21. How would your Jurisdiction like to be engaged in the Crisis Care Center
4048 Initiative planning and future siting process?
4049 22. Do you have recommendations for how community members should be
4050 engaged during Crisis Care Center siting processes?
4051 23. Do you have any additional feedback about Crisis Care Center siting?

4052

4053 B. **DOCUMENT REQUESTS**

4054 Please respond to the following request for documentation, if applicable.

4055

4056 24. Please attach additional documentation describing potential Crisis Care
4057 Center sites or properties that your Jurisdiction has identified (i.e., photos,
4058 maps, real estate documentation, etc.).

4059

4060 ## Appendix D: Coordination with State and County Partners
4061

State and County Partner Meetings June 2023 – November 2023
Partners Internal to King County
• Department of Adult and Juvenile Detention • Department of Natural Resources and Parks • Facilities Management Division • Metro • Prosecuting Attorney's Office • Public Health – Seattle & King County • Sheriff's Office
Washington State Partners and Meeting Topics

• Health Care Authority
  ○ Billing and sustainability of crisis services
  ○ Reimbursement for ambulance transport to alternate destinations
  ○ Pharmacy regulations and reimbursement
  ○ Peer specialist programs
  ○ Data sharing related to implementation of 988 and 2SHB 1477
  ○ Regulations regarding Institutes for Mental Disease
• Department of Health
  ○ 23-hour Crisis Relief Centers (direct meetings and participation in 2SSB 5120 public rulemaking process)
  ○ 988 implementation
  ○ Regulations on ambulance transport to alternate destinations
  ○ Pilots to embed behavioral health counselors in public safety answering points to divert 911 calls from law enforcement response
• Department of Social and Human Services
  ○ Department of Children, Youth, and Families
  ○ Developmental Disabilities Administration (DDA)

4062
4063

4064

4065 Appendix E: Site and Field Visits

4066

4067 The following site and field visits were conducted between June 2023 and October 2023 and helped
4068 inform this Plan.

4069

Site and Field Visits June 2023 – October 2023
Behavioral Health Crisis Facilities
Children's Emergency Screening Unit, San Diego, CA Crisis Solutions Center, DESC, Seattle, WA Connections Health Solutions, Phoenix, AZ Connections Health Solutions, Tucson, AZ (virtual site visit) Connections Health Solutions, Kirkland, WA* Oceanside Crisis Stabilization Unit, San Diego, CARI International, Federal Way, WA* RI International, Parkland, WA Spokane Regional Stabilization Center, Spokane, WA Sea Mar, White Center, WA*
Mental Health Residential Facilities
Cascade Hall, Community House, Seattle, WA Try House, Transitional Resources, Seattle, WA Stillwater, Sound, Redmond, WA Keystone, Sound, Seattle, WA Firwood, Community House, Seattle, WA Spring Manor, Community House, Seattle, WA Hilltop, Community House, Seattle, WA
Other Health Care Providers
Children's Hospital, Seattle, WA Crisis Connections, Seattle, WA
Field Visits
Designated Crisis Responder Ride Along, King County, WA

4070 * Facilities under construction or not yet operational
4071

4072 ## Appendix F: Community Engagement Activities
4073

Community Engagement Activities June 2023 – November 2023
Monthly CCC Levy Community Engagement Meetings
• Community Partner Evening Recap Meeting (1 meeting) • Community Partners Update Meeting (5 meetings) • Crisis System Integration Partners Meeting (3 meetings) • Substance Use Disorder Partners Meeting (3 meetings) • Youth Partners Meeting (5 meetings)
Presentations at Community Meetings
• CCORS Operations Meeting (2 meetings) • CCORS Young Adult Monthly Providers Meeting • CIT King County Coordinators Committee Meeting (2 meetings) • CRIS Committee • Cross Division Overdose Prevention Workgroup • External Partners Group • Just Access to Health Meeting • King County Behavioral Health Administrative Services Organization Inpatient Providers Quarterly Meeting • King County Behavioral Health Advisory Board (2 meetings) • King County Diversion and Reentry Services Managers Meeting • King County Hospital and Inpatient Psychiatric Leadership Meeting • King County Integrated Care Network, Network Provider Group (4 meetings) • King County Integrated Care Network, Clinical Operations Committee • King County Integrated Care Network, Joint Operations Committee • King County Outpatient Medical Leadership Team Meeting • King County Peer Network Meeting (4 meetings) • King County Youth Behavioral Health Learning Collaborative Meeting (2 meetings) • King County Behavioral Health and Recovery Division Clinical Provider Meeting • King County Behavioral Health and Recovery Division, Washington State Department of Youth and Family Services, and Coordinated Care Monthly Field Operations Meeting • King County Medications for Opioid Use Disorder (MOUD) Provider Meeting • King County Youth Service Providers Coalition (2 meetings) • Hospital and Mental Health Residential Provider Quarterly Meeting • MIDD Advisory Committee Meeting • Overdose Recovery and Care Access (ORCA) Center Planning Meetings (3 meetings) • Patient Placement Task Force (2 meetings) • Pediatrics Crisis Care Provider Meeting • Seattle/King County Coalition on Homelessness Member Meeting
Key Informant Interviews and Individual Engagement Meetings
• American Medical Response • Asian Counseling and Referral Services • Behavioral Health Institute, Harborview Medical Center • Challenge Seattle

- Children’s Hospital (2 meetings)
- Crisis Connections (3 meetings)
- Consejo Counseling
- Connections Health Solutions (4 meetings)
- DESC (2 meetings)
- Genoa Pharmacy
- Fairfax (2 meetings)
- Harborview Medical Center Addiction Medicine Program
- Health One and Mobile Integrated Health Program, Seattle Fire Department
- HealthierHere
- Hopelink Transportation
- International Community Health Services
- Islamic Trauma Health Program
- Kelley-Ross Pharmacy (2 meetings)
- MIDD Community Partnership Focus Group Follow-Up Meeting
- Muckleshoot Health
- North Star Advocates
- Pacific Hospital Public Development Association
- Individual People with Lived Experience of Crisis Services (7 meetings)
- Individual People with Professional Experience Delivering Crisis Services (2 meetings)
- Peer Washington
- Psychiatric Emergency Services, VA Puget Sound Health Care System
- RI International
- Ryther (2 meetings)
- Sea Mar (2 meetings)
- Seattle Fire Department and Public Health Seattle & King County Emergency Medical Services
- Seattle Indian Health Board
- Seattle/King County Coalition on Homelessness
- Seattle Police Department
- SEIU 1199 (5 meetings)
- School of Nursing, University of Washington
- Somali Health Board (2 meetings)
- Sound
- Sound Alliance
- Tubman Center for Health and Freedom
- Valley Cities
- Vietnamese Health Board
- Vocal-WA
- Washington State Pharmacy Association
- YMCA (3 meetings)
- Youth Eastside Services
- YouthCare and Kaiser

Focus Groups and Listening Sessions

- Aging and Older Adults Focus Group
- Behavioral Health Worker Focus Group

• Housing and Homelessness Focus Group • MIDD Community Partnership Focus Group • Mockingbird Society YAEH Chapter and New Members Chapter Listening Session • Peer Counselors Focus Group • Sound Alliance, United Tribes of All Indians, and FEEST Youth Partner Listening Session • Sound Alliance and United Indians of All Tribes Youth Services Listening Session • Veterans and Active Military Personnel Focus Group
King County Council and Local Jurisdiction Meetings
• City Mayor, Councilmember, and Staff Meetings (16 meetings) • Countywide Sub-Regional Human Service Convening • Councilmember Perry District Three First Responder Roundtable • Councilmember Perry District Three Mayors Roundtable • Councilmember Zahilay Community Mental Health Meeting (4 meetings) • King County Councilmember and Council Staff Meetings (10 meetings) • Snoqualmie Valley Government Association Quarterly Meeting • Sound Cities Association (2 meetings)
CCC Levy Request for Information (RFI) Public Information Sessions
• King County Local Jurisdictions RFI Information Session • Behavioral Health Organizations and Other Potential Partners RFI Information Session

4074
4075

4076 ## Appendix G: Clinical Best Practices in Behavioral Health Crisis Services
4077

Clinical Best Practices in Behavioral Health Crisis Services	
Best Practice	**Description**
Trauma-Informed	Trauma-informed programs and services acknowledge the widespread impact of trauma and understand potential paths for recovery; recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system, and respond by fully integrating knowledge about trauma into policies, procedures, and practices, while seeking to actively resist re-traumatization.[273]
Recovery-Oriented	Recovery-oriented care addresses reduction of symptoms related to mental health and substance use disorders and supports someone to have a life in the community that meets their recovery goals.[274]
Person-Centered	Person-centered care means people have control over their services, including the amount, duration, and scope of services, as well as choice of providers. Person-centered care is respectful and responsive to cultural, linguistic, and other social and environmental needs. Family-centered care recognizes the important role of family members and caregivers in the design and implementation of services.[275]
Culturally and Linguistically Appropriate	Culturally and linguistically appropriate services (CLAS) are a way to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and promote health equity.[276] CLAS are about respect and responsiveness: respect the whole individual and respond to the individual's health needs and preferences. By tailoring services to an individual's culture and language preferences, including with use of interpretation and translation services, health professionals can help support positive health outcomes for diverse populations.
Integrated Care	Integrated care is when mental health and substance use treatment is closely coordinated with physical and primary care.[277] While crisis care centers will primarily serve behavioral health needs, they should also be able to provide care for most minor physical or basic health needs that can be addressed without need for medical diagnosis or health care prescriber orders, with an identified pathway to transfer the person to more medically appropriate services if needed.[278]

[273] Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. [LINK]
[274] Davidson L, Rowe M, DiLeo P, Bellamy C, Delphin-Rittmon M. Recovery-Oriented Systems of Care: A Perspective on the Past, Present, and Future. Alcohol Res. 2021 Jul 22;41(1):09. doi: 10.35946/arcr.v41.1.09. [LINK]
[275] Substance Abuse and Mental Health Services Administration (SAMHSA) Person- and Family-centered Care and Peer Support [LINK]
[276] National Culturally and Linguistically Appropriate Services (CLAS) Standards. Think Cultural Health, U.S. Department of Health & Human Services [LINK].
[277] National Council for Mental Wellbeing, The Comprehensive Healthcare Integration (CHI) Framework, April 22, 2022. [LINK]
[278] Expectations for integrated medical care in a behavioral health crisis care setting are described here similar to state requirements for 23-hour Crisis Relief Centers as defined in RCW 71.24.916 – 23-hour crisis relief centers—Licensing and certification—Rules—Standards. [LINK]

Least Restrictive Setting	Least restrictive care refers to care provided in settings that least interfere with a person's civil rights and freedom to participate in society. The practice of care in least restrictive settings supports the key values of self-determination in behavioral health care: that people should be able to disagree with clinician recommendations for care; that people should be informed participants in defining their care plan, and that state laws and agency policies are applied only as a last resort for people who are unable to act in their own self-interests.[279]

4078
4079

[279] Detoxification and Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2006. (Treatment Improvement Protocol (TIP) Series, No. 45.) 2 Settings, Levels of Care, and Patient Placement. [LINK]

4080
4081 ## Appendix H: BHRD Capital Improvement Funding for Behavioral Health Facilities Request for Information (RFI)
4082
4083 The purpose of this RFI was to solicit information from contracted behavioral health provider
4084 organizations about necessary capital improvements, repairs, and innovations in behavioral health
4085 facilities located in County. Information provided through this RFI may be fused to inform a potential
4086 Request for Proposal and be used to improve access to and availability of behavioral health services by
4087 assisting with costs associated with building repairs, renovations, or expansion of existing behavioral
4088 health provider facilities. This RFI was open from June 23, 2023, to July 17, 2023.
4089
4090 Department of Community and Human Services
4091 Behavioral Health and Recovery Division
4092 401 Fifth Avenue, Suite 400
4093 Seattle, WA 98104
4094
4095 REQUEST FOR INFORMATION (RFI)
4096 BHRD Capital Improvement Funding for Behavioral Health Facilities
4097 RFI Release Date: June 23, 2023
4098 Questions Due: July 07, 2023
4099 Due Date: July 17, 2023
4100 RFI Lead: Brandon Paz, branpaz@kingcounty.gov
4101
4102 Purpose of RFI
4103 This Request for Information (RFI) is seeking input from contracted behavioral health provider
4104 organizations to inform a potential Request for Proposal (RFP) that may be released in late 2023. The
4105 King County Department of Community and Human Services (DCHS) Behavioral Health and Recovery
4106 Division (BHRD) seeks information related to necessary capital improvements, repairs and renovations in
4107 behavioral health treatment facilities located in King County. Information provided through this RFI may
4108 be used to improve access to and availability of behavioral health services by assisting with costs
4109 associated with building repairs, renovations or expansion of existing behavioral health provider
4110 facilities.
4111
4112 DCHS is releasing this RFI to understand the level of need agencies have for capital projects and
4113 expected costs. Please note that **no funding will be released as a result of this RFI**. Submitting a
4114 response to this RFI does **not** constitute a commitment to a project in any subsequent RFPs. This RFI is
4115 for informational purposes only, to inform potential investments by the County in late 2023.
4116
4117 Who should respond?
4118 The following entities are encouraged to respond:
4119
4120
4121
4122
4123
- Behavioral health provider organizations that are contracted with the King County Behavioral Health and Recovery Division, including but not limited to King County Integrated Care Network providers, King County Behavioral Health Administrative Service Organization (KCICN-BH-ASO) providers, and providers contracted through the MIDD program.

- Nonprofit organizations, community-based organizations, tribe/tribal organizations interested in capital improvements, including renovations and repairs to an existing facility used for behavioral health programming/treatment.

Background

There is a need for capital improvements for many behavioral health provider facilities in King County. Capital improvements are necessary to increase or maintain access to effective behavioral health treatment. BHRD is considering an investment through a future procurement, to provide funding for small-medium scale capital improvement projects that can increase the health and safety and/or functional space of a facility, so providers can increase or maintain capacity to effectively provide quality behavioral health services. Capital improvement projects may include: building repairs, renovations, or expansions of existing locations to improve access to high quality programs and services.

Request for Information

BHRD is requesting information related to behavioral health capital improvement projects. Information collected from RFI responses may inform the development of a RFP, including allowable costs and funding thresholds. Funded projects will be limited to existing facilities. New construction will not be eligible.

How to Respond

Please submit a response that clearly addresses the questions below by 2:00 PM Pacific Time on Monday, July 17, 2023, to Brandon Paz at branpaz@kingcounty.gov. If you have any questions regarding your submission, please contact Brandon Paz at branpaz@kingcounty.gov.

Questions

The following questions are for information only and will not be scored. Completing this RFI does not constitute a commitment to funding your project in any subsequent RFP.

1. Please provide the below information about your organization:
    a. Organization Name
    b. Address
    c. Point of Contact Name
    d. Title
    e. Phone
    f. Email
2. If your organization has a mission statement, please state it here.
3. Approximately how many clients annually does your organization provide services to?
4. Please briefly list the behavioral health services and/or programs that your organization offers to King County residents.
5. Why are you interested in applying for the anticipated Capital Improvement Funding for Behavioral Health Facilities RFP? Please explain in a short narrative, including describing the project and the need the project will address.
6. Please indicate the type of project you would be most likely to request funding for
    - Renovation of an existing property to maintain or increase access to behavioral health treatment services

4168 o Renovation and repairs of an existing property to address critical health and safety issues, or
4169 improve treatment environment
4170 o Facility improvements, including new paint and furniture to improve the treatment
4171 environment to promote healing
4172 o Expansion of an existing facility to increase availability of treatment services, or allow more
4173 clients to be served
4174 7. If you currently own or lease the project site, please provide the address. If not, please provide the
4175 zip code or general location of the proposed site and whether you plan to own or lease it.
4176 8. Please share the following information regarding the project's funding needs:

4177 a. What is the estimated total cost of your project?
4178 b. Do you have funding secured from other sources?
4179 c. Are you anticipating applying for other funding sources?
4180 d. How much funding do you anticipate requesting from a potential 2023 capital program
4181 RFP?
4182 e. What is the anticipated timeline for completion of the project?
4183
4184 RFI Terms and Conditions
4185
4186 **A. Revisions to the RFI**
4187 If DCHS determines in its sole discretion that it is necessary to revise any part of this RFI, an
4188 addendum to this RFI will issued via email. For this purpose, the published questions and
4189 answers and any other pertinent information will also be provided as an addendum to the RFI
4190 and will be issued via email. DCHS also reserves the right to cancel or to reissue the RFI in whole
4191 or in part, prior to execution of a contract.
4192
4193 **B. Cost to Propose**
4194 DCHS will not be liable for any costs incurred by the Responder in preparation of a Response
4195 submitted in response to this RFI, in conduct of a presentation, or any other activities related in
4196 any way to this RFI.
4197
4198 **C. No Obligation to Contract**
4199 DCHS will not contract with any vendor as a result of this RFI. While DCHS may use responses to
4200 this RFI to develop a competitive solicitation for the subject of this RFI, issuing this RFI does not
4201 compel DCHS to do so.
4202
4203 **D. Public Records Act**
4204 1. Washington State Public Records Act (RCW 42.56) requires public organizations in
4205 Washington to promptly make public records available for inspection and copying
4206 unless they fall within the specified exemptions contained in the Act or are otherwise
4207 privileged.
4208
4209 2. All submitted Responses and RFI materials become public information and may be
4210 reviewed by anyone requesting to do so at the conclusion of the RFI, negotiation, and award
4211 process. This process is concluded when a signed contract is completed between the County and
4212 the selected Responder. Note that if an interested party requests copies of submitted
4213 documents or RFI materials, a standard County copying charge per page must be received prior

4214 to processing the copies. King County will not make available photocopies of pre-printed
4215 brochures, catalogs, tear sheets or audiovisual materials that are submitted as support
4216 documents with a Response. Those materials will be available for review at King County
4217 Department of Community and Human Services.
4218
4219 3. No other distribution of Responses will be made by the Responder prior to any public
4220 disclosure regarding the RFI, the Response or any subsequent awards without written approval
4221 by King County. For this RFI all Responses received by King County shall remain valid for ninety
4222 (90) days from the date of Response. All Responses received in response to this RFI will be
4223 retained.
4224
4225 4. Responses submitted under this RFI shall be considered public documents and with limited
4226 exceptions, Responses that are recommended for contract award will be available for inspection
4227 and copying by the public. If a Responder considers any portion of his/her Response to be
4228 protected under the law, the Responder shall clearly identify on the page(s) affected such words
4229 as "CONFIDENTIAL," PROPRIETARY" or "BUSINESS SECRET." The Responder shall also use the
4230 descriptions above in the following table to identify the effected page number(s) and location(s)
4231 of any material to be considered as confidential. If a request is made for disclosure of such
4232 portion, the County will review the material in an attempt to determine whether it may be
4233 eligible for exemption from disclosure under the law. If the material is not exempt from public
4234 disclosure law, or if the County is unable to make a determination of such an exemption, the
4235 County will notify the Responder of the request and allow the Responder ten (10) days to take
4236 whatever action it deems necessary to protect its interests. If the Responder fails or neglects to
4237 take such action within said period, the County will release the portion of the Response deemed
4238 subject to disclosure. By submitting a Response, the Responder assents to the procedure
4239 outlined in this paragraph and shall have no claim against the County on account of action taken
4240 under such procedure. Please notify the County of your needs and reference the table
4241 information below
4242

Type of Exemption	Beginning Page/Location	Ending Page/Location

4243
4244 **E. American with Disabilities Act**
4245 DCHS complies with the Americans with Disabilities Act (ADA). Responder may contact the RFI
4246 Coordinator to receive materials for this RFI in alternative formats, such as Braille, large print, audio
4247 tape, or computer disc.

May 15, 2024

Drafting Technical

1 to S1

[S. Porter]

Sponsor: von Reichbauer

Proposed No.: 2024-0011

1 **AMENDMENT TO STRIKING AMENDMENT S1 TO PROPOSED ORDINANCE**

2 **2024-0011, VERSION 1**

3 In Attachment A., Crisis Care Centers Levy Implementation Plan 2024-2032, dated May

4 17, 2024:

5

6 On page 9, after line 269, insert:
7 "The financial plan is more fully described at the Plan's Section VI.B. Financial Plan. It
8 includes the CCC Levy's expected annual revenues and expenditures between 2024 and
9 2032, with the projected amounts of annual investment for each of the CCC Levy's
10 strategies. The financial plan includes health insurance revenue assumptions, which
11 account for the share of crisis care center expenses that are projected to be paid for by
12 health insurance, including Medicaid. CCC Levy reserves are also depicted in the
13 financial plan."
14
15 The clerk of the council is instructed, if applicable, to update the tables of contents in the
16 attachment, and to correct any internal hyperlinks, in accordance with any adopted
17 amendments.
18
19 **EFFECT prepared by *S. Porter*: *Replaces a paragraph that was unintentionally***

20 ***deleted in the Plan.***

May 15, 2024

Metro Access

2 to S1

[S. Porter]

Sponsor: Perry

Proposed No.: 2024-0011

1 **AMENDMENT TO STRIKING AMENDMENT S1 TO PROPOSED ORDINANCE**

2 **2024-0011, VERSION 1**

3 In Attachment A., Crisis Care Centers Levy Implementation Plan 2024-2032, dated May

4 17, 2024:

5

6 On page 53, after line 1429 insert:
7 "DCHS shall coordinate with the Metro Transit Department, which through its safety and
8 security functions will work to ensure that people in need of behavioral health crisis
9 services who are on transit, at a transit center, or at a transit stop are given assistance, that
10 may include fare assistance to access a crisis care center to the extent possible."
11
12 The clerk of the council is instructed, if applicable, to update the tables of contents in the
13 attachment, and to correct any internal hyperlinks, in accordance with any adopted
14 amendments.
15
16 **EFFECT prepared by *S. Porter*: *Requires DCHS to coordinate with King County***

17 ***Metro to ensure people in need of behavioral health crisis services who are on transit,***

18 ***at a center, or stop, receive assistance through Metro's safety and security functions, to***

19 ***access a CCC to the extent possible.***

May 15, 2024

Arrival Data

3 to S1

[S. Porter]

Sponsor: Perry

Proposed No.: 2024-0011

1 **AMENDMENT TO STRIKING AMENDMENT S1 TO PROPOSED ORDINANCE**

2 **2024-0011, VERSION 1**

3 In Attachment A., Crisis Care Centers Levy Implementation Plan 2024-2032, dated May

4 17, 2024:

5

6 On page 64, after line 1746, insert:
7 "DCHS shall collect and report detailed data about how individuals in behavioral health
8 crisis arrive at the 24/7 Behavioral Health Urgent Care clinics and the 23-Hour
9 Observation Units of each crisis care center. DCHS should collaborate with first
10 responders, Crisis Connections, and other entities in the crisis care continuum in securing
11 data. Transportation data must include but is not limited to people arriving in bus,
12 ambulance, police, fire, mobile crisis team, ride share, or private vehicle. Data must be
13 disaggregated for each crisis care center. Data collected for people using crisis care
14 center services, including those transported by first responders, shall include the person's
15 insurance coverage status at intake, including Medicaid, private insurance, other, or none,
16 when such data is known to the crisis care center operator. Aggregate data on people
17 using crisis care center services who are known to operators to have been transported by
18 first responders without any insurance coverage must be included in the annual report
19 described in Section VIII of this Plan."
20
21 On page 116, after line 3229 insert:
22 "6. Transportation data required by Section V.A. Strategy 1: Collect and Report High
23 Quality Data subsection;"
24
25 The clerk of the council is instructed, if applicable, to update the tables of contents in the
26 attachment, correct numbered lists, and to correct any internal hyperlinks, in accordance
27 with any adopted amendments.
28
29

30 **EFFECT prepared by** ***S. Porter*****:** ***Requires DCHS to collect and report data about how***

31 ***individuals arrive at the 24/7 Behavioral Health Urgent Care or 23-Hour Observation***

32 ***Units of each CCC and adds component to the annual report.***

4 to

S1

May 15, 2024

King County develops with jurisdiction support

[S. Porter]

Sponsor: von Reichbauer

Proposed No.: 2024-0011

1 **AMENDMENT TO STRIKING AMENDMENT S1 TO PROPOSED ORDINANCE**

2 **2024-0011, VERSION 1**

3 In Attachment A., Crisis Care Centers Levy Implementation Plan 2024-2032, dated May

4 17, 2024:

5

6 On page 72, line 1900, strike Figure 22, and insert:

7 "***Figure 22. Allowable Crisis Care Center Capital Development Scenarios***

Allowable Crisis Care Center Capital Development Scenarios	
Scenario	**Description**
Pre-Existing Facility	Crisis care centers may incorporate a pre-existing facility or program that provides crisis stabilization services if the program's site, services, and operations are compatible with crisis care center requirements.
Facility Acquisition	Crisis care centers may be developed by acquiring, renovating, or expanding an existing facility.
New Construction	Crisis care centers may be developed through new construction.
Multiple Facilities	In addition to individual facilities, the required crisis care center components may be located within geographically adjacent facilities or non-contiguous facilities if transportation is provided between facilities for people seeking and receiving services. Regardless of configuration, King County will prefer development proposals that provide easy access for patients to all crisis care center services.
A crisis care center proposal may combine two or more of these scenarios. DCHS will accept proposals from individual organizations and multiple organizations that are interested in forming a multi-organizational partnership or consortium to develop and operate a crisis care center. King County may use CCC levy proceeds to develop one or more crisis care centers through any of the scenarios described in *Figure 22. Allowable*	

Crisis Care Center Capital Development Scenarios before, during, or after a crisis care center operator procurement process if it has the support of the host jurisdiction.

8 "

9

10 The clerk of the council is instructed, if applicable, to update the tables of contents in the
11 attachment, and to correct any internal hyperlinks, in accordance with any adopted
12 amendments.

13

14 **EFFECT prepared by *S. Porter*: *To allow King County to spend Levy proceeds to***

15 ***develop a crisis care center before, during, or after an operator procurement process if***

16 ***there is host jurisdiction support.***

May 15, 2024

5 to S1

Scoring SME Representative

[S. Porter]

Sponsor: Birney

Proposed No.: 2024-0011

1 **AMENDMENT TO STRIKING AMENDMENT S1 TO PROPOSED ORDINANCE**

2 **2024-0011, VERSION 1**

3 In Attachment A., Crisis Care Centers Levy Implementation Plan 2024-2032, dated May

4 17, 2024:

5

6 On page 73, after line 1924, insert "In recognition that it is preferred to have host
7 jurisdiction support for operator and siting decisions, it is important to have robust local
8 jurisdiction participation in the process."
9
10 On page 73, line 1926, after "for" insert "operators of"
11
12 On page 73, line 1926, after "include" delete "non-scoring representatives" and insert "a
13 scoring subject matter expert representative"
14
15 On page 73, line 1929, after "processes." insert "The representatives must recuse
16 themselves from scoring for the remainder of the review process if there is an actual or
17 perceived conflict of interest at any stage in the review process."
18
19 The clerk of the council is instructed, if applicable, to update the tables of contents in the
20 attachment, and to correct any internal hyperlinks, in accordance with any adopted
21 amendments.
22
23

24 **EFFECT prepared by** ***S. Porter: Replaces the non-scoring representative on the***

25 ***proposal review panel with a scoring subject matter expert representative who would be***

26 ***required to recuse themselves from scoring for the remainder of the review process if***

27 ***there is an actual or perceived conflict of interest.***

May 15, 2024

6 to S1

Good Neighbor

[S. Porter]

Sponsor: Moore

Proposed No.: 2024-0011

1 **AMENDMENT TO PROPOSED ORDINANCE 2024-0011, VERSION 2**

2 In Attachment A., Crisis Care Centers Levy Implementation Plan 2024-2032, dated May
3 17, 2024:
4
5 On page 98, line 2676, after "implementation." insert: "After the siting and provider
6 selection process is completed, the selected crisis care center operator in each crisis
7 response zone will create a "Good Neighbor Policy" that proactively manages
8 relationships with the neighboring community of each crisis care center. The purpose of a
9 Good Neighbor Policy is to identify ways that community stakeholders can work together
10 to address potential impacts of the crisis care center and to formalize a positive working
11 relationship between stakeholders for the benefits of all neighbors, including those being
12 served by the crisis care center. At minimum, the Good Neighbor Policy should address
13 the process for communicating with neighboring businesses and residents and policies
14 and procedures for addressing neighborhood concerns, both during construction and
15 ongoing operations of the crisis care centers."
16
17 The clerk of the council is instructed, if applicable, to update the tables of contents in the
18 attachment, and to correct any internal hyperlinks, in accordance with any adopted
19 amendments.
20
21 **EFFECT prepared by *S. Porter*: *State that crisis care center operators will create a***
22 ***'Good Neighbor Policy' with the purpose of managing the relationship between the***
23 ***crisis care center and the neighboring community, and state minimum expectations for***
24 ***what the Policy should address.***
25

May 16, 2024

7 to S1

RPC BHAB Appointment
Notification

[S. Porter]

Sponsor: Birney

Proposed No.: 2024-0011

1 **AMENDMENT TO STRIKING AMENDMENT S1 TO PROPOSED ORDINANCE**

2 **2024-0011, VERSION 1**

3 In Attachment A., Crisis Care Centers Levy Implementation Plan 2024-2032, dated May

4 17, 2024:

5

6 On page 120, line 3339 after " with K.C.C. chapter 2.28.." insert "The Regional Policy
7 Committee will be copied on the appointment transmittal to Council."
8
9 The clerk of the council is instructed, if applicable, to update the tables of contents in the
10 attachment, and to correct any internal hyperlinks, in accordance with any adopted
11 amendments.
12
13 **EFFECT prepared by *S. Porter*: *To notify RPC when appointments to the Behavioral***

14 ***Health Advisory Board are transmitted to Council.***