



516 Third Avenue, Council  
Chambers, 10th Floor,  
Seattle, WA 98104

# King County

## Meeting Agenda

### Regional Policy Committee

*Councilmembers: Pete von Reichbauer, Chair;  
Jorge L. Barón, Sarah Perry*

*Sound Cities Association: Nancy Backus, Auburn, Vice Chair; Jay Arnold, Kirkland;  
Armondo Pavone, Renton; Lynne Robinson, Bellevue  
Alternates: Dana Ralph, Kent; Jim Ribail, Carnation*

*City of Seattle: Debora Juarez, Eddie Lin  
Alt: Dionne Foster, Alexis Mercedes Rinck*

*Lead Staff: Miranda Leskinen (206-263-5783)  
Committee Clerk: Angelica Calderon (206-477-0874)*

3:00 PM

Wednesday, October 14, 2026

Hybrid Meeting

**Hybrid Meetings:** Attend the King County Council committee meetings in person in Council Chambers (Room 1001), 516 3rd Avenue in Seattle, or through remote access. Details on how to attend and/or to provide comment remotely are listed below.

Pursuant to K.C.C. 1.24.035 A. and F., this meeting is also noticed as a meeting of the Metropolitan King County Council, whose agenda is limited to the committee business. In this meeting only the rules and procedures applicable to committees apply and not those applicable to full council meetings.

**HOW TO PROVIDE PUBLIC COMMENT:** The Regional Policy Committee values community input and looks forward to hearing from you on agenda items.

The Committee will accept public comment on items on today's agenda in writing. You may do so by submitting your written comments to [committees@kingcounty.gov](mailto:committees@kingcounty.gov). If your comments are submitted before 1:30 p.m. on the day of the meeting, your comments will be distributed to the committee members and appropriate staff prior to the meeting.



Sign language and interpreter services can be arranged given sufficient notice (206-848-0355).  
TTY Number - TTY 711.  
Council Chambers is equipped with a hearing loop, which provides a wireless signal that is picked up by a hearing aid when it is set to 'T' (Telecoil) setting.



**HOW TO WATCH/LISTEN TO THE MEETING REMOTELY:** There are three ways to watch or listen to the meeting:

- 1) Stream online via this link [www.kingcounty.gov/kctv](http://www.kingcounty.gov/kctv) or input the link web address into your web browser.
- 2) Watch King County TV on Comcast channel 22 and 322(HD) and Astound Broadband Channels 22 and 711(HD)
- 3) Listen to the meeting by telephone.

Dial: 1 253 215 8782

Webinar ID: 827 1647 4590

To help us manage the meeting, please use the Livestream or King County TV options listed above, if possible, to watch or listen to the meeting.

To show a PDF of the written materials for an agenda item, click on the agenda item below.

1. Call to Order
2. Roll Call
3. Approval of Minutes **p. 4**

*Minutes of September 30, 2026 meeting.*

## Discussion Only

4. [Proposed Ordinance No. 2026-0174](#) **p. 7**

AN ORDINANCE renaming and revising the mental illness and drug dependency fund and the mental illness and drug dependency advisory committee; amending Ordinance 16077, Section 4, as amended, and K.C.C. 2.130.010, Ordinance 18217, Section 2, as amended, and K.C.C. 2A.300.510, Ordinance 15955, Section 2, as amended, and K.C.C. 4A.200.430, and Ordinance 16693, Section 3, as amended, and K.C.C. 24.22.020, adding a new section to K.C.C. chapter 4A.200, and recodifying K.C.C. 4A.200.430.

**Sponsors:** Mosqueda

*Sam Porter, Council staff*

*All versions of Proposed Ordinance 2026-0174 are before the committee for discussion and are available on Legisearch.*



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5. [Proposed Ordinance No. 2026-0177](#) **p. 32**

AN ORDINANCE adopting the King County Behavioral Health Bridge Implementation Plan 2028-2034, Phase 1: Transition Strategic Framework, required by the 2026-2027 Biennial Budget Ordinance, Ordinance 20023, Section 70, Proviso P1, and requesting phase 2 of the implementation plan that, together with phase 1, will govern the expenditure of proceeds from 2028 through 2034 of the behavioral health sales and use tax authorized by RCW 82.14.460 and K.C.C. 4A.500.315.

**Sponsors:** Mosqueda

*Sam Porter, Council staff*

*All versions of Proposed Ordinance 2026-0177 are before the committee for discussion and are available on Legisearch.*

## Other Business

## Adjournment



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# King County

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## Meeting Minutes Regional Policy Committee

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3:00 PM

Wednesday, September 30, 2026

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### DRAFT MINUTES -SPECIAL MEETING

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1. **Call to Order**

*Chair von Reichbauer called the meeting to order at 3:00 p.m*

2. **Roll Call**

**Present:** 7 - Arnold, Backus, von Reichbauer, Barón, Perry, Lin and Ralph

**Excused:** 3 - Juarez, Pavone and Robinson

3. **Approval of Minutes**

*Mayor Ralph moved approval of May 13, June 10, and August 26, 2026, meeting minutes. There being no objections, the minutes were approved.*

## **Briefing**

4. **Briefing No. 2026-B0112**

King County's Energy Resilience

**This matter was Presented**

*Mike Miller, Senior VP, Transmission Services, BPA, Kara Durbin, Director of Clean Energy Strategy, PSE, and Siobhan Doherty, Power Supply Officer, Seattle City Light, briefed the Committee via PowerPoint presentation and answered questions from the members. Mo McBroom, Director, King County Department of Natural Resources and Parks (DNRP), briefed and answered questions from the members, and Jeff Droubay, President, WECC, also briefed the Committee via PowerPoint presentation and answered questions from the members.*

## **Discussion and Possible Action**

5. **Proposed Motion No. 2026-0159**

A MOTION acknowledging receipt of the 2025 health through housing annual report, in accordance with K.C.C. chapter 24.30.

**Sponsors:** Mosqueda

**A motion was made by Mayor Backus that this Motion be Recommended Do Pass Consent. The motion carried by the following vote:**

**Yes:** 7 - Arnold, Backus, von Reichbauer, Barón, Lin and Ralph

**Excused:** 4 - Juarez, Pavone, Perry and Robinson

*Olivia Brey, Council staff, briefed the Committee on the legislation and answered questions from members.*

*Shanna Clinton, Acting Manager, Health Through Housing Initiative, Department of Community and Human Services (DCHS) and Jelani Jackson, Acting Director, Housing and Community Development Division, briefed the Committee via PowerPoint presentation and answered questions from the members.*

*Due to the design of the legislative tracking software used to produce the proceedings, the vote on this item is misreported. The correct vote is:*

*Votes: Yes: 8 von Reichbauer, Barón, Arnold, Backus, Ralph and Lin*

*Excused: Juarez, Pavone, Robinson and Perry*

## Briefing

### 6. Briefing No. 2026-B0087

Best Starts for Kids 2025 Annual Report.

#### **This matter was Presented**

*Miranda Leskinen, Council staff, briefed the Committee on the legislation and answered questions from members. Dr. Jamalia Jones, Best Starts for Kids Co-Lead, Department of Community and Human Services (DCHS), Jessica Tollenaar Cafferty, Best Starts for Kids Co-Lead, DCHS, briefed the Committee via PowerPoint presentation and answered questions from the members.*

## Adjournment

*The meeting was adjourned at 4:52 p.m.*

Approved this \_\_\_\_\_ day of \_\_\_\_\_

\_\_\_\_\_  
Clerk's Signature



## Metropolitan King County Council Staff Report

|                      |                           |                      |                         |
|----------------------|---------------------------|----------------------|-------------------------|
| <b>Committee:</b>    | Regional Policy Committee |                      |                         |
| <b>Agenda Item:</b>  | 4                         | <b>Analyst(s):</b>   | Sam Porter<br>Jenny Ngo |
| <b>Proposed No.:</b> | 2026-0174                 | <b>Meeting Date:</b> | October 14, 2026        |

### OVERVIEW

**TOPIC:** A proposed ordinance to rename the Mental Illness and Drug Dependency behavioral health sales tax fund and Advisory Committee the "Behavioral Health Bridge" and making additional changes to the Advisory Committee.

### LEGISLATION SUMMARY

Proposed Ordinance 2026-0174 would rename and revise the Mental Illness and Drug Dependency (MIDD) fund and Advisory Committee to the Behavioral Health Bridge fund and Advisory Committee and make additional changes to the Advisory Committee. This legislation is a mandatory dual referral to Health, Housing, and Human Services (HHHS) Committee, then the Regional Policy Committee (RPC).

The RPC received an initial briefing on the item at its August 26<sup>th</sup> special meeting. This item was voted out of the HHHS Committee, as amended, on October 6<sup>th</sup>. A summary of adopted HHHS Committee amendments is provided later in this staff report.

It is important to note that transmitted in tandem with this item is Proposed Ordinance 2026-0177, which would adopt the Behavioral Health Bridge Implementation Plan. Proposed Ordinance 2026-0177 is a mandatory dual referral to the Regional Policy Committee. Table 12 of the staff report for Proposed Ordinance 2026-0177 provides an overview of the schedule for both items, which anticipates RPC action at a special committee meeting on November 5<sup>th</sup>.

### KEY ISSUES FROM THE ANALYSIS

- A. Duty Changes.** Proposed Ordinance 2026-0174 would change the duties of the Advisory Committee from "review and report to the Executive and Council" to "review and provide guidance on Behavioral Health Bridge annual reports."
- B. Membership Changes.** Proposed Ordinance 2026-0174 would change two representatives of behavioral health consumer interests and community interests to two positions representing behavioral health consumer interests who have lived experience with behavioral health conditions.

- C. **Reserve Change.** Proposed Ordinance 2026-0174 would remove the New Strategy Reserve because it was not included in the transmitted implementation plan and is no longer funded. Removing the New Strategy Reserve is a policy choice.

## BACKGROUND & TIMING CONSIDERATIONS

**MIDD Sales Tax History.** In 2005, the Washington State Legislature provided a funding option enabling county legislative authorities to raise the local sales tax by one tenth of one percent to fund behavioral health and therapeutic court programs. By law, funds raised by this tax are to be dedicated to new or expanded behavioral health services and new or expanded therapeutic court programs. Furthermore, RCW 82.14.460(3) requires that every county that authorizes this tax must operate a therapeutic court for dependency proceedings.

The MIDD sales tax was first adopted in 2007 through Ordinance 15949 (MIDD I 2008-2016), renewed in 2016 through Ordinance 18333 (MIDD II 2017-2025), and most recently renewed in 2025 through Ordinance 19976 (MIDD III 2026-2035). In August 2016, the Executive transmitted the MIDD II service improvement plan (SIP) to guide MIDD II investments. The SIP was approved through Ordinance 18406 in November 2016, and notes that stakeholder feedback indicated concern that the name of the sales tax is outdated and recommends a plan to select a new name for the tax.

In accordance with the 2026-2027 Biennial Budget Ordinance 20023, Expenditure Restriction 6 on the MIDD appropriation unit, MIDD expenditures shall remain consistent with the MIDD II SIP<sup>1</sup>, Implementation Plan<sup>2</sup>, and the Evaluation Plan<sup>3</sup>.

From 2017 through 2025, MIDD programs served more than 130,000 unduplicated residents.

**MIDD Advisory Committee.** The 37-member King County MIDD Advisory Committee (K.C.C. 2.130.010) is composed of separately elected officials, King County agency directors, representatives of behavioral health service providers, managed care organizations operating in King County, and individuals with lived experience. The committee acts as an advisory body to the Council and the Executive.

In accordance with King County Code, the Advisory Committee is tasked with:

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<sup>1</sup> Ordinance 18406

<sup>2</sup> Motion 15093

<sup>3</sup> Motion 15058

- Reviewing and providing written recommendations to the Executive and Council on the implementation and effectiveness of the county's MIDD sales tax-funded programs in meeting the goals;
- Reviewing and reporting to the Executive and the Council on annual evaluation reports for MIDD;
- Reviewing and commenting on emerging and evolving priorities for the use of MIDD sales tax revenue;
- Serving as a forum to promote coordination and collaboration between entities involved with MIDD sales tax programs;
- Educating the public, policymakers, and stakeholders on MIDD sales tax-funded programs; and
- Coordinating and sharing information with other related efforts and groups.

## ANALYSIS

Transmitted in tandem with the Behavioral Health Bridge sales tax implementation plan,<sup>4</sup> Proposed Ordinance 2026-0174 would change the name of the sales tax from Mental Illness and Drug Dependency to Behavioral Health Bridge. The term "behavioral health" encompasses both mental illness and drug dependency, also referred to as substance use disorders. The transmittal states this proposed change is because the terms "mental illness and drug dependency" no longer reflect the values and priorities that guide behavioral health work today and that the terms contribute to stigma. Executive staff indicate that the new name is responsive to community feedback, and the proposed title of "Behavioral Health Bridge" was selected because the programs and services funded through the tax, "bridge critical gaps in behavioral health funding left by insufficient federal and state resources, and help create a bridge between people experiencing mental health or substance use disorder-related needs, community behavioral health treatment services, other systems people interact with including the criminal legal system, and pathways to recovery."

**Section 1. Advisory Committee Changes.** Section 1 of the proposed ordinance makes changes to the Advisory Committee. In addition to revising the name to Behavioral Health Bridge Advisory Committee, the proposed ordinance updates reference to expired portions of King County Code, and references to groups such as All Home, the Regional Human Services Levy Citizen Oversight Board, and the Adult and Juvenile Justice Operational Master Plan Advisory Groups which no longer exist.

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<sup>4</sup> Proposed Ordinance 2026-0177, <https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=8125181&GUID=F7713E11-9782-46B6-9FF7-91FC684D6BB2&Options=Advanced&Search=>

**Key Issue A. Advisory Committee Duty Changes.** The proposed ordinance changes the activities the Advisory Committee is tasked with, from "review and report to the Executive and Council" to "review and provide guidance on Behavioral Health Bridge annual reports." Executive staff state that this change is intended to "better reflect the MIDD Advisory Committee's current role and engagement regarding the annual report process. The Advisory Committee, which includes representatives from the Executive and the Council, reviews, provides feedback, and approves the annual report that the Behavioral Health and Recovery Division drafts but the Advisory Committee has not historically reported directly to the Executive or Council."

The proposed change in Advisory Committee duties reflects a policy choice.

Section 1 also changes the representative on the Advisory Committee for All Home to an entity serving individuals experiencing homelessness in King County. All Home, which no longer exists, served individuals experiencing homelessness in King County.

**Key Issue B. Advisory Committee Membership Changes.** Additionally, the proposed ordinance replaces positions for an individual representing behavioral health consumer interests and an individual representing community interests from the MIDD Consumers and Communities Ad Hoc Work Group with two positions representing behavioral health consumer interests who have lived experience with behavioral health conditions. Executive staff state that "During the renewal process, the MIDD Advisory Committee advised adding additional members with lived experience. Changing the seats to focus on individuals with lived experience allows the Advisory Committee to draw from a broader pool of prospective members while fulfilling the same goals of having community and consumer representation."

The proposed change from these positions as representatives of behavioral health consumer interests and community interests to two positions representing behavioral health consumer interests who have lived experience with behavioral health conditions represents a policy choice. Executive staff indicate that there are additional positions on the MIDD AC that unofficially represent consumer and community interests.

**Section 2. Updated Outdated References.** Section 2 would update an outdated reference to the MIDD Oversight Board to the Behavioral Health Bridge Advisory Committee as it pertains to coordinating with other county boards and groups regarding the Youth Action Plan. This section would also remove outdated reference to the Regional Human Services Levy Citizen Oversight Board which no longer exists.

**Section 3. Recodify Code Section.** Section 3 would recodify the revised Behavioral Health Bridge fund in a new section of K.C.C. chapter 4A.200 as recommended by the Code Reviser.

**Section 4. Fund Name Change.** Section 4 would update the name of the MIDD fund to the Behavioral Health Bridge fund.

**Key Issue C. New Strategy Reserve Fund Change.** Section 4 would also remove the New Strategy Reserve fund from King County Code. According to Executive staff, the MIDD 2 initiative SI-05: Emerging Issues in Behavioral Health was launched in the 2023-2024 biennium through a partnership with the MIDD Advisory Committee and served the purpose of the New Strategy Reserve fund. Executive staff state that during the 2023-2024 biennium, "SI-05 funded four time-limited projects, including Seattle Public Schools creation of a substance use reduction workgroup, virtual parent education sessions, standardized training evaluations, and tools to support classroom education implementation. It also funded the Y+ Master's in Mental Health Counseling Program and the development of culturally congruent behavioral health models with the Tubman Center for Health & Freedom, as well as a project by Lutheran Family Services focused on Muslim Trauma Healing. The Council-approved biennial budgets for 2025 and 2026-2027 allocated \$0 to SI-05."

The removal of the New Strategy Reserve fund is proposed because the strategy SI-05 is no longer funded and Executive staff state it "has historically been challenging to administer under short timelines and in response to new and emerging needs." Executive staff indicate that "DCHS hopes that innovative and best practice programs will be funded in the future through the Bridge and the [implementation] plan supports the ability for that to occur in any of the strategy or goal areas."

In addition to the standard reserves, the transmitted implementation plan (Proposed Ordinance 2026-0177) does include a sustainability reserve from 2028 through 2031 to mitigate the projected decrease in sales tax revenues due to 2026 changes to state law allowing many products and services to be exempt from sales tax in Washington State starting in 2029.

Removing the New Strategy Reserve fund from King County Code is a policy choice. The New Strategy Reserve fund was not included in the transmitted implementation plan's financial plan and the strategy associated with it is no longer funded. If the new strategy reserve is retained an amendment may be needed to the implementation plan's financial plan to include the fund.

**Section 5. Update Name in Housing and Community Development Fund.** Section 5 would update the name of MIDD housing services moneys in the Housing and Community Development fund to the Behavioral Health Bridge housing services moneys.

There is no fiscal impact of the proposed ordinance according to the fiscal note.

Council's legal counsel has reviewed the proposed ordinance.

**Summary of October 6, 2026, Health, Housing, and Human Services Committee meeting action.** Amendment S1 was adopted by the Health, Housing, and Human Services Committee on October 6, 2026, and made the following changes to Proposed Ordinance 2026-0174:

- Added a youth representative age 24 or younger who has lived experience with behavioral health conditions.
- Removed reference to “annual” regarding the Behavioral Health Bridge reporting cycle because it is biennial and not annual.
- Provided compensation of \$75 per Bridge AC meeting (max of \$150/month) for members serving in positions representing lived experience who are neither employees of King County or other municipal governments, and are not compensated for their participation on the committee as part of their employment.
- Made technical corrections to drafting.

#### INVITED

- Isabel Jones – Interim Director, BHRD
- Laura Smith – MIDD Renewal Manager, BHRD
- Susan McLaughlin – Director, DCHS
- Liz Arjun – Behavioral Health Policy Lead, Office of the Executive

#### ATTACHMENTS

1. Proposed Ordinance 2026-0174.2
2. Transmittal Letter
3. Fiscal Note





## KING COUNTY

1200 King County Courthouse  
516 Third Avenue  
Seattle, WA 98104

## Signature Report

## Ordinance

Proposed No. 2026-0174.2

Sponsors Mosqueda

1 AN ORDINANCE renaming and revising the mental  
2 illness and drug dependency fund and the mental illness  
3 and drug dependency advisory committee; amending  
4 Ordinance 16077, Section 4, as amended, and K.C.C.  
5 2.130.010, Ordinance 18217, Section 2, as amended, and  
6 K.C.C. 2A.300.510, Ordinance 15955, Section 2, as  
7 amended, and K.C.C. 4A.200.430, and Ordinance 16693,  
8 Section 3, as amended, and K.C.C 24.22.020, adding a new  
9 section to K.C.C. chapter 4A.200, and recodifying K.C.C.  
10 4A.200.430.

## STATEMENT OF FACTS:

- 11 1. The one-tenth of one percent sales and use tax supporting behavioral  
12 health programs and services and therapeutic court programs and services  
13 authorized by RCW 82.14.460 and K.C.C. 4A.500.315, which has been  
14 known in King County as the mental illness and drug dependency  
15 ("MIDD") sales and use tax, generates significant local revenue each year  
16 to support behavioral health care in the county.
- 17 2. For more than eighteen years, this tax has helped make behavioral  
18 health treatment and related services more available, accessible, and  
19 effective for King County residents.  
20

21           3. While the tax remains a critical source of funding for the region's  
22           behavioral health services, the "mental illness and drug dependency" name  
23           no longer reflects the values and priorities that guide behavioral health  
24           work today. Behavioral health providers, partners, and community  
25           members have shared that the "mental illness and drug dependency" name  
26           contributes to stigma around behavioral health.

27           4. The programs and services supported by the tax bridge critical gaps in  
28           behavioral health funding left by insufficient federal and state resources,  
29           and help create a bridge between people experiencing mental health or  
30           substance use disorder-related needs, community behavioral health  
31           treatment services, other systems people interact with including the  
32           criminal legal system, and pathways to recovery. As a result, it is  
33           appropriate to rename the tax, fund, advisory committee, and associated  
34           plans, programs, and services that have used the "MIDD" and "mental  
35           illness and drug dependency" name since 2007 to recognize their  
36           collective role as the King County "behavioral health bridge."

37           5. The proposed purpose, role, and activities of the behavioral health  
38           bridge advisory committee remain consistent with the established purpose,  
39           role, and activities of the committee.

40           6. The proposed King County behavioral health bridge implementation  
41           plan includes a financial plan that no longer contains a new strategy  
42           reserve, but instead includes a sustainability reserve to ensure program  
43           stability despite volatile revenue.

44 BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:

45 SECTION 1. Ordinance 16077, Section 4, as amended, and K.C.C. 2.130.010 are  
46 hereby amended to read as follows:

47 A. There is hereby established a King County (~~((mental illness and drug~~  
48 ~~dependency))~~) behavioral health bridge advisory committee.

49 B.1. The advisory committee shall act as an advisory body to the county  
50 executive and council. The advisory committee shall conduct reviews, provide comment  
51 on and make recommendations on the (~~((mental illness and drug dependency))~~) behavioral  
52 health bridge tax-funded initiatives, services, and programs (~~((and policy goals outlined in~~  
53 ~~Ordinance 15949, Section 3, as amended, and K.C.C. 4A.500.340 and consistent with the~~  
54 ~~mental illness and drug dependency service improvement plan that is approved in~~  
55 ~~accordance with Ordinance 17998))~~). The advisory committee shall provide ongoing  
56 review, comments and recommendations on (~~((mental illness and drug dependency))~~)  
57 behavioral health bridge tax-funded programs until all sales tax revenues have been  
58 expended and the final evaluation of the (~~((mental illness and drug dependency))~~)  
59 behavioral health bridge programs and services has been submitted to the council.

60 2. The advisory committee shall:

61 a. review and provide written recommendations to the executive and the  
62 council on the implementation and effectiveness of the county's sales tax funded  
63 programs in meeting the (~~((goals))~~) purpose established in (~~((Ordinance 15949, Section 3, as~~  
64 ~~amended, and K.C.C. 4A.500.300 through 4A.500.340))~~) K.C.C. 4A.500.315 and the  
65 goals described in implementation plans that guide the uses of the behavioral health  
66 bridge fund;

67           b. review and ~~((report to the executive and the council))~~ provide guidance on  
68 ~~((annual evaluation))~~ behavioral health bridge reports ~~((as required by Ordinance 15949,~~  
69 ~~Section 3, as amended, and K.C.C. 4A.500.300 through 4A.500.340))~~);

70           c. review and make comment on emerging and evolving priorities for the use  
71 of the ~~((mental illness and drug dependency))~~ behavioral health bridge sales tax revenue;

72           d. serve as a forum to promote coordination and collaboration between entities  
73 involved with sales tax programs;

74           e. educate the public, policymakers and stakeholders on ~~((mental illness and~~  
75 ~~drug dependency))~~ the behavioral health bridge sales tax funded programs; and

76           f. coordinate and share information with other related efforts and groups.

77           C. The advisory committee shall be composed of one representative from each of  
78 the following:

- 79           1. The council;
- 80           2. The executive;
- 81           3. The superior court;
- 82           4. The district court;
- 83           5. The prosecuting attorney's office;
- 84           6. The sheriff's office;
- 85           7. The department of public health;
- 86           8. The department of judicial administration;
- 87           9. The department of adult and juvenile detention;
- 88           10. The department of community and human services;

- 89           11. A provider of both mental health and chemical dependency services in King  
90 County;
- 91           12. A provider of culturally specific mental health services in King County;
- 92           13. A provider of culturally specific chemical dependency services in King  
93 County;
- 94           14. A representative of an organization with expertise in helping individuals  
95 with behavioral health needs in King County get jobs and live independent lives;
- 96           15. A provider of domestic violence prevention services in King County;
- 97           16. A provider of sexual assault victim services in King County;
- 98           17. An agency providing mental health and chemical dependency services to  
99 youth;
- 100          18. Harborview Medical Center;
- 101          19. ~~((All Home))~~ An entity serving individuals experiencing homelessness in  
102 King County;
- 103          20. King County systems integration initiative, which is an ongoing work group  
104 established by the executive for addressing juvenile justice matters;
- 105          21. The Community Health Council;
- 106          22. The Washington State Hospital Association, representing King County  
107 hospitals;
- 108          23. The Sound Cities Association;
- 109          24. The city of Seattle;
- 110          25. The city of Bellevue;
- 111          26. Labor representing a bona fide labor organization;
-

- 112           27. The office of the public defender;
- 113           28. The National Alliance on Mental Illness;
- 114           29. Puget Sound educational services district;
- 115           30. A representative of a philanthropic organization;
- 116           31. The King County behavioral health advisory board;
- 117           32. A representative of an organization with expertise in recovery;
- 118           33. A representative of the five managed care organizations operating in King
- 119 County;
- 120           34. ~~((An))~~ Two individuals representing behavioral health consumer interests
- 121 ~~((from the mental illness and drug dependency advisory committee's consumers and~~
- 122 ~~communities ad hoc work group;~~
- 123           ~~35. An individual representing community interests from the mental illness and~~
- 124 ~~drug dependency advisory committee's consumers and communities ad hoc work group))~~
- 125 who have lived experience with behavioral health conditions;
- 126           ~~((36.))~~ 35. A representative of a grassroots organization serving a cultural
- 127 population or cultural populations; ~~((and))~~
- 128           ~~((37.))~~ 36. A representative of unincorporated King County; and
- 129           37. A youth representative who shall be a person who is twenty-four years of
- 130 age or under, who has lived experience with behavioral health conditions.
- 131           D.1. Separately elected officials and King County agency directors or their
- 132 designees are not required to be appointed or confirmed.

133           2. A member of the advisory committee who has been confirmed to serve on  
134 another county board or commission is not required to be confirmed to serve on the  
135 advisory committee.

136           3. All other members of the advisory committee are subject to appointment by  
137 the county executive and confirmation by the county council.

138           4. The executive shall appoint advisory committee members to staggered terms  
139 in accordance with K.C.C. 2.28.010.C.

140           E.1. The advisory committee shall adopt rules governing its operations at its first  
141 meeting.

142           2. The committee shall elect a chair or cochairs.

143           3. Subcommittees and workgroups may be formed at the discretion of the  
144 advisory committee.

145           4. At each meeting of the advisory committee, the advisory committee shall  
146 provide an open comment period.

147           F. The advisory committee shall coordinate with other county groups including,  
148 but not limited to, ~~((the All Home coordinating board, the regional human services levy~~  
149 ~~citizen oversight board,))~~ the veterans, seniors, and human services levy citizen  
150 ~~((oversight))~~ board, the children and youth advisory board, the behavioral health advisory  
151 ~~((and recovery))~~ board, and the board of health ~~((and the adult and juvenile justice~~  
152 ~~operational master plan advisory groups))~~, or their successors, to ensure that information  
153 is shared and, when appropriate, efforts are coordinated and not duplicated.

154           G. The behavioral health and recovery division of the department of community  
155 and human services shall provide staffing of the advisory committee.

156 H. Members of the advisory committee who are not full-time county employees  
157 may be reimbursed for parking expenses in the King County parking garage when  
158 attending meetings of the committee.

159 I.1. In accordance with K.C.C. 2.28.006, committee members who are serving in  
160 positions representing lived experience who are neither employees of King County nor  
161 employees of other municipal governments, and who are not otherwise compensated for  
162 their participation on the committee as part of a professional role, shall receive  
163 compensation for attendance at official committee meetings. The compensation may  
164 only be paid a maximum of twice per month.

165 2. The initial compensation shall be seventy-five dollars per official committee  
166 meeting and shall not exceed one-hundred fifty dollars per month. Beginning January 1,  
167 2027, the compensation amount per meeting shall be automatically adjusted annually,  
168 and every year thereafter, at the rate equivalent to the twelve-month change in the United  
169 States Department of Labor, Bureau of Labor Statistics Consumer Price Index for All  
170 Urban Consumers for the Seattle-Tacoma-Bellevue Statistical Metropolitan Area, which  
171 is known as the CPI-U. However, if the twelve-month CPI-U is negative, there shall not  
172 be an adjustment.

173 J. The department of community and human services shall provide recruitment  
174 assistance for positions representing lived experience. Recruitment assistance shall  
175 consist of actively recruiting and supporting candidates as they go through the application  
176 process. The assistance may include such things as posting vacancies on relevant  
177 communications platforms, such as King County blogs or email listservs, or connecting  
178 with peer networks and community-based organizations to notify partners of vacancies.

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179 The notifications should use plain language application materials as should King County  
180 staff providing technical assistance to applicants to complete the application paperwork  
181 as needed.

182 SECTION 2. Ordinance 18217, Section 2, as amended, and K.C.C. 2A.300.510 is  
183 hereby amended to read as follows:

184 A. For the purposes of this section:

185 1. "Best Starts for Kids children and youth strategies" means those strategies  
186 that are eligible expenditures as defined in Ordinance 19267, Section 4.C.1. and 2.,  
187 Section 4.D. and Section 4.E.;

188 2. "Collective impact" means a process for achieving meaningful and  
189 sustainable progress on complex social issues that involves convening stakeholders  
190 across sectors and communities, who share a common vision and a shared agenda for  
191 assuring accountability and measuring results; and

192 3. "Youth Action Plan" means the Youth Action Plan approved under Motion  
193 14378.

194 B. As recommended in the Youth Action Plan and as required by Ordinance  
195 18088 and 19267, the King County children and youth advisory board is created to act in  
196 an advisory capacity to the executive and council to:

197 1. Assist King County policy makers as they consider outcomes, policies and  
198 investments for children and families and youth and young adults; and

199 2. Serve as the Best Starts for Kids children and youth strategies oversight and  
200 advisory body, including making recommendations on and monitoring the distributions

of levy proceeds described in Ordinance 19267, Section 4.C.1. and 2., Section 4.D. and Section 4.E..

C. The goal of the board is to improve the health and well-being of children and youth by utilizing a collective impact model to implement strategies that focus on prevention and early intervention.

D.1. The board shall make recommendations to the executive and county council regarding children and youth services, consistent with the recommendations in the Youth Action Plan.

2. The board shall receive and review King County outcomes and data, recommending improvements and modifications to achieve outcomes and support strong data collection and indicator protocols.

3. The board shall assist the executive and the council with the comprehensive review and analysis of King County government's programs, services and outcomes for children, families, youth and young adults for alignment with other initiatives and coalitions that have outcomes identified for children, families, youth and young adults.

4. The board shall recommend policy, budget, and other findings to the executive and the council, ensuring alignment with other initiatives and coalitions that have outcomes identified for children, families, youth and young adults.

5. The board shall participate with, track and report on efforts of partnerships, coalitions and networks throughout the region to inform the development of an aligned, region wide response that leads to improved outcomes.

6. The board shall be a forum for discussion and exchange of ideas in response to emergent needs, promising practices, and continuous improvement.

224 E. The board shall provide oversight for the Best Starts for Kids children and  
225 youth strategies outlined in the Best Starts for Kids implementation plan. The board shall:

- 226 1. Advise on development of indicators and targets for Best Starts for Kids  
227 children and youth strategies;
- 228 2. Monitor the distribution of best starts for kids levy proceeds;
- 229 3. Work in collaboration with executive staff on any recommended changes to  
230 the children and youth strategies in the Best Starts for Kids implementation plan; and
- 231 4. Consult on and review annual reports to the council and community that  
232 demonstrate transparency regarding the expenditure of levy proceeds and the  
233 effectiveness of the best starts for kids children and youth strategies in meeting the goals  
234 and outcomes established in Ordinance 19267.

235 F. The board may establish standing and ad hoc work groups focusing on specific  
236 components of children and youth services and Best Starts for Kids strategies. Individuals  
237 or representative from entities whose work is closely related to children and youth  
238 prevention and early intervention strategies may be invited to participate in work groups  
239 as nonvoting members.

240 G. Consistent with a collective impact model, the board shall:

- 241 1. Review and advise the executive and council on emerging and evolving best  
242 and promising practices to improve the health and well-being of children and youth;
- 243 2. Coordinate with other county boards and groups including, but not limited to,  
244 the steering committee to address juvenile justice disproportionality, the ~~((mental illness  
245 and drug dependency oversight board))~~ behavioral health bridge advisory committee,  
246 ~~((the regional human services levy citizen oversight board,))~~ and the veterans, seniors,

247 and human services levy advisory ((~~citizen oversight~~)) board, to maximize the impact of  
248 the county's children and youth services;

249           3. Serve as a forum to promote coordination and collaboration between entities  
250 involved in improving the health and well-being of children and youth; and

251           4. Coordinate and share information with other related external efforts and  
252 groups.

253           H. The board shall adopt rules governing its operations at its first meeting, which  
254 may be revised in subsequent meetings.

255           I.1. The board shall be composed of not more than forty members, at least five of  
256 whom shall be youth age twenty-four or under.

257           2. As required by Ordinance 18088, the board shall be comprised of a wide  
258 array of King County residents and stakeholders with geographically and culturally  
259 diverse perspectives.

260           3. Members of the advisory board shall be appointed by the executive and  
261 confirmed by the council.

262           J. Terms for members of the board shall be for three years.

263           K. In accordance with K.C.C. 2.28.006, youth members aged twenty-four years  
264 old and younger of the board who are neither employees of King County nor employees  
265 of other municipal governments shall receive compensation. The initial compensation  
266 shall be one hundred twenty-five dollars per meeting and shall not exceed one hundred  
267 twenty-five dollars per month before December 31, 2022. Beginning January 1, 2023,  
268 the compensation amount per meeting and the maximum compensation amount per  
269 month shall be automatically adjusted annually, and every year thereafter, at the rate

equivalent to the twelve-month change in the U.S. Department of Labor, Bureau of Labor Statistics Consumer Price Index for All Urban Consumers for the Seattle-Tacoma-Bellevue Statistical Metropolitan Area, which is known as "the CPI-U." However, if the twelve-month change in the CPI-U is negative, there shall not be an adjustment.

L. The board shall provide support to enable youth board members aged twenty-four years old and younger to earn service-learning hours and community service hours for their participation on the board, where participation so qualifies.

SECTION 3. K.C.C. 4A.200.430, as amended by this ordinance, is recodified as a new section in K.C.C. chapter 4A.200.

SECTION 4. Ordinance 15955, Section 2, as amended, and K.C.C. 4A.200.430 is hereby amended to read as follows:

A. There is hereby created the ~~((mental illness and drug dependency))~~ behavioral health bridge fund.

B. The fund shall be a first tier fund. It is a special revenue fund.

C. The director of the department of community and human services shall be the manager of the fund.

D. The fund shall account for the proceeds of an additional one-tenth of one percent sales tax imposed by the county as authorized in RCW 82.14.460.

E.~~((1. In accordance with K.C.C. chapter 4.33, t))~~The proceeds of the sales tax shall be used solely for the purpose of providing new or expanded chemical dependency or mental health treatment services and for the operation of new or expanded therapeutic court programs and shall not be used to supplant existing funding for these purposes, except as authorized in RCW 82.14.460(4).

293           ~~((2.a. In order to reserve funds for new strategies not currently specified in the~~  
294 ~~implementation plan, a new strategy reserve is hereby created in the mental illness and~~  
295 ~~drug dependency fund. The purpose of the reserve is to fund new strategies and programs~~  
296 ~~that meet the county's policy goals established in K.C.C. 4.33.010.~~

297           ~~b. Mental illness and drug dependency programs or strategies that are financed~~  
298 ~~from the new strategy reserve shall receive financing from the reserve. A project or~~  
299 ~~strategy funded from the new strategy reserve shall not utilize more than twenty percent~~  
300 ~~of the total annual new strategy reserve amount. The annual new strategy reserve amount~~  
301 ~~is based on the later of either the annual mental illness and drug dependency fund~~  
302 ~~financial plan as transmitted by the executive with the proposed annual county budget or~~  
303 ~~as amended by ordinance. Funding new strategies from the new strategy reserve shall~~  
304 ~~commence when the ordinance approving the new strategy is enacted. These programs~~  
305 ~~and strategies shall be reviewed as part of the annual mental illness and drug dependency~~  
306 ~~evaluation cycles.~~

307           ~~c. The new strategy reserve shall be limited to five million dollars.~~

308           ~~d. All unencumbered funds in the new strategy reserve shall be transferred to~~  
309 ~~the undesignated fund balance.~~

310           ~~e. In 2011 and thereafter, the new strategy reserve shall be replenished each~~  
311 ~~year by allocating up to one half of the mental illness and drug dependency fund's~~  
312 ~~previous ending year's undesignated fund balance less the target fund balance to the~~  
313 ~~reserve until the five million dollar limit is reached.))~~

314           SECTION 5. Ordinance 16693, Section 3, as amended, and K.C.C. 24.22.020 is  
315 hereby amended to read as follows:

316           The interim loan program will add to the stock of housing for low-income and  
317 special needs residents of King County by facilitating acquisition of low-income housing  
318 using homeless housing and services program moneys and ~~((mental illness and drug~~  
319 ~~dependency))~~ behavioral health bridge housing services moneys in the housing and  
320 community development fund. These funding sources are collected and awarded to  
321 projects annually but are spent down in a manner that creates a fund balance that is  
322 carried over from year to year. The interim loan program will allow the county to loan  
323 moneys from these low-cost fund balances to experienced housing developers on a short-  
324 term, interim basis to acquire property for affordable and homeless housing for  
325 households at or below fifty percent of area median income for King County. Interim  
326 loans will be awarded only when the project sponsor can provide satisfactory assurances  
327 of project feasibility such that permanent funding for the project is highly likely to be  
328 secured and the interim loan amount will be repaid within a reasonable ~~((period of))~~ time,

329 not to exceed five years. No more than fifteen million dollars shall be made available for  
330 interim loans at any time.

KING COUNTY COUNCIL  
KING COUNTY, WASHINGTON

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Sarah Perry, Chair

ATTEST:

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Melani Pedroza, Clerk of the Council

APPROVED this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_.

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Girmay Zahilay, County Executive

**Attachments:** None





**Executive Girmay Zahilay**

Chinook Building, CNK-EX-0800  
401 Fifth Avenue, Suite 800  
Seattle, WA 98104-2391

July 1, 2026

The Honorable Sarah Perry  
Chair, King County Council  
Room 1200  
C O U R T H O U S E

Dear Councilmember Perry:

This letter transmits a proposed Ordinance that would, if adopted, rename and revise the Mental Illness and Drug Dependency (“MIDD”) fund and the MIDD Advisory Committee, updating the King County Code to establish the new name King County Behavioral Health Bridge (“the Bridge”) for the fund and advisory committee.

Responsive to community feedback, the proposed new “King County Behavioral Health Bridge” name replaces the outdated language in the phrase “mental illness and drug dependency” that no longer reflects the values and priorities that guide behavioral health work today and contributes to stigma around behavioral health. The new name emphasizes the role of sales tax-funded programs in creating a bridge between people experiencing behavioral health conditions and community behavioral health treatment, other systems people interact with including the criminal-legal system, and pathways to recovery.

Investments through this fund support programs that improve health and wellness, recovery, and connection to community, especially for people most affected by inequities related to race, income, housing status, and access to care. From 2017 through 2025, these programs served over 130,000 unduplicated King County residents.

The King County Behavioral Health Bridge is projected to generate nearly \$800 million for behavioral health care in King County between 2028 and 2034. The King County Behavioral Health Bridge Implementation Plan for 2028-2034, which I am proposing for Council adoption through a separate concurrent transmittal, invests strategically to break the cycle and prevent incarceration, hospitalization, homelessness, and crisis for low-income people with mental health and

The Honorable Sarah Perry

July 1, 2026

Page 2

substance use conditions. The proposed Plan reflects and further describes the name change in this proposed Ordinance.

I look forward to working with the Council to provide access to high-quality behavioral health care for King County residents. Thank you for considering this important proposed Ordinance to ensure that the updated name for this fund and advisory committee, as well as associated plans, programs, and services, likewise reflects their role as a bridge to long term recovery, stability, and wellbeing.

If your staff have any questions, please contact Dr. Susan McLaughlin, Director of the Department of Community and Human Services, at 206-477-9309.

Sincerely,



for

Girmay Zahilay  
King County Executive

Enclosure

cc: King County Councilmembers

ATTN: Stephanie Cirkovich, Chief of Staff

Melani Hay, Clerk of the Council

Karan Gill, Deputy Executive, Office of the Executive

Jasmin Weaver, Chief of Staff, Office of the Executive

Hyeok Kim, Chief Operating Officer, Office of the Executive

Sierra Howlett Browne, Director of Government Relations, Office of the Executive

Garrett Holbrook, Council Relations Manager, Office of the Executive

Dr. Susan McLaughlin, Director, Department of Community and Human Services

## 2026 FISCAL NOTE

Ordinance/Motion: Ordinance

An ordinance renaming and revising the mental illness and drug dependency fund and the mental illness and drug dependency advisory committee; amending Ordinance 16077, Section 4, as amended, and K.C.C. 2.130.010, Ordinance 18217, Section 2, as amended, and K.C.C. 2A.300.510, Ordinance 15955, Section 2, as amended, and K.C.C. 4A.200.430, and Ordinance 16693, Section 3, as amended, and K.C.C. 24.22.020, adding a new section to K.C.C. chapter 4A.200, and recodifying K.C.C. 4A.200.430.

Title:

Affected Agency and/or Agencies: DCHS

Note Prepared By: Scott Miller

Date Prepared: 6/3/2026

Note Reviewed By: Kevin Lo

Date Reviewed: 6/3/2026

**Description of request:**

This proposed ordinance would rename and revise the Mental Illness and Drug Dependency (MIDD) fund and advisory committee to reflect the new name King County Behavioral Health Bridge. It includes other technical changes and updates related to the fund and advisory committee.

**Revenue to:**

| Agency       | Fund Code | Revenue Source | 2026-2027 | 2028-2029 | 2030-2031 |
|--------------|-----------|----------------|-----------|-----------|-----------|
|              |           |                |           |           |           |
|              |           |                |           |           |           |
|              |           |                |           |           |           |
|              |           |                |           |           |           |
| <b>TOTAL</b> |           |                | <b>0</b>  | <b>0</b>  | <b>0</b>  |

**Expenditures from:**

| Agency       | Fund Code | Department | 2026-2027 | 2028-2029 | 2030-2031 |
|--------------|-----------|------------|-----------|-----------|-----------|
|              |           |            |           |           |           |
|              |           |            |           |           |           |
|              |           |            |           |           |           |
|              |           |            |           |           |           |
| <b>TOTAL</b> |           |            | <b>0</b>  | <b>0</b>  | <b>0</b>  |

**Expenditures by Categories**

|              | 2026-2027 | 2028-2029 | 2030-2031 |
|--------------|-----------|-----------|-----------|
|              |           |           |           |
|              |           |           |           |
|              |           |           |           |
|              |           |           |           |
|              |           |           |           |
|              |           |           |           |
| <b>TOTAL</b> | <b>0</b>  | <b>0</b>  | <b>0</b>  |

Does this legislation require a budget supplemental? No.

Notes and Assumptions:



## Metropolitan King County Council Staff Report

|                      |                           |                      |                                             |
|----------------------|---------------------------|----------------------|---------------------------------------------|
| <b>Committee:</b>    | Regional Policy Committee |                      |                                             |
| <b>Agenda Item:</b>  | 5                         | <b>Analyst(s):</b>   | Sam Porter<br>Miranda Leskinen<br>Jenny Ngo |
| <b>Proposed No.:</b> | 2026-0177                 | <b>Meeting Date:</b> | October 14, 2026                            |

### OVERVIEW

**TOPIC:** An ordinance adopting the “Behavioral Health Bridge” Implementation Plan.

**LEGISLATION SUMMARY:** Proposed Ordinance 2026-0177 would adopt the implementation plan for the Behavioral Health Bridge (Bridge) sales tax funded services from 2028 through 2034. The Mental Illness and Drug Dependency (MIDD) sales tax is proposed to be renamed the Behavioral Health Bridge sales tax through Proposed Ordinance 2025-0174.

Starting in 2028, this implementation plan will govern the administration and implementation of the Behavioral Health Bridge sales tax revenue. The existing MIDD II Service Improvement Plan<sup>1</sup>, Implementation Plan<sup>2</sup>, and the Evaluation Plan<sup>3</sup> will continue to govern investments through 2027 in accordance with an Expenditure Restriction in the County’s 2026-2027 Biennial Budget (Ordinance 20023, Section 70, ER 6).

The Executive transmitted Proposed Ordinance 2026-0177 on July 1, 2026. This item is dually referred to the Health, Housing, and Human Services Committee, as a mandatory referral, and to the Regional Policy Committee (RPC).

The RPC received an initial briefing at its August 26<sup>th</sup> meeting. This item was voted out of the HHHS Committee, as amended, on October 6<sup>th</sup>. A summary of adopted HHHS Committee amendments is provided later in this staff report. Table 12 of this staff report provides an overview of the schedule for this item, which anticipates RPC action at a special committee meeting on November 5<sup>th</sup>.

*Timing Considerations.* There is no mandated deadline by which the legislation must be adopted. Executive staff initially expressed their desire to have the legislation adopted in October but have since agreed to final adoption by the end of 2026.

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<sup>1</sup> Ordinance 18406

<sup>2</sup> Motion 15093

<sup>3</sup> Motion 15058

It is important to note that transmitted in tandem with the implementation plan is Proposed Ordinance 2026-0174, which proposes to rename MIDD the "Behavioral Health Bridge" and update the Advisory Committee. Proposed Ordinance 2026-0174 is a mandatory dual referral to the Regional Policy Committee. Both ordinances are anticipated to be taken up on the same schedule.

## KEY ISSUES FROM THE ANALYSIS

A. **Potential policy issues.** Staff identified nine policy issues with the transmitted implementation plan for the Behavioral Health Bridge which is Attachment A to Proposed Ordinance 2026-0177. These policy issues present policy choices.

1. Proposed new priorities.
2. Performance measurement and evaluation plan.
3. Notification to Council regarding substantial adjustment.
4. Priorities for allocating undesignated fund balance.
5. Permissive language.
6. Reporting requirements.
7. Procurement engagement.
8. Implementation plan perspective.
9. Lack of specificity in the plan.

## BACKGROUND & TIMING CONSIDERATIONS

**MIDD Sales Tax History.** In 2005, the Washington State Legislature provided a funding option enabling county legislative authorities to raise the local sales tax by one tenth of one percent to fund behavioral health and therapeutic court programs. By law, funds raised by this tax are to be dedicated to new or expanded behavioral health services and new or expanded therapeutic court programs. Furthermore, RCW 82.14.460(3) requires that every county that authorizes this tax must operate a therapeutic court for dependency proceedings.

The MIDD sales tax was first adopted in King County in 2007 through Ordinance 15949 (MIDD I 2008-2016), renewed in 2016 through Ordinance 18333 (MIDD II 2017-2025), and most recently renewed in 2025 through Ordinance 19976 (MIDD III 2026-2035). In August 2016, the Executive transmitted the MIDD II service improvement plan (SIP) to guide MIDD II investments. The SIP was approved through Ordinance 18406 in November 2016. The MIDD II implementation plan which outlined the programs to be funded through MIDD II was adopted by Motion 15093 in March 2018. The MIDD II evaluation plan was approved by Motion 15058 in February 2018.

From 2017 through 2025, MIDD programs served more than 130,000 unduplicated residents.

**MIDD II Implementation Plan.** The MIDD II Implementation Plan governed MIDD expenditures from 2017-2025 and included narrative descriptions of every funded initiative and a spending plan for each initiative for the first biennium (2017-2018) of expenditures.

Per an Expenditure Restriction in the County's 2026-2027 Biennial Budget (Ordinance 20023, Section 70, ER 6), the existing MIDD II Service Improvement Plan<sup>4</sup>, Implementation Plan<sup>5</sup>, and the Evaluation Plan<sup>6</sup> will continue to govern investments through 2027.

**MIDD Renewal.** The MIDD Sales Tax was renewed in 2025 through Ordinance 19976 and the 1/10<sup>th</sup> of one penny sales tax is currently projected to generate approximately \$971 million over the nine-year collection period<sup>7</sup>. Table 1 identifies current annual projected sales tax revenues based on the July 2026 Office of Economic and Financial Analysis forecast.<sup>8</sup>

**Table 1. 2026-2034 MIDD Estimated Collections**

| Year | Amount        |
|------|---------------|
| 2026 | \$101,148,041 |
| 2027 | \$102,758,300 |
| 2028 | \$103,569,657 |
| 2029 | \$101,423,239 |
| 2030 | \$105,381,475 |
| 2031 | \$109,101,359 |
| 2032 | \$112,092,438 |
| 2033 | \$116,166,596 |
| 2034 | \$119,770,981 |

**MIDD Expenditure Requirements.** Per state law<sup>9</sup>, MIDD revenue must be used solely for the purpose of providing for the operation or delivery of new or expanded chemical dependency (also known as substance use disorder) or mental health treatment programs and services and for the operation or delivery of therapeutic court programs and services.

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<sup>4</sup> Ordinance 18406

<sup>5</sup> Motion 15093

<sup>6</sup> Motion 15058

<sup>7</sup> This is approximately \$27 million less than was projected by the March 2026 OEFA forecast.

<sup>8</sup> The forecast accounts for adjusted tax base expansion under ESSB 5814 and the tax base reduction from 2029 and beyond under ESSB 6346. Table 1 has been updated from the July 23, HHHS Committee Staff report which was based on the March 2026 OEFA forecast.

<sup>9</sup> RCW 82.14.460

MIDD sales tax revenue may also be used for new construction of facilities and modifications to existing facilities to address health and safety needs necessary for the provision of programs otherwise funded by MIDD revenue. Furthermore, every county that authorizes the MIDD sales tax is required to establish and operate a therapeutic court component for dependency proceedings.

**MIDD Advisory Committee.** The 37-member King County MIDD Advisory Committee (established by K.C.C. 2.130.010) is composed of separately elected officials, King County agency directors, representatives of behavioral health service providers, managed care organizations operating in King County, and individuals with lived experience. The committee acts as an advisory body to the Council and the Executive.

In accordance with King County Code, the Advisory Committee is tasked with:

- Reviewing and providing written recommendations to the Executive and Council on the implementation and effectiveness of the County's MIDD sales tax-funded programs in meeting the goals;
- Reviewing and reporting to the Executive and the Council on annual evaluation reports for MIDD;
- Reviewing and commenting on emerging and evolving priorities for the use of MIDD sales tax revenue;
- Serving as a forum to promote coordination and collaboration between entities involved with MIDD sales tax programs;
- Educating the public, policymakers, and stakeholders on MIDD sales tax-funded programs; and
- Coordinating and sharing information with other related efforts and groups.

## ANALYSIS

**Proposed Ordinance 2026-0177.** This section provides staff analysis of the transmitted implementation plan as follows:

- Implementation plan overview
  - Primary purpose
  - Five strategies and 13 goals
- Community engagement
- Equity framework
- Advisory Committee
- Phased, competitive procurement and base budget analysis
- Measurement and evaluation
- Reporting
- Financial plan and policies for underspend and deficit

- Inflation rate adjustment policy proviso response
- Potential policy issues
- Next steps and key dates

Of note, MIDD is proposed to be renamed "Behavioral Health Bridge" (the Bridge) per companion legislation (Proposed Ordinance 2026-0174) that was transmitted in tandem with the proposed 2028-2034 implementation plan.<sup>10</sup>

**Implementation plan overview.** The transmitted plan is organized around a primary purpose and five updated strategy areas, which are identified in Table 2. Programs that receive Bridge funding, according to the plan, will advance the primary strategy areas and will be tied to performance measures and outcomes that achieve 13 strategy goals (see Table 2).

It is important to note that the transmitted 2028-2034 plan, unlike the MIDD 2 implementation plan, does not identify specific programs that will receive Bridge funding as allowed by RCW 82.14.460. The transmitted plan states that "rather than focusing solely on service delivery, the renewed framework seeks to create sustainable system change by aligning investments around measurable outcomes driven by five strategic areas." The plan further indicates this structure allows the Behavioral Health and Recovery Division in the Department of Community and Human Services (DCHS) to make programmatic decisions through procurement.

The phased, competitive procurement and base budget analyses section later in this staff report provides more detail on the new procurement process proposed by the transmitted plan, which notes that procurements will be guided by the anticipated "activities" that appear with the logic models described in more detail in the performance measurement section of this staff report. Attachment 5 to this staff report contains a crosswalk provided by Executive staff that illustrates MIDD programs and the corresponding anticipated Bridge activity under which programs may be eligible for funding.

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<sup>10</sup> For context, the Executive has proposed renaming "MIDD" as the King County Behavioral Health Bridge, or "the Bridge", in response to community and provider feedback.



**Table 2. Implementation Plan Primary Purpose, Strategy Areas and Goals**

| <b>Primary Purpose<sup>11</sup></b> | <b>To invest in the long-term availability, accessibility, effectiveness, and equity of the county's behavioral health system, especially where people are falling through the cracks of existing systems.</b>                                                                                                                                                                                                                                 |
|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Strategy Area 1</b>              | <b>Care transitions and diversion services:</b> Enhance navigation and system coordination to ensure people receive timely, appropriate behavioral health services across all levels of care, divert individuals with behavioral health conditions from criminal-legal involvement to support long-term stability, and provide appropriate supportive services for individuals with behavioral health conditions involved in the legal system. |
| Goal 1                              | Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.                                                                                                                                                                                                                                                                                   |
| Goal 2                              | Help people with behavioral health conditions achieve and maintain stable housing.                                                                                                                                                                                                                                                                                                                                                             |
| Goal 3                              | Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.                                                                                                                                                                                                                                                                                                 |
| <b>Strategy Area 2</b>              | <b>Substance use disorder (SUD) prevention, treatment, and recovery:</b> Treat SUD by providing effective, low-barrier services that address people's holistic needs and support sustainable paths to long-term recovery.                                                                                                                                                                                                                      |
| Goal 1                              | Drive engagement and retention in SUD care.                                                                                                                                                                                                                                                                                                                                                                                                    |
| Goal 2                              | Provide effective, low-barrier SUD treatment that meets people's holistic needs.                                                                                                                                                                                                                                                                                                                                                               |
| Goal 3                              | Support paths to achieve and maintain recovery after treatment.                                                                                                                                                                                                                                                                                                                                                                                |
| <b>Strategy Area 3</b>              | <b>Equitable access to behavioral health care:</b> Decrease barriers to behavioral health services and increase access to culturally and linguistically responsive care.                                                                                                                                                                                                                                                                       |
| Goal 1                              | Provide behavioral health care for low-income people who are ineligible for Medicaid.                                                                                                                                                                                                                                                                                                                                                          |
| Goal 2                              | Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.                                                                                                                                                                                                                                                                                                     |
| <b>Strategy Area 4</b>              | <b>Child, youth, and young adult mental wellbeing:</b> Address the youth behavioral health crisis by investing in developmentally tailored services and programs that meet youth where they are.                                                                                                                                                                                                                                               |
| Goal 1                              | Improve youth access to behavioral health care by providing developmentally appropriate services that meet young people where they are, at school and in community.                                                                                                                                                                                                                                                                            |
| Goal 2                              | Provide behavioral health and therapeutic services to youth involved in the legal system, including diversion from deeper legal system involvement.                                                                                                                                                                                                                                                                                            |
| Goal 3                              | Invest in the behavioral health of youth who are marginalized or experience inequities.                                                                                                                                                                                                                                                                                                                                                        |
| <b>Strategy Area 5</b>              | <b>Behavioral health workforce development:</b> Strengthen and diversify the behavioral health workforce to meet growing community needs.                                                                                                                                                                                                                                                                                                      |
| Goal 1                              | Strengthen and diversify the behavioral health provider pipeline.                                                                                                                                                                                                                                                                                                                                                                              |
| Goal 2                              | Advance and develop the skills of the current workforce to meet growing community needs.                                                                                                                                                                                                                                                                                                                                                       |

<sup>11</sup> The intent of the stated primary purpose is to focus on low-income residents with behavioral health conditions, in particular those "who are marginalized or experience intersectional inequalities" to invest where the need is greatest and where Bridge dollars can make meaningful impact.

**Community engagement.** The transmitted plan indicates that DCHS solicited feedback from community members from 2024 through 2025. These efforts included 46 in-person and 34 virtual listening sessions, eight community events, and an online survey translated into 21 languages. In total, 2,226 people provided feedback across all regions of King County. Detailed information about the listening sessions and community engagement, including demographic and Council District breakdown of participants appears in Appendix B of the transmitted plan. A crosswalk of strategy areas and community engagement themes appears in Appendix C of the plan.

DCHS also conducted a multi-sector, subject matter expert engagement process from April to July 2025 for each proposed strategy area. Membership consisted of more than 100 clinical providers, licensed peers, criminal-legal system representatives, researchers, and more to inform the implementation plan's 13 goals. A detailed crosswalk of the goals presented in the implementation plan and subject matter expert suggestions that informed the activities of each goal appears in Appendix D of the plan.

**Equity framework.** The plan states that Black, Indigenous, and People of Color, refugee and immigrant, LGBTQIA+, and disability communities are more likely to struggle with behavioral health conditions and less likely to access supportive care than the King County population overall. Therefore, DCHS developed an equity framework for the King County Behavioral Health Bridge to "embed services and outcomes for marginalized communities across all domains of Bridge services, not just the Equitable Access strategy area." The plan states that the framework for the Bridge "describes five pillars of an equitable, anti-racist, multi-cultural King County behavioral health system." The framework states that investments will be designed to advance a behavioral health system that is:

1. Connected and coordinated,
2. Transparent and accountable,
3. Inclusive, collaborative, diverse, and people-focused,
4. Responsive and adaptive to community-identified needs, and
5. Accessible and available.

The plan provides examples for how the equity framework was utilized in the process to develop the implementation plan in Appendix E.

**Advisory Committee.** Proposed Ordinance 2026-0174 transmitted concurrently with the implementation plan would change the name of the MIDD behavioral health sales tax, update the name of the Advisory Committee, and make additional changes to the committee including removing outdated references in King County Code and updating representative positions. This includes converting a representative of All Home to an entity

serving individuals experiencing homelessness in King County, and changing two positions for individuals representing behavioral health consumer interests and representing community interests from the MIDD Consumers and Communities Ad Hoc Work Group to two positions representing behavioral health consumer interests who have lived experience with behavioral health conditions. This legislation is a mandatory dual referral to the Regional Policy Committee. Additional details are provided in the staff report for Proposed Ordinance 2026-0174.

**Phased, competitive procurement and base budget analyses.** The transmitted plan states that the Executive intends to implement phased, competitive procurements beginning in 2028 for nearly all Bridge-funded programs administered by contracted providers (75% of Bridge investments according to Appendix A). The plan states that the phased timeline will allow for careful design of the procurement process. The plan includes a list of components that are "expected" to be included in the procurement process design, a selection of which includes:

- Analyzing current financial projections, policy updates, performance data, and potential funding sources for each strategy area;
- Completing a review of crosswalk existing programs to strategy areas and identifying alternative funding sources where applicable; and
- Notifying the Council, issuing award letters, and finalizing scopes of work, goals, and outcome measures with awardees.<sup>12</sup>

Executive staff indicate that the procurement process will "follow standard departmental procurement procedures, including new safeguards that DCHS is implementing to respond to the results of the 2025 audit." Additionally, procurements will be guided by the anticipated "activities" that appear with the logic models described in more detail in the performance measurement section of this staff report.

According to the plan, the new procurement process would not always mean that programs would be changed drastically. "In some cases, this might mean that an existing program is continued with minimal changes. In other cases, existing programs might undergo significant changes, be shifted to another fund source, or be phased out to redirect Behavioral Health Bridge resources to better achieve the County's goals while still providing community members with access to needed services."<sup>13</sup> The plan does not include detail regarding which programs would be phased out or shifted to other fund sources. MIDD 2 initiatives that align with a strategy area will continue until the strategy is reprocured. Attachment 5 to this staff report provides some detail regarding which

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<sup>12</sup> Behavioral Health Bridge Implementation Plan, page 21.

<sup>13</sup> Behavioral Health Bridge Implementation Plan, page 19.

programs may not be aligned with the activities described in the Bridge implementation plan and would therefore not be eligible for funding under the transmitted plan.

According to the plan, the phased, competitive procurement is intended to improve transparency and accountability, encourage innovation, expand opportunities for provider organizations, align funding with demonstrated outcomes, and ensure investments remain responsive to changing needs. The report also states that the majority of current programming is implemented by providers selected many years ago, and that there are new organizations in the field that have not had the opportunity to apply for behavioral health sales tax funding and this approach would increase those opportunities.

The transmitted plan states that all Bridge-funded programs that are managed or administered by King County departments and agencies outside of DCHS (25% of Bridge investments according to Appendix A, including those operated by the Courts and Public Health) will receive a base budget analysis. Details about what this base budget analysis will entail are not included in the plan. The plan states that the Executive anticipates initial base budget analysis to be completed ahead of the 2028-2029 budget.

Due to the scale of planning and staffing, the plan states that the procurements and base budget analyses cannot occur all at once and will be done in a phased manner as described in Figure 3<sup>14</sup> in the report depicted in Table 3 below.

**Table 3. Timeline of Phased Procurement**

| <b>Strategy Area</b>                                         | <b>Anticipated launch of programs (reprocured or with new base budget)</b> |
|--------------------------------------------------------------|----------------------------------------------------------------------------|
| <b>SUD Treatment and Recovery (SUD)</b>                      | Quarter 3 of 2028                                                          |
| <b>Equitable Access to Behavioral Health Care (EA)</b>       | Quarter 3 of 2028                                                          |
| <b>Care Transitions and Diversion Services (CTD)</b>         | Quarter 1 of 2029                                                          |
| <b>Behavioral Health Workforce Development (WF)</b>          | Quarter 1 of 2029                                                          |
| <b>Child, Youth, and Young Adult Mental Wellbeing (CYYA)</b> | Quarter 3 of 2029                                                          |

The plan states that this phased procurement approach will provide an opportunity to coordinate the Children, Youth, and Young Adult Mental Wellbeing strategy with the Best

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<sup>14</sup> Behavioral Health Bridge Implementation Plan, page 20.

Starts for Kids (BSK) renewal (anticipated in 2027), to ensure the funding streams complement rather than duplicate one another. According to the plan, DCHS plans to announce awards three to six months in advance of program launch dates to provide sufficient ramp down periods for programs or providers that do not receive continued funding. Executive staff provided Table 4 that shows an estimated timeline for phased procurements and non-funded program ramp down periods.

**Table 4. Estimated Timeline for Phased Procurements and Non-funded Program Ramp Down**

| Strategy Area                                                | Procurements Announced | Applications Due & Selection Process | Successful Applicants Announced | Ramp Down for MIDD 2 Programs No Longer Receiving Funding |
|--------------------------------------------------------------|------------------------|--------------------------------------|---------------------------------|-----------------------------------------------------------|
| <b>SUD Treatment and Recovery (SUD)</b>                      | Start of Q2 2027       | Q3 2027                              | End of Q4 2027                  | Q1 & 2 2028                                               |
| <b>Equitable Access to Behavioral Health Care (EA)</b>       | Start of Q2 2027       | Q3 2027                              | End of Q4 2027                  | Q1 & 2 2028                                               |
| <b>Care Transitions and Diversion Services (CTD)</b>         | Start of Q4 2027       | End of Q1 2028                       | End of Q2 2028                  | Q3 & 4 2028                                               |
| <b>Behavioral Health Workforce Development (WF)</b>          | Start of Q4 2027       | End of Q1 2028                       | End of Q2 2028                  | Q3 & 4 2028                                               |
| <b>Child, Youth, and Young Adult Mental Wellbeing (CYYA)</b> | Start of Q2 2028       | End of Q3 2028                       | End of Q4 2028                  | Q1 & 2 2029                                               |

The transmitted plan states that the process to develop and implement procurements is expected to include notifying the Council. Additional details are not included in the plan but in response to Council staff questions Executive staff stated that "the Bridge will continue the standard DCHS practice to notify council of procurements and invite Councilmembers or their staff, to attend panel deliberations." Councilmembers may wish to include additional details in the plan to ensure this practice occurs.

**Measurement and evaluation.** According to Executive staff, there will not be a companion evaluation plan transmitted for the Bridge (a change from MIDD II). In other words,

provisions for measurement and evaluation of Bridge investments are addressed in the transmitted implementation plan (Plan Section VII).

The transmitted implementation plan states that measurement and evaluation for the Bridge, like MIDD II, will utilize the Results Based Accountability (RBA) framework to assess investment results, supplemented with additional evaluation activities.

The RBA framework for evaluation includes performance measurement, population indicators, and in-depth evaluation. This framework, which is used for other human services initiatives like Best Starts for Kids, groups performance measures into three categories:

- How much was done (i.e., service quantity);
- How well was it done (i.e., service quality); and
- Is anyone better off (i.e., participant outcomes).

Performance measures for the Bridge, per the transmitted implementation plan, may be qualitative and/or quantitative and will vary across programs and strategy areas depending on the population served, types of services, and intended outcomes. A couple of example performance measures are provided in Figure 22 of the plan.

RFPs will include the strategy's intended goals and system-wide outcomes and associated performance measures for transparency. DCHS staff will work with service providers during the contracting process to finalize a performance measurement plan. For County-administered programs, agencies will collaborate with DCHS to develop program performance measurement plans.

*Strategy Area Logic Models.* With the introduction of the primary purpose-strategy area approach for the Bridge, the plan explains that its measurement and evaluation approach builds upon the RBA framework using the logic models contained in Appendices F through J.

Each strategy area's logic model highlights the types of programs or "activities" anticipated for funding and illustrates the envisioned relationship between investments, measures, and outcomes. Tables 5 through 9 provide a summary of anticipated activities identified in each strategy area's logic model.

**Table 5. Care Transitions and Diversion Strategy Area and Goal Activities**

|                 |                                                                                                                                                                     |
|-----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Goal 1</b>   | <b>Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.</b> |
| <b>Activity</b> | Diversion from criminal-legal system involvement                                                                                                                    |
| <b>Activity</b> | Services for people with behavioral health conditions who have cycled repeatedly through the criminal-legal system                                                  |
| <b>Activity</b> | Supports for people to reenter the community after incarceration                                                                                                    |
| <b>Activity</b> | Behavioral health services and supports for people involved in the legal system, including therapeutic courts.                                                      |
| <b>Goal 2</b>   | <b>Help people with behavioral health conditions achieve and maintain stable housing.</b>                                                                           |
| <b>Activity</b> | Behavioral health services in permanent supportive housing                                                                                                          |
| <b>Activity</b> | High-intensity services for people with behavioral health conditions leaving institutional settings who are experiencing or at risk of homelessness                 |
| <b>Goal 3</b>   | <b>Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.</b>               |
| <b>Activity</b> | Care navigation, including peer navigation and care coordination                                                                                                    |
| <b>Activity</b> | Technology investments to facilitate care coordination across all levels of care                                                                                    |
| <b>Activity</b> | Promoting timely access to appropriate care                                                                                                                         |

**Table 6. Substance Use Disorder Treatment and Recovery Strategy Area and Goal Activities**

|                 |                                                                                                        |
|-----------------|--------------------------------------------------------------------------------------------------------|
| <b>Goal 1</b>   | <b>Drive engagement and retention in SUD care.</b>                                                     |
| <b>Activity</b> | Proactive outreach to people with SUD, especially those experiencing homelessness                      |
| <b>Activity</b> | Screening and referrals integrated into multiple settings                                              |
| <b>Activity</b> | Sobering services                                                                                      |
| <b>Goal 2</b>   | <b>Provide effective, low-barrier SUD treatment that meets people's holistic needs.</b>                |
| <b>Activity</b> | Low-barrier access to medications for substance use disorder and medication-first treatment approaches |
| <b>Activity</b> | Provision of mobile and in-community services                                                          |
| <b>Activity</b> | SUD treatment for incarcerated people                                                                  |
| <b>Activity</b> | Alleviating barriers to enter inpatient SUD treatment and withdrawal management                        |
| <b>Activity</b> | Culturally and linguistically responsive SUD care                                                      |
| <b>Activity</b> | Overdose prevention and tracking                                                                       |
| <b>Goal 3</b>   | <b>Support paths to achieve and maintain recovery after treatment.</b>                                 |
| <b>Activity</b> | Peer recovery services                                                                                 |

|                 |                                          |
|-----------------|------------------------------------------|
| <b>Activity</b> | Access to housing that supports recovery |
| <b>Activity</b> | Employment supports                      |

**Table 7. Equitable Access to Behavioral Health Care Strategy Area and Goal Activities**

|                 |                                                                                                                                                   |
|-----------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Goal 1</b>   | <b>Provide behavioral health care for low-income people who are ineligible for Medicaid.</b>                                                      |
| <b>Activity</b> | Non-Medicaid behavioral health services and supports                                                                                              |
| <b>Goal 2</b>   | <b>Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.</b> |
| <b>Activity</b> | Community-driven culturally and linguistically responsive services and programs that support behavioral health outside of clinical settings       |
| <b>Activity</b> | Behavioral health treatment services tailored for priority populations                                                                            |

**Table 8. Child, Youth, Young Adult Mental Wellbeing Strategy Area and Goal Activities**

|                 |                                                                                                                                                                            |
|-----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Goal 1</b>   | <b>Improve youth access to behavioral health care by providing developmentally appropriate services that meet young people where they are, at school and in community.</b> |
| <b>Activity</b> | Youth behavioral health services in schools                                                                                                                                |
| <b>Activity</b> | Sober learning environments                                                                                                                                                |
| <b>Activity</b> | Youth behavioral health services in community                                                                                                                              |
| <b>Goal 2</b>   | <b>Provide behavioral health and therapeutic services to youth involved in the legal system, including diversion from deeper legal system involvement</b>                  |
| <b>Activity</b> | Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system                                                              |
| <b>Goal 3</b>   | <b>Invest in the behavioral health of youth who are marginalized or experience inequities.</b>                                                                             |
| <b>Activity</b> | Tailored supports for youth who are marginalized or experience inequities                                                                                                  |

**Table 9. Behavioral Health Workforce Development Strategy Area and Goal Activities**

|                 |                                                                                                 |
|-----------------|-------------------------------------------------------------------------------------------------|
| <b>Goal 1</b>   | <b>Strengthen and diversify the behavioral health provider pipeline.</b>                        |
| <b>Activity</b> | Building pathways to behavioral health careers                                                  |
| <b>Activity</b> | Supporting high-quality behavioral health clinical internships                                  |
| <b>Goal 2</b>   | <b>Advance and develop the skills of the current workforce to meet growing community needs.</b> |
| <b>Activity</b> | Clinical supervision                                                                            |
| <b>Activity</b> | Continuing education for community behavioral health providers                                  |



**Data Collection.** The transmitted plan indicates that data collection practices for the Bridge will be outcomes-driven and reflect systems-level objectives for each strategy area as described in the logic models.

Provider performance measurement plans will include key performance measures (balancing tailored and standardized metrics), types of data collection, reporting cycles, and activities to review data and use data to inform continuous improvements. Providers will submit data and relevant information to the County as required by their contract and/or documented in their performance measurement plans.

For direct services investments, the plan indicates that DCHS intends to collect and monitor performance measures about individuals served (where appropriate and legally allowable), nature of provided services, and associated outcomes.

For community infrastructure or systems investments, the plan indicates that DCHS intends to collect and monitor performance measures such as the number of activities conducted or milestones progress.

The plan further notes that DCHS intends to collect system-level data as appropriate, such as changes to the community behavioral health workforces (e.g., retention and turnover rates). Available data systems will also be utilized to measure and assess long-term data and outcomes at the participant level. Additionally, the Bridge evaluation team will monitor key population-level behavioral health indicators (e.g., countywide rate of overdose fatalities), disaggregated by demographic characteristics where data are available.

The ability to conduct in-depth evaluations will be different for each program and strategy, and the plan identifies criteria to guide the evaluation team in prioritizing projects for in-depth evaluation. It's important to note, however, that causality relating to Bridge investments and population-level measures is not likely feasible to study outside of costly randomized controlled trial evaluations.

**Reporting.** The transmitted plan states that DCHS will offer an annual briefing to Council coinciding with the release of annual data dashboard updates to report on Results Based Accountability indicators and planned or implemented improvements to the Behavioral Health Bridge. The plan proposes that the Executive transmit a biennial report to Council detailing programs and services funded by the Bridge transmitted no later than August 31 every other year beginning in 2030. This is a change from the current annual report cadence.

The biennial reports would be transmitted with a motion acknowledging receipt of the report. Executive staff stated that "the proposed transition to biennial narrative reports is

intended to redirect Executive branch staff resources to increase continuous improvement and taking action to use information on program performance and outcomes to make adjustments when needed. However, the shift to biennial transmitted reports does not replace annual monitoring or accountability."

Biennial Behavioral Health Bridge reports would include the following:

- An overview of Behavioral Health Bridge accomplishments during the previous two calendar years and a description of continuous improvement changes that have been implemented based on performance results, as well as planned operational adjustments to improve performance when applicable;
- The Behavioral Health Bridge fund's fiscal and performance management during the applicable calendar years;
- The expenditure of Behavioral Health Bridge proceeds by strategy area by ZIP code in King County;
- The number of individuals receiving Behavioral Health Bridge-supported services by strategy area by ZIP code where the individuals reside at the time of service;
- A map or summary describing the Behavioral Health Bridge's geographic distribution; and
- Summaries of findings from in-depth evaluations related to Behavioral Health Bridge programs, and actions taken or planned based on those findings in years where such findings are available.

The transmitted plan states that the Bridge evaluation team will report program and strategy expenditures by ZIP code beginning in 2028. The approach will be aligned with those implemented in 2023 for Best Starts for Kids, 2024 for Veterans, Seniors, and Human Services Levy (VSHSL), and 2025 for the Crisis Care Centers (CCC) Levy and will utilize provider locations and participant residences. The transition to biennial reports and what is included in the report represent policy choices.

### **Financial policies.**

*Financial Plan.* The transmitted plan includes a financial plan<sup>15</sup> with estimated collections and estimated expenditures. Table 10 shows a summary of the estimated annual revenue from 2028 to 2034, based on the King County OEFA July 2026 forecast and Table 11 shows the estimated expenditures for each strategy area based on the March 2026 OEFA forecast. Staff analysis is ongoing regarding the impact of the July OEFA forecast on the financial plan and estimated expenditures for the Bridge.

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<sup>15</sup> Bridge Implementation Plan, p. 50.

**Table 10. Bridge Projected Revenue in Millions, 2028-2034<sup>16</sup>**

|                           | 2028           | 2029           | 2030           | 2031           | 2032           | 2033           | 2034           |
|---------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
| Projected Sales Tax       | \$103.6        | \$101.4        | \$105.4        | \$109.1        | \$112.1        | \$116.2        | \$119.8        |
| Projected Interest, est.  | \$0.7          | \$0.8          | \$0.7          | \$0.6          | \$0.6          | \$0.6          | \$0.7          |
| <b>Total Est. Revenue</b> | <b>\$104.3</b> | <b>\$102.2</b> | <b>\$106.1</b> | <b>\$109.7</b> | <b>\$112.7</b> | <b>\$116.8</b> | <b>\$120.5</b> |

**Table 11. Bridge Strategy Area Estimated Expenditures in Millions, 2028-2034**

|                                                                   | 2028           | 2029           | 2030          | 2031          | 2032          | 2033          | 2034          |
|-------------------------------------------------------------------|----------------|----------------|---------------|---------------|---------------|---------------|---------------|
| <b>Strategy 1: Care Transitions and Diversion</b>                 |                |                |               |               |               |               |               |
| <b>Goal 1</b>                                                     | \$25.8*        | \$24.0         | \$24.6        | \$25.1        | \$25.7        | \$26.2        | \$26.8        |
| <b>Goal 2</b>                                                     | \$5.7*         | \$5.0          | \$5.1         | \$5.3         | \$5.4         | \$5.5         | \$5.7         |
| <b>Goal 3</b>                                                     | \$5.2*         | \$3.5          | \$3.6         | \$3.7         | \$3.8         | \$4.2         | \$4.5         |
| <b>Total</b>                                                      | <b>\$36.7*</b> | <b>\$32.5</b>  | <b>\$33.3</b> | <b>\$34.1</b> | <b>\$34.9</b> | <b>\$35.9</b> | <b>\$36.9</b> |
| <b>Strategy 2: Substance Use Disorder Treatment and Recovery</b>  |                |                |               |               |               |               |               |
| <b>Goal 1</b>                                                     | \$1.7*         | \$2.2          | \$2.3         | \$2.4         | \$2.4         | \$2.5         | \$2.5         |
| <b>Goal 2</b>                                                     | \$15.6*        | \$16.3         | \$16.8        | \$17.3        | \$17.7        | \$18.1        | \$18.5        |
| <b>Goal 3</b>                                                     | \$2.1*         | \$1.6          | \$1.7         | \$1.7         | \$1.8         | \$2.1         | \$2.4         |
| <b>Total</b>                                                      | <b>\$19.5*</b> | <b>\$20.2</b>  | <b>\$20.8</b> | <b>\$21.4</b> | <b>\$21.9</b> | <b>\$22.6</b> | <b>\$23.3</b> |
| <b>Strategy 3: Equitable Access to Behavioral Health Care</b>     |                |                |               |               |               |               |               |
| <b>Goal 1</b>                                                     | \$12.0         | \$12.3         | \$12.7        | \$13.0        | \$13.3        | \$13.6        | \$13.9        |
| <b>Goal 2</b>                                                     | \$4.1*         | \$4.2          | \$4.3         | \$4.5         | \$4.6         | \$5.0         | \$5.3         |
| <b>Total</b>                                                      | <b>\$16.1*</b> | <b>\$16.5</b>  | <b>\$17.0</b> | <b>\$17.5</b> | <b>\$17.9</b> | <b>\$18.6</b> | <b>\$19.2</b> |
| <b>Strategy 4: Child, Youth, and Young Adult Mental Wellbeing</b> |                |                |               |               |               |               |               |
| <b>Goal 1</b>                                                     | \$3.5*         | \$4.0*         | \$4.5         | \$4.6         | \$4.7         | \$4.9         | \$5.0         |
| <b>Goal 2</b>                                                     | \$5.2*         | \$4.9*         | \$4.7         | \$4.8         | \$5.0         | \$5.1         | \$5.2         |
| <b>Goal 3</b>                                                     | \$2.6*         | \$2.8*         | \$3.0         | \$3.1         | \$3.1         | \$3.5         | \$3.8         |
| <b>Total</b>                                                      | <b>\$11.2*</b> | <b>\$11.7*</b> | <b>\$12.2</b> | <b>\$12.5</b> | <b>\$12.8</b> | <b>\$13.4</b> | <b>\$13.9</b> |
| <b>Strategy 5: Behavioral Health Workforce Development</b>        |                |                |               |               |               |               |               |
| <b>Goal 1</b>                                                     | \$0            | \$2.5          | \$2.5         | \$2.6         | \$2.7         | \$2.9         | \$3.0         |
| <b>Goal 2</b>                                                     | \$1.3*         | \$4.1          | \$4.2         | \$4.4         | \$4.5         | \$4.7         | \$4.9         |

<sup>16</sup> Table 10 has been updated from the July 23, HHHS Committee Staff report which was based on the March 2026 OEFA forecast.

|              |               |              |              |              |              |              |              |
|--------------|---------------|--------------|--------------|--------------|--------------|--------------|--------------|
| <b>Total</b> | <b>\$1.3*</b> | <b>\$6.6</b> | <b>\$6.8</b> | <b>\$7.0</b> | <b>\$7.1</b> | <b>\$7.6</b> | <b>\$8.0</b> |
|--------------|---------------|--------------|--------------|--------------|--------------|--------------|--------------|

*\*This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised WF programs in 2029.*

Executive staff indicate that estimated expenditures are based on engagement with subject matter experts and staff estimates based on the revenue estimates and how much DCHS thinks would be needed to move the needle on each goal. Actual spending will be determined at the time of procurement. The financial plan fully allocates projected Bridge revenue. If additional goals or strategies were added to the plan by amendment, adjustments to the financial plan would be needed.

Technical assistance and capacity building. The transmitted plan indicates that the Behavioral Health Bridge will set aside 0.5% of revenue for technical assistance and capacity building to support the implementation of the identified goals. This is intended to support organizations with information, tools, and resources to strengthen their infrastructure in the areas of fiscal management, documentation, and reporting, as well as opportunities for areas with service gaps to build capacity.

Administration and compliance. In response to the 2025 audit, the transmitted plan states that the Behavioral Health Bridge will increase the proportion of funds supporting administrative functions in 2028-2034 to enhance fiscal controls and contract management. Executive staff indicate that additional staff will be needed to support procurement, evaluation, program management, compliance, financial management, and reporting.

Reserves. Consistent with the County's Comprehensive Financial Management Policies, the Bridge will maintain a fund reserve equivalent to 60 days of budgeted spending in the current adopted or projected biennial budget under this plan. Additionally, the fund will maintain a Sustainability Reserve starting in 2028 to maintain program commitments despite the projected decrease in sales tax revenue in 2029 due to 2026 changes in state law pertaining to products and services that will be exempt from sales tax beginning in 2029. This Sustainability Reserve will be spent down by 2031.

Behavioral Health Fund transfer. The transmitted plan would formalize the continuation of a transfer of MIDD revenue to the Behavioral Health Fund that has occurred since 2021. The transfer is to support the Behavioral Health and Recovery Division's infrastructure and the King County Integrated Care Network which costs more to operate than is covered by Medicaid. In the 2026-2027 Biennial Budget this transfer is \$16.8 million. The transmitted plan's financial plan shows the 2028-2029 biennium transfer as \$16.3 million with annual increases of approximately 2.5% thereafter.

Process for adjusting plan investments. The plan states that investment amounts identified in the plan are based on fiscal and programmatic assumptions. A substantial adjustment is defined as a "change or series of changes within the same calendar year to a strategy area's annual funding allocation by ten percent or more." Consistent with Health Through Housing, VSHSL, CCC, and BSK levies, if a substantial adjustment were planned by the Executive to the funding allocations identified in the proposed implementation plan, then the Executive would transmit a notification letter to the Council explaining the rationale and scope of the planned change, upon which time the Council would have 30 days to pass a motion rejecting the change – otherwise, the change would proceed after the 30 days.

A change is not considered a substantial adjustment if it is due to additional Behavioral Health Bridge sales tax revenue or other funding sources becoming available. In this scenario, the additional sales tax revenue would be allocated according to the priorities described in the next subsection of this staff report and cannot reduce another strategy area's allocation. In addition, Bridge sales tax proceeds that are not spent within a strategy area may be retained within the same strategy area for use in a subsequent year without being considered a substantial adjustment for the purpose of this plan.

Priorities for allocating undesignated fund balance. The transmitted plan would establish priorities for allocating the undesignated fund balance which is new for this revenue stream. The plan states that the Executive intends to apply the following three priorities to allocate undesignated fund balance when the Executive determines that it represents an opportunity for long-term, sustainable investment:

1. In any year where inflation rates have been reduced due to limited funding availability, provide inflationary adjustments to contracted providers up to the amount of CPI-U (Consumer Price Index for All Urban Consumers) Seattle inflation rates.
2. Augment existing investments to mitigate losses of Medicaid coverage to the degree necessary and feasible within available funds. This includes increasing funding to Equitable Access Goal 1, "Provide behavioral health care for low-income people who are ineligible for Medicaid." It may also include increasing investment in other programs negatively affected by growth of the uninsured rate among the Behavioral Health Bridge's service population.
3. Scale high-performing or innovative Behavioral Health Bridge investments to address unmet need. The investments to be augmented shall be selected through a process that includes Behavioral Health Bridge Advisory Committee consultation and is guided by performance and measurement data.

The plan states that when the Executive determines that fund availability is one-time in nature and cannot reasonably support sustained programming, the Executive intends to consider using these funds for one-time investments including capital projects such as building behavioral health facilities or housing for people with behavioral health conditions, or in pilot programs that can later transition to other funding sources such as Medicaid.

Supplantation considerations. The plan states that the strategic investment areas proposed comply with the supplantation restrictions in RCW 82.14.460(4) that are currently in effect.

**Ordinance 20023, Section 70, Proviso P1.** The 2026-2027 Biennial Budget included a proviso (Ordinance 20023, Section 70, Proviso P1) that withheld \$500,000 from the MIDD budget until the Executive transmitted the new MIDD implementation plan including an analysis about the DCHS inflation rate adjustment policy, how it was determined to be applicable to this revenue source, its projected impact on the revenue source, and a process for mitigating negative impacts. The transmitted implementation plan includes the proviso response in Section X and appears to respond to the proviso. Passage of Proposed Ordinance 2026-0177 adopting the Bridge implementation plan would release the \$500,000 withheld from the MIDD budget. The proviso language is in italics below.

*A. A description of how the inflation rate adjustment policy was determined to be applicable to the mental illness and drug dependency fund given the incompatibility with the requirements of the fund source due to the volatile nature of sales tax revenue;*

The inflation rate adjustment policy was determined to be applicable to the MIDD fund because the "policy applies to local funding sources managed by DCHS because these funds are under greater local control." The response states that the inflation rate increase would only be implemented "to the degree possible while maintaining healthy financial reserves consistent with King County Comprehensive Financial Management Policies."

*B. An analysis regarding the effect of the inflation rate adjustment policy on the mental illness and drug dependency fund, which is projecting an average future growth rate for mental illness and drug dependency of 2.7 percent per year according to 2025 data from King County's office of economic and financial analysis;*

The proviso response states that the "Behavioral Health Bridge fund's projected long-term revenue grows at an average of 2.6 percent per year [...] this growth rate falls below typical King County Budget and Financial Planning Assumptions (BFPA), the policy has a structural impact on the fund's long-range sustainability." Further, "if CPI-U inflation assumptions continue to track near the current range [...] Behavioral Health Bridge expenditure growth would outpace revenue growth." The response states that there are mechanisms in the

inflation policy and budget process to identify these trends and mitigate the impacts. This includes the department being able to delay or suspend the increases if appropriate reserves are not achieved and if revenue forecasts project a decline in fund balance compared to revenue. The report indicates that "despite the risks, DCHS is not projecting a structural gap in the Behavioral Health Bridge from 2028 through 2034. However, if inflationary adjustments were included at Consumer Price Index-Urban (CPI-U) Seattle [King County's Budget and Financial Planning Assumptions] rates every year, the fund would be at risk of not having enough cash to cover expenses after 2028." Consequently, DCHS will take steps to mitigate this risk described in subsections C and D.

*C. An exploration of how the inflation rate adjustment policy could result in expenditures outpacing sales tax revenues and whether inflation rate adjustment policy creates a structural gap for the mental illness and drug dependency fund; and D. Proposed mitigation strategies to address a possible structural gap due to the inflation rate adjustment policy*

The response states that the implementation plan provides inflation adjustments that are lower than CPI-U Seattle to eligible providers with continuing contracts in 2029, this is the year there is a projected 3.55 percent decrease in sales tax revenues as shown in the financial plan. New contracts do not receive an inflation increase, only in the second year of a program and beyond would providers become eligible and are expected to receive this increase. These adjustments are included in the financial plan and are reviewed annually to confirm funding availability. Figure 24 of the implementation plan shows the projected inflation adjustments for contracted providers as compared to the CPI-U inflation factor. The projected inflation adjustment to be provided to Bridge-contracted providers is CPI-U Seattle every year except 2029. The report states that the reduced inflation adjustment in 2029 is "intended to enable the County to continue providing critical Behavioral Health Bridge-funded services without exceeding revenues, despite the inherent volatility of the sales tax."

The response states that if a deficit or reserve shortfall arises in the future DCHS intends to consult with the King County Behavioral Health Bridge Advisory Committee to take one or more of the following actions:

1. Forgo program expansions and investments in new programs.
2. Prohibit or cap future provider inflation rate increases.
3. Propose and implement reductions to Behavioral Health Bridge-funded programs or services.

**Implementation plan appendices.** There are ten appendices to the implementation plan. Key appendices are:

- Appendix B. Community engagement activities and results
- Appendix C. Crosswalk of strategy areas and community engagement themes
- Appendix F - J. Logic model and anticipated activities for each strategy area

**Potential policy issues.** Staff have identified some potential policy issues as summarized below. The issues all represent policy choices for the committees to consider.

1. Proposed new priorities. The transmitted plan replaces the MIDD 2 strategies with five new strategies to address care transitions and diversion services; substance use disorder treatment and recovery; equitable access to behavioral health care; child, youth, and young adult mental wellbeing; and behavioral health workforce development. Whether to accept these new strategies in the implementation plan as proposed present policy choices.

2. Performance measurement and evaluation plan. The transmitted plan does not require transmittal of a companion evaluation plan for the Bridge (a change from MIDD II). The transmitted plan will use the Results Based Accountability framework used in MIDD II to assess investments. The transmitted plan states that performance measures may be qualitative or quantitative and will vary across programs and strategy areas with a couple of examples provided in the plan. The performance measurement plans would be developed with the selected provider for each program. Whether to require more detail about the performance measurement and evaluation plans represents a policy choice.

3. Notification to the Council regarding substantial adjustments. The transmitted plan indicates that a substantial adjustment to the financial plan is a change or series of changes within the same calendar year to a strategy area's annual funding allocation by ten percent or more. The threshold amount for requiring notification to Council presents a policy choice.

4. Priorities for allocating undesignated fund balance. The transmitted plan includes priorities for allocating an undesignated fund balance. Whether to include priorities, or what priorities are included, represent policy choices.

5. Permissive language. The transmitted plan uses permissive language such as "intends", "plans", and "anticipates" throughout the plan with respect to various components of the plan that the Executive may implement. Using these terms allows the Executive the option to not implement components, whereas terms such as "shall" or "will" would require the Executive to follow through on implementation of these components. Whether to change the terminology represents a policy choice.



6. Reporting requirements. The transmitted plan requires a biennial report to be transmitted to Council beginning in 2030 along with offering an annual briefing to Council starting in 2028. The biennial report would be transmitted with a motion acknowledging receipt of the report and no legislation or materials would be transmitted for the annual briefing. This change from an annual report presents a policy choice.

7. Procurement Engagement. The transmitted plan states that the process to develop and implement procurements is expected to include notifying the Council. Additional details are not included in the plan but in response to Council staff questions Executive staff stated that "the Bridge will continue the standard DCHS practice to notify council of procurements and invite Councilmembers or their staff to attend panel deliberations." Councilmembers may wish to include additional details in the plan to ensure this practice is implemented.

8. Implementation Plan Perspective. The transmitted plan is drafted as if this is the Executive's implementation plan and not that of the County. Throughout the plan, language is used leaving this impression. For example, at page 10 the plan states, "In addition to a new name, and in keeping with the Executive's priorities, the new implementation plan includes other key changes including [...]" It is a policy choice whether to edit these statements so that the implementation plan reflects that it is a King County plan, not just that of the Executive.

9. Lack of Specificity in the Plan. The implementation does not identify specific programs that will receive funding. Based on communications with Executive staff, it appears that they may not have additional details to share at this time regarding programmatic investments, finalized performance measures, or evaluation plans. If Councilmembers wanted additional information about these topics, prior to 2028, the Council could add a new section to Proposed Ordinance 2026-0177 to request that a plan update be transmitted in Q3 of 2027 that provides these details. Language could also be added to the Executive Summary of the Bridge plan attached to PO 2026-0177 reflecting this change.

**Next steps and key dates.** The Executive transmitted Proposed Ordinance 2026-0177 on July 1, 2026. This item is dually referred to the Health, Housing, and Human Services Committee, as a mandatory referral, and to the Regional Policy Committee.

Table 12 provides the anticipated legislative schedule for the proposed ordinance as it was updated on August 19, 2026, including amendment deadlines. This proposed schedule accommodates, if necessary, one rereferral to the Regional Policy Committee.

**Table 12. Proposed Ordinance 2026-0177 Anticipated Legislative Schedule**  
**Updated August 19, 2026**

| Action                                                                                  | Committee /Council     | Date                            | Amendment Deadline                                                                                                     |
|-----------------------------------------------------------------------------------------|------------------------|---------------------------------|------------------------------------------------------------------------------------------------------------------------|
| Submitted to Clerk                                                                      |                        | July 1                          |                                                                                                                        |
| Introduction and referral                                                               | Full Council           | July 7                          |                                                                                                                        |
| <b>Discussion Only</b>                                                                  | HHHS (special meeting) | July 23                         |                                                                                                                        |
| <b>Briefing</b> ( <i>legislation is in HHHS control</i> )                               | RPC (special meeting)  | August 26                       |                                                                                                                        |
| <b>Discussion Only</b>                                                                  | HHHS                   | September 1                     |                                                                                                                        |
| <b>Discussion and Possible Action</b>                                                   | HHHS                   | October 6                       | Striker direction due: 9/22 COB<br>Striker distribution: 9/29 COB<br>Line amendment direction due: 10/2 COB            |
| <b>Discussion Only</b>                                                                  | RPC                    | October 14                      |                                                                                                                        |
| <b>Discussion and Possible Action</b>                                                   | RPC (special meeting)  | <b>November 5</b>               | Striker direction due: <b>10/22</b><br>Striker distribution: <b>10/29</b><br>Line amendment direction due: <b>11/2</b> |
| <b>Potential Final Action</b>                                                           | Full Council           | November 17 (Regular)           | Line amendment direction due: 11/13 COB                                                                                |
| <b>If legislation is amended after RPC, then re-referral to RPC would be necessary:</b> |                        |                                 |                                                                                                                        |
| <b>Action</b>                                                                           | RPC (special meeting)  | Week of November 30 -December 4 | Line amendment direction due: TBD                                                                                      |
| <b>Final Action</b>                                                                     | Full Council           | December 8 (Expedited)          |                                                                                                                        |

Of note, companion legislation (Proposed Ordinance 2026-0174) which proposes to rename the MIDD the "Behavioral Health Bridge" and update the Advisory Committee was transmitted concurrent to Proposed Ordinance 2026-0177. Proposed Ordinance 2026-

0174 is also a mandatory dual referral to the Regional Policy Committee and is discussed in a separate staff report. Both ordinances are anticipated to be taken up on the same schedule.

**Previous Committee Questions and Answers.** Executive staff provided responses to questions asked by members during the July 23<sup>rd</sup> meeting of the Health, Housing, and Human Services Committee. These questions and answers are provided in Attachments 6 and 7 to this staff report. Additionally, Attachment 8 provides a reference for the names and associated strategy numbers for current MIDD initiatives as referenced in Attachment 7.

Council's legal counsel has reviewed the implementation plan.

**Action at the October 6, 2026, Health, Housing, and Human Services Committee Meeting.** Proposed Ordinance 2026-0177 was amended at the HHHS meeting on October 6, by Striking Amendment S1, two amendments to S1, and Title Amendment T1.

Striking Amendment S1 made the following changes to the legislation:

1. Conformed the language in the proposed ordinance to the revised Attachment A dated October 2026.
2. Replaced the transmitted plan in Attachment A, with a revised Attachment A, dated October 2026, that incorporates the following changes:
  1. Creates two phases to the Bridge implementation plan. Phase 1 of the implementation plan, now titled “Transition Strategic Framework,” requires Phase 2 which is described in Section XI of the revised plan, and requires DCHS to transmit pre-procurement Council notification reports prior to each Bridge Strategy being procured.
  2. Makes a statement that “Bridge investments and all other local human service levy dollars and contracted service providers should be coordinated to the maximum extent possible in order to support continuity of care across County-funded resources.”
  3. Adds language to include reference to survivors of trauma or domestic, sexual, and gender-based violence in multiple sections of the plan,
  4. Makes a statement related to geographic equity and considering rural areas and smaller incorporated jurisdictions,
  5. Adds statements in the procurement process that 1.) Council notification should include inviting councilmembers and their staff to attend panel deliberations, 2.) each procurement should involve continuity of care requirements, 3.) DCHS shall provide meaningful opportunities to provide

input for current DCHS-contracted service providers, and 4.) contracted service provider reporting requirements should be proportionate to contract size and minimize duplicative data collection.

6. Adds a provision that to the extent allowable by law and County policy, DCHS is encouraged to provide flexible upfront funding to some successful applicants to procurements,
7. Adds specificity to the base budget analysis for programs managed by County agencies,
8. Adds language stating that Bridge programming should be designed to deter unnecessary growth in the legal system where diversion is feasible,
9. Adds language to CTD Goal 3 pertaining to whole-person care to accommodate the cultural and language preferences of patients, and that investments should bridge gaps between Medicaid providers, insurers, and community-based organizations with a focus on empowering the secure sharing of data that captures whole person information,
10. Adds language to EA Goal 1 requested by Executive staff to replace a section inadvertently omitted in the transmitted version,
11. Adds language to EA Goal 2 to 1.) include survivors of trauma or domestic, sexual, or gender-based violence, and people living unsheltered, 2.) state that DCHS will procure behavioral health treatment and care navigation for survivors and should support organizations that can aggregate de-identified data points, and 3.) state that investments will be made with the recognition that providers most capable of administering complex culturally competent care may not be able to meet governmental RFP requirements and that new investments will make access to Behavioral Health Bridge support more administratively accessible,
12. Adds language to WF Goal 1 to reference apprenticeship programs, registered apprenticeships, and apprenticeship degree pathways, and states that these should be invested in “to the degree feasible within available funding,”
13. Adds language to WF Goal 2 to state, “To the degree feasible within available funding, this may include investments in registered apprenticeships and apprenticeship degree pathways,”
14. Adds language stating that qualitative data will include participant experiences and be meaningfully incorporated alongside quantitative measures, when possible,

15. Adds language requiring the Executive to work in partnership with County agencies and DCHS to establish standardized performance measures that enable comparison across programs if they serve similar populations or pursue the same goal,
16. Adds language stating whenever possible, reporting on standardized outcome measures will be broken down by Council District and countywide,
17. Adds an abbreviated report requirement for each year a biennial report is not transmitted to Council starting in 2031, and describes required components as:
  - Expenditures by strategy area,
  - Number of individuals served by strategy area,
  - Relevant outcomes by strategy area, and
  - Notable financial information including:
    - Any substantial adjustments made to the financial plan,
    - The calculation of any undesignated fund balance or underspend, the amount identified, and
    - Any activities paid for with those monies.
18. Requires that during the procurement process from 2027-2029, the Executive is required to transmit Phase 2 of the implementation plan in accordance with Section XI, including all pre-procurement development plans,
19. Shifts funding from SUD Strategy 2 (Goal 2) to Equitable Access (Goal 1) in the following ways:
  - Add a policy statement directing that funding for EA-1 be at least \$16.6M annually from 2028-2034.
  - Adjusting applicable EA expenditure/financial figures to reflect the EA-1 funding increase.
  - Adjusting applicable SUD expenditure/financial figures to reflect the funding decrease to SUD-2 that offsets the increase to EA-1.
  - Adds language stating that, to the degree funding is available, technical assistance should be made available to prospective applicants before and during each procurement,
20. Adds language stating that the University of Washington's Institute for Health Metrics and Evaluation could be an external evaluator engaged by DCHS to conduct a third-party evaluation, and that third-party evaluations should be done every three years, as existing resources allow,
21. Changes the period for substantial adjustments from the same calendar year to 24 months, and changes the threshold for a substantial adjustment from

ten percent or more to “the greater of ten percent or more, or \$500,000, elimination of an existing activity, or a redesign of an activity that substantially changes the population served or eligibility for service.”

22. Adds clarity in the Priorities for allocating undesignated fund balance that 1.) it is the “ending undesignated fund balance on the financial plan” this is referring to, 2.) adds a councilmanic innovation and small grant program to be funded by the first 1% of the ending undesignated fund balance, and 3.) adds a requirement that the Executive shall obtain Council approval by ordinance when using one-time undesignated fund balance for capital improvements,
23. Adds language requiring DCHS consult with the Bridge Advisory Committee, and notify Council in writing before taking actions to due to a deficit or reserve shortfall,
24. Moves the logic models and activities for all strategies from the appetencies to Section XI that requests Implementation Plan Phase 2: Pre-Procurement Development Plan, and Council Notification which includes:
  - Council notification prior to procurement for each strategy area at least 30 days prior to soliciting service providers,
  - Council engagement opportunities and notification of awards,
  - Anticipated procurement timelines, and
  - Examples of anticipated activities to be procured for the five strategy areas.
25. Adds the following Activity to CTD Goal 2: “Behavioral health supports in low-barrier shelter,”
26. Changes the Activity under CTD Goal 3, “Technology investments to facilitate care coordination across all levels of care” to, “HIPAA-compliant case management technologies that employ close-loop referral systems to help providers see what services someone is already engaged in, identify available resources, and connect them seamlessly while keeping patient data secure,” and adds information about closed-loop referral systems,
27. Adds the following Activity to EA Goal 2: “Organizations which provide culturally competent care practices that address behavioral health inequities informed by an understanding of shared history related to race, immigration status, sexual orientation, gender identity, trauma history, and geographic access.”
28. Removes some permissive language throughout Attachment A as directed by the sponsor, and

29. Makes technical, clarifying, and consistency edits throughout Attachment A.

Amendment 1 to S1 made cleanup changes to the Attachment A dated October 2026 in the following ways:

1. Changes the term "successful applicants to procurements" on line 794 of the plan to "contracted service providers."
2. Corrects the phrasing in the Substantial Adjustment to the Financial Plan section that clarifies but does not change the intent.
3. Inserts the term "Council" in reference to in reference to District-specific pilot programs that could be funded with the councilmanic innovation and small grant funding in the plan's policy for the use of ending undesignated fund balance.
4. Makes changes to the councilmanic innovation and small grant plan recommended by legal counsel that cleans up language but does not change intent.
5. Updates endnote 148 in the plan so it does not conflict with changes made to the Substantial Adjustments to the Financial Plan Notification section of the plan.

Amendment 2 to S1 removed the phrase "the first" in reference to the 1% of the ending undesignated fund balance that would be used for the proposed councilmanic grant program. There is not a hierarchy of spending in this section so the words "the first" are superfluous in this context.

Title Amendment T1 conformed the title of the proposed ordinance to the revised Attachment A adopted by Striking Amendment S1.

## INVITED

- Isabel Jones – Interim Director, Behavioral Health and Recovery Division (BHRD), Department of Community and Human Services (DCHS)
- Laura Smith – MIDD Renewal Manager, BHRD, DCHS
- Susan McLaughlin – Director, DCHS
- Liz Arjun – Behavioral Health Policy Lead, Office of the Executive

## ATTACHMENTS

1. Proposed Ordinance 2026-0177.2 (and its attachment)
2. Transmittal Letter
3. Fiscal Note
4. Financial Plan

5. Behavioral Health Bridge and MIDD Strategy Crosswalk
6. Q&A in response to the July 23<sup>rd</sup> HHHS Committee meeting
7. Behavioral Health Bridge and MIDD Strategy Financial Crosswalk (updated 8/31/26)
8. Current MIDD Initiative Reference for Attachment 7
9. Executive Staff PowerPoint Presentation
10. 2026-0177\_AttachA\_Striker\_RedLine\_v3\_20261006 (for illustrative purposes only)





## KING COUNTY

1200 King County Courthouse  
516 Third Avenue  
Seattle, WA 98104

## Signature Report

## Ordinance

Proposed No. 2026-0177.2

Sponsors Mosqueda

AN ORDINANCE adopting the King County Behavioral Health Bridge Implementation Plan 2028-2034, Phase 1: Transition Strategic Framework, required by the 2026-2027 Biennial Budget Ordinance, Ordinance 20023, Section 70, Proviso P1, and requesting phase 2 of the implementation plan that, together with phase 1, will govern the expenditure of proceeds from 2028 through 2034 of the behavioral health sales and use tax authorized by RCW 82.14.460 and K.C.C. 4A.500.315.

## STATEMENT OF FACTS:

1. In 2005, the state Legislature authorized counties to implement a one-tenth of one percent sales and use tax to support new and expanded behavioral health programs, as described in RCW 82.14.460.
2. The behavioral health sales and use tax, originally enacted in King County in 2007 through Ordinance 15949, was extended in 2016 through Ordinance 18333. Ordinance 19976, Section 2, which is codified as K.C.C. 4A.500.315, provided for the continued collection of the sales and use tax without interruption and at the same rate through January 1, 2035.
3. The tax, originally known in King County by the mental illness and drug dependency ("MIDD") name, is renamed through Ordinance

21 XXXXX (Proposed Ordinance 2026-0174), the King County behavioral  
22 health bridge ("the bridge").

23 4. The bridge is projected to generate nearly eight hundred million dollars  
24 for behavioral health care in King County between 2028 and 2034.

25 5. Between 2017 and 2025, participants in relevant sales-tax-funded  
26 programs had sixty-two percent fewer engagements with publicly funded  
27 crisis services, thirty-eight percent fewer episodes of hospitalization and  
28 involuntary detention, fifty-nine percent fewer bookings into King County  
29 and municipal jails, and thirty-two percent fewer emergency department  
30 visits three years after enrollment.

31 6. Significant behavioral health need persists in King County, fueling a  
32 cycle of homelessness, incarceration, and hospitalization that affects too  
33 many people. For example, nearly one thousand four hundred individuals  
34 in King County are regularly cycling through County and municipal jails,  
35 which means being booked into a correctional facility located in King  
36 County four or more times per year in two of the past three years, and  
37 ninety-six percent of these individuals have a behavioral health condition  
38 or a history of interaction with publicly funded behavioral health or crisis  
39 services.

40 7. The bridge sales tax continues to fill critical gaps in the availability of  
41 behavioral health care in King County, including paying for behavioral  
42 health care for low-income people not eligible for Medicaid and whose  
43 services are not covered by state funding. Bridge-funded programs and

44 services also complement and strengthen the investments of other county  
45 funding streams, such as the Crisis Care Centers Levy and Health Through  
46 Housing, by paying for services and programs that those targeted local  
47 moneys do not support.

48 8. The King County Behavioral Health Bridge Implementation Plan 2028-  
49 2034, Phase 1: Transition Strategic Framework invests where the need is  
50 greatest and where dollars can make the most meaningful impact. The  
51 plan seeks to break the cycle of behavioral health crises, incarceration,  
52 hospitalization, and homelessness by streamlining systems, coordinating  
53 across care settings, investing in technology, and paying for essential  
54 services that help people achieve and maintain stability. The plan  
55 promotes holistic and high-quality behavioral health care for years to  
56 come by addressing long-term workforce shortages and the youth  
57 behavioral health crisis. The plan invests strategically to improve the  
58 availability, accessibility, effectiveness, and equity of behavioral health  
59 care in King County across five interconnected strategy areas, which are:  
60 care transitions and diversion services; substance use disorder treatment,  
61 and recovery; equitable access to behavioral health care; child, youth, and  
62 young adult mental well-being; and behavioral health workforce  
63 development.

64 9. The 2026-2027 Biennial Budget Ordinance, Ordinance 20023, Section  
65 70, Expenditure Restriction ER6, restricts nearly all behavioral health  
66 sales and use tax revenues in 2026 and 2027 to be expended or

67           encumbered consistent with the processes and practices established in  
68           Ordinance 18406 and Motions 15093 and 15058. As a result, the King  
69           County Behavioral Health Bridge Implementation Plan 2028-2034, Phase  
70           1: Transition Strategic Framework encompasses the years 2028 through  
71           2034.

72           10. Ordinance 20023, Section 70, Proviso P1, states that the executive  
73           should electronically file the mental illness and drug dependency sales tax  
74           implementation plan by July 1, 2026. Consistent with Ordinance XXXXX  
75           (Proposed Ordinance 2026-0174), the plan called for in the proviso is  
76           renamed the King County Behavioral Health Bridge Implementation Plan  
77           2028-2034, Phase 1: Transition Strategic Framework.

78           BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:

79           SECTION 1. The King County Behavioral Health Bridge Implementation Plan  
80           2028-2034, Phase 1: Transition Strategic Framework, which is Attachment A to this  
81           ordinance, as required by the 2026-2027 Biennial Budget Ordinance, Ordinance 20023,  
82           Section 70, Proviso P1, is hereby adopted to govern the expenditure of behavioral health  
83           sales and use tax proceeds as authorized under Ordinance 19976 and K.C.C. 4A.500.315.

84           SECTION 2. Recognizing the need for transparency, a preprocurement  
85           development strategy, and council notification are required in phase 2 of the

86 implementation plan. The executive shall transmit phase 2 of the implementation plan in  
87 accordance with subsection XI of phase 1 in Attachment A to this ordinance.

KING COUNTY COUNCIL  
KING COUNTY, WASHINGTON

---

Sarah Perry, Chair

ATTEST:

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Melani Pedroza, Clerk of the Council

APPROVED this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_.

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Girmay Zahilay, County Executive

**Attachments:** A. King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1:  
Transition Strategic Framework, Dated October 2026

**King County Behavioral Health Bridge Implementation Plan  
2028-2034  
Phase 1: Transition Strategic Framework**

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October 2026



**King County**

20 **I. Contents**

|    |                                                                                             |           |
|----|---------------------------------------------------------------------------------------------|-----------|
| 21 | <b>I. Contents</b>                                                                          | <b>2</b>  |
| 22 | <b>II. Executive Summary</b>                                                                | <b>4</b>  |
| 23 | <b>III. Background</b>                                                                      | <b>8</b>  |
| 24 | A. The King County Behavioral Health Bridge                                                 | 8         |
| 25 | B. Primary purpose                                                                          | 9         |
| 26 | C. A new name and a new process to meet current needs                                       | 9         |
| 27 | D. Overview of DCHS and community behavioral health services                                | 11        |
| 28 | <b>IV. The process to develop the Behavioral Health Bridge Implementation Plan, Phase 1</b> | <b>13</b> |
| 29 |                                                                                             |           |
| 30 | A. Behavioral health policy and funding changes                                             | 13        |
| 31 | B. Changes in regional behavioral health needs                                              | 13        |
| 32 | C. Community and subject matter expert engagement                                           | 15        |
| 33 | <b>V. A renewed King County Behavioral Health Bridge</b>                                    | <b>17</b> |
| 34 | A. Equity framework                                                                         | 18        |
| 35 | B. Phased, competitive procurement and base budget analyses                                 | 19        |
| 36 | C. Advisory Committee                                                                       | 22        |
| 37 | <b>VI. Investments across the five strategy areas</b>                                       | <b>24</b> |
| 38 | A. Care Transitions and Diversion Services (CTD)                                            | 24        |
| 39 | B. Substance Use Disorder Treatment and Recovery (SUD)                                      | 27        |
| 40 | C. Equitable Access to Behavioral Health Care (EA)                                          | 30        |
| 41 | D. Child, Youth, and Young Adult Mental Wellbeing (CYYA)                                    | 32        |
| 42 | E. Behavioral Health Workforce Development (WF)                                             | 35        |
| 43 | <b>VII. Measurement and evaluation</b>                                                      | <b>38</b> |
| 44 | A. Overarching principles                                                                   | 38        |
| 45 | B. Performance measurement and evaluation framework                                         | 40        |
| 46 | <b>VIII. Reporting for continuous improvement and accountability</b>                        | <b>48</b> |
| 47 | <b>IX. Financial plan and policies</b>                                                      | <b>50</b> |
| 48 | A. Overview                                                                                 | 50        |
| 49 | B. Financial plan                                                                           | 51        |
| 50 | C. Fiscal policies                                                                          | 55        |
| 51 | <b>X. Inflation rate adjustment policy analysis</b>                                         | <b>57</b> |
| 52 | A. How the inflation policy was determined to be applicable to the King County Behavioral   |           |
| 53 | Health Bridge                                                                               | 57        |

|    |                                                                                                   |            |
|----|---------------------------------------------------------------------------------------------------|------------|
| 54 | B. Analysis of the effect of the inflation rate adjustment policy on the Behavioral Health Bridge |            |
| 55 | and risk of a structural gap .....                                                                | 57         |
| 56 | C. Process for mitigating fund shortfalls or structural gaps.....                                 | 58         |
| 57 | <b>XI. Requesting Implementation Plan Phase 2: Pre-Procurement Development Plan and</b>           |            |
| 58 | <b>Council Notifications .....</b>                                                                | <b>61</b>  |
| 59 | A. Pre-procurement Council notification .....                                                     | 61         |
| 60 | B. Council engagement opportunities and notification of awards .....                              | 62         |
| 61 | C. Anticipated procurement timeline.....                                                          | 62         |
| 62 | D. Examples of anticipated activities to be procured for the five strategy areas .....            | 63         |
| 63 | E. Logic model and anticipated activities for Care Transitions and Diversion Strategy Area .....  | 63         |
| 64 | F. Logic model and anticipated activities for Substance Use Disorder Treatment and Recovery       |            |
| 65 | Strategy Area .....                                                                               | 68         |
| 66 | G. Logic model and anticipated activities for Equitable Access to Behavioral Health Care          |            |
| 67 | Strategy Area .....                                                                               | 72         |
| 68 | H. Logic model and anticipated activities for Child, Youth, Young Adult Mental Wellbeing          |            |
| 69 | Strategy Area .....                                                                               | 75         |
| 70 | I. Logic model and anticipated activities for the Behavioral Health Workforce Development         |            |
| 71 | Strategy Area .....                                                                               | 78         |
| 72 | <b>XII. Conclusion .....</b>                                                                      | <b>82</b>  |
| 73 | <b>XIII. Appendices .....</b>                                                                     | <b>83</b>  |
| 74 | A. Appendix A. Behavioral Health Bridge investments in DCHS and other County agencies .....       | 83         |
| 75 | B. Appendix B. Community engagement activities and results .....                                  | 84         |
| 76 | C. Appendix C. Crosswalk of strategy areas and community engagement themes .....                  | 92         |
| 77 | D. Appendix D. Multi-sector subject matter expert process .....                                   | 93         |
| 78 | E. Appendix E. Implementation examples of the five equity pillars.....                            | 102        |
| 79 | <b>XIV. Endnotes .....</b>                                                                        | <b>104</b> |
| 80 |                                                                                                   |            |



## 81 **II. Executive Summary**

82 The King County Behavioral Health Bridge (“the Bridge”), formerly known as the MIDD (Mental  
83 Illness and Drug Dependency) behavioral health sales tax, currently infuses approximately \$100  
84 million per year into the King County community behavioral health system through a countywide  
85 0.1 percent sales tax authorized under RCW 82.14.460 and K.C.C. 4A.500.315.<sup>1,2,3</sup> The Behavioral  
86 Health Bridge Implementation Plan 2028-2034 (“Behavioral Health Bridge Implementation Plan”)  
87 describes a strategic approach to guide investments for the sales tax revenues from 2028-2034  
88 (“implementation period”) to make behavioral health treatment more available, accessible,  
89 effective, and equitable for King County residents. This implementation plan is divided into two  
90 phases, with this Phase 1 document serving as the transition strategic framework (“Phase 1  
91 Implementation Plan”), and a pre-procurement development strategy to be submitted in the future  
92 as Phase 2.

93  
94 The primary purpose of the King County Behavioral Health Bridge is to invest in the long-term  
95 availability, accessibility, effectiveness, and equity of the county’s behavioral health system,  
96 especially where people are falling through the cracks of existing systems.

97  
98 By focusing on low-income residents with mental health conditions and substance use disorders,  
99 particularly those who are marginalized or experience intersectional inequities, the Behavioral  
100 Health Bridge invests where the need is greatest and where its dollars can make the most  
101 meaningful impact.

102  
103 The Behavioral Health Bridge strengthens publicly funded behavioral health care in King County by  
104 investing in prevention, treatment, and recovery services that are often unavailable, inaccessible,  
105 or insufficiently resourced. These investments help break cycles of incarceration, hospitalization,  
106 homelessness, and crisis by ensuring people receive timely, culturally responsive, and effective  
107 care.

### 108 **A new name**

109 The behavioral health sales tax was most recently renewed in 2025. In response to community and  
110 provider feedback, as part of this renewal, the Executive proposes to rename MIDD as the King  
111 County Behavioral Health Bridge, or “the Bridge.” The new name reflects the program’s essential  
112 role in bridging critical gaps in behavioral health funding left by insufficient federal and state  
113 resources. It also helps create bridges between people experiencing behavioral health conditions  
114 and community behavioral health treatment, other systems people interact with such as the  
115 criminal-legal system, and pathways to recovery.

### 116 **Context and need**

117 Behavioral health needs in King County have evolved considerably since the 2018 adoption of the  
118 MIDD 2 Implementation Plan, which guides investments through 2027.<sup>4,5</sup> King County faces  
119 growing uncertainty regarding federal and state behavioral health funding. Anticipated Medicaid  
120 eligibility changes and coverage reductions are expected to increase the number of residents who  
121 require behavioral health services but lack insurance coverage. As a flexible local funding source,  
122 the Behavioral Health Bridge is uniquely positioned to fill service gaps that cannot be addressed  
123 through Medicaid or other state and federal funding streams.

Community engagement conducted during development of the renewal reached more than 2,200 residents, contracted service providers, people with lived experience, advocates, and system partners through listening sessions, community events, surveys, and culturally specific outreach efforts. Participants consistently identified five priority needs:

- Increasing access to behavioral health care and reducing barriers to treatment;
- Strengthening culturally relevant and responsive services;
- Improving coordination across fragmented systems;
- Expanding services for children, youth, and young adults; and
- Addressing workforce shortages and improving workforce diversity.

### A countywide approach guided by five strategy areas

The Behavioral Health Bridge Implementation Plan represents a shift from funding a collection of individual programs toward investing in a coordinated, countywide behavioral health system. The implementation plan emphasizes integration across behavioral health, health care, crisis response, homelessness, housing, and criminal-legal systems to improve outcomes and reduce fragmentation. Investments will be designed to have a definite, clear public impact, reducing the challenges experienced across the county due to unmet behavioral health needs, law violations related to meeting basic needs, and homelessness. Rather than focusing solely on service delivery, the renewed framework seeks to create sustainable system change by aligning investments around measurable outcomes driven by five strategic areas.

The five strategy areas emerged from deep engagement with community members and subject matter experts, as well as the latest available county-level behavioral health data.

1. **Care Transitions and Diversion Services (CTD):** Enhance navigation and system coordination to ensure people receive timely, appropriate behavioral health services across all levels of care, divert individuals with behavioral health conditions from criminal-legal involvement to support long-term stability, and provide appropriate supportive services for individuals with behavioral health conditions involved in the legal system.
2. **Substance Use Disorder Treatment and Recovery (SUD):** Treat substance use disorders by providing effective, low-barrier services that address people's holistic needs and support sustainable paths to long-term recovery.
3. **Equitable Access to Behavioral Health Care (EA):** Decrease barriers to behavioral health services and increase access to culturally and linguistically responsive care.
4. **Child, Youth, and Young Adult Mental Wellbeing (CYYA):** Address the youth behavioral health crisis by investing in developmentally tailored services and programs that meet youth where they are.
5. **Behavioral Health Workforce Development (WF):** Strengthen and diversify the behavioral health workforce to meet growing community needs.

### Phased, competitive procurement and base budget analyses

A significant feature of the renewal is the Executive's intention is to implement competitive procurements for nearly all contracted community-based programs. Many currently funded initiatives were established years ago, and the County seeks to ensure future investments align with contemporary evidence, emerging community needs, and best practices.

Through phased procurements beginning in 2028, the County will create opportunities for both existing and new contracted service providers to compete for Behavioral Health Bridge funding. This approach is intended to:

- Improve transparency and accountability;
- Encourage innovation;
- Expand opportunities for community-based organizations;
- Align funding with demonstrated outcomes; and
- Ensure investments remain responsive to changing needs.

Program components directly operated by other County agencies, including, but not limited to, Executive departments and offices, will generally not be procured with requests for proposal (RFPs) competitively. All investments, whether County-run or run through external providers, will advance the primary strategy areas for the Behavioral Health Bridge as described in this Phase 1 Implementation Plan, and will be tied to performance measures and outcomes that achieve 13 goals identified in [Section VI](#). Procurements will be designed to complement and coordinate with Medicaid, the Crisis Care Centers Levy, Best Starts for Kids, and other major behavioral health funding sources. Bridge investments and all other local human service levy dollars and contracted service providers should be coordinated to the maximum extent possible in order to support continuity of care across County-funded resources. DCHS should provide the infrastructure to facilitate warm handoffs between County-funded providers to the extent possible. The Executive Office will work alongside DCHS and partner agencies to conduct base budget analyses, align investments with strategic priorities, identify efficiencies, and ensure accountability across agencies.

## Measurement and evaluation

The Behavioral Health Bridge will take a renewed approach to measurement and evaluation focusing on accountability, transparency, actionability, and consistency across all funded programs. Approximately one-quarter of current Behavioral Health Bridge funding supports programs administered outside the Department of Community and Human Services (DCHS), including investments in public health, courts, detention, public defense, and other County agencies. The Bridge renewal framework establishes a more coordinated countywide approach to ensure all investments align with shared goals and measurable outcomes.

While MIDD had substantial collaboration that resulted in extensive data collection, in the coming years the Behavioral Health Bridge can deliver outcomes through shared accountability and data-driven decision-making that crosses agencies with support from the Executive Office. This process will be informed by performance measures, outcome data, and participant experiences.

King County will measure and evaluate behavioral health sales tax investments with an evaluation approach that is transparent, outcomes-driven, and equity-focused, utilizing both quantitative and qualitative data. The County will track population-level indicators, implement strategy and program-specific performance measures aligned with the Results Based Accountability framework, and conduct business reviews and in-depth evaluations when appropriate. Results will be published through detailed annual online dashboards, annual briefings, and a biennial report to the King County Council. The Executive Office and DCHS will work together to monitor operations,

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 6

direct operational continuous improvement, and make investment adjustments to best achieve the Bridge’s purpose. See [Section VII](#) and [Section VIII](#) for more information about the Behavioral Health Bridge’s evaluation, performance measurement, and reporting in 2028-2034.

## Reporting

The Executive will transmit to the Council a Behavioral Health Bridge Biennial Report, which includes data on expenditures, services, and outcomes, no later than August 31 every other year beginning in 2030. This report will include an overview of Behavioral Health Bridge accomplishments during the previous two calendar years, fiscal and performance management, expenditure of Behavioral Health Bridge proceeds by strategy area and by ZIP code, the number of individuals receiving services by strategy area and by ZIP code, and summaries of evaluation findings by strategy area and by ZIP code or Council district when available. The biennial report will include descriptions of specific actions to improve programs based on reporting and evaluation and inform potential investment changes that the Executive may include in budget proposals. The Executive will make the biennial reports widely available to the Council, the Regional Policy Committee, and the community through DCHS’ communication channels.<sup>6</sup>

Detailed performance measurements will be available online through interactive dashboards that include data disaggregated by strategy area, as well as historical data that can be used to make year-over-year comparisons of services and outcomes. DCHS staff along with the Executive Office will offer to brief the Council annually with information collected through the dashboards.

Reporting commitments are fully described in [Section VIII](#).

## Financial plan and policies

The financial plan includes projected annual revenues and expenditures for the Behavioral Health Bridge for 2028-2034. This includes the anticipated amounts of annual investment for each of the Behavioral Health Bridge’s strategies and annual reserves, though specific investment amounts will depend on fund availability at the time of procurement. This section includes an inflation policy analysis as called for by the King County Council in a proviso in the 2026-2027 biennial budget ordinance. It describes the impact of the DCHS inflation policy on the Behavioral Health Bridge and presents a process to mitigate a potential structural gap between inflationary increases and sales tax revenues. The financial plan and policies are more fully described in [Section IX](#).

## Conclusion

The Behavioral Health Bridge Implementation Plan represents an evolution of King County’s behavioral health investment strategy. The framework builds on nearly two decades of local innovation while responding to emerging challenges.

By prioritizing systems integration, equitable access, substance use treatment and recovery, youth behavioral health, workforce development, and outcome-driven investments, the Behavioral Health Bridge seeks to support a more coordinated, effective, and sustainable behavioral health system. The renewal positions King County to address immediate community needs while laying the foundation for long-term improvements in health, recovery, housing stability, and public safety.

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 7

### 259 **III. Background**

#### 260 **A. The King County Behavioral Health Bridge**

261  
262 The King County Behavioral Health Bridge (“the Bridge”), formerly known as the MIDD (Mental  
263 Illness and Drug Dependency) behavioral health sales tax, currently infuses approximately \$100  
264 million per year into the King County community behavioral health system.<sup>7</sup> The Behavioral Health  
265 Bridge is a countywide 0.1 percent sales tax that was created by the Legislature in 2005 and  
266 authorized under RCW 82.14.460 and K.C.C.4A.500.315.<sup>8,9</sup> It allows counties in Washington to  
267 contribute funding for substance use and mental health treatment and services, including  
268 therapeutic courts for County residents.<sup>10</sup> King County passed local legislation to enact the sales  
269 tax in this region in 2007 and began collections and programming in 2008.<sup>11</sup> The King County  
270 Council renewed the tax for an additional nine years in 2016 and again in 2025.<sup>12,13</sup> Consistent with  
271 Ordinance 19976, as at the time of plan adoption, tax collections will extend to January 1, 2035.<sup>14</sup>  
272

273 The Bridge is intended to augment longstanding inadequate federal and state investments to make  
274 behavioral health treatment more available, accessible, effective, and equitable for King County  
275 residents.<sup>15</sup> Between 2017 and 2025, MIDD programs directly served over 130,000 unduplicated  
276 King County residents and reached many more through community-wide education and  
277 outreach.<sup>16</sup> The MIDD 2 Implementation Plan, which currently guides MIDD program investments,  
278 expires at the end of 2027.<sup>17,18</sup>  
279

280 Behavioral Health Bridge investments improve health and wellness, recovery, and connection to  
281 community, especially for people most affected by inequities related to race, income, and access  
282 to healthcare and are primarily managed by the Department of Community and Human Services  
283 (DCHS) Behavioral Health and Recovery Division (BHRD) within King County.<sup>19</sup> State law requires  
284 that counties that implement a behavioral health sales tax under RCW 82.14.460 also maintain a  
285 dependency therapeutic treatment court (King County’s Family Treatment Court).<sup>20</sup> State law  
286 grants counties discretion to direct funding to many different kinds of behavioral health services in  
287 different settings, enabling the fund to invest where the need is greatest, at times in agencies  
288 outside of DCHS.<sup>21</sup>  
289

290 The flexibility in state law has allowed King County to invest in programs and services that  
291 collectively reduce reliance on jails, emergency rooms, and hospitals, and create engagement in  
292 and connections to community-based behavioral health treatment for King County residents most  
293 in need. In the 2026-2027 biennium, about 25 percent of Bridge<sup>22</sup> funds are managed by other King  
294 County agencies, including the Prosecuting Attorney’s Office, Public Health - Seattle & King  
295 County, the Department of Judicial Administration, the Department of Adult and Juvenile  
296 Detention, the Sheriff’s Office, the District Court, the Superior Court, and the Department of Public  
297 Defense (see Figure 34 in [Appendix A](#)). DCHS also currently manages some community contracts  
298 for behavioral health services that are connected to programs primarily operated by other County  
299 agencies.  
300

301 Programs funded by MIDD in 2017-2025 reached over 20,000 people each year through more than  
302 50 initiatives.<sup>23</sup> MIDD programs and initiatives since 2017 were organized under the following  
303 strategy areas:

- 304 • Recovery and Reentry

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 8



- Crisis Diversion
- Prevention and Early Intervention
- Therapeutic Courts
- System Improvement

Behavioral Health Bridge sales tax investments help people achieve recovery and stability. Three years after engagement in relevant MIDD initiatives, participants experienced:

- 62 percent fewer engagements with adult crisis programs;
- 32 percent fewer emergency department visits;
- 59 percent fewer bookings into King County jails; and
- 38 percent fewer involuntary psychiatric hospitalizations.<sup>24</sup>

For more information about key outcomes and feedback about past MIDD investments, please view each MIDD Annual Report available on the DCHS website, including interactive data dashboards for each annual report starting in 2020.<sup>25</sup>

### **B. Primary purpose**

The primary purpose of the Behavioral Health Bridge is to invest in the long-term availability, accessibility, effectiveness, and equity of the county's behavioral health system, especially where people are falling through the cracks of existing systems.

By focusing on low-income residents with mental health conditions and substance use disorders, particularly those who are marginalized or experience intersectional inequities, the Behavioral Health Bridge invests where the need is greatest and where its dollars can make the most meaningful impact.

The Behavioral Health Bridge strengthens publicly funded behavioral health care in King County by investing in prevention, treatment, and recovery services that are often unavailable, inaccessible, or insufficiently resourced. These investments help break cycles of incarceration, hospitalization, homelessness, and crisis by ensuring people receive timely, culturally responsive, and effective care.

### **C. A new name and a new process to meet current needs**

While MIDD remains a critical source of funding for behavioral health services, its name and the language "mental illness and drug dependency" no longer reflect the values and priorities that guide behavioral health work today. Community engagement and "Being in Community" are central to the Executive's approach to behavioral health. Over the years, DCHS has consistently heard from behavioral health providers, partners, and community members that the current name contributes to stigma around behavioral health. In response to this feedback, the Executive proposes to rename MIDD as the Behavioral Health Bridge, or "the Bridge." Legislation transmitted concurrently with this Phase 1 Implementation Plan formalizes the name change in King County Code.

The new name reflects the program's essential role in bridging critical gaps in behavioral health funding left by insufficient federal and state resources. Through this support, the Bridge helps ensure that more people can access behavioral health care when they need it most, especially

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 9

low-income residents who lack access to care or do not qualify for Medicaid. It also helps create a bridge between people experiencing behavioral health conditions and engagement with community behavioral health treatment and the many other systems people interact with, including the criminal-legal system, and pathways to recovery.

This plan uses the name “MIDD” to refer to investments prior to 2026 and uses “the Behavioral Health Bridge” and related terms to refer to current and future investments.

In addition to a new name, and in keeping with the Executive’s priorities, the Behavioral Bridge Implementation Plan includes other key changes, including:

- **A whole-county approach to investing, monitoring and measuring impacts of invested resources.** As noted earlier, in the 2026-2027 biennium, about 25 percent of Bridge funds are managed by County agencies outside of DCHS, including the Prosecuting Attorney’s Office, Public Health - Seattle & King County, the Department of Judicial Administration, the Department of Adult and Juvenile Detention, the Sheriff’s Office, the District Court, the Superior Court, and the Department of Public Defense. Partnership and coordination between multiple County systems can improve health and wellness, support recovery, and forge connection to community for King County residents. Achieving the purpose of the Bridge requires many systems working together towards the same vision and goals through aligned strategies. As such, the Executive Office will coordinate with DCHS and these other County agencies in using information from Bridge measurement and evaluation to make informed budget and operational improvements. The Executive Office will play a lead role to support alignment across the County.
- **A procurement process guided by five strategy areas.** For the approximately 75 percent of Behavioral Health Bridge dollars administered directly through DCHS, this Phase 1 Implementation Plan lays out a public procurement process that will happen in phases over the course of an 18-month period beginning in 2028. The phased timeline is structured to allow for careful design, including alignment and incorporation of base budget assessments of county-provided services being conducted by the Executive Office’s Budget Team in collaboration with DCHS, reassignment of programs to other, more appropriate funding sources such as Medicaid and new county funding sources, and recommendations from the Breaking the Cycle Workgroup.<sup>26</sup>

The behavioral health sales tax, which supports the Bridge, is a countywide funding source that has the potential to be transformative for people who are low-income with behavioral health conditions, especially those who are farthest from access and opportunity. The Behavioral Health Bridge Implementation Plan includes a new framework to guide investments for 2028- 2034. It maintains core investments while establishing a new process to strategically address the most pressing behavioral health issues in King County as reflected in population health data and in a deep and robust community engagement process. All investments will improve the availability, accessibility, effectiveness, and equity of behavioral health care in King County.

## **D. Overview of DCHS and community behavioral health services**

### **The Department of Community and Human Services (DCHS)**

DCHS' mission is to provide equitable opportunities for King County residents to be healthy, happy, and connected to community. DCHS' five divisions provide human services for adults, including veterans and seniors; behavioral health care across the lifespan; services supporting children, youth, and young adults to thrive; services for people with developmental disabilities; and affordable housing and homelessness prevention. The department manages more than \$3 billion per biennium in public funds to support King County residents to access a broad range of services, including the Behavioral Health Bridge.

### **Community behavioral health services in King County**

DCHS' Behavioral Health and Recovery Division (BHRD) oversees the public behavioral health system in King County, which includes managing and implementing the Behavioral Health Bridge sales tax and the Crisis Care Centers (CCC) Levy. In addition to the Behavioral Health Bridge sales tax and the CCC Levy, BHRD oversees the publicly funded behavioral health system, including the King County Integrated Care Network (KCICN) and the Behavioral Health Administrative Services Organization (BHASO), and braids these distinct funding streams into a coherent continuum of care rather than a collection of siloed programs.

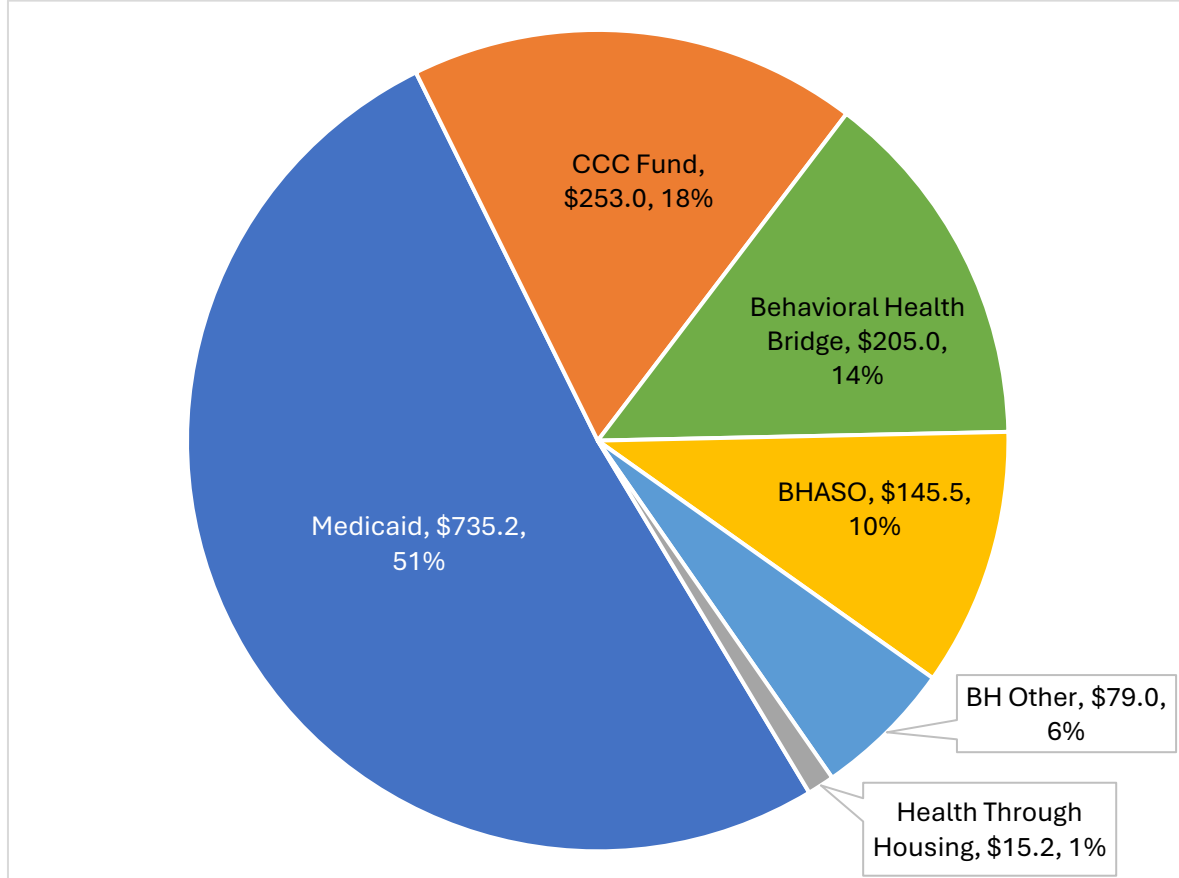
BHRD manages state and federally funded behavioral health services for people with low incomes, including Medicaid services delivered through the KCICN. Created in 2019 as a partnership between BHRD and more than 50 licensed community behavioral health providers, the KCICN represents the county's core behavioral health treatment capacity (outpatient services, residential treatment, case management, and more).<sup>27</sup> It serves approximately 50,000 low-income residents each year, and ensures access to community-based behavioral health treatment regardless of ability to pay.

Through its BHASO role, BHRD also administers the regional crisis system, providing and coordinating 24/7 crisis response, involuntary treatment investigations, and other non-Medicaid programs for all residents, including those who are uninsured or underinsured. Across these roles, BHRD manages all publicly funded behavioral health crisis services in the county, serving roughly 70,000 people each year. While most services are delivered through contracted community behavioral health agencies, BHRD also provides certain statutory functions directly, such as Designated Crisis Responder (DCR) investigations and involuntary commitment processes.

Behavioral Health Bridge sales tax proceeds comprise 14 percent of BHRD's projected revenues in 2026-27 (Figure 1).



**Figure 1: Behavioral Health and Recovery Division projected revenue by fund source according to 2026-2027 financial plans (dollars in millions)<sup>28</sup>**



*\*BH Other includes non-BHASO federal, state, local, and private grants, interfund transfers, and local taxes.*

## 439 IV. The process to develop the Behavioral Health Bridge Implementation 440 Plan, Phase 1

441  
442 The development of the Phase 1 Implementation Plan involved a number of components, including  
443 a scan of changes to the behavioral health policy and funding landscape and a regional population-  
444 level data review coupled with robust community engagement process.

### 446 A. Behavioral health policy and funding changes

447  
448 The behavioral health funding landscape has evolved significantly at the federal, state, and local  
449 levels since the MIDD 2 Implementation Plan was adopted in 2018.<sup>29</sup>

- 451 • **Local changes:** The creation of the KCICN in 2019, the passage of the Health Through  
452 Housing sales tax (2020) and the Crisis Care Centers Levy (2023), and the renewal of the  
453 Best Starts for Kids Levy (2021) and Veterans, Seniors, and Human Services Levy (2023).<sup>30,</sup>  
454 <sup>31,32,33</sup>
- 455 • **State changes:** Changes to coverage for non-citizen Washingtonians with the introduction  
456 of Apple Health Expansion in 2024 and its contraction in 2026, federal approval of Apple  
457 Health's Medicaid Transformation Project 2.0 in 2023, and reductions in state funding for  
458 non-citizen health care, pre-release services, and several behavioral health programs  
459 serving King County as result of a state budget shortfall in the 2025-2027 state fiscal  
460 biennium.<sup>34,35,36,37</sup>
- 461 • **Federal changes:** The passage of H.R.1 in 2025 which imposes significant changes to  
462 Medicaid, including work requirements and more frequent eligibility redeterminations,  
463 anticipated to reduce Medicaid enrollment in Washington State by 26 percent starting in  
464 2027.<sup>38,39,40</sup>

465  
466 The presence of new and expanded funding sources for behavioral health, combined with the  
467 possibility of losing other sources, creates an opportunity to evaluate and restructure behavioral  
468 health sales tax investments. Coordinating and aligning investments will maximize existing revenue  
469 and improve the County's ability to meet the increasing behavioral health needs of County  
470 residents.

### 472 B. Changes in regional behavioral health needs

473  
474 Since the implementation of MIDD 2, behavioral health challenges in King County have also  
475 undergone significant changes, including the fentanyl epidemic and a global pandemic which  
476 produced crises in youth behavioral health and in the behavioral health workforce. King County  
477 must invest strategically to meet these new challenges head-on. Community input and the most  
478 current available local data indicate that the greatest current challenges in King County are:

479  
480 **Complex, siloed systems.** As the behavioral health system has grown over the past decade, the  
481 connections between parts of the system have not kept pace. For example, among Medicaid  
482 enrollees in King County in 2023, 67 percent of people who went to an emergency department for a  
483 substance use disorder (SUD) concern did not have a follow-up outpatient visit within 30 days.<sup>41</sup> In  
484 addition, analysis shows that people who died from overdose in King County had engaged with a  
[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

variety of public services such as jails, emergency departments, homeless services, or mental health care in the year before their death.<sup>42</sup> However, fewer than half (48 percent) had been receiving publicly funded SUD services during that time.<sup>43</sup> To achieve its goal of an effective behavioral health system, King County must invest in care transitions directly to ensure that all parts of the system work together and people can access timely and appropriate care no matter where they enter the system.

**Substance use disorders.** In 2017, only nine percent of fatal overdoses involved fentanyl; in 2025, that number was 78 percent.<sup>44</sup> After reaching a peak in 2023, the rate of fatal overdoses has begun to decline but it is still twice as high as in 2017.<sup>45</sup> Treatment methods have shifted to adapt to this new form of the opioid crisis. Medications for opioid use disorder (MOUD) have become the standard of care, but are still not available to everyone who needs them.<sup>46</sup> In addition, the proportion of unhoused, unsheltered people with SUD has increased from 29 percent in 2017 to 41 percent in 2026.<sup>47,48</sup> Innovative strategies that go beyond traditional office-based appointments are needed to help this population access care and move toward recovery.

**Behavioral health inequities.** As of 2024, 48 percent of King County's population and 62 percent of the population under age 18 were Black, Indigenous, or people of color (BIPOC).<sup>49</sup> Further, one in four County residents is an immigrant, and almost one third report speaking a language other than English at home.<sup>50,51</sup> Decades of research demonstrate racial and ethnic inequities in access to behavioral health care, and King County is no exception.<sup>52</sup> For example, Black/African American and American Indian/Alaska Native residents of King County are much more likely to experience a fatal overdose than their White, non-Hispanic peers.<sup>53</sup> Lesbian, gay, bisexual and transgender adults are two to three times as likely to experience frequent mental distress as their cisgender and heterosexual peers.<sup>54</sup> Targeted investments are needed to address inequities and ensure all King County residents can access and receive high-quality, culturally-relevant behavioral health care.

**Youth mental health crisis.** The COVID-19 pandemic produced a youth mental health crisis that is still creating ripple effects years later.<sup>55</sup> Death by drug overdose or poisoning has become the third leading cause of death for people under 20 years old, with Washington State youth experiencing mortality at nearly twice the national average.<sup>56</sup> In 2023 among King County young people ages 11 to 24, Emergency Medical Services responded to 868 non-fatal opioid overdoses and 53 fatal overdoses.<sup>57</sup> In 2025, approximately one in 12 King County eighth and tenth graders reported considering suicide during the previous year.<sup>58</sup> Young people who do not receive help with their behavioral health are more likely to struggle with substance use, become homeless, or be arrested, whether during adolescence or later in life.<sup>59</sup> These youth and families need additional behavioral health support during the 2028-2034 implementation period to keep them from becoming trapped in a cycle of behavioral health crisis, incarceration, and homelessness.

**Behavioral health workforce shortage.** It takes people to treat people. The behavioral health workforce has been strained for years, but the crisis escalated during the COVID-19 pandemic, which produced a nationwide surge in demand for behavioral health services at the same time that many clinical staff exited the workforce.<sup>60,61</sup> Locally, a 2023 survey of KCICN providers found that vacancies had doubled since 2021, and 65 percent of MIDD initiatives identified problems with staff recruitment and retention as a key factor impacting program reach and performance.<sup>62,63</sup> In 2025, KCICN provider agencies had an overall vacancy rate of nearly 10 percent, equating to 414 open positions.<sup>64</sup> The persistent workforce shortage means that treatment needs go unmet and

care is delayed.<sup>65</sup> In addition, community and subject matter expert feedback (detailed in the next subsection) demonstrates a significant need for a behavioral health workforce that better represents the racial, cultural, and linguistic backgrounds of the people being served. Strategic investments in the behavioral health workforce are expected to reduce treatment delays and gaps, help build a diverse provider pipeline, and promote the skills needed to treat the Behavioral Health Bridge’s high-need service population.

### C. Community and subject matter expert engagement

Community and subject matter expert engagement included consultation with the MIDD Advisory Committee, analysis of successes and challenges from the past 18 years of MIDD programming, coordination with other County agencies and partners, dialogue with internal workgroups within DCHS, engagement with over 2,200 County residents, and convenings of multi-disciplinary subject matter expert workgroups. The community engagement activities and multi-sector workgroups are broadly described below and further detailed in Appendices A, B, and C.

#### Community engagement

Throughout 2024 and 2025, DCHS solicited feedback from community members about behavioral health needs through:

- 46 in-person listening sessions,
- 34 virtual listening sessions,
- eight community events, and
- an online survey in 21 languages.<sup>66</sup>

This feedback was complemented with data from the “Be Heard: Community Voices about Mental Health and Wellness Community Listening Project,” which gathered information from 543 individuals across 14 culturally-centered community-based organizations.<sup>67</sup>

In total, feedback from 2,226 people across all regions of King County informed the direction of the Behavioral Health Bridge renewal. Conversations revealed the following themes:

- Increase access and reduce barriers.
- Strengthen culturally relevant and responsive care.
- Reduce system fragmentation and improve service coordination.
- Strengthen and increase services for children, youth, and young adults.
- Strengthen and expand the behavioral health workforce.
- Strengthen wraparound services that use team-based care and connect people to basic needs.

Combining the recommendations from the community and the behavioral health needs analysis described above, DCHS identified five strategy areas for the next iteration of the sales tax: Care Transitions and Diversion Services; Substance Use Disorder Treatment and Recovery; Equitable Access to Behavioral Health Care; Child, Youth, and Young Adult Mental Wellbeing; and Behavioral Health Workforce Development. The MIDD Advisory Committee reviewed these five strategy areas and collectively agreed they were the highest priority areas for the renewal.<sup>68</sup>

Additional details about methods of engagement, demographics of people engaged, emergent themes, and influences on this Phase 1 Implementation Plan can be found in Appendices A and B.

## **Multi-sector subject matter expert workgroups**

To explore potential investments within each strategy area, DCHS conducted a multi-sector subject matter expert (SME) engagement process from April to July of 2025. DCHS established a workgroup of SMEs for each strategy area, with membership consisting of over 100 clinical providers, licensed peer support specialists, criminal-legal system representatives, researchers, educators, outreach workers, advocates, nonprofit leaders, members of the MIDD Advisory Committee, King County staff, and people with lived experience. Participant names and a crosswalk of recommendations to plan elements can be found in [Appendix D](#).

SME input aligned closely with the feedback gathered from the broader community around themes like mitigating barriers and improving access, improving coordination across different parts of the behavioral health system, diversifying the behavioral health workforce, ensuring availability of culturally responsive services, enhancing care for youth and young adults, and continuing to support recovery from substance use disorders. Potential recommendations for future investments were intended to bridge gaps, address problems, and build upon existing services to improve behavioral health for County residents.

## **Strategic approach for King County Behavioral Health Bridge investments**

After the conclusion of the workgroups, DCHS evaluated all SME recommendations on a range of factors, including feasibility, cost, equity, and alignment with the county's broader vision for behavioral health. DCHS also examined evaluation data for active MIDD 2 investments. Using this information, the Executive developed a plan that addresses present needs, responds to anticipated federal cuts, and builds capacity for system transformation in the future framed around five strategy areas described in [Section VI](#).

## 599 V. A renewed King County Behavioral Health Bridge

600 The Bridge will fund investment in five areas:

601

602 1. **Care Transitions and Diversion Services (CTD):** Enhance navigation and system  
603 coordination to ensure people receive timely, appropriate behavioral health services  
604 across all levels of care, divert individuals with behavioral health conditions from  
605 criminal-legal involvement to support long-term stability, and provide appropriate  
606 supportive services for individuals with behavioral health conditions involved in the  
607 legal system.

608 2. **Substance Use Disorder Treatment and Recovery (SUD):** Treat substance use  
609 disorders by providing effective, low-barrier services that address people's holistic  
610 needs and support sustainable paths to long-term recovery.

611 3. **Equitable Access to Behavioral Health Care (EA):** Decrease barriers to behavioral  
612 health services and increase access to culturally and linguistically responsive care.

613 4. **Child, Youth, and Young Adult Mental Wellbeing (CYA):** Address the youth  
614 behavioral health crisis by investing in developmentally tailored services and programs  
615 that meet youth where they are.

616 5. **Behavioral Health Workforce Development (WF):** Strengthen and diversify the  
617 behavioral health workforce to meet growing community needs.

618 The renewal outlines an approach to future investments that:

619

- 620 • Emphasizes integration of behavioral health, crisis response, criminal legal, health care  
621 and homelessness service systems. This countywide approach streamlines fragmented  
622 funding streams across many County agencies to maximize resources and seeks to  
623 measure and monitor impact for the people being served across systems.
- 624 • Seeks to break the cycle of behavioral health crises, incarceration, hospitalization, and  
625 homelessness by streamlining systems, coordinating across care settings, investing in  
626 technology, and paying for essential services that help people achieve and maintain  
627 stability.
- 628 • Provides opportunity to build on the strengths of previous investments while strategically  
629 tackling the most pressing behavioral health issues in King County communities, including  
630 siloed systems, substance use disorders, and inequitable access to care.
- 631 • Promotes holistic and high-quality behavioral health care for years to come by addressing  
632 long-term workforce shortages and the youth behavioral health crisis.
- 633 • Improves the availability, accessibility, effectiveness, and equity of behavioral health care  
634 in King County through data-driven decisions, performance measurement across policy  
635 areas, continuous improvement, and innovation.

636

637 Strategic investment areas in this Phase 1 Implementation Plan comply with the supplantation  
638 restrictions in RCW 82.14.460(4) that were in effect at the time of plan adoption.<sup>69</sup> They are also  
639 intended to complement other available funding sources for behavioral health treatment and  
640 services. For example, the Bridge should not pay for behavioral health treatment for an individual  
641 when the same treatment could be provided to the individual under Medicaid coverage or another  
642 fund source. Instead, the Bridge is uniquely positioned to fund programs and services beyond the  
643 limited scope of federal, state, or other local funding.

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 17



## A. Equity framework

King County places equity at the heart of its core values, recognizing it is essential to addressing systemic challenges and creating fair opportunities for all residents. By centering equity in actions, policies, and decision making, King County aims to disrupt disparities, promote mental well-being, and foster a community where all individuals and families can thrive.

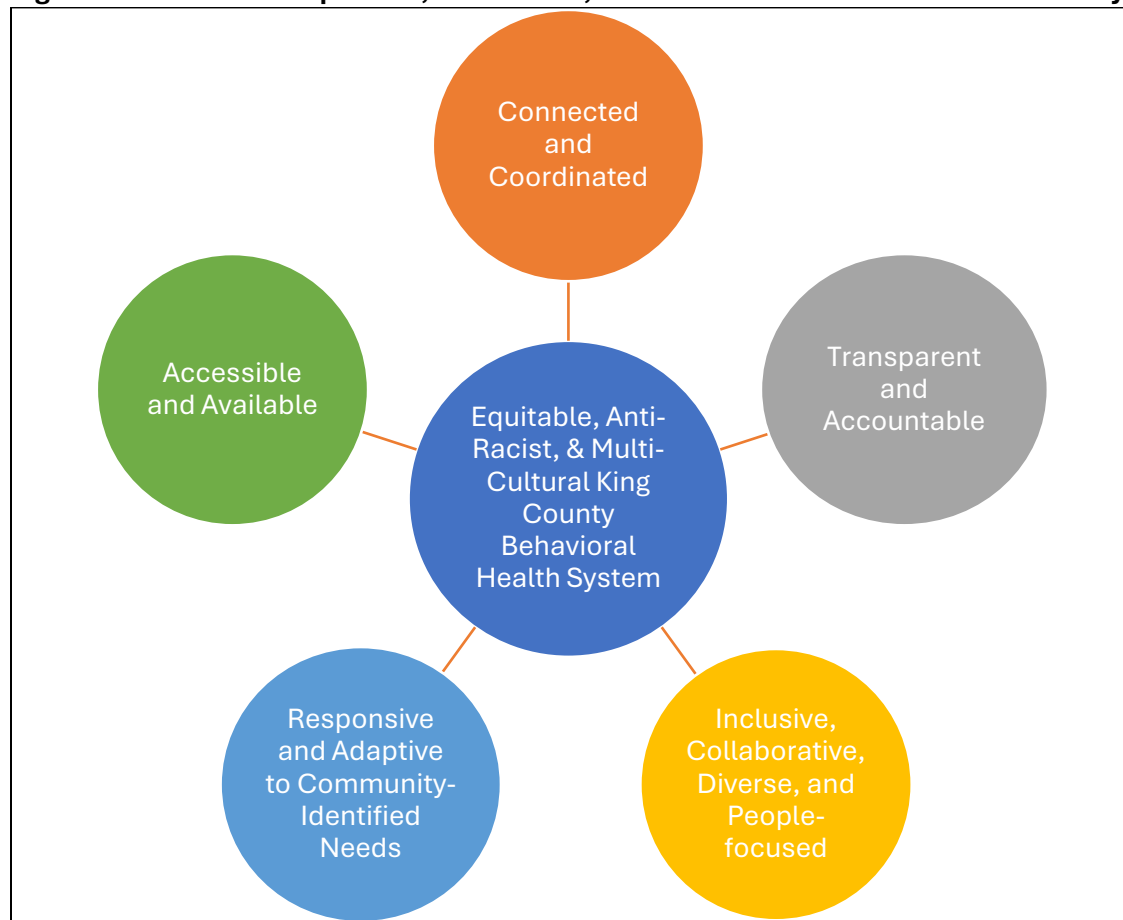
BIPOC, refugee and immigrant, LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual), and disability communities, as well as survivors of trauma or domestic, sexual, and gender-based violence, are more likely to struggle with behavioral health conditions and less likely to access supportive care than the King County population overall (see [Subsection IV.B.](#) and [Subsection VI.C.](#)). Direct, intentional policies designed to promote equity and racial justice for all County residents are needed to address these inequities. Through community engagement and collaboration with internal program managers, DCHS developed an equity framework for the Behavioral Health Bridge to embed services and outcomes for marginalized communities across all domains of Bridge services, not just the Equitable Access strategy area.

The equity framework for the Bridge describes five pillars of an equitable, anti-racist, multi-cultural behavioral health system (Figure 2). Behavioral Health Bridge investments will be designed to advance a behavioral health system that is:

- **Connected and coordinated:** Investing strategically across County agencies and partners to strengthen behavioral health coordination; expanding equitable and low-barrier services; aligning with King County’s commitment to racial justice; and enhancing continuity of care.
- **Transparent and accountable:** Conducting transparent and equitable procurement processes; embedding equity expectations across provider relationships; and ensuring accountability by tracking outcomes and disparities, supporting contracted service providers to improve, and using data to continuously center culturally responsive, equitable services.
- **Inclusive, collaborative, diverse, and people-focused:** Elevating and partnering with people with lived experience through inclusive engagement; centering racial equity and antiracism in funding and program decisions; and resourcing contracted service providers to advance equitable, community-driven solutions.
- **Responsive and adaptive to community-identified needs:** Providing community-driven, culturally responsive services that address systemic biases; expanding access for underserved populations; and supporting programs informed and led by the communities most impacted.
- **Accessible and available:** Providing culturally responsive services and seeking to reduce barriers related to cost, wait times, travel, stigma, and physical accessibility.

For examples of how the equity framework was utilized in the process to develop the Behavioral Health Bridge Implementation Plan please see [Appendix E](#).

**Figure 2: Pillars of an Equitable, Anti-Racist, and Multi-Cultural Behavioral Health System**



## **B. Phased, competitive procurement and base budget analyses**

The Executive intends to implement competitive procurements for nearly all Behavioral Health Bridge-supported programs that will be administered by contracted service providers in the community. The intention of new procurements is to ensure that future investments are made to achieve the goals of each strategy area. In some cases, this might mean that an existing program is continued with minimal changes. In other cases, existing programs might undergo significant changes, be shifted to another fund source, or be phased out to redirect Behavioral Health Bridge resources to better achieve the County’s goals while still providing community members with access to needed services. These shifts are part of realizing the Executive’s priority of Better Government, which “commits King County to operating as a more transparent, effective and accountable organization”<sup>70,71</sup>

Competitive procurements will allow King County to evaluate program models and applicants, including new provider organizations and those that have previously received Bridge funding, to identify the most promising, responsive, and effective investments. Behavioral health interventions have continued to evolve and improve as new evidence has emerged over the past 18 years of the [King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)



behavioral health sales tax.<sup>72,73</sup> Although many initiatives have evolved through continuous quality improvement since their inception, some are based in program models that are outdated and require a more substantial overhaul to maximize effectiveness. Of the 49 initiatives active in 2026, 27 were continued from MIDD 1 (2008-2016).<sup>74</sup> As a result, the majority of current programming is implemented by contracted service providers selected many years ago. Many new organizations have been established in King County but have not had the opportunity to apply for behavioral health sales tax funding. New procurements will provide equitable opportunities for all qualified service providers to apply for the Bridge contracts and are expected to help ensure that public monies support the most effective programs.

The Executive should be mindful of geographic equity as they deliberate on which contracted service providers will receive awards during the procurement process; such as taking into account rural areas and smaller incorporated jurisdictions that may have less access to behavioral health services and revenue sources to support the expansion of behavioral health services in the rural area. The Executive should consider including geographic distribution of services as an evaluation criterion in the selection process of service providers.

Due to the scale of programs and services supported by the Behavioral Health Bridge, procurements for all strategy areas in the Behavioral Health Bridge Implementation Plan and related base budget analyses require significant planning and staffing and cannot all occur at once. Therefore, DCHS plans to phase procurements through the third quarter of 2029, according to the progression described in Figure 3.

The Executive anticipates initial base budget analysis to be completed ahead of the 2028-2029 budget, but further review and adjustment will align with DCHS strategy area procurement.

**Figure 3: Phased introduction of reprocured and revised Behavioral Health Bridge programs**

| Strategy Area                                               | Anticipated launch of programs (reprocured or with new base budget) |
|-------------------------------------------------------------|---------------------------------------------------------------------|
| <b>SUD Treatment and Recovery (SUD)</b>                     | Quarter 3 of 2028                                                   |
| <b>Equitable Access to Behavioral Health Care (EA)</b>      | Quarter 3 of 2028                                                   |
| <b>Care Transitions and Diversion Services (CTD)</b>        | Quarter 1 of 2029                                                   |
| <b>Behavioral Health Workforce Development (WF)</b>         | Quarter 1 of 2029                                                   |
| <b>Child, Youth, and Young Adult Mental Wellbeing (CYA)</b> | Quarter 3 of 2029                                                   |

MIDD 2 initiatives that align with each strategy area will generally continue until the area is reprocured. For example, current initiatives that align with the SUD Treatment and Recovery strategy area are expected to continue until programs governed by the activities described in this plan launch in Quarter 3 of 2028. DCHS will announce awards three to six months in advance of program launch dates to enable appropriate ramp-down periods for programs or currently contracted service providers that will not receive continued funding. Phased procurements also ensure currently contracted service providers do not have to apply for RFPs in multiple strategy areas simultaneously.

The order of strategy area procurements is strategically designed to facilitate smooth transitions. For example, the complexity of the Care Transitions and Diversion (CTD) Services area will require

significant County staff resources for implementation. Because Behavioral Health Bridge program planning in 2027 will primarily rely on existing DCHS staff, new programs in the CTD area are scheduled to launch in the first quarter of 2029 to ensure enough staff resources are in place to achieve an effective transition in 2028. In addition, the Child, Youth, and Young Adult Mental Wellbeing (CYYA) strategy area will be closely coordinated with the Best Starts for Kids ("Best Starts") program to ensure the funding streams complement rather than duplicate one another. If voters approve renewal of the Best Starts for Kids levy, the next implementation plan for Best Starts is expected to be due to King County Council in late 2027, with procurement for new strategies likely to take place during 2028 and 2029. The Bridge's CYYA strategy area is scheduled for procurement during the same period so that the Behavioral Health Bridge and Best Starts teams can coordinate activities, ensure investments are complimentary and not duplicative, and invest in a continuum of care that best serves youth and families. If the Best Starts levy is not approved by voters, DCHS will reevaluate optimal investments of the Behavioral Health Bridge for children, youth, and young adults to reflect that substantial loss of services for youth and families.

The process to develop and implement procurements is expected to include:

- Analyzing current financial projections, policy updates, performance data, and potential funding sources for each strategy area.
- Conducting base budget analysis of programs directly operated by County agencies.
- Completing a review of crosswalk existing programs to strategy areas and identifying alternative funding sources where applicable.
- Drafting procurement materials for anticipated activities, goals, and preliminary outcome measures.
- Launching competitive procurement with community outreach, information sessions, and technical assistance.
- Recruiting and training review panelists and conducting equitable application scoring.
- Selecting potential awardees and completing all required due diligence steps.
- Notifying the Council of procurements and inviting councilmembers and their staff to attend panel deliberations, consistent with standard DCHS practices.
- Issuing award letters, and finalizing scopes of work, goals, and outcome measures with awardees.
- Each procurement shall include continuity of care requirements governing the transition of existing program participants when a provider does not receive continued funding, including warm handoff to a provider that receives ongoing or new support from Bridge, continuity of medication access, and transfer of care coordination. Where a service area is discontinued, DCHS should work with providers coordinate participant transitions to available alternatives.
- Monitoring contract performance and evaluating outcomes to inform future adjustments to contracts and procurements.
- DCHS shall provide meaningful opportunities for current DCHS-contracted service providers to share input, impacts, and feedback on the reporting requirements and identify unintended administrative burdens.
- Contracted service provider reporting requirements should be proportionate to contract size and minimize duplicative data collection to the extent possible.

To the extent allowed by law and County policy, DCHS is encouraged to use flexibility to provide upfront funding to contracted service providers that have previously executed successful contracts, are currently in good standing with DCHS policies, and have a history of appropriate fiscal management practices with County monies, to expedite contracting to established and effective programs.

#### **Updated landscape and population needs assessment**

Prior to procurement of each strategy area, DCHS will review and incorporate the latest information on population needs, policy changes, and updated fiscal information.

#### **Base budget analysis**

About 25 percent of the 2026-2027 MIDD funding for programs is transferred to or managed directly by King County agencies, meaning County departments or offices, other than DCHS. These programs include funding for County employees and community contracts held by other agencies.

Services that are most appropriately or legally required to be implemented by County employees will not be procured by DCHS-managed requests for proposal (RFPs). All investments, whether County-run or contracted service providers, will advance the primary purpose for the Behavioral Health Bridge as described in this Phase 1 Implementation Plan, and will be tied to measurable outcomes that achieve the 13 goals identified in [Section VI](#).

The Executive Office will coordinate with DCHS on base budget analyses for all Bridge-funded programs that are managed or administered by King County agencies outside DCHS.<sup>75</sup> These analyses will assess investments for alignment with overall Behavioral Health Bridge goals, identify efficiencies, and ensure budget amounts are responsive to current needs. Each base budget analysis shall assess, at minimum: alignment with the strategy area goals and anticipated activities; program performance against established measures; availability of alternative funding sources; and whether the current budget amount is responsive to demonstrated need. The Executive shall transmit the results to the Council with the biennial budget in which they are reflected.

#### **Review and crosswalk of existing programs and initiatives**

As noted earlier, several new funding resources have become available during MIDD 2 including new Medicaid benefits such as the reentry initiative which allows Medicaid reimbursement for transition planning and targeted case management for individuals in carceral settings and new county taxes such as the Crisis Care Centers levy. In developing the procurements, DCHS intends to ensure that the County investments are strategically targeted towards bridging the gaps in the behavioral health service continuum and filling gaps in services for populations that are not eligible for other sources of coverage.

### **C. Advisory Committee**

The Behavioral Health Bridge Advisory Committee (AC), known in previous generations of behavioral health sales tax investments as the MIDD AC, is an advisory body to the Executive and Council. AC members are representatives from the health and human services and criminal-legal system communities. The AC ensures that the implementation and evaluation of the strategies and

836 programs funded by the Behavioral Health Bridge sales tax revenue are transparent, accountable,  
837 collaborative and effective.

838

839 Ordinance 16077 established the committee in 2008, and Ordinance 18452 renamed and revised it  
840 for MIDD 2 in 2017.<sup>76,77</sup> Following conversations throughout 2025, the AC agreed that the core  
841 functions of the committee as outlined in Ordinance 18452 remain constant.<sup>78</sup> Proposed legislation  
842 transmitted concurrently with this Phase 1 Implementation Plan updates the name of the  
843 committee from the King County MIDD Advisory Committee to the Behavioral Health Bridge  
844 Advisory Committee, consistent with the broader name change discussed in [Subsection III.C](#). It  
845 also makes other limited technical updates to the Advisory Committee code, including  
846 to rename or clarify the represented sectors to continue to support effective cross-system  
847 engagement.

848

849 The Behavioral Health Bridge Advisory Committee will to maintain its strong commitment to  
850 centering the expertise and lived experience of its members, engaging them as deeply as possible  
851 so they stay well-informed, connected, and meaningfully involved.

## 852 VI. Investments across the five strategy areas

853 This section outlines the identified goals of the five strategy areas for 2028–2034 that form the  
854 foundation of the Behavioral Health Bridge Implementation Plan. For each of the five strategy  
855 areas, this Phase 1 Implementation Plan outlines:

- 856 • the overarching aim of the strategy area; and
- 857 • further description of the specific goals within the strategy area that show the desired  
858 outcomes for potential investments.

859 [Section XI](#) provide logic models for each of the strategy areas to show how Behavioral Health  
860 Bridge investments will drive towards the outcomes and goals for that identified area along with  
861 activities that are anticipated to be procured under each goal area.

862

### 863 A. Care Transitions and Diversion Services (CTD)

864 *Enhance navigation and system coordination to ensure people receive timely,*  
865 *appropriate behavioral health services across all levels of care, divert individuals*  
866 *with behavioral health conditions from criminal-legal involvement to support long-*  
867 *term stability, and provide appropriate services for individuals with behavioral health*  
868 *conditions involved in the legal system.*

### 869 CTD strategy area summary

870 Behavioral health services in King County include a wide array of treatment types and supports for  
871 people across the spectrum of behavioral health needs, and include many services delivered  
872 through community agencies as well as some delivered in the criminal legal (including carceral) or  
873 hospital settings. The treatment system’s size and complexity can create challenges for individuals  
874 attempting to navigate between settings, types, and intensities of care. Fragmentation and siloed  
875 decision-making across care types and the housing, emergency response, and criminal-legal  
876 systems result in inefficiencies, repeated institutional involvement, and preventable harm.<sup>79</sup> Bridge  
877 programs combine supports related to behavioral health, housing stabilization, and reentry in order  
878 to break cycles of homelessness, crisis, and incarceration or hospitalization.<sup>80</sup>

879

880 This strategy area will move the County toward a future state in which progress toward recovery is  
881 not undermined by logistical barriers or administrative siloes. Investments in this area will build on  
882 existing efforts to help people access lower-acuity services before their behavioral health  
883 conditions escalate, divert people from criminal-legal system involvement, support behavioral  
884 health services for those involved in the legal system, and support successful community reentry  
885 after incarceration. This includes addressing intersecting needs (such as but not limited to mental  
886 health conditions, SUD, housing insecurity, and cultural and linguistic barriers) and strengthening  
887 linkages between care settings. Bridge-supported programming should be designed to deter  
888 unnecessary growth in the legal system where diversion is a feasible and suitable alternative.

889

890 King County will pursue three goals in the area of Care Transitions and Diversion Services:

- 891 • Goal 1: Divert people from criminal-legal involvement, provide supportive services for those  
892 involved in the legal system, and support successful community reentry.
- 893 • Goal 2: Help people with behavioral health conditions achieve and maintain stable housing.

- Goal 3: Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.

**Figure 4: Estimated expenditures in the Care Transitions and Diversion strategy area, 2028-2034 (millions of dollars)**

|               | 2028           | 2029          | 2030          | 2031          | 2032          | 2033          | 2034          |
|---------------|----------------|---------------|---------------|---------------|---------------|---------------|---------------|
| <b>Goal 1</b> | \$25.8*        | \$24.0        | \$24.6        | \$25.1        | \$25.7        | \$26.2        | \$26.8        |
| <b>Goal 2</b> | \$5.7*         | \$5.0         | \$5.1         | \$5.3         | \$5.4         | \$5.5         | \$5.7         |
| <b>Goal 3</b> | \$5.2*         | \$3.5         | \$3.6         | \$3.7         | \$3.8         | \$4.2         | \$4.5         |
| <b>Total</b>  | <b>\$36.7*</b> | <b>\$32.5</b> | <b>\$33.3</b> | <b>\$34.1</b> | <b>\$34.9</b> | <b>\$35.9</b> | <b>\$36.9</b> |

<sup>^</sup>The complete financial plan for the Bridge can be found in [Section IX](#). Totals may not sum exactly due to rounding.

<sup>\*</sup>This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CTD programs in 2029.

### **CTD Goal 1: Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.**

A core aim of the behavioral health sales tax since its inception has been to divert individuals with mental health and substance use conditions from costly settings and systems, such as jails, and to help them successfully re-enter society when leaving institutions. These programs and services remain a high priority, and the Behavioral Health Bridge will improve upon existing work by providing services with a focus on coordination and breaking down siloes. Rather than funding programs in isolation, DCHS will strive for care transition services that maintain a cohesive thread of care across diversion, incarceration, and reentry. Rather than intervening separately at discrete moments in a person's journey, programs in this goal area are intended to work together to promote holistic wellbeing and connection to appropriate services, interrupting cycles of incarceration, hospitalization, and crisis.

**Population served:** Services procured under this goal are intended to serve low-income people with behavioral health conditions who are involved in or at risk of becoming involved in the criminal-legal system.

**Anticipated timeline:** Reprocured programs are expected to launch in the first quarter of 2029.

**Figure 5: Funding estimate for CTD Goal 1 (millions of dollars)**

|                               | 2028    | 2029   | 2030   | 2031   | 2032   | 2033   | 2034   |
|-------------------------------|---------|--------|--------|--------|--------|--------|--------|
| <b>Anticipated Activities</b> | \$25.8* | \$24.0 | \$24.6 | \$25.1 | \$25.7 | \$26.2 | \$26.8 |

<sup>\*</sup>This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CTD programs in 2029.

### **CTD Goal 2: Help people with behavioral health conditions achieve and maintain stable housing.**

According to the King County Point in Time Count in 2024, 31 percent of unsheltered people experiencing homelessness have a serious mental illness, and 41 percent have a SUD.<sup>81</sup> Although the Behavioral Health Bridge focuses on behavioral health services, housing that is connected to

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)



behavioral health services is a permissible expenditure under RCW 82.14.460(3).<sup>82</sup> Also, the Executive’s Breaking the Cycle priority recognizes that homelessness, untreated behavioral health needs, and repeated legal-system involvement are interconnected challenges that require urgent, coordinated solutions.<sup>83</sup> Investments in this goal will align with future recommendations from the Breaking the Cycle Workgroup and will provide services and supports at the intersection of housing instability and behavioral health needs.<sup>84</sup>

**Population served:** Services procured under this goal are intended to serve low-income people with behavioral health conditions who are experiencing or at risk of experiencing homelessness or housing instability, or who live in King County-funded permanent supportive housing.

**Anticipated timeline:** Reprocured programs are expected to launch in the first quarter of 2029.

**Figure 6: Funding estimate for CTD Goal 2 (millions of dollars)**

|                               | 2028   | 2029  | 2030  | 2031  | 2032  | 2033  | 2034  |
|-------------------------------|--------|-------|-------|-------|-------|-------|-------|
| <b>Anticipated Activities</b> | \$5.7* | \$5.0 | \$5.1 | \$5.3 | \$5.4 | \$5.5 | \$5.7 |

\*This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CTD programs (in 2029).

### **CTD Goal 3: Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.**

A significant theme from community engagement that informed this renewal proposal was system fragmentation and service coordination. When services fail to communicate or coordinate with each other, people can fall through the cracks, experience delays in care, or receive duplicative or conflicting support. This not only creates gaps in care but also places additional strain on contracted service providers and reduces the overall effectiveness of the system. When services are better connected across clinics, hospitals, community-based organizations, and social service agencies, individuals are more likely to receive comprehensive, continuous, whole-person care. To meet the commitment to whole-person care, investments should be made in services that accommodate the cultural and language preferences of patients, ensuring information is as clear and actionable as possible. Investments in this goal focus on improving coordination and reducing fragmentation to make care more efficient, easier to access, and more responsive to the needs of the people being served. Investments should bridge communication gaps between state-supported Medicaid providers, insurers, and community-based organizations enrolling patients in services and directly administering care. King County will focus on empowering the secure sharing of behavioral health data that best captures whole-person behavioral health treatments and continued patient needs to a range of community-based providers, care navigators, and clinical systems.

#### **Behavioral Health Equity Highlight**

CTD Goal 3 supports the behavioral health equity pillar *Connected and Coordinated*. The administrative burdens of navigating public systems and services worsen inequities.<sup>85</sup> By investing in programs that help all eligible people access the care they are entitled to, the Behavioral Health Bridge alleviates barriers and promotes equity.

**Population served:** Services procured under this goal are intended to serve low-income people with behavioral health conditions and the contracted service providers who work with that population.

**Anticipated timeline:** Reprocured programs are expected to launch in the first quarter of 2029.

**Figure 7: Funding estimate for CTD Goal 3 (millions of dollars)**

|                               | 2028   | 2029  | 2030  | 2031  | 2032  | 2033  | 2034  |
|-------------------------------|--------|-------|-------|-------|-------|-------|-------|
| <b>Anticipated Activities</b> | \$5.2* | \$3.5 | \$3.6 | \$3.7 | \$3.8 | \$4.2 | \$4.5 |

\*This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CTD programs in 2029.

## **B. Substance Use Disorder Treatment and Recovery (SUD)**

*Treat substance use disorders by providing effective, low-barrier services that address people's holistic needs and support sustainable paths to long-term recovery.*

### **SUD strategy area summary**

King County's vision for SUD treatment in the region is to provide timely access to high-quality, evidence-based treatments that support individuals to achieve and sustain recovery. This includes offering peer-based recovery support in tandem with medication, outpatient, inpatient, and residential care. Behavioral Health Bridge sales tax investments will complement and strengthen the existing services of Medicaid, the CCC Levy, and other local and state investments, building upon existing efforts to prevent and treat substance use disorders and help people recover. When procuring services under this strategy area, the County will include people with co-occurring mental health conditions alongside SUD to avoid perpetuating fragmented care.

King County will pursue three goals in the area of Substance Use Disorder Treatment and Recovery:

- Goal 1: Drive engagement and retention in SUD care.
- Goal 2: Provide effective, low-barrier SUD treatment that meets people's holistic needs.
- Goal 3: Support paths to achieve and maintain recovery after treatment.

**Figure 8: Estimated expenditures in the Substance Use Disorder Treatment and Recovery strategy area, 2028-2034 (millions of dollars)**

|               | 2028           | 2029          | 2030          | 2031          | 2032          | 2033          | 2034          |
|---------------|----------------|---------------|---------------|---------------|---------------|---------------|---------------|
| <b>Goal 1</b> | \$1.7*         | \$2.2         | \$2.3         | \$2.4         | \$2.4         | \$2.5         | \$2.5         |
| <b>Goal 2</b> | \$11.0*        | \$12.0        | \$12.9        | \$13.7        | \$14.4        | \$15.1        | \$15.8        |
| <b>Goal 3</b> | \$2.1*         | \$1.6         | \$1.7         | \$1.7         | \$1.8         | \$2.1         | \$2.4         |
| <b>Total</b>  | <b>\$14.9*</b> | <b>\$15.9</b> | <b>\$16.9</b> | <b>\$17.8</b> | <b>\$18.6</b> | <b>\$19.6</b> | <b>\$20.7</b> |

^The complete financial plan for the Bridge can be found in [Section IX](#). Totals may not sum exactly due to rounding.

\*A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised SUD programs in mid-2028.



## SUD Goal 1: Drive engagement and retention in SUD care.

In order to break the cycle of substance use, incarceration, and homelessness, people need accessible paths to treatment. Access to treatment for substance use came up repeatedly during community engagement related to the sales tax renewal. Respondents to BHRD’s 2024 online survey about the behavioral health system named “difficulty understanding where and how to access services” as the leading barrier to accessing behavioral health services. (See Figure 42 in [Appendix B](#).) At listening sessions, participants noted that the County has made progress in improving access to emergency and on-demand services, improving access across geographic regions, and increasing culturally specific outreach. However, they still described problems finding the SUD services they needed, transportation barriers, and insufficient flexibility in appointment times and locations, as well as a desire for more culturally responsive care.

Consistent with the priorities expressed by community and subject matter experts, the next iteration of the behavioral health sales tax will build on existing programs to help people access care when they are struggling with SUD.

**Population served:** Services procured under this goal are intended to serve low-income people with SUD who are not currently connected to treatment, especially those experiencing homelessness.

**Anticipated timeline:** Reprocured programs are expected to launch in the third quarter of 2028.

**Figure 9: Funding estimate for SUD Goal 1 (millions of dollars)**

|                               | 2028   | 2029  | 2030  | 2031  | 2032  | 2033  | 2034  |
|-------------------------------|--------|-------|-------|-------|-------|-------|-------|
| <b>Anticipated Activities</b> | \$1.7* | \$2.2 | \$2.3 | \$2.4 | \$2.4 | \$2.5 | \$2.5 |

\*A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised SUD programs in mid-2028.

## SUD Goal 2: Provide effective, low-barrier SUD treatment that meets people’s holistic needs.

King County’s publicly funded behavioral health treatment system is extensive and funded by a blend of sources, including Medicaid, Medicare, and state and local funds. In 2025, more than 4,400 youth and adults received outpatient SUD services and over 1,750 received residential services for substance use disorder.<sup>86</sup> Over 4,700 people received medication for opioid use disorder (MOUD) from DCHS-contracted providers. The Executive plans to strategically invest Behavioral Health Bridge revenues to ensure SUD services are as effective as possible by sustaining core programs, breaking down barriers to care, and implementing best practices and innovative approaches to treatment.

**Population served:** Services procured under this goal are intended to serve low-income people with SUD who are ready to initiate or have initiated treatment. This goal is also intended to serve people at risk of overdose through overdose prevention, and the broader community through overdose data collection and tracking.

**Anticipated timeline:** Reprocured programs are expected to launch in the third quarter of 2028.

**Figure 10: Funding estimate for SUD Goal 2 (millions of dollars)**

|                               | 2028    | 2029   | 2030   | 2031   | 2032   | 2033   | 2034   |
|-------------------------------|---------|--------|--------|--------|--------|--------|--------|
| <b>Anticipated Activities</b> | \$11.0* | \$12.0 | \$12.9 | \$13.7 | \$14.4 | \$15.1 | \$15.8 |

\*A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised SUD programs in mid-2028.

#### Behavioral Health Equity Highlight

SUD Goal 2 supports the behavioral health equity pillar *Inclusive, collaborative, diverse, and people-focused*. Expanding access to culturally responsive SUD treatment that aligns with individuals' languages, cultures, and lived experiences reduces barriers to care and improves outcomes for historically marginalized communities in King County.

#### SUD Goal 3: Support paths to achieve and maintain recovery after treatment.

The purpose of treatment is to help people achieve recovery, which is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”<sup>87</sup> People in recovery need housing, employment, and social supports to maintain the gains they earned during treatment.<sup>88</sup> In the absence of these supports, vulnerable people often have no choice but to return to unstable living situations where they are surrounded by triggers, making it very likely they will fall back into the cycle of SUD and behavioral health crisis.<sup>89</sup> The Bridge will invest in services and supports that help people achieve and maintain stability after treatment for SUD or co-occurring conditions, increasing the likelihood of lasting recovery and long-term wellbeing.

**Population served:** Services procured under this goal are intended to serve low-income people with SUD who self-identify as being in recovery from SUD, especially those who have recently completed treatment.

**Anticipated timeline:** Reprocured programs are expected to launch in the third quarter of 2028.

**Figure 11: Funding estimate for SUD Goal 3 (millions of dollars)**

|                               | 2028   | 2029  | 2030  | 2031  | 2032  | 2033  | 2034  |
|-------------------------------|--------|-------|-------|-------|-------|-------|-------|
| <b>Anticipated Activities</b> | \$2.1* | \$1.6 | \$1.7 | \$1.7 | \$1.8 | \$2.1 | \$2.4 |

\*A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised SUD programs) in mid-2028.

## C. Equitable Access to Behavioral Health Care (EA)

*Decrease barriers to behavioral health services and increase access to culturally and linguistically responsive care.*

### EA strategy area summary

Equity is a critical dimension of health care quality.<sup>90</sup> To increase the availability, accessibility, and effectiveness of behavioral health care for King County residents, the Executive is prioritizing intentional investments in equitable access for the Behavioral Health Bridge's diverse, high-need, low-income service population. This includes providing behavioral health care for people who are uninsured or underinsured. Immigrants are disproportionately affected by lack of insurance because people with certain immigration statuses are not eligible for Medicaid coverage regardless of income, and the passage of federal bill H.R. 1 in 2025 will further restrict Medicaid access for immigrants beginning in October 2026.<sup>91,92,93</sup> In Washington, an estimated 620,000 people, both immigrants and US-born residents, are expected to be affected by the addition of work requirements in Medicaid in 2027, which can result in loss of coverage if a person is unable to prove their eligibility to the State every six months.<sup>94</sup> The administrative tasks required to stay enrolled in Medicaid may be especially difficult for people with behavioral health conditions.<sup>95</sup> In addition, Behavioral Health Bridge investments in this strategy area will directly address access barriers related to racism, immigration status, sexual orientation, gender identity, trauma history, and geographic location through investments in community-based services that meet people where they are.

King County will pursue two goals in the area of equitable access to behavioral health care:

- Goal 1: Provide behavioral health care for low-income people who are ineligible for Medicaid.
- Goal 2: Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.

**Figure 12: Estimated expenditures in the Equitable Access to Behavioral Health Care strategy area, 2028-2034 (millions of dollars)**

|               | 2028           | 2029          | 2030          | 2031          | 2032          | 2033          | 2034          |
|---------------|----------------|---------------|---------------|---------------|---------------|---------------|---------------|
| <b>Goal 1</b> | \$16.6         | \$16.6        | \$16.6        | \$16.6        | \$16.6        | \$16.6        | \$16.6        |
| <b>Goal 2</b> | \$4.1*         | \$4.2         | \$4.3         | \$4.5         | \$4.6         | \$5.0         | \$5.3         |
| <b>Total</b>  | <b>\$20.7*</b> | <b>\$20.8</b> | <b>\$20.9</b> | <b>\$21.1</b> | <b>\$21.2</b> | <b>\$21.6</b> | <b>\$21.9</b> |

<sup>^</sup>The complete financial plan for the Bridge can be found in [Section IX](#). Totals may not sum exactly due to rounding.

<sup>\*</sup>A portion of this amount funds continues MIDD 2 initiatives, prior to the launch of new and revised programs in this strategy area in mid-2028.

### EA Goal 1: Provide behavioral health care for low-income people who are ineligible for Medicaid.

As MIDD transitions to the Behavioral Health Bridge, the behavioral health sales tax will continue to pay for behavioral health services for low-income uninsured or underinsured King County residents who are ineligible for Medicaid coverage.

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 30

Since its inception, the behavioral health sales tax has provided access to behavioral health treatment services for uninsured, low-income people. Every year since 2008, the tax has served between 3,000 and 4,000 uninsured people with outpatient mental health and substance use treatment services, including immigrants and refugees, and people who are pending Medicaid coverage.

This funding addresses inequities for these populations by enabling them to access safety-net behavioral health treatment that would otherwise be out of reach. Supporting access to low-barrier, preventative treatment services helps keep people from delaying needed treatment and accessing higher levels of care at a later time. The Behavioral Health Bridge will sustain this important program in 2028-2034 to continue supporting treatment equity between people with insurance coverage and those who lack access due to coverage gaps, income, immigration status or other barriers to care (such as transportation or language). In addition, the Executive plans to use the Bridge to pay for translation and interpretation services and connection to cultural responsive healthcare practices for people receiving outpatient treatment through this program who speak a language other than English.

To support accessibility to these vital services, particularly in light of federal funding changes, the County shall invest no less than \$16.6 million annually in EA Goal 1 services from 2028 through 2034.

During a time in which costs of care are outpacing patient ability to afford care, there is a growing population in King County of those who may not meet federal requirements for Medicaid and do not have the financial resources to access essential behavioral healthcare resources. It is crucial to dedicate resources to organizations who are already established as trusted community service providers, or organizations that serve to aggregate direct service access points for patients with a community-based workforce. Local funding for these organizations can support continued care access for people who lose Medicaid and enhance the County's response to the behavioral health needs of individuals who lack access to behavioral healthcare coverage.

**Population served:** Services procured under this goal are intended to serve low-income people with behavioral health conditions who are ineligible for Medicaid.

**Anticipated timeline:** Reprocured programs are expected to launch in the first quarter of 2028.

**Figure 13: Funding estimate for EA Goal 1 (millions of dollars)**

|                               | 2028   | 2029   | 2030   | 2031   | 2032   | 2033   | 2034   |
|-------------------------------|--------|--------|--------|--------|--------|--------|--------|
| <b>Anticipated Activities</b> | \$16.6 | \$16.6 | \$16.6 | \$16.6 | \$16.6 | \$16.6 | \$16.6 |

#### Behavioral Health Equity Highlight

EA Goal 1 supports the behavioral health equity pillar *Accessible and Available*. Expanding timely access to services for people without Medicaid helps ensure that individuals and families across King County can receive the care they need when and where they need it.

## EA Goal 2: Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.

People who are BIPOC, LGBTQIA+, survivors of trauma or domestic, sexual, or gender-based violence, living unsheltered, or living in a rural area are vulnerable to behavioral health inequities caused by structural failures to meet their needs.<sup>96,97,98</sup> Culturally centered organizations design and deliver behavioral health supports by and for the communities they serve. Wellbeing is not one-size-fits-all, and healing and recovery are about much more than clinical medical practices. Healing and recovery also include people feeling a sense of connection to their community and culturally competent healing practices. Partnerships with trusted community organizations are critical for people's recovery journeys.<sup>99</sup> Intentional investment under this goal will directly address inequities in behavioral health outcomes related to race, immigration status, sexual orientation, gender identity, trauma history, and geographic access. DCHS will procure behavioral health treatment and enhanced care navigation for survivors of trauma, domestic, sexual, and gender-based violence. Investments should support organizations that can aggregate de-identified data points across multiple patients, giving the County a more detailed understanding of how patients with a range complex behavioral health care needs present themselves across provider sites over time.

Investments will be made with the recognition that community-based service providers most capable of administering complex, culturally competent care with already-established patient trust may presently lack administrative, compliance or data infrastructure to respond to governmental RFP requirements. Ideally, new investments will make access to Bridge support more accessible to service providers that are closest to community but in need of greater internal administrative support.

**Population served:** Services procured under this goal are intended to serve low-income people with behavioral health conditions who face behavioral health inequities as demonstrated by service and outcomes data, including those who are BIPOC, immigrants or refugees, LGBTQIA+, rural, older adults, or survivors of trauma or domestic, sexual, or gender-based violence.

**Anticipated timeline:** Reprocured programs are expected to launch in the third quarter of 2028.

**Figure 14: Funding estimate for EA Goal 2 (millions of dollars)**

|                               | 2028   | 2029  | 2030  | 2031  | 2032  | 2033  | 2034  |
|-------------------------------|--------|-------|-------|-------|-------|-------|-------|
| <b>Anticipated Activities</b> | \$4.1* | \$4.2 | \$4.3 | \$4.5 | \$4.6 | \$5.0 | \$5.3 |

\*A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised EA programs in mid-2028.

### D. Child, Youth, and Young Adult Mental Wellbeing (CYA)

*Address the youth behavioral health crisis by investing in developmentally tailored services and programs that meet youth where they are.*

#### CYA strategy area summary

King County is committed to providing equitable opportunities for all children to progress through childhood happy, healthy, safe, and thriving.<sup>100</sup> The need to bolster behavioral health services for

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

children, youth, and young adults emerged as a consistent theme across all community engagement. Long before young people reach a behavioral health crisis, they are feeling lonely, disconnected, or bullied – upstream issues that need to be addressed to prevent behavioral health issues down the line.<sup>101</sup> The Behavioral Health Bridge is intentionally designed to invest in areas of unmet need and in services where funding is not currently available or stable, particularly prevention, engagement, early intervention, recovery, and treatment access for individuals who are uninsured or ineligible for Medicaid. By building on family and community strengths, and providing services when youth and families need support, the Bridge will complement other County investments (such as Medicaid, Best Starts, and the CCC Levy) to promote positive behavioral health for King County residents ages zero to 25 and their families.

King County will pursue three goals in the area of child, youth, and young adult mental wellbeing:

- Goal 1: Improve youth access to behavioral health care by providing developmentally appropriate services that meet young people where they are, at school and in community.
- Goal 2: Provide behavioral health and therapeutic services to youth involved in the legal system, including diversion from deeper legal system involvement.
- Goal 3: Invest in the behavioral health of youth who are marginalized or experience inequities.

**Figure 15: Estimated expenditures in the Child, Youth, and Young Adult Mental Wellbeing strategy area, 2028-2034 (millions of dollars)**

|               | 2028           | 2029           | 2030          | 2031          | 2032          | 2033          | 2034          |
|---------------|----------------|----------------|---------------|---------------|---------------|---------------|---------------|
| <b>Goal 1</b> | \$3.5*         | \$4.0*         | \$4.5         | \$4.6         | \$4.7         | \$4.9         | \$5.0         |
| <b>Goal 2</b> | \$5.2*         | \$4.9*         | \$4.7         | \$4.8         | \$5.0         | \$5.1         | \$5.2         |
| <b>Goal 3</b> | \$2.6*         | \$2.8*         | \$3.0         | \$3.1         | \$3.1         | \$3.5         | \$3.8         |
| <b>Total</b>  | <b>\$11.2*</b> | <b>\$11.7*</b> | <b>\$12.2</b> | <b>\$12.5</b> | <b>\$12.8</b> | <b>\$13.4</b> | <b>\$13.9</b> |

<sup>^</sup>The complete financial plan for the Bridge can be found in [Section IX](#). Totals may not sum exactly due to rounding.

<sup>\*</sup>A portion of this amount funds continuing MIDD 2 initiatives, prior to the launch of new and revised programs in this strategy area.

### **CYYA Goal 1: Improve youth access to behavioral health care by providing developmentally appropriate services that meet young people where they are, at school and in community.**

The adopted 2025 Youth Action Plan calls for the County to “co-create and embed behavioral health support in youth development programs, schools, and other community-centered organizations.”<sup>102</sup> To further this aim, investments under this goal will facilitate access to behavioral health care for young people by placing behavioral health supports in places where youth already spend time, such as schools and community locations.

**Population served:** Services procured under this goal are intended to serve youth and young adults with behavioral health symptoms or conditions who would benefit from outpatient care, especially those whose families are low-income.<sup>103</sup>

**Anticipated timeline:** Reprocured programs are expected to launch in the third quarter of 2029.



**Figure 16: Funding estimate for CYYA Goal 1 (millions of dollars)**

|                               | 2028   | 2029   | 2030  | 2031  | 2032  | 2033  | 2034  |
|-------------------------------|--------|--------|-------|-------|-------|-------|-------|
| <b>Anticipated Activities</b> | \$3.5* | \$4.0* | \$4.5 | \$4.6 | \$4.7 | \$4.9 | \$5.0 |

*\*A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CYYA programs in mid-2029.*

**CYYA Goal 2: Provide behavioral health and therapeutic services to youth involved in the legal system, including diversion from deeper legal system involvement.**

Youth involved with the criminal-legal system are some of the most vulnerable members of King County communities and need additional support to break the cycle of behavioral health issues and incarceration. Nationally, an estimated 50 to 70 percent of youth involved in the juvenile legal system meet criteria for at least one psychiatric disorder.<sup>104</sup> In 2025, 2,095 juvenile cases were referred by law enforcement to the King County Prosecuting Attorney's Office.<sup>105</sup> In the first five months of 2026, an average of 31.2 young people were in secure detention at the Clark Children and Family Justice Center, with another 38.5 assigned to Electronic Home Monitoring.<sup>106</sup> Young people involved in the legal system and their families need additional behavioral health support to keep them from becoming trapped in a cycle of incarceration.

**Population served:** Services procured under this goal are intended to serve youth with behavioral health conditions who are involved in or at risk of becoming involved in the criminal-legal system.

**Anticipated timeline:** Reprocured programs are expected to launch in the third quarter of 2029.

**Figure 17: Funding estimate for CYYA Goal 2 (millions of dollars)**

|                               | 2028   | 2029   | 2030  | 2031  | 2032  | 2033  | 2034  |
|-------------------------------|--------|--------|-------|-------|-------|-------|-------|
| <b>Anticipated Activities</b> | \$5.2* | \$4.9* | \$4.7 | \$4.8 | \$5.0 | \$5.1 | \$5.2 |

*\*A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CYYA programs in mid-2029.*

**CYYA Goal 3: Invest in the behavioral health of youth who are marginalized or experience inequities.**

The youth mental health crisis is widespread across King County communities, but not all youth encounter systems of support in the same way. Due to systemic racism and structural exclusion, some groups of young people are less likely to experience behavioral health services as accessible, affirming, culturally grounded, or responsive to their lived experiences. As a result, King County data show differences in mental health, substance use, and suicidality across youth populations, including among LGBTQIA+ youth, Black youth, Indigenous youth, youth of color, immigrant and refugee youth, and youth with complex behavioral health needs. For example:

- In 2025, Washington eighth graders identifying as American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Hispanic/Latino, or LGBTQ+ were more likely than the statewide average to report depressive feelings.<sup>107</sup> In King County in 2025, about half of LGBTQ+ youth in King County experienced depression.<sup>108</sup>
- The rate of emergency department visits related to suicidal ideation among King County Black youth ages eight to 17 climbed every year from 2020 to 2023. Black youth and youth

identifying with multiple races were the only groups without a decline in rates of suicidal ideation-related emergency department visits between 2022 and 2023.<sup>109</sup>

- In 2025, Washington tenth graders identifying as American Indian/Alaska Native, LGBTQ+, or having a disability were more likely than the Washington average to report using alcohol or vape products within the past 30 days.<sup>110</sup>

These differences highlight the importance of approaches that build on youth strengths, reflect community knowledge, and create more meaningful pathways to support.

**Population served:** Services procured under this goal are intended to serve youth with behavioral health conditions who face behavioral health inequities as demonstrated by service and outcomes data, including those who are BIPOC, immigrants or refugees, LGBTQIA+, rural, survivors of trauma or violence, or have complex or co-occurring behavioral health conditions.

**Anticipated timeline:** Reprocured programs are expected to launch in the third quarter of 2029.

**Figure 18: Funding estimate for CYYA Goal 3 (millions of dollars)**

|                               | 2028   | 2029   | 2030  | 2031  | 2032  | 2033  | 2034  |
|-------------------------------|--------|--------|-------|-------|-------|-------|-------|
| <b>Anticipated Activities</b> | \$2.6* | \$2.8* | \$3.0 | \$3.1 | \$3.1 | \$3.5 | \$3.8 |

\*A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CYYA programs in mid-2029.

## E. Behavioral Health Workforce Development (WF)

*Strengthen and diversify the behavioral health workforce to meet growing community needs.*

### WF strategy area summary

It takes people to treat people. A robust, skilled, and diverse workforce is foundational to delivering quality, timely behavioral health care. Nearly every service supported by the Behavioral Health Bridge relies on qualified behavioral health workers in community agencies, and there is a serious shortage of such professionals.<sup>111</sup> In 2025, the King County Integrated Care Network (KCICN) had an overall vacancy rate of nearly 10 percent, equivalent to 414 open positions.<sup>112</sup> Workforce investments are critical to sustaining services in community behavioral health, but are ineligible for payment by Medicaid. In concert with the activities of the CCC Levy to support the crisis workforce and alongside enhanced data collection to ensure that investments are achieving their intended impact, Bridge sales tax investments will provide a much-needed infusion of resources to help more people start and succeed in careers across the continuum of behavioral health care.<sup>113</sup>

King County will pursue two goals in the area of Behavioral Health Workforce Development:

- Goal 1: Strengthen and diversify the behavioral health provider pipeline.
- Goal 2: Advance and develop the skills of the current workforce to meet growing community needs.



**Figure 19: Estimated expenditures in the Behavioral Health Workforce Development strategy area, 2028-2034 (millions of dollars)**

|               | 2028          | 2029         | 2030         | 2031         | 2032         | 2033         | 2034         |
|---------------|---------------|--------------|--------------|--------------|--------------|--------------|--------------|
| <b>Goal 1</b> | \$0           | \$2.5        | \$2.5        | \$2.6        | \$2.7        | \$2.9        | \$3.0        |
| <b>Goal 2</b> | \$1.3*        | \$4.1        | \$4.2        | \$4.4        | \$4.5        | \$4.7        | \$4.9        |
| <b>Total</b>  | <b>\$1.3*</b> | <b>\$6.6</b> | <b>\$6.8</b> | <b>\$7.0</b> | <b>\$7.1</b> | <b>\$7.6</b> | <b>\$8.0</b> |

<sup>^</sup>The complete financial plan for the Bridge can be found in [Section IX](#). Totals may not sum exactly due to rounding.

<sup>\*</sup>This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised WF programs in 2029.

### **WF Goal 1: Strengthen and diversify the behavioral health provider pipeline.**

Community members and subject matter experts who advised the Behavioral Health Bridge renewal reported difficulty accessing care due to a shortage of service providers, especially those from diverse linguistic and cultural backgrounds. This echoes national trends: by 2038, behavioral health workforce shortages are projected to create cascading impacts on service access and availability across the country.<sup>114</sup> A national survey of community behavioral health workers found that fewer than half (42 percent) expected to be at their current practice in five years, and a Washington state survey found that community behavioral health organizations lose 25-60 percent of their clinical workforce every year.<sup>115,116</sup> At KCICN agencies in 2025, the highest number of vacancies were among Master's level mental health counselors, followed by non-peer Registered Agency Affiliated Counselors, who are usually Bachelor's-level case managers or student interns practicing under the agency's license.<sup>117,118</sup> SUD Professional trainees (SUDPTs) also had a very high vacancy rate of 16 percent.<sup>119</sup>

Registered apprenticeships support both workforce expansion and incumbent-worker advancement. National apprenticeship initiatives demonstrate that these programs can reach populations historically underrepresented in apprenticeship while providing structured pathways for existing employees to build skills and advance. Degree-based apprenticeship can further connect paid work-based learning with postsecondary education and college credit, reducing barriers to continued education and career advancement.

DCHS plans to use this data to target investments intended to reduce vacancies and thereby increase service access.<sup>120</sup> In addition, KCICN agencies report wanting to diversify their staff, but struggling to pay competitive wages and to find qualified candidates who speak the languages in greatest demand.<sup>121</sup> To address these issues proactively and prevent continued challenges in people's ability to access behavioral health care, Goal 1 will focus on increasing the number of licensed behavioral health workers in King County and building a more representative provider population. To the degree feasible within available funding, this may include investments in pre-apprenticeship programs, registered apprenticeships, and apprenticeship degree pathways that expand entry into behavioral health careers, support advancement of incumbent workers, and create more accessible pathways for individuals from communities underrepresented in the behavioral health workforce. This goal should create stability and longevity in the workforce, and should include things such as annual contract adjustments that support providers in increasing staff wages to aid recruitment and retention, thus facilitating operational stability.

**Population served:** Services procured under this goal are intended to serve entrants and potential entrants into the behavioral health workforce, as well as people in behavioral health clinical internships, with a focus on increasing the diversity and representativeness of the workforce.

**Anticipated timeline:** Reprocured programs are expected to launch in the first quarter of 2029.

**Figure 20: Funding estimate for WF Goal 1 (millions of dollars)**

|                               | 2028 | 2029  | 2030  | 2031  | 2032  | 2033  | 2034  |
|-------------------------------|------|-------|-------|-------|-------|-------|-------|
| <b>Anticipated Activities</b> | \$0  | \$2.5 | \$2.5 | \$2.6 | \$2.7 | \$2.9 | \$3.0 |

#### Behavioral Health Equity Highlight

WF Goal 1 supports the behavioral health equity pillar *Responsive and Adaptive to Community-Identified Needs*. Community members have consistently shared that they feel more comfortable accessing behavioral health care when service providers reflect the communities they serve. The Executive is responding to this need by investing in a diverse provider pipeline.

### WF Goal 2: Advance and develop the skills of the current workforce to meet growing community needs.

In contrast to private practice, community behavioral health service providers are more likely to see patients with complex and co-occurring disorders or high-acuity needs, who may also be low-income, unhoused, uninsured, or have limited English proficiency. Bridge investments will strengthen the capacity of the behavioral health workforce to meet these needs by supporting education, training, and career development opportunities that build clinical, cultural, linguistic, and interdisciplinary competencies. To the degree feasible within available funding, this may include investments in registered apprenticeships and apprenticeship degree pathways that allow both new and incumbent workers to develop advanced skills, earn recognized credentials and degrees, and progress into higher-skill behavioral health roles while remaining connected to the workforce.

**Population served:** Services procured under this goal are intended to serve the current and future behavioral health workforce of King County's publicly funded community-based behavioral health system.

**Anticipated timeline:** Reprocured programs are expected to launch in the first quarter of 2029.

**Figure 21: Funding estimate for WF Goal 2 (millions of dollars)**

|                               | 2028   | 2029  | 2030  | 2031  | 2032  | 2033  | 2034  |
|-------------------------------|--------|-------|-------|-------|-------|-------|-------|
| <b>Anticipated Activities</b> | \$1.3* | \$4.1 | \$4.2 | \$4.4 | \$4.5 | \$4.7 | \$4.9 |

\*This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised WF programs in 2029.

## 1383 VII. Measurement and evaluation

1384 This section presents the overarching principles and approaches that will guide the evaluation and  
1385 performance measurement of the Behavioral Health Bridge investments. The performance  
1386 measurement and evaluation framework for 2028-2034 continues and builds upon the existing  
1387 framework used by MIDD 2.<sup>122, 123, 124</sup> Consistent with other King County human services initiatives,  
1388 measurement and evaluation for the Behavioral Health Bridge will use the Results Based  
1389 Accountability (RBA) framework, and DCHS plans to work with the Executive Office, other agencies  
1390 and in partnership with contracted service providers to finalize performance measures.<sup>125</sup>

1391  
1392 With the introduction of a new primary purpose and new strategy areas in the Behavioral Health  
1393 Bridge Implementation Plan, the measurement and evaluation approach for the Behavioral Health  
1394 Bridge builds on RBA through the use of logic models in each strategy area that ensure program  
1395 outcomes are designed to achieve the overall goals of each area, as shown in [Section VI](#). Further,  
1396 the use of SMART (specific, measurable, achievable, realistic, time-bound) outcomes for each  
1397 program and strategy are expected to improve understanding of how each program helps drive the  
1398 <sup>126</sup> each strategy area.<sup>127</sup>

### 1399 1400 A. Overarching principles

1401  
1402 The Behavioral Health Bridge evaluation approach is collaborative, transparent, outcomes-driven,  
1403 person-centered, equity-focused, and continuously improving. This approach equips the  
1404 Behavioral Health Bridge with the information needed to understand what works, foster shared  
1405 accountability, and make data-driven decisions across programs.

1406  
1407 **Collaborative:** Performance measurement and evaluation require DCHS, other County agencies,  
1408 the Executive Office, contracted service providers, and Bridge-supported programs to work  
1409 together to identify actionable metrics. In partnership with program staff and contracted service  
1410 providers, King County evaluation staff intend to develop performance measures that facilitate  
1411 strategy-wide impact measurement and capture information meaningful to programs and pertinent  
1412 to community needs. Each program's performance measures will be finalized in performance  
1413 measurement plans that align with the Executive's vision and long-term goals for the Behavioral  
1414 Health Bridge as described in this Phase 1 Implementation Plan. Where relevant, these  
1415 performance measurement plans will coincide with other initiatives and countywide strategic  
1416 plans, such as the Breaking the Cycle Workgroup. For programs that cross multiple County  
1417 agencies, metrics will be developed collaboratively, with the Executive Office facilitating  
1418 consistency and coordination across County agencies.

1419  
1420 **Transparent:** To foster public accountability and transparency, King County regularly shares  
1421 performance measurement and evaluation outcomes, methods, and data sources with the public  
1422 via annual dashboards and biennial reports, which are described further in [Section VIII](#).<sup>128</sup> King  
1423 County evaluation staff will also regularly review data and outcomes with program managers and  
1424 contracted service providers to ensure that information received by King County is accurate,  
1425 reliable, and valid.

1426  
1427 **Outcomes-driven:** Assessment and evaluation of data are essential tools for understanding what  
1428 works, identifying the results of investments, determining whether interventions are effectively

addressing relevant issues, and supporting accountability. Behavioral Health Bridge data collection practices will be outcomes-driven and reflect system-level objectives for each strategy area as described in the logic models throughout this Phase 1 Implementation Plan. Data collection is expected to incorporate quantitative and qualitative data and will include demographic information to ensure service recipients are reflective of the community. Qualitative data will include participant experiences and should be meaningfully incorporated alongside quantitative measures whenever possible. King County staff regularly review data and performance measures to inform program or contract modifications, repurposing of funds, and future procurement of services.

**Person-centered:** Data influences the narrative about the communities from which it is collected and guides policy decisions and resource distribution. King County seeks to present data in ways that move beyond historical deficit-based portrayals. More importantly, King County intends to regularly share data with community for reflection and to ensure data is person-centered, accurate, and grounded in lived experience. This transparency is essential for strengthening accountability, supporting better government, and reinforcing trust. Whenever possible and feasible, King County staff will continue to center the voices of Behavioral Health Bridge program participants to understand and respond to their experiences of what is working and what is not working. By acknowledging systemic barriers and elevating community strengths, resilience, and stamina, King County aims to ensure the data tells a more complete story that supports equitable decision making.

**Equity-focused:** The Executive will deepen the Behavioral Health Bridge's commitment to the principles of equitable evaluation.<sup>129</sup> DCHS will ensure data reflect the communities from which they are gathered and help illuminate how needs, strengths, and outcomes vary across populations in ways that inform policy and resource decisions. During the 2028–2034 implementation period, DCHS intends to specifically expand the visibility of BIPOC communities within data and strengthen their involvement in determining what data are collected and how findings are interpreted. This may include enhancing the ways evaluators disaggregate results by race, ethnicity, and other demographics; developing new data collection methods; continuing to value and report qualitative outcomes; and increasing opportunities for community reflection and feedback on data analysis and results. Together, these approaches are expected to support both stronger accountability to outcomes and a more accurate, community grounded understanding of what is working.

**Continuous improvement:**

DCHS evaluation staff will process data at least quarterly to ensure completeness, accuracy, and timely course correction. Findings will be shared with DCHS staff, County agencies, the Executive Office, and contracted service providers to support evidence-informed decisions that improve program reach, quality, and outcomes. As countywide practices evolve, King County may include Bridge-related metrics in department or cross-department business reviews<sup>130</sup>. The Executive may also establish an Executive-level decision-making forum that reviews data holistically across departments, strengthens measurement practices, and directs coordinated action to improve outcomes and cross-departmental alignment. The Executive Office will lead cross-agency routine review and monitoring, including for programs managed by separately elected agencies. Recommendations from the Breaking the Cycle workgroup are expected to influence performance reporting. DCHS evaluation staff, in collaboration with other County agencies and contracted

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 39

service providers, will also regularly reexamine measurement and evaluation approaches to improve data sources and methodologies and to remain responsive to emerging evaluation challenges and program implementation needs.

## B. Performance measurement and evaluation framework

The Behavioral Health Bridge's performance measurement and evaluation framework is designed to monitor performance, improve quality, generate actionable insights, and inform decision-makers and the public. Measurement and evaluation results give insight into which programs are effective and why, inform operational adjustments, and help hold contracted service providers accountable for the activities they are funded to implement. Monitoring and evaluation will also inform DCHS and Executive Office decisions about budget proposals.

The Behavioral Health Bridge's scale and complexity requires an approach that encompasses a range of measurement techniques. The Bridge's measurement and evaluation framework begins with Results Based Accountability (RBA), a method for assessing the results of strategies, and is supplemented with additional evaluation activities.<sup>131</sup> The resulting framework includes:

- **Performance measurement:** Performance measures will regularly track program outcomes to assess how well an investment or strategy is performing. In addition to measuring operational and contractual expectations of programs and strategies, such as the number of individuals served or activities conducted with Behavioral Health Bridge resources, performance measures will also track whether strategies contained in the Behavioral Health Bridge Implementation Plan are achieving intended outcomes, whether outcomes are equitable, and whether program participants are better off. These indicators will inform deliberations about adjustments to contracts, future procurement, operational direction from the Executive Office, and budget decisions.
- **Population indicators:** The Behavioral Health Bridge will use population indicators to identify needs, understand baseline conditions, and track trends. Population indicators are broad measures of community-level conditions (such as rates of homelessness, emergency department usage, or criminal legal involvement) that reflect the overall well-being of a population rather than the performance of any single program. Because many factors influence population indicators over the long term, changes cannot be attributed specifically or exclusively to Bridge investments. However, tracking these indicators is beneficial in understanding whether the combined efforts of initiatives are impacting regional challenges.
- **In-depth evaluation:** Additional evaluation will complement performance measurement to deepen knowledge of what is effective and inform continuous improvement for specific strategies. This may include assessing new pilot programs, designing new measurement and evaluation tools, and conducting studies of program effectiveness. DCHS may contract with one or more independent organizations or engage in public-private partnerships to conduct in-depth evaluations. Results from in-depth evaluation will inform County decision-making by providing evidence on implementation quality, program mechanisms, and contribution to desired outcomes, and will also strengthen the broader evidence base for effective behavioral health interventions that can be applied in other jurisdictions.



These three approaches are described in more detail in the following subsections.

## Performance measurement

The Behavioral Health Bridge will measure the performance of individual programs or strategies to assess how the program is being implemented and whether it is successfully driving positive outcomes for participants (i.e., “performance accountability”). As appropriate, programs will measure each of the three domains defined by RBA:

1. How much did we do?
2. How well did we do it?
3. Is anyone better off?

Performance measures will vary across programs and strategy areas depending on the population served, type of services, and intended outcomes; these measures can be qualitative, quantitative, or both. To measure outcomes across different investments, performance measurement and evaluation will align with the outcomes and goals identified in the logic models in [Section VI](#) and [Section XI](#). Aligning performance measures under the logic models enables King County evaluation staff to assess how well investments contribute to the shared goals and intended longer-term impact of the Behavioral Health Bridge strategy areas. Each program will have performance measures that assess progress toward the specific program’s intended goals, as well as standard measures that facilitate evaluation of the Behavioral Health Bridge’s collective impact across strategy areas. Example performance measures for programs within the RBA framework are shown below in Figure 22. The examples of “How well did we do it?” and “Is anyone better off?” performance measurement could also be rolled up into a strategy area’s broader goal for long-term impact (such as “reduce overdoses and overdose deaths” or “maintain behavioral healthcare for people transitioning through treatment settings”).

**Figure 22: Example performance measures**

| How much did we do?                                                      | How well did we do it?                                                           | Is anyone better off?                                                                                                        |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
| Number of individuals engaged through outreach                           | Percent of individuals receiving a warm handoff/referral to a treatment provider | Percent of individuals consistently accessing medication for opioid use disorder                                             |
| Number of individuals assessed for diversion from involuntary commitment | Percent of individuals enrolled with an outpatient treatment provider            | Percent of individuals with no involuntary treatment act (ITA) court referrals in the 12 months following program enrollment |

Contracted service providers and County agencies across all strategies and programs will be expected to regularly submit data and information that form the basis of performance measures. The timeline for finalizing and reporting performance measures is expected to be distinct for each program and will depend on contracting and implementation timelines.

For every strategy that is competitively procured, RFPs will include the strategy’s intended goals and system-wide outcomes and associated performance measures. By including this information in RFPs, King County will transparently communicate reporting requirements and expectations based on each investment’s intended impact. These expectations provide clear direction on

priority outcomes and areas where progress must be demonstrated, while still allowing flexibility for program-specific approaches.

During the contract negotiation process, DCHS staff will engage with contracted service providers to finalize a performance measurement plan. The finalized performance measurement plan will capture the unique aspects of each program's model while also adopting standardized measures that support assessment of the Behavioral Health Bridge's collective impact.

County-run programs by other County agencies will similarly collaborate with DCHS to develop performance measurement plans that are aligned with each program's purpose, service model, operational context, and data capacity, with the Executive Office playing a lead role in supporting alignment across County agencies. This coordinated approach is expected to result in specific performance measures and outcomes that track program capacity and outcomes for participants, while also working toward systemic goals across programs with similar functions or intended outcomes. See "Continuous improvement" in the above [Overarching principles](#) section for how this data will feed into decision-making and continuous improvement at the program and system levels.

For programs administered by County agencies outside of DCHS that serve similar populations or pursue the same goal, the Executive Office shall work in partnership with those County agencies and DCHS to establish standardized performance measures that enable comparison across programs. For programs focused on serving people involved in the criminal-legal system, standardized measures should include common measures about the program's impact on reducing involvement in the criminal-legal system over time, in addition to any program-specific measures.

Whenever possible, when reporting on standardized outcome measures, the data should be broken down by Council District in addition to countywide so that the collective impact of Bridge programs can be assessed by geographic area.

## **Data collection**

King County invests heavily in data systems and infrastructure to responsibly collect, manage, and share information, with the goal of making data widely accessible and informative for direct programming and policy decisions. Data collection and reporting to King County is dependent on the type of strategy or program being measured. The format and reporting mechanisms for collecting data will also adapt to available reporting systems and provider capacity. Data will be collected at different intervals, depending on the program or strategy, although information will typically be received by King County following each month or each quarter. Contracted Service providers will submit data and relevant information to King County as required by their contract and/or documented in their performance measurement plans.

Data collection types to be detailed in the performance measurement plan may include:

- **Individual-level data:** Individual-level data is comprised of person-specific demographic information, information about services provided, survey information gathered at regular intervals, program outcomes, and other information.

- **Aggregate-level data:** Aggregate-level data is comprised of high-level summary statistics about program services or participants. This can include counts, totals, and averages reported to King County at regular intervals.
- **Qualitative data:** When appropriate for the program model, qualitative data will be reported by the contracted service provider. Qualitative data may include focus groups, open-ended surveys and questionnaires, and interviews.
- **Narrative reports:** Contracted service providers are expected to submit to King County annual or biannual narrative reports comprised of information about operations, client stories, system change efforts, and other program activities as requested.

The Bridge will also leverage administrative data sources to assess participants' involvement with systems such as jails, psychiatric inpatient hospitals, emergency departments, and crisis services. Data will typically be reported as the change over time in participants' total number of bookings, hospitalizations, emergency department admissions, or crisis episodes in a given period. Long-term outcomes can be measured with administrative data by comparing participant data from a baseline year to the years subsequent to receiving services. As appropriate, outcomes will be assessed by cohort (participants' enrollment year), making it possible to follow a group of participants over time, track consistency in outcomes across cohorts, and increase King County's understanding of the impact of Behavioral Health Bridge programming on participants' interactions with various publicly funded systems. DCHS also shall collect system-level data as appropriate, such as changes to the community behavioral health workforce, including job vacancies, retention and turnover rates, and workforce diversity.

Recommendations from the Breaking the Cycle workgroup are expected to inform improvements to data collection, sharing, and reporting.

In addition, performance measurement plans will capture each program model's unique aspects, while also establishing standardized measures to facilitate measurement of the Behavioral Health Bridge's collective impact across goal areas. This approach aims to minimize the burden of data collection on contracted service providers while ensuring that measurement and evaluation reflect programs' and communities' definitions of progress, and that contracted service providers and County agencies engaged in Bridge-funded work are aligned on reporting requirements. The approach also promotes strategic learning and accountability through transparency and collaboration with contracted service providers and King County.

Performance measurement plans will include key performance measures, types of data collection, reporting cycles, and activities to review the data and support continuous quality improvement. For investments that fund direct behavioral health services to clients, DCHS shall collect and monitor performance measures about individuals served, the nature of services provided, and associated outcomes. Participant-level data about people receiving services may be disaggregated by race, ethnicity, or other demographic characteristics. For investments that do not provide direct services to individuals, but are instead investing in community infrastructure or systems, DCHS shall collect and monitor performance measures such as the number of activities conducted or progress toward milestones. For example, King County staff could assess an investment in capital funding for housing sites by monitoring the number of buildings constructed, facilities opened, or



beds created. DCHS will work with contracted service providers and County agencies to collect individual level data where appropriate and legally allowable.

#### *Disaggregation by demographic characteristics*

To address behavioral health inequities, Behavioral Health Bridge measurement and evaluation methods will measure race, ethnicity, and other demographic characteristics at both the program level and across programs to analyze equity in access, engagement, and outcomes. These analyses will yield critical information to advance the behavioral health equity framework.

#### **Behavioral Health Equity Highlight**

Disaggregation by race and ethnicity supports the behavioral health equity pillar *Transparent and Accountable*. Collecting, analyzing, and reporting data by race and ethnicity increases awareness of disparities, strengthens accountability for equitable outcomes, and informs targeted strategies to address inequities experienced by historically and currently marginalized communities in King County.

#### **Measuring the King County Behavioral Health Bridge’s collective impact**

Whenever possible, each program will include standardized performance measures that are common across all programs with a similar intended outcome within a strategy area. This will make it possible for the County to describe the collective impact of the Behavioral Health Bridge by reporting summarized performance measures for all programs within the same strategy area. The standardized performance measures will be publicly available as part of the Behavioral Health Bridge biennial reporting described further in [Section VIII](#).

To facilitate measurement across DCHS investments, Behavioral Health Bridge performance measurement and reporting will be aligned with other human services funding initiatives, including the CCC Levy, Best Starts, VSHSL, and Health Through Housing. Behavioral Health Bridge performance measurement and reporting will also continue to be integrated into the DCHS dashboard, and particular outcome measures will be aligned with DCHS-wide performance measures and the Executive Office’s performance measurement approach to ensure alignment in reporting. The subsequent subsection “[Aligning performance measurement with other dedicated human services initiatives](#)” describes this in further detail.

Where appropriate, the Executive Office will collaborate with DCHS and other County agencies to elevate data and performance measures as part of a whole-county approach to human services investments and align with countywide initiatives such as recommendations from the Executive’s Breaking the Cycle Workgroup.

#### **Reporting methodology to show geographic distribution by ZIP code**

The ZIP code data on where participants reside has been a staple of behavioral health sales tax reporting to date. During the 2028-2034 implementation period, DCHS shall expand Behavioral Health Bridge reporting to include expenditures by ZIP code for each program or strategy. ZIP code data will be reported using maps or other visualizations to aid interpretation of the data. All reporting by ZIP code will continue to abide by privacy and confidentiality guidelines to ensure individuals cannot be identified.

Beginning with the online dashboard update that reflects 2028 calendar year data and through the 2028-2034 implementation period, the Behavioral Health Bridge evaluation team will report program and strategy expenditures by ZIP code. The methods and dissemination practices for reporting expenditures by ZIP code will be aligned with the approaches implemented in 2023 for Best Starts, 2024 for VSHSL, and 2025 for the CCC Levy. These approaches utilize provider locations *and* participant residences, recognizing that Behavioral Health Bridge partners provide a mix of virtual, mobile, and in-person programs and services. Reporting by contracted service providers' location may not fully capture the reach of services, and alternatively, reporting by participants' residence may not capture the difficulties some participants have in accessing services, including transportation. Many program participants access programs in more than one way. Using this combined methodology to assess expenditures by ZIP code can help deepen understanding of how programs are accessible to people throughout the county.

Collection of program participant ZIP code data may be limited for some programs. The limitations include activities associated with, but not limited to, mobile programs or programs serving people experiencing homelessness, refugees, people experiencing acute behavioral health crisis, or people who are survivors of trauma or domestic, sexual, or gender-based violence. Geographic information may also not be available or relevant for programs and strategies that invest in systems and environment change and strategies that support systemwide capacity building. ZIP code collection may also not be possible for programs that are required to use an existing data system that DCHS cannot revise, or when a legal framework prevents the sharing of these data. All reporting by ZIP code will continue to abide by privacy and confidentiality guidelines. All data collection for the Behavioral Health Bridge is grounded in the principle that data collection should never be a barrier to individuals accessing necessary services.

Whenever possible, when reporting on standardized outcome measures, the data should be broken down by Council District in addition to countywide so that the collective impact of Bridge programs can be assessed by geographic area.

### **Aligning performance measurement with other dedicated human services initiatives**

The health and human services needs of King County residents outstrip the sources of federal, state, and local funding. Revenue from the Behavioral Health Bridge, along with VSHSL, Best Starts, the CCC Levy, and HTH constitute a substantial portion of local human services investments. DCHS staff coordinated planning efforts across these initiatives during the development of this Phase 1 Implementation Plan, as many of these human services funding streams will require renewal during the course of the 2028-2034 implementation period. The overlapping funding renewal timelines offer opportunities to innovate and adapt to emerging community needs over the course of Behavioral Health Bridge implementation.

In response to a 2018 budget proviso, DCHS invested heavily in data systems and infrastructure to responsibly collect, manage, and share information, with the goal to make data widely accessible and to direct programming and policy decisions.<sup>132</sup> These investments have made new data products possible, including dashboards, that provide insight on participants in programs and activities and how they access services, as well as how investments and services are geographically distributed. Using these tools, DCHS collaborates with participants, contracted

service providers, and County staff directly providing services to collect high-quality data, review program performance, and develop and monitor quality improvement initiatives.

In 2022, DCHS released a consolidated dashboard to report data on MIDD, Best Starts, and VSHSL funded services.<sup>133</sup> In 2023, the consolidated dashboard added data for all programs and activities, including those that were federally funded, in the Behavioral Health and Recovery Division and the Developmental Disabilities and Early Childhood Supports Division. In 2025, this dashboard was expanded to include further information from all DCHS divisions. With all of these data sources now represented, the dashboard transparently shares how the department's investments strengthen the communities of King County.

## **Population indicators**

The Behavioral Health Bridge evaluation team will monitor critical population indicators related to behavioral health, disaggregated by demographic characteristics (such as age, race, ethnicity, place, and gender) where data are available. These measures could include countywide metrics such as the size of the adult carceral population with known behavioral health conditions, the rate of overdose fatalities, or the number of behavioral health contracted service providers serving youth. King County measurement of population-level indicators is expected to focus on how they change over time in both size and demographic composition. Where relevant, population-level indicators are intended to align with the Executive Office's performance measurement approach.

While the goal is for Behavioral Health Bridge programs and strategies to work in combination to impact population-level outcomes in the long term, multiple factors influence these measures. Therefore, Behavioral Health Bridge evaluation efforts will not attribute changes in population indicators, positive or negative, to Behavioral Health Bridge investments alone. Population accountability may be tracked and monitored for Behavioral Health Bridge strategy areas, though programs and strategies will be measured on performance accountability.

Population-level measures, such as number of people experiencing behavioral health crisis or the number of people booked into jail are influenced by many extenuating factors (such as state policy, criminal-legal system practices, judicial sentencing alternatives, underlying social and economic factors, broader resource constraints, and more). Except for randomized controlled trial evaluations, which can be cost-prohibitive and often present political, operational, and feasibility challenges, Behavioral Health Bridge monitoring and evaluation will not be able to definitively provide causal evidence that intervention led to population-level outcomes. However, these measures provide crucial information on King County residents and can indicate overall areas for further investment or changes in approach.

## **In-depth evaluation**

Behavioral Health Bridge investments include many programs with existing evidence bases, as well as new, innovative programs or adaptations to evidence-based programs. In-depth evaluation provides an opportunity to inform program decision making and ensure that programs are effective through the combination of qualitative and quantitative data with rigorous, tested methodological approaches. The ability to conduct in-depth evaluations will be different for each program and strategy, depending on the availability of reliable data, sufficient and representative enrollment in programs, and the time needed for data collection and analysis.

Behavioral Health Bridge evaluators intend to prioritize projects for in-depth evaluation as capacity allows in collaboration with program staff and the provider community using the following criteria:

- **High interest from partners, including:** the Executive, King County Council, Behavioral Health Bridge Advisory Committee, community-based organizations, DCHS leadership, grantees, the public, or program participants.
- **High potential to improve equity** by identifying disproportionalities in service access and engagement or improvement in services for historically underserved communities and communities most in need. This includes evaluating how programs contribute to breaking cycles of addiction, homelessness, and incarceration in communities disproportionately affected by the behavioral health, housing, and criminal-legal systems.
- **New programming or novel implementation** of pilot programs, or existing programs in new settings or among different populations, to expand the evidence base for services and effective program adaptations.
- **High-quality data** with sustainable and robust sources of information that enable King County staff to track changes over time.

In-depth evaluation design is expected to be based on what is appropriate for the program's stage of implementation. Design options include, but are not limited to, developmental evaluation, process evaluation, and outcomes evaluation. Examples of in-depth evaluation may include case control or quasi-experimental designs that include resource intensive data collection. To conduct such evaluations for the Behavioral Health Bridge, DCHS may contract with external research partners or engage in public-private partnerships to augment its own data collection, measurement, and evaluation work.

### **Data and evaluation for decision-making**

Data collection and analysis will be used to inform decision-making and continuously improve outcomes. Contracted service providers will be responsible for achieving goals and objectives and DCHS will monitor results to facilitate operational improvements and make adjustments to contracts over time. DCHS will regularly meet with the Executive Office, leaders, analysts and subject matter experts to review investment performance across the Behavioral Health Bridge portfolio and discuss opportunities for system learning and improvement. Performance measurement and evaluation information will inform Executive budget proposals, alongside program context, community need, and other relevant factors, to strengthen services and the overall approach of the Bridge investments.

## VIII. Reporting for continuous improvement and accountability

At the time of plan adoption, DCHS is working to capture, share, and evaluate Behavioral Health Bridge information through a variety of methods that did not exist when the behavioral health sales tax was last renewed. This includes:

- **Consolidated Reporting via DCHS Dashboard:** In response to a 2018 proviso, DCHS developed the capacity to report across programs and funding streams by analyzing large amounts of data from hundreds of contracted service providers without duplicating the counting of participants.<sup>134,135</sup> This effort resulted in the consolidated DCHS Dashboard.<sup>136</sup> While the 2018 proviso asked for reporting on the combined impact of Best Starts, MIDD, and the VSHSL, the DCHS Dashboard also reports on King County residents' participation in services funded by the CCC Levy, the Health Through Housing sales tax, and the KCICN (mostly Medicaid-funded), among other components of the DCHS budget.
- **Behavioral Health Bridge Dashboard:** The Behavioral Health Bridge Dashboard, formerly known as the MIDD Dashboard, portrays data about who participates in Bridge-funded services, where they live and access services, and how those services impact their lives.<sup>137</sup> Offered in an interactive format, the dashboard provides a snapshot across the entire investment portfolio or by strategy area. It also makes it possible for users to focus on the performance of a single program. The dashboard also offers financial information about the Behavioral Health Bridge.
- **Comprehensive Contract Management:** In 2024, DCHS implemented new contract management software, Agiloft, that supports the department's procurement, contracting, and invoicing activities. Agiloft centralizes and standardizes information about DCHS' contracted service providers, including where their brick-and-mortar offices are located. This allows for more complete and consistent reporting of the geographic location of services throughout the region.
- **Enhancements to whole-county monitoring:** Executive Office-led base budget analysis and development of an ongoing monitoring structure in collaboration with DCHS and other County agencies will enhance collaboration and a shared understanding of non-contracted programs. County agencies will continue to participate in standard DCHS-led reporting, with the Executive Office playing a lead role in supporting alignment between County agencies. Results from monitoring will inform both operational adjustments and budget decisions to better achieve intended outcomes.

These advancements will allow for action-oriented reporting using recent data to facilitate continuous improvement and operational adjustments. DCHS and the Executive will offer an annual briefing to Council coinciding with the release of annual dashboard updates to report on Results Based Accountability indicators and planned or implemented improvements.

As part of this comprehensive performance data collection, assessment, and reporting, the Executive will transmit a biennial report to Council detailing the programs and services funded by the Behavioral Health Bridge that will be transmitted no later than August 31 every other year. Each report will focus on data from the prior two calendar years. The first report, to be provided by August 31, 2030, will report on data from calendar years 2028 and 2029. Subsequent biennial reports will be provided by August 31, 2032, and August 31, 2034. The Advisory Committee

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 48



described in this Phase 1 Implementation Plan will review and provide guidance on the biennial reports. The Executive will make the reports available widely to the Council, the Regional Policy Committee, and the community through DCHS' communication channels.<sup>138</sup>

Biennial reports about the Behavioral Health Bridge will include the following:

- An overview of Behavioral Health Bridge accomplishments during the previous two calendar years, and a description of continuous improvement changes that have been implemented based on performance results, as well as planned operational adjustments to improve performance when applicable;
- The Behavioral Health Bridge fund's fiscal and performance management during the applicable calendar years;
- The expenditure of Behavioral Health Bridge proceeds by strategy area by ZIP code in King County as described in [Subsection VII.B.](#);
- The expenditure of Behavioral Health Bridge proceeds by strategy area by ZIP code in King County as described in The number of participants receiving Behavioral Health Bridge-supported services by strategy area by ZIP code where the individuals reside at the time of service as described in [Subsection VII.B.](#);
- A map or summary describing the Behavioral Health Bridge's geographic distribution, including by Council District;
- Reporting on standardized outcome measures by Council District, whenever possible, so the collective impact of Bridge activities can be assessed by strategy area and across the county; and
- Summaries of findings from in-depth evaluations related to Behavioral Health Bridge programs, and actions taken or planned based on those findings in years where such findings are available.

The Executive will accompany each biennial report with a motion acknowledging receipt of the report. The Executive will be prepared to brief the King County Council or its committees, including the Regional Policy Committee, on the biennial report to inform the Council's consideration of this motion.

Starting in 2031, in each year a biennial report is not transmitted to Council, the Executive shall transmit an abbreviated annual update on Behavioral Health Bridge activities summarizing the following:

1. Expenditures by strategy area,
2. Number of individuals served by strategy area,
3. Relevant outcomes by strategy area, and
4. Notable financial information including:
  - a. Any substantial adjustments made to the financial plan,
  - b. The calculation of any undesignated fund balance or underspend, the amount identified, and
  - c. Any activities paid for with those monies.

During the procurement process from 2027-2029, the Executive shall transmit the Phase 2 Implementation Plan in accordance with [Section XI](#), including all pre-procurement development plans.

## 1900 IX. Financial plan and policies

### 1901 A. Overview

1902

1903 This section describes the plans and policies for Behavioral Health Bridge revenues and  
1904 expenditures for the period of 2028-2034 based on current available information. The financial plan  
1905 in this section includes a sustainability reserve to mitigate a projected reduction in 2029 behavioral  
1906 health sales tax revenues and assumes most economic adjustments for contracted service  
1907 providers are maintained through 2034.

1908

1909 Beginning on January 1, 2029, many products and services will become exempt from sales tax in  
1910 Washington State, including diapers, hygiene products, over-the-counter medications, information  
1911 technology services, software, security and safety, temporary staffing services, and live  
1912 performances, as a result of changes made during the 2026 state legislative session.<sup>139</sup> These  
1913 reductions in the sales tax base have a direct impact on the Behavioral Health Bridge, decreasing  
1914 projected sales tax revenue by 3.55 percent between 2028 and 2029.<sup>140</sup> At the same time, as  
1915 discussed in [Section X](#), DCHS' inflation policy is designed to ensure, whenever possible, that  
1916 County funding for human services programs keeps up with the rising costs to deliver services.<sup>141</sup>

1917

1918 The financial plan shown in Figure 23 represents the best available estimates of projected revenue  
1919 and planned expenditures at the time of plan adoption. However, during the 2028-2034  
1920 implementation period, multiple factors could potentially drive changes to Bridge spending:

- 1921 • **The Executive's Breaking the Cycle Workgroup** will provide recommendations that may  
1922 influence the way collaboration works across and within programs.<sup>142</sup>
- 1923 • **The competitive procurement process** may identify organizations with different  
1924 approaches to achieving Bridge goals.
- 1925 • **A continuous focus on shifting Bridge costs to Medicaid or other County funds such as**  
1926 **but not limited to the CCC Levy, Best Starts, or VSHSL that may have closer alignment**  
1927 **with the program goal.** This may mean up-front investment of Behavioral Health Bridge  
1928 funds to sustain services but potential reallocation of funding over time as Medicaid  
1929 replaces local dollars or funds are shifted between levies.
- 1930 • **Federal changes to Medicaid** may require the Bridge to shift to support populations and  
1931 services that are no longer eligible for Medicaid reimbursement.<sup>143</sup>
- 1932 • **Base budget analyses for all programs** are expected to right-size programs in other  
1933 County agencies and reveal opportunities for better collaboration.<sup>144</sup>
- 1934 • **Rigorous performance measurement of contracts** is expected to drive future investment  
1935 decisions.
- 1936 • **Performance and outcome monitoring systems** will inform decisions about investments  
1937 with a focus on real results for people, as described in [Section VII](#).
- 1938 • As a **sales tax levy**, Behavioral Health Bridge revenues can be volatile and fluctuations in  
1939 revenue projections may drive budget adjustments. Specific investment amounts will  
1940 depend on fund availability at the time of procurement.

1941

1942 As a result, the Behavioral Health Bridge Implementation Plan includes processes for adapting  
1943 Behavioral Health Bridge expenditures to these or other changing conditions. Policies relating to  
1944 the processes for adjusting sales tax allocations, allocating undesignated fund balance, and  
1945 implementing the DCHS inflation policy can be found in [Subsection IX.C.](#) and [Section X](#).

1946  
1947  
1948  
1949

## B. Financial plan

**Figure 23: Anticipated Behavioral Health Bridge Sales Tax Revenues and Expenditures 2028-2034 (in millions)\***

|                                                                           |                |                |                |                |                |                |                |                |
|---------------------------------------------------------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
| <b>Projected Beginning Fund Balance</b>                                   | <b>\$19.5</b>  | <b>\$23.4</b>  | <b>\$20.4</b>  | <b>\$19.0</b>  | <b>\$18.8</b>  | <b>\$19.2</b>  | <b>\$19.8</b>  |                |
| <b>Behavioral Health Bridge Sales Tax Projected Revenue (2028 - 2034)</b> |                |                |                |                |                |                |                |                |
|                                                                           | <b>2028</b>    | <b>2029</b>    | <b>2030</b>    | <b>2031</b>    | <b>2032</b>    | <b>2033</b>    | <b>2034</b>    | <b>Total</b>   |
| <b>Projected Sales Tax Revenue</b>                                        | \$107.6        | \$103.7        | \$108.7        | \$112.9        | \$116.2        | \$120.5        | \$124.2        | <b>\$793.8</b> |
| <b>Projected Annual Interest</b>                                          | \$0.7          | \$0.8          | \$0.7          | \$0.6          | \$0.6          | \$0.6          | \$0.7          | <b>\$4.8</b>   |
| <b>Total Revenue</b>                                                      | <b>\$108.3</b> | <b>\$104.5</b> | <b>\$109.4</b> | <b>\$113.6</b> | <b>\$116.8</b> | <b>\$121.2</b> | <b>\$124.8</b> | <b>\$798.6</b> |

|                                                                                            |             |             |             |             |             |             |             |                |
|--------------------------------------------------------------------------------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|----------------|
| <b>Behavioral Health Bridge Sales Tax Approximate Allocation by Strategy (2028 - 2034)</b> |             |             |             |             |             |             |             |                |
|                                                                                            | <b>2028</b> | <b>2029</b> | <b>2030</b> | <b>2031</b> | <b>2032</b> | <b>2033</b> | <b>2034</b> | <b>Total</b>   |
| <b>Strategy Area 1: Care Transitions and Diversion Services</b>                            | \$36.7      | \$32.5      | \$33.3      | \$34.1      | \$34.9      | \$35.9      | \$36.9      | <b>\$244.4</b> |
| <b>Strategy Area 2: SUD Treatment and Recovery</b>                                         | \$14.9      | \$15.9      | \$16.9      | \$17.8      | \$18.6      | \$19.6      | \$20.7      | <b>\$124.4</b> |
| <b>Strategy Area 3: Equitable Access to Behavioral Health Care</b>                         | \$20.7      | \$20.8      | \$20.9      | \$21.1      | \$21.2      | \$21.6      | \$21.9      | <b>\$148.2</b> |
| <b>Strategy Area 4: Child, Youth, and Young Adult Mental Wellbeing</b>                     | \$11.2      | \$11.7      | \$12.2      | \$12.5      | \$12.8      | \$13.4      | \$13.9      | <b>\$87.8</b>  |
| <b>Strategy Area 5: Behavioral Health</b>                                                  | \$1.3       | \$6.6       | \$6.8       | \$7.0       | \$7.1       | \$7.6       | \$8.0       | <b>\$44.3</b>  |



|                                                       |                |                |                |                |                |                |                |                |
|-------------------------------------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
| <b>Workforce Development</b>                          |                |                |                |                |                |                |                |                |
| <b>Technical Assistance &amp; Capacity Building</b>   | \$0.5          | \$0.5          | \$0.5          | \$0.6          | \$0.6          | \$0.6          | \$0.60         | <b>\$4.0</b>   |
| <b>Administration &amp; Compliance</b>                | \$8.5          | \$8.8          | \$9.0          | \$9.3          | \$9.5          | \$9.7          | \$9.9          | <b>\$64.8</b>  |
| <b>Performance Measurement &amp; Evaluation</b>       | \$2.5          | \$2.6          | \$2.7          | \$2.7          | \$2.8          | \$2.9          | \$2.9          | <b>\$19.0</b>  |
| <b>Behavioral Health Fund Transfer:</b>               | \$8.0          | \$8.3          | \$8.5          | \$8.7          | \$9.0          | \$9.2          | \$9.4          | <b>\$60.9</b>  |
| <b>Total Behavioral Health Bridge Sales Tax Costs</b> | <b>\$104.4</b> | <b>\$107.5</b> | <b>\$110.8</b> | <b>\$113.8</b> | <b>\$116.5</b> | <b>\$120.5</b> | <b>\$124.2</b> | <b>\$797.7</b> |
| <b>Ending Fund Balance</b>                            | <b>\$23.4</b>  | <b>\$20.4</b>  | <b>\$19.0</b>  | <b>\$18.8</b>  | <b>\$19.2</b>  | <b>\$19.8</b>  | <b>\$20.4</b>  |                |
| <b>Rainy Day Reserve (60 Days of Expenditure)</b>     | \$17.2         | \$17.7         | \$18.2         | \$18.7         | \$19.1         | \$19.8         | \$20.4         |                |
| <b>Long-Term Sales Tax Sustainability Reserve</b>     | \$6.3          | \$2.7          | \$0.8          | \$0.1          | \$0            | \$0            | \$0            |                |
| <b>Undesignated Fund Balance/Reserve Shortfall</b>    | <b>\$0</b>     | <b>\$0</b>     | <b>\$0</b>     | <b>\$0</b>     | <b>\$0</b>     | <b>\$0</b>     | <b>\$0</b>     |                |

1950  
1951      *\*Totals may not sum exactly due to rounding.*

## Allocations across the five strategy areas

Figure 23 depicts how Behavioral Health Bridge revenues will be allocated annually across the five strategy areas. Detailed descriptions of goals, intended outcomes and anticipated expenditures within each area can be found in the following subsections:

- [VI.A. Care Transitions and Diversion Services](#) and [XI.E. Logic Model and Anticipated Activities](#)
- [VI.B. Substance Use Disorder Treatment and Recovery](#) and [XI.F. Logic Model and Anticipated Activities](#)
- [VI.C. Equitable Access to Behavioral Health Care](#) and [XI.G. Logic Model and Anticipated Activities](#)
- [VI.D. Child, Youth, and Young Adult Mental Wellbeing](#) and [XI.H. Logic Model and Anticipated Activities](#)
- [VI.E. Behavioral Health Workforce Development](#) and [XI.I. Logic Model and Anticipated Activities](#)

Figure 23 also reflects changes to funding amounts in 2028 and 2029 due to the phased procurement and base budget analyses scheduled to take place during those years, as described in [Subsection V.B.](#) Increases and decreases in strategy area spending in the first two years reflect phased procurement and reprioritization of investments as the Executive works to rebalance the Behavioral Health Bridge portfolio to focus on the most pressing needs for King County's publicly funded behavioral health system. Some reductions also reflect plans to move investments to other fund sources. The estimated expenditures for each strategy area are projections based on current information.

## Technical assistance and capacity building

For the first time, beginning in 2028 the Behavioral Health Bridge will provide funding for technical assistance and capacity building activities to support the implementation of the goals described in the Behavioral Health Bridge Implementation Plan. Through investments like the Bridge, DCHS strives to partner with organizations that serve, and are led by, their own communities. Community-led organizations are best positioned to implement programs that will have positive impacts on the members of their communities. DCHS recognizes that many organizations, and the communities they serve, have historically experienced barriers to accessing funding opportunities from government agencies such as King County. Technical assistance is intended to meet organizations where they are and to support them in understanding King County's contract requirements and assist them in developing capacity to manage public funds.

The Bridge will provide funding for technical assistance and capacity building activities to support the implementation of the goals described in this Phase 1 Implementation Plan. After contracts are awarded, technical assistance and capacity building offer provision and co-creation of information, tools, and resources to strengthen the infrastructure of those community-led organizations selected to provide contracted services, particularly in areas of fiscal management, documentation, and reporting, as well as opportunities for areas with service gaps to build capacity. DCHS will set aside 0.5 percent of revenues toward these activities.

1995 To the degree funding is available, technical assistance should be made available to prospective  
1996 applicants before and during each procurement window on the same basis as other County  
1997 procurement processes, in addition to post-award technical assistance and capacity building.

#### 1998 **Administration and compliance**

1999 The Behavioral Health Bridge will increase the proportion of funds supporting administrative  
2000 functions in 2028-2034. DCHS is working to enhance its fiscal controls and contract management  
2001 in response to the results of a 2025 audit.<sup>145, 146</sup> This process requires additional staff to ensure  
2002 enough resources are in place for proper contract monitoring and quality assurance. The level of  
2003 administrative funding reflected in the financial plan (Figure 23) will better support DCHS to  
2004 conduct all required contract monitoring and fraud prevention activities for Behavioral Health  
2005 Bridge programs, as well as program development, procurements and continuous quality  
2006 improvement.

#### 2007 **Performance measurement and evaluation**

2008 The Behavioral Health Bridge increases the proportion of funds allocated to measurement and  
2009 evaluation in 2028-2034. These investments fund a team of skilled staff, the development and  
2010 maintenance of robust data systems, assessment and analysis of Behavioral Health Bridge  
2011 programs, and partnerships with external evaluators and subject matter experts, such as the  
2012 University of Washington's Institute for Health Metrics and Evaluation. Third-party evaluation  
2013 should be done every three years, as existing resources allow. With this investment, the Executive  
2014 intends to develop insights that enable contracted service providers, communities, and  
2015 policymakers to make data-informed decisions and engage in continuous quality improvement  
2016 efforts. More information about the performance measurement and accountability strategies for  
2017 the next iteration of the Behavioral Health Bridge is in [Section VII](#).

#### 2018 **Behavioral Health Fund transfer**

2019 The Behavioral Health Bridge maintains a similar level of funding as MIDD 2 for a transfer to the  
2020 Behavioral Health Fund. King County operates a unique behavioral health delivery system  
2021 incorporating a public-private partnership for delivering community behavioral health care, a  
2022 nation-leading crisis care system, and innovative local services to provide access to care  
2023 regardless of insurance or immigration status. A key component is the Behavioral Health Fund,  
2024 which collects and redistributes dollars that underwrite King County's ability to administer the  
2025 complex behavioral health system, which leverages over 140 funding sources to develop and  
2026 sustain life-saving community-based programs. The behavioral health sales tax has supported the  
2027 Behavioral Health Fund with a transfer of resources since 2021. This strategic resource supports  
2028 BHRD's organizational infrastructure and ability to continue administering and monitoring  
2029 Behavioral Health Bridge programs and the broader behavioral health treatment and support  
2030 system. It also ensures that King County can continue to deliver on its promise of a diverse and  
2031 high-quality network that is widely available to meet residents' expectations and needs.

#### 2032 **Sustainability reserve**

2033 The state law changes decreasing the number of products and services subject to sales tax  
2034 described earlier in this section require a new mechanism to ensure program stability in the  
2035 Behavioral Health Bridge. In order to maintain program commitments despite an abrupt decrease  
2036 in projected sales tax revenue in 2029, the financial plan in Figure 23 includes a sustainability  
2037 reserve. This sets aside money in 2028 to be spent down slowly through 2031. This is in addition to

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 54

the rainy-day reserve called for by the County’s comprehensive financial management policies and is expected to enable the County to sustain Bridge-funded programs despite volatile revenue.<sup>147</sup> The sustainability reserve is not intended to be an undesignated fund balance. Reappropriating it to fund programs and services in the short term would create significant reserve shortfalls for the remaining six years of the 2028-2034 Behavioral Health Bridge planning period.

### **C. Fiscal policies**

This subsection describes policies for making and communicating about substantial adjustments to Behavioral Health Bridge expenditures, and priorities for allocating undesignated fund balance.

#### **Process for making substantial adjustments to the financial plans**

This part of this subsection describes the process of communicating and making substantial adjustments to the Bridge’s financial plan, which is consistent with the change process for the HTH sales tax and VSHSL, CCC, and Best Starts levies. A substantial adjustment is a change or series of changes to a strategy area’s annual funding allocation by the greater of ten percent or \$500,000 within a 24-month period, or would have the effect of eliminating an existing activity, or redesigning an activity that substantially changes the population served or eligibility for service.<sup>148</sup>

A change is not considered a substantial adjustment if it is due to additional Behavioral Health Bridge sales tax revenue or other funding sources becoming available. In this scenario, the additional sales tax revenue should be allocated according to the priorities described in the next subsection and cannot reduce another strategy area’s allocation. In addition, behavioral health sales tax proceeds that are not spent within a strategy area may be retained within the same strategy area for use in a subsequent year without being considered a substantial adjustment for the purpose of the Behavioral Health Bridge Implementation Plan.

Substantial adjustments to the financial plan will be communicated according to the process defined in this subsection, and whenever feasible, such modifications shall incorporate briefings to the Behavioral Health Bridge Advisory Committee to allow committee members to review and provide guidance on the changes. If, without Council direction or concurrence, the Executive determines a substantial adjustment to the funding allocations specified in the financial plan is needed, the Executive will transmit a notification letter to Council detailing the scope of and rationale for the changes. The Executive may only send 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 Health, Housing, and Human Services Committee, 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 allocating ending undesignated fund balance**

This part of this subsection describes the process for prioritizing allocations of ending undesignated fund balance on the financial plan. Ending undesignated fund balance may result from circumstances such as, but not limited to, Behavioral Health Bridge revenue exceeding revenue projections or Bridge revenue becoming available because other funding sources

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 55

(including federal, state, or philanthropic sources) are contributing funding toward Bridge strategy areas and goals at a higher level than anticipated. Expenditures of Behavioral Health Bridge revenues allocated through this prioritization remain subject to the appropriation limits authorized through the County’s budget process. Any proposals requiring additional appropriation will be proposed by the Executive in budget ordinances and be subject to County Council deliberation and adoption. The Executive will assess whether ending undesignated fund balance is the result of one-time fund availability or represents an opportunity for long-term, sustainable investment.

In the event of an ending undesignated fund balance, whether determined to be one-time or long-term in nature, 1% shall be used to support a councilmanic innovation and small grant program. The Executive shall notify Council of the availability of funds on an annual basis. The Council shall provide an equal amount of funding to each Council District office to allocate to emerging needs or Council District-specific pilot programs. Programs that receive Bridge support shall meet the requirements of RCW 82.14.460(3) and execute a service provider contract.

The Executive shall apply the following priorities to allocate undesignated fund balance when the Executive determines that it represents an opportunity for long-term, sustainable investment:

1. In any year where inflation rates have been reduced due to limited funding availability, provide inflationary adjustments to contracted service providers up to the amount of CPI-U Seattle inflation rates.
2. Augment existing investments to mitigate losses of Medicaid coverage to the degree necessary and feasible within available funds. This includes increasing funding to EA Goal 1, “Provide behavioral health care for low-income people who are ineligible for Medicaid.” It may also include increasing investment in other programs negatively affected by growth of the uninsured rate among the Behavioral Health Bridge’s service population.
3. Scale high-performing or innovative Behavioral Health Bridge investments to address unmet need. The investments to be augmented shall be selected through a process that includes Behavioral Health Bridge Advisory Committee consultation and is guided by performance and measurement data.

When the Executive determines there are moneys in the ending undesignated fund balance that are one-time in nature and cannot reasonably support sustained programming, the Executive shall use these moneys for one-time investments, including capital projects such as building behavioral health facilities or housing for people with behavioral health conditions, or for pilot programs that can later transition to other funding sources such as Medicaid. When using these one-time moneys for capital investments, the Executive shall expend these moneys consistent with existing Behavioral Health Bridge goals or activities or shall obtain appropriation authority before expending or encumbering these one-time Bridge moneys.

[Section X](#) below describes strategies that would be applied to the Bridge fund if a deficit or reserve shortfall occurs when planned expenditures exceed available revenue. (See [Subsection X.C.](#))

## 2124 **X. Inflation rate adjustment policy analysis**

2125 This section responds to Ordinance 20023, Section 70, Proviso P1. It examines how the DCHS  
2126 Inflation Rate Adjustment Policy was determined to apply to the Behavioral Health Bridge fund,  
2127 evaluating the financial impact of applying inflationary adjustments that exceed projected revenue  
2128 growth, and assessing whether this dynamic contributes to a structural gap in the fund.<sup>149</sup> The parts  
2129 of this subsection below address each of these questions by describing the policy rationale,  
2130 analyzing the relationship between expenditure growth and revenue projections, and exploring the  
2131 long-term implications for fund stability.

2132

### 2133 **A. How the inflation policy was determined to be applicable to the King County** 2134 **Behavioral Health Bridge**

2135 DCHS adopted the Inflation Rate Adjustment Policy for Human Services Contracts on September  
2136 1, 2024.<sup>150</sup> Developed in response to Council interest expressed in a 2021 budget proviso, the  
2137 policy's intent is to promote contract payments that increase with the rate of inflation by directing  
2138 inflation rate adjustments to be applied to all local investments in DCHS human services  
2139 contracts.<sup>151</sup> The application of this policy across local human services funds is important because  
2140 when contract payments do not increase amidst growth in operating costs and living expenses,  
2141 service providers struggle to maintain service levels or to provide living wages to their employees.

2142

2143 The policy directs DCHS to integrate inflation rate adjustments into biennial budget proposals,  
2144 financial plans, and implementation plans when proposed to the Executive and King County  
2145 Council. When Council adoption of these plans allows, DCHS shall implement inflation rate  
2146 adjustments in relevant and applicable program contracts. However, consistent with the policy,  
2147 DCHS plans to implement inflation rate increases only to the degree possible while maintaining  
2148 healthy financial reserves consistent with King County Comprehensive Financial Management  
2149 Policies.<sup>152</sup>

2150

2151 The policy applies to local funding sources managed by DCHS because these funds are under  
2152 greater local control. These sources include both more volatile sales tax sources such as, but not  
2153 limited to, the Behavioral Health Bridge, and less volatile property tax levy sources. As a result, the  
2154 County can design spending plans through implementation plans and budgets that incorporate  
2155 appropriate inflationary adjustments that respond to contracted service providers' need to  
2156 maintain services.

2157

### 2158 **B. Analysis of the effect of the inflation rate adjustment policy on the Behavioral** 2159 **Health Bridge and risk of a structural gap**

2160 The inflation rate adjustment policy calls for the Behavioral Health Bridge to incorporate inflation  
2161 factors based on King County's Budget and Financial Planning Assumptions (BFPA).<sup>153</sup> The  
2162 Behavioral Health Bridge fund's projected long-term revenue grows at an average of 2.6 percent per  
2163 year, according to 2026 OEFA data.<sup>154</sup> Because this growth rate falls below typical BFPA provider  
2164 inflation assumptions, the policy has a structural impact on the fund's long-range sustainability.

2165

2166 During the 2028-2034 implementation period, the Behavioral Health Bridge is expected to continue  
2167 reflecting inflation adjustments for contracted behavioral health program services, tracking the  
2168 CPI-U Seattle BFPA inflation rate. If CPI-U inflation assumptions continue to track near the current  
2169 range (generally between three and four percent), Behavioral Health Bridge expenditure growth

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 57



would outpace revenue growth. Continuing to provide inflation rate increases at a higher rate than sales tax revenue creates a risk of a structural operating gap in the outyears of the 2028-2034 implementation period, independent of one-time factors such as beginning fund balance or temporary underspending. Both the inflation policy and the County budget process provide mechanisms to identify these trends and take mitigating actions through fiscal monitoring and appropriation processes.

The inflation rate policy itself does not appropriate funds. It is instead a vehicle for DCHS to propose inflation rate increases to the Executive and the Council for consideration. While the policy directs DCHS to implement the inflation rate increases once they have been adopted by Council, it also includes administrative provisions allowing for the department to delay or suspend the increases in the following circumstances:

- Inflation rate increases will not be implemented until appropriate reserves have been achieved.<sup>155</sup>
- When the King County Office of Economic and Financial Analysis (OEFA) revenue forecasts for a fund source project a decline in fund balance compared to the revenue forecasts used in the adopted budget for that fiscal year, inflation rate increases may be suspended or reduced. Adjustments will resume when positive revenue growth is reflected in the revenue forecasts underlying the adopted budget.<sup>156</sup>

A structural gap is based on the relationship between recurring revenues and recurring expenditures, not on whether the fund has enough cash on hand in any given year. Despite the risks, DCHS is not projecting a structural gap in the Behavioral Health Bridge from 2028 through 2034. However, if inflationary adjustments were included at CPI-U Seattle BFPA rates every year, the fund would be at risk of not having enough cash to cover expenses after 2028. As a result, maintaining the 2028 service portfolio through 2034 requires temporary changes regarding inflation adjustments in 2029. The steps DCHS will take to mitigate this risk are described in the following subsection.

### **C. Process for mitigating fund shortfalls or structural gaps**

The financial plan in Figure 23 provides for adequate Behavioral Health Bridge dollars to continue funding critical services throughout the 2028-2034 implementation period despite volatility in revenue. To do this while maintaining 60-day operating reserves, the Behavioral Health Bridge Implementation Plan provides lower inflation adjustments to eligible contracted service providers with continuing contracts in 2029, the same year as a projected 3.55 percent decrease in sales tax revenues (as shown in Figure 24 below). This is consistent with the inflation policy, which allows for inflation rate adjustments when revenue forecasts anticipate a decline in underlying revenues.<sup>157</sup>

Inflation adjustments are not applicable at the start of new contracts, which are calculated as new base budgets. Because phased implementation will take place throughout 2028 and 2029, some contracted service providers operating existing programs will be eligible for adjustments in 2028 in the final year of their MIDD 2 contracts, while others will be eligible in 2029 in the second year of their new Behavioral Health Bridge contracts. By 2030, contracted service providers of new or revised Bridge programs are expected to be in their second or third year, and eligible contracted service providers are expected to receive an inflation adjustment. These adjustments are included in the expenditures projected in the financial plan (Figure 23 above).

The financial projections included in this and other multi-year implementation plans are likely to change over the course of their planning periods. In order to account for this uncertainty, the DCHS inflation policy calls for the financial outlook of the fund to be reviewed annually to confirm funding availability. DCHS most recently completed this review for MIDD in 2025 and determined that behavioral health sales tax funds could be made available to continue inflationary adjustments for 2026 and 2027. The inflationary adjustments were reviewed by the Executive Office, included in the 2026-2027 Executive Proposed budget, and adopted by the County Council through the budget. DCHS will reevaluate and confirm 2027 inflation adjustments in late 2026 and to continue these annual reviews throughout the 2028-2034 implementation period. Each biennial budget process will include an assessment of whether inflationary adjustments can be afforded based on the most recent revenue and expenditure forecasts for the Bridge fund. The budget process provides the Executive Office and Council an opportunity to evaluate, adjust if necessary, and approve any inflationary adjustment budget proposal.

**Figure 24: Projected inflation adjustments for Behavioral Health Bridge contracted service providers, 2028-2034**

| Year | Projected CPI-U Seattle BFPa inflation factor <sup>158</sup> | Projected inflation adjustment to be provided to Bridge-contracted service providers |
|------|--------------------------------------------------------------|--------------------------------------------------------------------------------------|
| 2028 | 3.30%                                                        | 3.30%                                                                                |
| 2029 | 3.11%                                                        | 2.50%                                                                                |
| 2030 | 2.98%                                                        | 2.98%                                                                                |
| 2031 | 2.91%                                                        | 2.91%                                                                                |
| 2032 | 2.34%                                                        | 2.34%                                                                                |
| 2033 | 2.22%                                                        | 2.22%                                                                                |
| 2034 | 2.18%                                                        | 2.18%                                                                                |

The reduced inflation adjustment in 2029 is intended to enable the County to continue providing critical Behavioral Health Bridge-funded services without exceeding revenues, despite the inherent volatility of the sales tax. Full CPI-U Seattle inflation adjustments will be provided if funds become available, in accordance with the inflation policy and as reflected in the priorities for allocating ending undesignated fund balance in [Subsection IX.C](#).

Actual revenues and expenditures inevitably deviate from projections. If a deficit or a reserve shortfall arises in the future, DCHS shall consult with the Behavioral Health Bridge Advisory Committee and shall notify the Council in writing before taking one or more of the following actions:

- **Forgo program expansions and investments in new programs.** Priority will be given to maintaining existing programs and service levels, except for reducing or sunseting programs for other policy reasons.
- **Prohibit or cap future provider inflation rate increases.** DCHS may suspend or reduce inflation rate adjustments below the rates shown in Figure 24:
  - when revenue forecasts anticipate a decline in fund balance, or
  - if the inflation rate surpasses the rate of growth of the fund's revenue and surpasses the assumed inflation rate in applicable budgets, financial plans, and implementation plans.<sup>159</sup>

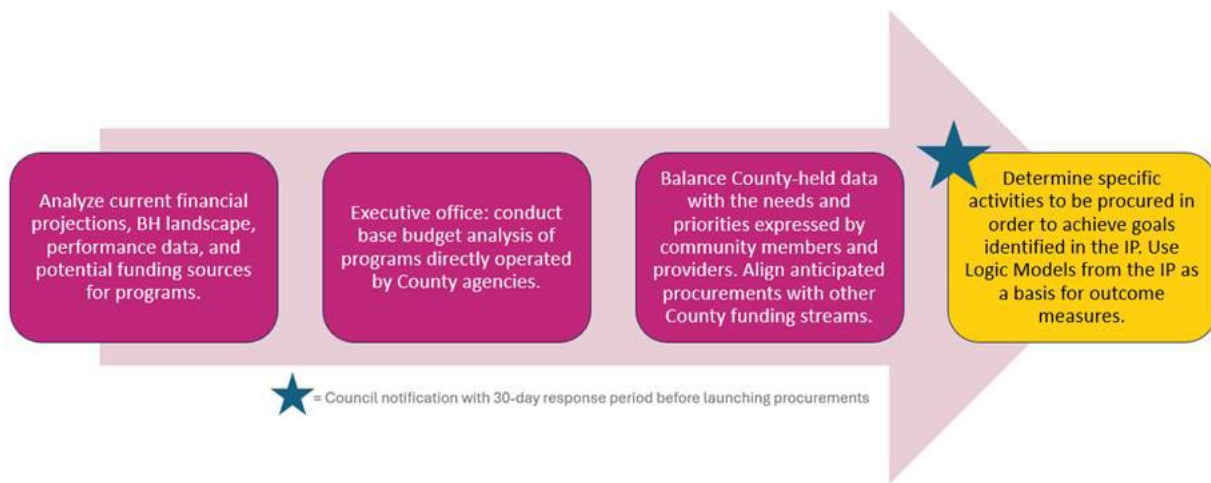


- 2252       • **Propose and implement reductions to Behavioral Health Bridge-funded programs or**  
2253       **services.** Reductions to existing programs and service levels are viewed as a last resort. If  
2254       service cuts are necessary, they would be informed by performance outcomes and  
2255       reviewed in advance with the Behavioral Health Bridge Advisory Committee for feedback  
2256       and advice.

2257 **XI. Requesting Implementation Plan Phase 2: Pre-Procurement**  
2258 **Development Plan and Council Notifications**

2259 As noted and described in Section V.B, the Executive intends to implement competitive  
2260 procurements for nearly all Behavioral Health Bridge-funded programs that will be implemented  
2261 through providers. Due to the scale of programs and services supported by the King County  
2262 Behavioral Health Bridge procurements for all strategy areas, DCHS intends to phase  
2263 procurements through the first 18 months of the implementation period. This section offers a  
2264 timeline and the steps to develop procurements for each strategy area, how and when Council will  
2265 be notified and engaged in the procurement process, and anticipated activities to be procured for  
2266 in each strategy area.

2267  
2268 **Figure 25: Anticipated Steps to Procurement**



2269  
2270 **A. Pre-procurement Council notification**

2271 As shown in Figure 25, once these procurement development steps have been completed for each  
2272 strategy area, and at least 30 days prior to soliciting service providers for a particular Behavioral  
2273 Health Bridge strategy area, the Executive will transmit a notification letter to the Council that  
2274 includes:

- 2275 • all activities for which services will be procured and the type of service provider, and  
2276 anticipated dollar range of magnitude for each activity within the strategy area to the degree  
2277 known at the time of procurement;
- 2278 • for any existing MIDD 2-supported initiative that will not be continued under the Behavioral  
2279 Health Bridge Implementation Plan but will be transitioned to another funding source,  
2280 identification of the proposed funding source, the service provider contracts affected, and  
2281 information regarding how service levels are changed, including whether they are  
2282 maintained, expanded, or reduced, and by what amount;
- 2283 • for any existing MIDD 2-supported initiatives that will not be continued under the Behavioral  
2284 Health Bridge Implementation Plan and will not be transitioned to another funding source,

- identification of the service provider contracts affected, and information regarding how many people the contracts served in the prior year;
- the overarching outcomes that programs are expected to work toward;
- specificity for performance metrics anticipated to be applicable to each activity and applied to each contracted service provider, including definitions for baseline metrics, equity-specific metrics, youth-specific metrics, SUD retention metrics, and standardized anticipated reporting cycles, to the degree known at the time of the letter;
- a description of how the strategy area’s planned procurements will further the goals and recommendations from the Executive’s Breaking the Cycle workgroup, where applicable;
- a description of how the strategy area’s planned procurements relate to the Behavioral Health Strategic Plan report called for by Ordinance 20086, Section 39, Proviso P1;
- a description of how community engagement and service provider input informed the formation of the strategy area’s planned procurements; and
- any feedback from the Behavioral Health Bridge Advisory Committee regarding the strategy area’s planned procurements.

The Executive may address multiple strategy areas in a single letter, if appropriate. 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. Unless the Council passes a motion rejecting the plans within 30 days of the Executive’s transmittal, the Executive may proceed with the programs and identified procurements as set forth in the notification letter.

#### **B. Council engagement opportunities and notification of awards**

DCHS will notify King County Councilmembers by email when the department announces a solicitation. This announcement will include an invitation for the Councilmember or a member of the Councilmember’s staff to participate on the review panel as a non-scoring member. DCHS should also notify the Council at least three days before contract awards are announced, identifying the successful contract awardees, and the anticipated contract amount.

#### **C. Anticipated procurement timeline**

Upon release of a solicitation, DCHS will provide community-based service providers three months to apply to open Bridge procurements. Figure 26 shows the anticipated timeline for each strategy area’s procurements, which lead to the program launch estimates shown in Figure 3 in [Subsection V.B.](#) To minimize provider burden and service disruption and when appropriate, DCHS aims to announce contract award decisions three to six months before launching new or reprocured programs. This provides for ramp-down periods for programs or service providers that will not be receiving continued support under the implementation plan, and time to thoughtfully transition ongoing clients and participants between programs and service providers as needed. It also allows time to complete all due diligence related to County contracting, establishment of evaluation measures, and expectations of program outcomes.

**Figure 26: Procurement Steps and Anticipated Timelines**

| Strategy area | Solicitations announced | Applications due | Awardees announced | Ramp down | Anticipated launch of IP programs and contracts |
|---------------|-------------------------|------------------|--------------------|-----------|-------------------------------------------------|
|---------------|-------------------------|------------------|--------------------|-----------|-------------------------------------------------|

|                                                             |         |                |                |              |         |
|-------------------------------------------------------------|---------|----------------|----------------|--------------|---------|
| <b>SUD Treatment and Recovery (SUD)</b>                     | Q2 2027 | Q3 2027        | End of Q4 2027 | Q1& 2 2028   | Q3 2028 |
| <b>Equitable Access to Behavioral Health Care (EA)</b>      | Q2 2027 | Q3 2027        | End of Q4 2027 | Q1& 2 2028   | Q3 2028 |
| <b>Care Transitions and Diversion Services (CTD)</b>        | Q4 2027 | End of Q1 2028 | End of Q2 2028 | Q3 & Q4 2028 | Q1 2029 |
| <b>Behavioral Health Workforce Development (WF)</b>         | Q4 2027 | End of Q1 2028 | End of Q2 2028 | Q3 & Q4 2028 | Q1 2029 |
| <b>Child, Youth, and Young Adult Mental Wellbeing (CYA)</b> | Q2 2028 | End of Q3 2028 | End of Q4 2028 | Q1 & Q2 2029 | Q3 2029 |

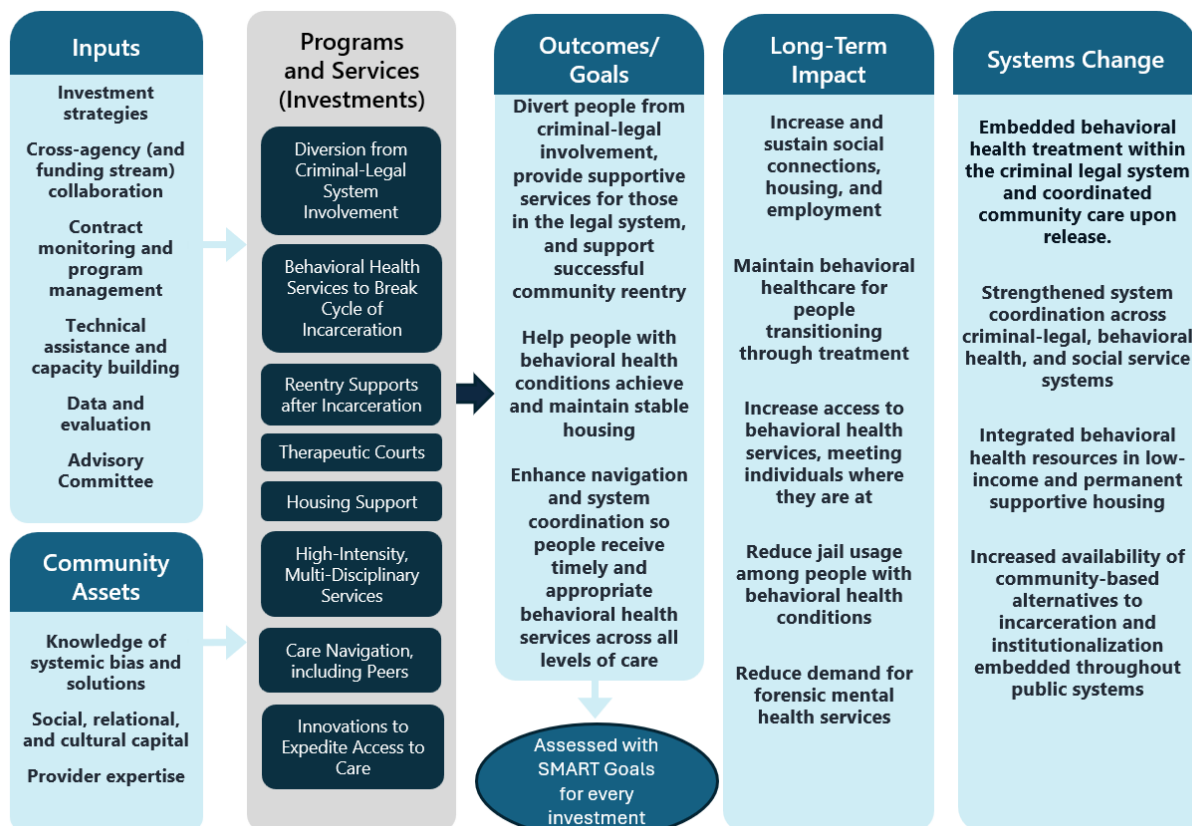
#### **D. Examples of anticipated activities to be procured for the five strategy areas**

This section offers examples of the types of services that will be procured for each of the strategy areas' goals. These align with the logic models for each of the strategy areas in this Phase 1 Implementation Plan. Each logic model explains the inputs (what services will be procured) necessary to achieve the expected outcomes for each strategy area. During the phased pre-procurement work for each strategy area, through the second quarter of 2028, more current information, including data and other intersecting initiatives, will help to shape what outcomes and activities will be included in Bridge procurements. Information and data that will be factored into procurement development will include, but will not be limited to, recommendations from the Breaking the Cycle Workgroup, and the Behavioral Health Strategic Plan report called for by Ordinance 20086, Section 39, Proviso P1. These additional variables will guide formation of the planned procurements for each Bridge strategy area and will shape plans for the Bridge-funded, County-operated services administered by other County agencies where applicable. The Executive will share this information in the pre-procurement notification letter described above.

#### **E. Logic model and anticipated activities for Care Transitions and Diversion Strategy Area**

Additional detail about the Care Transitions and Diversion Services strategy area, including descriptions of each goal and financial estimates, can be found in [Subsection VI.A](#).

**Figure 2728: Logic Model for Care Transitions and Diversion Servies (CTD) Strategy Area**



## CTD Goal 1: Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.

### **Activity: Diversion from criminal-legal system involvement**

Criminal-legal system diversion programs direct individuals with behavioral health conditions who commit legal offenses away from more formal or deeper legal system involvement to programs and services that are designed to address their specific needs. The Executive plans to continue services such as:

- Intensive case management that promotes well-being and independence and helps connect participants to stabilizing services such as housing and employment through a low-barrier, harm reduction approach.
- Services that collaborate with local law enforcement to refer people to appropriate behavioral health supports.
- Peer programs in which people with lived experience guide others on a path toward recovery and stability.
- Training for first responders to best address behavioral health incidents.

### **Activity: Services for people with behavioral health conditions who have cycled repeatedly through the criminal-legal system**

Recent DCHS analysis of jail data reveal that nearly 1,400 individuals in King County are regularly cycling through County and municipal jails, meaning they are being booked into a correctional facility located in King County four or more times per year in two of the past three years.<sup>160</sup> Further [King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

analysis reveals that 96 percent of these individuals have interacted with King County's behavioral health or crisis service systems. The Executive will fund programs for highly vulnerable people with behavioral health conditions who have cycled repeatedly through the court system and require additional help to maintain stability, such as:

- Prosecutorial resources to help track and, when possible, resolve outstanding warrants and criminal cases for individuals who have high utilization of King County jails.
- Programs to help individuals remain in the community and connect with therapeutic interventions and other resources, such as permanent supportive housing.
- Integrated, community-based approaches to serving people at the intersection of behavioral health and the criminal legal system, promoting recovery, public safety, and harm reduction.

**Activity: Supports for people to reenter the community after incarceration**

People with behavioral health conditions need support to successfully reenter society after incarceration. The Executive will fund services that provide this support, including:

- Reentry care coordination and peer navigation providing linkages to behavioral health treatment, public benefits, and access to basic needs, particularly for unstably housed adults transitioning out of King County jails.
- Timely, complex release planning and coordination of community services for people with behavioral health needs to ensure lifesaving continuity of care at release.
- Programs that provide a supply of medications, culturally appropriate linkages to care, next day appointments for SUD treatment, and re-entry items (identification, phone, clothing, hygiene kits, transportation, Medicaid enrollment, etc.).
- Follow-up support and services, that help individuals link to and attend ongoing treatment visits after release.

**Activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts.**

If or when a person with a behavioral health condition is arrested and charged as a result of their condition, services within the legal system often offer a pathway toward treatment and recovery as an alternative to incarceration or deeper legal system involvement. These services provide a treatment plan, points of accountability, and a treatment team, typically made up of legal system staff and therapeutic or case management staff, who support the individual to get the care they need. These services can include therapeutic courts, such as the Regional Mental Health and Veterans Court (RMHC), Seattle Municipal Mental Health Court (SMMHC), Community Court (CC), Adult Drug Court (ADC). Services for individuals with civil legal involvement, such as Family Treatment Court (FTC), are also included.<sup>161</sup>

**CTD Goal 2: Help people with behavioral health conditions achieve and maintain stable housing.**

**Activity: Behavioral health services in permanent supportive housing**

As of September 2025, there were 5,953 units of permanent supportive housing (PSH) in King County, and the Executive has committed to continuing to expand supportive housing in the region.<sup>162,163</sup> Permanent supportive housing is an evidence-based approach to chronic homelessness that pairs affordable housing with supportive services like case management, transportation resources and health care services. Many residents of permanent supportive housing have a behavioral health condition. For example, in 2023, more than half (51 percent) of

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 65



residents in King County’s Health Through Housing sites accessed behavioral health care services.<sup>164</sup> Many PSH sites currently provide some limited behavioral health supports, but additional services are needed, especially for people with higher-acuity conditions who need more intensive, hands-on services. On-site services are critical to ensuring PSH sites are safe and sustainable for residents, neighbors, and housing operators, and respite can provide much-needed opportunities for recuperation in a temporary, safe environment outside of the PSH setting. The Executive will use the Behavioral Health Bridge to address this need by funding increased behavioral health services at PSH sites and/or in respite settings in order to support residents’ long-term stability and keep them from re-entering the cycle of homelessness, incarceration, and hospitalization. The Executive should consider implementing this activity especially in rural areas where transit infrastructure is less developed.

***Activity: High-intensity services for people with behavioral health conditions leaving institutional settings who are experiencing or at risk of homelessness***

This activity supports programs that facilitate access to affordable and supportive housing for individuals who are experiencing homelessness or discharging from an institutional setting (such as a jail, a local hospital, or Western State Hospital) and would otherwise discharge into homelessness. Once housed, teams can provide support services to assist participants in maintaining housing and increasing independent living and tenancy skills.

***Activity: Behavioral health supports in low-barrier shelter***

This activity provides intensive supports for people with behavioral health conditions in low-barrier shelter. Low-barrier shelter provides immediate, easy access to people with behavioral health conditions that are experiencing homelessness. There should be minimal entry requirements to access services and supports shall be provided to assist recovery with behavioral health conditions, and help people with behavioral health conditions achieve and maintain stable housing. Supports provided could include case management, access to recovery resources, overdose prevention protocols, and person-centered, trauma-informed design.

Wherever possible, individuals enrolled in other County-funded services, irrespective of funding source, who have behavioral health conditions and are living unsheltered should be prioritized for low-barrier high support shelter in order to maximize the efficacy of the other County investments.

**CTD Goal 3: Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.**

***Activity: Care navigation, including peer navigation and care coordination, that is equipped to respond with cultural competency***

One way to help people move through a fragmented system is to fund care navigators or case managers. These professionals help individuals find the services they need and support them to get there. Care navigation has been proven to increase engagement with treatment and reduce reliance on emergency departments.<sup>165, 166</sup> Navigation can be especially effective for BIPOC participants when navigators are people with lived experience who come from the same background as the service participant.<sup>167, 168</sup> In the next iteration of the Behavioral Health Bridge, the Executive plans to continue to build on existing care navigation services, including services provided by peers and services that are culturally and linguistically responsive.

**Activity: HIPAA-compliant case management technologies that employ close-loop referral systems to help providers see what services someone is already engaged in, identify available resources, and connect them seamlessly while keeping patient data secure.**

In an era of extraordinary technological advances, more can be done to streamline connections between systems and make it easier for people to get the care they need. Subject matter experts requested technology that would allow service providers and provider networks to easily see what services a participant is already engaged in, identify available resources that meet their needs, and connect them to care as quickly and seamlessly as possible. There is also a need for technology solutions and support staff that identify when someone has been referred and to ensure that the linkage was made. If the connection does not occur as planned, technology can make it easier to initiate additional outreach and engagement to support successful connections to care for those who may be at risk of falling through the cracks. Contracted service providers that maintain closed-loop referral systems and information-share with other providers help community organizations by presenting a whole-person snapshot of need across a complete trajectory of care. Closed-loop referrals allow case managers to send and receive status updates about participants between organizations through inter-organizational data management systems. This requires adequate staff and reliable data infrastructure to maintain patient records and document the patient experience at each step in the care process.

Activities under this goal will support contracted service providers in implementing systems for HIPAA-compliant status reporting and referrals between local service providers, based on a whole-person care model (proactive case management to ensure access to services that address the social determinants of health outside of clinical settings), thereby reducing redundancy through cross-organizational transparency and accountability.

Several technology supports designed to facilitate better behavioral health care navigation already exist in King County, such as the BHRD Quality and Care Coordination Resources SharePoint.<sup>169</sup> Subject matter experts who advised on the renewal shared that while these supports each serve important functions, some are only available to a limited group of service providers and none offers the full spectrum of information and tools that would be needed to truly streamline care. The forthcoming Crisis Care Coordination Platform (CCP) funded by the CCC Levy is intended to address many provider-identified issues by providing clinicians with real-time information to support critical decision-making during and after behavioral health crisis encounters. However, other features requested by contracted service providers are out of scope for the first phase of the CCP, such as real-time tracking of available beds and services, or a decision support tool to help navigators identify the right services for a client among a range of options.

The Executive will invest funds under this goal to enhance and build on the CCP after it is launched to make care navigation easier, faster, and more effective by adding features that respond to community-identified needs.

**Activity: Services to ensure timely access to appropriate care and break down treatment siloes between providers**

The behavioral health system is most effective when people can get the type of care they need when they need it. The Executive will invest the next iteration of the behavioral health sales tax in programs that support timely and appropriate care, such as:

- Same-day or next-day initiation of outpatient treatment for youth and adults.

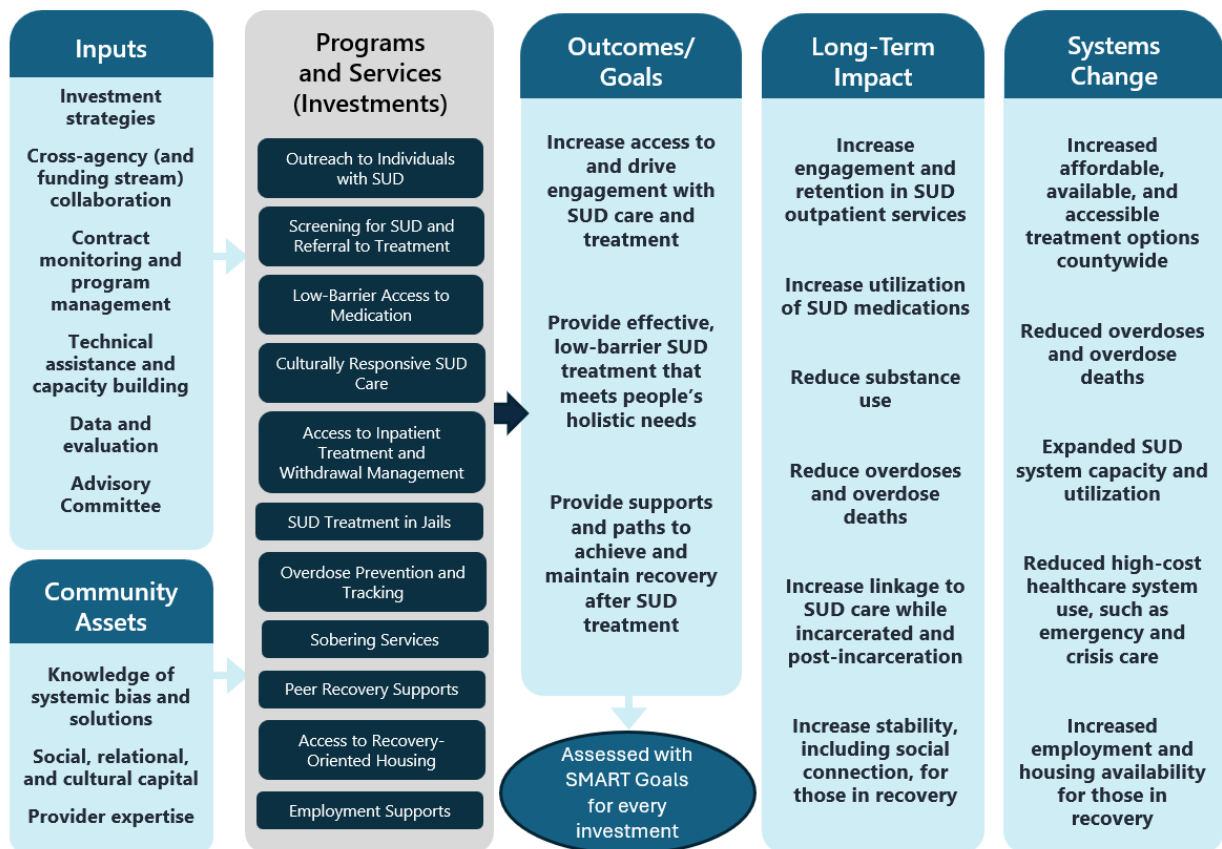


- Support for people with the highest levels of need to get to safe settings.
- Step-down or respite care for people with behavioral health conditions to continue healing after a crisis or acute care episode.

## F. Logic model and anticipated activities for Substance Use Disorder Treatment and Recovery Strategy Area

Additional detail about the SUD Treatment and Recovery strategy area, including descriptions of each goal and financial estimates, can be found in [Section VI.B](#).

**Figure 29: Logic model for the Substance Use Disorder Treatment and Recovery (SUD) strategy area**



### SUD Goal 1: Drive engagement and retention in SUD care.

#### **Activity: Proactive outreach to people with SUD, especially those experiencing homelessness**

Decades of research, as well as feedback from community members and subject matter experts, show that outreach is a key part of connecting people to care, especially for people with substance use disorders who are experiencing homelessness.<sup>170</sup> The Executive expects that the behavioral health sales tax will pay for community-based and behavioral health organizations to provide evidence-based practices that support engagement in treatment, such as:

- Engaging individuals experiencing homelessness through regular, consistent outreach that builds rapport and trust.

- Conducting basic needs and safety assessments to identify immediate risks, service needs, and eligibility for SUD treatment or other supports.
- Providing information on SUD treatment options, including low-barrier programs, medications, inpatient and residential, outpatient, and withdrawal management services.
- Offering harm reduction supplies and education, such as naloxone distribution, overdose prevention information, and safer-use strategies.
- Facilitating warm handoffs to treatment contracted service providers, behavioral health agencies, medical partners, or crisis services, including accompanying clients when appropriate.

**Activity: Screening and referrals integrated into multiple settings**

Another way to connect people to the care they need is to intervene in key moments, such as when a person goes to a housing site, community center, school, medical appointment, or emergency department. For example, an average of 3,800 King County Medicaid members visit an emergency department multiple times per year with a behavioral health condition as the primary diagnosis.<sup>171</sup> Many of these individuals are served by Behavioral Health Bridge programs. In addition, more individuals who do not have Medicaid repeatedly visit emergency departments due to behavioral health diagnoses. Providing screenings and appropriate referrals at a moment when someone is already in contact with a care provider reduces the risk that the individual will end up back in the emergency department again for the same issue.<sup>172</sup> It also provides a path to treatment that does not require the person to escalate to the point of criminal-legal system involvement in order for their conditions to be addressed. The Executive anticipates funding programs that screen people for SUD across service settings, provide individualized needs assessments, and refer them to treatment as well as other services.

**Activity: Sobering services**

Sobering services are a safe and secure shelter for adults to sleep off the acute effects of intoxication under the supervision of staff trained in medical assessment and response. They also serve as a recovery access point where people receive case management services and assistance to move towards greater self-determination and recovery. The Executive anticipates that the Bridge can support this important linkage pathway for people with SUD in need of treatment and other services.

**SUD Goal 2: Provide effective, low-barrier SUD treatment that meets people’s holistic needs.**

**Activity: Low-barrier access to medications for substance use disorder and medication-first treatment approaches**

Low-barrier access to medications for substance use disorder is a critical aspect of SUD treatment. In particular, medications for opioid use disorder (MOUD) have become the standard of care for treating opioid use disorder regardless of the specific opiate being used, and is associated with longer retention in treatment, decreased opioid use, and reduced mortality from overdose.<sup>173,174</sup> The increased prevalence of fentanyl means that access to MOUD is more important than ever, as fentanyl is metabolized so quickly that even an hour without the drug can make people sick from withdrawal.<sup>175,176</sup> Utilizing a medication-first approach provides a level of stabilization that can often enable enrollment in ongoing treatment services. However, because medications for substance use disorders are not available through all SUD treatment providers, King County’s SUD system is not yet optimized to provide access to these lifesaving

medications.<sup>177,178,179</sup> Successes like the launch of the Tele-buprenorphine Hotline in 2024, which is partially funded by the Behavioral Health Bridge and provides low-barrier MOUD support, are making progress in this area.<sup>180</sup> However, more work remains to increase the availability of medications in outpatient and residential treatment programming across the County.

The Executive will leverage Behavioral Health Bridge investments to improve the availability of MOUD and other medications to help people recover from substance use disorders. Behavioral Health Bridge funds can support medication-first treatment approaches in formal treatment settings and in community, such as the buprenorphine line, MOUD in shelters and encampments, and mobile medication access. These on-demand services help people initiate treatment when and where they are ready. The Executive is also considering investing Behavioral Health Bridge funds to increase access to medications within SUD treatment and care by supporting partnerships between treatment providers and pharmacies, adding medical staff to an agency's care team, covering of co-pays, or employing other strategies to help people access medications on demand.

***Activity: Provision of mobile and in-community services***

In addition to medication, the Executive anticipates supporting the broader provision of SUD services in the community. This means offering treatment, support, and medications in settings where people already are, such as shelters, outreach sites, and other community-based locations, rather than relying primarily on traditional office-based models of care. By paying for services that meet individuals in their own environments, the Behavioral Health Bridge can reduce barriers, build trust, and ensure that services are accessible to those who may not otherwise engage in treatment.

***Activity: SUD treatment for incarcerated people***

Another area of focus for the Bridge is SUD treatment for people in County jail. This population is vulnerable to repeatedly cycling through the criminal-legal system, with a high cost in human potential as well as taxpayer dollars. Services that help people continue or initiate SUD treatment while in jail can help break this cycle and move people toward long-term recovery and stability. During community engagement around the Behavioral Health Bridge renewal, listening sessions held in King County jails indicated that many people have a desire to engage in treatment while incarcerated, and would benefit from services to connect them to treatment, including counseling and access to MOUD. The Behavioral Health Bridge will build on current efforts to continue providing SUD treatment to people who are incarcerated. Bridge investments are expected to include, but are not limited to, expanding access to MOUD for people in custody in King County jails through medications, contracts, and additional County staff, to comply with the Americans with Disabilities Act (ADA).<sup>181</sup>

***Activity: Alleviating barriers to enter inpatient SUD treatment and withdrawal management***

Some people have complex medical needs that must be addressed alongside behavioral health conditions, such as open wounds or uncontrolled diabetes. This is common among people who are living unsheltered, as well as older adults who need continuous medical monitoring. Many behavioral health facilities are not equipped to treat these medical concerns, which effectively prevents these individuals from receiving withdrawal management and other inpatient behavioral health treatment. The Executive anticipates that Behavioral Health Bridge investments can address this barrier to treatment so that the county's most vulnerable residents can get the SUD care they need.

**Activity: Culturally and linguistically responsive SUD care**

A one-size-fits-all approach to SUD treatment will not meet the needs of King County's diverse communities. For treatment to be effective and equitable, people must be able to access services in their preferred language, from contracted service providers who understand and respect their unique backgrounds. Culturally responsive SUD care is proven to improve outcomes for marginalized communities, especially when developed and provided by people from the relevant culture in participants' preferred language.<sup>182, 183, 184</sup> Participants in the Be Heard: Community Voices About Mental Health and Wellness project and renewal-focused community engagement noted that current treatment options often do not provide care that resonates with their culture or worldview, leaving them feeling alienated and unsure where to turn for help.<sup>185, 186</sup> Increasing culturally responsive options for people with SUD is a key way to address inequitable outcomes across King County communities.

The Executive will Behavioral Health Bridge dollars to pay for treatment and supports that address the unique needs of people from diverse backgrounds, spiritual traditions, family structures, and cultural approaches to behavioral health by helping existing contracted service providers become more culturally responsive and expanding Behavioral Health Bridge services to more culturally grounded SUD treatment providers.

**Activity: Overdose prevention and tracking**

King County has a robust overdose surveillance program, administered by Public Health – Seattle & King County and partially funded by the behavioral health sales tax. In addition to prevention activities such as naloxone distribution, this program produces the Opioid Overdose Deaths Data Dashboard, a key source for understanding the landscape and impact of opioid use in King County.<sup>187</sup> Maintaining this resource is critical to understanding and evaluating the effectiveness of interventions designed to curb overdose. It also aligns with the Executive's priority of Better Government, ensuring transparency and accountability in the outcomes of County investments related to overdose. The Executive will continue funding these important tracking activities in the renewal period.

**SUD Goal 3: Support paths to achieve and maintain recovery after treatment.**

**Activity: Peer recovery services**

Throughout community engagement and the multi-sector subject matter expert process, participants were adamant that peer services are critical to successful recovery. Research shows that peer services improve relationships with treatment and social service providers, reduce rates of relapse, and increase retention in treatment.<sup>188</sup> The Executive will continue to invest in peer-based supports, including services that:

- Offer support, mentorship, and practical advice based on personal recovery experiences.
- Provide system navigation through treatment options, housing, transportation, and other community resources.
- Work in community settings, including emergency rooms and encampments, to connect at-risk individuals to care.
- Assist in developing, refining, and implementing self-defined recovery plans.
- Teach coping mechanisms, social skills, and strategies for managing daily life.

**Activity: Access to housing that supports recovery**

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 71

Housing is an important component of long-term recovery. There is a high correlation between housing instability and substance use disorders. The Substance Use and Mental Health Administration (SAMHSA) identifies “Home” as one of the four dimensions of recovery, alongside “Health,” “Purpose,” and “Community.”<sup>189,190</sup> People need safe places to live after treatment in order to maintain recovery, through program models such as rapid rehousing, housing vouchers, or permanent supportive housing. The Executive anticipates that the Bridge can continue to support these important pathways to stability for people in recovery from SUDs.

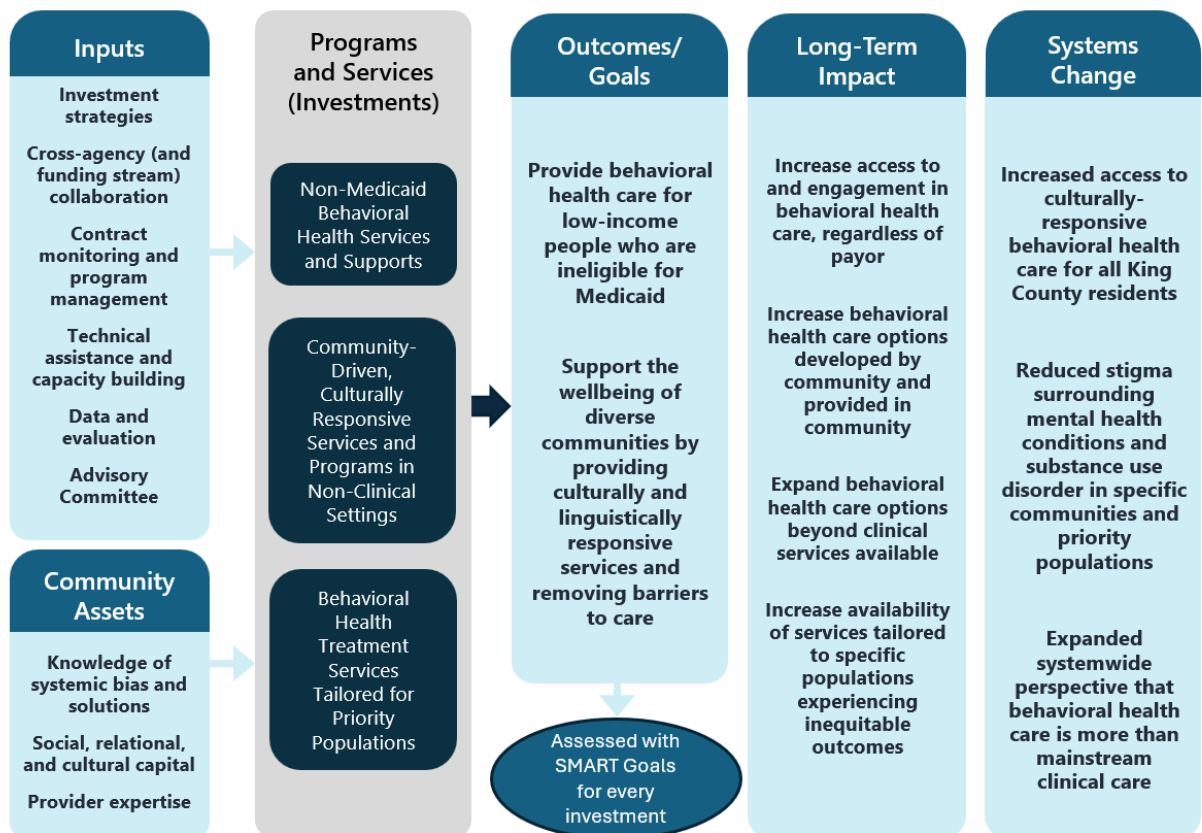
#### **Activity: Employment supports**

Since 2008, the behavioral health sales tax has paid for a supported employment program that helps people with severe mental illnesses achieve self-sufficiency and improve non-vocational outcomes such as improved self-esteem, sense of purpose, decreased isolation, and participation in meaningful activities. Program participation is correlated with decreases in hospitalization and jail utilization. In the 2028-2034 implementation period, the Executive is considering broadening eligibility for this program to include individuals in recovery from SUDs, so they too can have access to support to get and maintain jobs and contribute to their communities.

### **G. Logic model and anticipated activities for Equitable Access to Behavioral Health Care Strategy Area**

Additional detail about the Equitable Access to Behavioral Health Care strategy area, including descriptions of each goal and financial estimates, can be found in [Subsection VI.C](#).

**Figure 30: Logic model for the Equitable Access to Behavioral Health Care strategy area**





**EA Goal 1: Provide behavioral health care for low-income people who are ineligible for Medicaid.**

**Activity: Expanded funding stream designated for behavioral health services for people not covered by Medicaid**

In its next iteration, the behavioral health sales tax will continue to pay for behavioral health services for low-income uninsured or underinsured King County residents who are ineligible for Medicaid coverage.

Since its inception, the behavioral health sales tax has provided access to behavioral health treatment services for uninsured low-income people. Every year since 2008, this program has served between 3,000 and 4,000 uninsured people with outpatient mental health and substance use treatment services, including immigrants and refugees, people on Medicare, and people who are pending Medicaid coverage. This funding addresses inequities for these populations by enabling them to access safety-net behavioral health treatment that would otherwise be out of reach. Supporting access to low-barrier, preventative treatment services helps keep people from delaying needed treatment and accessing higher levels of care at a later time. The Behavioral Health Bridge will sustain this important program in 2028-2034 to continue supporting treatment equity between people with insurance coverage and those who lack access due to coverage gaps, income, immigration status or other barriers to care (such as transportation or language). In addition, the Executive plans to use the Bridge to pay for translation and interpretation services and connection to culturally responsive healthcare practices for people receiving outpatient treatment through this program who speak a language other than English.

**EA Goal 2: Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.**

**Activity: Community-driven culturally and linguistically responsive services and programs that support behavioral health outside of clinical settings**

Community engagement participants and subject matter experts were clear that community-based organizations are better positioned to address the needs of their communities than well-intentioned outsiders. Services procured under this goal can directly fund community-based organizations to increase access to culturally and linguistically appropriate prevention, early intervention, care navigation, and recovery supports for BIPOC, immigrant or refugee, LGBTQIA+, and rural King County residents. By working with communities to design and implement service approaches that meet their needs, this goal directly addresses race- and place- based inequities and promotes King County's commitment to equity as a core value.

DCHS shall release one or more RFPs to identify organizations that can provide tailored supports to populations that experience behavioral health inequities, such as those who:

- Identify as Black, Indigenous, or people of color.
- Are immigrants, refugees, or asylees.
- Identify as LGBTQIA+.
- Live in rural areas.
- Are survivors of trauma or domestic, sexual, and gender-based violence.
- Live unsheltered.

Examples of the types of programs that could be procured to further this goal include:

- Behavioral health education paired with culturally responsive programming such as sweat lodges or art therapy.
- Community conversations focused on de-stigmatization and healing, including cross-generational programming.
- Queer-affirming suicide prevention provided by an LGBTQIA+ organization.
- Wellness programs in safe spaces that build strong community connections.
- Mental health awareness and education, in preferred languages by trusted organizations.

**Activity: Behavioral health treatment services tailored for at-risk populations**

Participants in the Be Heard: Community Voices About Mental Health and Wellness project shared that culture, beliefs, values, race, language, and personal identity affect perspectives on mental health and substance use.<sup>191</sup> The same report found that people are less likely to seek help when the only available treatments do not resonate with their cultural background or the lens through which they see the world. Community members stressed the need for culturally responsive services that are developed by and for their community and provided by individuals from similar backgrounds. Research also shows that culturally adapted clinical care, particularly options co-created by the communities intended to benefit from them, significantly improve outcomes across a range of health conditions.<sup>192, 193</sup>

Services procured under this goal will focus on making the publicly funded behavioral health system, such as the King County Integrated Care Network of Medicaid providers, more welcoming and responsive to King County's diverse populations by removing barriers to treatment and providing culturally responsive treatment.

DCHS shall release one or more RFPs to identify organizations that can support low-income populations experiencing inequitable behavioral health outcomes, such as people who:

- Identify as Black, Indigenous, or people of color.
- Are immigrants, refugees, or asylees.
- Identify as LGBTQIA+.
- Live in rural areas.
- Are older adults.
- Are survivors of trauma or domestic, sexual, and gender-based violence.
- Live unsheltered.

Examples of the types of programs that could be procured to further this goal include:

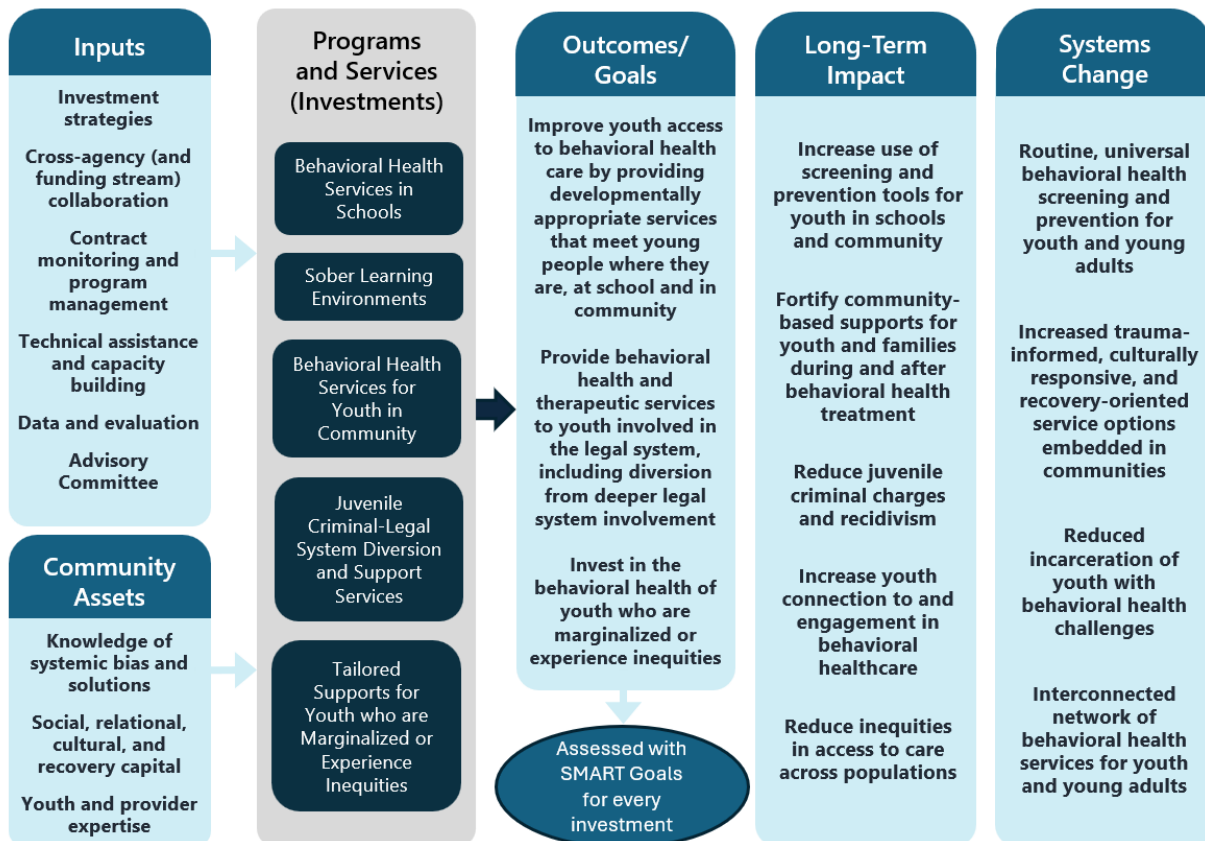
- Tailored therapies for LGBTQIA+ people facing behavioral health challenges.
- Behavioral health treatment and enhanced care navigation for survivors of trauma or domestic, sexual, and gender-based-violence, including flexible financial assistance where material barriers interfere with behavioral health access, safety, or continuity of care.
- Behavioral health treatment and supports for people living in rural or unincorporated Community Service Areas.
- Culturally specific, responsive, and trauma informed behavioral health treatment and supports for Black, Indigenous, and immigrant and refugee communities.
- Behavioral health treatment services for older adults with mental health and/or substance use conditions.

**Activity: Organizations which provide culturally competent care practices that address behavioral health inequities informed by an understanding of shared history related to race, immigration status, sexual orientation, gender identity, trauma history, and geographic access.**

#### H. Logic model and anticipated activities for Child, Youth, Young Adult Mental Wellbeing Strategy Area

Additional detail about the Child, Youth, and Young Adult Mental Wellbeing strategy area, including descriptions of each goal and financial estimates, can be found in [Subsection VI.D](#).

**Figure 31: Logic model for the Child, Youth, and Young Adult Mental Wellbeing (CYA) strategy area**



**CYYA Goal 1: Improve youth access to behavioral health care by providing developmentally appropriate services that meet young people where they are, at school and in community.**

**Activity: Youth behavioral health services in schools**

Locating services in schools is an effective way to facilitate access to care and reduce stigma for young people in need of behavioral health support. Since 2018, the behavioral health sales tax (alongside braided funding from Best Starts) has supported school-based Screening, Brief Intervention, and Referral to Treatment (SB-SBIRT), which screens over 13,000 King County middle



and high schoolers across 13 districts each year and helps connect them to needed services. After participating in screening, the students who indicate areas of potential need meet with trained staff to discuss their goals, areas of growth, and connections to needed services.

These programs are most effective when students can be referred to brief treatment (defined as 8 or fewer sessions) on campus, alleviating the need to make a separate appointment, find transportation, or navigate an unfamiliar clinical environment. On-campus services are currently available in some schools, but not all, resulting in inconsistent access. Services offered on campus are also exclusive to mental health concerns and do not include supports for students struggling with substance use. Through the Bridge's investments in 2028-2034, the Executive intends to build on existing School-Based SBIRT programs to allow more schools to offer brief on-campus behavioral health care, including substance use counseling in addition to mental health services. These brief services also support youth and families' transition to care in the community, if they need ongoing or higher-level care.

**Activity: Sober learning environments**

There are few youth-centered recovery resources, and young people who have experienced substance use disorders need safer and sober environments in which to continue their education while working on their recovery. Since 2014, King County has partnered with Seattle Public Schools Interagency Academy to operate the only public sober high school in Washington. The Interagency Recovery Campus (IRC), known colloquially as Recovery High School, provides a safe and sober environment where young people in recovery from substance use disorder and other behavioral health conditions can pursue their academic and career goals.<sup>194</sup> In 2013, only 25 percent of young people who received publicly funded substance use disorder treatment graduated from high school. For students with co-occurring mental health conditions, the number dropped to 17 percent.<sup>195</sup> At the Recovery High School, however, 67 percent of students earned or are working toward a high school diploma.<sup>196</sup> After enrolling in the program, 53 percent of IRC students have more than one year of recovery.<sup>197</sup> This activity would make it possible for the Bridge to support this valuable educational model.

**Activity: Youth behavioral health services in community**

During community engagement for the Bridge renewal, survey respondents rated "difficulty understanding where and how to access services" as the primary barrier to accessing behavioral health care for young people, as shown in [Appendix B](#). Adolescents are often dependent on their caregivers' motivation, knowledge, and resources to help them identify when behavioral health care is needed, find a provider, make appointments, and travel to care. Young people often forego care when their caregivers cannot provide this support, or when youth do not want their caregivers to know they are struggling. One effective way to overcome this barrier is to bring care to locations where youth already spend time.<sup>198</sup> This activity enhances access to care in other community locations (beyond schools) where young people already spend time and have relationships with trusted adults. The Bridge is anticipated to support programs that make behavioral health care more accessible, and therefore more effective, for youth and families, such as:

- Mobile screenings, brief interventions, MOUD, or young adult crisis response services that travel to shelters, community centers, and other youth-serving locations.
- Behavioral health staff in non-clinical youth-serving spaces like community centers, homeless shelters, summer camps, or community-based sports or arts programs.

**CYYA Goal 2: Provide behavioral health and therapeutic services to youth involved in the legal system, including diversion from deeper legal system involvement**

**Activity: Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system**

Since 2017, the behavioral health sales tax has supported 3,443 young people who were involved with the criminal-legal system and have a behavioral health need.<sup>199</sup> These supportive services included risk and needs assessments, community-based behavioral health support and system navigation, youth and family counseling, mental health and SUD services, and referrals to ongoing treatment.

In its next iteration, the Behavioral Health Bridge will continue to provide critical services to help young people avoid long-term involvement in the criminal-legal system, such as:

- Behavioral health screenings and assessments,
- System navigation and warm handoff referrals to behavioral health care,
- Parent and family supports,
- De-escalation counseling,
- Mental health services,
- Substance use services,
- Diversion services, and
- Trauma informed, behavioral health focused services for youth with Court involvement, such as those provided by the Juvenile Response and Accountability Court – Behavioral Health Response (JTRAC-BHR).

These programs help young people who have contact with the criminal-legal system get their lives back on track. This prevents them from languishing in detention while waiting for behavioral health care, or falling deeper into a cycle of behavioral health conditions, criminalization, and homelessness.

**CYYA Goal 3: Invest in the behavioral health of youth who are marginalized or experience inequities.**

**Activities: Tailored supports for youth who are marginalized or experience inequities**

DCHS will release one or more RFPs to contract with service providers that can provide tailored, culturally responsive, and affirming supports to youth and families from communities that have been historically underserved or marginalized by behavioral health systems. Among these are young people and families who:

- Identify as LGBTQIA+.
- Identify as Black, Indigenous, or people of color.
- Are immigrants, refugees, asylees, or the children of immigrants, refugees, and asylees.
- Have complex and co-occurring behavioral health conditions, or behavioral health conditions with neurodivergence or intellectual or developmental disabilities.
- Have witnessed or experienced trauma or violence, including domestic, sexual, or gender-based violence, stalking, trafficking, or gun violence.

Tailored interventions have been proven more effective than standard interventions at improving outcomes among LGBTQIA+ youth and youth of color.<sup>200,201,202</sup> Examples of the types of programs that the Executive intends to procure include:

- Suicide prevention approaches designed with and for Black youth.
- Sober community-building and substance use prevention for LGBTQIA+ youth.
- In-language therapy groups for youth who speak a language other than English at home.
- Trauma healing programs for American Indian/Alaska Native youth who have witnessed or experienced violence.

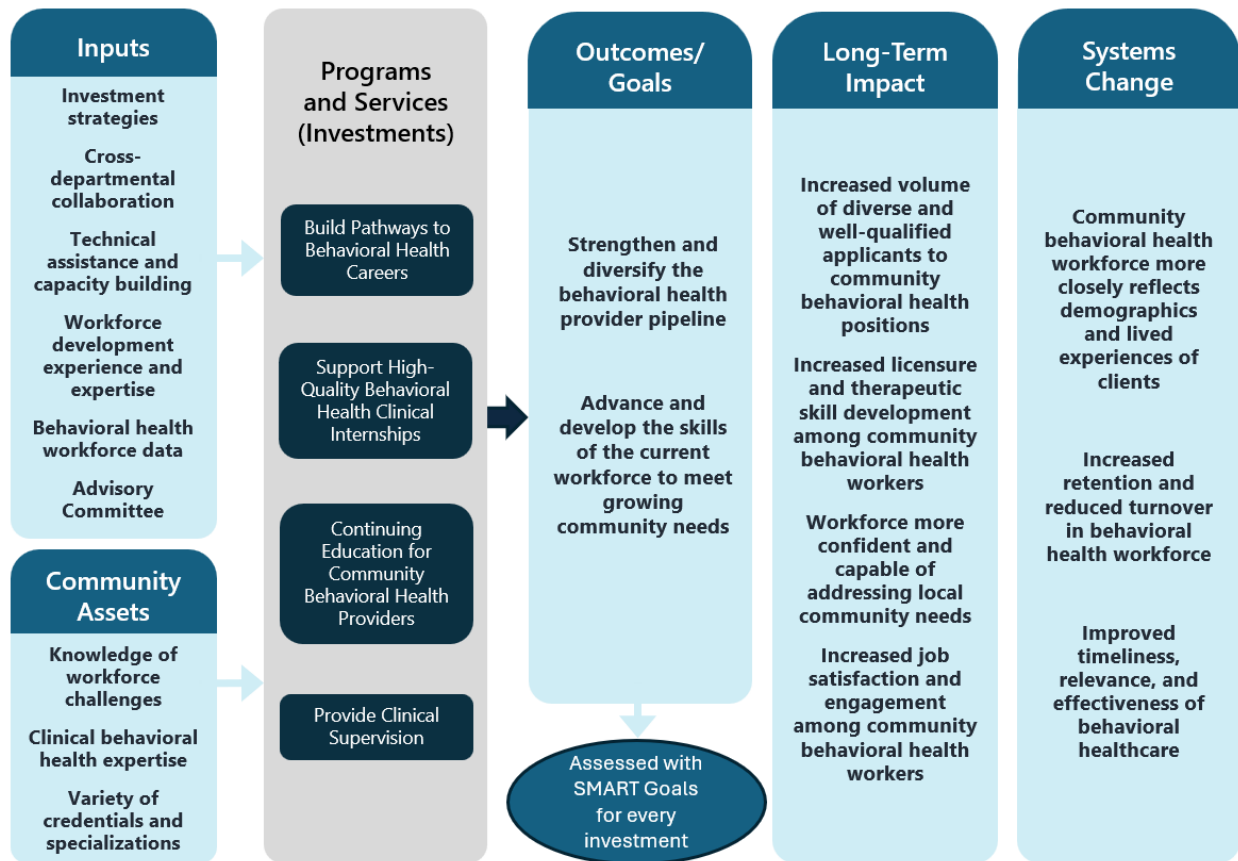
During the procurement process, King County plans to evaluate proposals from community organizations that are already known and respected by the families this goal is intended to serve, which may include KCICN providers. Providers should have training on the unique confidentiality, safety, caregiver involvement, and mandatory-reporting considerations that arise when providing behavioral health services to young survivors of trauma or domestic, sexual, and gender-based violence. Bridge-funded programs will focus on early intervention, treatment (especially for uninsured youth), and recovery. Services will complement rather than duplicate investments from other funding sources and will streamline connections to the publicly funded behavioral health system for participating youth and families.

This investment creates an opportunity to strengthen culturally responsive, community-rooted pathways into care so that youth can access support earlier and in ways that better meet their needs.

#### **I. Logic model and anticipated activities for the Behavioral Health Workforce Development Strategy Area**

Additional detail about the Behavioral Health Workforce Development strategy area, including descriptions of each goal and financial estimates, can be found in [Subsection VI.E](#).

**Figure 32: Logic model for the Behavioral Health Workforce Development (WF) strategy area**



## WF Goal 1: Strengthen and diversify the behavioral health provider pipeline.

### **Activity: Building pathways to behavioral health careers**

The Executive intends for the Behavioral Health Bridge to fund programs and activities that bring people into the provider pipeline, with a focus on recruiting a representative workforce, including by raising awareness of behavioral health career opportunities, preparing people for jobs in the field, and connecting people to careers in behavioral health. The Executive will invest in activities such as:

- Educating under-resourced communities on non-clinical and clinical career pathways and ways to access free or no-cost trainings.
- Delivering programs in diverse middle and high schools to increase behavioral health career awareness among BIPOC youth.
- Building “connection to industry” through hands-on learning, job shadowing, career tours, and clinical simulations.
- Sponsoring Behavioral Health Career Pathways Fairs in collaboration with community-based organizations that serve underrepresented populations, including youth.
- Continuing summer programs for youth interested in pursuing behavioral health careers.
- Expanding existing relationships with technical colleges and skills centers.
- Targeted outreach to individuals enrolled in higher education behavioral health programs, highlighting benefits of working in community behavioral health, diversity of careers available, and opportunities for career growth within the behavioral health system.

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 79

**Activity: Supporting high-quality behavioral health clinical internships**

Ensuring the availability of well-supported clinical internships in community behavioral health will not only increase the number of new providers entering the workforce, it will also help improve the representativeness of the workforce. Clinical internships provide on-the-job learning experience and are a required component of graduate degree programs to become a behavioral health provider. These internships are typically unpaid and take place while a person is in school pursuing a Master of Social Work or other degree requirement. This step in the training process is cost-prohibitive for many people who cannot afford to work without pay. This barrier is particularly difficult for people from lower-income backgrounds, who are often more representative of the population being served in community behavioral health settings. Additionally, an individual's experience during internship can shape whether they choose to continue to work in community behavioral health settings after they obtain their degree. Clinical interns continue to be the primary pipeline for developing community behavioral health workers, especially those with advanced degrees, including diverse workers.<sup>203</sup>

The Executive will invest in activities to support high-quality behavioral health clinical internships, such as:

- Providing financial support for paid internships, building on the work of the CCC Levy's career pathways (CP) funding, which is effective but does not have enough funds to fully meet the needs.
- Developing supervisor training and support initiatives that assist community behavioral health supervisors in providing training and coaching in best practices and culturally relevant core competencies for interns and clinical trainees.
- Developing internship programs to treat people with co-occurring substance use disorders and mental health conditions. No similar internship programs exist at the time of plan adoption, despite the prevalence of co-occurring disorders.
- Supporting training around clinical best practices and ensuring interns have the competencies needed to serve the complex needs seen in community behavioral health.

**WF Goal 2: Advance and develop the skills of the current workforce to meet growing community needs.**

**Activity: Clinical supervision**

To promote an adequate supply of behavioral health workers prepared to treat the low-income, high-need population served by community behavioral health, DCHS will work to alleviate the barriers around clinical supervision that currently limit the number of new providers who can begin their careers in community behavioral health.

After graduation from a Master's program, new clinicians must complete 1,000 to 3,000 hours of clinical supervision to become a fully licensed behavioral health worker, depending on the license type.<sup>204</sup> The cost of paying to receive clinical supervision is a barrier for providers' career advancement and disproportionately affects low-income and BIPOC individuals.<sup>205</sup> Historically, community behavioral health agencies have offered free clinical supervision as a key benefit and recruitment tool for clinical staff, but clinical supervision itself is not reimbursable by insurance or Medicaid. The hours the supervisor spends supporting a new colleague are unpaid and compete with time they could spend providing services to clients and generating revenue for their agency. As a result, community behavioral health agencies are limited in how many new clinicians they can

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 80

supervise, which in turn limits the number of new clinicians who can enter community behavioral health. Across 47 KCICN agencies surveyed in 2025, the main reported barrier to hosting clinical trainees was lack of supervisor availability.<sup>206</sup> This creates a bottleneck preventing new clinicians from entering the community behavioral health.

The Executive will leverage the Behavioral Health Bridge to pay for clinical supervision through methods such as:

- Funding the provision of clinical supervision within a community behavioral health agency.
- Developing a centralized clinical supervision model for the King County Integrated Care Network that leverages opportunities for shared clinical supervision across multiple behavioral health provider agencies.
- Developing a centralized model for virtual clinical supervision, that could be widely available to community behavioral health agencies to augment and supplement existing agency-provided clinical supervision.

**Activity: Specialized training for community behavioral health providers**

The Executive will sustain and expand the workforce investments that began in MIDD 2 through continuing Bridge investments. Since 2025, the behavioral health sales tax has supported KCICN providers to receive specialized training through avenues like:

- KCICN Training Academy, which provides evidence-based practice (EBP) trainings in Dialectical Behavioral Therapy and Cognitive Behavioral Therapy for Psychosis with continuing education units (CEUs) and follow-up consultation.
- Access to a learning management system, such as Relias.
- Access to EBP training software, such as Lyssn.
- Access to an umbrella license and coverage of training costs for certain training programs, such as the Seven Challenges program for youth SUD treatment.

The Bridge will enable KCICN providers to continue to access training software, along with new high-demand trainings such as but not limited to motivational interviewing, racial socialization and addressing racial trauma, LGBTQIA+ affirming and responsive treatment, family-based interventions for disruptive behavior, parent-child interaction therapy. These additions will support contracted service providers in offering the highest quality of care through King County's publicly funded behavioral health system.

The Executive will also continue or expand support for partnerships with technical colleges and higher education institutions to create affordable pathways for individuals who already hold credentials in mental health to earn credentials in SUD treatment, and vice versa. For example, the Y+Heritage Master's Program allows current KCICN clinical staff from underrepresented communities to pursue master's degrees in mental health counseling.<sup>207</sup> With support from the Behavioral Health Bridge, the Executive will expand this or similar programs to provide pathways for existing students to obtain licensure as Substance Use Disorder Professionals (SUDPs) to be able to treat people with co-occurring conditions.



## 3036 **XII. Conclusion**

3037 The Behavioral Health Bridge Implementation Plan 2028-2034 contains an approach to developing  
3038 an equity-driven set of investments to strengthen King County's behavioral health system in a time  
3039 of profound community need. Grounded in extensive community engagement, informed by  
3040 multidisciplinary expertise, and aligned to complement the County's other behavioral health and  
3041 human services funding sources, this plan sets a direction toward a behavioral health system that  
3042 is more available, accessible, effective, and equitable.

3043  
3044 The Behavioral Health Bridge Implementation Plan features investments across five strategy areas:  
3045 Care Transitions and Diversion Services; Substance Use Disorder Treatment and Recovery;  
3046 Equitable Access to Behavioral Health Care; Child, Youth, and Young Adult Mental Wellbeing; and  
3047 Behavioral Health Workforce Development. The investments in the Behavioral Health Bridge  
3048 Implementation Plan are expected to help break the cycle of crisis, homelessness, incarceration,  
3049 and hospitalization by helping people receive the right treatment and support at the right time.  
3050 Strategy areas, goal areas, and anticipated activities are designed not only to meet immediate  
3051 needs but also to strengthen community behavioral health care against potential shifts in funding,  
3052 workforce capacity, and service demand that are expected in the coming years.

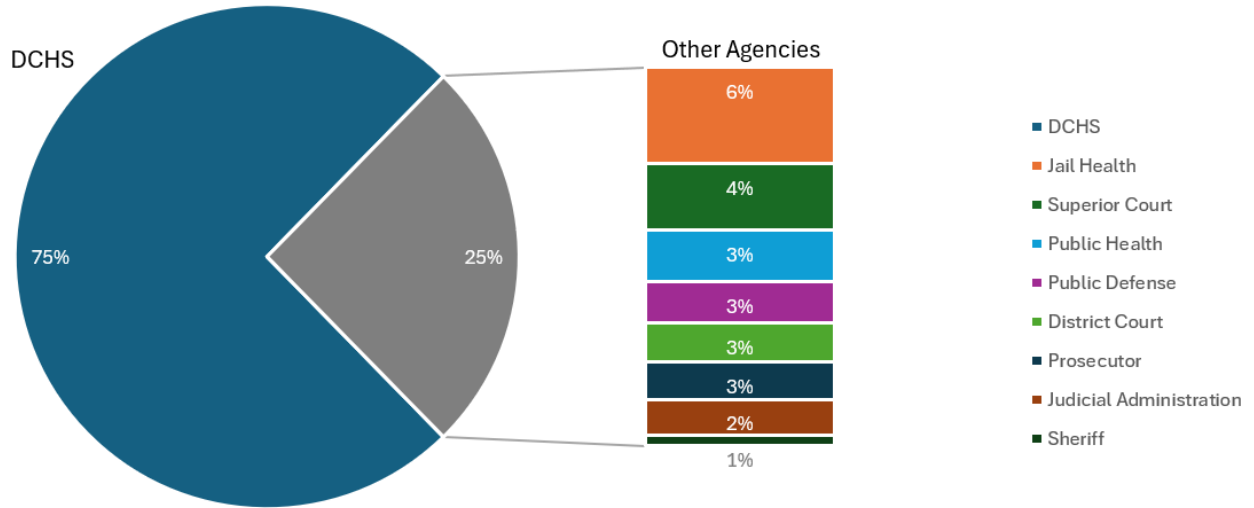
3053  
3054 Successful implementation will depend on continued partnership with community-based  
3055 organizations, behavioral health service providers, people with lived experience, and across  
3056 County agencies. Ongoing evaluation, transparent reporting, and a phased procurement approach  
3057 will help deliver a smooth transition from the current set of investments to the planned Behavioral  
3058 Health Bridge investments.

3059  
3060 With the Behavioral Health Bridge Implementation Plan, King County reaffirms its commitment to  
3061 enabling all residents, especially those most impacted by inequities, to access effective, high-  
3062 quality behavioral health care and pursue long term recovery, stability, and wellbeing.

3062 **XIII. Appendices**

3064 **A. Appendix A. Behavioral Health Bridge investments in DCHS and other County**  
3065 **agencies**

3067 **Figure 33: 2026-2027 adopted Behavioral Health Bridge budget by King County agency**





## B. Appendix B. Community engagement activities and results<sup>208</sup>

### Listening sessions and community-based events

Between Behavioral Health Bridge-focused listening sessions and the Be Heard: Community Voices About Mental Health and Wellness project, BHRD staff conducted 46 in-person listening sessions and 486 interviews about the King County behavioral health system in 2024 and 2025 (Figure 35). Additional efforts to gather in-person feedback included attending community-based events, which engaged 447 community members throughout King County. To ensure representation across the county, BHRD held at least one in-person listening session in each council district.

**Figure 34: Dates and locations of in-person listening sessions and community-based events**

| Council District | Date (2024-2025) | Location                                                        |
|------------------|------------------|-----------------------------------------------------------------|
| District 1       | Spring 2024      | CHARMD Behavioral Health, Shoreline                             |
| District 1       | Spring 2024      | Korean Community Service Center (KCS), Edmonds                  |
| District 2       | Spring 2024      | Communities of Rooted Brilliance (CRB), Seattle                 |
| District 2       | Spring 2024      | Ethiopian Community in Seattle (ECS), Seattle                   |
| District 2       | Spring 2024      | Filipino Community of Seattle (FCS), Seattle                    |
| District 2       | Spring 2024      | New Americans Alliance for Policy and Research (NAAPR), Seattle |
| District 2       | Spring 2024      | Therapy Fund Foundation (TFF), Seattle                          |
| District 2       | Spring 2024      | Vietnamese Health Board (VHB), Seattle                          |
| District 5       | Spring 2024      | Association of Zambians in Seattle (AZS), Kent                  |
| District 5       | Spring 2024      | Congolese Integration Network (CIN), SeaTac                     |
| District 6       | Spring 2024      | Ayan Maternity Health Care Services (AMHS), Kirkland            |
| District 6       | Spring 2024      | Indian American Community Services (IACS), Bellevue             |
| District 6       | Spring 2024      | NAMI Eastside (NAMI), Redmond                                   |
| District 8       | Spring 2024      | Alimentando al Pueblo, Burien                                   |
| District 4       | July 18, 2024    | Interagency School, Seattle                                     |
| District 8       | September 15     | Recovery Day Event, Seattle                                     |
| District 6       | September 23     | Redmond Community Center at Marymoor Village                    |
| District 2       | September 24     | El Centro de la Raza, Seattle                                   |
| District 9       | September 26     | Lake Wilderness Lodge, Maple Valley                             |
| District 4       | September 30     | KEXP, Seattle                                                   |
| District 8       | October 1        | Hatten Hall, West Seattle Senior Center                         |
| District 3       | October 3        | Riverview School District, Duvall                               |
| District 5       | October 8        | Puget Sound ESD Conference Center, Renton                       |
| District 7       | October 9        | William C Warren Building, Auburn                               |
| District 1       | October 10       | Spartan Recreation Center, Shoreline                            |
| District 5       | October 31       | Consejo Clinica, Renton                                         |
| District 7       | November 11      | Todd Beamer High School, Federal Way                            |
| District 4       | December 4       | Behavioral Health Legislature Forum, Seattle                    |
| District 2       | January 22, 2025 | Entre Hermanos, Seattle                                         |

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 84

| <b>Council District</b> | <b>Date (2024-2025)</b> | <b>Location</b>                                                      |
|-------------------------|-------------------------|----------------------------------------------------------------------|
| District 8              | March 17,19             | King County Correctional Facility (KCCF), Seattle [4 visits]         |
| District 5              | March 20, 21            | Maleng Regional Justice Center (MRJC), Kent [5 visits]               |
| District 8              | March 20                | Denny Middle School, Seattle                                         |
| District 1              | April 4                 | Shoreline Senior Center                                              |
| District 8              | April 4                 | Chief Sealth High School, Seattle                                    |
| District 4              | April 11                | Ballard Senior Center                                                |
| District 5              | April 14, 18            | South Correctional Facility (SCORE), Des Moines [4 visits]           |
| District 8              | April 15, 16            | Clark Children and Family Justice Center (CCFJC), Seattle [6 visits] |
| District 2              | April 17                | Fresh Start Housing, Seattle                                         |
| District 3              | April 23                | Issaquah Teen Cafe, Issaquah                                         |
| District 7              | June 25                 | Substance Use Recovery Conference, Auburn                            |
| District 3              | June 25                 | Cascade Park Apartments, North Bend                                  |
| District 3              | June 25                 | Sno-Ridge Apartments, North Bend                                     |
| District 3              | June 30                 | Sno-Valley Apartment, Carnation                                      |
| District 3              | July 16                 | Sno-Valley Senior Center, Carnation                                  |
| District 9              | July 17                 | King County Fair, Enumclaw                                           |
| District 8              | July 18                 | Reclaiming Wellness Conference                                       |
| District 9              | July 18                 | King County Fair, Enumclaw                                           |
| District 9              | July 19                 | King County Fair Enumclaw                                            |
| District 9              | July 20                 | King County Fair, Enumclaw                                           |
| District 7              | July 31                 | We are Comunidad, Federal Way                                        |
| District 3              | July 31                 | Mt. Si Senior Center                                                 |
| District 9              | August 4                | Maple Valley Community Center, Maple Valley                          |
| District 6              | August 30               | Redmond Pride Event, Redmond                                         |
| District 3              | October 15              | Sno-Valley Pride, Carnation                                          |

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3082

3083 **Figure 35: Number of individuals engaged per King County district**

| District where event occurred                                                 | Number of people engaged overall |
|-------------------------------------------------------------------------------|----------------------------------|
| 1                                                                             | 158                              |
| 2                                                                             | 282                              |
| 3                                                                             | 108                              |
| 4                                                                             | 179                              |
| 5                                                                             | 201                              |
| 6                                                                             | 326                              |
| 7                                                                             | 165                              |
| 8                                                                             | 365                              |
| 9                                                                             | 135                              |
| No District (Virtual listening sessions/participants didn't provide district) | 307                              |
| <b>Total number of community members engaged</b>                              | <b>2226</b>                      |

3084  
 3085 In addition, BHRD staff conducted 33 virtual listening sessions from a wide range of King County  
 3086 organizations (Figure 37).

3087  
 3088 **Figure 36: Virtual listening sessions and organizations engaged**

| Partner Engagement<br>July 2024 – October 2025                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Virtual Listening Sessions (2024-2025)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <ul style="list-style-type: none"> <li>• Behavioral Health Advisory Board [BHAB] Listening Session</li> <li>• Community-based Organization Listening Session (4 sessions)</li> <li>• General Public Listening Session (3 sessions)</li> <li>• HCHN Governance Council Listening Session</li> <li>• King County Alliance for Human Services (KCAHS) Listening Session</li> <li>• King County Employees Listening Session (2 sessions)</li> <li>• King County Rural Behavioral Health Collaborative Listening Session</li> <li>• MIDD Advisory Group Listening Session</li> <li>• MIDD Community Owned Behavioral Health Collaborative Listening Session</li> <li>• MIDD Leads Listening Session</li> <li>• One-on-one Virtual Interview (Consejo Counseling)</li> <li>• One-on-one Virtual Interview (Interagency Schools)</li> <li>• One-on-one Virtual Interview (Kent Youth &amp; Family Services)</li> <li>• One-on-one Virtual Interview (Mental Health Policy Roundtable)</li> <li>• One-on-one Virtual Interview (King County Drug Diversion Court)</li> <li>• Peer Listening Session (3 sessions)</li> <li>• Provider Listening Session (4 sessions)</li> <li>• Rural Community Listening Session (2 sessions)</li> <li>• SB SBIRT Listening Session</li> <li>• Sound Cities Association Listening Session</li> <li>• Vocal-WA Virtual Listening Session</li> </ul> |

#### **Affiliation of Organizations engaged**

- Alimentando al Pueblo (AAP)
- Association of Zambians in Seattle (AZS)
- Ayan Maternity Health Care Services (AMHS)
- Catholic Community Services
- CHARMD Behavioral Health (CHARMD)
- Children's Crisis Outreach Response System (CCORS)
- Choose 180
- City of Bellevue
- City of Renton
- Comunidad Latino De Vashon
- Communities of Rooted Brilliance (CRB)
- Consejo Counseling and Referral Services
- Empower Youth Network
- Encompass Northwest
- Ethiopian Community in Seattle (ECS)
- Filipino Community of Seattle (FCS)
- Friends of Youth
- Indian American Community Services (IACS)
- International Rescue Committee
- KCPH Community Navigator
- Kent Youth & Family Services (KYFS)
- KidVantage
- King County (DCHS-ASD, BHRD, CYAD, HCD & PHS)
- Khmer Community Services of Seattle King County (KCSKC)
- Korean Community Service Center (KCS)
- Peer Washington
- Pioneer Human Services
- Mental Health Policy Roundtable
- NAMI Eastside (NAMI)
- Neighborhood House
- New Americans Alliance for Policy and Research (NAAPR)
- Real Change
- Recovery Beyond
- Sea Mar
- SOUND Behavioral Health
- Southwest Youth & Family Services (SWYFS)
- The Dove Project
- Therapy Fund Foundation (TFF)
- Trail Youth
- Unkitawa
- Urban League
- Valley Cities Counseling and Consultation
- Vietnamese Health Board (VHB)
- Yoga Behind Bars

- YMCA
- Washington Therapy Fund Foundation
- Wagner Pediatrics Speech & Language

Listening sessions engaged people from diverse racial and ethnic backgrounds (Figure 38). At least 55 percent of participants identified as Black, Indigenous, or people of color, closely matching the overall demographics of King County.<sup>209</sup>

**Figure 37: Demographic information provided during Behavioral Health Bridge Renewal engagement**

| Race/Ethnicity                       | Percentage and Number of people engaged overall |
|--------------------------------------|-------------------------------------------------|
| Asian American/Pacific Islander      | 10% [225]                                       |
| Black                                | 15% [325]                                       |
| Latin(a/e/o/x)                       | 14% [320]                                       |
| Indigenous                           | 1% [30]                                         |
| Middle Eastern/ North African (MENA) | 2% [35]                                         |
| White                                | 13% [288]                                       |
| BIPOC/Prefer not to specify*         | 8% [175]                                        |
| Race/Ethnicity data not gathered**   | 37% [828]                                       |
| <b>Total individuals:</b>            | <b>2226</b>                                     |

\* The category “BIPOC/Prefer not to specify” was used by individuals who identified as BIPOC but did not feel comfortable providing more specific information.

\*\* The category of “Race/Ethnicity data not gathered” comes from engagement modalities where race/ethnicity were not requested during the engagement process, such as community-based events, and from participants who did not share their race/ethnicity information.

During behavioral health sales tax renewal engagement efforts in 2024, several groups were identified as communities that often face greater challenges in accessing behavioral healthcare and engagement in feedback processes: LGBTQIA+ people, incarcerated individuals, older adults, people with lived experience, and youth (Figure 39). Based on this information, 2025 engagement efforts related to the renewal focused on reaching these priority populations to ensure their perspectives were fully represented. One highlight of this effort was conducting 19 listening sessions in King County jails, hearing the perspectives of adults and youth who are currently incarcerated. The insights into the challenges these community members face, which often lead to cycling in and out of the detention centers, informed the criminal-legal system elements of this implementation plan.

**Figure 38: Priority populations engaged during Behavioral Health Bridge Renewal engagement**

| Priority population                                              | Number of people engaged |
|------------------------------------------------------------------|--------------------------|
| LGBTQIA+                                                         | 108 (4.9%)               |
| Incarcerated Individuals                                         | 126 (5.7%)               |
| Older adults (55+)                                               | 362 (16.3%)              |
| Peers (People with lived experience)                             | 356 (16.0%)              |
| Youth (12-25)                                                    | 209 (9.4%)               |
| <b>Total individuals that were part of a priority population</b> | <b>1161 (52.1%)</b>      |

During in-person and virtual listening sessions, the Behavioral Health Bridge Renewal team asked community members about their affiliations to better understand who was providing feedback. Figure 40 below shows the affiliation of these attendees throughout the years of engagement.

**Figure 39: Affiliations of attendees at listening sessions (in-person and virtual)**

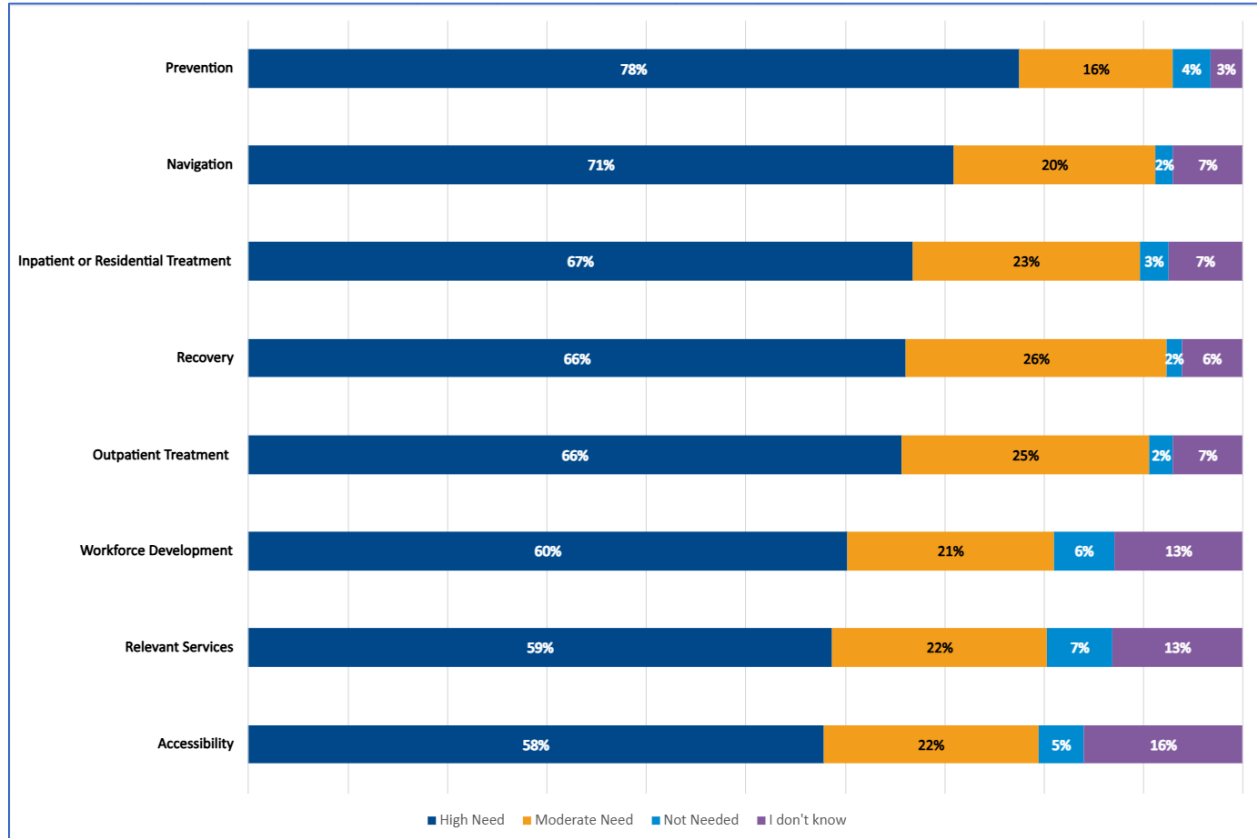
| Affiliation or self-identification of attendees                                | Number of people engaged |
|--------------------------------------------------------------------------------|--------------------------|
| LGBTQIA+ community members                                                     | 23 (3%)                  |
| Behavioral health providers                                                    | 72 (9%)                  |
| City government agencies                                                       | 50 (7%)                  |
| Community-based organizations (CBOs)                                           | 62 (8%)                  |
| Correctional officers                                                          | 15 (2%)                  |
| Incarcerated adults                                                            | 99 (13%)                 |
| Incarcerated youth                                                             | 27 (4%)                  |
| King County community members                                                  | 27 (4%)                  |
| King County employees                                                          | 47 (6%)                  |
| Older adults (55+)                                                             | 72 (9%)                  |
| Older adults with Limited English Proficiency (LEP) (Khmer & Spanish speaking) | 27 (4%)                  |
| Peers (People with lived/living experience)                                    | 61 (8%)                  |
| Rural health providers                                                         | 22 (3%)                  |
| School district staff                                                          | Δ                        |
| Volunteer at non-profit                                                        | Δ                        |
| Youth (Middle & high schoolers)                                                | 142 (19%)                |
| <b>Total individuals who provided affiliation data</b>                         | <b>763</b>               |

Δ Number of participants is suppressed when less than ten to protect privacy.

### Online survey

The Behavioral Health Bridge Renewal team published an online survey to gather feedback from community members who couldn't participate in the other engagement modalities. This survey was available in over 20 languages and was open from August to October 2024 and July to October 2025. 473 respondents to the online survey were asked to identify the greatest barriers to accessing behavioral health services (Figure 41). Every factor was identified as a "high need" by more than half of the respondents, painting a portrait of widespread unmet need.

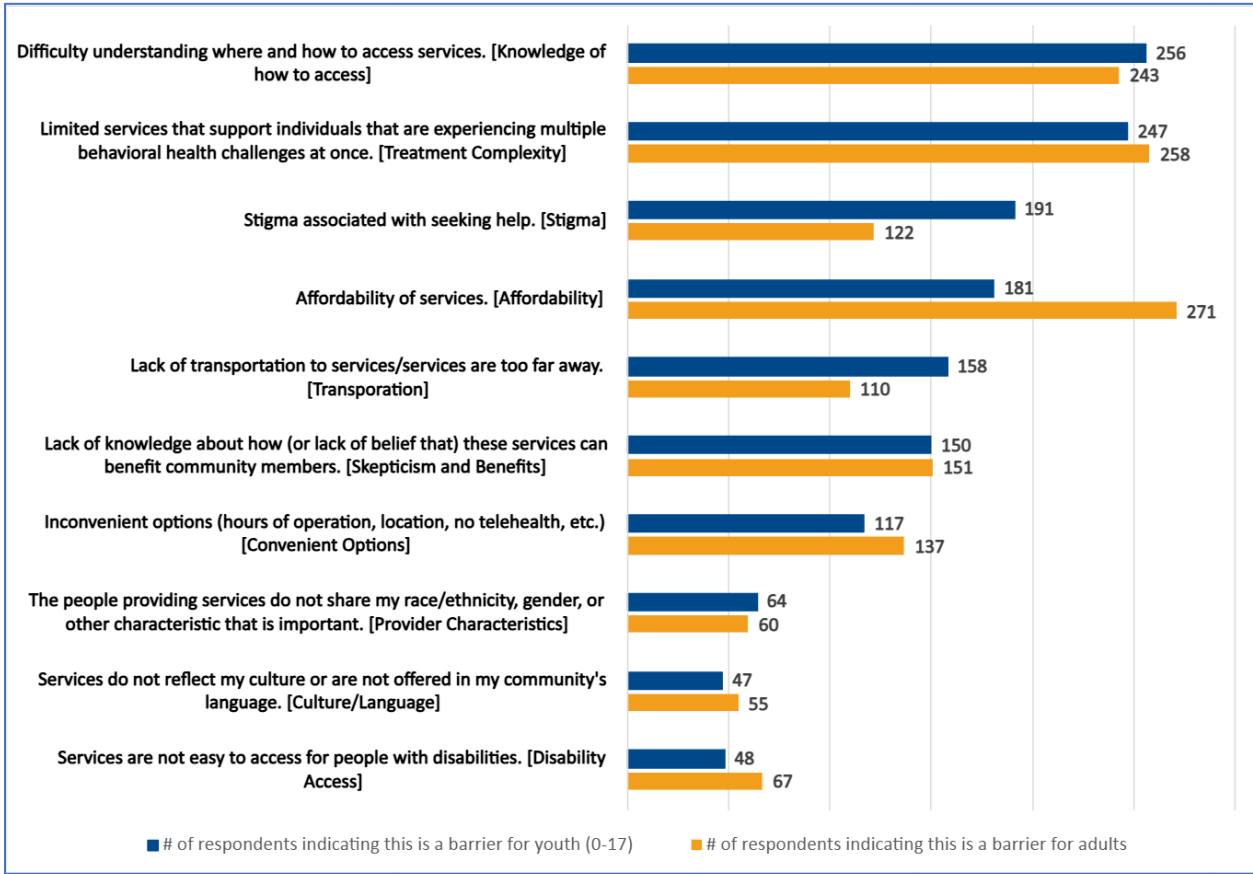
**Figure 40: Online survey respondents' rating of behavioral health system barriers**



In separate questions about barriers for adults and youth (ages 0-17), respondents were provided with a set of potential barriers and were asked to select the three most pressing (Figure 42). The top two barriers for both adults and youth were “difficulty understanding where and how to access services” and “lack of services for co-occurring conditions, consistent with the themes that emerged from the listening sessions.”

On other topics, however, answers differed across age groups. Thirty-six percent of respondents said stigma associated with seeking help was a barrier for youth, while only 25 percent said it was a barrier for adults. Similarly, 42 percent of respondents indicated that affordability of services was a barrier for adults, but only 26 percent said the same for youth.

**Figure 41: Percent of online survey respondents indicating a barrier as “most pressing”**



All community engagement data was used to inform the strategy areas, goals, and anticipated activities described in this implementation plan. Specific influences are reflected in [Appendix C](#).



### C. Appendix C. Crosswalk of strategy areas and community engagement themes

Figure 43 summarizes the relationships between the Behavioral Health Bridge strategy areas and the themes that emerged from renewal-related community engagement. Although all themes will influence all strategy areas to some degree (for example, the theme of “Culturally relevant and responsive care” will be incorporated into all strategy areas), the table displays the themes that are most strongly connected to each strategy area.

**Figure 42: Community engagement themes informing each Behavioral Health Bridge strategy area**

| Strategy area                                         | Most relevant community engagement themes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Care Transitions and Diversion Services</b>        | <ul style="list-style-type: none"> <li>• <b>Reduce system fragmentation and improve service coordination</b> (subthemes: struggles with system navigation; transitional service gaps)</li> <li>• <b>Strengthen wraparound services</b> (subthemes: crisis diversion and harm reduction; housing crisis; aftercare for those leaving incarceration or inpatient settings)</li> </ul>                                                                                                                                                                                     |
| <b>Substance Use Disorder Treatment and Recovery</b>  | <ul style="list-style-type: none"> <li>• <b>Reduce system fragmentation and improve service coordination</b> (subthemes: SUD struggles with system navigation; SUD service gaps)</li> <li>• <b>Strengthen and expand the behavioral health workforce</b> (subthemes: SUD peer support models)</li> <li>• <b>Strengthen wraparound services that use team-based care and connect people to basic needs</b> (subthemes: crisis diversion and harm reduction; housing crisis; support for community-based organizations to address SUD)</li> </ul>                         |
| <b>Equitable Access to Behavioral Health Care</b>     | <ul style="list-style-type: none"> <li>• <b>Increase access and reduce barriers</b> (subthemes: lack of affordable care; insurance barriers; transportation barriers)</li> <li>• <b>Strengthen culturally relevant and responsive care</b> (subthemes: provider diversity and cultural responsiveness; unique trauma and stressors; language access)</li> </ul>                                                                                                                                                                                                         |
| <b>Child, Youth, and Young Adult Mental Wellbeing</b> | <ul style="list-style-type: none"> <li>• <b>Strengthen and increase services for children, youth, and young adults</b> (subthemes: support for parents/caregivers; crafting safe spaces; increase awareness and decrease stigma)</li> <li>• <b>Priority population: LGBTQIA+</b> (heightened concern for queer and trans youth in current sociopolitical climate)</li> <li>• <b>Priority population: Youth</b> (more attention to young people with co-occurring mental health and SUD conditions, as well as those involved in the criminal justice system)</li> </ul> |
| <b>Behavioral Health Workforce Development</b>        | <ul style="list-style-type: none"> <li>• <b>Strengthen and expand the behavioral health workforce</b> (subthemes: staffing shortages and high turnover; career development and advancement; peer support models)</li> <li>• <b>Strengthen culturally relevant and responsive care</b> (subthemes: provider diversity and cultural responsiveness; language access)</li> </ul>                                                                                                                                                                                           |

## D. Appendix D. Multi-sector subject matter expert process

### Recommendations

Figure 44 displays a crosswalk of the goals presented in this implementation plan alongside the SME workgroup suggestions that informed anticipated activities for each goal.

**Figure 43: Crosswalk of SME suggestions and investments for a renewed Behavioral Health Bridge**

| Implementation plan goal                                                                                                                                                        | SME suggestions that informed the anticipated activities for each goal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CTD Goal 1. Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.</b> | <p>From the SUD group:</p> <ul style="list-style-type: none"><li>• Scale and strengthen established diversion frameworks that feature a workforce emphasizing those with lived experience, including certified peers.</li><li>• Medications and other forms of treatment and support for people in jail, both before and after release.</li><li>• Tailored navigation and wraparound services (transportation, housing) for people with SUD leaving incarceration.</li><li>• Low-barrier places to stay with behavioral health supports for people leaving incarceration.</li></ul>                                                                                                                                                                                                                    |
| <b>CTD Goal 2. Help people with behavioral health conditions achieve and maintain stable housing.</b>                                                                           | <p>From the CTD group:</p> <ul style="list-style-type: none"><li>• More immediate and transitional shelter/housing options for people transitioning out of incarceration, hospitals, treatment facilities, or homelessness, that include a few key 24/7 essential supports.</li></ul> <p>From the SUD group:</p> <ul style="list-style-type: none"><li>• Wraparound services connecting people to housing and other supports when accessing SUD care (and vice versa).</li></ul>                                                                                                                                                                                                                                                                                                                       |
| <b>CTD Goal 3. Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.</b>               | <p>From the CTD group:</p> <ul style="list-style-type: none"><li>• Contract a technology platform that is accessible to all providers that bridges and simplifies communication across existing programs, organizations, and systems, such as behavioral health, criminal-legal, and housing, and others.</li><li>• Benefit and resource navigators (for people exiting incarceration, among others).</li><li>• Care navigation programs.</li><li>• Benefit navigators to help people get food, housing, legal help, medical care, etc.</li></ul> <p>From the SUD group:</p> <ul style="list-style-type: none"><li>• Enhance coordination and support services for people moving between withdrawal management and inpatient programs, as well as between inpatient and outpatient providers</li></ul> |

| Implementation plan goal                                                                            | SME suggestions that informed the anticipated activities for each goal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                     | <ul style="list-style-type: none"> <li>Technology that allows real-time tracking of available supports, facilitates warm handoffs, and streamlines linkage to care (community information exchange).</li> <li>Reimagine SUD Next Day Appointments (NDA) for youth and young adults.</li> </ul> <p>From the EA group:</p> <ul style="list-style-type: none"> <li>Low-barrier case management and robust behavioral health services for people with low incomes who are uninsured, underinsured, or unhoused.</li> </ul> <p>From the CYYA group:</p> <ul style="list-style-type: none"> <li>Coordinated, high-quality, billable navigation and case management to help families find and coordinate multiple types of services at once</li> <li>Funding technology to alleviate administrative burdens.</li> </ul> <p>From the WF group:</p> <ul style="list-style-type: none"> <li>Leverage technology as appropriate to reduce administrative burdens.</li> </ul>                                       |
| <b>SUD Goal 1. Drive engagement and retention in SUD care.</b>                                      | <p>From the SUD group:</p> <ul style="list-style-type: none"> <li>Outreach strategies that are delivered in a non-mobile setting, such as emergency departments and primary care.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>SUD Goal 2. Provide effective, low-barrier SUD treatment that meets people's holistic needs.</b> | <p>From the SUD group:</p> <ul style="list-style-type: none"> <li>Mobile services, such as peer navigation, mobile medication for opioid use disorder (MOUD), and outreach services, that meet people where they are in coordination with available well-designed low-barrier services such as shelter, intensive case management, housing navigation and legal coordination.</li> <li>Increased access to medication for substance use disorders (MSUD), including through innovative strategies like long-acting injectables</li> <li>Low-barrier harm reduction services</li> <li>Medications and other forms of treatment and support for people in jail, both before and after release.</li> <li>Achieve equitable rates of access to SUD treatment and recovery across races, ethnicities, languages, ages, sexual orientations, gender identities, and parts of the county by bolstering community-based paths to recovery that are tailored to the needs of the people being served.</li> </ul> |
| <b>SUD Goal 3. Support paths to achieve and maintain recovery after treatment.</b>                  | <p>From the SUD group:</p> <ul style="list-style-type: none"> <li>Achieve equitable rates of access to SUD treatment and recovery across races, ethnicities, languages, ages, sexual orientations, gender identities, and parts of the county by bolstering community-based paths to recovery that are tailored to the needs of the people being served.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

| Implementation plan goal                                                                                                                                     | SME suggestions that informed the anticipated activities for each goal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>EA Goal 1. Provide behavioral health care for low-income people who are ineligible for Medicaid.</b>                                                      | <p>From the SUD group:</p> <ul style="list-style-type: none"> <li>• Clinical treatment and case management for people not covered by Medicaid that are tailored to the needs of the people being served.</li> <li>• Medicaid services for non-Medicaid youth, such as outpatient, intensive outpatient, and residential treatment</li> </ul> <p>From the EA group:</p> <ul style="list-style-type: none"> <li>• Language access/Language justice.</li> </ul>                                                                                                                                                                                                                                                                                                                                                         |
| <b>EA Goal 2. Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.</b> | <p>From the SUD group:</p> <ul style="list-style-type: none"> <li>• Non-clinical services and supports that are not covered by Medicaid and are tailored to the needs of the people being served</li> </ul> <p>From the EA group:</p> <ul style="list-style-type: none"> <li>• Fund culturally centered organizations to develop and provide community-based programs that address community-identified needs.</li> <li>• Pay for culturally centered organizations to hire peer supporters who can provide relationship-based case management and navigation services, including accompanying people to behavioral health appointments.</li> <li>• Affirming services for LGBTQIA+ communities.</li> <li>• Services by and for rural communities.</li> <li>• Trauma-informed and trauma-responsive care.</li> </ul> |
| <b>CYYA Goal 1. Improve youth access to behavioral health care by providing services that meet young people where they are, at school and in community.</b>  | <p>From the SUD group:</p> <ul style="list-style-type: none"> <li>• School-based SBIRT.</li> <li>• Recovery High Schools for a safe and sober environment where students pursue academic and career goals.</li> <li>• Mobile MSUD and intensive case management for youth and young adults who are experiencing homelessness.</li> <li>• Increased withdrawal management and MOUD treatment options for youth.</li> </ul> <p>From the CYYA group:</p> <ul style="list-style-type: none"> <li>• Universal screenings and tiered response with brief intervention.</li> <li>• School-based health services that include SUD as well as mental health.</li> <li>• Mobile therapy</li> </ul>                                                                                                                             |
| <b>CYYA Goal 2. Provide behavioral health and therapeutic services to youth involved in the legal system, including</b>                                      | <p>From the CYYA group:</p> <ul style="list-style-type: none"> <li>• Tailored services, wraparound supports, and partnership programs between the County and community-based organizations (CBOs) to identify and support youth who are involved or at-risk of being involved in the criminal-legal system, including programs serving their families.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

| Implementation plan goal                                                                                    | SME suggestions that informed the anticipated activities for each goal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>diversion from deeper legal system involvement</b>                                                       | <ul style="list-style-type: none"> <li>• Innovative community-based programs that engage youth who are involved or at risk of being involved in the criminal-legal system in healthy activities.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>CYYA Goal 3. Invest in the behavioral health of youth who are marginalized or experience inequities.</b> | <p>From the CYYA group:</p> <ul style="list-style-type: none"> <li>• Ensure that youth with complex needs can have their needs met, regardless of acuity.</li> <li>• Fund culturally centered organizations to incorporate behavioral health supports into existing youth-focused programming.</li> <li>• Targeted, identify-affirming supports for LGBTQIA+ youth.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>WF Goal 1. Strengthen and diversify the behavioral health provider pipeline.</b>                         | <p>From the CTD group:</p> <ul style="list-style-type: none"> <li>• Grow the non-clinical workforce (peers, CHWs, wellbeing specialists, care navigators, benefit navigators, non-clinical case managers, etc.), which can act as trusted supports.</li> </ul> <p>From the SUD group:</p> <ul style="list-style-type: none"> <li>• Support workforce development for peer and non-clinical providers</li> </ul> <p>From the EA group:</p> <ul style="list-style-type: none"> <li>• Support for behavioral health workforce development activities in community-centered organizations, such as internships and other provider training programs to create a more diverse provider pipeline.</li> </ul> <p>From the CYYA group:</p> <ul style="list-style-type: none"> <li>• Recruitment and retention programs that attract providers from diverse backgrounds and communities, especially multilingual providers.</li> </ul> <p>From the WF group:</p> <ul style="list-style-type: none"> <li>• Fund well-supported internships to bolster a diverse provider pipeline.</li> <li>• Recruitment and training in clinical and non-clinical provider roles, such as peers, mental health care practitioners (MHCPs), etc.</li> <li>• Programs in diverse middle and high schools to increase BH career awareness and pathways among BIPOC youth.</li> </ul> |
| <b>WF Goal 2. Advance and develop the skills of the current workforce to meet growing community needs.</b>  | <p>From the CTD group:</p> <ul style="list-style-type: none"> <li>• Training and development to implement best practices in crisis, navigation, and transition services, such as implementing peer supports and meeting basic needs first</li> <li>• Additional support for supervision and internship with a particular focus on diversifying the workforce.</li> </ul> <p>From the CYYA group:</p> <ul style="list-style-type: none"> <li>• Training and workforce support to ensure there are enough providers who can successfully work with high-acuity youth.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

| Implementation plan goal | SME suggestions that informed the anticipated activities for each goal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                          | <ul style="list-style-type: none"> <li>Develop pathways to multi-licensure or team-based care to enable providers to better serve youth with complex needs.</li> </ul> <p>From the WF group:</p> <ul style="list-style-type: none"> <li>Increase support for clinical supervision.</li> <li>Training curricula that better prepare students for the realities of the job.</li> <li>Support clinical competency by offering ongoing clinical supervision and support.</li> <li>Trainings on cultural humility and trauma-informed care, including funding to access trainings and replace lost income from billable activities.</li> <li>Create training programs in evidence-based practices (EBPs) within community behavioral health settings.</li> <li>Programs that help mental health practitioners become licensed for SUD, and vice versa.</li> <li>Training pathways on specialized skills for serving children, youth, and young adults, including those with developmental disabilities.</li> </ul> |

## 3166 Participants

3167 The names of participants in the multi-sector subject matter expert workgroups and the  
3168 organization they represented at the time of their participation are listed below. Workgroup  
3169 meetings took place between April 21 and July 16, 2025. Each workgroup was overseen by a  
3170 steering committee, whose members are also listed below.

3171  
3172 An asterisk (\*) indicates the individual is also a member of the MIDD Advisory Committee.  
3173

### 3174 *Care Transitions and Diversion Services (CTD)*

#### 3175 3176 **Steering committee:**

- 3177 • Amanda Besel, King County DCHS
- 3178 • Ash Warren, King County DCHS
- 3179 • Chelsea Baylen, King County DCHS
- 3180 • Kari Taylor, King County DCHS
- 3181 • Kayla Rodriguez, King County DCHS
- 3182 • Sara Tapia, King County DCHS
- 3183 • Stephanie Moyes, King County DCHS
- 3184 • Susan Peacey, King County DCHS

#### 3185 3186 **Workgroup:**

- 3187 • Amanda Bieber-Mayberry, Wellpoint
- 3188 • Anthony Hoffer, Crisis Connections
- 3189 • Bethany O'Neill, Psychologist/Court Evaluator (Options Psychological)
- 3190 • Brian Allender, King County Chief Medical Officer

- 3191 • Chloe Gale, ETS/REACH
- 3192 • Christina Mason, King County Adult Drug Diversion Court (delegate of Catherine Cornwall\*)
- 3193 • Dominique Davis, Community Passageways/Choose 180
- 3194 • Emily Shapiro, DESC
- 3195 • Freyton Castillo, King County DCHS
- 3196 • Jennifer McPherson, Pioneer Human Services
- 3197 • Jessica Rosado, Valley Cities
- 3198 • Jim Conroy, King County ASD Veterans Reentry Program
- 3199 • Jose “Neaners” Garcia, Second Chance Outreach
- 3200 • Joshua Thorne, King County DCHS
- 3201 • Kate Anderson, DCYF
- 3202 • Kate Tramontana, King County District Court – Therapeutic Courts
- 3203 • Kimberly Hardy, Regional Crisis Response (RCR)
- 3204 • Kimmy Reedy, Peer Washington
- 3205 • LaTrecia Smith, King County DCHS
- 3206 • Lt. Jeff Gepner, SCorE
- 3207 • Dr. Matthew Goldman, King County DCHS, Crisis Systems Medical Director
- 3208 • Megan Murphy, King County Jail Health Services
- 3209 • Owen Riley, Harborview
- 3210 • Rachel Dryden, King County Department of Public Defense
- 3211 • Rheanell Roberts, King County DCHS
- 3212 • Stacey Devenney, Harborview\*
- 3213 • Sue Rash, YMCA Mobile Crisis Team

3214

3215 *Substance Use Disorder Treatment and Recovery (SUD)*

3216

3217 **Steering committee:**

- 3218 • Brad Finegood, Public Health – Seattle & King County\*
- 3219 • Dan Floyd, King County DCHS
- 3220 • David Perlmutter, King County DCHS
- 3221 • Dedra Barrow, Public Health – Seattle & King County
- 3222 • Delton Mosby, King County DCHS
- 3223 • Ericka Turley, Public Health – Seattle & King County
- 3224 • Ileana Janovich, King County DCHS
- 3225 • Jennifer Wyatt, King County DCHS
- 3226 • Robyn Smith, King County DCHS

3227

3228 **Workgroup:**

- 3229 • Angie Thompson, St Frances, St Anne, and St Elizabeth Hospitals
- 3230 • Apoorva Mallya, Hepatitis Education Project
- 3231 • Elsa Tamru, Harborview
- 3232 • Esther Lucero, Seattle Indian Health Board
- 3233 • Harumi Hashimoto, Asian Counseling and Referral Service (ACRS)
- 3234 • Hussein Ugas, Rahma Recovery Center
- 3235 • James Lovell, Chief Seattle Club

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 98



- 3236 • Jessica Levy, Interagency Academy/Recovery High School
- 3237 • Joe Barsana, King County Drug Diversion Court
- 3238 • Johnny Ohta, Ryther
- 3239 • Joshua Wallace, Peer Washington\*
- 3240 • Laura Quinn, King County Community Prevention and Wellness Initiative
- 3241 • Leslie Enzian, UW Medicine
- 3242 • Lisa Rogers, Sound
- 3243 • Malika Lamont – Purpose Dignity Action / LEAD
- 3244 • Manuela Raunig-Berho, ETS/REACH
- 3245 • Mark Varela, Coordinated Care Washington
- 3246 • Mary Hatch – UW Addictions, Drug, and Alcohol Institute
- 3247 • Monika Whitfield, Washington Recovery Alliance
- 3248 • Nicole Davis-Westbrook, WA Recovery Helpline and Crisis Connections
- 3249 • Sabrina de la Fuente, Consejo Counseling and Referral Services
- 3250 • Scott Reding, Integrative Counseling Services
- 3251 • Taylor Richards, Recovery Beyond
- 3252 • Thea Oliphant-Wells, Public Health – Seattle & King County
- 3253 • Vania Rudolph – Swedish Recovery Services
- 3254 • Vicki Brinigar – Valley Cities

3255  
3256 *Equitable Access to Behavioral Health Care (EA)*

3257  
3258 **Steering committee:**

- 3259 • Anne-Marie Bishop, King County DCHS
- 3260 • Idabelle Fosse, King County DCHS
- 3261 • Karen Spoelman, King County DCHS
- 3262 • Makayla Wright, Public Health – Seattle & King County
- 3263 • Robin Pfohman, King County DCHS
- 3264 • Tyler Corwin, King County DCHS
- 3265 • Ziyang Hu, King County DCHS

3266  
3267 **Workgroup:**

- 3268 • Amarinthia Torres, Coalition Ending Gender-Based Violence
- 3269 • Bonnie Wang, Asian Counseling and Referral Service (ACRS)
- 3270 • Candace Hunsucker, Community Health Plan of Washington
- 3271 • Carline Stephens, King County DCHS
- 3272 • David Bulindah, Wakulima
- 3273 • David Coffey, Recovery Café
- 3274 • Eben Pobee, CharmD Behavioral Health
- 3275 • Fartun Mohamed, Somali Health Board\*
- 3276 • Jade Park, Harborview
- 3277 • Jams Stuvenga, Sound Generations
- 3278 • Jessica Knaster Wasse, Public Health – Seattle & King County
- 3279 • Lea Aromin, Coalition Ending Gender-Based Violence
- 3280 • Marc Oommen, NAMI Eastside\*

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 99



- 3281 • Nimo Abdullahi, Peer Community
- 3282 • Rashaun Renggli, The DOVE Project
- 3283 • Rosario Lopez, Super Familia
- 3284 • Someireh Amirfaiz, New American Alliance for Policy and Research\*
- 3285 • Thyda Chhom, Khmer Community of Seattle – King County
- 3286 • Wilbur Klein, King County DCHS

3287 *Child, Youth, and Young Adult Mental Wellbeing*

3288

3289 **Steering committee:**

- 3290 • Caress Piña, King County DCHS
- 3291 • Delaney Kottnerus, King County DCHS
- 3292 • Fatima Al-Shimari, King County DCHS
- 3293 • Jim Ott, King County DCHS
- 3294 • Latonya Rogers, King County DCHS
- 3295 • Nacoubi Jiles, King County DCHS
- 3296 • Rebekah Woods, King County DCHS
- 3297 • Sarah Wilhelm, Public Health – Seattle & King County

3298

3299 **Workgroup:**

- 3300 • Anthony Austin, Southeast Youth and Family Services\*
- 3301 • Connie Gonzales, Guided Pathways for Youth and Families
- 3302 • Dianne Boyd, Children’s Crisis Outreach Response (CCORS) for Developmental Disabilities
- 3303 • Emmy Bell, Vashon Youth & Family Services
- 3304 • Eric Mayne, Therapeutic Health Services
- 3305 • Hodan Mohamed, Washington Multicultural Services Link
- 3306 • Jeni Johnson, Vashon Youth & Family Services\*
- 3307 • Jorene Reiber, Family Court (King County Superior Court)\*
- 3308 • Kashi Arora, Seattle Children’s Hospital
- 3309 • Kate Garvey, King County Sexual Assault Resource Center
- 3310 • Kristen Prentice, SeaMar
- 3311 • Letha Fernandez, Sound
- 3312 • Libby Hein, Molina Healthcare
- 3313 • M’Liss Moon, Empower Youth Network
- 3314 • Martha Aguiniga, Mente Counseling and Consulting
- 3315 • Megan Walsh, Encompass
- 3316 • Robert Gant, Juvenile Court Services (King County Superior Court)
- 3317 • Sarah Burdell, International Community Health Services (ICHS)
- 3318 • Sarah Walker, UW CoLab for Community & Behavioral Health Policy
- 3319 • Sarah Wilhelm, Best Starts for Kids (Public Health – Seattle & King County)
- 3320 • William Hairston, Center for Children and Youth Justice

3321

3322 *Behavioral Health Workforce Development*

3323

3324 **Steering committee:**

- 3325 • Brandon Paz, King County DCHS

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 100

- 3326 • David Perlmutter, King County DCHS
- 3327 • Jessamyn Findlay, King County DCHS
- 3328 • Karen Manuel, King County DCHS
- 3329 • Lisa Floyd, King County DCHS
- 3330 • Margaret Soukup, King County DCHS
- 3331 • Molly Bauer, King County DCHS
- 3332 • Sarah Boye, King County DCHS

3333

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- 3336 • Anna Duncan, UW CoLab for Community & Behavioral Health Policy
- 3337 • Dr. Brian Allender, King County Chief Medical Officer
- 3338 • Dan Ferguson, Washington State Allied Health Center of Excellence
- 3339 • Danie Eagleton, Seattle University
- 3340 • Elizabeth Schaumberg, Crisis Connections
- 3341 • Erin Lloyd, Valley Cities
- 3342 • Genell Hennings, YMCA Heritage Masters Program
- 3343 • Jackie Bui, Youth Eastside Services
- 3344 • Jasmeet Singh, Crisis Text Line\*
- 3345 • Laura Knapp, Seattle Children's Hospital
- 3346 • Mario Paredes, Consejo Counseling and Referral Services\*
- 3347 • Melody McKee, SEIU Healthcare Training Fund
- 3348 • Renee Fullerton, Washington Training & Education Coordinating Board
- 3349 • Robyn Smith, King County DCHS
- 3350 • Sachi Horback, United Healthcare
- 3351 • Shaena Spoor, Deconstructing the Mental Health System
- 3352 • Stacey Lopez, Sound
- 3353 • Stephanie Lane, Peer Washington
- 3354 • Tavish Donahue, Healthier Here

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## E. Appendix E. Implementation examples of the five equity pillars

Figure 44: Implementation examples of the equity framework pillars

| Pillar                                                       | Examples of the equity framework in action during the renewal process and in the renewed Behavioral Health Bridge                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|--------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Connected and coordinated</b>                             | <ul style="list-style-type: none"><li>- Renewal process: Consulted with a wide range of County and non-County partners to understand the behavioral health landscape and identify high-potential investments where the behavioral health sales tax can make the greatest impact.</li><li>- Behavioral Health Bridge 2028-2034: Goals are interconnected (for example, workforce investments to increase the number and diversity of SUD professionals will also make SUD goals more successful).</li></ul>                                                                                                                                                     |
| <b>Transparent and accountable</b>                           | <ul style="list-style-type: none"><li>- Renewal process: DCHS published community engagement results online in 2024 and 2025.</li><li>- Behavioral Health Bridge 2028-2034: The implementation plan includes crosswalks showing how community feedback was incorporated (see <a href="#">Appendix C</a> and <a href="#">Appendix D</a>).</li><li>- Behavioral Health Bridge 2028-2034: Robust evaluation will ensure transparency and accountability, including through disaggregation of performance data by race, ethnicity, and language.</li></ul>                                                                                                         |
| <b>Inclusive, collaborative, diverse, and people-focused</b> | <ul style="list-style-type: none"><li>- Renewal process: Translated written materials and provided language interpretation at community listening sessions to ensure inclusivity and language access.</li><li>- Renewal process: Included people with lived experience in the subject matter expert workgroups that developed recommendations for behavioral health sales tax investments.</li><li>- Behavioral Health Bridge 2028-2034: Outcome evaluation will use participatory and community-based models when appropriate and feasible.</li></ul>                                                                                                         |
| <b>Responsive and adaptive to community-identified needs</b> | <ul style="list-style-type: none"><li>- Renewal process: Incorporated community and subject matter expert feedback into the implementation plan.</li><li>- Behavioral Health Bridge 2028-2034: DCHS will procure programs that support community-identified solutions to behavioral health concerns (EA goal 2 and CYYA goal 3).</li><li>- Behavioral Health Bridge 2028-2034: Contracted providers will have an opportunity to receive capacity-building and technical assistance to help them become more culturally and linguistically accessible.</li></ul>                                                                                                |
| <b>Accessible and available</b>                              | <ul style="list-style-type: none"><li>- Behavioral Health Bridge 2028-2034: Investments will make behavioral health care more accessible and available, including through care navigation and timely services (CTD and SUD strategy areas), culturally responsive and developmentally appropriate care (EA and CYYA strategy areas), and by addressing workforce shortages and increasing provider diversity (WF strategy area).</li><li>- Behavioral Health Bridge 2028-2034: Program evaluation will include monitoring the number of clients being served, and for how long, to alleviate capacity constraints and increase service availability.</li></ul> |

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## 336XIV. Endnotes

<sup>1</sup> Office of Economic and Financial Analysis. *March 2026 King County Economic and Revenue Forecast*. [[https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026\\_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99](https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99)]

<sup>2</sup> RCW 82.14.460. [<https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460>]

<sup>3</sup> K.C.C. 4A.500.315: Sales and use tax - for behavioral health programs and services, and therapeutic courts programs and services. [[https://aqua.kingcounty.gov/council/clerk/code/07\\_Title\\_4A.htm#\\_Toc54697846](https://aqua.kingcounty.gov/council/clerk/code/07_Title_4A.htm#_Toc54697846)]

<sup>4</sup> 2026-2027 King County Biennial Budget Ordinance 20023, Section 70, Expenditure Restriction ER6. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7680373&GUID=B4E9E09C-A982-4A8C-A0DA-6CC195D69EE0>]

<sup>5</sup> MIDD 2 Implementation Plan (2018). [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804\\_midd\\_implementation\\_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_implementation_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72)]

<sup>6</sup> DCHS' communication channels include, but are not limited to, the Cultivating Connections department blog and department social media accounts.

<sup>7</sup> Office of Economic and Financial Analysis. *March 2026 King County Economic and Revenue Forecast*. [[https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026\\_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99](https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99)]

<sup>8</sup> RCW 82.14.460. [<https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460>]

<sup>9</sup> K.C.C. 4A.500.315. [[https://aqua.kingcounty.gov/council/clerk/code/07\\_Title\\_4A.htm#\\_Toc54697846](https://aqua.kingcounty.gov/council/clerk/code/07_Title_4A.htm#_Toc54697846)]

<sup>10</sup> RCW 82.14.460. [<https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460>]

<sup>11</sup> Ordinance 15949 (2007). [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=554785&GUID=D03F4D6D-19CA-4973-AB42-558B5BAC250E>]

<sup>12</sup> Ordinance 18333 (2016). [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=2745995&GUID=70E5373E-EAD8-4E04-8470-ADF157652B25>]

<sup>13</sup> Ordinance 19976 (2025). [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7477276&GUID=C9F88779-E410-4BF9-9D6C-1E5CF80E02DE>]

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<sup>14</sup> Ordinance 19976 (2025). [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7477276&GUID=C9F88779-E410-4BF9-9D6C-1E5CF80E02DE>]

<sup>15</sup> Greenstone, S. (August 2023). *22 Washington counties sue state for ‘refusing’ to provide mental health services* [KNKX Public Radio]. [<https://www.knkx.org/law/2023-08-23/washington-state-counties-lawsuit-mental-health-services>]; Archibald, A. (August 2022). Investing in health | Missing money. *Real Change* [<https://www.realchangenews.org/news/2022/08/17/investing-health-missing-money>]

<sup>16</sup> King County DCHS. *MIDD Behavioral Health Sales Tax dashboard*. [<https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-behavioral-health-tax/midd-behavioral-health-sales-tax-dashboard>]

<sup>17</sup> MIDD 2 Implementation Plan (2018). [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804\\_midd\\_implementation\\_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_implementation_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72)]

<sup>18</sup> 2026-2027 King County Biennial Budget Ordinance 20023, Section 70, Expenditure Restriction ER6. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7680373&GUID=B4E9E09C-A982-4A8C-A0DA-6CC195D69EE0>]

<sup>19</sup> MIDD 2 Implementation Plan (2018). [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804\\_midd\\_implementation\\_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_implementation_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72)]

<sup>20</sup> RCW 82.14.460. [<https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460>]

<sup>21</sup> RCW 82.14.460. [<https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460>]

<sup>22</sup> This plan uses the name “MIDD” to refer to investments prior to 2026 and uses “the Bridge” and related terms to refer to current and future investments.

<sup>23</sup> MIDD 2 Initiative Descriptions. [<https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-behavioral-health-tax/initiatives>]

<sup>24</sup> These outcomes describe the experiences of individuals enrolled in relevant MIDD initiatives between 2017 and 2022, three years following program participation.

<sup>25</sup> King County DCHS. *MIDD Behavioral Health Sales Tax dashboard*. [<https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-behavioral-health-tax/midd-behavioral-health-sales-tax-dashboard>]; Click on “Plans, Reports, and Briefing Papers” on the right sidebar to see reports prior to 2024.

<sup>26</sup> King County Executive Order, “Breaking the Cycle.” Document Code ACO-8-34-EO. March 31, 2026.

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[[https://content.govdelivery.com/attachments/WAKING/2026/03/31/file\\_attachments/3602521/Breaking%20the%20Cycle%20Executive%20Order%20Final.pdf](https://content.govdelivery.com/attachments/WAKING/2026/03/31/file_attachments/3602521/Breaking%20the%20Cycle%20Executive%20Order%20Final.pdf)]

<sup>27</sup> King County Department of Community and Human Services. (2023, July). *The KCICN Improves Access to Behavioral Health Care for Residents Furthest from Care*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/2023-kcicn-legislative-handout.pdf?rev=c5a838bfcdba42a590b5dd1d078bc0d8&hash=DA4ADD564B01D20B4402B3C3D424F07B>]

<sup>28</sup> Based on the BHRD financial plan as of January 1, 2026, consistent with projections available at the time of adoption of the 2026-2027 Biennial Budget Ordinance.

<sup>29</sup> Motion 15093. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=3119993&GUID=ABA47252-DF74-49B5-A4DA-C5391A5F71CD>]

<sup>30</sup> King County DCHS. (2023). *The KCICN Improves Access to Behavioral Health Care for Residents Furthest from Care*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/2023-kcicn-legislative-handout.pdf?rev=c5a838bfcdba42a590b5dd1d078bc0d8&hash=DA4ADD564B01D20B4402B3C3D424F07B>]

<sup>31</sup> King County DCHS. *Crisis Care Centers Initiative*. [<https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/crisis-care-centers-levy>]

<sup>32</sup> King County DCHS. *Health Through Housing Initiative*. [<https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/health-through-housing>]

<sup>33</sup> Veterans, Seniors, and Human Services Levy (VSHSL) Implementation Plan for 2024-2029. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/asd/2024-2029-vshsl-implementation-plan.pdf?rev=e319cf4d9d2e410c8e4777061315145b&hash=CE5452BA60853FC0B26C240224388DFD>]

<sup>34</sup> Washington State Health Care Authority. (2024). *Apple Health Expansion enrollment cap*. [<https://www.hca.wa.gov/about-hca/news/announcements/apple-health-expansion-enrollment-cap>]

<sup>35</sup> Washington State Health Care Authority. *Medicaid Transformation Project (MTP)*. [<https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp>]

<sup>36</sup> Brunner, J. and Sowersby, S. (2026). WA budget woes dominate as Ferguson, lawmakers begin 2026 session. *The Seattle Times*. [<https://www.seattletimes.com/seattle-news/politics/wa-budget-woes-dominate-as-ferguson-lawmakers-begin-2026-session/>]

<sup>37</sup> State budget cuts affected long-term civil commitment beds, the children's long-term inpatient program, the Recovery Navigator Program, and Law Enforcement Assisted Diversion (LEAD).



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<sup>38</sup> One Big Beautiful Bill Act, H.R.1, 119th Congress (2025-2026). [<https://www.congress.gov/bill/119th-congress/house-bill/1>]; Federal legislation requires states to implement work requirements and 6-month reauthorizations for Medicaid enrollment as soon as 2027.

<sup>39</sup> Washington State Health Care Authority. (2026). *Impact of Federal Budget on Medicaid in Washington State*. [<https://www.hca.wa.gov/assets/program/medicaid-in-washington-state.pdf>]

<sup>40</sup> Westneat, D. (2025). WA is the No. 1 target in the GOP's health care slashing bill. *The Seattle Times*. [<https://www.seattletimes.com/seattle-news/politics/wa-is-the-no-1-target-in-the-gops-health-care-slashing-bill/>]

<sup>41</sup> Washington State Health Care Authority. (2024). *Follow-Up After ED Visit for Substance Use: 30 Days. Healthier Washington Measure Explorer & Trend Dashboard*. [<https://hca-tableau.watech.wa.gov/t/51/views/HealthierWashingtonDashboard/Measures?%3AisGuestRedirectFromVizportal=y&%3Aembed=y>]

<sup>42</sup> King County DCHS. (2022). *DCHS Data Insights Series: Integrating Data to Better Understand Fatal Overdoses and Service System Engagement*. [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/departments/documents/FINAL\\_integrated\\_overdose\\_brief.ashx?la=en](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/departments/documents/FINAL_integrated_overdose_brief.ashx?la=en)]

<sup>43</sup> King County DCHS. (2022). *DCHS Data Insights Series: Integrating Data to Better Understand Fatal Overdoses and Service System Engagement*. [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/departments/documents/FINAL\\_integrated\\_overdose\\_brief.ashx?la=en](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/departments/documents/FINAL_integrated_overdose_brief.ashx?la=en)]

<sup>44</sup> Public Health – Seattle & King County. *Overdose deaths data dashboard*. [<https://kingcounty.gov/en/dept/dph/health-safety/safety-injury-prevention/overdose-prevention-response/data-dashboards/>]

<sup>45</sup> Public Health – Seattle & King County. *Overdose deaths data dashboard*. [<https://kingcounty.gov/en/dept/dph/health-safety/safety-injury-prevention/overdose-prevention-response/data-dashboards/>]; In 2017, there were 16 fatal overdoses per 100,000 people. In 2025, there were 35.2 per 100,000.

<sup>46</sup> Dickson-Gomez J., Spector A., Weeks M., Galletly C., McDonald M., Green Montaque H.D. (2022). You're Not Supposed to be on it Forever: Medications to Treat Opioid Use Disorder (MOUD) Related Stigma Among Drug Treatment Providers and People who Use Opioids. *Substance Abuse*. 27(16). [<https://journals.sagepub.com/doi/10.1177/11782218221103859>]

<sup>47</sup> All Home. (2017). *Count Us In: Seattle/King County Point-in-Time Count of Persons Experiencing Homelessness*. [<https://kcrha.org/wp-content/uploads/2022/05/2017-King-PIT-Count-Comprehensive-Report-FINAL-DRAFT-5.31.17.pdf>]

<sup>48</sup> King County Regional Homelessness Authority. (2026). *Seattle/King County Point-in-Time Count 2026*. [<https://kcrha.org/community-data/king-county-point-in-time-count/>]



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- <sup>49</sup> Communities Count. *King County Population Dashboard*. [<https://www.communitiescount.org/population-dashboard>]
- <sup>50</sup> Public Health – Seattle & King County. *Community Health Needs Assessment*. [<https://kingcounty.gov/en/dept/dph/about-king-county/about-public-health/chna>]
- <sup>51</sup> Balk, G. (2023) New King County milestone: One-quarter of residents born outside U.S. *The Seattle Times*. [<https://www.seattletimes.com/seattle-news/data/new-king-county-milestone-one-quarter-of-residents-born-outside-u-s/>]
- <sup>52</sup> KFF. (2024). *Racial and Ethnic Disparities in Mental Health Care: Findings from the KFF Survey of Racism, Discrimination and Health*. [<https://www.kff.org/racial-equity-and-health-policy/racial-and-ethnic-disparities-in-mental-health-care-findings-from-the-kff-survey-of-racism-discrimination-and-health/>]
- <sup>53</sup> Public Health – Seattle & King County. *Data to inform King County’s overdose response*. [<https://kingcounty.gov/en/dept/dph/health-safety/safety-injury-prevention/overdose-prevention-response/data-dashboards/>]. 2025 fatal overdose rates per 100,000 people: AI/AN: 211.4; Black: 95.2; White, non-Hispanic: 31.3.
- <sup>54</sup> Communities Count. *Frequent Mental Distress*. [<https://www.communitiescount.org/frequent-mental-distress>]
- <sup>55</sup> Chatterjee, R. (2024). We’re not ‘out of the woods’ in the youth mental health crisis, a CDC researcher says. *NPR*. [<https://www.npr.org/sections/shots-health-news/2024/08/07/nx-s1-5064406/cdc-youth-risk-behavior-survey-suicide-mental-health-drugs-alcohol>]
- <sup>56</sup> Friedman, J., Hadland, S. E. (2024). The Overdose Crisis among U.S. Adolescents. *The New England Journal of Medicine*, 390(2), 97–100. [<https://doi.org/10.1056/NEJMp2312084>]
- <sup>57</sup> Public Health-Seattle & King County. (2024). *From Data to Action: Addressing Youth Mental Health and Substance Use in King County*. [<https://www.communitiescount.org/blog/2025/3/20/from-data-to-action-addressing-youth-mental-health-and-substance-use-in-king-county>]
- <sup>58</sup> Washington State Healthy Youth Survey. [<https://www.askhys.net/SurveyResults/FactSheets>]
- <sup>59</sup> Youth.gov. *Behavioral Health*. [<https://youth.gov/youth-topics/homelessness-and-housing-instability/behavioral-health>]
- <sup>60</sup> MIDD 2 Implementation Plan (2018). [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804\\_midd\\_implementation\\_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_implementation_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72)]. The 2017 MIDD 2 Implementation Plan noted that “the behavioral health workforce is in crisis.”

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<sup>61</sup> The Council of State Governments. (2024). *Mental Health Matters: Addressing Behavioral Health Workforce Shortages*. [<https://www.csg.org/2024/10/10/mental-health-matters-addressing-behavioral-health-workforce-shortages/>]

<sup>62</sup> King County. KCICN Workforce Survey 2021.

<sup>63</sup> King County. (2024). *2024 MIDD Behavioral Health Sales Tax Fund Annual Summary Report*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/reports/2024-midd-annual-summary-report.pdf?rev=edfcfcbcc624444a871b804afc335f66&hash=DC1226BDA3A9431F948BED3D97F42160>]

<sup>64</sup> King County. KCICN Workforce Survey 2025.

<sup>65</sup> United States Health Resources & Services Administration. (2025, December). *State of the Behavioral Health Workforce, 2025*. [<https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf>]

<sup>66</sup> King County DCHS. (2025). *MIDD Renewal Community Engagement Report*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd-renewal-community-engagement-report-final-2025.pdf?rev=158a78c33eab4cdda443da39d874f040&hash=3EDD11B4F9CAF6A7C4BDDCB16EAF1FD>]

<sup>67</sup> King County DCHS. (2025). *Be Heard: Community Voices About Mental Health and Wellness Report*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/MIDD/Be-Heard-Community-Listening-Report>]

<sup>68</sup> MIDD AC Meeting Notes, January 23, 2025. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/advisory-committee/2025-02-27/item-2-midd-meeting-notes-12325.pdf?rev=9590bfd12154478d93cd3bed1faa80f1&hash=1FE6DAA83E16AD08A8E75EC512C1FA10>]

<sup>69</sup> RCW 82.14.460(4). [<https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460>]

<sup>71</sup> King County Executive Order, “Better Governance and Financial Management.” Document Code ACO-8-33-EO. March 4, 2026. [<https://cdn.kingcounty.gov/-/media/king-county/depts/executive-services/policies/documents/aco-8-33-eo-03-04-2026.pdf?rev=f11305dd68fd4c29af2a8ca8e60145a5&hash=95EA94BF839EAEFD42E3EDA908D8368F>]

<sup>72</sup> Heinz A., Liu S. (2022). Challenges and chances for mental health care in the 21<sup>st</sup> century. *World Psychiatry* (8;21(3)), 423-424. [<https://pmc.ncbi.nlm.nih.gov/articles/PMC9453898/>]

<sup>73</sup> Recovery.com. (2024). *Timeline: History of Addiction Treatment*. [<https://recovery.org/drug-treatment/history/>]

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<sup>74</sup> MIDD 2 Implementation Plan (2018). [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804\\_midd\\_implementation\\_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFEB0B56EA0AFE73E42032C2876738B72](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_implementation_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFEB0B56EA0AFE73E42032C2876738B72)]

<sup>75</sup> King County Executive Order, “Better Governance and Financial Management.” Document Code ACO-8-33-EO. Section 6. Reviewing and Prioritizing Base Budgets. March 4, 2026. [<https://cdn.kingcounty.gov/-/media/king-county/depts/executive-services/policies/documents/aco-8-33-eo-03-04-2026.pdf?rev=f11305dd68fd4c29af2a8ca8e60145a5&hash=95EA94BF839EAEDF42E3EDA908D8368F>]

<sup>76</sup> Ordinance 16077. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=555168&GUID=59A067B4-E1D8-4A40-9775-50FA651696E1>]

<sup>77</sup> Ordinance 18452. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=2819659&GUID=43729153-15C2-4825-89CD-C8885F90D04B>]

<sup>78</sup> Ordinance 18452. [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/ordinance\\_18452.pdf?la=en&rev=92633d2b80584444a3af3c7827dda4ae&hash=5C0B38DE9C3143EEC710B1889431B656](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/ordinance_18452.pdf?la=en&rev=92633d2b80584444a3af3c7827dda4ae&hash=5C0B38DE9C3143EEC710B1889431B656)].

<sup>79</sup> King County Executive Order, “Breaking the Cycle.” Document Code ACO-8-34-EO. March 31, 2026. [<https://cdn.kingcounty.gov/-/media/king-county/depts/executive-services/policies/documents/ACO-8-34-EO.pdf>]

<sup>80</sup> King County Executive Order, “Breaking the Cycle.” Document Code ACO-8-34-EO. March 31, 2026. [<https://cdn.kingcounty.gov/-/media/king-county/depts/executive-services/policies/documents/ACO-8-34-EO.pdf>]

<sup>81</sup> King County Regional Homelessness Authority. (2026). *Point-in-Time Count*. [<https://kcrha.org/community-data/king-county-point-in-time-count/>]

<sup>82</sup> RCW 82.14.460. [<https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460>]

<sup>83</sup> King County Executive Order, “Breaking the Cycle.” Document Code ACO-8-34-EO. March 31, 2026. [<https://cdn.kingcounty.gov/-/media/king-county/depts/executive-services/policies/documents/ACO-8-34-EO.pdf>]

<sup>84</sup> King County Executive Order, “Breaking the Cycle.” Document Code ACO-8-34-EO. March 31, 2026. [<https://cdn.kingcounty.gov/-/media/king-county/depts/executive-services/policies/documents/ACO-8-34-EO.pdf>]

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<sup>85</sup> Center on Budget and Policy Priorities. (2022). *States Can Reduce Medicaid’s Administrative Burdens to Advance Health and Racial Equity*. [<https://www.cbpp.org/research/health/states-can-reduce-medicoids-administrative-burdens-to-advance-health-and-racial>]

<sup>86</sup> King County DCHS. (2026). *Cultivating Connections: Update on King County’s Response to the Opioid Overdose Crisis*. [<https://dchsblog.com/2026/03/10/update-on-king-countys-response-to-the-opioid-overdose-crisis/>]

<sup>87</sup> Substance Abuse and Mental Health Administration. *SAMHSA’s Working Definition of Recovery: 10 Guiding Principles of Recovery*. [<https://library.samhsa.gov/sites/default/files/pep12-recdef.pdf>]

<sup>88</sup> Islam M.F., Guerrero M., Nguyen R.L., Porcaro A., Cummings C., Stevens E., Kang A., Jason L.A. (2023). The Importance of Social Support in Recovery Populations: Toward a Multilevel Understanding. *Alcohol Treat Q*. [<https://pmc.ncbi.nlm.nih.gov/articles/PMC10259869/>]

<sup>89</sup> Abramo, A. (2020). After leaving addiction treatment, young adults often face homelessness. *Cascade PBS*. [<https://www.cascadepbs.org/equity/2020/07/after-leaving-addiction-treatment-young-adults-often-face-homelessness/>]

<sup>90</sup> The Agency for Healthcare Research and Quality (AHRQ). *Six Domains of Health Care Quality*. [<https://www.ahrq.gov/talkingquality/measures/six-domains.html>]

<sup>91</sup> KFF. (2026). *How states verify citizenship and immigration status in Medicaid*. [<https://www.kff.org/medicaid/how-states-verify-citizenship-and-immigration-status-in-medicoid/>]

<sup>92</sup> Communities Count. *Health Insurance*. [<https://www.communitiescount.org/health-insurance>]; In King County in 2024, 14.9 percent of non-citizens lacked health insurance, compared to only 5.3 percent of the overall population.

<sup>93</sup> KFF. (2026). *How states verify citizenship and immigration status in Medicaid*. [<https://www.kff.org/medicaid/how-states-verify-citizenship-and-immigration-status-in-medicoid/>]

<sup>94</sup> Tens of thousands of Washingtonians could soon be in healthcare limbo. (2026). *KOMO News*. [<https://komonews.com/news/politics/tens-of-thousands-of-washingtonians-could-soon-be-in-healthcare-limbo>]

<sup>95</sup> National Alliance for Mental Illness. *Budget Reconciliation: Impact on People with Mental Health Conditions*. [<https://www.nami.org/wp-content/uploads/2025/09/Budget-Reconciliation-Impact-on-People-With-Mental-Health-Conditions-FINAL.pdf>]

<sup>96</sup> KFF. (2024). *Racial and Ethnic Disparities in Mental Health Care: Findings from the KFF Survey of Racism, Discrimination and Health*. [<https://www.kff.org/racial-equity-and-health-policy/racial->

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[and-ethnic-disparities-in-mental-health-care-findings-from-the-kff-survey-of-racism-discrimination-and-health/](#)]

<sup>97</sup> Masanori, K. (2025). The rising predictive power of LGBT identity in mental health: An analysis of variable importance. *Annals of Epidemiology*, Volume 111. [<https://www.sciencedirect.com/science/article/abs/pii/S1047279725002777>]

<sup>98</sup> Morales D.A., Barksdale C.L., Beckel-Mitchener A.C. (2020). A call to action to address rural mental health disparities. *J Clin Transl Sci*, 4(5):463-467. [<https://pmc.ncbi.nlm.nih.gov/articles/PMC7681156/>]

<sup>99</sup> Blatchford, T. (2026). King County's mental health expansion moving too slowly, Zahilay says. *The Seattle Times*. [<https://www.seattletimes.com/seattle-news/mental-health/king-countys-mental-health-expansion-moving-way-too-slowly-zahilay-says/>]

<sup>100</sup> Best Starts for Kids Implementation Plan: 2022-2027. [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/best-starts/documents/best\\_starts\\_for\\_kids\\_implementation\\_plan\\_approved\\_2021.pdf?la=en&rev=982959618c9246df82d2f6a68272c68f&hash=072B4DA6104EBC2E7F728B175898696D](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/best-starts/documents/best_starts_for_kids_implementation_plan_approved_2021.pdf?la=en&rev=982959618c9246df82d2f6a68272c68f&hash=072B4DA6104EBC2E7F728B175898696D)]

<sup>101</sup> Blatchford, T. (2026, April). King County's mental health expansion moving too slowly, Zahilay says. *Seattle Times*. [<https://www.seattletimes.com/seattle-news/mental-health/king-countys-mental-health-expansion-moving-way-too-slowly-zahilay-says/>]

<sup>102</sup> Motion 16966. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7760680&GUID=69D1C7DC-BC39-4093-BC56-3B473E58E1B7>]

<sup>103</sup> Consistent with all Behavioral Health Bridge investments, services provided by this goal are not intended to replace Medicaid payment for equivalent services.

<sup>104</sup> Piper K., Stielow S., Hines-Wilson M., Van Alstine E., Sheerin K., Modrowski C., Kemp K. (2025). Barriers to Behavioral Health Treatment among Youth and Caregivers Involved in the Juvenile Legal System. *Evid Based Pract Child Adolesc Ment Health*. [<https://pmc.ncbi.nlm.nih.gov/articles/PMC12803726/>]

<sup>105</sup> King County Prosecuting Attorney's Office Data Dashboard. [<https://kingcounty.gov/en/dept/pao/about-king-county/about-pao/data-reports/dashboard#toc-The-Data-Dashboard>]

<sup>106</sup> King County Department of Adult and Juvenile Detention. Detention and Alternatives Report Year 2026. [[https://cdn.kingcounty.gov/-/media/king-county/depts/dajd/documents/population-information-pdfs/dar\\_scorecard-2026-august-accessible.pdf?rev=7f3c4d83c32c40ca9e649819872cf6c2&hash=F263554DA5F2A036247A6934C7E547C8&\\_gl=1\\*ayymiy\\*\\_ga\\*MTM3MzM5ODY4LjE3OTA3MTEzMDg.\\*\\_ga\\_W2BH6TXD2Z\\*cZ3OTA3MTEzMDgkbzEkZzEkdDE3OTA3MTEzNTAkajE4JGwWJGgw](https://cdn.kingcounty.gov/-/media/king-county/depts/dajd/documents/population-information-pdfs/dar_scorecard-2026-august-accessible.pdf?rev=7f3c4d83c32c40ca9e649819872cf6c2&hash=F263554DA5F2A036247A6934C7E547C8&_gl=1*ayymiy*_ga*MTM3MzM5ODY4LjE3OTA3MTEzMDg.*_ga_W2BH6TXD2Z*cZ3OTA3MTEzMDgkbzEkZzEkdDE3OTA3MTEzNTAkajE4JGwWJGgw)]

<sup>107</sup> Washington State Healthy Youth Survey. [<https://www.askhys.net/SurveyResults/FactSheets>]

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<sup>108</sup> Washington State Healthy Youth Survey. [<https://www.askhys.net/SurveyResults/FactSheets>]

<sup>109</sup> Rapid Health Information NetWOrk (RHINO). [<https://kingcounty.gov/en/dept/dph/about-king-county/about-public-health/data-reports/population-health-data/community-health-indicators/rhino?shortname=Suicidal%20ideation>]

<sup>110</sup> Washington State Healthy Youth Survey. [<https://www.askhys.net/SurveyResults/FactSheets>]

<sup>111</sup> Health Resources and Services Administration. *Behavioral Health Workforce Projections*. [<https://data.hrsa.gov/topics/health-workforce/workforce-projections>]

<sup>112</sup> King County. KCICN Workforce Survey 2025.

<sup>113</sup> Other DCHS funds also support aspects of the human services workforce. VSHSL focuses on nonprofit staff, the CCC Levy focuses on crisis staff, and the Behavioral Health Bridge is intended to focus on behavioral health workers across the care continuum (beyond crisis services). These fund sources will work in concert, with complementary rather than duplicative investments.

<sup>114</sup> National Center for Health Workforce Analysis. (2025). *State of the Behavioral Health Workforce, 2025*. [<https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf>]; Report highlight: “Substantial shortages of addiction counselors, marriage and family therapists, mental health counselors, psychologists, mental health and substance use disorder social workers, adult psychiatrists, child and adolescent psychiatrists, and school counselors are projected in 2038.”

<sup>115</sup> Pathman D.E., de Saxe Zerden L., Konrad T.R., Shafer A.B., Harrison J.N., Fannell J., Lombardi B.M. (2025, April). Job assessments and the anticipated retention of behavioral health clinicians working in U.S. Health Professional Shortage Areas. *BMC Health Serv Res*, 25(1):592. [<https://pmc.ncbi.nlm.nih.gov/articles/PMC12020279/>]

<sup>116</sup> Harrison, J.P. (2020). *Therapist turnover in community mental health: Testing the applicability of job embeddedness and shocks*. [Doctoral dissertation, University of Washington]. [<https://digital.lib.washington.edu/server/api/core/bitstreams/a3b23e92-f797-4721-aa76-8d3ed2137be0/content>]

<sup>117</sup> King County. KCICN Workforce Survey 2025.

<sup>118</sup> Washington State Department of Health. *Agency-Affiliated Counselor – Frequently Asked Questions*. [<https://doh.wa.gov/licenses-permits-and-certificates/professions-new-renew-or-update/agency-affiliated-counselor/frequently-asked-questions>]

<sup>119</sup> King County. KCICN Workforce Survey 2025.

<sup>120</sup> King County. KCICN Workforce Survey 2025.

<sup>121</sup> King County. KCICN Workforce Survey 2025.



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<sup>122</sup> MIDD 2 Implementation Plan. (2018). [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804\\_midd\\_implementation\\_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_implementation_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72)]

<sup>123</sup> MIDD 2 Evaluation Plan. (2018). [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804\\_midd\\_evaluation\\_plan.pdf?la=en&rev=85c9a05460084507a190c1ce943d57b1&hash=6E4F1C75BCAC13288FBBB0C57A7E9BF1](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_evaluation_plan.pdf?la=en&rev=85c9a05460084507a190c1ce943d57b1&hash=6E4F1C75BCAC13288FBBB0C57A7E9BF1)]

<sup>124</sup> Ordinance 18407. [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/ordinance\\_18407.pdf?la=en&rev=5867c9491f1344488211221b2fd7fda8&hash=08258AC12F55E0E731E8DB355A154182](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/ordinance_18407.pdf?la=en&rev=5867c9491f1344488211221b2fd7fda8&hash=08258AC12F55E0E731E8DB355A154182)]

<sup>125</sup> Clear Impact. *What is Results-Based Accountability?* [<https://clearimpact.com/results-based-accountability/>]

<sup>127</sup> Substance Abuse and Mental Health Services Administration. (2024). *Developing Goals and Measurable Objectives*. [<https://www.samhsa.gov/grants/how-to-apply/forms-and-resources/developing-goals-measurable-objectives>]

<sup>128</sup> King County DCHS. *MIDD Behavioral Health Sales Tax dashboard, Plans, Reports, and Briefing Papers*. [<https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-behavioral-health-tax/midd-behavioral-health-sales-tax-dashboard/past-reports>]

<sup>129</sup> WestEd Justice & Prevention Research Center for the Annie E. Casey Foundation. (2019). *Reflections on Applying Principles of Equitable Evaluation*. [<https://www.aecf.org/resources/reflections-on-applying-principles-of-equitable-evaluation>]

<sup>130</sup> Implementation of a revised approach to performance metrics has begun in 2026. After reviewing best practices across many Departments, work has begun to start integrating performance metrics into the DNA of how the County does business. The Executive Office is standardizing an approach that will be extended across all Departments and will also be working on additional best practices with the Departments who are doing these processes today to continue with operational excellence work. This approach will eventually include monthly business reviews for every department and quarterly business reviews with the Executive Office.

<sup>131</sup> Clear Impact. *What is Results-Based Accountability?* [<https://clearimpact.com/results-based-accountability/>].

<sup>132</sup> Motion 15081. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=3307620&GUID=D5F273E9-C87F-40F1-97FE-C668F5DAA261>]. Motion 15081 accepted a report on consolidated human services reporting, as required by Ordinance 18409, Section 66, Proviso P2.

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<sup>133</sup> King County DCHS. *Measuring DCHS' Impact*. [<https://kingcounty.gov/en/dept/dchs/about-king-county/about-dchs/data-reports>]

<sup>134</sup> Motion 15081. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=3307620%20&GUID=D5F273E9-C87F-40F1-97FE-C668F5DAA261>]; Motion 15081 accepted a report on consolidated human services reporting, as required by Ordinance 18409, Section 66, Proviso P2.

<sup>135</sup> Multiple data system improvements support this data collection and reporting, including investments in data systems and infrastructure, performance measurement and evaluation staff to manage and analyze large amounts of data from hundreds of providers. DCHS partnered with PHSKC and KCIT to build an Integrated Data Hub that deduplicates service participants across a wide variety of programs and supports cross-systems analysis. DCHS also developed and implemented a first-of-its kind data system, known as the Client Outcomes Reporting Engine (CORE), to efficiently manage large volumes of data submissions from providers that enables consistent measures and transparent reporting.

<sup>136</sup> King County DCHS. *Explore the Data*. [<https://kingcounty.gov/en/dept/dchs/about-king-county/about-dchs/data-reports/impact-dashboard>]

<sup>137</sup> King County DCHS. *MIDD Behavioral Health Sales Tax dashboard*. [<https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-behavioral-health-tax/midd-behavioral-health-sales-tax-dashboard>].

<sup>139</sup> State of Washington. (2026). *ESSB 6346*. [<https://app.leg.wa.gov/BillSummary/?BillNumber=6346&Year=2025>]

<sup>140</sup> Office of Economic and Financial Analysis. *March 2026 King County Economic and Revenue Forecast*. [[https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026\\_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99](https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99)]

<sup>141</sup> King County DCHS. (2024). *DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy>]

<sup>142</sup> King County Executive Order, “Breaking the Cycle.” Document Code ACO-8-34-EO. March 31, 2026. [<https://cdn.kingcounty.gov/-/media/king-county/depts/executive-services/policies/documents/ACO-8-34-EO.pdf>]

<sup>143</sup> One Big Beautiful Bill Act, H.R.1, 119th Congress (2025-2026). [<https://www.congress.gov/bill/119th-congress/house-bill/1>]; Federal legislation requires states to implement work requirements and 6-month reauthorizations for Medicaid enrollment as soon as 2027.



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<sup>144</sup> Section 6. Reviewing and Prioritizing Base Budgets. King County Executive Order, “Better Governance and Financial Management.” Document Code ACO-8-33-EO. March 4, 2026. [<https://cdn.kingcounty.gov/-/media/king-county/depts/executive-services/policies/documents/aco-8-33-eo-03-04-2026.pdf?rev=f11305dd68fd4c29af2a8ca8e60145a5&hash=95EA94BF839EAEDF42E3EDA908D8368F>]

<sup>145</sup> King County DCHS. (2025). *An Update: Responding to the Audit. DCHS Blog: Cultivating Connections*. [<https://dchsblog.com/2025/12/11/an-update-responding-to-the-audit/>]

<sup>146</sup> Motion 16975. (2026). [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7965836&GUID=74EC9640-4DB4-4562-BF46-E39FCCC6E8AE>] Motion 16975 accepts the Report on the Status of Activities Related to Contract Management and Compliance Reporting Protocols.

<sup>147</sup> King County. *King County Comprehensive Financial Management Policies*. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5122778&GUID=EA35F767-889C-4ADA-A720-6342044F7413>]

<sup>148</sup> The substantial adjustment threshold shall be adjusted through any prior changes if applicable. Prior changes may include substantive changes that have been summarized in past notification letters to the Council like those described in this section; proceeds not spent within a strategy area in the originally planned year but retained within the same strategy area for use in a subsequent year; other non-substantive adjustments that do not meet the notification threshold; or changes that may have been initiated by the Council through a budget ordinance.

<sup>149</sup> 2026-2027 King County Biennial Budget. November 18, 2025. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7680373&GUID=B4E9E09C-A982-4A8C-A0DA-6CC195D69EE0>]

<sup>150</sup> King County DCHS. DCHS Inflation Rate Adjustment Policy for Human Services Contracts. (2024). [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy>]

<sup>151</sup> Ordinance 19364, Section 44, Proviso P3. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5153492&GUID=83A03492-A721-4832-BA46-BCD9D2951C3D>]; This proviso language was later amended to remove the report requirement.

<sup>152</sup> King County DCHS. (2024). *DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy>]

<sup>153</sup> King County. *King County Budget and Financial Planning Assumptions Dashboard*. [<https://app.powerbigov.us/groups/me/reports/b97a6283-2b3f-4a50-8f6d-c5d0d601df05/ReportSection3c4f835a513e65de275e>]

<sup>154</sup> Office of Economic and Financial Analysis. *March 2026 King County Economic and Revenue Forecast*. [<https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government->

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[oversight/forecasting/documents/march2026\\_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99\]](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99)

<sup>155</sup> King County DCHS. (2024). *Section 6.3 of DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy>]

<sup>156</sup> King County DCHS. (2024). *Section 6.7 of DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy>]

<sup>157</sup> King County DCHS. (2024). *Section 6.7 of DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy>]

<sup>158</sup> King County. *King County Budget and Financial Planning Assumptions Dashboard*. [<https://app.powerbigov.us/groups/me/reports/b97a6283-2b3f-4a50-8f6d-c5d0d601df05/ReportSection3c4f835a513e65de275e>]

<sup>159</sup> King County DCHS. (2024). *Section 6.1 of DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy>]

<sup>160</sup> King County DCHS. *Familiar Faces Data Packet*. [[https://www.naco.org/sites/default/files/event\\_attachments/Familiar%20Faces%20Data%20Packet.pdf](https://www.naco.org/sites/default/files/event_attachments/Familiar%20Faces%20Data%20Packet.pdf)]; This source provides an internal analysis of jail bookings in King County Correctional Facility, Maleng Regional Justice Center, South Correctional Entity, and municipal jails for the Cities of Enumclaw, Issaquah, Kent, and Kirkland.

<sup>161</sup> Therapeutic court services provided by the Juvenile Response and Accountability Court – Behavioral Health Response (JTRAC-BHR) are addressed under CYYA Goal 2.

<sup>162</sup> U.S. Department of Housing and Urban Development. *Homelessness Management Information System*. [<https://www.hudexchange.info/programs/hmis/>]

<sup>163</sup> King County Executive Order, “Breaking the Cycle.” Document Code ACO-8-34-EO. March 31, 2026. [<https://cdn.kingcounty.gov/-/media/king-county/depts/executive-services/policies/documents/ACO-8-34-EO.pdf>]

<sup>164</sup> King County DCHS. (2024). *2023 Health Through Housing Annual Report*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/housing/health-through-housing/annual-reports/2023-health-through-housing-annual-report.pdf?rev=508110dfaa6d4939b9925e2af0f3caf1&hash=6B38F2613B8573DCA8E926227019C3C7>]

<sup>165</sup> Kelly E., Fulginiti A., Pahwa R., et al. (2014). A Pilot Test of a Peer Navigator Intervention for Improving the Health of Individuals with Serious Mental Illness. *Community Ment Health J* 50, 435–446. [<https://link.springer.com/article/10.1007/s10597-013-9616-4>]

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<sup>166</sup> Anderson E.S., Rusoja E., Luftig J., Ullal M., Shardha R., Schwimmer H., Friedman A., Hailozian C., Herring A.A. (2023). Effectiveness of Substance Use Navigation for Emergency Department Patients with Substance Use Disorders: An Implementation Study. *Annals of Emergency Medicine*, Volume 81, Issue 3. [<https://www.sciencedirect.com/science/article/abs/pii/S0196064422011647>]

<sup>167</sup> Corrigan P., Sheehan L., Morris S., Larson J.E., Torres A., Lorena Lara J., Paniagua D., Mayes J., Doing S. (2018). The Impact of a Peer Navigator Program in Addressing the Health Needs of Latinos with Serious Mental Illness. *Psychiatric Services*, Volume 69, Issue 4. [<https://psychiatryonline.org/doi/full/10.1176/appi.ps.201700241>]

<sup>168</sup> Eliacin J., Burgess D., Rollins A.L., Patterson S., Damush T., Bair M.J., Salyers M.P., Spont M., Chinman M., Slaven J.E., Matthias M.S. (2023). Outcomes of a peer-led navigation program, PARTNER-MH, for racially minoritized Veterans receiving mental health services: a pilot randomized controlled trial to assess feasibility and acceptability, *Translational Behavioral Medicine*, Volume 13, Issue 9. [<https://academic.oup.com/tbm/article-abstract/13/9/710/7148295>]

<sup>169</sup> PointClickCare is an external platform that BHRD contracts with on behalf of KCICN members. Providers can see emergency department and hospitalization encounters for their enrolled clients. However, psychiatric inpatient encounters for some psychiatric hospitals (such as Fairfax and the VA) are not included. The Extended Client Lookup System is a BHRD platform where providers can see a client's Medicaid status and the BHRD-funded services the individual was historically or currently enrolled in, but it does not include services a person engaged in outside of BHRD. The BHRD Quality and Care Coordination Resources SharePoint contains many resources, including a Care Coordination Contact List, which lists the most appropriate contacts for care coordination purposes at various agencies.

<sup>170</sup> Tommasello A.C., Myers C.P., Gillis L., Treherne L.L., Plumhoff M. (1999). Effectiveness of outreach to homeless substance abusers. *Eval Program Plan*, 22(3):295-303. [<https://pubmed.ncbi.nlm.nih.gov/24011449/>]

<sup>171</sup> King County DCHS. (2026, April). *Internal analysis of Medicaid claims data*, Washington State Health Care Authority.

<sup>172</sup> Carpenter P., Mays S., Sharp J., Little S.H. (2025). Evaluating the Efficacy of Predischarge Referrals in Preventing Emergency Mental Health Hospital Readmissions: A Scoping Review. *Doctor of Nursing Practice Projects*, Paper 100. [<http://dx.doi.org/10.21007/con.dnp.2025.0100>]

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## King County | Office of the Executive

**Executive Girmay Zahilay**

Chinook Building, CNK-EX-0800

401 Fifth Avenue, Suite 800

Seattle, WA 98104-2391

July 1, 2026

The Honorable Sarah Perry

Chair, King County Council

Room 1200

C O U R T H O U S E

Dear Councilmember Perry:

This letter transmits the King County Behavioral Health Bridge Implementation Plan 2028-2034, which responds to Ordinance 20023, Section 70, Proviso P1, and a proposed Ordinance that would, if enacted, adopt the implementation plan. Adoption of this proposed legislation would reaffirm the County's commitment to high-quality, accessible, effective, and equitable behavioral health care in King County.

The "King County Behavioral Health Bridge" ("the Bridge") represents a new name for this plan and its programs, reflected in a separate proposed Ordinance, to replace the "Mental Illness and Drug Dependency" (MIDD) name that has been used for this fund and its programs and advisory committee since 2007. Responsive to community feedback, the King County Behavioral Health Bridge name emphasizes the role of sales tax-funded programs in creating a bridge between people experiencing behavioral health conditions and community behavioral health treatment, other systems people interact with including the criminal-legal system, and pathways to recovery.

Under its former name MIDD, this fund supported programs that served over 130,000 unduplicated King County residents between 2017 and 2025. These investments make programs possible that improve health and wellness, recovery, and connection to community, especially for people most affected by inequities related to race, income, housing status, and access to health care.

The King County Behavioral Health Bridge is projected to generate nearly \$800 million for behavioral health care in King County between 2028 and 2034. The proposed King County Behavioral Health Bridge Implementation Plan 2028-2034 invests strategically to break the cycle



and prevent incarceration, hospitalization, homelessness, and crisis for low-income people with mental health and substance use conditions. The plan builds on past successes while strategically tackling the most pressing behavioral health issues in King County communities through investments in five interconnected strategy areas:

- Care transitions and diversion services.
- Substance use disorder prevention, treatment, and recovery.
- Equitable access to behavioral health care.
- Child, youth, and young adult mental wellbeing.
- Behavioral health workforce development.

The proposed plan invests where the need is greatest and where dollars can make the most meaningful impact. It describes the forecasted expenditure of revenues in the five strategy areas to achieve the King County Behavioral Health Bridge's identified goals. It includes activities in which the County anticipates investing to reduce behavioral health system fragmentation, improve service availability, and align with other funding sources such as Medicaid and local funds. The plan also describes a performance measurement and evaluation framework to assess and report on how well Bridge investments are achieving desired results, and describes plans for regular reporting to the Council and community.

This plan and its five strategy areas are the product of an intensive engagement process that began in June 2024 and concluded in March 2026. The strategy areas, goals, and activities were informed by community engagement with over 2,200 King County residents, an extensive multi-sector process involving over 100 subject matter experts, and the most current available county-level data on needs and outcomes. Community engagement activities included participation from behavioral health agencies, people with lived experience of behavioral health, incarcerated people with behavioral health conditions, scholars, advocates, representatives of the legal system, the MIDD Advisory Committee, elected officials, and other community partners. Feedback from these diverse individuals significantly informed the investments described in this plan, and will inform future procurement and operational phases of the Behavioral Health Bridge.

The King County Behavioral Health Bridge Implementation Plan 2028-2034 and its programs will enable the County to continue to break cycles of incarceration, hospitalization, and homelessness and build toward a future of available, accessible, effective, and equitable behavioral health care. I look forward to working with the Council to provide access to high-quality behavioral health care that enables residents to pursue long term recovery, stability, and wellbeing. Thank you for your consideration of this important Plan and proposed Ordinance.

If your staff have any questions, please contact Dr. Susan McLaughlin, director of the Department of Community and Human Services, at 206-477-9309.

The Honorable Sarah Perry  
July 1, 2026  
Page 3

Sincerely,

A handwritten signature in black ink, appearing to read 'Girmay Zahilay', written in a cursive style.

for

Girmay Zahilay  
King County Executive

Enclosure

cc: King County Councilmembers  
    ATTN: Stephanie Cirkovich, Chief of Staff  
            Melani Hay, Clerk of the Council  
Karan Gill, Deputy Executive, Office of the Executive  
Jasmin Weaver, Chief of Staff, Office of the Executive  
Hyeok Kim, Chief Operating Officer, Office of the Executive  
Sierra Howlett Browne, Director of Government Relations, Office of the Executive  
Garrett Holbrook, Council Relations Manager, Office of the Executive  
Dr. Susan McLaughlin, Acting Director, Department of Community and Human Services

## 2026 FISCAL NOTE

|                                         |                                                                                                                                                                                                                                                                                                                                                           |
|-----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Ordinance/Motion:</b>                | Ordinance<br>An ordinance adopting the King County behavioral health bridge implementation plan, required by the 2026-2027 Biennial Budget Ordinance, Ordinance 20023, Section 70, Proviso P1, to govern the expenditure of proceeds from 2028 through 2034 of the behavioral health sales and use tax authorized by RCW 82.14.460 and K.C.C. 4A.500.315. |
| <b>Title:</b>                           |                                                                                                                                                                                                                                                                                                                                                           |
| <b>Affected Agency and/or Agencies:</b> | DCHS                                                                                                                                                                                                                                                                                                                                                      |
| <b>Note Prepared By:</b>                | Scott Miller                                                                                                                                                                                                                                                                                                                                              |
| <b>Date Prepared:</b>                   | 6/3/2026                                                                                                                                                                                                                                                                                                                                                  |
| <b>Note Reviewed By:</b>                | Kevin Lo                                                                                                                                                                                                                                                                                                                                                  |
| <b>Date Reviewed:</b>                   | 6/3/2026                                                                                                                                                                                                                                                                                                                                                  |

## Description of request:

The proposed ordinance would adopt the King County Behavioral Health Bridge Implementation Plan 2028-2034 to govern the expenditure of proceeds from 2028 through 2034 of the behavioral health sales and use tax authorized by RCW 82.14.460 and K.C.C. 4A.500.315.

## Revenue to:

| Agency       | Fund Code | Revenue Source    | 2028-2029          | 2030-2031          | 2032-2033          |
|--------------|-----------|-------------------|--------------------|--------------------|--------------------|
| DCHS         | 1135      | Sales Tax         | 211,280,000        | 221,610,000        | 236,730,000        |
| DCHS         | 1135      | Interest Earnings | 1,510,000          | 1,330,000          | 1,270,000          |
|              |           |                   |                    |                    |                    |
|              |           |                   |                    |                    |                    |
| <b>TOTAL</b> |           |                   | <b>212,790,000</b> | <b>222,940,000</b> | <b>238,000,000</b> |

## Expenditures from:

| Agency       | Fund Code | Department | 2028-2029          | 2030-2031          | 2032-2033          |
|--------------|-----------|------------|--------------------|--------------------|--------------------|
| DCHS         | 1135      | BHRD       | 211,910,000        | 224,580,000        | 236,990,000        |
|              |           |            |                    |                    |                    |
|              |           |            |                    |                    |                    |
|              |           |            |                    |                    |                    |
| <b>TOTAL</b> |           |            | <b>211,910,000</b> | <b>224,580,000</b> | <b>236,990,000</b> |

## Expenditures by Categories

|                                                                 | 2028-2029          | 2030-2031          | 2032-2033          |
|-----------------------------------------------------------------|--------------------|--------------------|--------------------|
| Strategy Area 1: Care Transitions and Diversion Services        | 69,180,000         | 67,460,000         | 70,810,000         |
| Strategy Area 2: SUD Treatment and Recovery                     | 39,650,000         | 42,120,000         | 44,510,000         |
| Strategy Area 3: Equitable Access to Behavioral Health Care     | 32,630,000         | 34,520,000         | 36,530,000         |
| Strategy Area 4: Child, Youth, and Young Adult Mental Wellbeing | 22,910,000         | 24,750,000         | 26,250,000         |
| Strategy Area 5: Behavioral Health Workforce Development        | 7,870,000          | 13,730,000         | 14,700,000         |
| Technical Assistance & Capacity Building                        | 1,060,000          | 1,110,000          | 1,180,000          |
| Administration                                                  | 17,270,000         | 18,290,000         | 19,240,000         |
| Performance Measurement & Evaluation                            | 5,080,000          | 5,380,000          | 5,660,000          |
| Behavioral Health Fund Transfer                                 | 16,260,000         | 17,220,000         | 18,110,000         |
|                                                                 |                    |                    |                    |
| <b>TOTAL</b>                                                    | <b>211,910,000</b> | <b>224,580,000</b> | <b>236,990,000</b> |

Does this legislation require a budget supplemental? No. Fiscal impacts begin in the 2028-29 budgetary biennium.

## Notes and Assumptions:

Biennial amounts are rounded to nearest \$10,000.

Behavioral health provider contract budgets assume inflationary increases based on BFPA rates (Seattle Consumer Price Index).

**Financial Plan - King County Behavioral Health Bridge Implementation Plan 2028-2034**  
**Behavioral Health Bridge / 1135**

| <b>Category</b>                                                 | <b>2028-2029<br/>Projected</b> | <b>2030-2031<br/>Projected</b> | <b>2032-2033<br/>Projected</b> | <b>2034<br/>Projected</b> |
|-----------------------------------------------------------------|--------------------------------|--------------------------------|--------------------------------|---------------------------|
| <b>Beginning Fund Balance</b>                                   | <b>\$ 19,550,000</b>           | <b>\$ 20,430,000</b>           | <b>\$ 18,790,000</b>           | <b>\$ 19,800,000</b>      |
| <b>Revenues</b>                                                 |                                |                                |                                |                           |
| Local Sales Tax                                                 | 211,280,000                    | 221,610,000                    | 236,730,000                    | 124,180,000               |
| Other/Interest                                                  | 1,510,000                      | 1,330,000                      | 1,270,000                      | 660,000                   |
| <b>Total Revenues</b>                                           | <b>\$ 212,790,000</b>          | <b>\$ 222,940,000</b>          | <b>\$ 238,000,000</b>          | <b>\$ 124,840,000</b>     |
| <b>Expenditures</b>                                             |                                |                                |                                |                           |
| Strategy Area 1: Care Transitions and Diversion Services        | 69,180,000                     | 67,460,000                     | 70,810,000                     | 36,900,000                |
| Strategy Area 2: SUD Treatment and Recovery                     | 39,650,000                     | 42,120,000                     | 44,510,000                     | 23,350,000                |
| Strategy Area 3: Equitable Access to Behavioral Health Care     | 32,630,000                     | 34,520,000                     | 36,530,000                     | 19,230,000                |
| Strategy Area 4: Child, Youth, and Young Adult Mental Wellbeing | 22,910,000                     | 24,750,000                     | 26,250,000                     | 13,920,000                |
| Strategy Area 5: Behavioral Health Workforce Development        | 7,870,000                      | 13,730,000                     | 14,700,000                     | 7,960,000                 |
| Technical Assistance & Capacity Building                        | 1,060,000                      | 1,110,000                      | 1,180,000                      | 620,000                   |
| Administration                                                  | 17,270,000                     | 18,290,000                     | 19,240,000                     | 9,950,000                 |
| Performance Measurement & Evaluation                            | 5,080,000                      | 5,380,000                      | 5,660,000                      | 2,930,000                 |
| Behavioral Health Fund Transfer                                 | 16,260,000                     | 17,220,000                     | 18,110,000                     | 9,360,000                 |
| <b>Total Expenditures</b>                                       | <b>\$ 211,910,000</b>          | <b>\$ 224,580,000</b>          | <b>\$ 236,990,000</b>          | <b>\$ 124,220,000</b>     |
| <b>Estimated Under expenditures</b>                             | -                              | -                              | -                              | -                         |
| <b>Other Fund Transactions</b>                                  | -                              | -                              | -                              | -                         |
| <b>Total Other Fund Transactions</b>                            | <b>\$ -</b>                    | <b>\$ -</b>                    | <b>\$ -</b>                    | <b>\$ -</b>               |
| <b>Ending Fund Balance</b>                                      | <b>\$ 20,430,000</b>           | <b>\$ 18,790,000</b>           | <b>\$ 19,800,000</b>           | <b>\$ 20,420,000</b>      |
| <b>Reserves</b>                                                 |                                |                                |                                |                           |
| Rainy Day Reserve                                               | 17,420,000                     | 18,460,000                     | 19,480,000                     | 20,420,000                |
| Sustainability Reserve                                          | 3,010,000                      | 330,000                        | 320,000                        | -                         |
| <b>Total Reserves</b>                                           | <b>\$ 20,430,000</b>           | <b>\$ 18,790,000</b>           | <b>\$ 19,800,000</b>           | <b>\$ 20,420,000</b>      |
| <b>Reserve Shortfall</b>                                        | -                              | -                              | -                              | -                         |
| <b>Ending Undesignated Fund Balance</b>                         | <b>\$ -</b>                    | <b>\$ -</b>                    | <b>\$ -</b>                    | <b>\$ -</b>               |

**Financial Plan Notes**

All financial plans have the following assumptions, unless otherwise noted in below rows:

- Outyear projections columns: revenue and expenditure inflation assumptions are consistent with figures provided by the Executive Budget Team's BFPA guidance and the agency's internal assumptions and methodology.
- Biennial amounts are rounded to nearest \$10,000.
- Beginning fund balance for 2028 is based on projections from the MIDD Fund Q1 2026 Financial Monitoring plan from March 2026.

**Revenue Notes:**

- Revenue amounts are based on March 2026 economic forecast for sales tax, and updated planning assumptions for interest earned.

**Expenditure Notes:**

- Projected amounts assume the King County Behavioral Health Bridge will implement the King County Behavioral Health Bridge Implementation Plan 2028-2034 as proposed, with expenditures grouped into the categories shown in this table and aligned to expected revenues for the plan period.

**Reserve Notes:**

- 2028-2034 Rainy Day reserves are based on 60 days of expenditures.

| Former MIDD Program and Number                                                                | Aligned "Bridge" Anticipated Activity                                                                                                                                                                                                                    | Notes                                                                                           |
|-----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| PRI-01 Screening, Brief Intervention and Referral to Treatment-SBIRT                          | SUD Goal 1 - activity: Screening and referrals integrated into multiple settings                                                                                                                                                                         |                                                                                                 |
| PRI-02 Juvenile Justice Youth Behavioral Health Assessments                                   | CYYA Goal 2 - activity: Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system                                                                                                                    |                                                                                                 |
| PRI-03: Prevention and Early Intervention Behavioral Health for Adults Over 50                | n/a                                                                                                                                                                                                                                                      | Funding ending 12/31/26 per Council-adopted biennial budget                                     |
| PRI-04 older Adult Crisis Intervention/Geriatric Regional Assessment Team                     | n/a                                                                                                                                                                                                                                                      | Funded by VSHSL-only in 2027                                                                    |
| PRI-05 Collaborative School Based Behavioral Health Services: Middle and High School Students | CYYA Goal 1: Youth behavioral health services in schools                                                                                                                                                                                                 |                                                                                                 |
| PRI-06: Zero Suicide Initiative Pilot                                                         | n/a                                                                                                                                                                                                                                                      | Already ended (before 2026-2027 biennium)                                                       |
| PRI-07: Mental Health First Aid                                                               | EA Goal 2: activity: Community-driven culturally and linguistically responsive services and programs that support behavioral health outside of clinical settings                                                                                         |                                                                                                 |
| PRI-08: Crisis Intervention Training – First Responders                                       | CTD Goal 1 - activity: Diversion from criminal-legal system involvement                                                                                                                                                                                  |                                                                                                 |
| PRI-09: Sexual Assault Behavioral Health Services                                             | EA Goal 2: activity: BH treatment services tailored for priority populations                                                                                                                                                                             |                                                                                                 |
| PRI-10: Domestic Violence Behavioral Health Services and System Coordination                  | EA Goal 2: activity: BH treatment services tailored for priority populations                                                                                                                                                                             |                                                                                                 |
| PRI-11: Community Behavioral Health Treatment                                                 | EA Goal 1: activity: Non-Medicaid behavioral health services and supports                                                                                                                                                                                |                                                                                                 |
| CD-01: Law Enforcement Assisted Diversion                                                     | CTD Goal 1 - activity: Diversion from criminal-legal system involvement                                                                                                                                                                                  |                                                                                                 |
| CD-02: Youth and Young Adult Homelessness Services                                            | CYYA Goal 2 - activity: Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system                                                                                                                    |                                                                                                 |
| CD-03: Outreach and In Reach System of Care                                                   | SUD Goal 1 - activity: Proactive outreach to people with SUD, especially those experiencing homelessness                                                                                                                                                 |                                                                                                 |
| CD-04: South County Crisis Diversion Services/Center                                          | n/a                                                                                                                                                                                                                                                      | Rolled into CD-06 several years ago                                                             |
| CD-05: High Utilizer Care Teams                                                               | n/a                                                                                                                                                                                                                                                      | No longer MIDD-funded (was moved to Harborview bond before 2026-2027 biennium)                  |
| CD-06: Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team  | n/a                                                                                                                                                                                                                                                      | Intended to shift to CCC before 2028                                                            |
| CD-07: Multipronged Opioid Strategies                                                         | SUD Goal 2 - activity: Low-barrier access to medications for substance use disorder and medication-first treatment approaches<br>SUD Goal 2 - activity: SUD treatment for incarcerated people<br>SUD Goal 2 - activity: overdose prevention and tracking | Current activities of CD-07 align with multiple anticipated future activities within SUD Goal 2 |

| Former MIDD Program and Number                                                    | Aligned "Bridge" Anticipated Activity                                                                                                     | Notes                                                                                                               |
|-----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
| CD-08: Children's Domestic Violence Response Team                                 | CYYA Goal 3 - activity: Tailored supports for youth who are marginalized or experience inequities                                         |                                                                                                                     |
| CD-09: Behavioral Health Urgent Care Walk-In Clinic                               | n/a                                                                                                                                       | Already ended (before 2026-2027 biennium)                                                                           |
| CD-10: Next-Day Crisis Appointments                                               | CTD Goal 3 - activity: Promoting timely access to appropriate care                                                                        |                                                                                                                     |
| CD-11: Children's Crisis Outreach Response System                                 | n/a                                                                                                                                       | Intended to shift to CCC before 2028                                                                                |
| CD-12: Parent Partners Family Assistance                                          | CYYA Goal 3 - activity: Tailored supports for youth who are marginalized or experience inequities                                         |                                                                                                                     |
| CD-13: Family Interventions Restorative Services                                  | CYYA Goal 2 - activity: Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system     |                                                                                                                     |
| CD-14: Involuntary Treatment Triage                                               | CTD Goal 1 - activity: Services for people with behavioral health conditions who have cycled repeatedly through the criminal-legal system |                                                                                                                     |
| CD-15: Wraparound Services for Youth                                              | CYYA Goal 3 - activity: Tailored supports for youth who are marginalized or experience inequities                                         |                                                                                                                     |
| CD-16: Youth Behavioral Health Alternatives to Secure Detention                   | n/a                                                                                                                                       | Already ended (before 2026-2027 biennium)                                                                           |
| CD-17: Young Adult Crisis Facility                                                | CYYA Goal 1: Youth behavioral health services in community                                                                                |                                                                                                                     |
| CD-18: RCR/TRU                                                                    | CTD Goal 1 - activity: Diversion from criminal-legal system involvement                                                                   |                                                                                                                     |
| RR-01: Housing Supportive Services                                                | CTD Goal 2 - activity: Behavioral health services in permanent supportive housing                                                         |                                                                                                                     |
| RR-02: Behavior Modification Classes at Community Center for Alternative Programs | n/a                                                                                                                                       | Intended to shift to General Fund before 2028                                                                       |
| RR-03: Housing Capital and Rental                                                 | n/a                                                                                                                                       | The Bridge IP reflects DCHS' plans to cease this transfer to HCD at the time that the CTD area is reprocured (2029) |
| RR-04: Rapid Rehousing Oxford House Model                                         | SUD Goal 3 - activity: Access to housing that supports recovery                                                                           |                                                                                                                     |
| RR-05: Housing – Adult Drug Court                                                 | n/a                                                                                                                                       | Modeled as part of Adult Drug Court beginning in 2028 (continuing, but not as a standalone program)                 |
| RR-06: Jail Reentry System of Care                                                | CTD Goal 1 - activity: Supports for people to reenter the community after incarceration                                                   |                                                                                                                     |
| RR-07: Behavioral Health Risk Assessment Tool for Adult Detention                 | n/a                                                                                                                                       | Already ended (before 2026-2027 biennium)                                                                           |
| RR-08: Hospital Reentry Respite Beds                                              | CTD Goal 3 - activity: Promoting timely access to appropriate care                                                                        |                                                                                                                     |
| RR-09: Recovery Café                                                              | SUD Goal 3 - activity: Peer recovery services                                                                                             |                                                                                                                     |
| RR-10: Behavioral Health Employment Services and Supported Employment             | SUD Goal 3 - activity: Employment supports                                                                                                |                                                                                                                     |
| RR-11: Peer Bridgers and Peer Support Pilot                                       | CTD Goal 3 - activity: Care navigation, including peer navigation and care coordination<br>SUD Goal 3 - activity: Peer recovery services  | Peer Bridgers (RR-11A) fits under CTD Goal 3 and SUD Peer Support (RR-11B) fits under SUD Goal 3                    |

| Former MIDD Program and Number                                                                    | Aligned "Bridge" Anticipated Activity                                                                                                                                                                                                            | Notes                                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| RR-12: Jail-Based Substance Abuse Treatment                                                       | SUD Goal 2 - activity: SUD treatment for incarcerated people                                                                                                                                                                                     |                                                                                                                                                                                                   |
| RR-13: Deputy Prosecuting Attorney for Familiar Faces                                             | CTD Goal 1 - activity: Services for people with behavioral health conditions who have cycled repeatedly through the criminal-legal system                                                                                                        |                                                                                                                                                                                                   |
| RR-14: Shelter Navigation Services                                                                | n/a                                                                                                                                                                                                                                              | Already ended (before 2026-2027 biennium)                                                                                                                                                         |
| RR-15: PreTrial Assessment and Linkage Services (PALS)                                            | n/a                                                                                                                                                                                                                                              | Intended to shift to General Fund before 2028                                                                                                                                                     |
| SI-01: Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities              | EA Goal 2: activity: Community-driven culturally and linguistically responsive services and programs that support behavioral health outside of clinical settings<br>EA Goal 2: activity: BH treatment services tailored for priority populations | Current activities of SI-01 that are more upstream in nature would fall under the first activity ("outside of clinical settings"), while treatment services would fall under the second activity. |
| SI-02: Behavioral Health Services in Rural King County                                            | EA Goal 2: activity: Community-driven culturally and linguistically responsive services and programs that support behavioral health outside of clinical settings<br>EA Goal 2: activity: BH treatment services tailored for priority populations | Current activities of SI-02 that are more upstream in nature would fall under the first activity ("outside of clinical settings"), while treatment services would fall under the second activity. |
| SI-03: Quality Coordinated Outpatient Care                                                        | CTD Goal 3 - activity: Technology investments to facilitate care coordination across all levels of care                                                                                                                                          |                                                                                                                                                                                                   |
| SI-04: Workforce Development                                                                      | WF Goal 2 - activity: continuing education for community behavioral health providers                                                                                                                                                             |                                                                                                                                                                                                   |
| TX-ADC: Adult Drug Court                                                                          | CTD Goal 1 - activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts                                                                                                             |                                                                                                                                                                                                   |
| TX-FTC: Family Treatment Court                                                                    | CTD Goal 1 - activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts                                                                                                             |                                                                                                                                                                                                   |
| TX-JTRAC-BHR: Juvenile Therapeutic Response and Accountability Court - Behavioral Health Response | CYYA Goal 2 - activity: Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system                                                                                                            |                                                                                                                                                                                                   |
| TX-RMHC: Regional Mental Health Court                                                             | CTD Goal 1 - activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts                                                                                                             |                                                                                                                                                                                                   |
| TX-SMC: Seattle Mental Health Municipal Court                                                     | CTD Goal 1 - activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts                                                                                                             |                                                                                                                                                                                                   |
| TX-CCPL: Community Court Planning                                                                 | CTD Goal 1 - activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts                                                                                                             |                                                                                                                                                                                                   |

## ATTACHMENT 6: JULY 23<sup>RD</sup> HEALTH, HOUSING, AND HUMAN SERVICES COMMITTEE Q&A

### 1. Please provide a summary of existing funding levels for MIDD II programs and strategies (annual and/or to date).

While the Bridge implementation plan calls for a more strategic and aligned approach to funding priorities, it is anticipated that many of the services currently provided under MIDD 2 initiatives programming will continue through updated procurements. Attachment 7 to the staff report provides an overview of current investments in services aligned with the Bridge strategy areas and shows those investments from 2026-2034.

The MIDD 2 to BH Bridge Comparison (Attachment 7 to the staff report) compares funding levels for current 2026-27 services with the planned investments under each Bridge Implementation Plan goal area.

Shifts from current funding amounts to planned investment under the Bridge Implementation Plan are summarized below:

- **Care Transitions and Diversion:** The slight reduction in Care Transitions and Diversion reflects a planned shift as some existing programs move to other funding streams, specifically CD-06, Crisis Diversion Services, and CD-11, Children's Crisis Outreach and Response System.
- **SUD Treatment and Recovery:** Increasing SUD investment is essential because growing overdose risks demand more effective, low-barrier care, including significant added funding to expand legally-mandated access to MOUD for people in custody in King County jails. Increased funding in this strategy area will strengthen early intervention and engagement, expand access to a full continuum of treatment, and enhance long-term recovery supports.
- **Equitable Access to BH Care:** A reduction in equitable access funding relative to 2026-2027 reflects a planned shift in the non-Medicaid outpatient benefit payment model and eligibility process while still prioritizing culturally responsive care for communities facing the greatest barriers. These changes are expected to support the non-Medicaid benefit program to support the same amount or more individuals within the proposed budget.
- **Children, Youth, and Young Adults:** Increasing investment in children and youth is critical because rising behavioral health needs in this population require earlier, developmentally tailored supports.



- **Workforce:** Investment is increasing to address persistent recruitment and retention challenges, stabilize provider capacity, and ensure the behavioral health system can effectively implement and sustain the plan's strategies and services.

## **2. How did the data from MIDD 2 inform the Bridge plan and process?**

DCHS reviewed data on enrollment patterns, outcomes, spending, and implementation challenges for MIDD 2 programs during the renewal process. DCHS will incorporate this information, along with assessment data for the current behavioral health landscape, along with an analysis of updated population trends and performance indicators and outcome data from MIDD 2 programs, into the procurement development phase. This process will help determine which existing service types and program models are best suited to continue (with updates to align under the Bridge Implementation Plan's strategy areas, goals, and evaluation approach), versus where new or revised models may be procured to meet emerging community needs.

DCHS intentionally refrained from asking the multidisciplinary subject matter expert workgroups that supported the Bridge Implementation Plan's program design to begin their process by evaluating current MIDD programming. This approach allowed workgroups to start from a blank slate, generating input based on community identified needs, updated behavioral health data, and the broader system challenges described in the Bridge Implementation Plan, to create a forward-looking investment framework that reflects the needs and priorities of King County residents. Later, during procurement, more recent MIDD program data will be integrated where applicable to align future investments with the proposed Implementation Plan's strategy areas and goals.

## **3. Please explain how decisions about what does/doesn't get funding are made (e.g., informed by MIDD II data/evaluation or community feedback)?**

Building on the process outlined in the Implementation Plan and in the question above that shaped the design of the Bridge Implementation Plan's strategy areas and goals, DCHS intends to continue to use data and feedback to inform the process of procuring and contracting for Bridge-funded services. Procurement development will integrate updated performance information, population level trends, and outcome data from existing MIDD programs. This analysis will help to determine which existing services and program models are strong candidates to continue as Bridge-funded programs (with updates to align under the Bridge Implementation Plan's strategy areas, goals, and evaluation approach); which may be better aligned with other funding sources such as Medicaid or the Crisis Care Centers Levy; and where new or revised models may be required to meet emerging community needs. The renewed process emphasizes the interconnectedness of the proposed goals, alignment with the broader behavioral health system, and responsiveness to significant changes in the funding landscape.

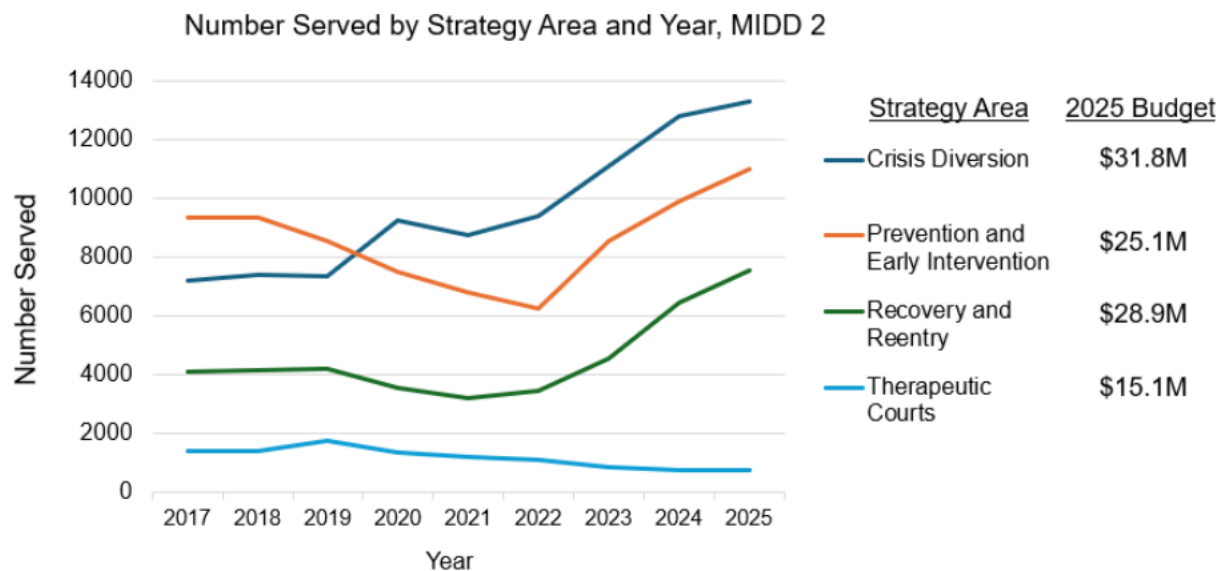
Community feedback also plays a central role in determining funding priorities. Engagement with more than 2,200 residents and providers directly informed the identification of the five strategy areas, the definition of community needs, and the elevation of equity issues across the system. Recommendations from multisector subject matter experts and community participants shaped the strategic direction rather than evaluations of existing services, ensuring that decisions reflect community identified priorities rather than legacy investments. Combined with data analysis, and attention to forthcoming shifts in state and federal funding streams, this ensures that funding decisions remain both evidence informed and responsive to evolving behavioral health needs in King County. Together, community identified needs and subject matter expert insights shaped the Bridge's strategy areas by pinpointing where investments can have the greatest impact in the behavioral health system. As described in the Implementation Plan, Bridge investments will directly impact these areas.

**4. Please provide available quantitative data that informed policy decisions in transmitted plan, generally speaking (tables, charts etc. that could be shared with providers) by 7/31.**

To inform future investments and strategy areas, DCHS staff conducted an extensive look back at the MIDD 2 implementation and the over 100,000 King County residents who were served since 2017. Staff identified successes and challenges of MIDD implementation, changes to community behavioral health needs over the past decade, and changes in the funding landscape (local, State, and Federal).

Staff assessed the number of County residents served by MIDD 2 within each strategy area, demographics characteristics of those served, program costs, geographic reach, and outcome data, all within the context of the current behavioral health landscape. The figure below displays the trends in the number of MIDD participants, organized by MIDD 2

strategy area, from 2017-2025.

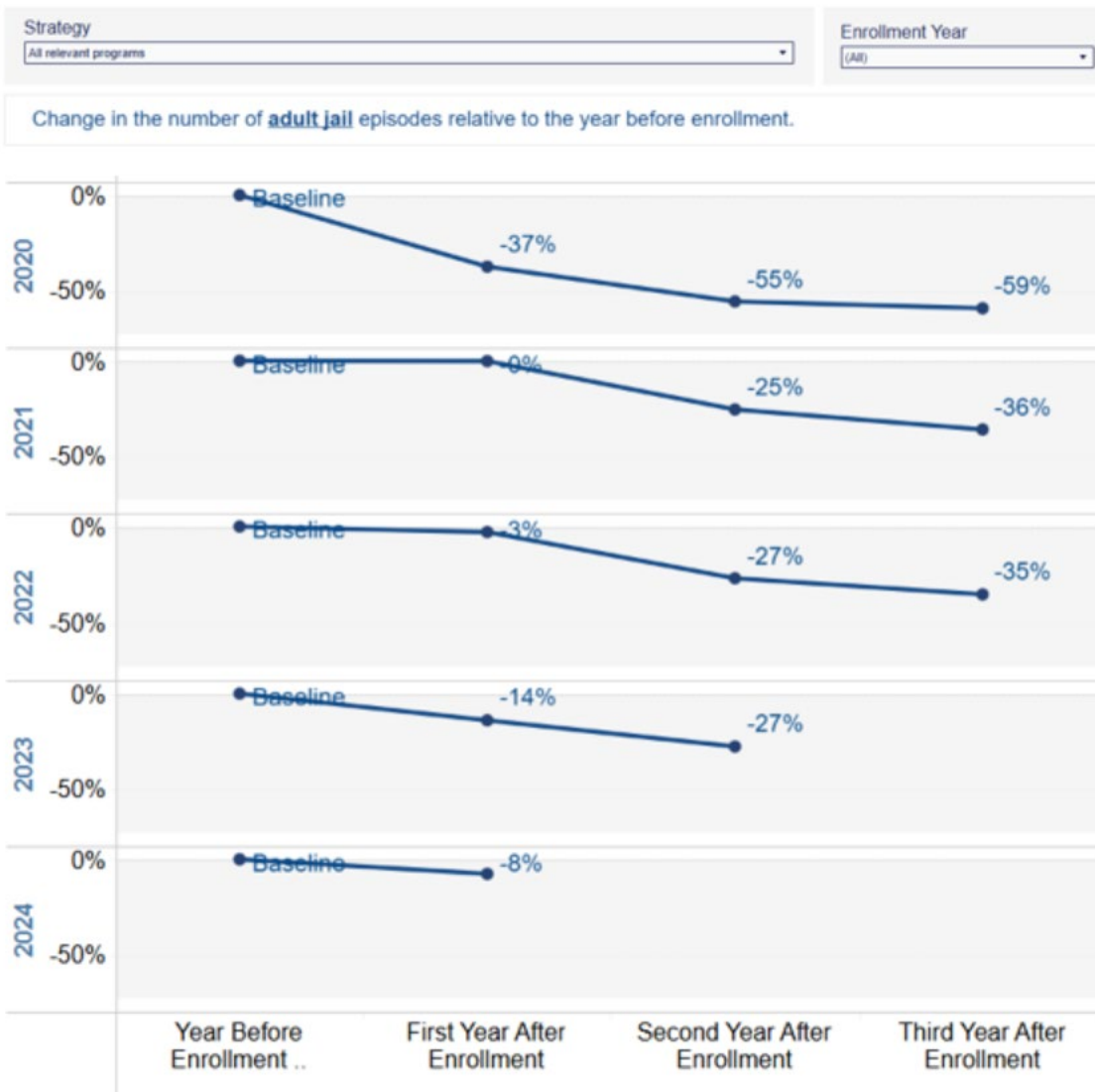


Every year, the MIDD Annual Report Data Dashboard<sup>1</sup> provides detailed information on each initiative that uses sales tax revenue. Long-term outcomes related to crisis episodes, emergency department visits, jail bookings, and psychiatric hospitalizations are displayed on the dashboard and can be filtered to the specific initiatives to which these outcomes pertain. See the example below of jail booking outcome data across the entire MIDD, which shows consistent reductions in jail bookings over the long-term for individuals participating in relevant MIDD programs. These outcomes are assessed over time by cohort (i.e., year) of MIDD 2 program participants. The example below illustrates that among individuals enrolled in relevant MIDD programs in 2020; jail bookings went down by 59% by the third year following their participation. Among individuals enrolled in relevant MIDD programs in 2021, jail bookings went down by 36% by the third year following their participation. This information demonstrates a consistent pattern, year-over-year, of the long-term outcomes for individuals participating in MIDD programs. The data is purely descriptive, however, and the new evaluation framework in the Bridge Implementation Plan will add the ability to assess relative impact across programs and the potential to assess program efficacy. DCHS staff used MIDD 2 data like this, at the strategy area and initiative level, to inform the development of the Bridge Implementation Plan, including its proposed strategy areas and goals and the anticipated activities that DCHS plans to procure.

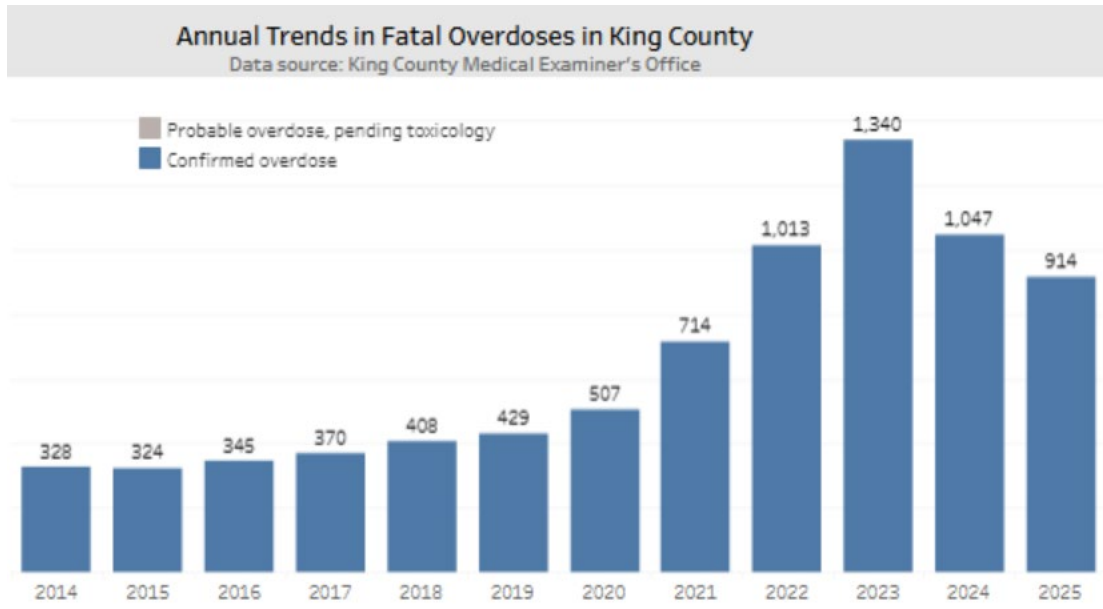
<sup>1</sup> MIDD Annual Report Data Dashboard, <https://kingcounty.gov/MIDDdashboard>

## LONG-TERM OUTCOME RESULTS

MIDD tracks the use of public systems by participants over time.



In addition to assessing patterns in outcome data for MIDD 2 programming, DCHS staff also assessed the existing behavioral health landscape using available data from Public Health – Seattle and King County (PHSKC) and other entities. For example, as shown below and summarized in the Implementation Plan, fatal overdose rates have increased and remain substantially higher than 2018 levels. This pattern in King County necessitates a renewed focus of behavioral health investments aimed at substance use. Patterns, such as those displayed below, informed the creation of the Substance Use Disorder Treatment and Recovery strategy area and the anticipated activities therein.



Source: Overdose deaths data dashboard, Public Health – Seattle & King County. [[LINK](#)]

Further, DCHS staff engaged over 2,200 community members to inform the creation of the Bridge Implementation Plan and identify needs and gaps in the King County behavioral health system (for more detail, see the Phase One Community Engagement Report<sup>2</sup>). This engagement process sought insight into how the Bridge might enhance behavioral health care for community members, reduce substance use risks (including overdose), improve the behavioral health workforce, and support integrated care. Community members who participated represented every King County Council district. The most oft-cited recommendations from community members were collapsed into major themes and summarized as follows:

1. Increase Access & Reduce Barriers
2. Strengthen Culturally Relevant & Responsive Care
3. Reduce System Fragmentation & Improve Service Coordination
4. Strengthen and Increase Services for Children, Youth, and Young Adults
5. Strengthen and Expand the Behavioral Health Workforce
6. Strengthen Wraparound Services

## 5. What is the proportion of funding going to different strategies under exec's proposed IP?

<sup>2</sup> Phase One Community Engagement Report, <https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd-renewal-community-engagement-report-final-2025.pdf?rev=158a78c33eab4cdda443da39d874f040&hash=3EDD11B4F9CAF6A7C4BDDCB16EAF1FD>

The figure below shows each strategy area and the total amount of Bridge revenue to be invested in each area during the 2028-34 implementation period.

| Behavioral Health Bridge Sales Tax Approximate Allocation by Strategy (2028 - 2034) |                  | Percentage of funding invested |
|-------------------------------------------------------------------------------------|------------------|--------------------------------|
|                                                                                     | Total (millions) |                                |
| Strategy Area 1: Care Transitions and Diversion Services                            | \$244.4          | 31%                            |
| Strategy Area 2: SUD Treatment and Recovery                                         | \$149.6          | 19%                            |
| Strategy Area 3: Equitable Access to Behavioral Health Care                         | \$122.9          | 15%                            |
| Strategy Area 4: Child, Youth, and Young Adult Mental Wellbeing                     | \$87.8           | 11%                            |
| Strategy Area 5: Behavioral Health Workforce Development                            | \$44.3           | 6%                             |
| Technical Assistance & Capacity Building                                            | \$4.0            | 1%                             |
| Administration & Compliance                                                         | \$64.8           | 8%                             |
| Performance Measurement & Evaluation                                                | \$19.0           | 2%                             |
| Behavioral Health Fund Transfer:                                                    | \$60.9           | 8%                             |
| <b>Total Behavioral Health Bridge Sales Tax Costs</b>                               | <b>\$797.7</b>   |                                |

NOTE: Numbers above may not sum exactly due to rounding.

To see a breakdown of the investments by year, please see the Implementation Plan, page 50, Figure 23.

**6. What are trade-offs of new funding strategies, what are we potentially not funding; explanation of why we are prioritizing some areas over others.**

The Behavioral Health Bridge Implementation Plan generally organizes the services supported by the fund to align under new strategy areas and goals, without excluding types of services funded under MIDD 2 from eligibility for future funding. Most service types funded under MIDD 2 align with the Behavioral Health Bridge strategy areas and goals. To

ensure an equitable and accountable process, most Bridge services will be competitively reprocured starting in 2028, with the exception of services directly operated by King County, such as therapeutic courts and some public health programs.

As described further in the Implementation Plan Section IV, page 13-16 and in the responses to Batch 2 questions 1, 2, and 4<sup>3</sup>, the selected strategy areas are prioritized because they emerged from an 18-month, comprehensive process that included a thorough behavioral health landscape assessment, extensive community engagement, and consultation with subject matter experts. This deliberate approach ensured that priorities in the Implementation Plan reflect the most pressing community needs. This process helped identify strategies that are positioned to create meaningful improvement on key issues and needs in behavioral health in King County, given the limited amount of funding available through the Bridge.

**7. Please provide more information about what programs utilize braided funds (and rationale for combined funding approach) and the rationale for ‘unbraiding’ some program funding for the Bridge.**

Historically, services have been structured with braided funding when the County wished to respond to an urgent or newly emerging community need, but no single funding stream had sufficient funding available to fund the requested program or service in its entirety. As the County has added or renewed several local funding streams in human services and behavioral health since the 2017 renewal of the MIDD fund, the Bridge renewal presents an opportunity to start to shift programs to single sources of local funding where possible. This approach is intended to streamline administration and oversight while enhancing transparency and accountability. It also supports the Executive’s priority of shifting from a collection of disparate programs to a thoughtfully planned and integrated system.

The chart below shows the MIDD 2 investments that have associated braided funding in 2026-27, with information about what other funding streams currently support each service.

At this time, DCHS does not have information about the presence or absence of braided funding in programs that receive direct appropriations from Council and are administered by courts or other criminal legal system agencies.

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<sup>3</sup> These are questions 2, 3, and 4 in Attachment 6.

| MIDD Initiative | Program Title- Official                               | Managing Division/<br>Department | Type of funding |          |       |             |     |     |       |             | OTHER - NON STATE, NON LOCAL [includes Juul/Atria settlement, Raikes Foundation, Opioid settlement] |
|-----------------|-------------------------------------------------------|----------------------------------|-----------------|----------|-------|-------------|-----|-----|-------|-------------|-----------------------------------------------------------------------------------------------------|
|                 |                                                       |                                  | OTHER FEDERAL   | MEDICAID | BHASO | OTHER STATE | CCC | BSK | VSHSL | OTHER LOCAL |                                                                                                     |
| TX-ADC          | Adult Drug Court                                      | BHRD                             |                 |          | Yes   |             |     |     |       |             |                                                                                                     |
| RR-02           | Community Center for Alternative Programs (CCAP)      | BHRD                             |                 |          |       | Yes         |     |     |       |             |                                                                                                     |
| CD-10           | Emergency Telephone Services - Regional Crisis Line   | BHRD                             |                 | Yes      | Yes   |             |     |     |       |             |                                                                                                     |
| SP-14 & RR-13   | Familiar Faces Intensive Case Management (VITAL)      | BHRD                             |                 |          | Yes   |             |     |     |       |             |                                                                                                     |
| CD-13           | Family Intervention Restorative Services              | BHRD                             |                 |          |       |             |     |     |       | Yes         |                                                                                                     |
| CD-13           | Functional Family Therapy (FFT)                       | BHRD                             |                 |          |       | Yes         |     |     |       | Yes         |                                                                                                     |
| RR-12           | Jail SUD Assessment Services                          | BHRD                             |                 |          | Yes   |             |     |     |       |             |                                                                                                     |
| PRI-02          | Juvenile Justice Youth Behavioral Health Assessments  | BHRD                             |                 |          |       | Yes         |     |     |       |             |                                                                                                     |
| RR-01           | KC Housing and Recovery Through Peer Services (HARPS) | BHRD                             | Yes             |          | Yes   | Yes         |     |     |       |             |                                                                                                     |
| CD-01           | Law enforcement Diversion (LEAD)                      | BHRD                             |                 |          |       |             |     |     |       | Yes         |                                                                                                     |
| TX-SMC          | Legal Intervention & Network of Care (LINC)           | BHRD                             |                 |          | Yes   | Yes         |     |     |       |             |                                                                                                     |
| CD-13           | Multisystemic Therapy (MST)                           | BHRD                             |                 |          |       | Yes         |     |     |       | Yes         |                                                                                                     |
| CD-10           | Next Day Appointments (MH)                            | BHRD                             |                 |          | Yes   | Yes         |     |     |       |             |                                                                                                     |
| PRI-04          | Geriatric Regional Assessment Team                    | BHRD                             |                 |          |       |             |     |     | Yes   |             |                                                                                                     |
| PRI-11          | Older Adult Substance Use Disorder Services           | BHRD                             |                 |          |       |             |     |     |       | Yes         |                                                                                                     |
| RR-11A          | Peer Bridger                                          | BHRD                             |                 |          |       | Yes         |     |     |       |             |                                                                                                     |
| SI-03           | Program for Assertive Community Treatment (PACT)      | BHRD                             | Yes             |          | Yes   | Yes         |     |     |       | Yes         |                                                                                                     |
| SP-09           | Recovery High School                                  | BHRD                             |                 |          | Yes   |             |     | Yes |       |             |                                                                                                     |
| SP-09           | Recovery Navigator Program                            | BHRD                             |                 |          | Yes   |             |     |     |       |             |                                                                                                     |
| PRI-11          | RSN Clubhouse Services                                | BHRD                             |                 | Yes      |       |             |     |     |       |             |                                                                                                     |
| PRI-05          | School-based SBIRT                                    | BHRD                             |                 |          |       |             |     | Yes |       |             |                                                                                                     |
| PRI-11          | Sobering Services                                     | BHRD                             | Yes             |          |       |             |     |     |       |             |                                                                                                     |
| PRI-11          | Standard Supportive Housing                           | BHRD                             |                 | Yes      |       |             |     |     |       |             |                                                                                                     |
| CD-11           | Youth Mobile Crisis Team (MRSS)                       | BHRD                             | Yes             | Yes      | Yes   |             | Yes |     |       | Yes         |                                                                                                     |
| SP-01           | Youth Support Services                                | BHRD                             |                 |          | Yes   |             |     |     |       | Yes         |                                                                                                     |
| CD-07H          | Jail-based Methadone Dosing                           | PHSKC                            |                 |          |       | Yes         |     |     |       |             |                                                                                                     |
| CD-03           | Healthcare for the Homeless Network (HCHN)            | PHSKC                            | Yes             | Yes      |       | Yes         |     |     |       | Yes         | Yes                                                                                                 |
| CD-14           | Opioid-Related Surveillance & Evaluation              | PHSKC                            | Yes             |          |       |             |     |     |       |             | Yes                                                                                                 |
| CD-07           | Street Medicine Team - Behavioral Health Specialist   | PHSKC                            | Yes             |          |       |             |     |     |       |             |                                                                                                     |



**8. What's the proportion of administration funding under MIDD II compared to the Bridge proposal?**

The figure below shows the proportion of administration funding reflected in the Bridge Implementation Plan in comparison to MIDD 2026-27 administration funding for MIDD 2 in 2026-27.

|                                         | <i>Time Period</i> | <i>Approximate Proportion</i> | <i>Total Amount</i>     | <i>Average Annual Amount</i> |
|-----------------------------------------|--------------------|-------------------------------|-------------------------|------------------------------|
| <i>MIDD 2<br/>(current budget)</i>      | 2026-27            | 6%                            | \$15M<br>over 2 years   | \$7.5M                       |
| <i>Bridge<br/>(implementation plan)</i> | 2028-34            | 8%                            | \$64.8M<br>over 7 years | \$9.3M                       |

In 2026-27, MIDD funding for administration is just above 6%, excluding evaluation functions. Under the Bridge Implementation as proposed, administration constitutes just below 8% of total planned expenditures for the 7-year planning period. The new implementation plan increases allocations to ensure the Bridge has sufficient staffing and systems capacity to meet audit aligned standards of oversight, strengthen contract monitoring, and improve data measurement and evaluation consistent with Better Government priorities. This includes expanding administrative and evaluation infrastructure to support a more rigorous procurement process, enhanced fiscal controls, continuous quality improvement, and expanded cross agency coordination.

**9. Please provide a comparison between current and proposed workforce investments and corresponding dollar amounts.**

| <b>MIDD/Bridge Workforce Investments Comparison</b> |                          |                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------|--------------------------|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Initiative/<br/>Funding<br/>Stream</b>           | <b>Dollar<br/>Amount</b> | <b>Investment<br/>Period</b> | <b>Investment Description</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |
| MIDD<br>Sales Tax                                   | \$6.7M                   | 2017-2027                    | <b>SI-04: Workforce Development</b> <ul style="list-style-type: none"> <li>Workforce Development supports providers to receive specialized training in clinical skills, such as Dialectical Behavior Therapy. This initiative also funds the annual umbrella license for SUD youth treatment providers to implement the evidence-based program, Seven Challenges. It also supports Seven Challenges national trainers to work with the</li> </ul> |

|                                            |         |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------------|---------|-----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                            |         |           | agencies by facilitating quarterly meetings and an annual fidelity meeting.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| BRIDGE<br>Sales Tax<br><br><i>Proposed</i> | \$36.4M | 2028-2034 | <b>Goal 1: Strengthen and diversify the behavioral health provider pipeline</b> <ul style="list-style-type: none"> <li>• Activity: Build pathways to behavioral health careers</li> <li>• Activity: Support high-quality behavioral health clinical internships</li> </ul><br><b>Goal 2: Advance and develop skills of the current workforce to meet growing community needs</b> <ul style="list-style-type: none"> <li>• Activity: Clinical supervision</li> <li>• Activity: Continuing education for community behavioral health providers, including expansion of King County Integrated Care Network (KCICN) Training Academy in Evidence-Based Practices and other culturally relevant clinical modalities effective for BHRD population</li> </ul> |

**10. Undesignated fund balance – please provide more information on what the proposal is for dealing with undesignated fund balance and alternative policy options.**

Section IX.C of the Bridge Implementation Plan addresses priorities for allocating undesignated fund balance, including how such allocations remain subject to the County’s budget process. The relevant section of the plan is excerpted below.

**Priorities for allocating undesignated fund balance**

This part of this subsection describes the process for prioritizing allocations of undesignated fund balance. Undesignated fund balance may result from circumstances such as, but not limited to, Behavioral Health Bridge revenue exceeding this plan’s revenue projections or Bridge revenue becoming available because other funding sources (including federal, state, or philanthropic sources) are contributing funding toward Bridge strategy areas and goals at a higher level than anticipated. Expenditures of Behavioral Health Bridge revenues allocated through this prioritization remain subject to the appropriation limits authorized through the County’s budget process. Any proposals requiring additional appropriation will be proposed by the Executive in budget ordinances and be subject to County Council deliberation and adoption. The Executive will assess whether undesignated fund balance is the result of one-time fund availability or represents an opportunity for long-term, sustainable investment.

The Executive intends to apply the following priorities to allocate undesignated fund balance when the Executive determines that it represents an opportunity for long-term, sustainable investment:

1. In any year where inflation rates have been reduced due to limited funding availability, provide inflationary adjustments to contracted providers up to the amount of CPI-U Seattle inflation rates.
2. Augment existing investments to mitigate losses of Medicaid coverage to the degree necessary and feasible within available funds. This includes increasing funding to EA Goal 1, “Provide behavioral health care for low-income people who are ineligible for Medicaid.” It may also include increasing investment in other programs negatively affected by growth of the uninsured rate among the Behavioral Health Bridge’s service population.
3. Scale high-performing or innovative Behavioral Health Bridge investments to address unmet need. The investments to be augmented shall be selected through a process that includes Behavioral Health Bridge Advisory Committee consultation and is guided by performance and measurement data.

When the Executive determines that fund availability is one-time in nature and cannot reasonably support sustained programming, the Executive intends to consider using these funds for one-time investments including capital projects such as building behavioral health facilities or housing for people with behavioral health conditions, or in pilot programs that can later transition to other funding sources such as Medicaid.

**11. Regarding the timeline for making decisions, is there a need to implement some strategies prior to the 2-year extension?**

The Executive requests that Expenditure Restriction ER6 governing expenditures during 2026-2027 be left in place, and that the Bridge Implementation Plan go into effect at the beginning of 2028 as proposed. As discussed further below, retaining the proposed Implementation Plan time period would enable the Executive branch to begin planning for the renewed Bridge, including its phased procurements, during 2027 ahead of the plan’s effective date.

The Executive supports any Council consideration timeline for the Bridge Implementation Plan that results in adoption by December 31, 2026, provided staffing for the renewed Bridge that is needed in 2027 to plan for procurements is adopted through the 2<sup>nd</sup> omnibus supplemental budget that will be transmitted to the Council this fall.

To support the procurement strategy that is necessary to carry out the strategies in the Implementation Plan, the Executive anticipates proposing additional staffing for Bridge

implementation planning through the 2<sup>nd</sup> omnibus, to begin in 2027. Section V.B of the plan describes the design of the procurement process, including planned phases and anticipated development and implementation steps. The procurement process will follow standard departmental procurement procedures, including new safeguards that DCHS is implementing to respond to the results of a 2025 KCAO audit of the department. As also described in the response to Batch 2 question 9<sup>4</sup>, procurements for each strategy area are anticipated to be publicly announced approximately one year in advance of the launch of new or repurchased programs within that strategy area. This timeline allows time for an application period, review period, transition or ramp-down period where applicable, and the thoughtful transfer of program participants to new providers as necessary.

**12. Please summarize any providers feedback about changing the procurement process for the Bridge and need for more measurable outcomes.**

Providers played an important role in shaping the planned shift to competitive procurement during the renewal process. Through listening sessions and SME workgroups, providers emphasized that the provider landscape has shifted over the years and that there is a need for transparent and equitable procurement processes and expressed support for revisiting longstanding program models to better reflect current behavioral health needs. Providers also called for using data to determine the services to provide which directly informed the Implementation Plan's strengthened performance measurement approach, including logic models, goals, and outcomes.

**13. How many contracts does MIDD currently have and how many contracts is the Bridge aiming to have?**

In 2025, MIDD's 52 initiatives involved 312 contracts across 166 different partners. DCHS anticipates conducting an average of 2-3 procurements per Bridge goal in 2028-2029, using the phased procurement approach outlined in the Implementation Plan. The number of applicants, the number of provider partners necessary to deliver a sufficient scope and range of services, and the amounts that applicants request will all be factors in determining the number of Bridge contracts in 2028-34.

**14. How is the provider community being made aware of the changes proposed by the new implementation plan, such as RFP/procurement approach and transition timing for new/continuing and noncontinuing programs from MIDD II? Please provide information about your communications plan.**

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<sup>4</sup> This is question 15 in Attachment 6.

The Bridge serves as a hub across the region for behavioral health providers, and throughout the process of extending the MIDD behavioral health sales tax and developing the implementation plan, the planning team has engaged providers in every step of the process. In 2027, DCHS will develop a plan to engage the provider community. The plan is expected to build on measurable outcomes and community engagement strategies that informed the sales tax extension, which include:

- Engaging with the MIDD Advisory Board, Behavioral Health Advisory Board, and the King County Integrated Care Network to bring providers along in the planning, procurement process, and forthcoming procurement timelines per the implementation plan.
- Partnering with regionally based behavioral health providers and human services coalitions (e.g. King County Human Services Alliance) and partner groups to host planning session on “what to expect” for upcoming procurement opportunities.
- Facilitating workgroups, which may consist of providers, County staff, and Councilmembers on specific topics to help inform upcoming procurements and inform the provider community about the rounds of procurements by quarter as outlined in the implementation plan.
- Sharing data with KCICN providers (who are also Bridge providers) to illustrate the needs and impacts of Bridge investments across the strategy areas.
- Conducting surveys to ensure provider voices are incorporated throughout the procurement process
- Providers will be informed about changes through DCHS’ communication channels, which include, but are not limited to, the Cultivating Connections department blog, department social media accounts, and email lists specific to MIDD renewal community engagement and MIDD renewal updates.

**15. Will providers know in advance if their work was going to continue under the Bridge?**

In preparing for the transition to the Behavioral Health Bridge, DCHS will continue sharing information about the strategy areas, goals, and anticipated activities. This information will help providers understand what goal areas are most relevant to the work they do and when those procurement processes open. When procurements are announced for each strategy area, current providers will be able to evaluate whether their current services are a good fit for the planned RFPs or not. DCHS intends to fund the availability of technical assistance to all potential applicants for Bridge funds, to help providers understand the scope of the procurement and any differences from the services they currently provide. In cases where current programs are not a strong match to a Bridge procurement, providers may choose to apply with modified programming approaches, parameters, or focus populations, or

they may opt to seek funding elsewhere. DCHS intends to announce Bridge procurements a year in advance of planned program launch, so that providers who choose not to apply or who are not selected in the Bridge procurement have enough time to identify other funding or prepare to ramp down their programs if needed.

**16. Please provide the rationale for switching from an annual to a biennial reporting cadence.**

The proposed transition to biennial narrative reports is intended to redirect Executive branch staff resources to increase continuous improvement and taking action to use information on program performance and outcomes to make adjustments when needed. However, the shift to biennial transmitted reports does not replace annual monitoring or accountability. The proposed implementation plan continues the same frequency of accountability and transparency by complementing transmitted reports with annual dashboard updates accompanied by Council briefings each year.

**17. Can you confirm that it is the intention of the Exec to align the procurement process with the anticipated activities in the logic models?**

Yes, this is the Executive branch's intention. Procurements will align with the plan's strategy areas, goals, and anticipated activities, as outlined in the logic models. In some cases, a single procurement may encompass multiple related activities to best support the goals of the strategy area.

**18. Are there Bridge programs that are operated by DCHS? If so, are they not planned to receive a base budget analysis?**

DCHS staff do not provide direct services in any current MIDD programs. All County agencies, including DCHS, are expected to participate in the Executive Office's base budget analysis process described in Executive Order "Better Governance and Financial Management" from March 4, 2026. The program level base-budget analyses planned for non-DCHS managed MIDD/Bridge programs are also responsive to the Executive Order but will provide more specialized and detailed analysis.

| Strategy Area                                                      | Goal                                                                                                                                                                       | MIDD 2 Initiatives currently aligned with anticipated activities                                                       | 2026   | 2027   | 2028    | 2029   | 2030   | 2031   | 2032   | 2033   | 2034   |
|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|--------|--------|---------|--------|--------|--------|--------|--------|--------|
| Care Transitions and Diversion Services (CTD)                      | CTD 1. Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.        | CD-01, CD-14, CD-18A, CD-18B, RR-06A, RR-06B, RR-13, PRI-08, TX-ADC (including RR-05), TX-SMHC, TX-RMHC, TX-FTC, TX-CC | \$27.2 | \$27.3 | \$25.8  | \$24.0 | \$24.6 | \$25.1 | \$25.7 | \$26.2 | \$26.8 |
|                                                                    | CTD 2. Help people with behavioral health conditions achieve and maintain stable housing.                                                                                  | RR-01, RR-03                                                                                                           | \$5.9  | \$6.1  | \$5.7   | \$5.0  | \$5.1  | \$5.3  | \$5.4  | \$5.5  | \$5.7  |
|                                                                    | CTD 3. Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.                      | RR-11A, RR-08, CD-10, SI-03                                                                                            | \$6.8  | \$7.2  | \$5.2   | \$3.5  | \$3.6  | \$3.7  | \$3.8  | \$4.2  | \$4.5  |
|                                                                    | CTD Total                                                                                                                                                                  |                                                                                                                        | \$39.8 | \$40.5 | \$36.7  | \$32.5 | \$33.3 | \$34.1 | \$34.9 | \$35.9 | \$36.9 |
| SUD Treatment and Recovery (SUD) Strategy Area                     | SUD 1. Drive engagement and retention in SUD care.                                                                                                                         | PRI-01, CD-03                                                                                                          | \$1.3  | \$1.4  | \$1.70  | \$2.2  | \$2.3  | \$2.4  | \$2.4  | \$2.5  | \$2.5  |
|                                                                    | SUD 2. Provide effective, low-barrier SUD treatment that meets people's holistic needs.                                                                                    | CD-07, RR-12                                                                                                           | \$7.9  | \$8.1  | \$15.60 | \$16.3 | \$16.8 | \$17.3 | \$17.7 | \$18.1 | \$18.5 |
|                                                                    | SUD 3. Support paths to achieve and maintain recovery after treatment.                                                                                                     | RR-04, RR-09, RR-10, RR-11B                                                                                            | \$2.8  | \$2.9  | \$2.10  | \$1.6  | \$1.7  | \$1.7  | \$1.8  | \$2.1  | \$2.4  |
|                                                                    | SUD Total                                                                                                                                                                  |                                                                                                                        | \$12.0 | \$12.3 | \$19.50 | \$20.2 | \$20.8 | \$21.4 | \$21.9 | \$22.6 | \$23.4 |
| Equitable Access to Behavioral Health Care (EA) Strategy Area      | EA 1. Provide behavioral health care for low-income people who are ineligible for Medicaid.                                                                                | PRI-11                                                                                                                 | \$16.0 | \$16.6 | \$12.0  | \$12.3 | \$12.7 | \$13.0 | \$13.3 | \$13.6 | \$13.9 |
|                                                                    | EA 2. Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.                           | SI-01, SI-02, PRI-07, PRI-09, PRI-10                                                                                   | \$4.2  | \$4.4  | \$4.1   | \$4.2  | \$4.3  | \$4.5  | \$4.6  | \$5.0  | \$5.3  |
|                                                                    | EA Total                                                                                                                                                                   |                                                                                                                        | \$20.3 | \$21.0 | \$16.1  | \$16.5 | \$17.0 | \$17.5 | \$17.9 | \$18.6 | \$19.2 |
| Child, Youth, and Young Adult Mental Wellbeing (CYA) Strategy Area | CYYA 1. Improve youth access to behavioral health care by providing developmentally appropriate services that meet young people where they are, at school and in community | PRI-05, CD-17                                                                                                          | \$3.6  | \$3.7  | \$3.5   | \$4.0  | \$4.5  | \$4.6  | \$4.7  | \$4.9  | \$5.0  |
|                                                                    | CYYA 2. Provide behavioral health and therapeutic services to youth involved in the legal system, including diversion from deeper legal system involvement.                | CD-02A, CD-02B, CD-13, PRI-02, TX-JTRAC-BHR                                                                            | \$5.3  | \$5.5  | \$5.2   | \$4.9  | \$4.7  | \$4.8  | \$5.0  | \$5.1  | \$5.2  |
|                                                                    | CYYA 3. Invest in the behavioral health of youth who are marginalized or experience inequities.                                                                            | CD-08, CD-12, CD-15                                                                                                    | \$2.9  | \$2.7  | \$2.6   | \$2.8  | \$3.0  | \$3.1  | \$3.1  | \$3.5  | \$3.8  |
|                                                                    | CYYA Total                                                                                                                                                                 |                                                                                                                        | \$11.8 | \$12.0 | \$11.2  | \$11.7 | \$12.2 | \$12.5 | \$12.8 | \$13.4 | \$13.9 |
| Behavioral Health Workforce Development (WF) Strategy Area         | WF 1. Strengthen and diversify the behavioral health provider pipeline.                                                                                                    |                                                                                                                        | \$0.0  | \$0.0  | \$0.0   | \$2.5  | \$2.5  | \$2.6  | \$2.7  | \$2.9  | \$3.0  |
|                                                                    | WF 2. Advance and develop the skills of the current workforce to meet growing community needs.                                                                             | SI-04                                                                                                                  | \$1.4  | \$1.4  | \$1.3   | \$4.1  | \$4.2  | \$4.4  | \$4.5  | \$4.7  | \$4.9  |
|                                                                    | WF Total                                                                                                                                                                   |                                                                                                                        | \$1.4  | \$1.4  | \$1.3   | \$6.6  | \$6.8  | \$7.0  | \$7.1  | \$7.6  | \$8.0  |

Consistent with the King County Behavioral Health Bridge Implementation Plan, amounts in this table are rounded to the nearest \$100,000.

## ATTACHMENT 8: MIDD 2 INITIATIVE REFERENCE FOR ATTACHMENT 7

This attachment provides a list of MIDD 2 initiatives as a reference to the information provided in Attachment 7. Initiatives that are aligned with anticipated Bridge activities as indicated in Attachment 7 are indicated with an asterisk. Initiatives that are not listed as aligned with Bridge activities in Attachment 7 are indicated with a light gray highlight.

### Prevention and Early Intervention Initiatives

PRI-01: Screening, Brief Intervention and Referral to Treatment\*

PRI-02: Juvenile Justice Youth Behavioral Health Assessments\*

PRI-03: Prevention and Early Intervention Behavioral Health for Adults Over 50

PRI-04: Older Adult Crisis Intervention/Geriatric Regional Assessment Team

PRI-05: Collaborative School Based Behavioral Health Services: Middle and High School Students\*

PRI-06: Zero Suicide Initiative Pilot

PRI-07: Mental Health First Aid\*

PRI-08: Crisis Intervention Training – First Responders\*

PRI-09: Sexual Assault Behavioral Health Services\*

PRI-10: Domestic Violence Behavioral Health Services and System Coordination\*

PRI-11: Community Behavioral Health Treatment\*

### Crisis Diversion Initiatives

CD-01: Law Enforcement Assisted Diversion\*

CD-02A: Youth Connection Services\*

CD-02B: Family Court Services Behavioral Health Program\*

CD-03: Outreach and In Reach System of Care\*

CD-04: South County Crisis Diversion Services/Center

CD-05: High Utilizer Care Teams



CD-06: Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team

CD-07: Multipronged Opioid Strategies\*

CD-08: Children's Domestic Violence Response Team\*

CD-09: Behavioral Health Urgent Care Walk-In Clinic

CD-10: Next-Day Crisis Appointments\*

CD-11: Children's Crisis Outreach Response System

CD-12: Parent Partners Family Assistance\*

CD-13: Family Interventions Restorative Services\*

CD-14: Involuntary Treatment Triage\*

CD-15: Wraparound Services for Youth\*

CD-16: Youth Behavioral Health Alternatives to Secure Detention

CD-17: Young Adult Crisis Facility\*

CD-18A: Regional Crisis Response\*

CD-18B: Therapeutic Response Unit\*

### **Recovery and Reentry Initiatives**

RR-01: Housing Supportive Services\*

RR-02: Behavior Modification Classes at Community Center for Alternative Programs

RR-03: Housing Capital and Rental\*

RR-04: Rapid Rehousing Oxford House Model\*

RR-05: Housing – Adult Drug Court\*

RR-06A: Jail Reentry System of Care\*

RR-06B: Jail Coordinated Discharge\*

RR-07: Behavioral Health Risk Assessment Tool for Adult Detention

RR-08: Hospital Reentry Respite Beds\*

RR-09: Recovery Café\*

RR-10: Behavioral Health Employment Services and Supported Employment\*

RR-11A: Peer Bridger Programs\*

RR-11B: Substance Use Disorder Peer Support\*

RR-11C: Peer Respite

RR-12: Jail-Based Substance Abuse Treatment\*

RR-13: Deputy Prosecuting Attorney for Familiar Faces\*

RR-14: Shelter Navigation Services

RR-15: Pretrial Assessment and Linkage Services (PALS)

### **System Improvement Initiatives**

SI-01: Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities\*

SI-02: Behavioral Health Services in Rural King County\*

SI-03: Quality Coordinated Outpatient Care\*

SI-04: Workforce Development\*

SI-05: Emerging Issues

### **Therapeutic Court Initiatives**

TX-ADC: Adult Drug Court\*

TX-FTC: Family Treatment Court\*

TX-JTRAC-BHR: Juvenile Therapeutic Response and Accountability Court - Behavioral Health Response\*

TX-RMHC: Regional Mental Health Court\*

TX-SMC: Seattle Mental Health Municipal Court\*

TX-CC: Community Courts\*

# Behavioral Health Bridge Briefing

Liz Arjun, Behavioral & Public Health Policy Advisor, King County Executive Office

Susan McLaughlin, Director, DCHS

Isabel Jones, Acting Director, Behavioral Health and Recovery Division, DCHS

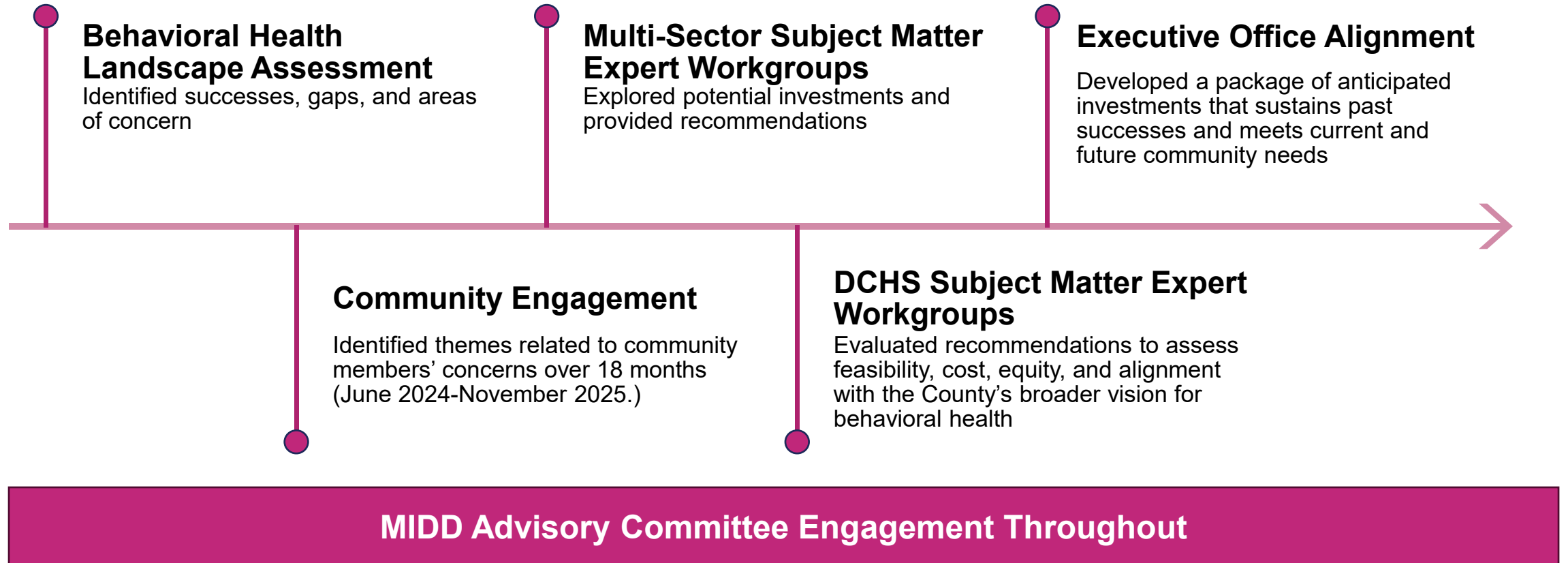
**Regional Policy Committee**

**August 26, 2026**

# Agenda

- Development of the Implementation Plan
  - Community engagement behind the plan
- What's Different
  - Updated 5 strategy areas
  - Procurement for DCHS
  - One County Approach to Outcomes, Measures, and Accountability
- Procurement Timeline and Process
- Inflation Analysis

# Implementation Plan Development Steps



# Community and Subject Matter Expert Engagement

# Community Engagement Overview

- Over 2200 people engaged over 18 months through listening sessions, community events, and an online survey in 21 languages.
- Half of people engaged were BIPOC, including Black, Latinx, AAPI, Middle Eastern, and Native/Indigenous.
- Significant engagement from youth, elders, LGBTQIA+ people, people with lived experience, and people who are incarcerated.

# Engaging Subject Matter Experts

## Multi-sector subject matter expert (SME) workgroups

- One workgroup for each strategy area, consisting of **over 100 subject matter experts**.
- They produced a set of **preliminary goals and investment ideas** to improve behavioral health for King County residents.
- Staff at DCHS, Public Health, and the Executive Office **evaluated and refined** the results.

**The result:** An implementation plan with 13 goals and a set of anticipated activities that respond to the most pressing needs in King County's behavioral health system.



# Executive Office Alignment & Priorities

- **Implement a countywide approach with an emphasis on integration** of behavioral health services and crisis response systems, as well as services for people who are incarcerated, hospitalized, or unhoused.
- **Promote overall accountability across county investments** that will respond to behavioral health needs across different systems, through competitive procurements and other accountability mechanisms.
- **Make stronger investments with data-driven decisions** that have clear performance goals across multiple systems, including the criminal-legal system.

# What's New

# BH Bridge Investment Considerations

- Investments respond to changing fiscal projections throughout implementation in 2028-2034.
- Introduction of a reserve to create flexibility during anticipated sales tax volatility.
- Strengthen monitoring and compliance by right-sizing staffing to support the investment of \$100M per year.

# BH Bridge Strategy Areas

1. Care Transitions & Diversion Services

2. Substance Use Disorder Treatment and Recovery

3. Equitable Access to Behavioral Health Care

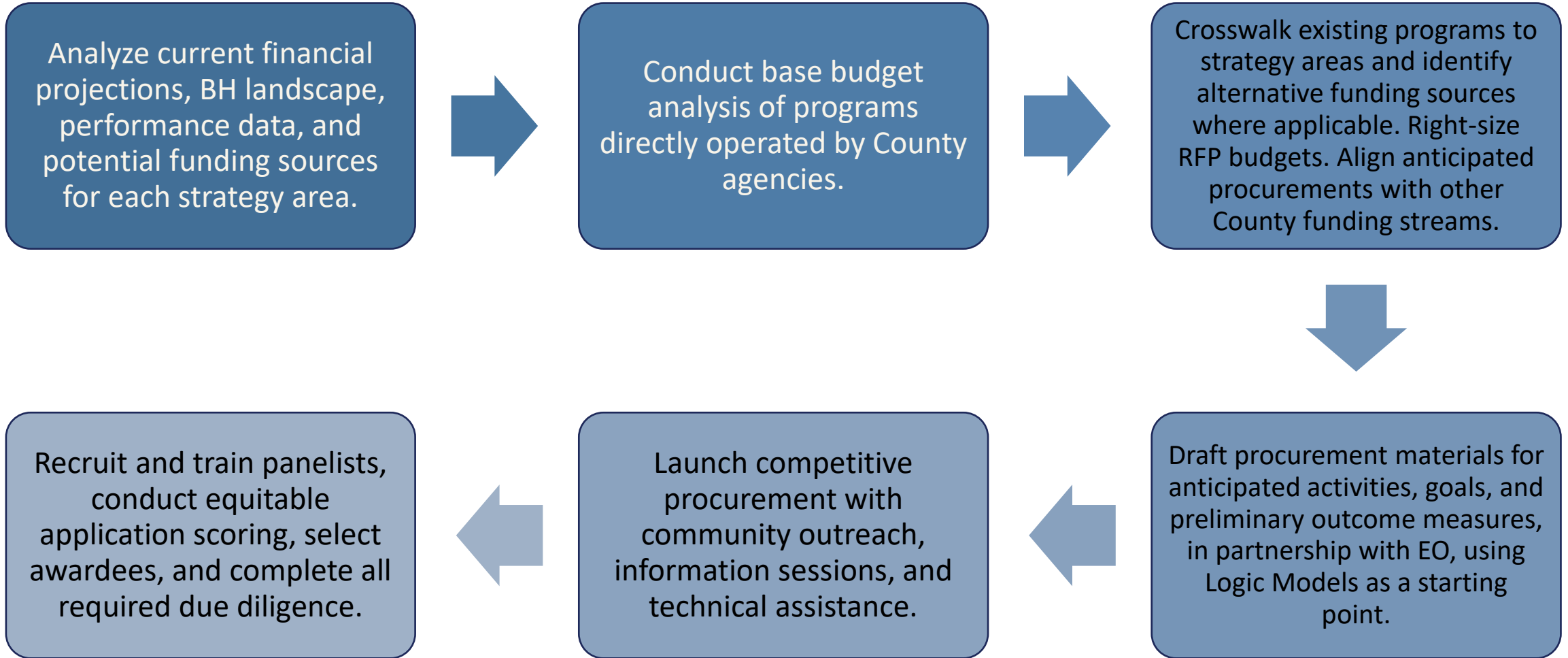
4. Child, Youth, and Young Adult Mental Wellbeing

5. Behavioral Health Workforce Development

# Countywide Approach to Accountability and Outcomes

- Five strategy areas with specific goals and identified measures.
- Competitive procurement process for DCHS programs.
- One County approach with Executive Office to measure, monitor and support accountability.

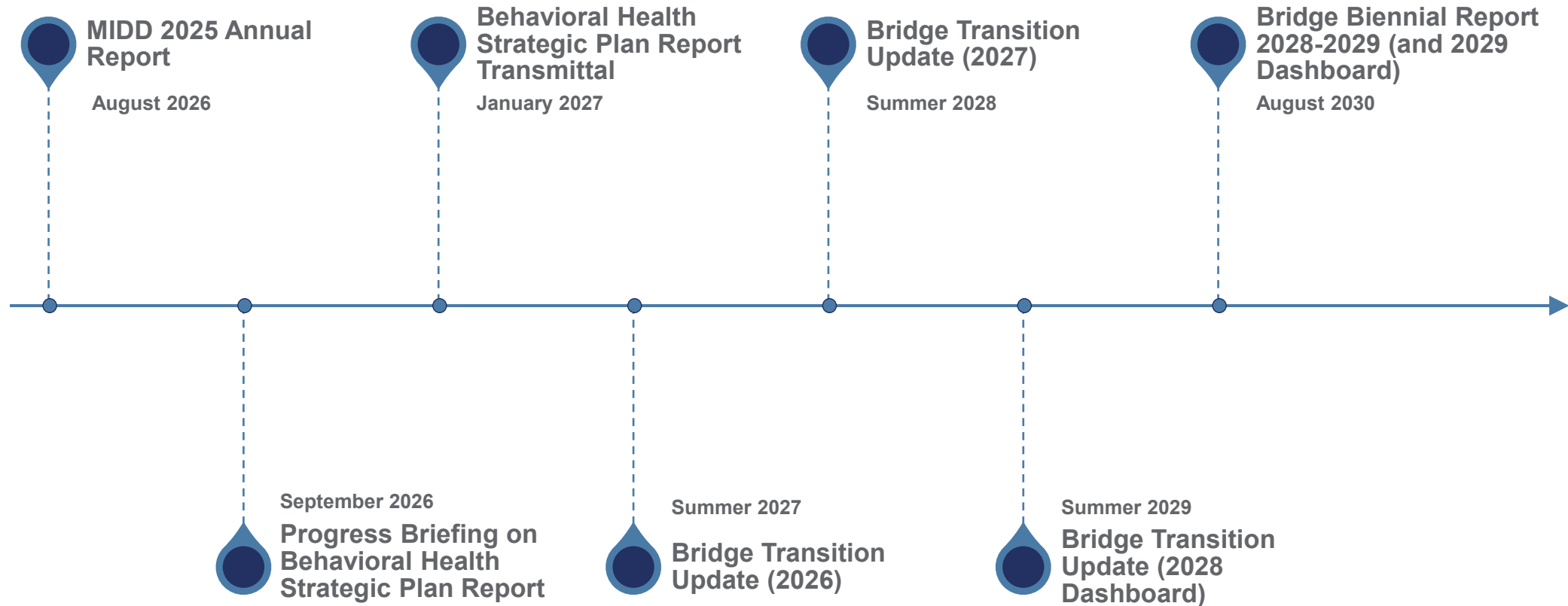
# Anticipated Steps to Procurement



# Estimated Timeline for Phased Procurements and Non-Funded Program Ramp-Down

| Strategy area                                                 | Procurements announced | Applications due & Selection process | Successful applicants announced | Ramp down for MIDD 2 programs no longer receiving funding | Anticipated launch of programs (reprocured or with new base budget) |
|---------------------------------------------------------------|------------------------|--------------------------------------|---------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------|
| <b>SUD Treatment and Recovery (SUD)</b>                       | Q2 2027                | Q3 2027                              | End of Q4 2027                  | Q 1& 2 of 2028                                            | Q3 of 2028                                                          |
| <b>Equitable Access to Behavioral Health Care (EA)</b>        | Q2 2027                | Q3 2027                              | End of Q4 2027                  | Q 1& 2 of 2028                                            | Q3 of 2028                                                          |
| <b>Care Transitions and Diversion Services (CTD)</b>          | Q4 2027                | End of Q1 2028                       | End of Q2 2028                  | Q 3 & 4 of 2028                                           | Q1 of 2029                                                          |
| <b>Behavioral Health Workforce Development (WF)</b>           | Q4 2027                | End of Q1 2028                       | End of Q2 2028                  | Q 3 & 4 of 2028                                           | Q1 of 2029                                                          |
| <b>Child, Youth, and Young Adult Mental Wellbeing (CY YA)</b> | Q2 2028                | End of Q3 2028                       | End of Q4 2028                  | Q 1 & 2 of 2029                                           | Q3 of 2029                                                          |

# Upcoming Reports and Briefings





# Inflation Analysis

# Inflation Analysis in this Plan

## Responsive to Council Budget Proviso

- DCHS integrates provider inflation rate adjustments into implementation plans and budget proposals for local funds to:
  - Support human services providers to maintain service levels/retain workers.
- Expenditure growth is predicted to outpace revenue growth.
- Implementation plan establishes sustainable Bridge spending for 2028-34 by:
  - Planning expenditures to fit within anticipated 7-year revenue total
  - Reducing inflation adjustments when a revenue drop is anticipated (2029) but maintaining them otherwise.

# Frequently Asked Questions

# Frequently Asked Questions

- **Will the Bridge invest equitably across the County?**
  - Future Bridge investments are expected to maintain or improve behavioral health service availability across the County through countywide services and targeted investments in both urban and rural areas.
- **Why shift from annual to biennial narrative reports?**
  - The proposed IP continues annual dashboard updates accompanied by Council briefings each year. The proposed transition to biennial narrative reports is intended to redirect Executive branch staff resources to increase continuous improvement.

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# Questions?



Department of Community  
and Human Services

RPC Meeting Materials

TRACK CHANGES COPY FOR ILLUSTRATIVE PURPOSES ONLY

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King County Behavioral Health Bridge Implementation Plan  
2028-2034

Phase 1: Transition Strategic Framework

July-October 2026



King County

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## 20 I. Contents

|    |                                                                                           |      |
|----|-------------------------------------------------------------------------------------------|------|
| 21 | I. Contents .....                                                                         | 2    |
| 22 | II. Executive Summary .....                                                               | 64   |
| 23 | III. Background .....                                                                     | 118  |
| 24 | A. The King County Behavioral Health Bridge .....                                         | 118  |
| 25 | B. Primary purpose .....                                                                  | 129  |
| 26 | C. A new name and a new process to meet current needs .....                               | 129  |
| 27 | D. Overview of DCHS and community behavioral health services .....                        | 1411 |
| 28 | IV. The process to develop the Behavioral Health Bridge Implementation Plan, Phase 1      |      |
| 29 | 1643                                                                                      |      |
| 30 | A. Behavioral health policy and funding changes .....                                     | 1613 |
| 31 | B. Changes in regional behavioral health needs .....                                      | 1613 |
| 32 | C. Community and subject matter expert engagement .....                                   | 1815 |
| 33 | V. A renewed King County Behavioral Health Bridge .....                                   | 2017 |
| 34 | A. Equity framework .....                                                                 | 2118 |
| 35 | B. Phased, competitive procurement and base budget analyses .....                         | 2219 |
| 36 | C. Advisory Committee .....                                                               | 2622 |
| 37 | VI. Investments across the five strategy areas .....                                      | 2724 |
| 38 | A. Care Transitions and Diversion Services (CTD) .....                                    | 2824 |
| 39 | B. Substance Use Disorder Treatment and Recovery (SUD) .....                              | 3227 |
| 40 | C. Equitable Access to Behavioral Health Care (EA) .....                                  | 3530 |
| 41 | D. Child, Youth, and Young Adult Mental Wellbeing (CYYA) .....                            | 3832 |
| 42 | E. Behavioral Health Workforce Development (WF) .....                                     | 4135 |
| 43 | VII. Measurement and evaluation .....                                                     | 4438 |
| 44 | A. Overarching principles .....                                                           | 4438 |
| 45 | B. Performance measurement and evaluation framework .....                                 | 4640 |
| 46 | VIII. Reporting for continuous improvement and accountability .....                       | 5448 |
| 47 | IX. Financial plan and policies .....                                                     | 5750 |
| 48 | A. Overview .....                                                                         | 5750 |
| 49 | B. Financial plan .....                                                                   | 5951 |
| 50 | C. Fiscal policies .....                                                                  | 6455 |
| 51 | X. Inflation rate adjustment policy analysis .....                                        | 6757 |
| 52 | A. How the inflation policy was determined to be applicable to the King County Behavioral |      |
| 53 | Health Bridge .....                                                                       | 6757 |

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 2

|    |                                                                                                                                     |               |
|----|-------------------------------------------------------------------------------------------------------------------------------------|---------------|
| 54 | B. Analysis of the effect of the inflation rate adjustment policy on the Behavioral Health Bridge and risk of a structural gap..... | 6757          |
| 56 | C. Process for mitigating fund shortfalls or structural gaps.....                                                                   | 6858          |
| 57 | <b>XI. Requesting Implementation Plan Phase 2: Pre-Procurement Development Plan and Council Notifications .....</b>                 | <b>7161</b>   |
| 59 | A. Pre-procurement Council notification.....                                                                                        | 7161          |
| 60 | B. Council engagement opportunities and notification of awards.....                                                                 | 7262          |
| 61 | C. Anticipated procurement timeline.....                                                                                            | 7262          |
| 62 | D. Examples of anticipated activities to be procured for the five strategy areas .....                                              | 7363          |
| 63 | E. Logic model and anticipated activities for Care Transitions and Diversion Strategy Area ..                                       | 7363          |
| 64 | F. Logic model and anticipated activities for Substance Use Disorder Treatment and Recovery Strategy Area .....                     | 7868          |
| 66 | G. Logic model and anticipated activities for Equitable Access to Behavioral Health Care Strategy Area .....                        | 8272          |
| 68 | H. Logic model and anticipated activities for Child, Youth, Young Adult Mental Wellbeing Strategy Area .....                        | 8575          |
| 70 | I. Logic model and anticipated activities for the Behavioral Health Workforce Development Strategy Area .....                       | 8978          |
| 72 | <b>XII. Conclusion .....</b>                                                                                                        | <b>9282</b>   |
| 73 | <b>XIII. Appendices .....</b>                                                                                                       | <b>9383</b>   |
| 74 | A. Appendix A. Behavioral Health Bridge investments in DCHS and other County agencies ..                                            | 9383          |
| 75 | B. Appendix B. Community engagement activities and results .....                                                                    | 9484          |
| 76 | C. Appendix C. Crosswalk of strategy areas and community engagement themes .....                                                    | 10292         |
| 77 | D. Appendix D. Multi-sector subject matter expert process .....                                                                     | 10393         |
| 78 | E. Appendix E. Implementation examples of the five equity pillars.....                                                              | 112102        |
| 79 | <b>XIV. Endnotes .....</b>                                                                                                          | <b>114104</b> |

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## 127 II. Executive Summary

128  
129 The King County Behavioral Health Bridge (“the Bridge”), formerly known as the MIDD (Mental  
130 Illness and Drug Dependency) behavioral health sales tax, currently infuses approximately \$100  
131 million per year into the King County community behavioral health system through a countywide  
132 0.1 percent sales tax authorized under RCW 82.14.460 and K.C.C. 4A.500.315.<sup>1,2,3</sup> **The Behavioral  
133 Health Bridge Implementation Plan 2028-2034 (“Behavioral Health Bridge Implementation Plan”)**  
134 describes a strategic approach to guide investments for the sales tax revenues from 2028 ~~through~~  
135 2034 **(“implementation period”)** to make behavioral health treatment more available, accessible,  
136 effective, and equitable for King County residents. **This implementation plan is divided into two  
137 phases, with this Phase 1 document serving as the transition strategic framework (“Phase 1  
138 Implementation Plan”), and a pre-procurement development strategy to be submitted in the future  
139 as Phase 2.**

140  
141 The primary purpose of the King County Behavioral Health Bridge is to invest in the long-term  
142 availability, accessibility, effectiveness, and equity of the county’s behavioral health system,  
143 especially where people are falling through the cracks of existing systems.

144  
145 By focusing on low-income residents with mental health conditions and substance use disorders,  
146 particularly those who are marginalized or experience intersectional inequities, the Behavioral  
147 Health Bridge invests where the need is greatest and where its dollars can make the most  
148 meaningful impact.

149  
150 The Behavioral Health Bridge strengthens publicly funded behavioral health care in King County by  
151 investing in prevention, treatment, and recovery services that are often unavailable, inaccessible,  
152 or insufficiently resourced. These investments help break cycles of incarceration, hospitalization,  
153 homelessness, and crisis by ensuring people receive timely, culturally responsive, and effective  
154 care.

### 155 A new name

156 **The behavioral health sales tax was most recently renewed in 2025.** In response to community and  
157 provider feedback, as part of this renewal, the Executive proposes to rename MIDD as the King  
158 County Behavioral Health Bridge, or “the Bridge.” The new name reflects the program’s essential  
159 role in bridging critical gaps in behavioral health funding left by insufficient federal and state  
160 resources. It also helps create **a bridge** between people experiencing behavioral health conditions  
161 and community behavioral health treatment, other systems people interact with **including such as**  
162 the criminal-legal system, and pathways to recovery.

### 163 Context and need

164 Behavioral health needs in King County have evolved considerably since the 2018 adoption of the  
165 MIDD 2 Implementation Plan, which guides investments through 2027.<sup>4,5</sup> King County faces growing  
166 uncertainty regarding federal and state behavioral health funding. Anticipated Medicaid eligibility  
167 changes and coverage reductions are expected to increase the number of residents who require  
168 behavioral health services but lack insurance coverage. As a flexible local funding source, the  
169 Behavioral Health Bridge is uniquely positioned to fill service gaps that cannot be addressed  
170 through Medicaid or other state and federal funding streams.

King County Behavioral Health Bridge Implementation Plan 2028-2034 **Phase 1: Transition Strategic  
Framework**

Page | 6

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**Commented [JN1]:** The Behavioral Health Bridge Implementation Plan is split into two phases, with this document comprising Phase 1 and Phase 2 being requested in Section XI.

Where this document references the entire plan (both Phase 1 and Phase 2), it is referred to as the “Behavioral Health Bridge Implementation Plan”. Where the document is specific to Phase 1, it references “Phase 1 Implementation Plan”, and where it refers to Phase 2, it references “Phase 2 Implementation Plan”.

Changes to reflect the splitting of Phase 1 and Phase 2.

**Commented [JN2]:** Connects the different behavioral health sales taxes, renewal, MIDD, and the Bridge

171  
172 Community engagement conducted during development of the renewal reached more than 2,200  
173 residents, **contracted** service providers, people with lived experience, advocates, and system  
174 partners through listening sessions, community events, surveys, and culturally specific outreach  
175 efforts. Participants consistently identified five priority needs:

- 176  
177
  - Increasing access to behavioral health care and reducing barriers to treatment;
  - 178 • Strengthening culturally relevant and responsive services;
  - 179 • Improving coordination across fragmented systems;
  - 180 • Expanding services for children, youth, and young adults; and
  - 181 • Addressing workforce shortages and improving workforce diversity.

## 182 A countywide approach guided by five strategy areas

183 The **proposed** Behavioral Health Bridge **implementation Pplan** represents a shift from funding a  
184 collection of individual programs toward investing in a coordinated, countywide behavioral health  
185 system. The **implementation** plan emphasizes integration across behavioral health, health care,  
186 crisis response, homelessness, housing, and criminal-legal systems to improve outcomes and  
187 reduce fragmentation. **Investments will be designed to have a definite, clear public impact,**  
188 **reducing the challenges experienced across the county due to unmet behavioral health needs, law**  
189 **violations related to meeting basic needs, and homelessness.** Rather than focusing solely on  
190 service delivery, the renewed framework seeks to create sustainable system change by aligning  
191 investments around measurable outcomes driven by five strategic areas.

192  
193 The **proposed** five strategy areas emerged from deep engagement with community members and  
194 subject matter experts, as well as the latest available county-level behavioral health data.

- 195  
196
  1. **Care Transitions and Diversion Services (CTD):** Enhance navigation and system  
197 coordination to ensure people receive timely, appropriate behavioral health services  
198 across all levels of care, divert individuals with behavioral health conditions from criminal-  
199 legal involvement to support long-term stability, and provide appropriate supportive  
200 services for individuals with behavioral health conditions involved in the legal system.
  - 201 2. **Substance Use Disorder Treatment and Recovery (SUD):** Treat substance use disorders  
202 by providing effective, low-barrier services that address people's holistic needs and  
203 support sustainable paths to long-term recovery.
  - 204 3. **Equitable Access to Behavioral Health Care (EA):** Decrease barriers to behavioral health  
205 services and increase access to culturally and linguistically responsive care.
  - 206 4. **Child, Youth, and Young Adult Mental Wellbeing (CYYA):** Address the youth behavioral  
207 health crisis by investing in developmentally tailored services and programs that meet  
208 youth where they are.
  - 209 5. **Behavioral Health Workforce Development (WF):** Strengthen and diversify the behavioral  
210 health workforce to meet growing community needs.

## 211 Phased, competitive procurement and base budget analyses

212 A significant feature of the renewal is the Executive's intention is to implement competitive  
213 procurements for nearly all contracted community-based programs. Many currently funded  
214 initiatives were established years ago, and the County seeks to ensure future investments align  
215 with contemporary evidence, emerging community needs, and best practices.

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 7

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**Commented [PS4]:** Policy statement regarding the nature of BH Bridge investments.

**Commented [JN5]:** With adoption, these strategy areas will no longer be proposed.

216  
217 Through phased procurements beginning in 2028, the County will create opportunities for both  
218 existing and new contracted service providers to compete for Behavioral Health Bridge funding.  
219 This approach is intended to:

- 220  
221
  - Improve transparency and accountability;
  - 222 • Encourage innovation;
  - 223 • Expand opportunities for community-based organizations;
  - 224 • Align funding with demonstrated outcomes; and
  - 225 • Ensure investments remain responsive to changing needs.

226 Program components directly operated by other County agencies, including, but not limited to,  
227 Executive departments and offices, will generally not be procured with requests for proposal (RFPs)  
228 competitively. All investments, whether County-run or run through contracted to external  
229 providers, will advance the primary strategy areas for the Behavioral Health Bridge as described in  
230 this Phase 1 Implementation Plan-plan, and will be tied to performance measures and outcomes  
231 that achieve 13 goals identified in Section VI. Procurements will be designed to complement and  
232 coordinate with Medicaid, the Crisis Care Centers Levy, Best Starts for Kids, and other major  
233 behavioral health funding sources. Bridge investments and all other local human service levy  
234 dollars and contracted service providers should be coordinated to the maximum extent possible in  
235 order to support continuity of care across County-funded resources. DCHS should provide the  
236 infrastructure to facilitate warm handoffs between County-funded providers to the extent possible.  
237 The Executive Office will work alongside DCHS and partner agencies to conduct base budget  
238 analyses, align investments with strategic priorities, identify efficiencies, and ensure accountability  
239 across agencies.  
240

## 241 Measurement and evaluation

242 ~~In 2028-2034, t~~The ~~King County~~ Behavioral Health Bridge will take a renewed approach to  
243 measurement and evaluation focusing on accountability, transparency, actionability, and  
244 consistency across all funded programs. Approximately one-quarter of current Behavioral Health  
245 Bridge funding supports programs administered outside the Department of Community and  
246 Human Services (DCHS), including investments in public health, courts, detention, public defense,  
247 and other County agencies. The Bridge renewal framework establishes a more coordinated  
248 countywide approach to ensure all investments align with shared goals and measurable outcomes.  
249

250 While MIDD had substantial collaboration that resulted in extensive data collection, in the coming  
251 years the Behavioral Health Bridge can deliver outcomes through shared accountability and data-  
252 driven decision-making that crosses agencies with support from the Executive Office. This process  
253 will be informed by performance measures, outcome data, and participant experiences.  
254

255 King County intends to will measure and evaluate behavioral health sales tax investments with an  
256 evaluation approach that is transparent, outcomes-driven, and equity-focused, utilizing both  
257 quantitative and qualitative data. The County will track population-level indicators, implement  
258 strategy and program-specific performance measures aligned with the Results Based  
259 Accountability framework, and conduct business reviews and in-depth evaluations when  
260 appropriate. Results will be published through detailed annual online dashboards, annual

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 8

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261 briefings, and a biennial report to the King County Council. The Executive Office and DCHS will  
262 work together to monitor operations, direct operational continuous improvement, and make  
263 investment adjustments to best achieve the Bridge's purpose. See [Section VII](#) and [Section VIII](#) for  
264 more information about the Behavioral Health Bridge's evaluation, performance measurement,  
265 and reporting in 2028-2034.  
266

## 267 Reporting

268 The Executive will transmit to the Council a ~~King County~~ Behavioral Health Bridge Biennial Report,  
269 which includes data on expenditures, services, and outcomes, no later than August 31 every other  
270 year beginning in 2030. This report will include an overview of Behavioral Health Bridge  
271 accomplishments during the previous two calendar years, fiscal and performance management,  
272 expenditure of Behavioral Health Bridge proceeds by strategy area and by ZIP code, the number of  
273 individuals receiving services by strategy area and by ZIP code, and summaries of evaluation  
274 findings ~~by strategy area and by ZIP code or Council district~~ when available. The biennial report will  
275 include descriptions of specific actions to improve programs based on reporting and evaluation  
276 and inform potential investment changes that the Executive may include in budget proposals. The  
277 Executive will make the biennial reports widely available widely to the Council, the Regional Policy  
278 Committee, and the community through DCHS' communication channels.<sup>6</sup>  
279

280 Detailed performance measurements will be available online through interactive dashboards that  
281 include data disaggregated by strategy area, as well as historical data that can be used to make  
282 year-over-year comparisons of services and outcomes. DCHS staff along with the Executive Office  
283 will offer to brief the Council annually with information collected through the dashboards.  
284

285 Reporting commitments are fully described in [Section VIII](#).  
286

## 287 Financial plan and policies

288 The financial plan includes projected annual revenues and expenditures for the ~~King County~~  
289 Behavioral Health Bridge ~~from for 2028 through 2034~~. This includes the anticipated amounts of  
290 annual investment for each of the Behavioral Health Bridge's strategies and annual reserves,  
291 though specific investment amounts will depend on fund availability at the time of procurement.  
292 This section includes an inflation policy analysis as called for by the King County Council in a  
293 proviso in the 2026-2027 biennial budget ordinance. It describes the impact of the DCHS inflation  
294 policy on the Behavioral Health Bridge and presents a process to mitigate a potential structural gap  
295 between inflationary increases and sales tax revenues. The financial plan and policies are more  
296 fully described in [Section IX](#).  
297

## 298 Conclusion

299 The ~~2028-2034~~ Behavioral Health Bridge Implementation Plan represents an evolution of King  
300 County's behavioral health investment strategy. The ~~proposed~~ framework builds on nearly two  
301 decades of local innovation while responding to emerging challenges.  
302

303 By prioritizing systems integration, equitable access, substance use treatment and recovery, youth  
304 behavioral health, workforce development, and outcome-driven investments, the Behavioral

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

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Commented [JN10]: Technical consistency edit

Commented [JN11]: With adoption, the framework will no longer be proposed.

305 Health Bridge seeks to support a more coordinated, effective, and sustainable behavioral health  
306 system. The renewal positions King County to address immediate community needs while laying  
307 the foundation for long-term improvements in health, recovery, housing stability, and public safety.  
308

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### 309 III. Background

#### 310 A. The King County Behavioral Health Bridge

312 The King County Behavioral Health Bridge (“the Bridge”), formerly known as the MIDD (Mental  
314 Illness and Drug Dependency) behavioral health sales tax, currently infuses approximately \$100  
315 million per year into the King County community behavioral health system.<sup>7</sup> The Behavioral Health  
316 Bridge is a countywide 0.1 percent sales tax that was created by the Legislature in 2005 and  
317 authorized under RCW 82.14.460 and K.C.C. ~~400-5A4A.500~~.<sup>8,9</sup> It allows counties in Washington  
318 to contribute funding for substance use and mental health treatment and services, including  
319 therapeutic courts for ~~Ce~~county residents.<sup>10</sup> King County passed local legislation to enact the sales  
320 tax in this region in 2007 and began collections and programming in 2008.<sup>11</sup> The King County  
321 Council renewed the tax for an additional nine years in 2016 and again in 2025.<sup>12,13</sup> Consistent with  
322 Ordinance 19976, as ~~of the date of this plan at the time of plan adoption~~, tax collections will extend  
323 to January 1, 2035.<sup>14</sup>

325 The Bridge is intended to augment longstanding inadequate federal and state investments to make  
326 behavioral health treatment more available, accessible, effective, and equitable for King County  
327 residents.<sup>15</sup> Between 2017 and 2025, MIDD programs directly served over 130,000 unduplicated  
328 King County residents and reached many more through community-wide education and  
329 outreach.<sup>16</sup> The MIDD 2 Implementation Plan, which currently guides MIDD program investments,  
330 expires at the end of 2027.<sup>17,18</sup>

332 Behavioral Health Bridge investments improve health and wellness, recovery, and connection to  
333 community, especially for people most affected by inequities related to race, income, and access  
334 to healthcare and are primarily managed by the Department of Community and Human Services  
335 (DCHS) Behavioral Health and Recovery Division (BHRD) within King County.<sup>19</sup> State law requires  
336 that counties that implement a behavioral health sales tax under RCW 82.14.460 also maintain a  
337 dependency therapeutic treatment court (King County’s Family Treatment Court).<sup>20</sup> State law  
338 grants counties discretion to direct funding to many different kinds of behavioral health services in  
339 different settings, enabling the fund to invest where the need is greatest, at times in agencies  
340 outside of DCHS.<sup>21</sup>

342 The flexibility in state law has allowed King County to invest in programs and services that  
343 collectively reduce reliance on jails, emergency rooms, and hospitals, and create engagement in  
344 and connections to community-based behavioral health treatment for King County residents most  
345 in need. In the 2026-2027 biennium, about 25 percent of Bridge<sup>22</sup> funds are managed by other King  
346 County agencies, including the Prosecuting Attorney’s Office, Public Health - Seattle & King  
347 County, the Department of Judicial Administration, the Department of Adult and Juvenile  
348 Detention, the Sheriff’s Office, the District Court, the Superior Court, and the Department of Public  
349 Defense (see Figure ~~3425~~ in [Appendix A](#)). DCHS also currently manages some community  
350 contracts for behavioral health services that are connected to programs primarily operated by  
351 other County agencies.

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 11

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353 Programs funded by MIDD in 2017-2025 reached over 20,000 people each year through more than  
354 50 initiatives.<sup>23</sup> MIDD programs and initiatives since 2017 were organized under the following  
355 strategy areas:

- 356 • Recovery and Reentry
- 357 • Crisis Diversion
- 358 • Prevention and Early Intervention
- 359 • Therapeutic Courts
- 360 • System Improvement

361 Behavioral Health Bridge sales tax investments help people achieve recovery and stability. Three  
362 years after engagement in relevant MIDD initiatives, participants experienced:

- 364 • 62 percent fewer engagements with adult crisis programs~~;~~
- 365 • 32 percent fewer emergency department visits~~;~~
- 366 • 59 percent fewer bookings into King County jails~~;~~ and
- 367 • 38 percent fewer involuntary psychiatric hospitalizations.<sup>24</sup>

368 For more information about key outcomes and feedback about past MIDD investments, please  
369 view each MIDD Annual Report available on the DCHS website, including interactive data  
370 dashboards for each annual report starting in 2020.<sup>25</sup>

## 372 B. Primary purpose

373 The primary purpose of the ~~King County~~ Behavioral Health Bridge is to invest in the long-term  
374 availability, accessibility, effectiveness, and equity of the county's behavioral health system,  
375 especially where people are falling through the cracks of existing systems.

376 By focusing on low-income residents with mental health conditions and substance use disorders,  
377 particularly those who are marginalized or experience intersectional inequities, the Behavioral  
378 Health Bridge invests where the need is greatest and where its dollars can make the most  
379 meaningful impact.

380 The Behavioral Health Bridge strengthens publicly funded behavioral health care in King County by  
381 investing in prevention, treatment, and recovery services that are often unavailable, inaccessible,  
382 or insufficiently resourced. These investments help break cycles of incarceration, hospitalization,  
383 homelessness, and crisis by ensuring people receive timely, culturally responsive, and effective  
384 care.

## 388 C. A new name and a new process to meet current needs

389 While MIDD remains a critical source of funding for behavioral health services, its name and the  
390 language "mental illness and drug dependency" no longer reflect the values and priorities that  
391 guide behavioral health work today. Community engagement and "Being in Community" are  
392 central to the Executive's approach to behavioral health. Over the years, ~~the Department of~~  
393 ~~Community and Human Services~~ (DCHS) has consistently heard from behavioral health providers,  
394 partners, and community members that the current name contributes to stigma around behavioral  
395 health. In response to this feedback, the Executive proposes to rename MIDD as the  
396 ~~King County~~ Behavioral Health Bridge, or "the Bridge." Legislation transmitted concurrently with  
397 this ~~Phase 1 Implementation pPlan~~ formalizes the name change in King County Code.

King County Behavioral Health Bridge Implementation Plan 2028-2034 ~~Phase 1: Transition Strategic~~  
~~Framework~~

Page | 12

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400  
401 The new name reflects the program's essential role in bridging critical gaps in behavioral health  
402 funding left by insufficient federal and state resources. Through this support, the Bridge helps  
403 ensure that more people can access behavioral health care when they need it most, especially  
404 low-income residents who lack access to care or do not qualify for Medicaid. It also helps create a  
405 bridge between people experiencing behavioral health conditions and engagement with  
406 community behavioral health treatment and the many other systems people interact with,  
407 including the criminal-legal system, and pathways to recovery.

408  
409 This plan uses the name "MIDD" to refer to investments prior to 2026 and uses "the **King County**  
410 Behavioral Health Bridge" and related terms to refer to current and future investments.

411  
412 In addition to a new name, and in keeping with the Executive's priorities, **the Behavioral Bridge**  
413 **Implementation Plan** ~~new implementation plan~~ includes other key changes, including:

- 414
- 415 • **A whole-county approach to investing, monitoring and measuring impacts of invested**  
416 **resources.** As noted earlier, in the 2026-2027 biennium, about 25 percent of Bridge funds  
417 are managed by **King County departments/agencies** outside of DCHS, including the  
418 Prosecuting Attorney's Office, Public Health - Seattle & King County, the Department of  
419 Judicial Administration, the Department of Adult and Juvenile Detention, the Sheriff's  
420 Office, the District Court, the Superior Court, and the Department of Public Defense.  
421 Partnership and coordination between multiple **County** systems can improve health and  
422 wellness, support recovery, and forge connection to community for King County residents.  
423 Achieving the purpose of the Bridge requires many systems working together towards the  
424 same vision and goals through aligned strategies. As such, the Executive Office will  
425 coordinate with DCHS and **partner these other County** agencies in using information from  
426 Bridge measurement and evaluation to make informed budget and operational  
427 improvements. The Executive Office will play a lead role to support alignment across the  
428 County.
  - 429 • **A procurement process guided by five strategy areas.** For the approximately 75 percent  
430 of Behavioral Health Bridge dollars administered directly through DCHS, **this Phase 1**  
431 **Implementation Plan** lays out a public procurement process that will happen in phases  
432 over the course of an 18-month period beginning in 2028. The phased timeline is structured  
433 to allow for careful design, including alignment and incorporation of base budget  
434 assessments of county-provided services being conducted by the Executive Office's  
435 Budget Team in collaboration with DCHS, reassignment of programs to other, more  
436 appropriate funding sources such as Medicaid and new county funding sources, and  
437 recommendations from the Breaking the Cycle Workgroup.<sup>26</sup>

438  
439 The **Bbehavioral Hhealth Bridgesales tax, which supports the Bridge**, is a countywide funding  
440 source that has the potential to be transformative for people who are low-income with behavioral  
441 health conditions, especially those who are farthest from access and opportunity. **Theis new**  
442 **implementation plan Behavioral Health Bridge Implementation Plan** includes a new framework to  
443 guide investments for 2028 ~~through~~ 2034. It maintains core investments while establishing a new  
444 process to strategically address the most pressing behavioral health issues in King County as  
445 reflected in population health data and in a deep and robust community engagement process. All

King County Behavioral Health Bridge Implementation Plan 2028-2034 **Phase 1: Transition Strategic Framework**

Page | 13

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investments will improve the availability, accessibility, effectiveness, and equity of behavioral health care in King County.

#### D. Overview of DCHS and community behavioral health services

##### The Department of Community and Human Services (DCHS)

DCHS' mission is to provide equitable opportunities for King County residents to be healthy, happy, and connected to community. DCHS' five divisions provide human services for adults, including veterans and seniors; behavioral health care across the lifespan; services supporting children, youth, and young adults to thrive; services for people with developmental disabilities; and affordable housing and homelessness prevention. The department manages more than \$3 billion per biennium in public funds to support King County residents to access a broad range of services, including the Behavioral Health Bridge.

##### Community behavioral health services in King County

DCHS' Behavioral Health and Recovery Division (BHRD) oversees the public behavioral health system in King County, which includes managing and implementing the Behavioral Health Bridge sales tax and the Crisis Care Clinic Centers (CCC) Levy. In addition to the Behavioral Health Bridge sales tax and the CCC Levy, BHRD oversees the publicly funded behavioral health system, including the King County Integrated Care Network (KCICN) and the Behavioral Health Administrative Services Organization (BHASO), and braids these distinct funding streams into a coherent continuum of care rather than a collection of siloed programs.

BHRD manages state and federally funded behavioral health services for people with low incomes, including Medicaid services delivered through the KCICN. Created in 2019 as a partnership between BHRD and more than 50 licensed community behavioral health providers, the KCICN represents the county's core behavioral health treatment capacity (outpatient services, residential treatment, case management, and more).<sup>27</sup> It serves approximately 50,000 low-income residents each year, and ensures access to community-based behavioral health treatment regardless of ability to pay.

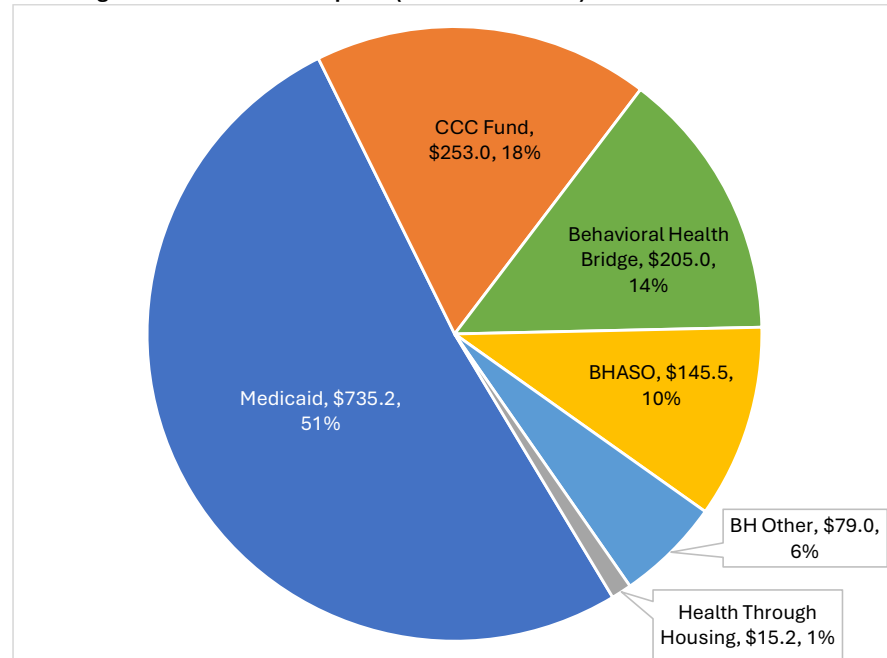
Through its BHASO role, BHRD also administers the regional crisis system, providing and coordinating 24/7 crisis response, involuntary treatment investigations, and other non-Medicaid programs for all residents, including those who are uninsured or underinsured. Across these roles, BHRD manages all publicly funded behavioral health crisis services in the county, serving roughly 70,000 people each year. While most services are delivered through contracted community behavioral health agencies, BHRD also provides certain statutory functions directly, such as Designated Crisis Responder (DCR) investigations and involuntary commitment processes.

Behavioral Health Bridge sales tax funds proceeds comprise 14 percent of BHRD's projected revenues in 2026-27 (Figure 1).

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487 **Figure 1: Behavioral Health and Recovery Division projected revenue by fund source**  
488 **according to 2026-2027 financial plans (dollars in millions)<sup>28</sup>**



489 \*BH Other includes non-BHASO federal, state, local, and private grants, interfund transfers, and local taxes.  
490  
491  
492

#### IV. The process to develop the Behavioral Health Bridge Implementation Plan, Phase 1

The development of the Behavioral Health BridgePhase 1 Implementation Plan involved a number of components, including a scan of changes to the behavioral health policy and funding landscape and a regional population-level data review coupled with robust community engagement process.

##### A. Behavioral health policy and funding changes

The behavioral health funding landscape has evolved significantly at the federal, state, and local levels since the MIDD 2 Implementation Plan was adopted in 2018.<sup>29</sup>

- **Local changes:** The creation of the KCICN in 2019, the passage of the Health Through Housing sales tax (2020) and the Crisis Care Centers Levy (2023), and the renewal of the Best Starts for Kids Levy (2021) and Veterans, Seniors, and Human Services Levy (2023).<sup>30, 31, 32, 33</sup>
- **State changes:** Changes to coverage for non-citizen Washingtonians with the introduction of Apple Health Expansion in 2024 and its contraction in 2026, federal approval of Apple Health's Medicaid Transformation Project 2.0 in 2023, and reductions in state funding for non-citizen health care, pre-release services, and several behavioral health programs serving King County as result of a state budget shortfall in the 2025-2027 state fiscal biennium.<sup>34, 35, 36, 37</sup>
- **Federal changes:** The passage of H.R. 1 in 2025 which imposes significant changes to Medicaid, including work requirements and more frequent eligibility redeterminations, anticipated to reduce Medicaid enrollment in Washington State by 26 percent starting in 2027.<sup>38, 39, 40</sup>

The presence of new and expanded funding sources for behavioral health, combined with the possibility of losing other sources, creates an opportunity to evaluate and restructure behavioral health sales tax investments. Coordinating and aligning investments will maximize existing revenue and improve the County's ability to meet the increasing behavioral health needs of County residents.

##### B. Changes in regional behavioral health needs

Since the implementation of MIDD 2, behavioral health challenges in King County have also undergone significant changes, including the fentanyl epidemic and a global pandemic which produced crises in youth behavioral health and in the behavioral health workforce. King County must invest strategically to meet these new challenges head-on. Community input and the most current available local data indicate that the greatest current challenges in King County are:

**Complex, siloed systems.** As the behavioral health system has grown over the past decade, the connections between parts of the system have not kept pace. For example, among Medicaid enrollees in King County in 2023, 67 percent of people who went to an emergency department for an **substance use disorder** (SUD) concern did not have a follow-up outpatient visit within 30 days.<sup>41</sup> In addition, analysis shows that people who died from overdose in King County had engaged with a [King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

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variety of public services such as jails, emergency departments, homeless services, or mental health care in the year before their death.<sup>42</sup> However, fewer than half (48 percent) had been receiving publicly funded SUD services during that time.<sup>43</sup> To achieve its goal of an effective behavioral health system, King County must invest in care transitions directly to ensure that all parts of the system work together and people can access timely and appropriate care no matter where they enter the system.

**Substance use disorders.** In 2017, only nine percent of fatal overdoses involved fentanyl; in 2025, that number was 78 percent.<sup>44</sup> After reaching a peak in 2023, the rate of fatal overdoses has begun to decline but it is still twice as high as in 2017.<sup>45</sup> Treatment methods have shifted to adapt to this new form of the opioid crisis. Medications for opioid use disorder (MOUD) have become the standard of care, but are still not available to everyone who needs them.<sup>46</sup> In addition, the proportion of unhoused, unsheltered people with a substance use disorder SUD has increased from 29 percent in 2017 to 41 percent in 2026.<sup>47,48</sup> Innovative strategies that go beyond traditional office-based appointments are needed to help this population access care and move toward recovery.

**Behavioral health inequities.** As of 2024, 48 percent of King County's population and 62 percent of the population under age 18 were Black, Indigenous, or people of color (BIPOC).<sup>49</sup> Further, one in four County residents is an immigrant, and almost one third report speaking a language other than English at home.<sup>50,51</sup> Decades of research demonstrate racial and ethnic inequities in access to behavioral health care, and King County is no exception.<sup>52</sup> For example, Black/African American and American Indian/Alaska Native residents of King County are much more likely to experience a fatal overdose than their White, non-Hispanic peers.<sup>53</sup> Lesbian, gay, bisexual and transgender adults are two to three times as likely to experience frequent mental distress as their cisgender and heterosexual peers.<sup>54</sup> Targeted investments are needed to address inequities and ensure all King County residents can access and receive high-quality, culturally-relevant behavioral health care.

**Youth mental health crisis.** The COVID-19 pandemic produced a youth mental health crisis that is still creating ripple effects years later.<sup>55</sup> Death by drug overdose or poisoning has become the third leading cause of death for people under 20 years old, with Washington State youth experiencing mortality at nearly twice the national average.<sup>56</sup> In 2023 among King County young people ages 11 to 24, Emergency Medical Services responded to 868 non-fatal opioid overdoses and 53 fatal overdoses.<sup>57</sup> In 2025, approximately one in 12 King County eighth and tenth graders reported considering suicide during the previous year.<sup>58</sup> Young people who do not receive help with their behavioral health are more likely to struggle with substance use, become homeless, or be arrested, whether during adolescence or later in life.<sup>59</sup> These youth and families need additional behavioral health support during the 2028-2034 Behavioral Health Bridge implementation period to keep them from becoming trapped in a cycle of behavioral health crisis, incarceration, and homelessness.

**Behavioral health workforce shortage.** It takes people to treat people. The behavioral health workforce has been strained for years, but the crisis escalated during the COVID-19 pandemic, which produced a nationwide surge in demand for behavioral health services at the same time that many clinical staff exited the workforce.<sup>60,61</sup> Locally, a 2023 survey of KCICN providers found that vacancies had doubled since 2021, and 65 percent of MIDD initiatives identified problems with staff recruitment and retention as a key factor impacting program reach and performance.<sup>62,63</sup> In 2025, KCICN provider agencies had an overall vacancy rate of nearly 10 percent, equating to 414

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 17

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open positions.<sup>64</sup> The persistent workforce shortage means that treatment needs go unmet and care is delayed.<sup>65</sup> In addition, community and subject matter expert feedback (detailed in the next subsection) demonstrates a significant need for a behavioral health workforce that better represents the racial, cultural, and linguistic backgrounds of the people being served. Strategic investments in the behavioral health workforce are expected to reduce treatment delays and gaps, help build a diverse provider pipeline, and promote the skills needed to treat the Behavioral Health Bridge's high-need service population.

### C. Community and subject matter expert engagement

Community and subject matter expert engagement included consultation with the MIDD Advisory Committee, analysis of successes and challenges from the past 18 years of MIDD programming, coordination with other County agencies and partners, dialogue with internal workgroups within DCHS, engagement with over 2,200 County residents, and convenings of multi-disciplinary subject matter expert workgroups. The community engagement activities and multi-sector workgroups are broadly described below and further detailed in Appendices A, B, and C.

#### Community engagement

Throughout 2024 and 2025, King County DCHS solicited feedback from community members about behavioral health needs through:

- 46 in-person listening sessions,
- 34 virtual listening sessions,
- eight community events, and
- an online survey in 21 languages.<sup>66</sup>

This feedback was complemented with data from the "Be Heard: Community Voices about Mental Health and Wellness Community Listening Project," which gathered information from 543 individuals across 14 culturally-centered community-based organizations.<sup>67</sup>

In total, feedback from 2,226 people across all regions of King County informed the direction of the Behavioral Health Bridge renewal. Conversations revealed the following themes:

- Increase access and reduce barriers.
- Strengthen culturally relevant and responsive care.
- Reduce system fragmentation and improve service coordination.
- Strengthen and increase services for children, youth, and young adults.
- Strengthen and expand the behavioral health workforce.
- Strengthen wraparound services that use team-based care and connect people to basic needs.

Combining the recommendations from the community and the behavioral health needs analysis described above, DCHS identified five strategy areas for the next iteration of the sales tax: Care Transitions and Diversion Services; Substance Use Disorder Treatment and Recovery; Equitable Access to Behavioral Health Care; Child, Youth, and Young Adult Mental Wellbeing; and Behavioral Health Workforce Development. The MIDD Advisory Committee reviewed these five strategy areas and collectively agreed they were the highest priority areas for the renewal.<sup>68</sup>

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 18

Additional details about methods of engagement, demographics of people engaged, emergent themes, and influences on this **Phase 1** implementation **Plan** can be found in Appendices **A** and **B**.

#### **Multi-sector subject matter expert workgroups**

To explore potential investments within each strategy area, DCHS conducted a multi-sector subject matter expert (SME) engagement process from April to July of 2025. DCHS established a workgroup of SMEs for each **proposed** strategy area, with membership consisting of over 100 clinical providers, licensed **peer support specialists**, criminal-legal system representatives, researchers, educators, outreach workers, advocates, nonprofit leaders, members of the MIDD Advisory Committee, King County staff, and people with lived experience. Participant names and a crosswalk of recommendations to plan elements can be found in [Appendix D](#).

SME input aligned closely with the feedback gathered from the broader community around themes like mitigating barriers and improving access, improving coordination across different parts of the behavioral health system, diversifying the behavioral health workforce, ensuring availability of culturally responsive services, enhancing care for youth and young adults, and continuing to support recovery from substance use disorders. Potential recommendations for future investments were intended to bridge gaps, address problems, and build upon existing services to improve behavioral health for County residents.

#### **Strategic approach for King County Behavioral Health Bridge investments**

After the conclusion of the workgroups, DCHS evaluated all SME recommendations on a range of factors, including feasibility, cost, equity, and alignment with the **County's** broader vision for behavioral health. DCHS also examined evaluation data for active MIDD 2 investments. Using this information, the Executive developed a plan that addresses present needs, responds to anticipated federal cuts, and builds capacity for system transformation in the future framed around five strategy areas described in [Section VI](#).

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## V. A renewed King County Behavioral Health Bridge

The Bridge will fund investment in five areas:

- 1. Care Transitions and Diversion Services (CTD):** Enhance navigation and system coordination to ensure people receive timely, appropriate behavioral health services across all levels of care, divert individuals with behavioral health conditions from criminal-legal involvement to support long-term stability, and provide appropriate supportive services for individuals with behavioral health conditions involved in the legal system.
- 2. Substance Use Disorder Treatment and Recovery (SUD):** Treat substance use disorders by providing effective, low-barrier services that address people's holistic needs and support sustainable paths to long-term recovery.
- 3. Equitable Access to Behavioral Health Care (EA):** Decrease barriers to behavioral health services and increase access to culturally and linguistically responsive care.
- 4. Child, Youth, and Young Adult Mental Wellbeing (CYYA):** Address the youth behavioral health crisis by investing in developmentally tailored services and programs that meet youth where they are.
- 5. Behavioral Health Workforce Development (WF):** Strengthen and diversify the behavioral health workforce to meet growing community needs.

The renewal outlines an approach to future investments that:

- Emphasizes integration of behavioral health, crisis response, criminal legal, health care and homelessness service systems. This countywide approach streamlines fragmented funding streams across many County agencies to maximize resources and seeks to measure and monitor impact for the people being served across systems.
- Seeks to break the cycle of behavioral health crises, incarceration, hospitalization, and homelessness by streamlining systems, coordinating across care settings, investing in technology, and paying for essential services that help people achieve and maintain stability.
- Provides opportunity to build on the strengths of previous investments while strategically tackling the most pressing behavioral health issues in King County communities, including siloed systems, substance use disorders, and inequitable access to care.
- Promotes holistic and high-quality behavioral health care for years to come by addressing long-term workforce shortages and the youth behavioral health crisis.
- Improves the availability, accessibility, effectiveness, and equity of behavioral health care in King County through data-driven decisions, performance measurement across policy areas, continuous improvement, and innovation.

Strategic investment areas in this **Phase 1 Implementation pPlan** comply with the supplantation restrictions in RCW 82.14.460(4) that were in effect at the time of **this plan's drafting and adoption**.<sup>69</sup> They are also intended to complement other available funding sources for behavioral health treatment and services. For example, the Bridge should not pay for behavioral health treatment for an individual when the same treatment could be provided to the individual under Medicaid

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 20

699 coverage or another fund source. Instead, the Bridge is uniquely positioned to fund programs and  
700 services beyond the limited scope of federal, state, or other local funding.

#### 702 A. Equity framework

703  
704 King County places equity at the heart of its core values, recognizing it is essential to addressing  
705 systemic challenges and creating fair opportunities for all residents. By centering equity in actions,  
706 policies, and decision making, King County aims to disrupt disparities, promote mental well-being,  
707 and foster a community where all individuals and families can thrive.

708  
709 BIPOC, refugee and immigrant, LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex,  
710 asexual), and disability communities, as well as survivors of trauma or domestic, sexual, and  
711 gender-based violence, are more likely to struggle with behavioral health conditions and less likely  
712 to access supportive care than the King County population overall (see Subsection IV.B. and  
713 Subsection VI.C.). Direct, intentional policies designed to promote equity and  
714 racial justice for all County residents are needed to address these inequities. Through community  
715 engagement and collaboration with internal program managers, DCHS developed an equity  
716 framework for the King County Behavioral Health Bridge to embed services and outcomes for  
717 marginalized communities across all domains of Bridge services, not just the Equitable Access  
718 strategy area.

719  
720 The equity framework for the Bridge describes five pillars of an equitable, anti-racist, multi-cultural  
721 King County behavioral health system (Figure 2). Behavioral Health Bridge investments will be  
722 designed to advance a behavioral health system that is:

- 723  
724 • **Connected and coordinated:** Investing strategically across Ceounty systems agencies  
725 and partners to strengthen behavioral health coordination; expanding equitable and low-  
726 barrier services; aligning with King County's commitment to racial justice; and enhancing  
727 continuity of care.
- 728 • **Transparent and accountable:** Conducting transparent and equitable procurement  
729 processes; embedding equity expectations across provider relationships; and ensuring  
730 accountability by tracking outcomes and disparities, supporting contracted service  
731 providers to improve, and using data to continuously center culturally responsive,  
732 equitable services.
- 733 • **Inclusive, collaborative, diverse, and people-focused:** Elevating and partnering with  
734 people with lived experience through inclusive engagement; centering racial equity and  
735 antiracism in funding and program decisions; and resourcing contracted service providers  
736 to advance equitable, community-driven solutions.
- 737 • **Responsive and adaptive to community-identified needs:** Providing community-driven,  
738 culturally responsive services that address systemic biases; expanding access for  
739 underserved populations; and supporting programs informed and led by the communities  
740 most impacted.
- 741 • **Accessible and available:** Providing culturally responsive services and seeking to reduce  
742 barriers related to cost, wait times, travel, stigma, and physical accessibility.

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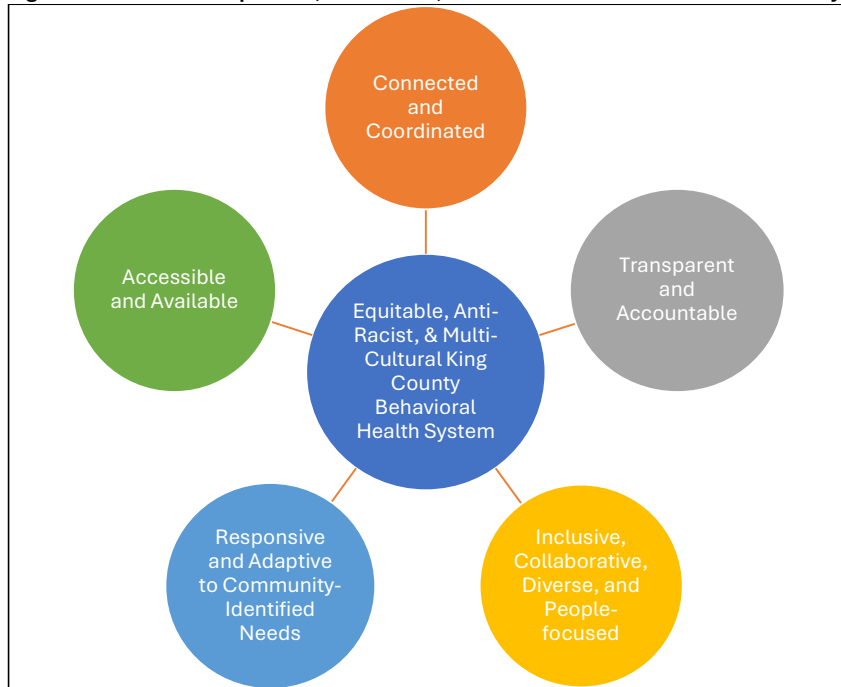
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For examples of how the equity framework was utilized in the process to develop ~~the implementation plan~~ the Behavioral Health Bridge Implementation Plan please see [Appendix E](#).

**Figure 2: Pillars of an Equitable, Anti-Racist, and Multi-Cultural Behavioral Health System**



#### B. Phased, competitive procurement and base budget analyses

The Executive intends to implement competitive procurements for nearly all Behavioral Health Bridge-~~funded-supported~~ programs that will be administered by contracted ~~community service~~ providers in the community. The intention of new procurements is to ensure that future investments are made to achieve the goals of each strategy area. In some cases, this might mean that an existing program is continued with minimal changes. In other cases, existing programs might undergo significant changes, be shifted to another fund source, or be phased out to redirect Behavioral Health Bridge resources to better achieve the County's goals while still providing community members with access to needed services. These shifts are part of realizing the Executive's priority of Better Government, which "commits King County to operating as a more transparent, effective and accountable organization"<sup>70,71</sup>

Competitive procurements will allow King County to evaluate program models and applicants, including new provider organizations and those that have previously received Bridge funding, to identify the most promising, responsive, and effective investments. Behavioral health interventions have continued to evolve and improve as new evidence has emerged over the past 18 years of the [King County Behavioral Health Bridge Implementation Plan 2028-2034](#) Phase 1: Transition Strategic Framework

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behavioral health sales tax.<sup>72,73</sup> Although many initiatives have evolved through continuous quality improvement since their inception, some are based in program models that are outdated and require a more substantial overhaul to maximize effectiveness. Of the 49 initiatives active in 2026, 27 were continued from MIDD 1 (2008-2016).<sup>74</sup> As a result, the majority of current programming is implemented by contracted service providers selected many years ago. Many new organizations have been established in King County but have not had the opportunity to apply for behavioral health sales tax funding. New procurements will provide equitable opportunities for all qualified King County service providers to apply for Behavioral Health the Bridge funds contracts and are expected to help ensure that funds public monies support the most effective programs.

The Executive should be mindful of geographic equity as they deliberate on which contracted service providers will receive awards during the procurement process; such as taking into account rural areas and smaller incorporated jurisdictions that may have less access to behavioral health services and revenue sources to support the expansion of behavioral health services in the rural area. The Executive should consider including geographic distribution of services as an evaluation criterion in the selection process of service providers.

Due to the scale of programs and services supported by the King County Behavioral Health Bridge, procurements for all strategy areas in the Behavioral Health Bridge Implementation Plan and related base budget analyses require significant planning and staffing and cannot all occur at once. Therefore, DCHS plans to phase procurements through the first 18 months third quarter of 2029 of the new implementation period, according to the progression described in Figure 3.

The Executive anticipates initial base budget analysis to be completed ahead of the 2028-2029 budget, but further review and adjustment will align with DCHS strategy area procurement.

**Figure 3: Phased introduction of reprocured and revised Behavioral Health Bridge programs**

| Strategy Area                                        | Anticipated launch of programs (reprocured or with new base budget) |
|------------------------------------------------------|---------------------------------------------------------------------|
| SUD Treatment and Recovery (SUD)                     | Quarter 3 of 2028                                                   |
| Equitable Access to Behavioral Health Care (EA)      | Quarter 3 of 2028                                                   |
| Care Transitions and Diversion Services (CTD)        | Quarter 1 of 2029                                                   |
| Behavioral Health Workforce Development (WF)         | Quarter 1 of 2029                                                   |
| Child, Youth, and Young Adult Mental Wellbeing (CYA) | Quarter 3 of 2029                                                   |

MIDD 2 initiatives that align with each strategy area will generally continue until the area is reprocured. For example, current initiatives that align with the SUD Treatment and Recovery strategy area are expected to continue until programs governed by the activities described in this plan launch in Quarter 3 of 2028. DCHS plans to will announce awards three to six months in advance of program launch dates to enable appropriate ramp-down periods for programs or currently contracted service providers that do will not receive continued funding. Phased procurements also ensure currently contracted service providers do not have to apply for RFPs in multiple strategy areas simultaneously.

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 23

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**Commented [PS20]:** Inclusion of policy statement regarding geographic equity considerations during the procurement process.

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805 The order of strategy area procurements is strategically designed to facilitate smooth transitions.  
806 For example, the complexity of the Care Transitions and Diversion (CTD) Services area will require  
807 significant County staff resources for implementation. Because Behavioral Health Bridge program  
808 planning in 2027 will primarily rely on existing DCHS staff, new programs in the CTD area are  
809 scheduled to launch in the first quarter of 2029 to ensure enough staff resources are in place to  
810 achieve an effective transition in 2028. In addition, the Child, Youth, and Young Adult Mental  
811 Wellbeing (CYYA) strategy area will be closely coordinated with the Best Starts for Kids ("Best  
812 Starts") program to ensure the funding streams complement rather than duplicate one another. As  
813 of the drafting of this plan, if voters approve renewal of the Best Starts for Kids levy, the next  
814 implementation plan for Best Starts is expected to be due to King County Council in late 2027, with  
815 procurement for new strategies likely to take place during 2028 and 2029. The Bridge's CYA  
816 strategy area is scheduled for procurement during the same period so that the Behavioral Health  
817 Bridge and Best Starts teams can coordinate activities, ensure investments are complimentary and  
818 not duplicative, and invest in a continuum of care that best serves youth and families. If the Best  
819 Starts levy is not approved by voters, DCHS will reevaluate optimal investments of the Behavioral  
820 Health Bridge for children, youth, and young adults to reflect that substantial loss of services for  
821 youth and families.

822  
823 The process to develop and implement procurements is expected to include:

- 825 • Analyzing current financial projections, policy updates, performance data, and potential  
826 funding sources for each strategy area.
- 827 • Conducting base budget analysis of programs directly operated by County agencies.
- 828 • Completing a review of crosswalk existing programs to strategy areas and identifying  
829 alternative funding sources where applicable.
- 830 • Drafting procurement materials for anticipated activities, goals, and preliminary outcome  
831 measures.
- 832 • Launching competitive procurement with community outreach, information sessions, and  
833 technical assistance.
- 834 • Recruiting and training review panelists and conducting equitable application scoring.
- 835 • Selecting potential awardees and completing all required due diligence steps.
- 836 • Notifying the Council of procurements and inviting councilmembers and their staff to  
837 attend panel deliberations, consistent with standard DCHS practices.
- 838 • Issuing award letters, and finalizing scopes of work, goals, and outcome measures with  
839 awardees.
- 840 • Supporting contracted service providers in transitioning program participants, where  
841 applicable. Each procurement shall include continuity of care requirements governing the  
842 transition of existing program participants when a provider does not receive continued  
843 funding, including warm handoff to a provider that receives ongoing or new support from  
844 Bridge, continuity of medication access, and transfer of care coordination. Where a service  
845 area is discontinued, DCHS should work with providers coordinate participant transitions  
846 to available alternatives.
- 847 • Monitoring contract performance and evaluating outcomes to inform future adjustments to  
848 contracts and procurements.
- 849 • DCHS shall provide meaningful opportunities for current DCHS-contracted service  
850 providers to share input, impacts, and feedback on the reporting requirements and identify  
851 unintended administrative burdens.

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic  
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Page | 24

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Commented [JN22]: Streamlining of text

Commented [PS23]: Documents DCHS express intent for Council involvement in procurement process

Commented [SP24]: Change to required procurement activities when a provider does not receive continued funding through the Bridge.

Commented [SP25]: DCHS requirement to provide opportunities for engagement with current DCHS contracted service providers in procurement process.

- 852 • Contracted service provider reporting requirements should be proportionate to contract  
853 size and minimize duplicative data collection to the extent possible.

854 To the extent allowed by law and County policy, DCHS is encouraged to use flexibility to provide  
855 upfront funding to successful applicants to procurements that have previously executed  
856 successful contracts, are currently in good standing with DCHS policies, and have a history of  
857 appropriate fiscal management practices with County monies, to expedite contracting to  
858 established and effective programs.

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## 862 Updated landscape and population needs assessment

863 Prior to procurement of each strategy area, DCHS will review and incorporate the latest information  
864 on population needs, policy changes, and updated fiscal information.

## 865 Base budget analysis

866 About 25 percent of the 2026-2027 MIDD funding for programs is transferred to or managed directly  
867 by King County agencies, meaning County departments or offices, other than DCHS. These  
868 programs include funding for County employees and community contracts held by other agencies.

870 Services that are most appropriately or legally required to be implemented by County employees  
871 Program components directly operated by County agencies will generally not be procured with by  
872 DCHS-managed requests for proposal (RFPs) as these services are most appropriately or legally  
873 required to be implemented by County employees. All investments, whether County-run or  
874 contracted to external service providers through DCHS or partner County agencies and  
875 departments, will advance the primary purpose for the Behavioral Health Bridge as described in  
876 this Phase 1 Implementation Plan, and will be tied to measurable outcomes that achieve the 13  
877 goals identified in Section VI.H.

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879 The Executive Office will coordinate with DCHS on base budget analyses for all Bridge-funded  
880 programs that are managed or administered by King County departments and agencies outside  
881 DCHS.<sup>75</sup> These analyses will assess investments for alignment with overall Behavioral Health  
882 Bridge goals, identify efficiencies, and ensure budget amounts are responsive to current needs.  
883 Each base budget analysis shall assess, at minimum: alignment with the strategy area goals and  
884 anticipated activities; program performance against established measures; availability of  
885 alternative funding sources; and whether the current budget amount is responsive to  
886 demonstrated need. The Executive shall transmit the results to the Council with the biennial  
887 budget in which they are reflected.

Commented [PS28]: Adds base budget analysis requirements

## 888 Review and crosswalk of existing programs and initiatives

889 As noted earlier, several new funding resources have become available during MIDD 2 including  
890 new Medicaid benefits such as the reentry initiative which allows Medicaid reimbursement for  
891 transition planning and targeted case management for individuals in carceral settings and new  
892 county taxes such as the Crisis Care Centers levy. In developing the procurements, DCHS intends  
893 to ensure that the County investments are strategically targeted towards bridging the gaps in the  
894 behavioral health service continuum and filling gaps in services for populations that are not eligible  
895 for other sources of coverage.

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 25

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### C. Advisory Committee

The ~~King County~~ Behavioral Health Bridge Advisory Committee (AC), known in previous generations of behavioral health sales tax investments as the MIDD AC, is an advisory body to the Executive and Council. AC members are representatives from the health and human services and criminal-legal system communities. The AC ensures that the implementation and evaluation of the strategies and programs funded by the Behavioral Health Bridge sales tax revenue are transparent, accountable, collaborative and effective.

Ordinance 16077 established the committee in 2008, and Ordinance 18452 renamed and revised it for MIDD 2 in 2017.<sup>76,77</sup> Following conversations throughout 2025, the AC agreed that the core functions of the committee as outlined in Ordinance 18452 remain constant.<sup>78</sup> Proposed legislation transmitted concurrently with this ~~Phase 1 Implementation p~~Plan updates the name of the committee from the King County MIDD Advisory Committee to the ~~King County~~ Behavioral Health Bridge Advisory Committee, consistent with the broader name change discussed in ~~Subsection III.C. of this plan~~. It also makes other limited technical updates to the Advisory Committee code, including to rename or clarify the represented sectors to continue to support effective cross-system engagement.

The ~~King County~~ Behavioral Health Bridge Advisory Committee ~~intends will~~ to maintain its strong commitment to centering the expertise and lived experience of its members, engaging them as deeply as possible so they stay well-informed, connected, and meaningfully involved.

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## 919 VI. Investments across the five strategy areas

920 This section outlines the identified goals of the five strategy areas for 2028–2034 that form the  
921 foundation of ~~this~~the Behavioral Health Bridge Implementation Plan. For each of the five strategy  
922 areas, this ~~Phase 1 Implementation Plan~~ outlines:

- 924 • the overarching aim of the strategy area; and
- 925 • further description of the specific goals within the strategy area that show the desired  
926 outcomes for potential investments.

927 ~~Appendices F–J~~Section XI provide logic models for each of the strategy areas to show how  
928 Behavioral Health Bridge investments will drive towards the outcomes and goals for that identified  
929 area along with activities that are anticipated to be procured under each goal area.  
930  
931

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Commented [JN31]: Appendices F through J are deleted and the text contained within those appendices are moved to Section XI.



## A. Care Transitions and Diversion Services (CTD)

*Enhance navigation and system coordination to ensure people receive timely, appropriate behavioral health services across all levels of care, divert individuals with behavioral health conditions from criminal-legal involvement to support long-term stability, and provide appropriate services for individuals with behavioral health conditions involved in the legal system.*

### CTD strategy area summary

Behavioral health services in King County include a wide array of treatment types and supports for people across the spectrum of behavioral health needs, and include many services delivered through community agencies as well as some delivered in the criminal legal (including carceral) or hospital settings. The treatment system's size and complexity can create challenges for individuals attempting to navigate between settings, types, and intensities of care. Fragmentation and siloed decision-making across care types and the housing, emergency response, and criminal-legal systems result in inefficiencies, repeated institutional involvement, and preventable harm.<sup>79</sup> Bridge programs combine supports related to behavioral health, housing stabilization, and reentry in order to break cycles of homelessness, crisis, and incarceration or hospitalization.<sup>80</sup>

This strategy area will move the County toward a future state in which progress toward recovery is not undermined by logistical barriers or administrative siloes. Investments in this area will build on existing efforts to help people access lower-acuity services before their behavioral health conditions escalate, divert people from criminal-legal system involvement, support behavioral health services for those involved in the legal system, and support successful community reentry after incarceration. This includes addressing intersecting needs (such as but not limited to mental health conditions, SUD, housing insecurity, and cultural and linguistic barriers) and strengthening linkages between care settings. **Bridge-supported programming should be designed to deter unnecessary growth in the legal system where diversion is a feasible and suitable alternative.**

King County ~~willintends to~~ pursue three goals in the area of Care Transitions and Diversion Services:

- Goal 1: Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.
- Goal 2: Help people with behavioral health conditions achieve and maintain stable housing.
- Goal 3: Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.

**Figure 4: Estimated expenditures in the Care Transitions and Diversion strategy area, 2028-2034 (millions of dollars)**

|               | 2028           | 2029          | 2030          | 2031          | 2032          | 2033          | 2034          |
|---------------|----------------|---------------|---------------|---------------|---------------|---------------|---------------|
| <b>Goal 1</b> | \$25.8*        | \$24.0        | \$24.6        | \$25.1        | \$25.7        | \$26.2        | \$26.8        |
| <b>Goal 2</b> | \$5.7*         | \$5.0         | \$5.1         | \$5.3         | \$5.4         | \$5.5         | \$5.7         |
| <b>Goal 3</b> | \$5.2*         | \$3.5         | \$3.6         | \$3.7         | \$3.8         | \$4.2         | \$4.5         |
| <b>Total</b>  | <b>\$36.7*</b> | <b>\$32.5</b> | <b>\$33.3</b> | <b>\$34.1</b> | <b>\$34.9</b> | <b>\$35.9</b> | <b>\$36.9</b> |

<sup>79</sup>The complete financial plan for the Bridge can be found in [Section IX](#). Totals may not sum exactly due to rounding.

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Commented [SP32]: Adds language regarding deterring growth in legal system

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971 \*This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CTD programs in  
972 2029.

973 **CTD Goal 1: Divert people from criminal-legal involvement, provide supportive**  
974 **services for those involved in the legal system, and support successful community**  
975 **reentry.**

976 A core aim of the behavioral health sales tax since its inception has been to divert individuals with  
977 mental health and substance use conditions from costly settings and systems, such as jails, and to  
978 help them successfully re-enter society when leaving institutions. These programs and services  
979 remain a high priority, and the **King County** Behavioral Health Bridge will improve upon existing  
980 work by providing services with a focus on coordination and breaking down siloes. Rather than  
981 funding programs in isolation, DCHS will strive for care transition services that maintain a cohesive  
982 thread of care across diversion, incarceration, and reentry. Rather than intervening separately at  
983 discrete moments in a person's journey, programs in this goal area are intended to work together to  
984 promote holistic wellbeing and connection to appropriate services, interrupting cycles of  
985 incarceration, hospitalization, and crisis.

986  
987 **Population served:** Services procured under this goal are intended to serve low-income people  
988 with behavioral health conditions who are involved in or at risk of becoming involved in the  
989 criminal-legal system.

990  
991 **Anticipated timeline:** Reprocured programs are expected to launch in the first quarter of 2029.

992  
993 **Figure 5: Funding estimate for CTD Goal 1 (millions of dollars)**

| Year                   | 2028    | 2029   | 2030   | 2031   | 2032   | 2033   | 2034   |
|------------------------|---------|--------|--------|--------|--------|--------|--------|
| Anticipated Activities | \$25.8* | \$24.0 | \$24.6 | \$25.1 | \$25.7 | \$26.2 | \$26.8 |

994 \*This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CTD programs in  
995 2029.

996 **CTD Goal 2: Help people with behavioral health conditions achieve and maintain**  
997 **stable housing.**

998 According to the King County Point in Time Count in 2024, 31 percent of unsheltered people  
999 experiencing homelessness have a serious mental illness, and 41 percent have a **substance-use**  
1000 **disorderSUD**.<sup>81</sup> Although the Behavioral Health Bridge focuses on behavioral health services,  
1001 housing that is connected to behavioral health services is a permissible expenditure under RCW  
1002 82.14.460(3).<sup>82</sup> Also, the Executive's Breaking the Cycle priority recognizes that homelessness,  
1003 untreated behavioral health needs, and repeated legal-system involvement are interconnected  
1004 challenges that require urgent, coordinated solutions.<sup>83</sup> Investments in this goal will align with  
1005 future recommendations from the Breaking the Cycle Workgroup and will provide services and  
1006 supports at the intersection of housing instability and behavioral health needs.<sup>84</sup>

1007  
1008 **Population served:** Services procured under this goal are intended to serve low-income people  
1009 with behavioral health conditions who are experiencing or at risk of experiencing homelessness or  
1010 housing instability, or who live in King County-funded permanent supportive housing.

1011  
1012 **Anticipated timeline:** Reprocured programs are expected to launch in the first quarter of 2029.

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 29

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Figure 6: Funding estimate for CTD Goal 2 (millions of dollars)

| Year                   | 2028   | 2029  | 2030  | 2031  | 2032  | 2033  | 2034  |
|------------------------|--------|-------|-------|-------|-------|-------|-------|
| Anticipated Activities | \$5.7* | \$5.0 | \$5.1 | \$5.3 | \$5.4 | \$5.5 | \$5.7 |

\*This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CTD programs (in 2029).

### CTD Goal 3: Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.

A significant theme from community engagement that informed this renewal proposal was system fragmentation and service coordination. When services fail to communicate or coordinate with each other, people can fall through the cracks, experience delays in care, or receive duplicative or conflicting support. This not only creates gaps in care but also places additional strain on [contracted service](#) providers and reduces the overall effectiveness of the system. When services are better connected across clinics, hospitals, community-based organizations, and social service agencies, individuals are more likely to receive comprehensive, continuous, whole-person care. [To meet the commitment to whole-person care, investments should be made in services that accommodate the cultural and language preferences of patients, ensuring information is as clear and actionable as possible.](#) Investments in this goal focus on improving coordination and reducing fragmentation to make care more efficient, easier to access, and more responsive to the needs of the people being served. [Investments should bridge communication gaps between state-supported Medicaid providers, insurers, and community-based organizations enrolling patients in services and directly administering care. King County will focus on empowering the secure sharing of behavioral health data that best captures whole-person behavioral health treatments and continued patient needs to a range of community-based providers, care navigators, and clinical systems.](#)

#### Behavioral Health Equity Highlight

CTD Goal 3 supports the behavioral health equity pillar *Connected and Coordinated*. The administrative burdens of navigating public systems and services worsen inequities.<sup>85</sup> By investing in programs that help all eligible people access the care they are entitled to, the Behavioral Health Bridge alleviates barriers and promotes equity.

**Population served:** Services procured under this goal are intended to serve low-income people with behavioral health conditions and the [contracted service](#) providers who work with that population.

**Anticipated timeline:** Reprocured programs are expected to launch in the first quarter of 2029.

Figure 7: Funding estimate for CTD Goal 3 (millions of dollars)

| Year                   | 2028   | 2029  | 2030  | 2031  | 2032  | 2033  | 2034  |
|------------------------|--------|-------|-------|-------|-------|-------|-------|
| Anticipated Activities | \$5.2* | \$3.5 | \$3.6 | \$3.7 | \$3.8 | \$4.2 | \$4.5 |

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 30

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Commented [JN34]: Adds language regarding whole-person care, communication, and patient needs.

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1047 \*This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CTD programs in  
1048 2029.  
1049  
1050

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## B. Substance Use Disorder Treatment and Recovery (SUD)

*Treat substance use disorders by providing effective, low-barrier services that address people's holistic needs and support sustainable paths to long-term recovery.*

### SUD strategy area summary

King County's vision for SUD treatment in the region is to provide timely access to high-quality, evidence-based treatments that support individuals to achieve and sustain recovery. This includes offering peer-based recovery support in tandem with medication, outpatient, inpatient, and residential care. Behavioral Health Bridge sales tax investments will complement and strengthen the existing services of Medicaid, the CCC Levy, and other local and state investments, building upon existing efforts to prevent and treat substance use disorders and help people recover. When procuring services under this strategy area, the County will include people with co-occurring mental health conditions alongside SUD to avoid perpetuating fragmented care.

King County ~~intends to~~will pursue three goals in the area of Substance Use Disorder Treatment and Recovery:

- Goal 1: Drive engagement and retention in SUD care.
- Goal 2: Provide effective, low-barrier SUD treatment that meets people's holistic needs.
- Goal 3: Support paths to achieve and maintain recovery after treatment.

**Figure 8: Estimated expenditures in the Substance Use Disorder Treatment and Recovery strategy area, 2028-2034 (millions of dollars)**

|        | 2028    | 2029   | 2030   | 2031   | 2032   | 2033   | 2034   |
|--------|---------|--------|--------|--------|--------|--------|--------|
| Goal 1 | \$1.7*  | \$2.2  | \$2.3  | \$2.4  | \$2.4  | \$2.5  | \$2.5  |
| Goal 2 | \$11.0* | \$12.0 | \$12.9 | \$13.7 | \$14.4 | \$15.1 | \$15.8 |
| Goal 3 | \$2.1*  | \$1.6  | \$1.7  | \$1.7  | \$1.8  | \$2.1  | \$2.4  |
| Total  | \$14.9* | \$15.9 | \$16.9 | \$17.8 | \$18.6 | \$19.6 | \$20.7 |

|        | 2028    | 2029   | 2030   | 2031   | 2032   | 2033   | 2034   |
|--------|---------|--------|--------|--------|--------|--------|--------|
| Goal 1 | \$1.7*  | \$2.2  | \$2.3  | \$2.4  | \$2.4  | \$2.5  | \$2.5  |
| Goal 2 | \$15.6* | \$16.3 | \$16.8 | \$17.3 | \$17.7 | \$18.1 | \$18.5 |
| Goal 3 | \$2.1*  | \$1.6  | \$1.7  | \$1.7  | \$1.8  | \$2.1  | \$2.4  |
| Total  | \$19.5* | \$20.2 | \$20.8 | \$21.4 | \$21.9 | \$22.6 | \$23.3 |

<sup>a</sup>The complete financial plan for the Bridge can be found in [Section IX](#). Totals may not sum exactly due to rounding.

<sup>\*</sup>A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised SUD programs in mid-2028.

### SUD Goal 1: Drive engagement and retention in SUD care.

In order to break the cycle of substance use, incarceration, and homelessness, people need accessible paths to treatment. Access to treatment for substance use came up repeatedly during community engagement related to the sales tax renewal. Respondents to BHRD's 2024 online survey about the behavioral health system named "difficulty understanding where and how to access services" as the leading barrier to accessing behavioral health services. (See Figure 342 in [Appendix B](#).) At listening sessions, participants noted that the County has made progress in [King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

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improving access to emergency and on-demand services, improving access across geographic regions, and increasing culturally specific outreach. However, they still described problems finding the SUD services they needed, transportation barriers, and insufficient flexibility in appointment times and locations, as well as a desire for more culturally responsive care.

Consistent with the priorities expressed by community and subject matter experts, the next iteration of the behavioral health sales tax will build on existing programs to help people access care when they are struggling with SUD.

**Population served:** Services procured under this goal are intended to serve low-income people with SUD who are not currently connected to treatment, especially those experiencing homelessness.

**Anticipated timeline:** Reprocurd programs are expected to launch in the third quarter of 2028.

**Figure 9: Funding estimate for SUD Goal 1 (millions of dollars)**

| Year                   | 2028   | 2029  | 2030  | 2031  | 2032  | 2033  | 2034  |
|------------------------|--------|-------|-------|-------|-------|-------|-------|
| Anticipated Activities | \$1.7* | \$2.2 | \$2.3 | \$2.4 | \$2.4 | \$2.5 | \$2.5 |

\*A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised SUD programs in mid-2028.

## SUD Goal 2: Provide effective, low-barrier SUD treatment that meets people's holistic needs.

King County's publicly funded behavioral health treatment system is extensive and funded by a blend of sources, including Medicaid, Medicare, and state and local funds. In 2025, more than 4,400 youth and adults received outpatient SUD services and over 1,750 received residential services for substance use disorder.<sup>86</sup> Over 4,700 people received medication for opioid use disorder (MOUD) from DCHS-contracted providers. The Executive plans to strategically invest Behavioral Health Bridge revenues to ensure SUD services are as effective as possible by sustaining core programs, breaking down barriers to care, and implementing best practices and innovative approaches to treatment.

**Population served:** Services procured under this goal are intended to serve low-income people with SUD who are ready to initiate or have initiated treatment. This goal is also intended to serve people at risk of overdose through overdose prevention, and the broader community through overdose data collection and tracking.

**Anticipated timeline:** Reprocurd programs are expected to launch in the third quarter of 2028.

**Figure 10: Funding estimate for SUD Goal 2 (millions of dollars)**

| Year                   | 2028    | 2029   | 2030   | 2031   | 2032   | 2033   | 2034   |
|------------------------|---------|--------|--------|--------|--------|--------|--------|
| Anticipated Activities | \$11.0* | \$12.0 | \$12.9 | \$13.7 | \$14.4 | \$15.1 | \$15.8 |

| Year                   | 2028    | 2029   | 2030   | 2031   | 2032   | 2033   | 2034   |
|------------------------|---------|--------|--------|--------|--------|--------|--------|
| Anticipated Activities | \$15.6* | \$16.3 | \$16.8 | \$17.3 | \$17.7 | \$18.1 | \$18.5 |

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 33

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**Commented [LM38]:** Lowers estimated expenditures in the SUD strategy area, with the offset in other strategy areas

**Commented [SP38R2]:** This decrease funds an increase to EA Goal 1 to \$16.6M annually during the levy period

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1121 \*A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised SUD  
1122 programs in mid-2028.  
1123

**Behavioral Health Equity Highlight**

SUD Goal 2 supports the behavioral health equity pillar *Inclusive, collaborative, diverse, and people-focused*. Expanding access to culturally responsive SUD treatment that aligns with individuals’ languages, cultures, and lived experiences reduces barriers to care and improves outcomes for historically marginalized communities in King County.

1124 **SUD Goal 3: Support paths to achieve and maintain recovery after treatment.**

1125 The purpose of treatment is to help people achieve recovery, which is defined by the Substance  
1126 Abuse and Mental Health **Services** Administration (**SAMHSA**) as “a process of change through  
1127 which individuals improve their health and wellness, live a self-directed life, and strive to reach  
1128 their full potential.”<sup>87</sup> People in recovery need housing, employment, and social supports to  
1129 maintain the gains they earned during treatment.<sup>88</sup> In the absence of these supports, vulnerable  
1130 people often have no choice but to return to unstable living situations where they are surrounded  
1131 by triggers, making it very likely they will fall back into the cycle of SUD and behavioral health  
1132 crisis.<sup>89</sup> The Bridge will invest in services and supports that help people achieve and maintain  
1133 stability after treatment for SUD or co-occurring conditions, increasing the likelihood of lasting  
1134 recovery and long-term wellbeing.

1135  
1136 **Population served:** Services procured under this goal are intended to serve low-income people  
1137 with SUD who self-identify as being in recovery from SUD, especially those who have recently  
1138 completed treatment.

1139  
1140 **Anticipated timeline:** Reprocured programs are expected to launch in the third quarter of 2028.

1141  
1142 **Figure 11: Funding estimate for SUD Goal 3 (millions of dollars)**

| Year                   | 2028   | 2029  | 2030  | 2031  | 2032  | 2033  | 2034  |
|------------------------|--------|-------|-------|-------|-------|-------|-------|
| Anticipated Activities | \$2.1* | \$1.6 | \$1.7 | \$1.7 | \$1.8 | \$2.1 | \$2.4 |

1143 \*A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised SUD  
1144 programs) in mid-2028.  
1145

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### C. Equitable Access to Behavioral Health Care (EA)

*Decrease barriers to behavioral health services and increase access to culturally and linguistically responsive care.*

#### EA strategy area summary

Equity is a critical dimension of health care quality.<sup>90</sup> To increase the availability, accessibility, and effectiveness of behavioral health care for King County residents, the Executive is prioritizing intentional investments in equitable access for the ~~King County~~ Behavioral Health Bridge's diverse, high-need, low-income service population. This includes providing behavioral health care for people who are uninsured or underinsured. Immigrants are disproportionately affected by lack of insurance because people with certain immigration statuses are not eligible for Medicaid coverage regardless of income, and the passage of federal bill H.R. 1 in 2025 will further restrict Medicaid access for immigrants beginning in October 2026.<sup>91,92,93</sup> In Washington, an estimated 620,000 people, both immigrants and US-born residents, are expected to be affected by the addition of work requirements in Medicaid in 2027, which can result in loss of coverage if a person is unable to prove their eligibility to the State every six months.<sup>94</sup> The administrative tasks required to stay enrolled in Medicaid may be especially difficult for people with behavioral health conditions.<sup>95</sup> In addition, Behavioral Health Bridge investments in this strategy area will directly address access barriers related to racism, immigration status, sexual orientation, gender identity, trauma history, and geographic location through investments in community-based services that meet people where they are.

King County will pursue two goals in the area of equitable access to behavioral health care:

- Goal 1: Provide behavioral health care for low-income people who are ineligible for Medicaid.
- Goal 2: Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.

**Figure 12: Estimated expenditures in the Equitable Access to Behavioral Health Care strategy area, 2028-2034 (millions of dollars)**

|        | 2028    | 2029   | 2030   | 2031   | 2032   | 2033   | 2034   |
|--------|---------|--------|--------|--------|--------|--------|--------|
| Goal 1 | \$16.6  | \$16.6 | \$16.6 | \$16.6 | \$16.6 | \$16.6 | \$16.6 |
| Goal 2 | \$4.1*  | \$4.2  | \$4.3  | \$4.5  | \$4.6  | \$5.0  | \$5.3  |
| Total  | \$20.7* | \$20.8 | \$20.9 | \$21.1 | \$21.2 | \$21.6 | \$21.9 |

|        | 2028    | 2029   | 2030   | 2031   | 2032   | 2033   | 2034   |
|--------|---------|--------|--------|--------|--------|--------|--------|
| Goal 1 | \$12.0  | \$12.3 | \$12.7 | \$13.0 | \$13.3 | \$13.6 | \$13.9 |
| Goal 2 | \$4.1*  | \$4.2  | \$4.3  | \$4.5  | \$4.6  | \$5.0  | \$5.3  |
| Total  | \$16.1* | \$16.5 | \$17.0 | \$17.5 | \$17.9 | \$18.6 | \$19.2 |

<sup>^</sup>The complete financial plan for the Bridge can be found in [Section IX](#). Totals may not sum exactly due to rounding.

<sup>\*</sup>A portion of this amount funds continues MIDD 2 initiatives, prior to the launch of new and revised programs in this strategy area in mid-2028.

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 35

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Commented [SP39]: Updates to Figure 12 reflect increase to EA Goal 1 to \$16.6M annually funded through a decrease to SUD Goal 2

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EA Goal 1: Provide behavioral health care for low-income people who are ineligible for Medicaid.

In its next iteration, As MIDD transitions to the Behavioral Health Bridge, the behavioral health sales tax will continue to pay for behavioral health services for low-income uninsured or underinsured King County residents who are ineligible for Medicaid coverage.

Since its inception, the behavioral health sales tax has provided access to behavioral health treatment services for uninsured, low-income people. Every year since 2008, this program the tax has served between 3,000 and 4,000 uninsured people with outpatient mental health and substance use treatment services, including immigrants and refugees, people on Medicare, and people who are pending Medicaid coverage.

This funding addresses inequities for these populations by enabling them to access safety-net behavioral health treatment that would otherwise be out of reach. Supporting access to low-barrier, preventative treatment services helps keep people from delaying needed treatment and accessing higher levels of care at a later time. The King County Behavioral Health Bridge will sustain this important program in 2028-2034 to continue supporting treatment equity between people with insurance coverage and those who lack access due to coverage gaps, income, immigration status or other barriers to care (such as transportation or language). In addition, the Executive plans to use the Bridge to pay for translation and interpretation services and connection to cultural responsive healthcare practices for people receiving outpatient treatment through this program who speak a language other than English.

To support accessibility to these vital services, particularly in light of federal funding changes, the County shall invest no less than \$16.6 million annually in EA Goal 1 services from 2028 through 2034.

During a time in which costs of care are outpacing patient ability to afford care, there is a growing population in King County of those who may not meet federal requirements for Medicaid and do not have the financial resources to access essential behavioral healthcare resources. It is crucial to dedicate resources to organizations who are already established as trusted community service providers, or organizations that serve to aggregate direct service access points for patients with a community-based workforce. Local funding for these organizations can support continued care access for people who lose Medicaid and enhance the County's response to the behavioral health needs of individuals who lack access to behavioral healthcare coverage.

**Population served:** Services procured under this goal are intended to serve low-income people with behavioral health conditions who are ineligible for Medicaid.

**Anticipated timeline:** Reprocurd programs are expected to launch in the first quarter of 2028.

Figure 13: Funding estimate for EA Goal 1 (millions of dollars)

| Year                   | 2028       | 2029       | 2030       | 2031       | 2032       | 2033       | 2034       |
|------------------------|------------|------------|------------|------------|------------|------------|------------|
| Anticipated Activities | \$12.016.6 | \$12.316.6 | \$12.716.6 | \$13.016.6 | \$13.316.6 | \$13.616.6 | \$13.916.6 |

Behavioral Health Equity Highlight

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 36

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Commented [PS40]: Add description for EA Goal 1 to match Executive intent

Commented [SP41]: Added policy requirement language regarding the funding shift from SUD Goal 2 to EA Goal 1.

Commented [PS42]: Added language regarding cost of care, Medicaid requirements, and financial resources to access care.

Commented [JN43]: Increases estimated expenditures in the EA strategy area, with the offset in other strategy areas

Commented [SP44]: Updates estimated funding for EA Goal 1. Increase is from a decrease to SUD Goal 2.

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EA Goal 1 supports the behavioral health equity pillar *Accessible and Available*. Expanding timely access to services for people without Medicaid helps ensure that individuals and families across King County can receive the care they need when and where they need it.

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## EA Goal 2: Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.

People who are BIPOC, LGBTQIA+, survivors of trauma or domestic, sexual, or gender-based violence, living unsheltered, or living in a rural area are vulnerable to behavioral health inequities caused by structural failures to meet their needs.<sup>96,97,98</sup> Culturally centered organizations design and deliver behavioral health supports by and for the communities they serve. Wellbeing is not one-size-fits-all, and healing and recovery are about much more than clinical medical practices. Healing and recovery also include people feeling a sense of connection to their community and culturally competent healing practices. Partnerships with trusted community organizations are critical for people's recovery journeys.<sup>99</sup> Intentional investment under this goal will directly address inequities in behavioral health outcomes related to race, immigration status, sexual orientation, gender identity, trauma history, and geographic access. DCHS will to procure behavioral health treatment and enhanced care navigation for survivors of trauma, domestic, and sexual, and gender-based violence. Investments should support organizations that can aggregate de-identified data points across multiple patients, giving the County a more detailed understanding of how patients with a range complex behavioral health care needs present themselves across provider sites over time.

Commented [JN45]: Adds reference to additional populations

Investments will be made with the recognition that community-based service providers most capable of administering complex, culturally competent care with already-established patient trust may presently lack administrative, compliance or data infrastructure to respond to governmental RFP requirements. Ideally, new investments will make access to Bridge support more accessible to service providers that are closest to community but in need of greater internal administrative support.

Commented [SP46]: Adds language regarding investments supporting organizations that can provide a more granular understanding of patients over time and across providers.

**Population served:** Services procured under this goal are intended to serve low-income people with behavioral health conditions who face behavioral health inequities as demonstrated by service and outcomes data, including those who are BIPOC, immigrants or refugees, LGBTQIA+, rural, older adults, or survivors of trauma or domestic, sexual, or gender-based violence.

**Anticipated timeline:** Reprocured programs are expected to launch in the third quarter of 2028.

Figure 14: Funding estimate for EA Goal 2 (millions of dollars)

| Year                   | 2028   | 2029  | 2030  | 2031  | 2032  | 2033  | 2034  |
|------------------------|--------|-------|-------|-------|-------|-------|-------|
| Anticipated Activities | \$4.1* | \$4.2 | \$4.3 | \$4.5 | \$4.6 | \$5.0 | \$5.3 |

\*A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised EA programs in mid-2028.

Commented [PS47]: Adds language to make investments in providers that can administer culturally competent care that may lack administrative capabilities to meet government RFP requirements

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#### D. Child, Youth, and Young Adult Mental Wellbeing (CYYA)

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*Address the youth behavioral health crisis by investing in developmentally tailored services and programs that meet youth where they are.*

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1262

#### CYYA strategy area summary

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King County is committed to providing equitable opportunities for all children to progress through childhood happy, healthy, safe, and thriving.<sup>100</sup> The need to bolster behavioral health services for children, youth, and young adults emerged as a consistent theme across all community engagement. Long before young people reach a behavioral health crisis, they are feeling lonely, disconnected, or bullied – upstream issues that need to be addressed to prevent behavioral health issues down the line.<sup>101</sup> The **King County** Behavioral Health Bridge is intentionally designed to invest in areas of unmet need and in services where funding is not currently available or stable, particularly prevention, engagement, early intervention, recovery, and treatment access for individuals who are uninsured or ineligible for Medicaid. By building on family and community strengths, and providing services when youth and families need support, the Bridge will complement other County investments (such as Medicaid, Best Starts, and the CCC Levy) to promote positive behavioral health for King County residents ages zero to 25 and their families.

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King County will pursue three goals in the area of child, youth, and young adult mental wellbeing:

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**Figure 15: Estimated expenditures in the Child, Youth, and Young Adult Mental Wellbeing strategy area, 2028-2034 (millions of dollars)**

|               | 2028           | 2029           | 2030          | 2031          | 2032          | 2033          | 2034          |
|---------------|----------------|----------------|---------------|---------------|---------------|---------------|---------------|
| <b>Goal 1</b> | \$3.5*         | \$4.0*         | \$4.5         | \$4.6         | \$4.7         | \$4.9         | \$5.0         |
| <b>Goal 2</b> | \$5.2*         | \$4.9*         | \$4.7         | \$4.8         | \$5.0         | \$5.1         | \$5.2         |
| <b>Goal 3</b> | \$2.6*         | \$2.8*         | \$3.0         | \$3.1         | \$3.1         | \$3.5         | \$3.8         |
| <b>Total</b>  | <b>\$11.2*</b> | <b>\$11.7*</b> | <b>\$12.2</b> | <b>\$12.5</b> | <b>\$12.8</b> | <b>\$13.4</b> | <b>\$13.9</b> |

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<sup>^</sup>The complete financial plan for the Bridge can be found in [Section IX](#). Totals may not sum exactly due to rounding.

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<sup>\*</sup>A portion of this amount funds continuing MIDD 2 initiatives, prior to the launch of new and revised programs in this strategy area.

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#### **CYYA Goal 1: Improve youth access to behavioral health care by providing developmentally appropriate services that meet young people where they are, at school and in community.**

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The adopted 2025 Youth Action Plan calls for the County to “co-create and embed behavioral health support in youth development programs, schools, and other community-centered organizations.”<sup>102</sup> To further this aim, investments under this goal will facilitate access to behavioral health care for young people by placing behavioral health supports in places where youth already spend time, such as schools and community locations.

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[King County Behavioral Health Bridge Implementation Plan 2028-2034](#) [Phase 1: Transition Strategic Framework](#)

Page | 38

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**Population served:** Services procured under this goal are intended to serve youth and young adults with behavioral health symptoms or conditions who would benefit from outpatient care, especially those whose families are low-income.<sup>103</sup>

**Anticipated timeline:** Reprocured programs are expected to launch in the third quarter of 2029.

**Figure 16: Funding estimate for CYYA Goal 1 (millions of dollars)**

| Year                   | 2028   | 2029   | 2030  | 2031  | 2032  | 2033  | 2034  |
|------------------------|--------|--------|-------|-------|-------|-------|-------|
| Anticipated Activities | \$3.5* | \$4.0* | \$4.5 | \$4.6 | \$4.7 | \$4.9 | \$5.0 |

*\*A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CYYA programs in mid-2029.*

**CYYA Goal 2: Provide behavioral health and therapeutic services to youth involved in the legal system, including diversion from deeper legal system involvement.**

Youth involved with the criminal-legal system are some of the most vulnerable members of King County communities and need additional support to break the cycle of behavioral health issues and incarceration. Nationally, an estimated 50 to 70 percent of youth involved in the juvenile legal system meet criteria for at least one psychiatric disorder.<sup>104</sup> In 2025, 2,095 juvenile cases were referred by law enforcement to the King County Prosecuting Attorney’s Office.<sup>105</sup> In the first five months of 2026, an average of 31.2 young people were in secure detention at the Clark Children and Family Justice Center, with another 38.5 assigned to Electronic Home Monitoring.<sup>106</sup> Young people involved in the legal system and their families need additional behavioral health support to keep them from becoming trapped in a cycle of incarceration.

**Population served:** Services procured under this goal are intended to serve youth with behavioral health conditions who are involved in or at risk of becoming involved in the criminal-legal system.

**Anticipated timeline:** Reprocured programs are expected to launch in the third quarter of 2029.

**Figure 17: Funding estimate for CYYA Goal 2 (millions of dollars)**

| Year                   | 2028   | 2029   | 2030  | 2031  | 2032  | 2033  | 2034  |
|------------------------|--------|--------|-------|-------|-------|-------|-------|
| Anticipated Activities | \$5.2* | \$4.9* | \$4.7 | \$4.8 | \$5.0 | \$5.1 | \$5.2 |

*\*A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CYYA programs in mid-2029.*

**CYYA Goal 3: Invest in the behavioral health of youth who are marginalized or experience inequities.**

The youth mental health crisis is widespread across King County communities, but not all youth encounter systems of support in the same way. Due to systemic racism and structural exclusion, some groups of young people are less likely to experience behavioral health services as accessible, affirming, culturally grounded, or responsive to their lived experiences. As a result, King County data show differences in mental health, substance use, and suicidality across youth populations,

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

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- including among LGBTQIA+ youth, Black youth, Indigenous youth, youth of color, immigrant and refugee youth, and youth with complex behavioral health needs. For example:
- In 2025, Washington eighth graders identifying as American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Hispanic/Latino, or LGBTQ+ were more likely than the statewide average to report depressive feelings.<sup>107</sup> In King County in 2025, about half of LGBTQ+ youth in King County experienced depression.<sup>108</sup>
  - The rate of emergency department visits related to suicidal ideation among King County Black youth ages eight to 17 climbed every year from 2020 to 2023. Black youth and youth identifying with multiple races were the only groups without a decline in rates of suicidal ideation-related ED-emergency department visits between 2022 and 2023.<sup>109</sup>
  - In 2025, Washington tenth graders identifying as American Indian/Alaska Native, LGBTQ+, or having a disability were more likely than the Washington average to report using alcohol or vape products within the past 30 days.<sup>110</sup>

These differences highlight the importance of approaches that build on youth strengths, reflect community knowledge, and create more meaningful pathways to support.

**Population served:** Services procured under this goal are intended to serve youth with behavioral health conditions who face behavioral health inequities as demonstrated by service and outcomes data, including those who are BIPOC, immigrants or refugees, LGBTQIA+, rural, survivors of trauma or violence, or have complex or co-occurring behavioral health conditions.

**Anticipated timeline:** Reprocured programs are expected to launch in the third quarter of 2029.

**Figure 18: Funding estimate for CYYA Goal 3 (millions of dollars)**

| Year                   | 2028   | 2029   | 2030  | 2031  | 2032  | 2033  | 2034  |
|------------------------|--------|--------|-------|-------|-------|-------|-------|
| Anticipated Activities | \$2.6* | \$2.8* | \$3.0 | \$3.1 | \$3.1 | \$3.5 | \$3.8 |

\*A portion of this amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised CYYA programs in mid-2029.

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## E. Behavioral Health Workforce Development (WF)

*Strengthen and diversify the behavioral health workforce to meet growing community needs.*

### WF strategy area summary

It takes people to treat people. A robust, skilled, and diverse workforce is foundational to delivering quality, timely behavioral health care. Nearly every service supported by the Behavioral Health Bridge relies on qualified behavioral health workers in community agencies, and there is a serious shortage of such professionals.<sup>111</sup> In 2025, the King County Integrated Care Network (KCICN) had an overall vacancy rate of nearly 10 percent, equivalent to 414 open positions.<sup>112</sup> Workforce investments are critical to sustaining services in community behavioral health, but are ineligible for payment by Medicaid. In concert with the activities of the CCC Levy to support the crisis workforce and alongside enhanced data collection to ensure that investments are achieving their intended impact, Bridge sales tax investments will provide a much-needed infusion of resources to help more people start and succeed in careers across the continuum of behavioral health care.<sup>113</sup>

King County will pursue two goals in the area of Behavioral Health Workforce Development:

- Goal 1: Strengthen and diversify the behavioral health provider pipeline.
- Goal 2: Advance and develop the skills of the current workforce to meet growing community needs.

**Figure 19: Estimated expenditures in the Behavioral Health Workforce Development strategy area, 2028-2034 (millions of dollars)**

|        | 2028   | 2029  | 2030  | 2031  | 2032  | 2033  | 2034  |
|--------|--------|-------|-------|-------|-------|-------|-------|
| Goal 1 | \$0    | \$2.5 | \$2.5 | \$2.6 | \$2.7 | \$2.9 | \$3.0 |
| Goal 2 | \$1.3* | \$4.1 | \$4.2 | \$4.4 | \$4.5 | \$4.7 | \$4.9 |
| Total  | \$1.3* | \$6.6 | \$6.8 | \$7.0 | \$7.1 | \$7.6 | \$8.0 |

<sup>111</sup>The complete financial plan for the Bridge can be found in [Section IX](#). Totals may not sum exactly due to rounding.

<sup>112</sup>\*This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised WF programs in 2029.

### WF Goal 1: Strengthen and diversify the behavioral health provider pipeline.

Community members and subject matter experts who advised the [King County Behavioral Health Bridge](#) renewal reported difficulty accessing care due to a shortage of [service](#) providers, especially those from diverse linguistic and cultural backgrounds. This echoes national trends: by 2038, behavioral health workforce shortages are projected to create cascading impacts on service access and availability across the country.<sup>114</sup> A national survey of community behavioral health workers found that fewer than half (42 percent) expected to be at their current practice in five years, and a Washington state survey found that community behavioral health organizations lose 25-60 percent of their clinical workforce every year.<sup>115,116</sup> At KCICN agencies in 2025, the highest number of vacancies were among Master's level mental health counselors, followed by non-peer Registered Agency Affiliated Counselors, who are usually Bachelor's-level case managers or student interns practicing under the agency's license.<sup>117,118</sup> SUD Professional trainees (SUDPts) also had a very high vacancy rate of 16 percent.<sup>119</sup>

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 41

1404 Registered apprenticeships support both workforce expansion and incumbent-worker  
1405 advancement. National apprenticeship initiatives demonstrate that these programs can reach  
1406 populations historically underrepresented in apprenticeship while providing structured pathways  
1407 for existing employees to build skills and advance. Degree-based apprenticeship can further  
1408 connect paid work-based learning with postsecondary education and college credit, reducing  
1409 barriers to continued education and career advancement.

1411 DCHS plans to use this data to target investments intended to reduce vacancies and thereby  
1412 increase service access.<sup>120</sup> In addition, KCICN agencies report wanting to diversify their staff, but  
1413 struggling to pay competitive wages and to find qualified candidates who speak the languages in  
1414 greatest demand.<sup>121</sup> To address these issues proactively and prevent continued challenges in  
1415 people's ability to access behavioral health care, Goal 1 will focus on increasing the number of  
1416 licensed behavioral health workers in King County and building a more representative provider  
1417 population. To the degree feasible within available funding, this may include investments in pre-  
1418 apprenticeship programs, registered apprenticeships, and apprenticeship degree pathways that  
1419 expand entry into behavioral health careers, support advancement of incumbent workers, and  
1420 create more accessible pathways for individuals from communities underrepresented in the  
1421 behavioral health workforce. This goal should create stability and longevity in the workforce, and  
1422 should include things such as annual contract adjustments that support providers in increasing  
1423 staff wages to aid recruitment and retention, thus facilitating operational stability.

1425 **Population served:** Services procured under this goal are intended to serve entrants and potential  
1426 entrants into the behavioral health workforce, as well as people in behavioral health clinical  
1427 internships, with a focus on increasing the diversity and representativeness of the workforce.

1429 **Anticipated timeline:** Reprocured programs are expected to launch in the first quarter of 2029.

1431 **Figure 20: Funding estimate for WF Goal 1 (millions of dollars)**

| Year                   | 2028 | 2029  | 2030  | 2031  | 2032  | 2033  | 2034  |
|------------------------|------|-------|-------|-------|-------|-------|-------|
| Anticipated Activities | \$0  | \$2.5 | \$2.5 | \$2.6 | \$2.7 | \$2.9 | \$3.0 |

1432 **Behavioral Health Equity Highlight**

WF Goal 1 supports the behavioral health equity pillar *Responsive and Adaptive to Community-Identified Needs*. Community members have consistently shared that they feel more comfortable accessing behavioral health care when service providers reflect the communities they serve. The Executive is responding to this need by investing in a diverse provider pipeline.

1434 **WF Goal 2: Advance and develop the skills of the current workforce to meet growing**  
1435 **community needs.**

1436 In contrast to private practice, community behavioral health service providers are more likely to  
1437 see patients with complex and co-occurring disorders or high-acuity needs, who may also be low-  
1438 income, unhoused, uninsured, or have limited English proficiency. Investments from the Bridge will  
1439 help equip contracted service providers with the range of skills necessary to offer high-quality,

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

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effective services to this population. Bridge investments will strengthen the capacity of the behavioral health workforce to meet these needs by supporting education, training, and career development opportunities that build clinical, cultural, linguistic, and interdisciplinary competencies. To the degree feasible within available funding, this may include investments in registered apprenticeships and apprenticeship degree pathways that allow both new and incumbent workers to develop advanced skills, earn recognized credentials and degrees, and progress into higher-skill behavioral health roles while remaining connected to the workforce.

**Population served:** Services procured under this goal are intended to serve ~~contracted service providers~~ the current and future behavioral health workforce in of King County's publicly funded community-based behavioral health system.

**Anticipated timeline:** Reprocured programs are expected to launch in the first quarter of 2029.

**Figure 21: Funding estimate for WF Goal 2 (millions of dollars)**

| Year                   | 2028   | 2029  | 2030  | 2031  | 2032  | 2033  | 2034  |
|------------------------|--------|-------|-------|-------|-------|-------|-------|
| Anticipated Activities | \$1.3* | \$4.1 | \$4.2 | \$4.4 | \$4.5 | \$4.7 | \$4.9 |

\*This amount pays for continuing MIDD 2 initiatives, prior to the launch of new and revised WF programs in 2029.

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**Commented [SP50]:** Adds reference to apprenticeships, career advancement in the field to create stability and longevity to WF Goal 2



## 1458 **II. Measurement and evaluation**

1459 This section presents the overarching principles and approaches that will guide the evaluation and  
1460 performance measurement of the ~~King County~~ Behavioral Health Bridge investments. The  
1461 performance measurement and evaluation framework for 2028-2034 continues and builds upon  
1462 the existing framework used by MIDD 2.<sup>122,123,124</sup> Consistent with other King County human services  
1463 initiatives, measurement and evaluation for the Behavioral Health Bridge will use the Results Based  
1464 Accountability (RBA) framework, and DCHS plans to work with the Executive Office, other agencies  
1465 and in partnership with ~~contracted~~ service providers to finalize performance measures.<sup>125</sup>

1466  
1467  
1468 With the introduction of a new primary purpose and ~~new~~ strategy areas in ~~this the Behavioral~~  
1469 ~~Health Bridge implementation Pplan~~, the measurement and evaluation approach for the  
1470 Behavioral Health Bridge builds on RBA through the use of logic models in each strategy area that  
1471 ensure program outcomes are designed to achieve the overall goals of each area, as shown in  
1472 ~~Section V~~Section VII of this plan. Further, the use of SMART (specific, measurable, achievable,  
1473 realistic, time-bound) outcomes for each program and strategy are expected to improve  
1474 understanding of how each program helps drive the <sup>126</sup> each strategy area.<sup>127</sup>

### 1475 **A. Overarching principles**

1476 The ~~King County~~ Behavioral Health Bridge evaluation approach is collaborative, transparent,  
1477 outcomes-driven, person-centered, equity-focused, and continuously improving. This approach  
1478 equips the Behavioral Health Bridge with the information needed to understand what works, foster  
1479 shared accountability, and make data-driven decisions across programs.

1482 **Collaborative:** Performance measurement and evaluation require DCHS, other County agencies,  
1483 the Executive Office, ~~contracted service providers~~, and Bridge-funded-supported providers and  
1484 programs to work together to identify actionable metrics. In partnership with program staff and  
1485 contracted ~~service~~ providers, King County evaluation staff intend to develop performance  
1486 measures that facilitate strategy-wide impact measurement and capture information meaningful  
1487 to programs and pertinent to community needs. Each program's performance measures will be  
1488 finalized in performance measurement plans that align with the Executive's vision and long-term  
1489 goals for the Behavioral Health Bridge as described in this ~~Phase 1 Implementation Pplan~~. Where  
1490 relevant, these performance measurement plans will coincide with other initiatives and  
1491 countywide strategic plans, such as the Breaking the Cycle Workgroup. For programs that cross  
1492 multiple County agencies, metrics will be developed collaboratively, with the Executive Office  
1493 facilitating consistency and coordination across County agencies.

1495 **Transparent:** To foster public accountability and transparency, King County regularly shares  
1496 performance measurement and evaluation outcomes, methods, and data sources with the public  
1497 via annual dashboards and biennial reports, which are described further in ~~Section VIII of this~~  
1498 ~~plan~~.<sup>128</sup> King County evaluation staff will also regularly review data and outcomes with program  
1499 managers and ~~Bridge-funded~~contracted service providers to ensure that information received by  
1500 King County is accurate, reliable, and valid.  
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1503 **Outcomes-driven:** Assessment and evaluation of data are essential tools for understanding what  
1504 works, identifying the results of investments, determining whether interventions are effectively  
1505 addressing relevant issues, and supporting accountability. Behavioral Health Bridge data  
1506 collection practices will be outcomes-driven and reflect system-level objectives for each strategy  
1507 area as described in the logic models throughout this **Phase 1 Implementation Pplan**. Data  
1508 collection is expected to incorporate quantitative and qualitative data and will include  
1509 demographic information to ensure service recipients are reflective of the community. **Qualitative**  
1510 **data will include participant experiences and should be meaningfully incorporated alongside**  
1511 **quantitative measures whenever possible.** King County staff regularly review data and performance  
1512 measures to inform program or contract modifications, repurposing of funds, and future  
1513 procurement of services.

1515 **Person-centered:** Data influences the narrative about the communities from which it is collected  
1516 and guides policy decisions and resource distribution. King County seeks to present data in ways  
1517 that move beyond historical deficit-based portrayals. More importantly, King County intends to  
1518 regularly share data with community for reflection and to ensure data is person-centered,  
1519 accurate, and grounded in lived experience. This transparency is essential for strengthening  
1520 accountability, supporting better government, and reinforcing trust. Whenever possible and  
1521 feasible, King County staff will continue to center the voices of Behavioral Health Bridge program  
1522 participants to understand and respond to their experiences of what is working and what is not  
1523 working. By acknowledging systemic barriers and elevating community strengths, resilience, and  
1524 stamina, King County aims to ensure the data tells a more complete story that supports equitable  
1525 decision making.

1527 **Equity-focused:** The Executive **intends to will** deepen the Behavioral Health Bridge's commitment  
1528 to the principles of equitable evaluation.<sup>129</sup> DCHS **intends to will** ensure data reflect the  
1529 communities from which they are gathered and help illuminate how needs, strengths, and  
1530 outcomes vary across populations in ways that inform policy and resource decisions. During the  
1531 2028–2034 **Bridge** implementation period, DCHS intends to specifically expand the visibility of  
1532 BIPOC communities within data and strengthen their involvement in determining what data are  
1533 collected and how findings are interpreted. This may include enhancing the ways evaluators  
1534 disaggregate results by race, ethnicity, and other demographics; developing new data collection  
1535 methods; continuing to value and report qualitative outcomes; and increasing opportunities for  
1536 community reflection and feedback on data analysis and results. Together, these approaches are  
1537 expected to support both stronger accountability to outcomes and a more accurate, community  
1538 **g**rounded understanding of what is working.

#### 1540 **Continuous improvement:**

1541 **King County** DCHS evaluation staff **will** process data at least quarterly to ensure completeness,  
1542 accuracy, and timely course correction. Findings **are will be** shared with DCHS staff, **partner**  
1543 **County** agencies, the Executive Office, and **community contracted service** providers to support  
1544 evidence-informed decisions that improve program reach, quality, and outcomes. As countywide  
1545 practices evolve, King County may include Bridge-related metrics in department or cross-  
1546 department business reviews<sup>130</sup>. The Executive may also establish an Executive-level decision-  
1547 making forum that reviews data holistically across departments, strengthens measurement  
1548 practices, and directs coordinated action to improve outcomes and cross-departmental  
1549 alignment. The Executive Office **intends to will** lead cross-agency routine review and monitoring,

King County Behavioral Health Bridge Implementation Plan 2028-2034 **Phase 1: Transition Strategic Framework**

Page | 45

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**Commented [SP53]:** Explicitly states participant experiences will be reflected in qualitative data

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including for programs managed by separately elected agencies. Recommendations from the Breaking the Cycle workgroup are expected to influence performance reporting. DCHS evaluation staff, in collaboration with [partnersother County agencies and contracted service providers](#), will also regularly reexamine measurement and evaluation approaches to improve data sources and methodologies and to remain responsive to emerging evaluation challenges and program implementation needs.

## B. Performance measurement and evaluation framework

The Behavioral Health Bridge's performance measurement and evaluation framework is designed to monitor performance, improve quality, generate actionable insights, and inform decision-makers and the public. Measurement and evaluation results give insight into which programs are effective and why, inform operational adjustments, and help hold contracted [partners-service providers](#) accountable for the activities they are funded to implement. Monitoring and evaluation will also inform DCHS and Executive Office decisions about budget proposals.

The Behavioral Health Bridge's scale and complexity requires an approach that encompasses a range of measurement techniques. The Bridge's measurement and evaluation framework begins with Results Based Accountability (RBA), a method for assessing the results of strategies, and is supplemented with additional evaluation activities.<sup>131</sup> The resulting framework includes:

- **Performance measurement:** Performance measures [will](#) regularly track program outcomes to assess how well an investment or strategy is performing. In addition to measuring operational and contractual expectations of programs and strategies, such as the number of individuals served or activities conducted with Behavioral Health Bridge resources, performance measures [will](#) also track whether strategies [contained in the Behavioral Health Bridge implementation pPlan](#) are achieving intended outcomes, whether outcomes are equitable, and whether program participants are better off. These indicators will inform deliberations about adjustments to contracts, future procurement, operational direction from the Executive Office, and budget decisions.
- **Population indicators:** The Behavioral Health Bridge [will use](#)s population indicators to identify needs, understand baseline conditions, and track trends. Population indicators are broad measures of community-level conditions (such as rates of homelessness, emergency department usage, or criminal legal involvement) that reflect the overall well-being of a population rather than the performance of any single program. Because many factors influence population indicators over the long term, changes cannot be attributed specifically or exclusively to Bridge investments. However, tracking these indicators is beneficial in understanding whether the combined efforts of initiatives are impacting regional challenges.
- **In-depth evaluation:** Additional evaluation will complement performance measurement to deepen knowledge of what is effective and inform continuous improvement for specific strategies. This may include assessing new pilot programs, designing new measurement and evaluation tools, and conducting studies of program effectiveness. DCHS may contract with one or more independent organizations or engage in public-private partnerships to conduct in-depth evaluations. Results from in-depth evaluation will inform County decision-making by providing evidence on implementation quality, program mechanisms,

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 46

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and contribution to desired outcomes, and will also strengthen the broader evidence base for effective behavioral health interventions that can be applied in other jurisdictions.

These three approaches are described in more detail in the following subsections.

### Performance measurement

The Behavioral Health Bridge will measure the performance of individual programs or strategies to assess how the program is being implemented and whether it is successfully driving positive outcomes for participants (i.e., “performance accountability”). As appropriate, programs will measure each of the three domains defined by RBA:

1. How much did we do?
2. How well did we do it?
3. Is anyone better off?

Performance measures will vary across programs and strategy areas depending on the population served, type of services, and intended outcomes; these measures can be qualitative, quantitative, or both. To measure outcomes across different investments, performance measurement and evaluation will align with the outcomes and goals identified in the logic models in [Section VI](#) and [Section XI Appendices F–J](#). Aligning performance measures under the logic models enables King County evaluation staff to assess how well investments contribute to the shared goals and intended longer-term impact of the Behavioral Health Bridge strategy areas. Each program will have performance measures that assess progress toward the specific program’s intended goals, as well as standard measures that facilitate evaluation of the Behavioral Health Bridge’s collective impact across [goal-strategy](#) areas. Example performance measures for programs within the RBA framework are shown below in Figure 22. The examples of “How well did we do it?” and “Is anyone better off?” performance measurement could also be rolled up into a strategy area’s broader goal for long-term impact (such as “reduce overdoses and overdose deaths” or “maintain behavioral healthcare for people transitioning through treatment settings”).

**Figure 22: Example performance measures**

| How much did we do?                                                      | How well did we do it?                                                           | Is anyone better off?                                                                                                        |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
| Number of individuals engaged through outreach                           | Percent of individuals receiving a warm handoff/referral to a treatment provider | Percent of individuals consistently accessing medication for opioid use disorder                                             |
| Number of individuals assessed for diversion from involuntary commitment | Percent of individuals enrolled with an outpatient treatment provider            | Percent of individuals with no involuntary treatment act (ITA) court referrals in the 12 months following program enrollment |

Contracted [community-service](#) providers and County [partners-agencies](#) across all strategies and programs will be expected to regularly submit data and information that form the basis of performance measures. The timeline for finalizing and reporting performance measures is expected to be distinct for each program and will depend on contracting and implementation timelines.

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 47

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For every strategy that is competitively procured, RFPs will include the strategy's intended goals and system-wide outcomes and associated performance measures. By including this information in RFPs, King County will transparently communicate reporting requirements and expectations based on each investment's intended impact. These expectations provide clear direction on priority outcomes and areas where progress must be demonstrated, while still allowing flexibility for program-specific approaches.

During the contract negotiation process, DCHS staff will engage with ~~funded-contracted service~~ providers to finalize a performance measurement-~~(PM)~~ plan. The finalized ~~performance measurement~~PM plan will capture the unique aspects of each program's model while also adopting standardized measures that support assessment of the Behavioral Health Bridge's collective impact.

County-run programs ~~in~~by other ~~County~~ agencies will similarly collaborate with DCHS to develop performance measurement plans that are aligned with each program's purpose, service model, operational context, and data capacity, with the Executive Office playing a lead role in supporting alignment across County agencies. This coordinated approach is expected to result in specific performance measures and outcomes that track program capacity and outcomes for participants, while also working toward systemic goals across programs with similar functions or intended outcomes. See "Continuous improvement" in the above [Overarching principles](#) section for how this data will feed into decision-making and continuous improvement at the program and system levels.

For programs administered by County agencies outside of DCHS that serve similar populations or pursue the same goal, the Executive Office shall work in partnership with those County agencies and DCHS to establish standardized performance measures that enable comparison across programs. For programs focused on serving people involved in the criminal-legal system, standardized measures should include common measures about the program's impact on reducing involvement in the criminal-legal system over time, in addition to any program-specific measures.

Whenever possible, when reporting on standardized outcome measures, the data should be broken down by Council District in addition to countywide so that the collective impact of Bridge programs can be assessed by geographic area.

## Data collection

King County invests heavily in data systems and infrastructure to responsibly collect, manage, and share information, with the goal of making data widely accessible and informative for direct programming and policy decisions. Data collection and reporting to King County is dependent on the type of strategy or program being measured. The format and reporting mechanisms for collecting data will also adapt to available reporting systems and provider capacity. Data will be collected at different intervals, depending on the program or strategy, although information will typically be received by King County following each month or each quarter. ~~Contracted Service P~~providers will submit data and relevant information to King County as required by their contract and/or documented in their ~~PM-performance measurement p~~Plans.

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 48

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**Commented [PS58]:** Adds language regarding coordination for programs serving similar populations or similar goals

**Commented [PS59]:** Requires that the Executive's Office work in partnership with county agencies and DCHS to analyze programs over time.

**Commented [JN60]:** Adds language on data by council district.

1678 Data collection types to be detailed in the **PM-performance measurement** plan may include:

- 1679 • **Individual-level data:** Individual-level data is comprised of person-specific demographic
- 1680 information, information about services provided, survey information gathered at regular
- 1681 intervals, program outcomes, and other information.
- 1682 • **Aggregate-level data:** Aggregate-level data is comprised of high-level summary statistics
- 1683 about program services or participants. This can include counts, totals, and averages
- 1684 reported to King County at regular intervals.
- 1685 • **Qualitative data:** When appropriate for the program model, qualitative data will be
- 1686 reported by the **funded-programcontracted service provider**. Qualitative data may include
- 1687 focus groups, open-ended surveys and questionnaires, and interviews.
- 1688 • **Narrative reports:** **Funded organizationsContracted service providers** are expected to
- 1689 submit to King County annual or biannual narrative reports comprised of information about
- 1690 operations, client stories, system change efforts, and other program activities as
- 1691 requested.

1693 The Bridge will also leverage administrative data sources to assess participants' **use of involvement**  
1694 **with** systems such as jails, psychiatric inpatient hospitals, emergency departments, and crisis  
1695 services. Data will typically be reported as the change over time in participants' total number of  
1696 bookings, hospitalizations, emergency department admissions, or crisis episodes in a given period.  
1697 Long-term outcomes can be measured with administrative data by comparing participant data  
1698 from a baseline year to the years subsequent to receiving services. As appropriate, outcomes will  
1699 be assessed by cohort (participants' enrollment year), making it possible to follow a group of  
1700 participants over time, track consistency in outcomes across cohorts, and increase King County's  
1701 understanding of the impact of Behavioral Health Bridge programming on participants' interactions  
1702 with various publicly funded systems. DCHS also **intends to shall** collect system-level data as  
1703 appropriate, such as changes to the community behavioral health workforce, including job  
1704 vacancies, retention and turnover rates, and workforce diversity.

1706 Recommendations from the Breaking the Cycle workgroup are expected to inform improvements to  
1707 data collection, sharing, and reporting.

1709 In addition, **PM-performance measurement** plans will capture **individual each** program model's  
1710 unique aspects, while also establishing standardized measures to facilitate measurement of the  
1711 Behavioral Health Bridge's collective impact across goal areas. This approach aims to minimize the  
1712 burden of data collection on **contracted service** providers while ensuring that measurement and  
1713 evaluation reflect programs' and communities' definitions of progress, and that **contracted service**  
1714 **providers and County agencies engaged in Bridge-funded work King County and funded entities** are  
1715 aligned on reporting requirements. The approach also promotes strategic learning and  
1716 accountability through transparency and collaboration with **contracted service providers and King**  
1717 **County**.

1719 **Performance measurementM** plans will include key performance measures, types of data  
1720 collection, reporting cycles, and activities to review the data and support continuous quality  
1721 improvement. For investments that fund direct behavioral health services to clients, DCHS **intends**  
1722 **to shall** collect and monitor performance measures about individuals served, the nature of services  
1723 provided, and associated outcomes. Participant-level data about people receiving services may be  
1724 disaggregated by race, ethnicity, or other demographic characteristics. For investments that do not  
[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 49

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1725 provide direct services to individuals, but are instead investing in community infrastructure or  
1726 systems, DCHS ~~intends to shall~~ collect and monitor performance measures such as the number of  
1727 activities conducted or progress toward milestones. For example, King County staff could assess  
1728 an investment in capital funding for housing sites by monitoring the number of buildings  
1729 constructed, facilities opened, or beds created. DCHS will work with ~~partner agencies~~ *contracted*  
1730 *service providers and County agencies* to collect individual level data where appropriate and  
1731 legally allowable.

#### 1732 *Disaggregation by demographic characteristics*

1733 To address behavioral health inequities, Behavioral Health Bridge measurement and evaluation  
1734 methods will measure race, ethnicity, and other demographic characteristics at both the program  
1735 level and across programs to analyze equity in access, engagement, and outcomes. These  
1736 analyses will yield critical information to advance the behavioral health equity framework.

#### Behavioral Health Equity Highlight

Disaggregation by race and ethnicity supports the behavioral health equity pillar  
*Transparent and Accountable*. Collecting, analyzing, and reporting data by race and  
ethnicity increases awareness of disparities, strengthens accountability for  
equitable outcomes, and informs targeted strategies to address inequities  
experienced by historically and currently marginalized communities in King County.

#### 1738 **Measuring the King County Behavioral Health Bridge's collective impact**

1739 Whenever possible, each program will include standardized performance measures that are  
1740 common across all programs with a similar intended outcome within a strategy area. This will make  
1741 it possible for the County to describe the collective impact of the Behavioral Health Bridge by  
1742 reporting summarized performance measures for all programs within the same strategy area. The  
1743 standardized performance measures will be publicly available as part of the Behavioral Health  
1744 Bridge biennial reporting described further in [Section VIII](#).

1745 To facilitate measurement across DCHS investments, Behavioral Health Bridge performance  
1746 measurement and reporting will be aligned with other human services funding initiatives, including  
1747 the CCC Levy, Best Starts, VSHSL, and Health Through Housing. Behavioral Health Bridge  
1748 performance measurement and reporting will also continue to be integrated into the DCHS  
1749 dashboard, and particular outcome measures will be aligned with DCHS-wide performance  
1750 measures and the Executive Office's performance measurement approach to ensure alignment in  
1751 reporting. The subsequent subsection "[Aligning performance measurement with other dedicated](#)  
1752 [human services initiatives](#)" describes this in further detail.

1753 Where appropriate, the Executive Office will collaborate with DCHS and ~~partner~~ *other County*  
1754 agencies to elevate data and performance measures as part of a whole-county approach to human  
1755 services investments and align with countywide initiatives such as recommendations from the  
1756 Executive's Breaking the Cycle Workgroup.

#### 1759 **Reporting methodology to show geographic distribution by ZIP code**

1760 The ZIP code data on where participants reside has been a staple of behavioral health sales tax  
1761 reporting to date. During the 2028-2034 implementation period, DCHS ~~intends to shall~~ expand  
[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic](#)  
[Framework](#)

Page | 50

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Behavioral Health Bridge reporting to include expenditures by ZIP code for each program or strategy. ZIP code data will be reported using maps or other visualizations to aid interpretation of the data. All reporting by ZIP code will continue to abide by privacy and confidentiality guidelines to ensure individuals cannot be identified.

Beginning with the online dashboard update that reflects 2028 calendar year data and through the 2028-2034 implementation period, the Behavioral Health Bridge evaluation team will report program and strategy expenditures by ZIP code. The methods and dissemination practices for reporting expenditures by ZIP code will be aligned with the approaches implemented in 2023 for Best Starts, 2024 for VSHSL, and 2025 for the CCC Levy. These approaches utilize provider locations and participant residences, recognizing that Behavioral Health Bridge partners provide a mix of virtual, mobile, and in-person programs and services. Reporting by contracted service providers' location may not fully capture the reach of services, and alternatively, reporting by participants' residence may not capture the difficulties some participants have in accessing services, including transportation. Many program participants access programs in more than one way. Using this combined methodology to assess expenditures by ZIP code can help deepen understanding of how programs are accessible to people throughout the county.

Collection of program participant ZIP code data may be limited for some programs. The limitations include activities associated with, but not limited to, mobile programs or programs serving people experiencing homelessness, refugees, people experiencing acute behavioral health crisis, or people who are survivors of trauma or domestic, sexual, or gender-based domestic violence. Geographic information may also not be available or relevant for programs and strategies that invest in systems and environment change and strategies that support systemwide capacity building. ZIP code collection may also not be possible for programs that are required to use an existing data system that DCHS cannot revise, or when a legal framework prevents the sharing of these data. All reporting by ZIP code will continue to abide by privacy and confidentiality guidelines. All data collection for the Behavioral Health Bridge is grounded in the principle that data collection should never be a barrier to individuals accessing necessary services.

Whenever possible, when reporting on standardized outcome measures, the data should be broken down by Council District in addition to countywide so that the collective impact of Bridge programs can be assessed by geographic area.

#### Aligning performance measurement with other dedicated human services initiatives

The health and human services needs of King County residents span the boundariesoutstrip the sources of federal, state, and local funding. Revenue from the Behavioral Health Bridge, along with VSHSL, Best Starts, the CCC Levy, and HTH constitute a substantial portion of local human services investments. DCHS staff coordinated planning efforts across these initiatives during the development of this Phase 1 implementation Pplan, as many of these human services funding streams will require renewal during the course of the next Behavioral Health Bridge2028-2034 implementation period. The overlapping funding renewal timelines offer opportunities to innovate and adapt to emerging community needs over the course of Behavioral Health Bridge implementation.

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 51

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1807 In response to a 2018 budget proviso, DCHS invested heavily in data systems and infrastructure to  
1808 responsibly collect, manage, and share information, with the goal to make data widely accessible  
1809 and to direct programming and policy decisions.<sup>132</sup> These investments have made new data  
1810 products possible, including dashboards, that provide insight on participants in programs and  
1811 activities and how they access services, as well as how investments and services are  
1812 geographically distributed. Using these tools, DCHS collaborates with **service** participants,  
1813 contracted **service** providers, and **internal direct services** County staff **directly providing services** to  
1814 collect high-quality data, review program performance, and develop and monitor quality  
1815 improvement initiatives.

1816  
1817 In 2022, DCHS released a consolidated dashboard to report data on MIDD, Best Starts, and VSHSL  
1818 funded services.<sup>133</sup> In 2023, the consolidated dashboard added data for all programs and activities,  
1819 including those that were federally funded, in the Behavioral Health and Recovery Division and the  
1820 Developmental Disabilities and Early Childhood Supports Division. In 2025, this dashboard was  
1821 expanded to include further information from all DCHS divisions. With all of these data sources  
1822 now represented, the dashboard transparently shares how the department's investments  
1823 strengthen the communities of King County.

#### 1824 **Population indicators**

1825 The Behavioral Health Bridge evaluation team will monitor critical population indicators related to  
1826 behavioral health, disaggregated by demographic characteristics (such as age, race, ethnicity,  
1827 place, and gender) where data are available. These measures could include countywide metrics  
1828 such as the size of the adult carceral population with known behavioral health conditions, the rate  
1829 of overdose fatalities, or the number of behavioral health **contracted service** providers serving  
1830 youth. King County measurement of population-level indicators is expected to focus on how they  
1831 change over time in both size and demographic composition. Where relevant, population-level  
1832 indicators are intended to align with the Executive Office's performance measurement approach.

1833  
1834 While the goal is for Behavioral Health Bridge programs and strategies to work in combination to  
1835 impact population-level outcomes in the long term, multiple factors influence these measures.  
1836 Therefore, Behavioral Health Bridge evaluation efforts will not attribute changes in population  
1837 indicators, positive or negative, to Behavioral Health Bridge investments alone. Population  
1838 accountability may be tracked and monitored for Behavioral Health Bridge strategy areas, though  
1839 programs and strategies will be measured on performance accountability.

1840  
1841 Population-level measures, such as number of people experiencing behavioral health crisis or the  
1842 number of people booked into jail are influenced by many extenuating factors (such as state policy,  
1843 criminal-legal system practices, judicial sentencing alternatives, underlying social and economic  
1844 factors, broader resource constraints, and more). Except for randomized controlled trial  
1845 evaluations, which can be cost-prohibitive and often present political, operational, and feasibility  
1846 challenges, Behavioral Health Bridge monitoring and evaluation will not be able to definitively  
1847 provide causal evidence that intervention led to population-level outcomes. However, these  
1848 measures provide crucial information on King County residents and can indicate overall areas for  
1849 further investment or changes in approach.

King County Behavioral Health Bridge Implementation Plan 2028-2034 **Phase 1: Transition Strategic Framework**

Page | 52

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## 1850 In-depth evaluation

1851 Behavioral Health Bridge investments include many programs with existing evidence bases, as well  
1852 as new, innovative programs or adaptations to evidence-based programs. In-depth evaluation  
1853 provides an opportunity to inform program decision making and ensure that programs are effective  
1854 through the combination of qualitative and quantitative data with rigorous, tested methodological  
1855 approaches. The ability to conduct in-depth evaluations will be different for each program and  
1856 strategy, depending on the availability of reliable data, sufficient and representative enrollment in  
1857 programs, and the time needed for data collection and analysis.

1858  
1859 Behavioral Health Bridge evaluators intend to prioritize projects for in-depth evaluation as capacity  
1860 allows in collaboration with program staff and the provider community using the following criteria:

- 1861 • **High interest from partners, including:** the Executive, King County Council, [King County](#)  
1862 Behavioral Health Bridge Advisory Committee, community-based organizations, DCHS  
1863 leadership, grantees, the public, or program participants.
- 1864 • **High potential to improve equity** by identifying disproportionalities in service access and  
1865 engagement or improvement in services for historically underserved communities and  
1866 communities most in need. This includes evaluating how programs contribute to breaking  
1867 cycles of addiction, homelessness, and incarceration in communities disproportionately  
1868 affected by the behavioral health, housing, and criminal-legal systems.
- 1869 • **New programming or novel implementation** of pilot programs, or existing programs in  
1870 new settings or among different populations, to expand the evidence base for services and  
1871 effective program adaptations.
- 1872 • **High-quality data** with sustainable and robust sources of information that enable King  
1873 County staff to track changes over time.

1874  
1875 In-depth evaluation design is expected to be based on what is appropriate for the program's stage  
1876 of implementation. Design options include, but are not limited to, developmental evaluation,  
1877 process evaluation, and outcomes evaluation. Examples of in-depth evaluation may include case  
1878 control or quasi-experimental designs that include resource intensive data collection. To conduct  
1879 such evaluations for the Behavioral Health Bridge, DCHS may contract with external research  
1880 partners or engage in public-private partnerships to augment its own data collection,  
1881 measurement, and evaluation work.

## 1883 Data and evaluation for decision-making

1884 Data collection and analysis will be used to inform decision-making and continuously improve  
1885 outcomes. Contracted service providers will be responsible for achieving goals and objectives and  
1886 DCHS will monitor results to facilitate operational improvements and make adjustments to  
1887 contracts over time. DCHS will regularly meet with the Executive Office, leaders, analysts and  
1888 subject matter experts to review investment performance across the Behavioral Health Bridge  
1889 portfolio and discuss opportunities for system learning and improvement. Performance  
1890 measurement and evaluation information will inform Executive budget proposals, alongside  
1891 program context, community need, and other relevant factors, to strengthen services and the  
1892 overall approach of the Bridge investments.

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## VIII. Reporting for continuous improvement and accountability

At the time of the writing of this plan adoption, DCHS is working to capture, share, and evaluate King County Behavioral Health Bridge information through a variety of methods that did not exist when the behavioral health sales tax was last renewed. This includes:

- **Consolidated Reporting via DCHS Dashboard:** In response to a 2018 proviso, DCHS developed the capacity to report across programs and funding streams by analyzing large amounts of data from hundreds of contracted service providers without duplicating service the counting of participants.<sup>134,135</sup> This effort resulted in the consolidated DCHS Dashboard.<sup>136</sup> While the 2018 proviso asked for reporting on the combined impact of Best Starts, MIDD, and the VSHSL, the DCHS Dashboard also reports on King County residents' participation in services funded by the CCC Levy, the Health Through Housing sales tax, and the KCICN (mostly Medicaid-funded), among other components of the DCHS budget.
- **Behavioral Health Bridge Dashboard:** The Behavioral Health Bridge Dashboard, formerly known as the MIDD Dashboard, portrays data about who participates in Bridge-funded services, where they live and access services, and how those services impact their lives.<sup>137</sup> Offered in an interactive format, the dashboard provides a snapshot across the entire investment portfolio or by strategy area. It also makes it possible for users to focus on the performance of a single program. The dashboard also offers financial information about the Behavioral Health Bridge.
- **Comprehensive Contract Management:** In 2024, DCHS implemented new contract management software, Agiloft, that supports the department's procurement, contracting, and invoicing activities. Agiloft centralizes and standardizes information about DCHS' contracted service providers, including where their brick-and-mortar offices are located. This allows for more complete and consistent reporting of the geographic location of services throughout the region.
- **Enhancements to whole-county monitoring:** Executive Office-led base budget analysis and development of an ongoing monitoring structure in collaboration with DCHS and other County partners-agencies will enhance collaboration and a shared understanding of non-contracted programs. County agencies will continue to participate in standard DCHS-led reporting, with the Executive Office playing a lead role in supporting alignment between County agencies. Results from monitoring will inform both operational adjustments and budget decisions to better achieve intended outcomes.

These advancements will allow for action-oriented reporting using recent data to facilitate continuous improvement and operational adjustments. DCHS and the Executive will offer an annual briefing to Council coinciding with the release of annual dashboard updates to report on Results Based Accountability indicators and planned or implemented improvements.

As part of this comprehensive performance data collection, assessment, and reporting, the Executive will transmit a biennial report to Council detailing the programs and services funded by the Behavioral Health Bridge that will be transmitted no later than August 31 every other year. Each report will focus on data from the prior two calendar years. The first report, to be provided by August 31, 2030, will report on data from calendar years 2028 and 2029. Subsequent biennial reports will be provided by August 31, 2032, and August 31, 2034. The Advisory Committee

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 54

described in this [Phase 1 Implementation pPlan](#) will review and provide guidance on the biennial reports. The Executive will make the reports available widely to the Council, the Regional Policy Committee, and the community through DCHS' communication channels.<sup>138</sup> ~~of this plan will review and provide guidance on the biennial reports. The Executive will make the reports available widely to the Council, the Regional Policy Committee, and the community through DCHS' communication channels.~~

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Biennial reports about the Behavioral Health Bridge will include the following:

- An overview of Behavioral Health Bridge accomplishments during the previous two calendar years, and a description of continuous improvement changes that have been implemented based on performance results, as well as planned operational adjustments to improve performance when applicable;
- The Behavioral Health Bridge fund's fiscal and performance management during the applicable calendar years;
- The expenditure of Behavioral Health Bridge proceeds by strategy area by ZIP code in King County as described in [Subsection VII.B Subsection VII.B.](#);
- ~~The expenditure of Behavioral Health Bridge proceeds by strategy area by ZIP code in King County as described in~~ The number of ~~individuals participants~~ receiving Behavioral Health Bridge-supported services by strategy area by ZIP code where the individuals reside at the time of service as described in [Subsection VII.B Subsection VII.B.](#);
- A map or summary describing the Behavioral Health Bridge's geographic distribution, ~~including by Council District;~~
- ~~Reporting on standardized outcome measures by Council District, whenever possible, so the collective impact of Bridge activities can be assessed by strategy area and across the county;~~ and
- Summaries of findings from in-depth evaluations related to Behavioral Health Bridge programs, and actions taken or planned based on those findings in years where such findings are available.

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The Executive will accompany each biennial report with a motion acknowledging receipt of the report. The Executive will be prepared to brief the King County Council or its committees, including the Regional Policy Committee, on the biennial report to inform the Council's consideration of this motion.

~~Starting in 2031, in each year a biennial report is not transmitted to Council, the Executive shall transmit an abbreviated annual update on Behavioral Health Bridge activities summarizing the following:~~

- ~~1. Expenditures by strategy area.~~
- ~~2. Number of individuals served by strategy area.~~
- ~~3. Relevant outcomes by strategy area, and~~
- ~~4. Notable financial information including:~~
  - ~~a. Any substantial adjustments made to the financial plan,~~
  - ~~b. The calculation of any undesignated fund balance or underspend, the amount identified, and~~
  - ~~c. Any activities paid for with those monies.~~

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 55

1986 During the procurement process from 2027-2029, the Executive shall transmit the Phase 2  
1987 Implementation Plan in accordance with Section XI, including all pre-procurement development  
1988 plans.  
1989  
1990

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**Commented [SP68]:** Requires an abbreviated reporting process for off-years from the biennial reports, starting in 2031.

## 1991 IX. Financial plan and policies

### 1992 A. Overview

1993 This section describes the plans and policies for ~~King County~~ Behavioral Health Bridge revenues  
1994 and expenditures for the period of 2028-~~through~~ 2034 based on current available information. The  
1995 financial plan in this section includes a sustainability reserve to mitigate a projected reduction in  
1996 2029 behavioral health sales tax revenues and assumes most economic adjustments for  
1997 ~~contracted service~~ providers are maintained through 2034.

2001 Beginning on January 1, 2029, many products and services will become exempt from sales tax in  
2002 Washington State, including diapers, hygiene products, over-the-counter medications, information  
2003 technology services, software, security and safety, temporary staffing services, and live  
2004 performances, as a result of changes made during the 2026 state legislative session.<sup>139</sup> These  
2005 reductions in the sales tax base have a direct impact on the Behavioral Health Bridge, decreasing  
2006 projected sales tax revenue by 3.55 percent between 2028 and 2029.<sup>140</sup> At the same time, as  
2007 discussed in [Section X](#), DCHS' inflation policy is designed to ensure, whenever possible, that  
2008 County funding for human services programs keeps up with the rising costs to deliver services.<sup>141</sup>

2010 The financial plan shown in Figure 23 represents the best available estimates of projected revenue  
2011 and planned expenditures ~~as of at the time of the plan's drafting adoption~~. However, during the ~~next~~  
2012 ~~2028-2034~~ implementation period, multiple factors could potentially drive changes to Bridge  
2013 spending:

- 2014 • **The Executive's Breaking the Cycle Workgroup** will provide recommendations that may  
2015 influence the way collaboration works across and within programs.<sup>142</sup>
- 2016 • **The competitive procurement process** may identify organizations with different  
2017 approaches to achieving Bridge goals.
- 2018 • **A continuous focus on shifting Bridge costs to Medicaid or other Ccounty funds such**  
2019 **as but not limited to the CCC Levy, Best Starts, or VSHSL that may have closer**  
2020 **alignment with the program goal.** This may mean up-front investment of Behavioral  
2021 Health Bridge funds to sustain services but potential reallocation of funding over time as  
2022 Medicaid replaces local dollars or funds are shifted between levies.
- 2023 • **Federal changes to Medicaid** may require the Bridge to shift to support populations and  
2024 services that are no longer eligible for Medicaid reimbursement.<sup>143</sup>
- 2025 • **Base budget analyses for all programs** are expected to right-size programs in other  
2026 ~~departments and County~~ agencies and reveal opportunities for better collaboration.<sup>144</sup>
- 2027 • **Rigorous performance measurement of contracts** is expected to drive future investment  
2028 decisions.
- 2029 • **Performance and outcome monitoring systems** will inform decisions about investments  
2030 with a focus on real results for people, as described in [Section VII](#) ~~of this plan~~.
- 2031 • As a **sales tax levy**, Behavioral Health Bridge revenues can be volatile and fluctuations in  
2032 revenue projections may drive budget adjustments. Specific investment amounts will  
2033 depend on fund availability at the time of procurement.

2035 As a result, ~~this the Behavioral Health Bridge Implementation Pplan~~ includes processes for  
2036 adapting Behavioral Health Bridge expenditures to these or other changing conditions. Policies

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 57

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Commented [JN72]: Changes to reflect the splitting of Phase 1 and Phase 2. This is intended to refer to the entire plan (Phase 1 and 2)

2037 relating to the processes for adjusting sales tax allocations, allocating undesignated fund balance,  
2038 and implementing the DCHS inflation policy can be found in Subsection IX.C and  
2039 Section X.

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## B. Financial plan

**Figure 23: Anticipated Behavioral Health Bridge Sales Tax Revenues and Expenditures 2028-2034 (in millions)\***

|                                                                 | 2028            | 2029            | 2030            | 2031            | 2032            | 2033            | 2034            | Total           |
|-----------------------------------------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Projected Beginning Fund Balance                                | \$ 19.5         | \$ 23.4         | \$ 20.4         | \$ 19.0         | \$ 18.8         | \$ 19.2         | \$ 19.8         |                 |
| <b>PROJECTED REVENUE</b>                                        |                 |                 |                 |                 |                 |                 |                 |                 |
| Projected Sales Tax Revenue                                     | \$ 107.6        | \$ 103.7        | \$ 108.7        | \$ 112.9        | \$ 116.2        | \$ 120.5        | \$ 124.2        | \$ 793.8        |
| Projected Annual Interest                                       | 0.7             | 0.8             | 0.7             | 0.6             | 0.6             | 0.6             | 0.7             | 4.8             |
| <b>Total Revenue</b>                                            | <b>\$ 108.3</b> | <b>\$ 104.5</b> | <b>\$ 109.4</b> | <b>\$ 113.6</b> | <b>\$ 116.8</b> | <b>\$ 121.2</b> | <b>\$ 124.8</b> | <b>\$ 798.6</b> |
| <b>APPROXIMATE EXPENDITURE ALLOCATION BY STRATEGY</b>           |                 |                 |                 |                 |                 |                 |                 |                 |
| Strategy Area 1: Care Transitions and Diversion Services        | \$ 36.7         | \$ 32.5         | \$ 33.3         | \$ 34.1         | \$ 34.9         | \$ 35.9         | \$ 36.9         | \$ 244.4        |
| Strategy Area 2: SUD Treatment and Recovery                     | 19.5            | 20.2            | 20.8            | 21.4            | 21.9            | 22.6            | 23.4            | 149.6           |
| Strategy Area 3: Equitable Access to Behavioral Health Care     | 16.1            | 16.5            | 17.0            | 17.5            | 17.9            | 18.6            | 19.2            | 122.9           |
| Strategy Area 4: Child, Youth, and Young Adult Mental Wellbeing | 11.2            | 11.7            | 12.2            | 12.5            | 12.8            | 13.4            | 13.9            | 87.8            |
| Strategy Area 5: Behavioral Health Workforce Development        | 1.3             | 6.6             | 6.8             | 7.0             | 7.1             | 7.6             | 8.0             | 44.3            |
| Technical Assistance & Capacity Building                        | 0.5             | 0.5             | 0.5             | 0.6             | 0.6             | 0.6             | 0.6             | 4.0             |
| Administration & Compliance                                     | 8.5             | 8.8             | 9.0             | 9.3             | 9.5             | 9.7             | 9.9             | 64.8            |
| Performance Measurement & Evaluation                            | 2.5             | 2.6             | 2.7             | 2.7             | 2.8             | 2.9             | 2.9             | 19.0            |
| Behavioral Health Fund Transfer                                 | 8.0             | 8.3             | 8.5             | 8.7             | 9.0             | 9.2             | 9.4             | 60.9            |
| <b>Total Expenditures</b>                                       | <b>\$ 104.4</b> | <b>\$ 107.5</b> | <b>\$ 110.8</b> | <b>\$ 113.8</b> | <b>\$ 116.5</b> | <b>\$ 120.5</b> | <b>\$ 124.2</b> | <b>\$ 797.7</b> |
| <b>ENDING FUND BALANCE AND RESERVES</b>                         |                 |                 |                 |                 |                 |                 |                 |                 |
| Ending Fund Balance                                             | \$ 23.4         | \$ 20.4         | \$ 19.0         | \$ 18.8         | \$ 19.2         | \$ 19.8         | \$ 20.4         |                 |
| Rainy Day Reserve (60 Days of Expenditure)                      | \$ 17.2         | \$ 17.7         | \$ 18.2         | \$ 18.7         | \$ 19.2         | \$ 19.8         | \$ 20.4         |                 |
| Sustainability Reserve                                          | 6.3             | 2.7             | 0.8             | 0.1             | -               | -               | -               |                 |
| <b>Total Reserves</b>                                           | <b>\$ 23.4</b>  | <b>\$ 20.4</b>  | <b>\$ 19.0</b>  | <b>\$ 18.8</b>  | <b>\$ 19.2</b>  | <b>\$ 19.8</b>  | <b>\$ 20.4</b>  |                 |

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Commented [SP73]: Inserts a new financial plan to reflect the shifting of Bridge dollars from SUD Goal 2 to Equitable Access Goal 1 to fund EA Goal 1 at \$16.6M annually during the levy period

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|                                                                           |                |                |                |                |                |                |                |                |
|---------------------------------------------------------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
| <b>Projected Beginning Fund Balance</b>                                   | <b>\$19.5</b>  | <b>\$23.4</b>  | <b>\$20.4</b>  | <b>\$19.0</b>  | <b>\$18.8</b>  | <b>\$19.2</b>  | <b>\$19.8</b>  |                |
| <b>Behavioral Health Bridge Sales Tax Projected Revenue (2028 - 2034)</b> |                |                |                |                |                |                |                |                |
|                                                                           | <b>2028</b>    | <b>2029</b>    | <b>2030</b>    | <b>2031</b>    | <b>2032</b>    | <b>2033</b>    | <b>2034</b>    | <b>Total</b>   |
| <b>Projected Sales Tax Revenue</b>                                        | <b>\$107.6</b> | <b>\$103.7</b> | <b>\$108.7</b> | <b>\$112.9</b> | <b>\$116.2</b> | <b>\$120.5</b> | <b>\$124.2</b> | <b>\$793.8</b> |
| <b>Projected Annual Interest</b>                                          | <b>\$0.7</b>   | <b>\$0.8</b>   | <b>\$0.7</b>   | <b>\$0.6</b>   | <b>\$0.6</b>   | <b>\$0.6</b>   | <b>\$0.7</b>   | <b>\$4.8</b>   |
| <b>Total Revenue</b>                                                      | <b>\$108.3</b> | <b>\$104.5</b> | <b>\$109.4</b> | <b>\$113.6</b> | <b>\$116.8</b> | <b>\$121.2</b> | <b>\$124.8</b> | <b>\$798.6</b> |

|                                                                                            |               |               |               |               |               |               |               |                |
|--------------------------------------------------------------------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|----------------|
| <b>Behavioral Health Bridge Sales Tax Approximate Allocation by Strategy (2028 - 2034)</b> |               |               |               |               |               |               |               |                |
|                                                                                            | <b>2028</b>   | <b>2029</b>   | <b>2030</b>   | <b>2031</b>   | <b>2032</b>   | <b>2033</b>   | <b>2034</b>   | <b>Total</b>   |
| <b>Strategy Area 1: Care Transitions and Diversion Services</b>                            | <b>\$36.7</b> | <b>\$32.5</b> | <b>\$33.3</b> | <b>\$34.1</b> | <b>\$34.9</b> | <b>\$35.9</b> | <b>\$36.9</b> | <b>\$244.4</b> |
| <b>Strategy Area 2: SUD Treatment and Recovery</b>                                         | <b>\$14.9</b> | <b>\$15.9</b> | <b>\$16.9</b> | <b>\$17.8</b> | <b>\$18.6</b> | <b>\$19.6</b> | <b>\$20.7</b> | <b>\$124.4</b> |
| <b>Strategy Area 3: Equitable Access to Behavioral Health Care</b>                         | <b>\$20.7</b> | <b>\$20.8</b> | <b>\$20.9</b> | <b>\$21.1</b> | <b>\$21.2</b> | <b>\$21.6</b> | <b>\$21.9</b> | <b>\$148.2</b> |
| <b>Strategy Area 4: Child, Youth, and Young Adult Mental Wellbeing</b>                     | <b>\$11.2</b> | <b>\$11.7</b> | <b>\$12.2</b> | <b>\$12.5</b> | <b>\$12.8</b> | <b>\$13.4</b> | <b>\$13.9</b> | <b>\$87.8</b>  |
| <b>Strategy Area 5: Behavioral Health Workforce Development</b>                            | <b>\$1.3</b>  | <b>\$6.6</b>  | <b>\$6.8</b>  | <b>\$7.0</b>  | <b>\$7.1</b>  | <b>\$7.6</b>  | <b>\$8.0</b>  | <b>\$44.3</b>  |
| <b>Technical Assistance &amp; Capacity Building</b>                                        | <b>\$0.5</b>  | <b>\$0.5</b>  | <b>\$0.5</b>  | <b>\$0.6</b>  | <b>\$0.6</b>  | <b>\$0.6</b>  | <b>\$0.60</b> | <b>\$4.0</b>   |

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 60

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|------------------------------------------------|---------|---------|---------|---------|---------|---------|---------|---------|
| Administration & Compliance                    | \$8.5   | \$8.8   | \$9.0   | \$9.3   | \$9.5   | \$9.7   | \$9.9   | \$64.8  |
| Performance Measurement & Evaluation           | \$2.5   | \$2.6   | \$2.7   | \$2.7   | \$2.8   | \$2.9   | \$2.9   | \$19.0  |
| Behavioral Health Fund Transfer:               | \$8.0   | \$8.3   | \$8.5   | \$8.7   | \$9.0   | \$9.2   | \$9.4   | \$60.9  |
| Total Behavioral Health Bridge Sales Tax Costs | \$104.4 | \$107.5 | \$110.8 | \$113.8 | \$116.5 | \$120.5 | \$124.2 | \$797.7 |
| Ending Fund Balance                            | \$23.4  | \$20.4  | \$19.0  | \$18.8  | \$19.2  | \$19.8  | \$20.4  | -       |
| Rainy Day Reserve (60 Days of Expenditure)     | \$17.2  | \$17.7  | \$18.2  | \$18.7  | \$19.1  | \$19.8  | \$20.4  | -       |
| Long-Term Sales Tax Sustainability Reserve     | \$6.3   | \$2.7   | \$0.8   | \$0.1   | \$0     | \$0     | \$0     | -       |
| Undesignated Fund Balance/Reserve Shortfall    | \$0     | \$0     | \$0     | \$0     | \$0     | \$0     | \$0     | -       |

\*Totals may not sum exactly due to rounding.

## 2046 Allocations across the five strategy areas

2047 Figure 23 depicts how ~~this plan annually allocates~~ Behavioral Health Bridge revenues ~~will be~~  
2048 ~~allocated annually~~ across the five strategy areas. Detailed descriptions of goals, intended  
2049 outcomes and anticipated expenditures within each area can be found in the following  
2050 subsections:

- 2051 • ~~VI.A.: Care Transitions and Diversion Services~~ and ~~XI.E. Logic Model and Anticipated~~  
2052 ~~ActivitiesAppendix F~~
- 2053 • ~~VI.B.: Substance Use Disorder Treatment and Recovery~~ and ~~XI.F. Logic Model and~~  
2054 ~~Anticipated ActivitiesAppendix G~~
- 2055 • ~~VI.C.: Equitable Access to Behavioral Health Care~~ and ~~XI.G. Logic Model and Anticipated~~  
2056 ~~ActivitiesAppendix H~~
- 2057 • ~~VI.D.: Child, Youth, and Young Adult Mental Wellbeing~~ and ~~XI.H. Logic Model and~~  
2058 ~~Anticipated ActivitiesAppendix I~~
- 2059 • ~~VI.E.: Behavioral Health Workforce Development~~ and ~~XI.I. Logic Model and Anticipated~~  
2060 ~~ActivitiesAppendix J~~

2061  
2062 Figure 23 also reflects changes to funding amounts in 2028 and 2029 due to the phased  
2063 procurement and base budget analyses scheduled to take place during those years, as described  
2064 in [Subsection V.B.](#) Increases and decreases in strategy area spending in the first two years reflect  
2065 phased procurement and reprioritization of investments as the Executive works to rebalance the  
2066 Behavioral Health Bridge portfolio to focus on the most pressing needs for King County's publicly  
2067 funded behavioral health system. Some reductions also reflect plans to move investments to other  
2068 fund sources. The estimated expenditures for each strategy area are projections based on current  
2069 information.

## 2070 Technical assistance and capacity building

2071 For the first time, beginning in 2028 the Behavioral Health Bridge will provide funding for technical  
2072 assistance and capacity building activities to support the implementation of the goals described in  
2073 ~~the Behavioral Health Bridge Implementation Plan~~. Through investments like the Bridge, DCHS  
2074 strives to partner with organizations that serve, and are led by, their own communities.  
2075 Community-led organizations are best positioned to implement programs that will have positive  
2076 impacts on the members of their communities. DCHS recognizes that many organizations, and the  
2077 communities they serve, have historically experienced barriers to accessing funding opportunities  
2078 from government agencies such as King County. Technical assistance is intended to meet  
2079 organizations where they are and to support them in understanding King County's contract  
2080 requirements and assist them in developing capacity to manage public funds.

2081  
2082 The Bridge will provide funding for technical assistance and capacity building activities to support  
2083 the implementation of the goals described in this ~~Phase 1 Implementation Plan~~. After contracts  
2084 are awarded, technical assistance and capacity building offer provision and co-creation of  
2085 information, tools, and resources to strengthen the infrastructure of ~~those community-led~~  
2086 ~~organizations selected to provide contracted servicesBehavioral Health Bridge-funded~~  
2087 ~~organizations~~, particularly in areas of fiscal management, documentation, and reporting, as well as  
2088 opportunities for areas with service gaps to build capacity. DCHS will set aside 0.5 percent of  
2089 revenues toward these activities.

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 62

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2091 To the degree funding is available, technical assistance should be made available to prospective  
2092 applicants before and during each procurement window on the same basis as other County  
2093 procurement processes, in addition to post-award technical assistance and capacity building.

#### 2094 Administration and compliance

2095 The Behavioral Health Bridge will increase the proportion of funds supporting administrative  
2096 functions in 2028-2034. DCHS is working to enhance its fiscal controls and contract management  
2097 in response to the results of a 2025 audit.<sup>145,146</sup> This process requires additional staff to ensure  
2098 enough resources are in place for proper contract monitoring and quality assurance. The level of  
2099 administrative funding reflected in the financial plan (Figure 23) will better support DCHS to  
2100 conduct all required contract monitoring and fraud prevention activities for Behavioral Health  
2101 Bridge programs, as well as program development, procurements and continuous quality  
2102 improvement.

#### 2103 Performance measurement and evaluation

2104 The Behavioral Health Bridge increases the proportion of funds allocated to measurement and  
2105 evaluation in 2028-2034. These investments fund a team of skilled staff, the development and  
2106 maintenance of robust data systems, assessment and analysis of Behavioral Health Bridge  
2107 programs, and partnerships with external evaluators and subject matter experts. such as the  
2108 University of Washington's Institute for Health Metrics and Evaluation. Third-party evaluation  
2109 should be done every three years, as existing resources allow. With this investment, the Executive  
2110 intends to develop insights that enable contracted service providers, communities, and  
2111 policymakers to make data-informed decisions and engage in continuous quality improvement  
2112 efforts. More information about the performance measurement and accountability strategies for  
2113 the next iteration of the Behavioral Health Bridge is in [Section VII](#).

#### 2114 Behavioral Health Fund transfer

2115 The Behavioral Health Bridge maintains a similar level of funding ~~to as~~ MIDD 2 for a transfer to the  
2116 Behavioral Health Fund. King County operates a unique behavioral health delivery system  
2117 incorporating a public-private partnership for delivering community behavioral health care, a  
2118 nation-leading crisis care system, and innovative local services to provide access to care  
2119 regardless of insurance or immigration status. A key component is the Behavioral Health Fund,  
2120 which collects and redistributes dollars that underwrite King County's ability to administer the  
2121 complex behavioral health system, which leverages over 140 funding sources to develop and  
2122 sustain life-saving community-based programs. The behavioral health sales tax has supported the  
2123 Behavioral Health Fund with a transfer of resources since 2021. This strategic resource supports  
2124 BHRD's organizational infrastructure and ability to continue administering and monitoring  
2125 Behavioral Health Bridge programs and the broader behavioral health treatment and support  
2126 system. It also ensures that King County can continue to deliver on its promise of a diverse and  
2127 high-quality network that is widely available to meet residents' expectations and needs.

#### 2128 Sustainability reserve

2129 The 2026 state law changes in-state-law decreasing the number of products and services subject to  
2130 sales tax described earlier in this section require a new mechanism to ensure program stability in  
2131 the Behavioral Health Bridge. In order to maintain program commitments despite an abrupt  
2132 decrease in projected sales tax revenue in 2029, the financial plan in Figure 23 includes a  
2133 sustainability reserve. This sets aside money in 2028 to be spent down slowly through 2031. This is

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 63

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**Commented [PS75]:** Allows for providing technical assistance to applicants before and during procurement, and after awards have been made, to the degree funding is available.

**Commented [PS76]:** Includes the UW Institute for Health Metrics and Evaluation as a possible third-party evaluator that DCHS could engage, and states that such evaluations should occur every three years to the degree finances allow.

2134 in addition to the rainy-day reserve called for by the County's comprehensive financial  
2135 management policies and is expected to enable the County to sustain Bridge-funded programs  
2136 despite volatile revenue.<sup>147</sup> The sustainability reserve is not intended to be an undesignated fund  
2137 balance. Reappropriating it to fund programs and services in the short term would create  
2138 significant reserve shortfalls for the remaining six years of the 2028-2034 Behavioral Health Bridge  
2139 planning period.

### 2141 C. Fiscal policies

2142 This subsection describes policies for making and communicating about substantial adjustments  
2144 to Behavioral Health Bridge expenditures, and priorities for allocating undesignated fund balance.

#### 2145 Process for making substantial adjustments to the financial plans

2146 This part of this subsection describes the process of communicating and making substantial  
2147 adjustments to the Bridge's financial plan, which is consistent with the change process for the HTH  
2148 sales tax and VSHSL, CCC, and Best Starts levies. A substantial adjustment is a change or series of  
2149 changes within the same calendar year to a strategy area's annual funding allocation by the greater  
2150 of ten percent or more, or \$500,000 within a 24-month period, elimination of an existing activity, or  
2151 a redesign of an activity that substantially changes the population served or eligibility for  
2152 service. <sup>148, 149</sup>

2154 A change is not considered a substantial adjustment if it is due to additional Behavioral Health  
2155 Bridge sales tax revenue or other funding sources becoming available. In this scenario, the  
2156 additional sales tax revenue should be allocated according to the priorities described in the next  
2157 subsection and cannot reduce another strategy area's allocation. In addition, behavioral health  
2158 sales tax proceeds that are not spent within a strategy area may be retained within the same  
2159 strategy area for use in a subsequent year without being considered a substantial adjustment for  
2160 the purpose of this the Behavioral Health Bridge Implementation Pplan.

2162 Substantial adjustments to thethis plan's financial plan will be communicated according to the  
2163 process defined in this subsection, and whenever feasible, such modifications shall incorporate  
2164 briefings to the Behavioral Health Bridge Advisory Committee to allow committee members to  
2165 review and provide guidance on the changes. If, without Council direction or concurrence, the  
2166 Executive determines a substantial adjustment to the funding allocations specified in the financial  
2167 plan is needed, the Executive will transmit a notification letter to Council detailing the scope of and  
2168 rationale for the changes. The Executive may only send notification letters as frequently as twice  
2169 per year when needed. The Executive will electronically file the letter with the Clerk of the Council,  
2170 who will retain an electronic copy and provide an electronic copy to all councilmembers, the  
2171 Council Chief of Staff, the lead staff for the Health, Housing, and Human Services Committee, or  
2172 its successor, and the Regional Policy Committee. Unless the Council passes a motion rejecting  
2173 the contemplated change within 30 days of the Executive's transmittal, the Executive may proceed  
2174 with the change as set forth in the notification letter.

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**Commented [JN77]:** Revises the substantial adjustment to include the greater of 10% or 500,000 within a 24-month period, elimination of existing activity, or redesign

2177 **Priorities for allocating ending undesignated fund balance**

2178 This part of this subsection describes the process for prioritizing allocations of ending  
2179 undesignated fund balance on the financial plan. Ending uUndesignated fund balance may result  
2180 from circumstances such as, but not limited to, Behavioral Health Bridge revenue exceeding this  
2181 plan's revenue projections or Bridge revenue becoming available because other funding sources  
2182 (including federal, state, or philanthropic sources) are contributing funding toward Bridge strategy  
2183 areas and goals at a higher level than anticipated. Expenditures of Behavioral Health Bridge  
2184 revenues allocated through this prioritization remain subject to the appropriation limits authorized  
2185 through the County's budget process. Any proposals requiring additional appropriation will be  
2186 proposed by the Executive in budget ordinances and be subject to County Council deliberation and  
2187 adoption. The Executive will assess whether ending undesignated fund balance is the result of one-  
2188 time fund availability or represents an opportunity for long-term, sustainable investment.

2190 In the event of an ending undesignated fund balance, whether determined to be one-time or long-  
2191 term in nature, the first 1% shall be used to support a councilmanic innovation and small grant  
2192 program. The Executive shall notify Council of the availability of funds on an annual basis. The  
2193 Council shall provide an equal amount of funding to each Council District office to allocate to  
2194 emerging needs or District-specific pilot programs. Programs that receive fundingBridge support  
2195 shall meet the requirements of RCW 82.14.460(3) and execute a service provider contract.

2197 The Executive intends to shall apply the following priorities to allocate undesignated fund balance  
2198 when the Executive determines that it represents an opportunity for long-term, sustainable  
2199 investment:

- 2200 1. In any year where inflation rates have been reduced due to limited funding availability,  
2201 provide inflationary adjustments to contracted service providers up to the amount of CPI-U  
2202 Seattle inflation rates.
- 2203 2. Augment existing investments to mitigate losses of Medicaid coverage to the degree  
2204 necessary and feasible within available funds. This includes increasing funding to EA Goal  
2205 1, "Provide behavioral health care for low-income people who are ineligible for Medicaid." It  
2206 may also include increasing investment in other programs negatively affected by growth of  
2207 the uninsured rate among the Behavioral Health Bridge's service population.
- 2208 3. Scale high-performing or innovative Behavioral Health Bridge investments to address  
2209 unmet need. The investments to be augmented shall be selected through a process that  
2210 includes Behavioral Health Bridge Advisory Committee consultation and is guided by  
2211 performance and measurement data.

2212 When the Executive determines that fund availability is one-time in nature and cannot reasonably  
2213 support sustained programming, the Executive intends to consider usingshall use these funds for  
2214 one-time investments including capital projects such as building behavioral health facilities or  
2215 housing for people with behavioral health conditions, or in pilot programs that can later transition  
2216 to other funding sources such as Medicaid. When using these one-time funds for capital  
2217 investments, the Executive shall expend funding consistent with existing Behavioral Health Bridge  
2218 goals or activities and within appropriated amounts, or shall obtain Council approval by ordinance  
2219 prior to spending Bridge monies.

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Commented [SP78]: Establishes a councilmanic innovation and small grant program with the first 1% of the ending undesignated fund balance.

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Commented [SP80]: Strengthens language to a requirement, rather than intention

Commented [PS81]: Requiring that Council approval by ordinance is needed prior to spending undesignated fund balance on capital investments.

2222 [Section X](#) below describes strategies that would be applied to the Bridge fund if a deficit or reserve  
2223 shortfall occurs when planned expenditures exceed available revenue. (See [Subsection](#)  
2224 ~~X.C~~[Subsection X.C.](#).)  
2225

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## 2226 X. Inflation rate adjustment policy analysis

2227 This section responds to Ordinance 20023, Section 70, Proviso P1. It examines how the DCHS  
2228 Inflation Rate Adjustment Policy was determined to apply to the Behavioral Health Bridge fund,  
2229 evaluating the financial impact of applying inflationary adjustments that exceed projected revenue  
2230 growth, and assessing whether this dynamic contributes to a structural gap in the fund.<sup>150</sup> The parts  
2231 of this subsection below address each of these questions by describing the policy rationale,  
2232 analyzing the relationship between expenditure growth and revenue projections, and exploring the  
2233 long-term implications for fund stability.

### 2235 A. How the inflation policy was determined to be applicable to the King County 2236 Behavioral Health Bridge

2237 DCHS adopted the Inflation Rate Adjustment Policy for Human Services Contracts on September  
2238 1, 2024.<sup>151</sup> Developed in response to Council interest expressed in a 2021 budget proviso, the  
2239 policy's intent is to promote contract payments that increase with the rate of inflation by directing  
2240 inflation rate adjustments to be applied to all local investments in DCHS human services  
2241 contracts.<sup>152</sup> The application of this policy across local human services funds is important because  
2242 when contract payments do not increase amidst growth in operating costs and living expenses,  
2243 ~~organizations-service providers~~ struggle to maintain service levels or to provide living wages to their  
2244 employees.

2245 The policy directs DCHS to integrate inflation rate adjustments into biennial budget proposals,  
2246 financial plans, and implementation plans when proposed to the Executive and King County  
2247 Council. When Council adoption of these plans allows, DCHS ~~intends to~~ shall implement inflation  
2248 rate adjustments in relevant and applicable program contracts. However, consistent with the  
2249 policy, DCHS plans to implement inflation rate increases only to the degree possible while  
2250 maintaining healthy financial reserves consistent with King County Comprehensive Financial  
2251 Management Policies.<sup>153</sup>

2252 The policy applies to local funding sources managed by DCHS because these funds are under  
2253 greater local control. These sources include both more volatile sales tax sources such as, but not  
2254 limited to, the Behavioral Health Bridge, and less volatile property tax levy sources. As a result, the  
2255 County can design spending plans through implementation plans and budgets that incorporate  
2256 appropriate inflationary adjustments that respond to contracted service providers' need to  
2257 maintain services.

### 2261 B. Analysis of the effect of the inflation rate adjustment policy on the Behavioral 2262 Health Bridge and risk of a structural gap

2263 The inflation rate adjustment policy calls for the Behavioral Health Bridge to incorporate inflation  
2264 factors based on King County's Budget and Financial Planning Assumptions (BFPA).<sup>154</sup> The  
2265 Behavioral Health Bridge fund's projected long-term revenue grows at an average of 2.6 percent per  
2266 year, according to 2026 OEFA data.<sup>155</sup> Because this growth rate falls below typical BFPA provider  
2267 inflation assumptions, the policy has a structural impact on the fund's long-range sustainability.

2268 During the 2028-2034 plan implementation period, the Behavioral Health Bridge is expected to  
2269 continue reflecting inflation adjustments ~~to-for~~ contracted behavioral health programs services,  
2270 tracking-informed by the CPI-U Seattle BFPA inflation rate. If CPI-U inflation assumptions continue  
2271 King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 67

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to track near the current range (generally between three and four percent), Behavioral Health Bridge expenditure growth would outpace revenue growth. Continuing to provide inflation rate increases at a higher rate than sales tax revenue creates a risk of a structural operating gap in the outyears of the ~~plan~~ 2028-2034 implementation period, independent of one-time factors such as beginning fund balance or temporary underspending. Both the inflation policy and the County budget process provide mechanisms to identify these trends and take mitigating actions through fiscal monitoring and appropriation processes.

The inflation rate policy itself does not appropriate funds. It is instead a vehicle for DCHS to propose inflation rate increases to the Executive and the Council for consideration. While the policy directs DCHS to implement the inflation rate increases once they have been adopted by Council, it also includes administrative provisions allowing for the department to delay or suspend the increases in the following circumstances:

- Inflation rate increases will not be implemented until appropriate reserves have been achieved.<sup>156</sup>
- When [the King County Office of Economic and Financial Analysis \(OEFA\)](#) revenue forecasts for a fund source project a decline in fund balance compared to the revenue forecasts used in the adopted budget for that fiscal year, inflation rate increases may be suspended or reduced. Adjustments will resume when positive revenue growth is reflected in the revenue forecasts underlying the adopted budget.<sup>157</sup>

A structural gap is based on the relationship between recurring revenues and recurring expenditures, not on whether the fund has enough cash on hand in any given year. Despite the risks, DCHS is not projecting a structural gap in the Behavioral Health Bridge from 2028 through 2034. However, if inflationary adjustments were included at CPI-U Seattle BFPAs rates every year, the fund would be at risk of not having enough cash to cover expenses after 2028. As a result, maintaining the 2028 service portfolio through 2034 requires temporary changes regarding inflation adjustments in 2029. The steps DCHS will take to mitigate this risk are described in the following subsection.

### C. Process for mitigating fund shortfalls or structural gaps

The financial plan in Figure 23 provides for adequate Behavioral Health Bridge dollars to continue funding critical services throughout the 2028-2034 implementation ~~plan~~ period despite volatility in revenue. To do this while maintaining 60-day operating reserves, the [Behavioral Health Bridge Implementation pPlan](#) provides lower inflation adjustments to eligible [contracted service](#) providers with continuing contracts in 2029, the same year as a projected 3.55 percent decrease in sales tax revenues (as shown in Figure 24 below). This is consistent with the inflation policy, which allows for inflation rate adjustments when revenue forecasts anticipate a decline in underlying revenues.<sup>158</sup>

[Inflation](#) adjustments are not applicable at the start of new contracts, which are calculated as new base budgets, ~~rather than adjusted in comparison to a prior year~~. Because phased implementation will take place throughout 2028 and 2029, some [contracted service](#) providers operating existing programs will be eligible for adjustments in 2028 in the final year of their MIDD 2 contracts, while others will be eligible in 2029 in the second year of their new Behavioral Health Bridge contracts. By 2030, [contracted service providers](#) of new or revised Bridge programs are expected to be in their second or third year, and eligible [contracted service](#) providers ~~delivering programs across the range of Bridge-funded services~~ are expected to receive an inflation adjustment. These adjustments are included in the expenditures projected in the financial plan (Figure 23 above). [King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 68

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The financial projections included in this and other multi-year implementation plans are likely to change over the course of their planning periods. In order to account for this uncertainty, the DCHS inflation policy calls for the financial outlook of the fund to be reviewed annually to confirm funding availability. DCHS most recently completed this review for MIDD in 2025 and determined that behavioral health sales tax funds could be made available to continue inflationary adjustments for 2026 and 2027. The inflationary adjustments were reviewed by the Executive Office, included in the 2026-2027 Executive Proposed budget, and adopted by the County Council through the budget. DCHS ~~intends to~~will reevaluate and confirm 2027 inflation adjustments in late 2026 and to continue these annual reviews throughout the 2028-2034 implementation ~~plan~~period. Each biennial budget process will include an assessment of whether inflationary adjustments can be afforded based on the most recent revenue and expenditure forecasts for the Bridge fund. The budget process provides the Executive Office and Council an opportunity to evaluate, adjust if necessary, and approve any inflationary adjustment budget proposal.

**Figure 24: Projected inflation adjustments for Behavioral Health Bridge contracted ~~service~~ providers, 2028-2034**

| Year | Projected CPI-U Seattle BFPa inflation factor <sup>159</sup> | Projected inflation adjustment to be provided to Bridge-contracted <del>service</del> providers |
|------|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| 2028 | 3.30%                                                        | 3.30%                                                                                           |
| 2029 | 3.11%                                                        | 2.50%                                                                                           |
| 2030 | 2.98%                                                        | 2.98%                                                                                           |
| 2031 | 2.91%                                                        | 2.91%                                                                                           |
| 2032 | 2.34%                                                        | 2.34%                                                                                           |
| 2033 | 2.22%                                                        | 2.22%                                                                                           |
| 2034 | 2.18%                                                        | 2.18%                                                                                           |

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The reduced inflation adjustment in 2029 is intended to enable the County to continue providing critical Behavioral Health Bridge-funded services without exceeding revenues, despite the inherent volatility of the sales tax. Full CPI-U Seattle inflation adjustments will be provided if funds become available, in accordance with the inflation policy and as reflected in the priorities for allocating ~~ending~~undesignated fund balance in [Subsection IX.C](#).

Actual revenues and expenditures inevitably deviate from projections. If a deficit or a reserve shortfall arises in the future, DCHS ~~intends to~~shall consult with the ~~King County~~ Behavioral Health Bridge Advisory Committee ~~and shall notify the Council in writing before to take taking~~ one or more of the following actions ~~to the degree necessary~~:

- **Forgo program expansions and investments in new programs.** Priority will be given to maintaining existing programs and service levels, except for reducing or sunsetting programs for other policy reasons.
- **Prohibit or cap future provider inflation rate increases.** DCHS may suspend or reduce inflation rate adjustments below the rates shown in Figure 24:
  - when revenue forecasts anticipate a decline in fund balance, or
  - if the inflation rate surpasses the rate of growth of the fund's revenue and surpasses the assumed inflation rate in applicable budgets, financial plans, and implementation plans.<sup>160</sup>

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

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**Commented [PS85]:** Requires that DCHS consult with the Behavioral Health Bridge Advisory Committee and notify Council in writing prior to taking action due to a deficit or reserve shortfall.

2356     • **Propose and implement reductions to Behavioral Health Bridge-funded programs or**  
2357     **services.** Reductions to existing programs and service levels are viewed as a last resort. If  
2358     service cuts are necessary, they would be informed by performance outcomes and  
2359     reviewed in advance with the Behavioral Health Bridge Advisory Committee for feedback  
2360     and advice.

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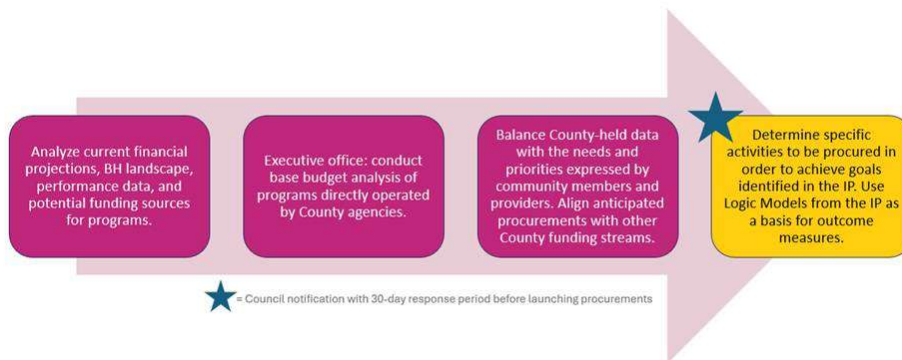
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**Commented [SP86]:** New section creating a Phase 2 reporting requirement. Executive staff would be required to report to Council on the procurement process prior to initiating the procurement process for each strategy. Each notification would include additional information about what each procurement would entail and an invitation for Council to engage in the process. This section also includes the anticipated timeline for procurements and the logic models (previously in the appendices) and Activities that would be procured for each Strategy.

## XI. Requesting Implementation Plan Phase 2: Pre-Procurement Development Plan, and Council Notifications, Council engagement opportunities, and examples of procured activities

As noted and described in Section V.B, the Executive intends to implement competitive procurements for nearly all Behavioral Health Bridge-funded programs that will be implemented through providers. Due to the scale of programs and services supported by the King County Behavioral Health Bridge procurements for all strategy areas, DCHS intends to phase procurements through the first 18 months of the implementation period. This section offers a timeline and the steps to develop procurements for each strategy area, how and when Council will be notified and engaged in the procurement process, and anticipated activities to be procured for in each strategy area.

Figure 25: Anticipated Steps to -Procurement



### A. Pre-procurement Council notification

As shown in Figure 25, once these procurement development steps have been completed for each strategy area, and at least 30 days prior to opening soliciting service providers for a particular a Behavioral Health Bridge strategy area, the Executive will transmit a notification letter to the Council that includes:

- all activities for which services will be procured and the type of service provider, and anticipated dollar range of magnitude for each activity within the strategy area to the degree known at the time of procurement;
- for any existing MIDD 2-supported initiative that will not be continued under the Behavioral Health Bridge Implementation Plan but will be transitioned to another funding source, identification of the proposed funding source, the service provider contracts affected, and information regarding how service levels are changed, including whether they are maintained, expanded, or reduced, and by what amount;
- for any existing MIDD 2-supported initiatives that will not be continued under the Behavioral Health Bridge Implementation Plan and will not be transitioned to another funding source.

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

- 2390 identification of the service provider contracts affected, and information regarding how  
2391 many people the contracts served in the prior year;
- 2392 • the overarching outcomes that programs are expected to work toward;
  - 2393 • specificity for performance metrics anticipated to be applicable to each activity and  
2394 applied to each contracted service provider, including definitions for baseline metrics,  
2395 equity-specific metrics, youth-specific metrics, SUD retention metrics, and standardized  
2396 anticipated reporting cycles, to the degree known at the time of the letter;
  - 2397 • a description of how the strategy area's planned procurements will further the goals and  
2398 recommendations from the Executive's Breaking the Cycle workgroup, where applicable;
  - 2399 • a description of how the strategy area's planned procurements relate to the Behavioral  
2400 Health Strategic Plan report called for by Ordinance 20086, Section 39, Proviso P1;
  - 2401 • a description of how community engagement and service provider input informed the  
2402 formation of the strategy area's planned procurements; and
  - 2403 • any feedback from the Behavioral Health Bridge Advisory Committee regarding the strategy  
2404 area's planned procurements.

2406 The Executive may address multiple strategy areas in a single letter, if appropriate. The Executive  
2407 will electronically file the letter with the clerk of the Council, who will retain an electronic copy and  
2408 provide an electronic copy to all Councilmembers. Unless the Council passes a motion rejecting  
2409 the plans within 30 days of the Executive's transmittal, the Executive may proceed with the  
2410 programs and identified procurements -as set forth in the notification letter.

2412 **B. Council engagement opportunities and notification of awards**

2413 DCHS will notify King County Councilmembers by email when the department announces a  
2414 solicitation. This announcement will include an invitation for the Councilmember or a member of  
2415 the Councilmember's staff to participate on the review panel as a non-scoring member. DCHS  
2416 should also notify the Council at least three days before contract awards are announced,  
2417 identifying the successful contract awardees, and the anticipated contract amount.

2418 **C. Anticipated procurement timeline**

2419 Upon release of a solicitation, DCHS will provide community-based service providers three months  
2420 to apply to open Bridge procurements. Figure 26 shows the anticipated timeline for each strategy  
2421 area's procurements, which lead to the program launch estimates shown in Figure 3 in Subsection  
2422 V.B. To minimize provider burden and service disruption and when appropriate, DCHS aims to  
2423 announce contract award decisions three to six months before launching new or reprocured  
2424 programs. This provides for possible ramp-down periods for programs or service providers that will  
2425 not be receiving continued support under the implementation plan, and time to thoughtfully  
2426 transition ongoing clients and participants between programs and service providers as needed. It  
2427 also allows time to complete all due diligence related to County contracting, establishment of  
2428 evaluation measures, and expectations of program outcomes.

2429 **Figure 26: Procurement Steps and Anticipated Timelines**

| Strategy area | Solicitations<br>announced | Applications<br>due | Awardees<br>announced | Ramp<br>down | Anticipated launch<br>of IP programs and<br>contracts |
|---------------|----------------------------|---------------------|-----------------------|--------------|-------------------------------------------------------|
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|                                                      |         |                |                |              |         |
|------------------------------------------------------|---------|----------------|----------------|--------------|---------|
| SUD Treatment and Recovery (SUD)                     | Q2 2027 | Q3 2027        | End of Q4 2027 | Q1 & 2 2028  | Q3 2028 |
| Equitable Access to Behavioral Health Care (EA)      | Q2 2027 | Q3 2027        | End of Q4 2027 | Q1 & 2 2028  | Q3 2028 |
| Care Transitions and Diversion Services (CTD)        | Q4 2027 | End of Q1 2028 | End of Q2 2028 | Q3 & Q4 2028 | Q1 2029 |
| Behavioral Health Workforce Development (WF)         | Q4 2027 | End of Q1 2028 | End of Q2 2028 | Q3 & Q4 2028 | Q1 2029 |
| Child, Youth, and Young Adult Mental Wellbeing (CYA) | Q2 2028 | End of Q3 2028 | End of Q4 2028 | Q1 & Q2 2029 | Q3 2029 |

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#### D. Examples of anticipated activities to be procured for the five strategy areas

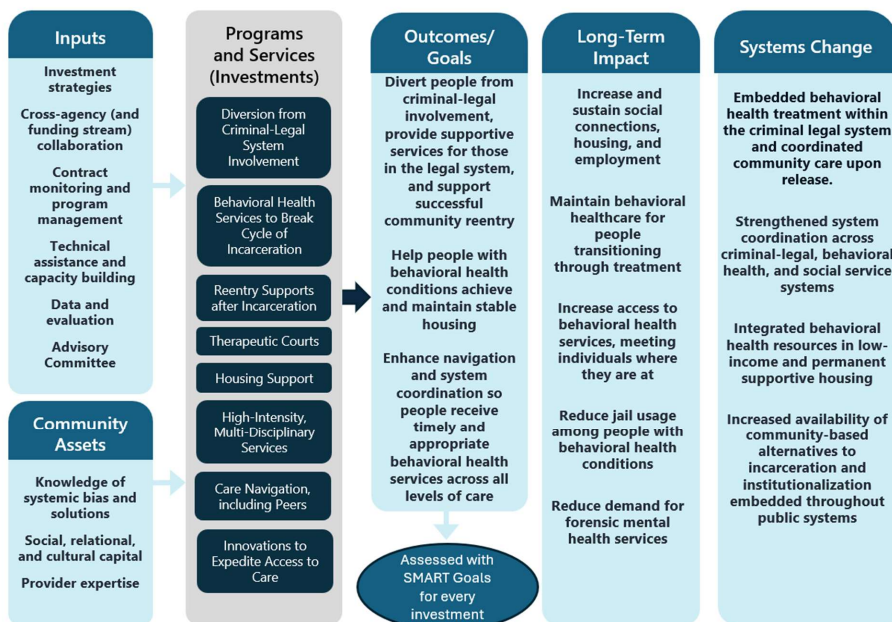
This section offers examples of the types of services that will be procured for each of the strategy areas' goals. These align with the logic models for each of the strategy areas in this Phase 1 Implementation Plan. Each logic model explains the inputs (what services will be procured) necessary to achieve the expected outcomes for each strategy area. During the phased pre-procurement work for each strategy area, through the second quarter of 2028, more current information, including data and other intersecting initiatives, will help to shape what outcomes and activities will be included in Bridge procurements. Information and data that will be factored into procurement development will include, but will not be limited to, recommendations from the Breaking the Cycle Workgroup, and the Behavioral Health Strategic Plan report called for by Ordinance 20086, Section 39, Proviso P1. These additional variables will guide formation of the planned procurements for each Bridge strategy area and will shape plans for the Bridge-funded, County-operated services administered by other County agencies where applicable. The Executive will share this information in the pre-procurement notification letter described above.

#### D.E. Logic model and anticipated activities for Care Transitions and Diversion Strategy Area

Additional detail about the Care Transitions and Diversion Services strategy area, including descriptions of each goal and financial estimates, can be found in Subsection VI.A.

**Commented [JN87]:** This language was moved from Appendix F to this Section XI. The language move was not show in track changes for ease of reading.

**Figure 27282836: Logic Model for Care Transitions and Diversion Servies (CTD) Strategy Area**



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## CTD Goal 1: Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.

### Activity: Diversion from criminal-legal system involvement

Criminal-legal system diversion programs direct individuals with behavioral health conditions who commit legal offenses away from more formal or deeper legal system involvement to programs and services that are designed to address their specific needs. The Executive plans to continue services such as:

- Intensive case management that promotes well-being and independence and helps connect participants to stabilizing services such as housing and employment through a low-barrier, harm reduction approach.
- Services that collaborate with local law enforcement to refer people to appropriate behavioral health supports.
- Peer programs in which people with lived experience guide others on a path toward recovery and stability.
- Training for first responders to best address behavioral health incidents.

### Activity: Services for people with behavioral health conditions who have cycled repeatedly through the criminal-legal system

Recent DCHS analysis of jail data reveal that nearly 1,400 individuals in King County are regularly cycling through County and municipal jails, meaning they are being booked into a correctional

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 74

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2474 facility located in King County four or more times per year in two of the past three years.<sup>161</sup> Further  
2475 analysis reveals that 96 percent of these individuals have interacted with King County's behavioral  
2476 health or crisis service systems. The Executive ~~intends to will~~ fund programs for highly vulnerable  
2477 people with behavioral health conditions who have cycled repeatedly through the court system and  
2478 require additional help to maintain stability, such as:

- 2479 • Prosecutorial resources to help track and, when possible, resolve outstanding warrants  
2480 and criminal cases for individuals who have high utilization of King County jails.
- 2481 • Programs to help individuals remain in the community and connect with therapeutic  
2482 interventions and other resources, such as permanent supportive housing.
- 2483 • Integrated, community-based approaches to serving people at the intersection of  
2484 behavioral health and the criminal legal system, promoting recovery, public safety, and  
2485 harm reduction.

2486  
2487 **Activity: Supports for people to reenter the community after incarceration**

2488 People with behavioral health conditions need support to successfully reenter society after  
2489 incarceration. The Executive ~~intends to will~~ fund services that provide this support, including:

- 2490 • Reentry care coordination and peer navigation providing linkages to behavioral health  
2491 treatment, public benefits, and access to basic needs, particularly for unstably housed  
2492 adults transitioning out of King County jails.
- 2493 • Timely, complex release planning and coordination of community services for people with  
2494 behavioral health needs to ensure lifesaving continuity of care at release.
- 2495 • Programs that provide a supply of medications, culturally appropriate linkages to care, next  
2496 day appointments for SUD treatment, and re-entry items (identification, phone, clothing,  
2497 hygiene kits, transportation, Medicaid enrollment, etc.).
- 2498 • Follow-up support and services, that help individuals link to and attend ongoing treatment  
2499 visits after release.

2500  
2501 **Activity: Behavioral health services and supports for people involved in the legal system,  
2502 including therapeutic courts.**

2503 If or when a person with a behavioral health condition is arrested and charged as a result of their  
2504 condition, services within the legal system often offer a pathway toward treatment and recovery as  
2505 an alternative to incarceration or deeper legal system involvement. These services provide a  
2506 treatment plan, points of accountability, and a treatment team, typically made up of legal system  
2507 staff and therapeutic or case management staff, who support the individual to get the care they  
2508 need. These services can include therapeutic courts, such as the Regional Mental Health and  
2509 Veterans Court (RMHC), Seattle Municipal Mental Health Court (SMMHC), Community Court (CC),  
2510 Adult Drug Court (ADC). Services for individuals with civil legal involvement, such as Family  
2511 Treatment Court (FTC), are also included.<sup>162</sup>

2512  
2513 **CTD Goal 2: Help people with behavioral health conditions achieve and maintain  
2514 stable housing.**

2515 **Activity: Behavioral health services in permanent supportive housing**

2516 As of September 2025, there were 5,953 units of permanent supportive housing (PSH) in King  
2517 County, and the Executive has committed to continuing to expand supportive housing in the  
2518 region.<sup>163,164</sup> Permanent supportive housing is an evidence-based approach to chronic  
2519 homelessness that pairs affordable housing with supportive services like case management,

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 75

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2520 transportation resources and health care services. Many residents of permanent supportive  
2521 housing have a behavioral health condition. For example, in 2023, more than half (51 percent) of  
2522 residents in King County's Health Through Housing sites accessed behavioral health care  
2523 services.<sup>165</sup> Many PSH sites currently provide some limited behavioral health supports, but  
2524 additional services are needed, especially for people with higher-acuity conditions who need more  
2525 intensive, hands-on services. On-site services are critical to ensuring PSH sites are safe and  
2526 sustainable for residents, neighbors, and housing operators, and respite can provide much-needed  
2527 opportunities for recouperation in a temporary, safe environment outside of the PSH setting. The  
2528 Executive ~~intends to will~~ use the Behavioral Health Bridge to address this need by funding increased  
2529 behavioral health services at PSH sites and/or in respite settings in order to support residents'  
2530 long-term stability and keep them from re-entering the cycle of homelessness, incarceration, and  
2531 hospitalization. The Executive should consider implementing this activity especially in rural areas  
2532 where transit infrastructure is less developed.

2533  
2534 **Activity: High-intensity services for people with behavioral health conditions leaving**  
2535 **institutional settings who are experiencing or at risk of homelessness**

2536 This activity supports programs that facilitate access to affordable and supportive housing for  
2537 individuals who are experiencing homelessness or discharging from an institutional setting (such  
2538 as a jail, a local hospital, or Western State Hospital) and would otherwise discharge into  
2539 homelessness. Once housed, teams can provide support services to assist participants in  
2540 maintaining housing and increasing independent living and tenancy skills.

2541  
2542 ~~**Activity: Behavioral health supports in Low-barrier shelter that includes behavioral health**~~  
2543 ~~**supports**~~

2544 ~~This activity supports low-barrier shelter that provides intensive supports for people with~~  
2545 ~~behavioral health conditions in low-barrier shelter. Low-barrier shelter would provides immediate,~~  
2546 ~~easy access to people with behavioral health conditions that are experiencing homelessness.~~  
2547 ~~There should be minimal entry requirements to access services and supports shall be provided to~~  
2548 ~~assist recovery with behavioral health conditions, and help people with behavioral health~~  
2549 ~~conditions achieve and maintain stable housing. Supports provided could include case~~  
2550 ~~management, access to recovery resources, overdose prevention protocols, and person-centered,~~  
2551 ~~trauma-informed design.~~

2552  
2553 ~~Wherever possible, individuals enrolled in other County-funded services, irrespective of funding~~  
2554 ~~source, who have behavioral health conditions and are living unsheltered should be prioritized for~~  
2555 ~~low-barrier high support shelter in order to maximize the efficacy of the other County investments.~~

2556 **CTD Goal 3: Enhance navigation and system coordination so that people receive**  
2557 **timely and appropriate behavioral health services across all levels of care.**

2558 **Activity: Care navigation, including peer navigation and care coordination, that is equipped to**  
2559 **respond with cultural competency**

2560 One way to help people move through a fragmented system is to fund care navigators or case  
2561 managers. These professionals help individuals find the services they need and support them to  
2562 get there. Care navigation has been proven to increase engagement with treatment and reduce  
2563 reliance on emergency departments.<sup>166,167</sup> Navigation can be especially effective for BIPOC  
2564 participants when navigators are people with lived experience who come from the same  
2565 background as the service participant.<sup>168,169</sup> In the next iteration of the Behavioral Health Bridge, the

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic  
Framework

Page | 76

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Commented [PS92]: Adds emphasis on rural areas

Commented [SP93]: Adds an activity that would allow Bridge dollars to be spent on behavioral health supports in low barrier shelter.

Commented [JN94]: Adds language regarding prioritizing investments

Commented [PS95]: Adds language on cultural competency

2566 Executive plans to continue to build on existing care navigation services, including services  
2567 provided by peers and services that are culturally and linguistically responsive.

2568 **Activity:** *HIPAA-compliant case management technologies that employ close-loop referral*  
2569 *systems to help providers see what services someone is already engaged in, identify available*  
2570 *resources, and connect them seamlessly while keeping patient data secure. Technology*  
2571 *investments to facilitate care coordination across all levels of care*

2573 In an era of extraordinary technological advances, more can be done to streamline connections  
2574 between systems and make it easier for people to get the care they need. Subject matter experts  
2575 requested technology that would allow *service* providers and provider networks to easily see what  
2576 services a participant is already engaged in, identify available resources that meet their needs, and  
2577 connect them to care as quickly and seamlessly as possible. There is also a need for technology  
2578 solutions and support staff that identify when someone has been referred and to ensure that the  
2579 linkage was made. If the connection does not occur as planned, technology can make it easier to  
2580 initiate additional outreach and engagement to support successful connections to care for those  
2581 who may be at risk of falling through the cracks. *Contracted service providers that maintain closed-*  
2582 *loop referral systems and information-share with other providers help community organizations by*  
2583 *presenting a whole-person snapshot of need across a complete trajectory of care. Closed-loop*  
2584 *referrals allow case managers to send and receive status updates about participants between*  
2585 *organizations through inter-organizational data management systems. This requires adequate staff*  
2586 *and reliable data infrastructure to maintain patient records and document the patient experience*  
2587 *at each step in the care process.*

2588 *Activities under this goal will support community behavioral health contracted service providers in*  
2589 *implementing systems for HIPAA-compliant status reporting and referrals between local service*  
2590 *providers, based on a whole-person care model (proactive case management to ensure access to*  
2591 *services that address the social determinants of health outside of clinical settings), thereby*  
2592 *reducing redundancy through cross-organizational transparency and accountability.*

2595 Several technology supports designed to facilitate better behavioral health care navigation already  
2596 exist in King County, such as the BHRD Quality and Care Coordination Resources SharePoint.<sup>170</sup>  
2597 Subject matter experts who advised on the renewal shared that while these supports each serve  
2598 important functions, some are only available to a limited group of *service* providers and none offers  
2599 the full spectrum of information and tools that would be needed to truly streamline care. The  
2600 forthcoming Crisis Care Coordination Platform (CCP) funded by the CCC Levy is intended to  
2601 address many provider-identified issues by providing clinicians with real-time information to  
2602 support critical decision-making during and after behavioral health crisis encounters. However,  
2603 other features requested by *community contracted service* providers are out of scope for the first  
2604 phase of the CCP, such as real-time tracking of available beds and services, or a decision support  
2605 tool to help navigators identify the right services for a client among a range of options.

2607 The Executive *intends to will* invest funds under this goal to enhance and build on the CCP after it is  
2608 launched to make care navigation easier, faster, and more effective by adding features that  
2609 respond to community-identified needs.

2610 **Activity:** *Promoting Services to ensure timely access to appropriate care and break down*  
2611 *treatment siloes between providers*

King County Behavioral Health Bridge Implementation Plan 2028-2034 *Phase 1: Transition Strategic*  
*Framework*

Page | 77

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Commented [SP97]: Adds reference to contracted service providers that use closed-loop referral systems.

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Commented [PS99]: Changing emphasis to ensure timely access to care and break down treatment siloes

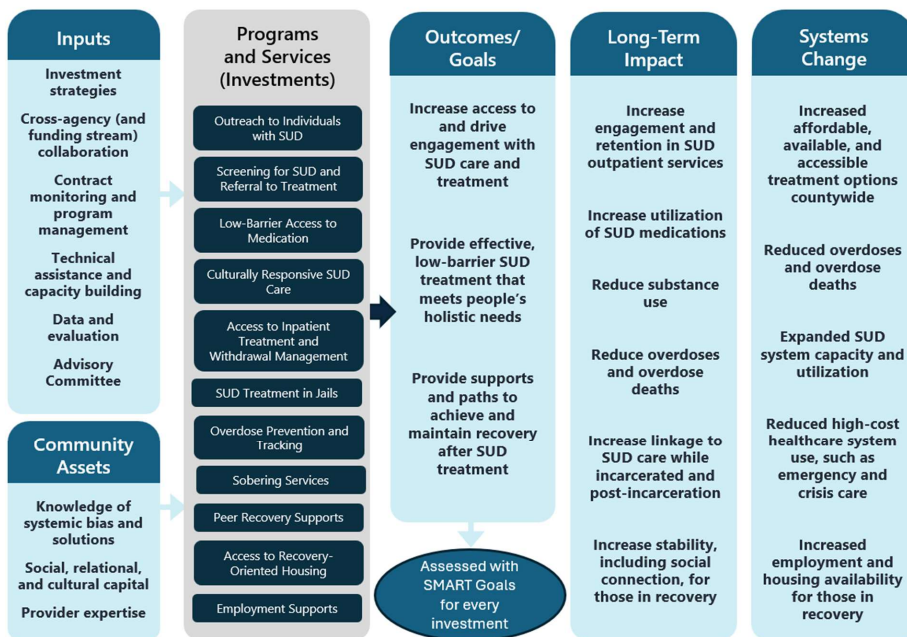
The behavioral health system is most effective when people can get the type of care they need when they need it. The Executive ~~intends to~~will invest the next iteration of the behavioral health sales tax in programs that support timely and appropriate care, such as:

- Same-day or next-day initiation of outpatient treatment for youth and adults.
- Support for people with the highest levels of need to get to safe settings.
- Step-down or respite care for people with behavioral health conditions to continue healing after a crisis or acute care episode.

#### F. Logic model and anticipated activities for Substance Use Disorder Treatment and Recovery Strategy Area

Additional detail about the SUD Treatment and Recovery strategy area, including descriptions of each goal and financial estimates, can be found in Section VI.B.

**Figure 2929292937: Logic model for the Substance Use Disorder Treatment and Recovery (SUD) strategy area**



#### SUD Goal 1: Drive engagement and retention in SUD care.

**Activity: Proactive outreach to people with SUD, especially those experiencing homelessness**  
Decades of research, as well as feedback from community members and subject matter experts, show that outreach is a key part of connecting people to care, especially for people with substance use disorders who are experiencing homelessness.<sup>171</sup> The Executive expects that the behavioral

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 78

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health sales tax will pay for community-based and behavioral health organizations to provide evidence-based practices that support engagement in treatment, such as:

- Engaging individuals experiencing homelessness through regular, consistent outreach that builds rapport and trust.
- Conducting basic needs and safety assessments to identify immediate risks, service needs, and eligibility for SUD treatment or other supports.
- Providing information on SUD treatment options, including low-barrier programs, medications, inpatient and residential, outpatient, and withdrawal management services.
- Offering harm reduction supplies and education, such as naloxone distribution, overdose prevention information, and safer-use strategies.
- Facilitating warm handoffs to treatment [contracted service](#) providers, behavioral health agencies, medical partners, or crisis services, including accompanying clients when appropriate.

**Activity: Screening and referrals integrated into multiple settings**

Another way to connect people to the care they need is to intervene in key moments, such as when a person goes to a housing site, community center, school, medical appointment, or emergency department. For example, an average of 3,800 King County Medicaid members visit an emergency department multiple times per year with a behavioral health condition as the primary diagnosis.<sup>172</sup> Many of these individuals are served by Behavioral Health Bridge programs.; [and still more in addition, more](#) individuals who do not have Medicaid repeatedly visit emergency departments due to behavioral health diagnoses. Providing screenings and appropriate referrals at a moment when someone is already in contact with a care provider reduces the risk that the individual will end up back in the emergency department again for the same issue.<sup>173</sup> It also provides a path to treatment that does not require the person to escalate to the point of criminal-legal system involvement in order for their conditions to be addressed. The Executive anticipates funding programs that screen people for SUD across service settings, provide individualized needs assessments, and refer them to treatment as well as other services.

**Activity: Sobering services**

Sobering services are a safe and secure shelter for adults to sleep off the acute effects of intoxication under the supervision of staff trained in medical assessment and response. They also serve as a recovery access point where people receive case management services and assistance to move towards greater self-determination and recovery. The Executive anticipates that the Bridge can support this important linkage pathway for people with SUD in need of treatment and other services.

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2671 **SUD Goal 2: Provide effective, low-barrier SUD treatment that meets people’s holistic**  
2672 **needs.**

2673 **Activity: Low-barrier access to medications for substance use disorder and medication-first**  
2674 **treatment approaches**

2675 Low-barrier access to medications for substance use disorder is a critical aspect of SUD  
2676 treatment. In particular, medications for opioid use disorder (MOUD) have become the standard of  
2677 care for treating opioid use disorder regardless of the specific opiate being used, and is associated  
2678 with longer retention in treatment, decreased opioid use, and reduced mortality from  
2679 overdose.<sup>174,175</sup> The increased prevalence of fentanyl means that access to MOUD is more  
2680 important than ever, as fentanyl is metabolized so quickly that even an hour without the drug can  
2681 make people sick from withdrawal.<sup>176,177</sup> Utilizing a medication-first approach provides a level of  
2682 stabilization that can often enable enrollment in ongoing treatment services. However, because  
2683 medications for substance use disorders are not available through all SUD treatment providers,  
2684 King County’s SUD system is not yet optimized to provide access to these lifesaving  
2685 medications.<sup>178,179,180</sup> Successes like the launch of the Tele-buprenorphine Hotline in 2024, which is  
2686 partially funded by the Behavioral Health Bridge and provides low-barrier MOUD support, are  
2687 making progress in this area.<sup>181</sup> However, more work remains to increase the availability of  
2688 medications in outpatient and residential treatment programming across the County.

2690 The Executive ~~intends to will~~ leverage ~~King County~~ Behavioral Health Bridge investments to improve  
2691 the availability of MOUD and other medications to help people recover from substance use  
2692 disorders. Behavioral Health Bridge funds can support medication-first treatment approaches in  
2693 formal treatment settings and in community, such as the buprenorphine line, MOUD in shelters  
2694 and encampments, and mobile medication access. These on-demand services help people initiate  
2695 treatment when and where they are ready. The Executive is also considering investing Behavioral  
2696 Health Bridge funds to increase access to medications within SUD treatment and care by  
2697 supporting partnerships between treatment providers and pharmacies, adding medical staff to an  
2698 agency's care team, covering of co-pays, or employing other strategies to help people access  
2699 medications on demand.

2701 **Activity: Provision of mobile and in-community services**

2702 In addition to medication, the Executive anticipates supporting the broader provision of SUD  
2703 services in the community. This means offering treatment, support, and medications in settings  
2704 where people already are, such as shelters, outreach sites, and other community-based locations,  
2705 rather than relying primarily on traditional office-based models of care. By paying for services that  
2706 meet individuals in their own environments, the Behavioral Health Bridge can reduce barriers, build  
2707 trust, and ensure that services are accessible to those who may not otherwise engage in treatment.

2709 **Activity: SUD treatment for incarcerated people**

2710 Another area of focus for the Bridge is SUD treatment for people in County jail. This population is  
2711 vulnerable to repeatedly cycling through the criminal-legal system, with a high cost in human  
2712 potential as well as taxpayer dollars. Services that help people continue or initiate SUD treatment  
2713 while in jail can help break this cycle and move people toward long-term recovery and stability.  
2714 During community engagement around the Behavioral Health Bridge renewal, listening sessions  
2715 held in King County jails indicated that many people have a desire to engage in treatment while  
2716 incarcerated, and would benefit from services to connect them to treatment, including counseling  
2717 and access to MOUD. The Behavioral Health Bridge will build on current efforts to continue

[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 80

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2718 providing SUD treatment to people who are incarcerated. Bridge investments are expected to  
2719 include, but are not limited to, expanding access to MOUD for people in custody in King County  
2720 jails through medications, contracts, and additional County staff, to comply with the Americans  
2721 with Disabilities Act (ADA).<sup>182</sup>

2722  
2723 **Activity: Alleviating barriers to enter inpatient SUD treatment and withdrawal management**  
2724 Some people have complex medical needs that must be addressed alongside behavioral health  
2725 conditions, such as open wounds or uncontrolled diabetes. This is common among people who are  
2726 living unsheltered, as well as older adults who need continuous medical monitoring. Many  
2727 behavioral health facilities are not equipped to treat these medical concerns, which effectively  
2728 prevents these individuals from receiving withdrawal management and other inpatient behavioral  
2729 health treatment. The Executive anticipates that Behavioral Health Bridge investments can address  
2730 this barrier to treatment so that the cCounty's most vulnerable residents can get the SUD care they  
2731 need.

2732  
2733 **Activity: Culturally and linguistically responsive SUD care**  
2734 A one-size-fits-all approach to SUD treatment will not meet the needs of King County's diverse  
2735 communities. For treatment to be effective and equitable, people must be able to access services  
2736 in their preferred language, from contracted service providers who understand and respect their  
2737 unique backgrounds. Culturally responsive SUD care is proven to improve outcomes for  
2738 marginalized communities, especially when developed and provided by people from the relevant  
2739 culture in participants' preferred language.<sup>183,184,185</sup> Participants in the Be Heard: Community Voices  
2740 About Mental Health and Wellness project and renewal-focused community engagement noted  
2741 that current treatment options often do not provide care that resonates with their culture or  
2742 worldview, leaving them feeling alienated and unsure where to turn for help.<sup>186,187</sup> Increasing  
2743 culturally responsive options for people with SUD is a key way to address inequitable outcomes  
2744 across King County communities.

2745  
2746 The Executive intends for will Behavioral Health Bridge dollars to pay for treatment and supports  
2747 that address the unique needs of people from diverse backgrounds, spiritual traditions, family  
2748 structures, and cultural approaches to behavioral health by helping existing contracted service  
2749 providers become more culturally responsive and expanding Behavioral Health Bridge services to  
2750 more culturally grounded SUD treatment providers.

2751  
2752 **Activity: Overdose prevention and tracking**  
2753 King County has a robust overdose surveillance program, administered by Public Health – Seattle &  
2754 King County and partially funded by the behavioral health sales tax. In addition to prevention  
2755 activities such as naloxone distribution, this program produces the Opioid Overdose Deaths Data  
2756 Dashboard, a key source for understanding the landscape and impact of opioid use in King  
2757 County.<sup>188</sup> Maintaining this resource is critical to understanding and evaluating the effectiveness of  
2758 interventions designed to curb overdose. It also aligns with the Executive's priority of Better  
2759 Government, ensuring transparency and accountability in the outcomes of County investments  
2760 related to overdose. The Executive intends to will continue funding these important tracking  
2761 activities in the renewal period.

### 2762 **SUD Goal 3: Support paths to achieve and maintain recovery after treatment.**

2763 **Activity: Peer recovery services**

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 81

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2764 Throughout community engagement and the multi-sector subject matter expert process,  
2765 participants were adamant that peer services are critical to successful recovery. Research shows  
2766 that peer services improve relationships with treatment and social service providers, reduce rates  
2767 of relapse, and increase retention in treatment.<sup>189</sup> The Executive **intends to will** continue to invest in  
2768 peer-based supports, including services that:

- 2769 • Offer support, mentorship, and practical advice based on personal recovery experiences.
- 2770 • Provide system navigation through treatment options, housing, transportation, and other  
2771 community resources.
- 2772 • Work in community settings, including emergency rooms and encampments, to connect at-  
2773 risk individuals to care.
- 2774 • Assist in developing, refining, and implementing self-defined recovery plans.
- 2775 • Teach coping mechanisms, social skills, and strategies for managing daily life.

2776  
2777 **Activity: Access to housing that supports recovery**

2778 Housing is an important component of long-term recovery. There is a high correlation between  
2779 housing instability and substance use disorders. The Substance Use and Mental Health  
2780 Administration (SAMHSA) identifies “Home” as one of the four dimensions of recovery, alongside  
2781 “Health,” “Purpose,” and “Community.”<sup>190,191</sup> People need safe places to live after treatment in  
2782 order to maintain recovery, through program models such as rapid rehousing, housing vouchers, or  
2783 permanent supportive housing. The Executive anticipates that the Bridge can continue to support  
2784 these important pathways to stability for people in recovery from SUDs.

2785  
2786 **Activity: Employment supports**

2787 Since 2008, the behavioral health sales tax has paid for a supported employment program that  
2788 helps people with severe mental illnesses achieve self-sufficiency and improve non-vocational  
2789 outcomes such as improved self-esteem, sense of purpose, decreased isolation, and participation  
2790 in meaningful activities. Program participation is correlated with decreases in hospitalization and  
2791 jail utilization. In the 2028-2034 implementation period, the Executive is considering broadening  
2792 eligibility for this program to include individuals in recovery from SUDs, so they too can have  
2793 access to support to get and maintain jobs and contribute to their communities.

2794  
2795 **E.G. Logic model and anticipated activities for Equitable Access to Behavioral**  
2796 **Health Care Strategy Area**

2797 **Additional detail about the Equitable Access to Behavioral Health Care strategy area, including**  
2798 **descriptions of each goal and financial estimates, can be found in Subsection VI.C.**

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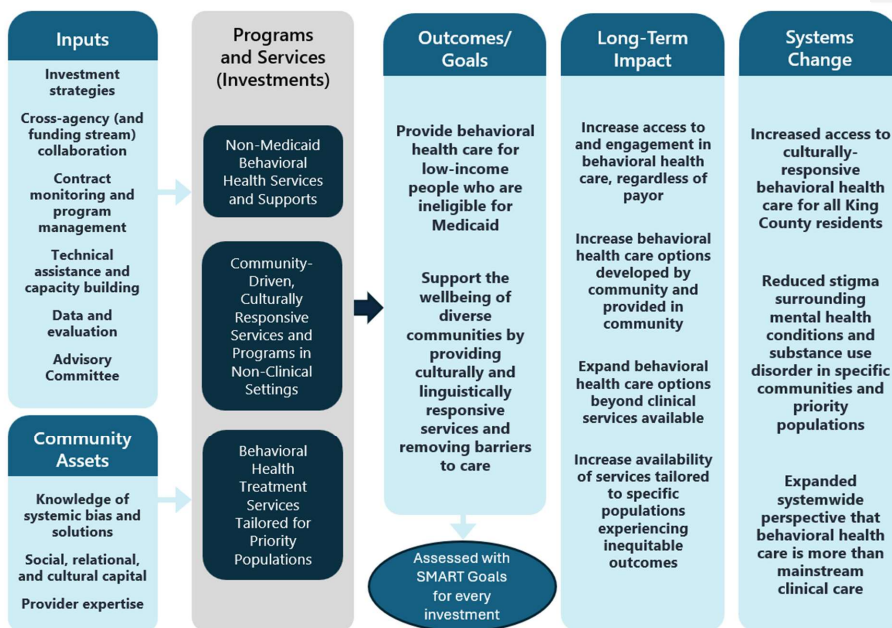
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2799  
2800  
2801

**Figure 30303138: Logic model for the Equitable Access to Behavioral Health Care strategy area**



2802

**EA Goal 1: Provide behavioral health care for low-income people who are ineligible for Medicaid.**

2803

**Activity:** Expanded funding stream designated for Non-Medicaid behavioral health services and supports for people not covered by Medicaid

2806

In its next iteration, the behavioral health sales tax will continue to pay for behavioral health services for low-income uninsured or underinsured King County residents who are ineligible for Medicaid coverage.

2807

2808

2809

2810

Since its inception, the behavioral health sales tax has provided access to behavioral health treatment services for uninsured low-income people. Every year since 2008, this program has served between 3,000 and 4,000 uninsured people with outpatient mental health and substance use treatment services, including immigrants and refugees, people on Medicare, and people who are pending Medicaid coverage. This funding addresses inequities for these populations by enabling them to access safety-net behavioral health treatment that would otherwise be out of reach. Supporting access to low-barrier, preventative treatment services helps keep people from delaying needed treatment and accessing higher levels of care at a later time. The King County Behavioral Health Bridge will sustain this important program in 2028-2034 to continue supporting treatment equity between people with insurance coverage and those who lack access due to coverage gaps, income, immigration status or other barriers to care (such as transportation or

2811

2812

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[King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

Page | 83

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2822 language). In addition, the Executive plans to use the Bridge to pay for translation and  
2823 interpretation services and connection to culturally responsive healthcare practices for people  
2824 receiving outpatient treatment through this program who speak a language other than English.  
2825

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Commented [JN108]: Adds language on culturally responsive healthcare practices

2826 **EA Goal 2: Support the wellbeing of diverse communities by providing culturally and**  
2827 **linguistically responsive services and removing barriers to care.**

2828 **Activity: Community-driven culturally and linguistically responsive services and programs**  
2829 **that support behavioral health outside of clinical settings**

2830 Community engagement participants and subject matter experts were clear that community-  
2831 based organizations are better positioned to address the needs of their communities than well-  
2832 intentioned outsiders. Services procured under this goal can directly fund community-based  
2833 organizations to increase access to culturally and linguistically appropriate prevention, early  
2834 intervention, care navigation, and recovery supports for BIPOC, immigrant or refugee, LGBTQIA+,  
2835 and rural King County residents. By working with communities to design and implement service  
2836 approaches that meet their needs, this goal directly addresses race- and place- based inequities  
2837 and promotes King County's commitment to equity as a core value.  
2838

2839 DCHS intends to shall release one or more RFPs to identify organizations that can provide tailored  
2840 supports to populations that experience behavioral health inequities, such as those who:

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- 2841 • Identify as Black, Indigenous, or people of color.
- 2842 • Are immigrants, refugees, or asylees.
- 2843 • Identify as LGBTQIA+.
- 2844 • Live in rural areas.
- 2845 • Are survivors of trauma or domestic, sexual, and gender-based violence.
- 2846 • Live unsheltered.
- 2847

Commented [JN110]: Adds reference to additional populations

2848 Examples of the types of programs that could be procured to further this goal include:

- 2849 • Behavioral health education paired with culturally responsive programming such as sweat  
2850 lodges or art therapy.
- 2851 • Community conversations focused on de-stigmatization and healing, including cross-  
2852 generational programming.
- 2853 • Queer-affirming suicide prevention provided by an LGBTQIA+ organization.
- 2854 • Wellness programs in safe spaces that build strong community connections.
- 2855 • Mental health awareness and education, in preferred languages by trusted organizations.
- 2856

2857 **Activity: Behavioral health treatment services tailored for priority at-risk populations**

2858 Participants in the Be Heard: Community Voices About Mental Health and Wellness project shared  
2859 that culture, beliefs, values, race, language, and personal identity affect perspectives on mental  
2860 health and substance use.<sup>192</sup> The same report found that people are less likely to seek help when  
2861 the only available treatments do not resonate with their cultural background or the lens through  
2862 which they see the world. Community members stressed the need for culturally responsive  
2863 services that are developed by and for their community and provided by individuals from similar  
2864 backgrounds. Research also shows that culturally adapted clinical care, particularly options co-  
2865 created by the communities intended to benefit from them, significantly improve outcomes across  
2866 a range of health conditions.<sup>193,194</sup>  
2867

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 84

2868 Services procured under this goal will focus on making the publicly funded behavioral health  
2869 system, such as the King County Integrated Care Network of Medicaid providers, more welcoming  
2870 and responsive to King County's diverse populations by removing barriers to treatment and  
2871 providing culturally responsive treatment.

2872  
2873 DCHS ~~intends to shall~~ release one or more RFPs to identify organizations that can support low-  
2874 income populations experiencing inequitable behavioral health outcomes, such as people who:

- 2875 • Identify as Black, Indigenous, or people of color.
- 2876 • Are immigrants, refugees, or asylees.
- 2877 • Identify as LGBTQIA+.
- 2878 • Live in rural areas.
- 2879 • Are older adults.
- 2880 • Are survivors of trauma or domestic, sexual, and gender-based violence.
- 2881 • Live unsheltered.

2882  
2883 Examples of the types of programs that could be procured to further this goal include:

- 2884 • Tailored therapies for LGBTQIA+ people facing behavioral health challenges.
- 2885 • Behavioral health treatment and enhanced care navigation for survivors of trauma or  
2886 domestic, or sexual, and gender-based violence, including flexible financial assistance  
2887 where material barriers interfere with behavioral health access, safety, or continuity of  
2888 care.
- 2889 • Behavioral health treatment and supports for people living in rural or unincorporated  
2890 Community Service Areas.
- 2891 • Culturally specific, responsive, and trauma informed behavioral health treatment and  
2892 supports for Black, Indigenous, and immigrant and refugee communities.
- 2893 • Behavioral health treatment services for older adults with mental health and/or substance  
2894 use conditions.

2895  
2896 *Activity: Organizations which provide culturally competent care practices that address*  
2897 *behavioral health inequities informed by an understanding of shared history related to race,*  
2898 *immigration status, sexual orientation, gender identity, trauma history, and geographic*  
2899 *access.*

2900  
2901 **F.H. Logic model and anticipated activities for Child, Youth, Young Adult**  
2902 **Mental Wellbeing Strategy Area**

2903 *Additional detail about the Child, Youth, and Young Adult Mental Wellbeing strategy area, including*  
2904 *descriptions of each goal and financial estimates, can be found in Subsection VI.D.*

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Commented [JN113]: Adds reference to additional populations

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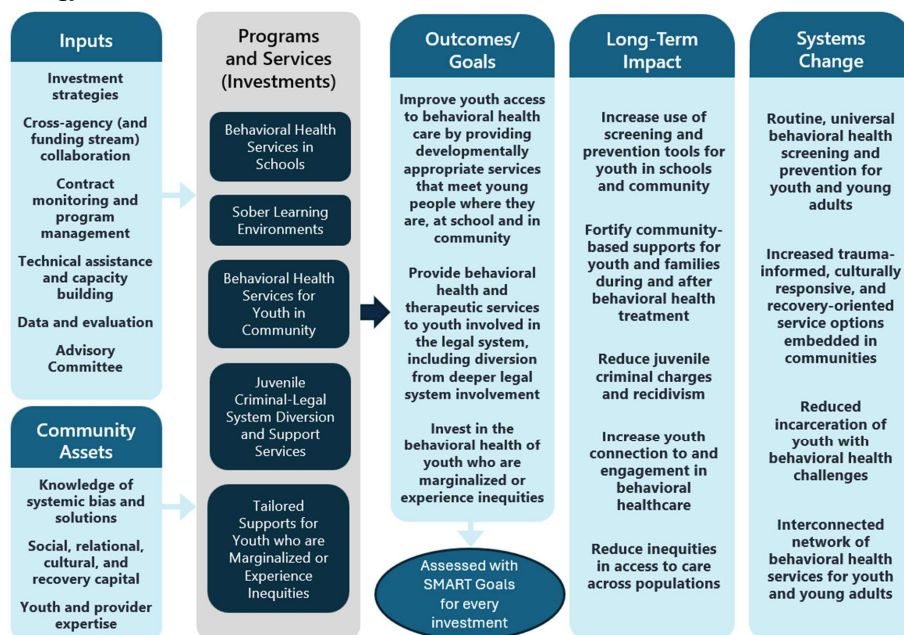
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2905  
2906  
2907

**Figure 31313239: Logic model for the Child, Youth, and Young Adult Mental Wellbeing (CYYA) strategy area**



2908  
2909

**CYYA Goal 1: Improve youth access to behavioral health care by providing developmentally appropriate services that meet young people where they are, at school and in community.**

**Activity: Youth behavioral health services in schools**

Locating services in schools is an effective way to facilitate access to care and reduce stigma for young people in need of behavioral health support. Since 2018, the behavioral health sales tax (alongside braided funding from Best Starts) has supported school-based Screening, Brief Intervention, and Referral to Treatment (SB-SBIRT), which screens over 13,000 King County middle and high schoolers across 13 districts each year and helps connect them to needed services. After participating in screening, the students who indicate areas of potential need meet with trained staff to discuss their goals, areas of growth, and connections to needed services.

These programs are most effective when students can be referred to brief treatment (defined as 8 or fewer sessions) on campus, alleviating the need to make a separate appointment, find transportation, or navigate an unfamiliar clinical environment. On-campus services are currently available in some schools, but not all, resulting in inconsistent access. Services offered on campus are also exclusive to mental health concerns and do not include supports for students struggling with substance use. Through the Bridge's investments in 2028-2034, the Executive intends to build [King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework](#)

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on existing School-Based SBIRT programs to allow more schools to offer brief on-campus behavioral health care, including substance use counseling in addition to mental health services. These brief services also support youth and families' transition to care in the community, if they need ongoing or higher-level care.

**Activity: Sober learning environments**

There are few youth-centered recovery resources, and young people who have experienced substance use disorders need safer and sober environments in which to continue their education while working on their recovery. Since 2014, King County has partnered with Seattle Public Schools Interagency Academy to operate the only public sober high school in Washington. The Interagency Recovery Campus (IRC), known colloquially as Recovery High School, provides a safe and sober environment where young people in recovery from substance use disorder and other behavioral health conditions can pursue their academic and career goals.<sup>195</sup> In 2013, only 25 percent of young people who received publicly funded substance use disorder treatment graduated from high school. For students with co-occurring mental health conditions, the number dropped to 17 percent.<sup>196</sup> At the Recovery High School, however, 67 percent of students earned or are working toward a high school diploma.<sup>197</sup> After enrolling in the program, 53 percent of IRC students have more than one year of recovery.<sup>198</sup> This activity would make it possible for the Bridge to support this valuable educational model.

**Activity: Youth behavioral health services in community**

During community engagement for the Bridge renewal, survey respondents rated "difficulty understanding where and how to access services" as the primary barrier to accessing behavioral health care for young people, as shown in [Appendix B](#). Adolescents are often dependent on their caregivers' motivation, knowledge, and resources to help them identify when behavioral health care is needed, find a provider, make appointments, and travel to care. Young people often forego care when their caregivers cannot provide this support, or when youth do not want their caregivers to know they are struggling. One effective way to overcome this barrier is to bring care to locations where youth already spend time.<sup>199</sup> This activity enhances access to care in other community locations (beyond schools) where young people already spend time and have relationships with trusted adults. The Bridge is anticipated to support programs that make behavioral health care more accessible, and therefore more effective, for youth and families, such as:

- Mobile screenings, brief interventions, MOUD, or young adult crisis response services that travel to shelters, community centers, and other youth-serving locations.
- Behavioral health staff in non-clinical youth-serving spaces like community centers, homeless shelters, summer camps, or community-based sports or arts programs.

**CYYA Goal 2: Provide behavioral health and therapeutic services to youth involved in the legal system, including diversion from deeper legal system involvement**

**Activity: Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system**

Since 2017, the behavioral health sales tax has supported 3,443 young people who were involved with the criminal-legal system and have a behavioral health need.<sup>200</sup> These supportive services included risk and needs assessments, community-based behavioral health support and system navigation, youth and family counseling, mental health and SUD services, and referrals to ongoing treatment.

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 87

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2974  
2975 In its next iteration, the **King County** Behavioral Health Bridge will continue to provide critical  
2976 services to help young people avoid long-term involvement in the criminal-legal system, such as:  
2977

- Behavioral health screenings and assessments,
- 2978 • System navigation and warm handoff referrals to behavioral health care,
- 2979 • Parent and family supports,
- 2980 • De-escalation counseling,
- 2981 • Mental health services,
- 2982 • Substance use services,
- 2983 • Diversion services, and
- 2984 • Trauma informed, behavioral health focused services for youth with Court involvement,
- 2985 such as those provided by the Juvenile Response and Accountability Court – Behavioral
- 2986 Health Response (JTRAC-BHR).

2987  
2988 These programs help young people who have contact with the criminal-legal system get their lives  
2989 back on track. This prevents them from languishing in detention while waiting for behavioral health  
2990 care, or falling deeper into a cycle of behavioral health conditions, criminalization, and  
2991 homelessness.  
2992

2993 **CYYA Goal 3: Invest in the behavioral health of youth who are marginalized or**  
2994 **experience inequities.**

2995 **Activities: Tailored supports for youth who are marginalized or experience inequities**

2996 DCHS ~~intends to will~~ release one or more RFPs to ~~identify contract with organizations~~  
2997 ~~providers that can provide tailored, culturally responsive, and affirming supports to youth and~~  
2998 families from communities that have been historically underserved or marginalized by behavioral  
2999 health systems. Among these are young people and families who:

- 3000
  - Identify as LGBTQIA+.
  - 3001 • Identify as Black, Indigenous, or people of color.
  - 3002 • Are immigrants, refugees, asylees, or the children of immigrants, refugees, and asylees.
  - 3003 • Have complex and co-occurring behavioral health conditions, or behavioral health
  - 3004 conditions with neurodivergence or intellectual or developmental disabilities.
  - 3005 • Have witnessed or experienced **trauma or violence, including domestic, sexual, or gender-**
  - 3006 **based violence, stalking, trafficking, or gun violence.**

3007  
3008 Tailored interventions have been proven more effective than standard interventions at improving  
3009 outcomes among LGBTQIA+ youth and youth of color.<sup>201,202,203</sup> Examples of the types of programs  
3010 that the Executive intends to procure include:

- 3011
  - Suicide prevention approaches designed with and for Black youth.
  - 3012 • Sober community-building and substance use prevention for LGBTQIA+ youth.
  - 3013 • In-language therapy groups for youth who speak a language other than English at home.
  - 3014 • Trauma healing programs for American Indian/Alaska Native youth who have witnessed or
  - 3015 experienced violence.

3016  
3017 During the procurement process, King County plans to evaluate proposals from community  
3018 organizations that are already known and respected by the families this goal is intended to serve,

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 88

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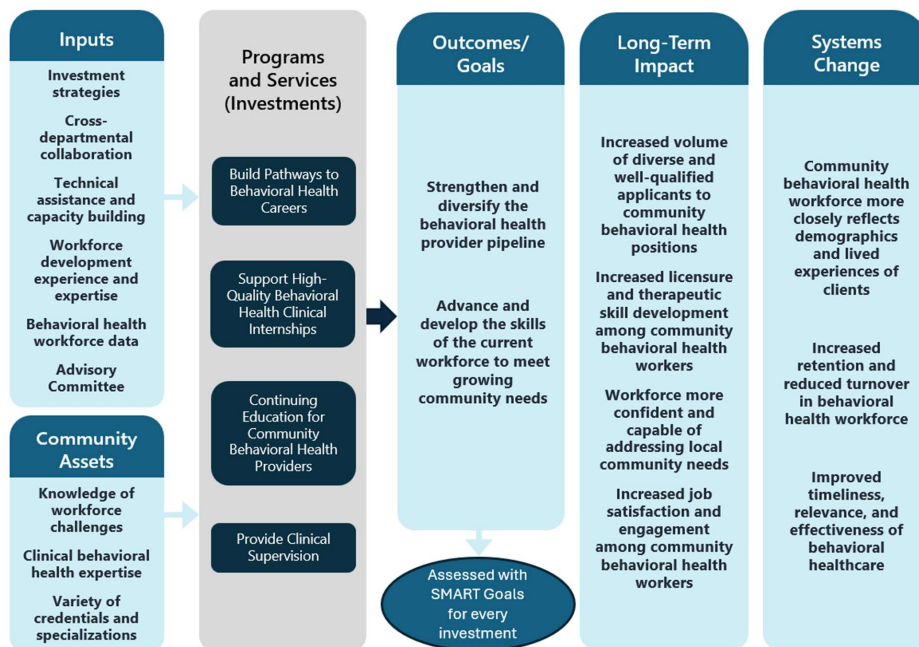
which may include KCICN providers. **Providers should have training on the unique confidentiality, safety, caregiver involvement, and mandatory-reporting considerations that arise when providing behavioral health services to young survivors of trauma or domestic, sexual, and gender-based violence.** Bridge-funded programs will focus on early intervention, treatment (especially for uninsured youth), and recovery. Services will complement rather than duplicate investments from other funding sources and will streamline connections to the publicly funded behavioral health system for participating youth and families.

This investment creates an opportunity to strengthen culturally responsive, community-rooted pathways into care so that youth can access support earlier and in ways that better meet their needs.

#### **G.I. Logic model and anticipated activities for the Behavioral Health Workforce Development Strategy Area**

**Additional detail about the Behavioral Health Workforce Development strategy area, including descriptions of each goal and financial estimates, can be found in Subsection VI.E.**

**Figure 32323346: Logic model for the Behavioral Health Workforce Development (WF) strategy area**



#### **WF Goal 1: Strengthen and diversify the behavioral health provider pipeline.**

##### **Activity: Building pathways to behavioral health careers**

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

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The Executive intends for the Behavioral Health Bridge to fund programs and activities that bring people into the provider pipeline, with a focus on recruiting a representative workforce, including by raising awareness of behavioral health career opportunities, preparing people for jobs in the field, and connecting people to careers in behavioral health. The Executive **plans to will** invest in activities such as:

- Educating under-resourced communities on non-clinical and clinical career pathways and ways to access free or no-cost trainings.
- Delivering programs in diverse middle and high schools to increase behavioral health career awareness among BIPOC youth.
- Building “connection to industry” through hands-on learning, job shadowing, career tours, and clinical simulations.
- Sponsoring Behavioral Health Career Pathways Fairs in collaboration with community-based organizations that serve underrepresented populations, including youth.
- Continuing summer programs for youth interested in pursuing behavioral health careers.
- Expanding existing relationships with technical colleges and skills centers.
- Targeted outreach to individuals enrolled in higher education behavioral health programs, highlighting benefits of working in community behavioral health, diversity of careers available, and opportunities for career growth within the behavioral health system.

**Activity: Supporting high-quality behavioral health clinical internships**

Ensuring the availability of well-supported clinical internships in community behavioral health will not only increase the number of new providers entering the workforce, it will also help improve the representativeness of the workforce. Clinical internships provide on-the-job learning experience and are a required component of graduate degree programs to become a behavioral health provider. These internships are typically unpaid and take place while a person is in school pursuing a Master of Social Work or other degree requirement. This step in the training process is cost-prohibitive for many people who cannot afford to work without pay. This barrier is particularly difficult for people from lower-income backgrounds, who are often more representative of the population being served in community behavioral health settings. Additionally, an individual’s experience during internship can shape whether they choose to continue to work in community behavioral health settings after they obtain their degree. Clinical interns continue to be the primary pipeline for developing community behavioral health workers, especially those with advanced degrees, including diverse workers.<sup>204</sup>

The Executive **intends to will** invest in activities to support high-quality behavioral health clinical internships, such as:

- Providing financial support for paid internships, building on the work of the CCC Levy’s career pathways (CP) funding, which is effective but does not have enough funds to fully meet the needs.
- Developing supervisor training and support initiatives that assist community behavioral health supervisors in providing training and coaching in best practices and culturally relevant core competencies for interns and clinical trainees.
- Developing internship programs to treat people with co-occurring substance use disorders and mental health conditions. No similar internship programs exist **as of at the time of this plan adoption’s drafting**, despite the prevalence of co-occurring disorders.
- Supporting training around clinical best practices and ensuring interns have the competencies needed to serve the complex needs seen in community behavioral health.

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 90

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3089 **WF Goal 2: Advance and develop the skills of the current workforce to meet growing**  
3090 **community needs.**

3091 **Activity: Clinical supervision**

3092 To promote an adequate supply of behavioral health workers prepared to treat the low-income,  
3093 high-need population served by community behavioral health, DCHS **intends to will** work to  
3094 alleviate the barriers around clinical supervision that currently limit the number of new providers  
3095 who can begin their careers in community behavioral health.

3096  
3097 After graduation from a Master's program, new clinicians must complete 1,000 to 3,000 hours of  
3098 clinical supervision to become a fully licensed behavioral health worker, depending on the license  
3099 type.<sup>205</sup> The cost of paying to receive clinical supervision is a barrier for providers' career  
3100 advancement and disproportionately affects low-income and BIPOC individuals.<sup>206</sup> Historically,  
3101 community behavioral health agencies have offered free clinical supervision as a key benefit and  
3102 recruitment tool for clinical staff, but clinical supervision itself is not reimbursable by insurance or  
3103 Medicaid. The hours the supervisor spends supporting a new colleague are unpaid and compete  
3104 with time they could spend providing services to clients and generating revenue for their agency. As  
3105 a result, community behavioral health agencies are limited in how many new clinicians they can  
3106 supervise, which in turn limits the number of new clinicians who can enter community behavioral  
3107 health. Across 47 KCICN agencies surveyed in 2025, the main reported barrier to hosting clinical  
3108 trainees was lack of supervisor availability.<sup>207</sup> This creates a bottleneck preventing new clinicians  
3109 from entering the community behavioral health.

3110  
3111 The Executive **intends to will** leverage the Behavioral Health Bridge to pay for clinical supervision  
3112 through methods such as:

- 3113 • Funding the provision of clinical supervision within a community behavioral health agency.
- 3114 • Developing a centralized clinical supervision model for the King County Integrated Care  
3115 Network that leverages opportunities for shared clinical supervision across multiple  
3116 behavioral health provider agencies.
- 3117 • Developing a centralized model for virtual clinical supervision, that could be widely  
3118 available to community behavioral health agencies to augment and supplement existing  
3119 agency-provided clinical supervision.

3120  
3121 **Activity: Continuing education Specialized training for community behavioral health providers**

3122 The Executive **will intends to** sustain and expand the workforce investments that began in MIDD 2  
3123 through continuing Bridge investments. Since 2025, the behavioral health sales tax has supported  
3124 KCICN providers to receive specialized training through avenues like:

- 3125 • KCICN Training Academy, which provides evidence-based practice (EBP) trainings in  
3126 Dialectical Behavioral Therapy and Cognitive Behavioral Therapy for Psychosis with  
3127 continuing education units (CEUs) and follow-up consultation.
- 3128 • Access to a learning management system, such as Relias.
- 3129 • Access to EBP training software, such as Lyssn.
- 3130 • Access to an umbrella license and coverage of training costs for certain training programs,  
3131 such as the Seven Challenges program for youth SUD treatment.

3132  
3133 The Bridge will enable KCICN providers to continue to access training software, along with new  
3134 high-demand trainings such as but not limited to motivational interviewing, racial socialization and

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3135 addressing racial trauma, LGBTQIA+ affirming and responsive treatment, family-based  
3136 interventions for disruptive behavior, parent-child interaction therapy. These additions will support  
3137 contracted service providers in offering the highest quality of care through King County's publicly  
3138 funded behavioral health system.

3140 The Executive ~~will also intends to~~ continue or expand support for partnerships with technical  
3141 colleges and higher education institutions to create affordable pathways for individuals who  
3142 already hold credentials in mental health to earn credentials in SUD treatment, and vice versa. For  
3143 example, the Y+Heritage Master's Program allows current KCICN clinical staff from  
3144 underrepresented communities to pursue master's degrees in mental health counseling.<sup>208</sup> With  
3145 support from the Behavioral Health Bridge, the Executive ~~will intends to~~ expand this or similar  
3146 programs to provide pathways for existing students to obtain licensure as Substance Use Disorder  
3147 Professionals (SUDPs) to be able to treat people with co-occurring conditions.

## 3149 XII. Conclusion

3150 The ~~King County~~ Behavioral Health Bridge Implementation Plan 2028-2034 contains an approach to  
3151 developing an equity-driven set of investments to strengthen King County's behavioral health  
3152 system in a time of profound community need. Grounded in extensive community engagement,  
3153 informed by multidisciplinary expertise, and aligned to complement the County's other behavioral  
3154 health and human services funding sources, this plan sets a direction toward a behavioral health  
3155 system that is more available, accessible, effective, and equitable.

3157 ~~Theis Behavioral Health Bridge Implementation pPlan~~ features investments across five strategy  
3158 areas: Care Transitions and Diversion Services; Substance Use Disorder Treatment and Recovery;  
3159 Equitable Access to Behavioral Health Care; Child, Youth, and Young Adult Mental Wellbeing; and  
3160 Behavioral Health Workforce Development. The investments in ~~theis Behavioral Health Bridge~~  
3161 ~~Implementation Pp~~lan are expected to help break the cycle of crisis, homelessness, incarceration,  
3162 and hospitalization by helping people receive the right treatment and support at the right time. ~~The~~  
3163 ~~plan's-s~~Strategy areas, goal areas, and anticipated activities are designed not only to meet  
3164 immediate needs but also to strengthen community behavioral health care against potential shifts  
3165 in funding, workforce capacity, and service demand that are expected in the coming years.

3167 Successful implementation will depend on continued partnership with community-based  
3168 organizations, behavioral health service providers, people with lived experience, and across  
3169 County agencies. Ongoing evaluation, transparent reporting, and a phased procurement approach  
3170 will help deliver a smooth transition from the current set of investments to the planned Behavioral  
3171 Health Bridge investments.

3173 With ~~this-the Behavioral Health Bridge Implementation Pp~~lan, King County reaffirms its  
3174 commitment to enabling all residents, especially those most impacted by inequities, to access  
3175 effective, high-quality behavioral health care and pursue long term recovery, stability, and  
3176 wellbeing.

King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework

Page | 92

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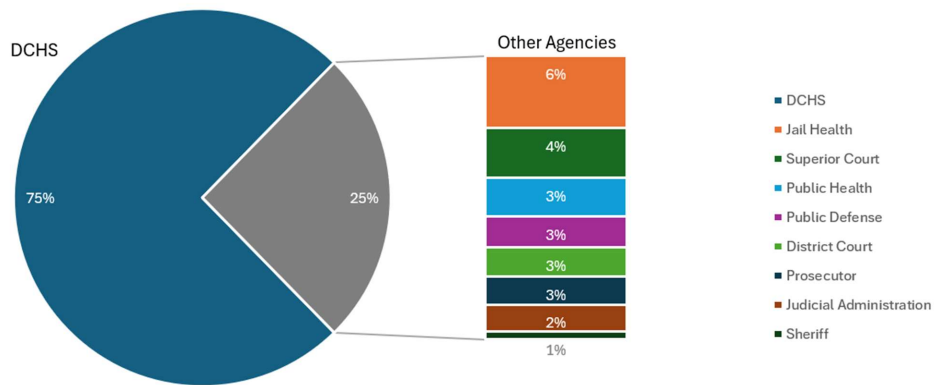
Commented [JN128]: Strengthens language to a requirement, rather than intention

Commented [JN129]: Changes to reflect the splitting of Phase 1 and Phase 2. This is intended to refer to the entire plan (Phase 1 and 2)

### III. Appendices

#### A. Appendix A. Behavioral Health Bridge investments in DCHS and other County agencies

Figure 33333425: 2026-2027 adopted Behavioral Health Bridge budget by King County agency



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**B. Appendix B. Community engagement activities and results<sup>209</sup>**

**Listening sessions and community-based events**

Between Behavioral Health Bridge-focused listening sessions and the Be Heard: Community Voices About Mental Health and Wellness project, BHRD staff conducted 46 in-person listening sessions and 486 interviews about the King County behavioral health system in 2024 and 2025 (Figure 235). Additional efforts to gather in-person feedback included attending community-based events, which engaged 447 community members throughout King County. To ensure representation across the county, BHRD held at least one in-person listening session in each council district.

**Figure 34343525: Dates and locations of in-person listening sessions and community-based events**

| Council District | Date (2024-2025) | Location                                                        |
|------------------|------------------|-----------------------------------------------------------------|
| District 1       | Spring 2024      | CHARMD Behavioral Health, Shoreline                             |
| District 1       | Spring 2024      | Korean Community Service Center (KCS), Edmonds                  |
| District 2       | Spring 2024      | Communities of Rooted Brilliance (CRB), Seattle                 |
| District 2       | Spring 2024      | Ethiopian Community in Seattle (ECS), Seattle                   |
| District 2       | Spring 2024      | Filipino Community of Seattle (FCS), Seattle                    |
| District 2       | Spring 2024      | New Americans Alliance for Policy and Research (NAAPR), Seattle |
| District 2       | Spring 2024      | Therapy Fund Foundation (TFF), Seattle                          |
| District 2       | Spring 2024      | Vietnamese Health Board (VHB), Seattle                          |
| District 5       | Spring 2024      | Association of Zambians in Seattle (AZS), Kent                  |
| District 5       | Spring 2024      | Congolese Integration Network (CIN), SeaTac                     |
| District 6       | Spring 2024      | Ayan Maternity Health Care Services (AMHS), Kirkland            |
| District 6       | Spring 2024      | Indian American Community Services (IACS), Bellevue             |
| District 6       | Spring 2024      | NAMI Eastside (NAMI), Redmond                                   |
| District 8       | Spring 2024      | Alimentando al Pueblo, Burien                                   |
| District 4       | July 18, 2024    | Interagency School, Seattle                                     |
| District 8       | September 15     | Recovery Day Event, Seattle                                     |
| District 6       | September 23     | Redmond Community Center at Marymoor Village                    |
| District 2       | September 24     | El Centro de la Raza, Seattle                                   |
| District 9       | September 26     | Lake Wilderness Lodge, Maple Valley                             |
| District 4       | September 30     | KEXP, Seattle                                                   |
| District 8       | October 1        | Hatten Hall, West Seattle Senior Center                         |
| District 3       | October 3        | Riverview School District, Duvall                               |
| District 5       | October 8        | Puget Sound ESD Conference Center, Renton                       |
| District 7       | October 9        | William C Warren Building, Auburn                               |
| District 1       | October 10       | Spartan Recreation Center, Shoreline                            |
| District 5       | October 31       | Consejo Clinica, Renton                                         |
| District 7       | November 11      | Todd Beamer High School, Federal Way                            |
| District 4       | December 4       | Behavioral Health Legislature Forum, Seattle                    |

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

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| Council District | Date (2024-2025) | Location                                                             |
|------------------|------------------|----------------------------------------------------------------------|
| District 2       | January 22, 2025 | Entre Hermanos, Seattle                                              |
| District 8       | March 17,19      | King County Correctional Facility (KCCF), Seattle [4 visits]         |
| District 5       | March 20, 21     | Maleng Regional Justice Center (MRJC), Kent [5 visits]               |
| District 8       | March 20         | Denny Middle School, Seattle                                         |
| District 1       | April 4          | Shoreline Senior Center                                              |
| District 8       | April 4          | Chief Sealth High School, Seattle                                    |
| District 4       | April 11         | Ballard Senior Center                                                |
| District 5       | April 14, 18     | South Correctional Facility (SCORE), Des Moines [4 visits]           |
| District 8       | April 15, 16     | Clark Children and Family Justice Center (CCFJC), Seattle [6 visits] |
| District 2       | April 17         | Fresh Start Housing, Seattle                                         |
| District 3       | April 23         | Issaquah Teen Cafe, Issaquah                                         |
| District 7       | June 25          | Substance Use Recovery Conference, Auburn                            |
| District 3       | June 25          | Cascade Park Apartments, North Bend                                  |
| District 3       | June 25          | Sno-Ridge Apartments, North Bend                                     |
| District 3       | June 30          | Sno-Valley Apartment, Carnation                                      |
| District 3       | July 16          | Sno-Valley Senior Center, Carnation                                  |
| District 9       | July 17          | King County Fair, Enumclaw                                           |
| District 8       | July 18          | Reclaiming Wellness Conference                                       |
| District 9       | July 18          | King County Fair, Enumclaw                                           |
| District 9       | July 19          | King County Fair Enumclaw                                            |
| District 9       | July 20          | King County Fair, Enumclaw                                           |
| District 7       | July 31          | We are Comunidad, Federal Way                                        |
| District 3       | July 31          | Mt. Si Senior Center                                                 |
| District 9       | August 4         | Maple Valley Community Center, Maple Valley                          |
| District 6       | August 30        | Redmond Pride Event, Redmond                                         |
| District 3       | October 15       | Sno-Valley Pride, Carnation                                          |

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**Figure 35353626: Number of individuals engaged per King County district**

| District where event occurred                                                 | Number of people engaged overall |
|-------------------------------------------------------------------------------|----------------------------------|
| 1                                                                             | 158                              |
| 2                                                                             | 282                              |
| 3                                                                             | 108                              |
| 4                                                                             | 179                              |
| 5                                                                             | 201                              |
| 6                                                                             | 326                              |
| 7                                                                             | 165                              |
| 8                                                                             | 365                              |
| 9                                                                             | 135                              |
| No District (Virtual listening sessions/participants didn't provide district) | 307                              |
| <b>Total number of community members engaged</b>                              | <b>2226</b>                      |

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In addition, BHRD staff conducted 33 virtual listening sessions from a wide range of King County organizations (Figure 237).

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**Figure 36363727: Virtual listening sessions and organizations engaged**

| Partner Engagement<br>July 2024 – October 2025                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Virtual Listening Sessions (2024-2025)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <ul style="list-style-type: none"><li>• Behavioral Health Advisory Board [BHAB] Listening Session</li><li>• Community-based Organization Listening Session (4 sessions)</li><li>• General Public Listening Session (3 sessions)</li><li>• HCHN Governance Council Listening Session</li><li>• King County Alliance for Human Services (KCAHS) Listening Session</li><li>• King County Employees Listening Session (2 sessions)</li><li>• King County Rural Behavioral Health Collaborative Listening Session</li><li>• MIDD Advisory Group Listening Session</li><li>• MIDD Community Owned Behavioral Health Collaborative Listening Session</li><li>• MIDD Leads Listening Session</li><li>• One-on-one Virtual Interview (Consejo Counseling)</li><li>• One-on-one Virtual Interview (Interagency Schools)</li><li>• One-on-one Virtual Interview (Kent Youth &amp; Family Services)</li><li>• One-on-one Virtual Interview (Mental Health Policy Roundtable)</li><li>• One-on-one Virtual Interview (King County Drug Diversion Court)</li><li>• Peer Listening Session (3 sessions)</li><li>• Provider Listening Session (4 sessions)</li><li>• Rural Community Listening Session (2 sessions)</li><li>• SB SBIRT Listening Session</li><li>• Sound Cities Association Listening Session</li><li>• Vocal-WA Virtual Listening Session</li></ul> |

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 96

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#### Affiliation of Organizations engaged

- Alimentando al Pueblo (AAP)
- Association of Zambians in Seattle (AZS)
- Ayan Maternity Health Care Services (AMHS)
- Catholic Community Services
- CHARMD Behavioral Health (CHARMD)
- Children's Crisis Outreach Response System (CCORS)
- Choose 180
- City of Bellevue
- City of Renton
- Comunidad Latino De Vashon
- Communities of Rooted Brilliance (CRB)
- Consejo Counseling and Referral Services
- Empower Youth Network
- Encompass Northwest
- Ethiopian Community in Seattle (ECS)
- Filipino Community of Seattle (FCS)
- Friends of Youth
- Indian American Community Services (IACS)
- International Rescue Committee
- KCPH Community Navigator
- Kent Youth & Family Services (KYFS)
- KidVantage
- King County (DCHS-ASD, BHRD, CYYAD, HCD & PHS)
- Khmer Community Services of Seattle King County (KCSKC)
- Korean Community Service Center (KCS)
- Peer Washington
- Pioneer Human Services
- Mental Health Policy Roundtable
- NAMI Eastside (NAMI)
- Neighborhood House
- New Americans Alliance for Policy and Research (NAAPR)
- Real Change
- Recovery Beyond
- Sea Mar
- SOUND Behavioral Health
- Southwest Youth & Family Services (SWYFS)
- The Dove Project
- Therapy Fund Foundation (TFF)
- Trail Youth
- Unkitawa
- Urban League
- Valley Cities Counseling and Consultation
- Vietnamese Health Board (VHB)
- Yoga Behind Bars

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 97



- YMCA
- Washington Therapy Fund Foundation
- Wagner Pediatrics Speech & Language

Listening sessions engaged people from diverse racial and ethnic backgrounds (Figure 238). At least 55 percent of participants identified as Black, Indigenous, or people of color, closely matching the overall demographics of King County.<sup>210</sup>

**Figure 37373828: Demographic information provided during Behavioral Health Bridge Renewal engagement**

| Race/Ethnicity                       | Percentage and Number of people engaged overall |
|--------------------------------------|-------------------------------------------------|
| Asian American/Pacific Islander      | 10% [225]                                       |
| Black                                | 15% [325]                                       |
| Latin(a/e/o/x)                       | 14% [320]                                       |
| Indigenous                           | 1% [30]                                         |
| Middle Eastern/ North African (MENA) | 2% [35]                                         |
| White                                | 13% [288]                                       |
| BIPOC/Prefer not to specify*         | 8% [175]                                        |
| Race/Ethnicity data not gathered**   | 37% [828]                                       |
| <b>Total individuals:</b>            | <b>2226</b>                                     |

\* The category “BIPOC/Prefer not to specify” was used by individuals who identified as BIPOC but did not feel comfortable providing more specific information.

\*\* The category of “Race/Ethnicity data not gathered” comes from engagement modalities where race/ethnicity were not requested during the engagement process, such as community-based events, and from participants who did not share their race/ethnicity information.

During behavioral health sales tax renewal engagement efforts in 2024, several groups were identified as communities that often face greater challenges in accessing behavioral healthcare and engagement in feedback processes: LGBTQIA+ people, incarcerated individuals, older adults, people with lived experience, and youth (Figure 239). Based on this information, 2025 engagement efforts related to the renewal focused on reaching these priority populations to ensure their perspectives were fully represented. One highlight of this effort was conducting 19 listening sessions in King County jails, hearing the perspectives of adults and youth who are currently incarcerated. The insights into the challenges these community members face, which often lead to cycling in and out of the detention centers, informed the criminal-legal system elements of this implementation plan.

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| Priority population                                              | Number of people engaged |
|------------------------------------------------------------------|--------------------------|
| LGBTQIA+                                                         | 108 (4.98%)              |
| Incarcerated Individuals                                         | 126 (5.76%)              |
| Older adults (55+)                                               | 362 (16.31%)             |
| Peers (People with lived experience)                             | 356 (16.03-1%)           |
| Youth (12-25)                                                    | 209 (9.43%)              |
| <b>Total individuals that were part of a priority population</b> | <b>1161 (52.1%)</b>      |

**Figure 39394030: Affiliations of attendees at listening sessions (in-person and virtual)**

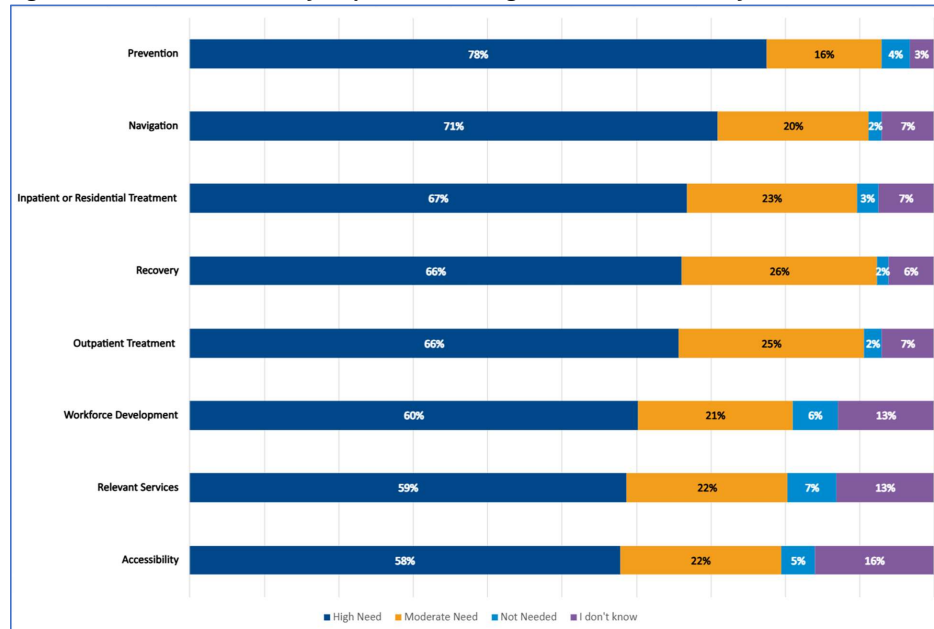
| Affiliation or self-identification of attendees                                   | Number of people engaged |
|-----------------------------------------------------------------------------------|--------------------------|
| LGBTQIA+ community members                                                        | 23 (3%)                  |
| Behavioral health providers                                                       | 72 (9%)                  |
| City government agencies                                                          | 50 (7%)                  |
| Community-based organizations (CBOs)                                              | 62 (8%)                  |
| Correctional officers                                                             | 15 (2%)                  |
| Incarcerated adults                                                               | 99 (13%)                 |
| Incarcerated youth                                                                | 27 (4%)                  |
| King County community members                                                     | 27 (4%)                  |
| King County employees                                                             | 47 (6%)                  |
| Older adults (55+)                                                                | 72 (9%)                  |
| Older adults with Limited English Proficiency (LEP)<br>(Khmer & Spanish speaking) | 27 (4%)                  |
| Peers (People with lived/living experience)                                       | 61 (8%)                  |
| Rural health providers                                                            | 22 (3%)                  |
| School district staff                                                             | Δ                        |
| Volunteer at non-profit                                                           | Δ                        |
| Youth (Middle & high schoolers)                                                   | 142 (19%)                |
| <b>Total individuals who provided affiliation data</b>                            | <b>763</b>               |

## Online survey

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

accessing behavioral health services (Figure 341). Every factor was identified as a “high need” by more than half of the respondents, painting a portrait of widespread unmet need.

**Figure 40404131: Online survey respondents’ rating of behavioral health system barriers**

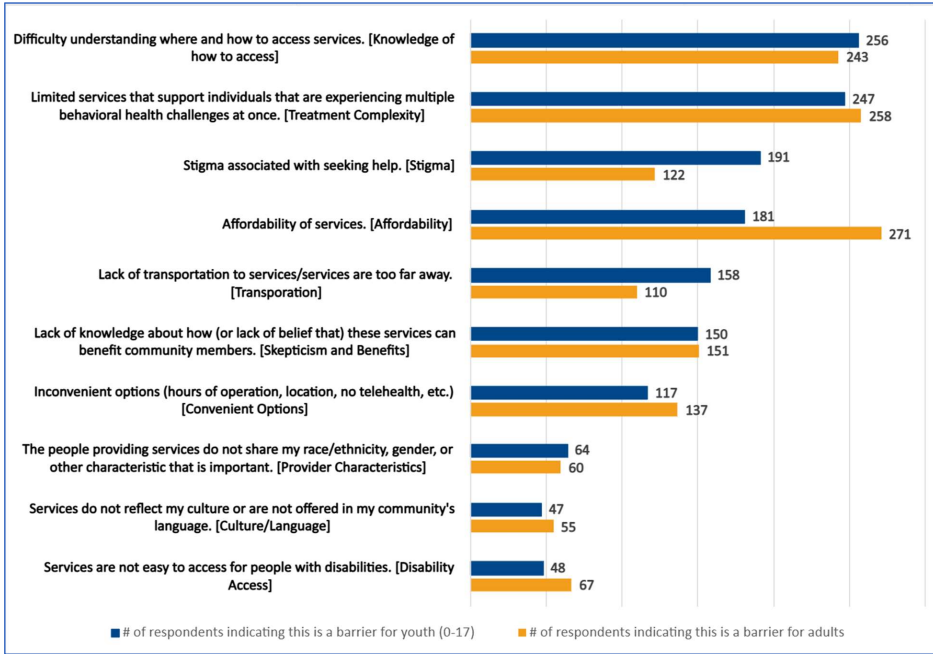


In separate questions about barriers for adults and youth (ages 0-17), respondents were provided with a set of potential barriers and were asked to select the three most pressing (Figure 342). The top two barriers for both adults and youth were “difficulty understanding where and how to access services” and “lack of services for co-occurring conditions, consistent with the themes that emerged from the listening sessions.”

On other topics, however, answers differed across age groups. Thirty-six percent of respondents said stigma associated with seeking help was a barrier for youth, while only 25 percent said it was a barrier for adults. Similarly, 42 percent of respondents indicated that affordability of services was a barrier for adults, but only 26 percent said the same for youth.

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**Figure 41414232: Percent of online survey respondents indicating a barrier as “most pressing”**



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All community engagement data was used to inform the strategy areas, goals, and anticipated activities described in this implementation plan. Specific influences are reflected in [Appendix C](#).

### C. Appendix C. Crosswalk of strategy areas and community engagement themes

Figure 343 summarizes the relationships between the proposed Behavioral Health Bridge strategy areas and the themes that emerged from renewal-related community engagement. Although all themes will influence all strategy areas to some degree (for example, the theme of “Culturally relevant and responsive care” will be incorporated into all strategy areas), the table displays the themes that are most strongly connected to each strategy area.

Figure 42424333: Community engagement themes informing each proposed Behavioral Health Bridge strategy area

| Proposed Strategy area                         | Most relevant community engagement themes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Care Transitions and Diversion Services        | <ul style="list-style-type: none"><li>• <b>Reduce system fragmentation and improve service coordination</b> (subthemes: struggles with system navigation; transitional service gaps)</li><li>• <b>Strengthen wraparound services</b> (subthemes: crisis diversion and harm reduction; housing crisis; aftercare for those leaving incarceration or inpatient settings)</li></ul>                                                                                                                                                                                    |
| Substance Use Disorder Treatment and Recovery  | <ul style="list-style-type: none"><li>• <b>Reduce system fragmentation and improve service coordination</b> (subthemes: SUD struggles with system navigation; SUD service gaps)</li><li>• <b>Strengthen and expand the behavioral health workforce</b> (subthemes: SUD peer support models)</li><li>• <b>Strengthen wraparound services that use team-based care and connect people to basic needs</b> (subthemes: crisis diversion and harm reduction; housing crisis; support for community-based organizations to address SUD)</li></ul>                         |
| Equitable Access to Behavioral Health Care     | <ul style="list-style-type: none"><li>• <b>Increase access and reduce barriers</b> (subthemes: lack of affordable care; insurance barriers; transportation barriers)</li><li>• <b>Strengthen culturally relevant and responsive care</b> (subthemes: provider diversity and cultural responsiveness; unique trauma and stressors; language access)</li></ul>                                                                                                                                                                                                        |
| Child, Youth, and Young Adult Mental Wellbeing | <ul style="list-style-type: none"><li>• <b>Strengthen and increase services for children, youth, and young adults</b> (subthemes: support for parents/caregivers; crafting safe spaces; increase awareness and decrease stigma)</li><li>• <b>Priority population: LGBTQIA+</b> (heightened concern for queer and trans youth in current sociopolitical climate)</li><li>• <b>Priority population: Youth</b> (more attention to young people with co-occurring mental health and SUD conditions, as well as those involved in the criminal justice system)</li></ul> |
| Behavioral Health Workforce Development        | <ul style="list-style-type: none"><li>• <b>Strengthen and expand the behavioral health workforce</b> (subthemes: staffing shortages and high turnover; career development and advancement; peer support models)</li><li>• <b>Strengthen culturally relevant and responsive care</b> (subthemes: provider diversity and cultural responsiveness; language access)</li></ul>                                                                                                                                                                                          |

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 102

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3277 **D. Appendix D. Multi-sector subject matter expert process**

3278 **Recommendations**

3279 Figure 344 displays a crosswalk of the goals presented in this implementation plan alongside the  
3280 SME workgroup suggestions that informed anticipated activities for each goal.

3281 **Figure 43434434: Crosswalk of SME suggestions and proposed investments for a renewed**  
3282 **Behavioral Health Bridge**  
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| Implementation plan goal                                                                                                                                                        | SME suggestions that informed the anticipated activities for each goal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>CTD Goal 1. Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.</b> | <p>From the SUD group:</p> <ul style="list-style-type: none"><li>• Scale and strengthen established diversion frameworks that feature a workforce emphasizing those with lived experience, including certified peers.</li><li>• Medications and other forms of treatment and support for people in jail, both before and after release.</li><li>• Tailored navigation and wraparound services (transportation, housing) for people with SUD leaving incarceration.</li><li>• Low-barrier places to stay with behavioral health supports for people leaving incarceration.</li></ul>                                                                                                                                                                                                                    |
| <b>CTD Goal 2. Help people with behavioral health conditions achieve and maintain stable housing.</b>                                                                           | <p>From the CTD group:</p> <ul style="list-style-type: none"><li>• More immediate and transitional shelter/housing options for people transitioning out of incarceration, hospitals, treatment facilities, or homelessness, that include a few key 24/7 essential supports.</li></ul> <p>From the SUD group:</p> <ul style="list-style-type: none"><li>• Wraparound services connecting people to housing and other supports when accessing SUD care (and vice versa).</li></ul>                                                                                                                                                                                                                                                                                                                       |
| <b>CTD Goal 3. Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.</b>               | <p>From the CTD group:</p> <ul style="list-style-type: none"><li>• Contract a technology platform that is accessible to all providers that bridges and simplifies communication across existing programs, organizations, and systems, such as behavioral health, criminal-legal, and housing, and others.</li><li>• Benefit and resource navigators (for people exiting incarceration, among others).</li><li>• Care navigation programs.</li><li>• Benefit navigators to help people get food, housing, legal help, medical care, etc.</li></ul> <p>From the SUD group:</p> <ul style="list-style-type: none"><li>• Enhance coordination and support services for people moving between withdrawal management and inpatient programs, as well as between inpatient and outpatient providers</li></ul> |

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| Implementation plan goal                                                                            | SME suggestions that informed the anticipated activities for each goal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                     | <ul style="list-style-type: none"><li>Technology that allows real-time tracking of available supports, facilitates warm handoffs, and streamlines linkage to care (community information exchange).</li><li>Reimagine SUD Next Day Appointments (NDA) for youth and young adults.</li></ul> <p>From the EA group:</p> <ul style="list-style-type: none"><li>Low-barrier case management and robust behavioral health services for people with low incomes who are uninsured, underinsured, or unhoused.</li></ul> <p>From the CYYA group:</p> <ul style="list-style-type: none"><li>Coordinated, high-quality, billable navigation and case management to help families find and coordinate multiple types of services at once</li><li>Funding technology to alleviate administrative burdens.</li></ul> <p>From the WF group:</p> <ul style="list-style-type: none"><li>Leverage technology as appropriate to reduce administrative burdens.</li></ul>                                           |
| <b>SUD Goal 1. Drive engagement and retention in SUD care.</b>                                      | <p>From the SUD group:</p> <ul style="list-style-type: none"><li>Outreach strategies that are delivered in a non-mobile setting, such as emergency departments and primary care.</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>SUD Goal 2. Provide effective, low-barrier SUD treatment that meets people's holistic needs.</b> | <p>From the SUD group:</p> <ul style="list-style-type: none"><li>Mobile services, such as peer navigation, mobile medication for opioid use disorder (MOUD), and outreach services, that meet people where they are in coordination with available well-designed low-barrier services such as shelter, intensive case management, housing navigation and legal coordination.</li><li>Increased access to medication for substance use disorders (MSUD), including through innovative strategies like long-acting injectables</li><li>Low-barrier harm reduction services</li><li>Medications and other forms of treatment and support for people in jail, both before and after release.</li><li>Achieve equitable rates of access to SUD treatment and recovery across races, ethnicities, languages, ages, sexual orientations, gender identities, and parts of the county by bolstering community-based paths to recovery that are tailored to the needs of the people being served.</li></ul> |
| <b>SUD Goal 3. Support paths to achieve and maintain recovery after treatment.</b>                  | <p>From the SUD group:</p> <ul style="list-style-type: none"><li>Achieve equitable rates of access to SUD treatment and recovery across races, ethnicities, languages, ages, sexual orientations, gender identities, and parts of the county by bolstering community-based paths to recovery that are tailored to the needs of the people being served.</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 104



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| Implementation plan goal                                                                                                                                     | SME suggestions that informed the anticipated activities for each goal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>EA Goal 1. Provide behavioral health care for low-income people who are ineligible for Medicaid.</b>                                                      | <p>From the SUD group:</p> <ul style="list-style-type: none"><li>• Clinical treatment and case management for people not covered by Medicaid that are tailored to the needs of the people being served.</li><li>• Medicaid services for non-Medicaid youth, such as outpatient, intensive outpatient, and residential treatment</li></ul> <p>From the EA group:</p> <ul style="list-style-type: none"><li>• Language access/Language justice.</li></ul>                                                                                                                                                                                                                                                                                                                                                      |
| <b>EA Goal 2. Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.</b> | <p>From the SUD group:</p> <ul style="list-style-type: none"><li>• Non-clinical services and supports that are not covered by Medicaid and are tailored to the needs of the people being served</li></ul> <p>From the EA group:</p> <ul style="list-style-type: none"><li>• Fund culturally centered organizations to develop and provide community-based programs that address community-identified needs.</li><li>• Pay for culturally centered organizations to hire peer supporters who can provide relationship-based case management and navigation services, including accompanying people to behavioral health appointments.</li><li>• Affirming services for LGBTQIA+ communities.</li><li>• Services by and for rural communities.</li><li>• Trauma-informed and trauma-responsive care.</li></ul> |
| <b>CYYA Goal 1. Improve youth access to behavioral health care by providing services that meet young people where they are, at school and in community.</b>  | <p>From the SUD group:</p> <ul style="list-style-type: none"><li>• School-based SBIRT.</li><li>• Recovery High Schools for a safe and sober environment where students pursue academic and career goals.</li><li>• Mobile MSUD and intensive case management for youth and young adults who are experiencing homelessness.</li><li>• Increased withdrawal management and MOUD treatment options for youth.</li></ul> <p>From the CYYA group:</p> <ul style="list-style-type: none"><li>• Universal screenings and tiered response with brief intervention.</li><li>• School-based health services that include SUD as well as mental health.</li><li>• Mobile therapy</li></ul>                                                                                                                              |
| <b>CYYA Goal 2. Provide behavioral health and therapeutic services to youth involved in the legal system, including</b>                                      | <p>From the CYYA group:</p> <ul style="list-style-type: none"><li>• Tailored services, wraparound supports, and partnership programs between the County and community-based organizations (CBOs) to identify and support youth who are involved or at-risk of being involved in the criminal-legal system, including programs serving their families.</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                              |

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 105

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| Implementation plan goal                                                                                    | SME suggestions that informed the anticipated activities for each goal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>diversion from deeper legal system involvement</b>                                                       | <ul style="list-style-type: none"><li>• Innovative community-based programs that engage youth who are involved or at risk of being involved in the criminal-legal system in healthy activities.</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>CYYA Goal 3. Invest in the behavioral health of youth who are marginalized or experience inequities.</b> | <p>From the CYYA group:</p> <ul style="list-style-type: none"><li>• Ensure that youth with complex needs can have their needs met, regardless of acuity.</li><li>• Fund culturally centered organizations to incorporate behavioral health supports into existing youth-focused programming.</li><li>• Targeted, identify-affirming supports for LGBTQIA+ youth.</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>WF Goal 1. Strengthen and diversify the behavioral health provider pipeline.</b>                         | <p>From the CTD group:</p> <ul style="list-style-type: none"><li>• Grow the non-clinical workforce (peers, CHWs, wellbeing specialists, care navigators, benefit navigators, non-clinical case managers, etc.), which can act as trusted supports.</li></ul> <p>From the SUD group:</p> <ul style="list-style-type: none"><li>• Support workforce development for peer and non-clinical providers</li></ul> <p>From the EA group:</p> <ul style="list-style-type: none"><li>• Support for behavioral health workforce development activities in community-centered organizations, such as internships and other provider training programs to create a more diverse provider pipeline.</li></ul> <p>From the CYYA group:</p> <ul style="list-style-type: none"><li>• Recruitment and retention programs that attract providers from diverse backgrounds and communities, especially multilingual providers.</li></ul> <p>From the WF group:</p> <ul style="list-style-type: none"><li>• Fund well-supported internships to bolster a diverse provider pipeline.</li><li>• Recruitment and training in clinical and non-clinical provider roles, such as peers, mental health care practitioners (MHCPs), etc.</li><li>• Programs in diverse middle and high schools to increase BH career awareness and pathways among BIPOC youth.</li></ul> |
| <b>WF Goal 2. Advance and develop the skills of the current workforce to meet growing community needs.</b>  | <p>From the CTD group:</p> <ul style="list-style-type: none"><li>• Training and development to implement best practices in crisis, navigation, and transition services, such as implementing peer supports and meeting basic needs first</li><li>• Additional support for supervision and internship with a particular focus on diversifying the workforce.</li></ul> <p>From the CYYA group:</p> <ul style="list-style-type: none"><li>• Training and workforce support to ensure there are enough providers who can successfully work with high-acuity youth.</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

| Implementation plan goal | SME suggestions that informed the anticipated activities for each goal                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                          | <ul style="list-style-type: none"> <li>Develop pathways to multi-licensure or team-based care to enable providers to better serve youth with complex needs.</li> </ul> <p>From the WF group:</p> <ul style="list-style-type: none"> <li>Increase support for clinical supervision.</li> <li>Training curricula that better prepare students for the realities of the job.</li> <li>Support clinical competency by offering ongoing clinical supervision and support.</li> <li>Trainings on cultural humility and trauma-informed care, including funding to access trainings and replace lost income from billable activities.</li> <li>Create training programs in evidence-based practices (EBPs) within community behavioral health settings.</li> <li>Programs that help mental health practitioners become licensed for SUD, and vice versa.</li> <li>Training pathways on specialized skills for serving children, youth, and young adults, including those with developmental disabilities.</li> </ul> |

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## Participants

The names of participants in the multi-sector subject matter expert workgroups and the organization they represented at the time of their participation are listed below. Workgroup meetings took place between April 21 and July 16, 2025. Each workgroup was overseen by a steering committee, whose members are also listed below.

An asterisk (\*) indicates the individual is also a member of the MIDD Advisory Committee.

### *Care Transitions and Diversion Services (CTD)*

#### **Steering committee:**

- Amanda Besel, King County DCHS
- Ash Warren, King County DCHS
- Chelsea Baylen, King County DCHS
- Kari Taylor, King County DCHS
- Kayla Rodriguez, King County DCHS
- Sara Tapia, King County DCHS
- Stephanie Moyes, King County DCHS
- Susan Peacey, King County DCHS

#### **Workgroup:**

- Amanda Bieber-Mayberry, Wellpoint
- Anthony Hoffer, Crisis Connections
- Bethany O'Neill, Psychologist/Court Evaluator (Options Psychological)
- Brian Allender, King County Chief Medical Officer

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 107

- 3309 • Chloe Gale, ETS/REACH
- 3310 • Christina Mason, King County Adult Drug Diversion Court (delegate of Catherine Cornwall\*)
- 3311 • Dominique Davis, Community Passageways/Choose 180
- 3312 • Emily Shapiro, DESC
- 3313 • Freyton Castillo, King County DCHS
- 3314 • Jennifer McPherson, Pioneer Human Services
- 3315 • Jessica Rosado, Valley Cities
- 3316 • Jim Conroy, King County ASD Veterans Reentry Program
- 3317 • Jose “Neeners” Garcia, Second Chance Outreach
- 3318 • Joshua Thorne, King County DCHS
- 3319 • Kate Anderson, DCYF
- 3320 • Kate Tramontana, King County District Court – Therapeutic Courts
- 3321 • Kimberly Hardy, Regional Crisis Response (RCR)
- 3322 • Kimmy Reedy, Peer Washington
- 3323 • LaTrecia Smith, King County DCHS
- 3324 • Lt. Jeff Gepner, SCorE
- 3325 • Dr. Matthew Goldman, King County DCHS, Crisis Systems Medical Director
- 3326 • Megan Murphy, King County Jail Health Services
- 3327 • Owen Riley, Harborview
- 3328 • Rachel Dryden, King County Department of Public Defense
- 3329 • Rheanell Roberts, King County DCHS
- 3330 • Stacey Devenney, Harborview\*
- 3331 • Sue Rash, YMCA Mobile Crisis Team
- 3332

3333 *Substance Use Disorder Treatment and Recovery (SUD)*

3334

3335 **Steering committee:**

- 3336 • Brad Finegood, Public Health – Seattle & King County\*
- 3337 • Dan Floyd, King County DCHS
- 3338 • David Perlmutter, King County DCHS
- 3339 • Dedra Barrow, Public Health – Seattle & King County
- 3340 • Delton Mosby, King County DCHS
- 3341 • Ericka Turley, Public Health – Seattle & King County
- 3342 • Ileana Janovich, King County DCHS
- 3343 • Jennifer Wyatt, King County DCHS
- 3344 • Robyn Smith, King County DCHS
- 3345

3346 **Workgroup:**

- 3347 • Angie Thompson, St Frances, St Anne, and St Elizabeth Hospitals
- 3348 • Apoorva Mallya, Hepatitis Education Project
- 3349 • Elsa Tamru, Harborview
- 3350 • Esther Lucero, Seattle Indian Health Board
- 3351 • Harumi Hashimoto, Asian Counseling and Referral Service (ACRS)
- 3352 • Hussein Ugas, Rahma Recovery Center
- 3353 • James Lovell, Chief Seattle Club

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 108

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- 3354 • Jessica Levy, Interagency Academy/Recovery High School  
3355 • Joe Barsana, King County Drug Diversion Court  
3356 • Johnny Ohta, Ryther  
3357 • Joshua Wallace, Peer Washington\*  
3358 • Laura Quinn, King County Community Prevention and Wellness Initiative  
3359 • LeslieENZIAN, UW Medicine  
3360 • Lisa Rogers, Sound  
3361 • Malika Lamont – Purpose Dignity Action / LEAD  
3362 • Manuela Raunig-Berho, ETS/REACH  
3363 • Mark Varela, Coordinated Care Washington  
3364 • Mary Hatch – UW Addictions, Drug, and Alcohol Institute  
3365 • Monika Whitfield, Washington Recovery Alliance  
3366 • Nicole Davis-Westbrook, WA Recovery Helpline and Crisis Connections  
3367 • Sabrina de la Fuente, Consejo Counseling and Referral Services  
3368 • Scott Reding, Integrative Counseling Services  
3369 • Taylor Richards, Recovery Beyond  
3370 • Thea Oliphant-Wells, Public Health – Seattle & King County  
3371 • Vania Rudolph – Swedish Recovery Services  
3372 • Vicki Brinigar – Valley Cities  
3373

*Equitable Access to Behavioral Health Care (EA)*

- 3374  
3375  
3376 **Steering committee:**  
3377 • Anne-Marie Bishop, King County DCHS  
3378 • Idabelle Fosse, King County DCHS  
3379 • Karen Spoelman, King County DCHS  
3380 • Makayla Wright, Public Health – Seattle & King County  
3381 • Robin Pfohman, King County DCHS  
3382 • Tyler Corwin, King County DCHS  
3383 • Ziying Hu, King County DCHS  
3384

- 3385 **Workgroup:**  
3386 • Amarinthia Torres, Coalition Ending Gender-Based Violence  
3387 • Bonnie Wang, Asian Counseling and Referral Service (ACRS)  
3388 • Candace Hunsucker, Community Health Plan of Washington  
3389 • Carline Stephens, King County DCHS  
3390 • David Bulindah, Wakulima  
3391 • David Coffey, Recovery Café  
3392 • Eben Pobee, CharmD Behavioral Health  
3393 • Fartun Mohamed, Somali Health Board\*  
3394 • Jade Park, Harborview  
3395 • Jams Stuvenga, Sound Generations  
3396 • Jessica Knaster Wasse, Public Health – Seattle & King County  
3397 • Lea Aromin, Coalition Ending Gender-Based Violence  
3398 • Marc Oommen, NAMI Eastside\*

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 109

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- 3399 • Nimo Abdullahi, Peer Community  
3400 • Rashaun Renggli, The DOVE Project  
3401 • Rosario Lopez, Super Familia  
3402 • Someireh Amirfaiz, New American Alliance for Policy and Research\*  
3403 • Thyda Chhom, Khmer Community of Seattle – King County  
3404 • Wilbur Klein, King County DCHS
- 3405 *Child, Youth, and Young Adult Mental Wellbeing*  
3406  
3407 **Steering committee:**  
3408 • Caress Piña, King County DCHS  
3409 • Delaney Knottnerus, King County DCHS  
3410 • Fatima Al-Shimari, King County DCHS  
3411 • Jim Ott, King County DCHS  
3412 • Latonya Rogers, King County DCHS  
3413 • Nacoubi Jiles, King County DCHS  
3414 • Rebekah Woods, King County DCHS  
3415 • Sarah Wilhelm, Public Health – Seattle & King County  
3416  
3417 **Workgroup:**  
3418 • Anthony Austin, Southeast Youth and Family Services\*  
3419 • Connie Gonzales, Guided Pathways for Youth and Families  
3420 • Dianne Boyd, Children’s Crisis Outreach Response (CCORS) for Developmental Disabilities  
3421 • Emmy Bell, Vashon Youth & Family Services  
3422 • Eric Mayne, Therapeutic Health Services  
3423 • Hodan Mohamed, Washington Multicultural Services Link  
3424 • Jeni Johnson, Vashon Youth & Family Services\*  
3425 • Jorene Reiber, Family Court (King County Superior Court)\*  
3426 • Kashi Arora, Seattle Children’s Hospital  
3427 • Kate Garvey, King County Sexual Assault Resource Center  
3428 • Kristen Prentice, SeaMar  
3429 • Letha Fernandez, Sound  
3430 • Libby Hein, Molina Healthcare  
3431 • M’Liss Moon, Empower Youth Network  
3432 • Martha Aguiniga, Mente Counseling and Consulting  
3433 • Megan Walsh, Encompass  
3434 • Robert Gant, Juvenile Court Services (King County Superior Court)  
3435 • Sarah Burdell, International Community Health Services (ICHS)  
3436 • Sarah Walker, UW CoLab for Community & Behavioral Health Policy  
3437 • Sarah Wilhelm, Best Starts for Kids (Public Health – Seattle & King County)  
3438 • William Hairston, Center for Children and Youth Justice  
3439
- 3440 *Behavioral Health Workforce Development*  
3441  
3442 **Steering committee:**  
3443 • Brandon Paz, King County DCHS

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 110

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- 3444 • David Perlmutter, King County DCHS
- 3445 • Jessamyn Findlay, King County DCHS
- 3446 • Karen Manuel, King County DCHS
- 3447 • Lisa Floyd, King County DCHS
- 3448 • Margaret Soukup, King County DCHS
- 3449 • Molly Bauer, King County DCHS
- 3450 • Sarah Boye, King County DCHS

**Workgroup:**

- 3453 • Adrian Lopez Romero, Public Health – Seattle & King County
- 3454 • Anna Duncan, UW CoLab for Community & Behavioral Health Policy
- 3455 • Dr. Brian Allender, King County Chief Medical Officer
- 3456 • Dan Ferguson, Washington State Allied Health Center of Excellence
- 3457 • Danie Eagleton, Seattle University
- 3458 • Elizabeth Schaumberg, Crisis Connections
- 3459 • Erin Lloyd, Valley Cities
- 3460 • Genell Hennings, YMCA Heritage Masters Program
- 3461 • Jackie Bui, Youth Eastside Services
- 3462 • Jasmeet Singh, Crisis Text Line\*
- 3463 • Laura Knapp, Seattle Children's Hospital
- 3464 • Mario Paredes, Consejo Counseling and Referral Services\*
- 3465 • Melody McKee, SEIU Healthcare Training Fund
- 3466 • Renee Fullerton, Washington Training & Education Coordinating Board
- 3467 • Robyn Smith, King County DCHS
- 3468 • Sachi Horback, United Healthcare
- 3469 • Shaena Spoor, Deconstructing the Mental Health System
- 3470 • Stacey Lopez, Sound
- 3471 • Stephanie Lane, Peer Washington
- 3472 • Tavish Donahue, Healthier Here

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#### E. Appendix E. Implementation examples of the five equity pillars

Figure 44444535: Implementation examples of the equity framework pillars

| Pillar                                                       | Examples of the equity framework in action during the renewal process and in the renewed Behavioral Health Bridge                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Connected and coordinated</b>                             | <ul style="list-style-type: none"><li>- Renewal process: Consulted with a wide range of County and non-County partners to understand the behavioral health landscape and identify high-potential investments where the behavioral health sales tax can make the greatest impact.</li><li>- Behavioral Health Bridge 2028-2034: Goals are interconnected (for example, workforce investments to increase the number and diversity of SUD professionals will also make SUD goals more successful).</li></ul>                                                                                                                                                    |
| <b>Transparent and accountable</b>                           | <ul style="list-style-type: none"><li>- Renewal process: DCHS published community engagement results online in 2024 and 2025.</li><li>- Behavioral Health Bridge 2028-2034: The implementation plan includes crosswalks showing how community feedback was incorporated <del>into the Plan</del> (see <a href="#">Appendix C</a> and <a href="#">Appendix D</a>).</li><li>- Behavioral Health Bridge 2028-2034: Robust evaluation will ensure transparency and accountability, including through disaggregation of performance data by race, ethnicity, and language.</li></ul>                                                                               |
| <b>Inclusive, collaborative, diverse, and people-focused</b> | <ul style="list-style-type: none"><li>- Renewal process: Translated written materials and provided language interpretation at community listening sessions to ensure inclusivity and language access.</li><li>- Renewal process: Included people with lived experience in the subject matter expert workgroups that developed recommendations for behavioral health sales tax investments.</li><li>- Behavioral Health Bridge 2028-2034: Outcome evaluation will use participatory and community-based models when appropriate and feasible.</li></ul>                                                                                                        |
| <b>Responsive and adaptive to community-identified needs</b> | <ul style="list-style-type: none"><li>- Renewal process: Incorporated community and subject matter expert feedback into the implementation plan.</li><li>- Behavioral Health Bridge 2028-2034: DCHS will procure programs that support community-identified solutions to behavioral health concerns (EA goal 2 and CYA goal 3).</li><li>- Behavioral Health Bridge 2028-2034: Contracted providers will have an opportunity to receive capacity-building and technical assistance to help them become more culturally and linguistically accessible.</li></ul>                                                                                                |
| <b>Accessible and available</b>                              | <ul style="list-style-type: none"><li>- Behavioral Health Bridge 2028-2034: Investments will make behavioral health care more accessible and available, including through care navigation and timely services (CTD and SUD strategy areas), culturally responsive and developmentally appropriate care (EA and CYA strategy areas), and by addressing workforce shortages and increasing provider diversity (WF strategy area).</li><li>- Behavioral Health Bridge 2028-2034: Program evaluation will include monitoring the number of clients being served, and for how long, to alleviate capacity constraints and increase service availability.</li></ul> |

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3477 **F. Appendix F. Logic model and anticipated activities for Care Transitions and**  
3478 **Diversion Strategy Area**  
3479  
3480 **G. Appendix G. Logic model and anticipated activities for Substance Use Disorder**  
3481 **Treatment and Recovery Strategy Area**  
3482  
3483 **H. Appendix H. Logic model and anticipated activities for Equitable Access to**  
3484 **Behavioral Health Care Strategy Area**  
3485  
3486 **I. Appendix I. Logic model and anticipated activities for Child, Youth, Young Adult**  
3487 **Mental Wellbeing Strategy Area**  
3488  
3489 **J. Appendix J. Logic model and anticipated activities for the Behavioral Health**  
3490 **Workforce Development Strategy Area**  
3491

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## IV. Endnotes

<sup>1</sup> Office of Economic and Financial Analysis. *March 2026 King County Economic and Revenue Forecast*. [[https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026\\_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99](https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99)]

<sup>2</sup> RCW 82.14.460. [<https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460>]

<sup>3</sup> K.C.C. 4A.500.315: Sales and use tax - for behavioral health programs and services, and therapeutic courts programs and services. [[https://aqua.kingcounty.gov/council/clerk/code/07\\_Title\\_4A.htm#\\_Toc54697846](https://aqua.kingcounty.gov/council/clerk/code/07_Title_4A.htm#_Toc54697846)]

<sup>4</sup> 2026-2027 King County Biennial Budget Ordinance 20023, Section 70, Expenditure Restriction ER6. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7680373&GUID=B4E9E09C-A982-4A8C-A0DA-6CC195D69EE0&Options=Advanced&Search=&FullText=1>]

<sup>5</sup> MIDD 2 Implementation Plan (2018). [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804\\_midd\\_implementation\\_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFEOB56EA0AFE73E42032C2876738B72](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_implementation_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFEOB56EA0AFE73E42032C2876738B72)]

<sup>6</sup> DCHS' communication channels include, but are not limited to, the Cultivating Connections department blog and department social media accounts.

<sup>7</sup> Office of Economic and Financial Analysis. *March 2026 King County Economic and Revenue Forecast*. [[https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026\\_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99](https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99)]

<sup>8</sup> RCW 82.14.460. [<https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460>]

<sup>9</sup> K.C.C. 4A.500.315. [[https://aqua.kingcounty.gov/council/clerk/code/07\\_Title\\_4A.htm#\\_Toc54697846](https://aqua.kingcounty.gov/council/clerk/code/07_Title_4A.htm#_Toc54697846)]

<sup>10</sup> RCW 82.14.460. [<https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460>]

<sup>11</sup> Ordinance 15949 (2007). [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=554785&GUID=D03F4D6D-19CA-4973-AB42-558B5BAC250E&Options=Advanced&Search=&FullText=1>]

<sup>12</sup> Ordinance 18333 (2016). [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=2745995&GUID=70E5373E-EAD8-4E04-8470-ADF157652B25&Options=Advanced&Search=&FullText=1https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=2745995&GUID=70E5373E-EAD8-4E04-8470-ADF157652B25>]

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 114

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<sup>13</sup> Ordinance 19976 (2025).

[<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7477276&GUID=C9F88779-E410-4BF9-9D6C-1E5CF80E02DE&Options=Advanced&Search=&FullText=1https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7477276&GUID=C9F88779-E410-4BF9-9D6C-1E5CF80E02DE>]

<sup>14</sup> Ordinance 19976 (2025).

[<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7477276&GUID=C9F88779-E410-4BF9-9D6C-1E5CF80E02DE&Options=Advanced&Search=&FullText=1https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7477276&GUID=C9F88779-E410-4BF9-9D6C-1E5CF80E02DE>]

<sup>15</sup> Greenstone, S. (August 2023). *22 Washington counties sue state for ‘refusing’ to provide mental health services* [KNKX Public Radio]. [<https://www.knkn.org/law/2023-08-23/washington-state-counties-lawsuit-mental-health-services>]; Archibald, A. (August 2022). Investing in health | Missing money. *Real Change* [<https://www.realchangenews.org/news/2022/08/17/investing-health-missing-money>]

<sup>16</sup> King County DCHS. *MIDD Behavioral Health Sales Tax dashboard*. [<https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-behavioral-health-tax/midd-behavioral-health-sales-tax-dashboard>]

<sup>17</sup> MIDD 2 Implementation Plan (2018). [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804\\_midd\\_implementation\\_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_implementation_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72)]

<sup>18</sup> 2026-2027 King County Biennial Budget Ordinance 20023, Section 70, Expenditure Restriction ER6.

[<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7680373&GUID=B4E9E09C-A982-4A8C-A0DA-6CC195D69EE0&Options=Advanced&Search=&FullText=1https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7680373&GUID=B4E9E09C-A982-4A8C-A0DA-6CC195D69EE0>]

<sup>19</sup> MIDD 2 Implementation Plan (2018). [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804\\_midd\\_implementation\\_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_implementation_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72)]

<sup>20</sup> RCW 82.14.460. [<https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460>]

<sup>21</sup> RCW 82.14.460. [<https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460>]

<sup>22</sup> This plan uses the name “MIDD” to refer to investments prior to 2026 and uses “the Bridge” and related terms to refer to current and future investments.

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

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<sup>23</sup> MIDD 2 Initiative Descriptions. [<https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-behavioral-health-tax/initiatives>]

<sup>24</sup> These outcomes describe the experiences of individuals enrolled in relevant MIDD initiatives between 2017 and 2022, three years following program participation.

<sup>25</sup> King County DCHS. *MIDD Behavioral Health Sales Tax dashboard*. [<https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-behavioral-health-tax/midd-behavioral-health-sales-tax-dashboard>]; Click on “Plans, Reports, and Briefing Papers” on the right sidebar to see reports prior to 2024.

<sup>26</sup> King County Executive Order, “Breaking the Cycle.” Document Code ACO-8-34-EO. March 31, 2026. [[https://content.govdelivery.com/attachments/WAKING/2026/03/31/file\\_attachments/3602521/Breaking%20the%20Cycle%20Executive%20Order%20Final.pdf](https://content.govdelivery.com/attachments/WAKING/2026/03/31/file_attachments/3602521/Breaking%20the%20Cycle%20Executive%20Order%20Final.pdf)]

<sup>27</sup> King County Department of Community and Human Services. (2023, July). *The KCICN Improves Access to Behavioral Health Care for Residents Furthest from Care*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/2023-kcicn-legislative-handout.pdf?rev=c5a838bfcdba42a590b5dd1d078bc0d8&hash=DA4ADD564B01D20B4402B3C3D424F07B>]

<sup>28</sup> Based on the BHRD financial plan as of January 1, 2026, consistent with projections available at the time of adoption of the 2026-2027 Biennial Budget Ordinance.

<sup>29</sup> Motion 15093. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=3119993&GUID=ABA47252-DF74-49B5-A4DA-C5391A5F71CD&Options=Advanced&Search=https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=3119993&GUID=ABA47252-DF74-49B5-A4DA-C5391A5F71CD>]

<sup>30</sup> King County DCHS. (2023). *The KCICN Improves Access to Behavioral Health Care for Residents Furthest from Care*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/2023-kcicn-legislative-handout.pdf?rev=c5a838bfcdba42a590b5dd1d078bc0d8&hash=DA4ADD564B01D20B4402B3C3D424F07B>]

<sup>31</sup> King County DCHS. *Crisis Care Centers Initiative*. [<https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/crisis-care-centers-levy>]

<sup>32</sup> King County DCHS. *Health Through Housing Initiative*. [<https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/health-through-housing>]

<sup>33</sup> Veterans, Seniors, and Human Services Levy (VSHSL) Implementation Plan for 2024-2029. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/asd/2024-2029-vshsl-implementation-plan.pdf?rev=e319cf4d9d2e410c8e4777061315145b&hash=CE5452BA60853FC0B26C240224388DFD>]

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

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<sup>34</sup> Washington State Health Care Authority. (2024). *Apple Health Expansion enrollment cap*. [<https://www.hca.wa.gov/about-hca/news/announcements/apple-health-expansion-enrollment-cap>]

<sup>35</sup> Washington State Health Care Authority. *Medicaid Transformation Project (MTP)*. [<https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp>]

<sup>36</sup> Brunner, J. and Sowersby, S. (2026). WA budget woes dominate as Ferguson, lawmakers begin 2026 session. *The Seattle Times*. [<https://www.seattletimes.com/seattle-news/politics/wa-budget-woes-dominate-as-ferguson-lawmakers-begin-2026-session/>]

<sup>37</sup> State budget cuts affected long-term civil commitment beds, the children's long-term inpatient program, the Recovery Navigator Program, and Law Enforcement Assisted Diversion (LEAD).

<sup>38</sup> One Big Beautiful Bill Act, H.R.1, 119th Congress (2025-2026). [<https://www.congress.gov/bills/119th-congress/house-bill/1>]; Federal legislation requires states to implement work requirements and 6-month reauthorizations for Medicaid enrollment as soon as 2027.

<sup>39</sup> Washington State Health Care Authority. (2026). *Impact of Federal Budget on Medicaid in Washington State*. [<https://www.hca.wa.gov/assets/program/medicaid-in-washington-state.pdf>]

<sup>40</sup> Westneat, D. (2025). WA is the No. 1 target in the GOP's health care slashing bill. *The Seattle Times*. [<https://www.seattletimes.com/seattle-news/politics/wa-is-the-no-1-target-in-the-gops-health-care-slashing-bill/>]

<sup>41</sup> Washington State Health Care Authority. (2024). *Follow-Up After ED Visit for Substance Use: 30 Days*. *Healthier Washington Measure Explorer & Trend Dashboard*. [<https://hca-tableau.watech.wa.gov/t/51/views/HealthierWashingtonDashboard/Measures?%3AisGuestRedirectFromVizportal=y&%3Aembed=y>]

<sup>42</sup> King County DCHS. (2022). *DCHS Data Insights Series: Integrating Data to Better Understand Fatal Overdoses and Service System Engagement*. [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/departments/documents/FINAL\\_integrated\\_overdose\\_brief.ashx?la=en](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/departments/documents/FINAL_integrated_overdose_brief.ashx?la=en)]

<sup>43</sup> King County DCHS. (2022). *DCHS Data Insights Series: Integrating Data to Better Understand Fatal Overdoses and Service System Engagement*. [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/departments/documents/FINAL\\_integrated\\_overdose\\_brief.ashx?la=en](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/departments/documents/FINAL_integrated_overdose_brief.ashx?la=en)]

<sup>44</sup> Public Health – Seattle & King County. *Overdose deaths data dashboard*. [<https://kingcounty.gov/en/dept/dph/health-safety/safety-injury-prevention/overdose-prevention-response/data-dashboards/>]

<sup>45</sup> Public Health – Seattle & King County. *Overdose deaths data dashboard*. [<https://kingcounty.gov/en/dept/dph/health-safety/safety-injury-prevention/overdose-prevention-response/data-dashboards/>]; In 2017, there were 16 fatal overdoses per 100,000 people. In 2025, there were 35.2 per 100,000.

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 117

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<sup>46</sup> Dickson-Gomez J., Spector A., Weeks M., Galletly C., McDonald M., Green Montaque H.D. (2022). You're Not Supposed to be on it Forever: Medications to Treat Opioid Use Disorder (MOUD) Related Stigma Among Drug Treatment Providers and People who Use Opioids. *Substance Abuse*. 27(16). [<https://journals.sagepub.com/doi/10.1177/11782218221103859>]

<sup>47</sup> All Home. (2017). *Count Us In: Seattle/King County Point-in-Time Count of Persons Experiencing Homelessness*. [<https://kcrha.org/wp-content/uploads/2022/05/2017-King-PIT-Count-Comprehensive-Report-FINAL-DRAFT-5.31.17.pdf>]

<sup>48</sup> King County Regional Homelessness Authority. (2026). *Seattle/King County Point-in-Time Count 2026*. [<https://kcrha.org/community-data/king-county-point-in-time-count/>]

<sup>49</sup> Communities Count. *King County Population Dashboard*. [<https://www.communitiescount.org/population-dashboard>]

<sup>50</sup> Public Health – Seattle & King County. *Community Health Needs Assessment*. [<https://kingcounty.gov/en/dept/dph/about-king-county/about-public-health/chna>]

<sup>51</sup> Balk, G. (2023) New King County milestone: One-quarter of residents born outside U.S. *The Seattle Times*. [<https://www.seattletimes.com/seattle-news/data/new-king-county-milestone-one-quarter-of-residents-born-outside-u-s/>]

<sup>52</sup> KFF. (2024). *Racial and Ethnic Disparities in Mental Health Care: Findings from the KFF Survey of Racism, Discrimination and Health*. [<https://www.kff.org/racial-equity-and-health-policy/racial-and-ethnic-disparities-in-mental-health-care-findings-from-the-kff-survey-of-racism-discrimination-and-health/>]

<sup>53</sup> Public Health – Seattle & King County. *Data to inform King County's overdose response*. [<https://kingcounty.gov/en/dept/dph/health-safety/safety-injury-prevention/overdose-prevention-response/data-dashboards/>]. 2025 fatal overdose rates per 100,000 people: AI/AN: 211.4; Black: 95.2; White, non-Hispanic: 31.3.

<sup>54</sup> Communities Count. *Frequent Mental Distress*. [<https://www.communitiescount.org/frequent-mental-distress>]

<sup>55</sup> Chatterjee, R. (2024). We're not 'out of the woods' in the youth mental health crisis, a CDC researcher says. *NPR*. [<https://www.npr.org/sections/shots-health-news/2024/08/07/nx-s1-5064406/cdc-youth-risk-behavior-survey-suicide-mental-health-drugs-alcohol>]

<sup>56</sup> Friedman, J., Hadland, S. E. (2024). The Overdose Crisis among U.S. Adolescents. *The New England Journal of Medicine*, 390(2), 97–100. [<https://doi.org/10.1056/NEJMp2312084>]

<sup>57</sup> Public Health-Seattle & King County. (2024). *From Data to Action: Addressing Youth Mental Health and Substance Use in King County*. [<https://www.communitiescount.org/blog/2025/3/20/from-data-to-action-addressing-youth-mental-health-and-substance-use-in-king-county>]

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 118

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<sup>58</sup> Washington State Healthy Youth Survey. [<https://www.askhys.net/SurveyResults/FactSheets>]

<sup>59</sup> Youth.gov. *Behavioral Health*. [<https://youth.gov/youth-topics/homelessness-and-housing-instability/behavioral-health>]

<sup>60</sup> MIDD 2 Implementation Plan (2018). [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804\\_midd\\_implementation\\_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFEOB56EA0AFE73E42032C2876738B72](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_implementation_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFEOB56EA0AFE73E42032C2876738B72)]. The 2017 MIDD 2 Implementation Plan noted that “the behavioral health workforce is in crisis.”

<sup>61</sup> The Council of State Governments. (2024). *Mental Health Matters: Addressing Behavioral Health Workforce Shortages*. [<https://www.csg.org/2024/10/10/mental-health-matters-addressing-behavioral-health-workforce-shortages/>]  
[<https://www.csg.org/2024/10/10/mental-health-matters-addressing-behavioral-health-workforce-shortages/>]

<sup>62</sup> King County. KCICN Workforce Survey 2021.

<sup>63</sup> King County. (2024). *2024 MIDD Behavioral Health Sales Tax Fund Annual Summary Report*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/reports/2024-midd-annual-summary-report.pdf?rev=edfcfcbbc62444a871b804afc335f66&hash=DC1226BDA3A9431F948BED3D97F42160>]

<sup>64</sup> King County. KCICN Workforce Survey 2025.

<sup>65</sup> United States Health Resources & Services Administration. (2025, December). *State of the Behavioral Health Workforce, 2025*. [<https://bhwh.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf>]

<sup>66</sup> King County DCHS. (2025). *MIDD Renewal Community Engagement Report*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd-renewal-community-engagement-report-final-2025.pdf?rev=158a78c33eab4cdda443da39d874f040&hash=3EDD11B4F9CAF6A7C4BDDCB16EAF1FD>]  
[<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd-renewal-community-engagement-report-final-2025.pdf?rev=158a78c33eab4cdda443da39d874f040&hash=3EDD11B4F9CAF6A7C4BDDCB16EAF1FD>]

<sup>67</sup> King County DCHS. (2025). *Be Heard: Community Voices About Mental Health and Wellness Report*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/MIDD/Be-Heard-Community-Listening-Report>]

<sup>68</sup> MIDD AC Meeting Notes, January 23, 2025. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/advisory-committee/2025-02-27/item-2-midd-meeting-notes-12325.pdf?rev=9590bfd12154478d93cd3bed1faa80f1&hash=1FE6DAA83E16AD08A8E75EC512C1FA10>]

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)  
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<sup>71</sup> King County Executive Order, “Better Governance and Financial Management.” Document Code ACO-8-33-EO. March 4, 2026. [<https://cdn.kingcounty.gov/-/media/king-county/depts/executive-services/policies/documents/aco-8-33-eo-03-04-2026.pdf?rev=f11305dd68fd4c29af2a8ca8e60145a5&hash=95EA94BF839EAEDF42E3EDA908D8368F>]

<sup>72</sup> Heinz A., Liu S. (2022). Challenges and chances for mental health care in the 21<sup>st</sup> century. *World Psychiatry* (8;21(3)), 423-424. [<https://pmc.ncbi.nlm.nih.gov/articles/PMC9453898/>]

<sup>73</sup> Recovery.com. (2024). *Timeline: History of Addiction Treatment*. [<https://recovery.org/drug-treatment/history/>]

<sup>74</sup> MIDD 2 Implementation Plan (2018). [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804\\_midd\\_implementation\\_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_implementation_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72)]

<sup>75</sup> King County Executive Order, “Better Governance and Financial Management.” Document Code ACO-8-33-EO. Section 6. Reviewing and Prioritizing Base Budgets. March 4, 2026. [<https://cdn.kingcounty.gov/-/media/king-county/depts/executive-services/policies/documents/aco-8-33-eo-03-04-2026.pdf?rev=f11305dd68fd4c29af2a8ca8e60145a5&hash=95EA94BF839EAEDF42E3EDA908D8368F>]

<sup>76</sup> Ordinance 16077. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=555168&GUID=59A067B4-E1D8-4A40-9775-50FA651696E1>]

<sup>77</sup> Ordinance 18452. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=2819659&GUID=43729153-15C2-4825-89CD-C8885F90D04B>]

<sup>78</sup> Ordinance 18452. [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/ordinance\\_18452.pdf?la=en&rev=92633d2b80584444a3af3c7827dda4ae&hash=5C0B38DE9C3143EEC710B1889431B656](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/ordinance_18452.pdf?la=en&rev=92633d2b80584444a3af3c7827dda4ae&hash=5C0B38DE9C3143EEC710B1889431B656)].

<sup>79</sup> King County Executive Order, “Breaking the Cycle.” Document Code ACO-8-34-EO. March 31, 2026. [[https://content.govdelivery.com/attachments/WAKING/2026/03/31/file\\_attachments/3602521/Breaking%20the%20Cycle%20Executive%20Order%20Final.pdf](https://content.govdelivery.com/attachments/WAKING/2026/03/31/file_attachments/3602521/Breaking%20the%20Cycle%20Executive%20Order%20Final.pdf)]<https://cdn.kingcounty.gov/-/media/king-county/depts/executive-services/policies/documents/ACO-8-34-EO.pdf>]

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King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

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<sup>81</sup> King County Regional Homelessness Authority. (2026). *Point-in-Time Count*. <https://kcrha.org/community-data/king-county-point-in-time-count/>

<sup>82</sup> RCW 82.14.460. <https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460>

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<sup>85</sup> Center on Budget and Policy Priorities. (2022). *States Can Reduce Medicaid’s Administrative Burdens to Advance Health and Racial Equity*. <https://www.cbpp.org/research/health/states-can-reduce-medicoids-administrative-burdens-to-advance-health-and-racial>

<sup>86</sup> King County DCHS. (2026). *Cultivating Connections: Update on King County’s Response to the Opioid Overdose Crisis*. <https://dchsblog.com/2026/03/10/update-on-king-countys-response-to-the-opioid-overdose-crisis/>

<sup>87</sup> Substance Abuse and Mental Health Administration. *SAMHSA’s Working Definition of Recovery: 10 Guiding Principles of Recovery*. <https://library.samhsa.gov/sites/default/files/pep12-recdef.pdf>

<sup>88</sup> Islam M.F., Guerrero M., Nguyen R.L., Porcaro A., Cummings C., Stevens E., Kang A., Jason L.A. (2023). The Importance of Social Support in Recovery Populations: Toward a Multilevel Understanding. *Alcohol Treat Q*. <https://pmc.ncbi.nlm.nih.gov/articles/PMC10259869/>

<sup>89</sup> Abramo, A. (2020). After leaving addiction treatment, young adults often face homelessness. *Cascade PBS*. <https://www.cascadepbs.org/equity/2020/07/after-leaving-addiction-treatment-young-adults-often-face-homelessness/>

<sup>90</sup> The Agency for Healthcare Research and Quality (AHRQ). *Six Domains of Health Care Quality*. <https://www.ahrq.gov/talkingquality/measures/six-domains.html>

<sup>91</sup> KFF. (2026). *How states verify citizenship and immigration status in Medicaid*. <https://www.kff.org/medicaid/how-states-verify-citizenship-and-immigration-status-in-medicoid/>

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 121

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<sup>92</sup> Communities Count. *Health Insurance*. [<https://www.communitiescount.org/health-insurance>]; In King County in 2024, 14.9 percent of non-citizens lacked health insurance, compared to only 5.3 percent of the overall population.

<sup>93</sup> KFF. (2026). *How states verify citizenship and immigration status in Medicaid*. [<https://www.kff.org/medicaid/how-states-verify-citizenship-and-immigration-status-in-medicaid/>]

<sup>94</sup> Tens of thousands of Washingtonians could soon be in healthcare limbo. (2026). *KOMO News*. [<https://komonews.com/news/politics/tens-of-thousands-of-washingtonians-could-soon-be-in-healthcare-limbo>]

<sup>95</sup> National Alliance for Mental Illness. *Budget Reconciliation: Impact on People with Mental Health Conditions*. [<https://www.nami.org/wp-content/uploads/2025/09/Budget-Reconciliation-Impact-on-People-With-Mental-Health-Conditions-FINAL.pdf>]

<sup>96</sup> KFF. (2024). *Racial and Ethnic Disparities in Mental Health Care: Findings from the KFF Survey of Racism, Discrimination and Health*. [<https://www.kff.org/racial-equity-and-health-policy/racial-and-ethnic-disparities-in-mental-health-care-findings-from-the-kff-survey-of-racism-discrimination-and-health/>]

<sup>97</sup> Masanori, K. (2025). The rising predictive power of LGBT identity in mental health: An analysis of variable importance. *Annals of Epidemiology*, Volume 111. [<https://www.sciencedirect.com/science/article/abs/pii/S1047279725002777>]

<sup>98</sup> Morales D.A., Barksdale C.L., Beckel-Mitchener A.C. (2020). A call to action to address rural mental health disparities. *J Clin Transl Sci*, 4(5):463-467. [<https://pmc.ncbi.nlm.nih.gov/articles/PMC7681156/>]

<sup>99</sup> Blatchford, T. (2026). King County's mental health expansion moving too slowly, Zahilay says. *The Seattle Times*. [<https://www.seattletimes.com/seattle-news/mental-health/king-countys-mental-health-expansion-moving-way-too-slowly-zahilay-says/>]

<sup>100</sup> Best Starts for Kids Implementation Plan: 2022-2027. [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/best-starts/documents/best\\_starts\\_for\\_kids\\_implementation\\_plan\\_approved\\_2021.pdf?la=en&rev=982959618c9246df82d2f6a68272c68f&hash=072B4DA6104EBC2E7F728B175898696D](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/best-starts/documents/best_starts_for_kids_implementation_plan_approved_2021.pdf?la=en&rev=982959618c9246df82d2f6a68272c68f&hash=072B4DA6104EBC2E7F728B175898696D)]

<sup>101</sup> Blatchford, T. (2026, April). King County's mental health expansion moving too slowly, Zahilay says. *Seattle Times*. [<https://www.seattletimes.com/seattle-news/mental-health/king-countys-mental-health-expansion-moving-way-too-slowly-zahilay-says/>]

<sup>102</sup> Motion 16966. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7760680&GUID=69D1C7DC-BC39-4093-BC56->

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 122

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<sup>103</sup> Consistent with all Behavioral Health Bridge investments, services provided by this goal are not intended to replace Medicaid payment for equivalent services.

<sup>104</sup> Piper K., Stielow S., Hines-Wilson M., Van Alstine E., Sheerin K., Modrowski C., Kemp K. (2025). Barriers to Behavioral Health Treatment among Youth and Caregivers Involved in the Juvenile Legal System. *Evid Based Pract Child Adolesc Ment Health*.  
[<https://pmc.ncbi.nlm.nih.gov/articles/PMC12803726/>]

<sup>105</sup> King County Prosecuting Attorney's Office Data Dashboard. [<https://kingcounty.gov/en/dept/pao/about-king-county/about-pao/data-reports/dashboard#toc-The-Data-Dashboard>]

<sup>106</sup> King County Department of Adult and Juvenile Detention. Detention and Alternatives Report Year 2026. [[https://cdn.kingcounty.gov/-/media/king-county/depts/dajd/documents/population-information-pdfs/2026-05-kc-dar-scorecard.pdf?rev=4df996b290e5462487e3be5d6052a39c&hash=A17AFCE0F5EE810290D73181AEB6E711https://cdn.kingcounty.gov/-/media/king-county/depts/dajd/documents/population-information-pdfs/dar\\_scorecard-2026-august-accessible.pdf?rev=7f3c4d83c32c40ca9e649819872cf6c2&hash=F263554DA5F2A036247A6934C7E547C8&\\_gl=1\\*ayymiy\\*\\_ga\\*MTM3MzM5ODY4LjE3OTA3MTEzMjEzMDgkZzEkZzEkZzEkZzOTA3MTEzNTAkajE4JGwWJGgw](https://cdn.kingcounty.gov/-/media/king-county/depts/dajd/documents/population-information-pdfs/2026-05-kc-dar-scorecard.pdf?rev=4df996b290e5462487e3be5d6052a39c&hash=A17AFCE0F5EE810290D73181AEB6E711https://cdn.kingcounty.gov/-/media/king-county/depts/dajd/documents/population-information-pdfs/dar_scorecard-2026-august-accessible.pdf?rev=7f3c4d83c32c40ca9e649819872cf6c2&hash=F263554DA5F2A036247A6934C7E547C8&_gl=1*ayymiy*_ga*MTM3MzM5ODY4LjE3OTA3MTEzMjEzMDgkZzEkZzEkZzEkZzOTA3MTEzNTAkajE4JGwWJGgw)]

<sup>107</sup> Washington State Healthy Youth Survey. [<https://www.askhys.net/SurveyResults/FactSheets>]

<sup>108</sup> Washington State Healthy Youth Survey. [<https://www.askhys.net/SurveyResults/FactSheets>]

<sup>109</sup> Rapid Health Information NetwOrk (RHINO). [<https://kingcounty.gov/en/dept/dph/about-king-county/about-public-health/data-reports/population-health-data/community-health-indicators/rhino?shortname=Suicidal%20ideation>]

<sup>110</sup> Washington State Healthy Youth Survey. [<https://www.askhys.net/SurveyResults/FactSheets>]

<sup>111</sup> Health Resources and Services Administration. *Behavioral Health Workforce Projections*. [<https://data.hrsa.gov/topics/health-workforce/workforce-projections>]

<sup>112</sup> King County. KCICN Workforce Survey 2025.

<sup>113</sup> Other DCHS funds also support aspects of the human services workforce. VSHSL focuses on nonprofit staff, the CCC Levy focuses on crisis staff, and the Behavioral Health Bridge is intended to focus on behavioral health workers across the care continuum (beyond crisis services). These fund sources will work in concert, with complementary rather than duplicative investments.

<sup>114</sup> National Center for Health Workforce Analysis. (2025). *State of the Behavioral Health Workforce*, 2025. [<https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf>]; Report highlight: "Substantial shortages of

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 123

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addiction counselors, marriage and family therapists, mental health counselors, psychologists, mental health and substance use disorder social workers, adult psychiatrists, child and adolescent psychiatrists, and school counselors are projected in 2038.”

<sup>115</sup> Pathman D.E., de Saxe Zerden L., Konrad T.R., Shafer A.B., Harrison J.N., Fannell J., Lombardi B.M. (2025, April). Job assessments and the anticipated retention of behavioral health clinicians working in U.S. Health Professional Shortage Areas. *BMC Health Serv Res*, 25(1):592. [<https://pmc.ncbi.nlm.nih.gov/articles/PMC12020279/>]

<sup>116</sup> Harrison, J.P. (2020). *Therapist turnover in community mental health: Testing the applicability of job embeddedness and shocks*. [Doctoral dissertation, University of Washington]. [<https://digital.lib.washington.edu/server/api/core/bitstreams/a3b23e92-f797-4721-aa76-8d3ed2137be0/content>]

<sup>117</sup> King County. KCICN Workforce Survey 2025.

<sup>118</sup> Washington State Department of Health. *Agency-Affiliated Counselor – Frequently Asked Questions*. [<https://doh.wa.gov/licenses-permits-and-certificates/professions-new-renew-or-update/agency-affiliated-counselor/frequently-asked-questions>]

<sup>119</sup> King County. KCICN Workforce Survey 2025.

<sup>120</sup> King County. KCICN Workforce Survey 2025.

<sup>121</sup> King County. KCICN Workforce Survey 2025.

<sup>122</sup> MIDD 2 Implementation Plan. (2018). [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804\\_midd\\_implementation\\_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_implementation_plan.pdf?la=en&rev=620583891f9244ddb76dfb7e5c4b1f6f&hash=BFE0B56EA0AFE73E42032C2876738B72)]

<sup>123</sup> MIDD 2 Evaluation Plan. (2018). [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804\\_midd\\_evaluation\\_plan.pdf?la=en&rev=85c9a05460084507a190c1ce943d57b1&hash=6E4F1C75BCAC13288FBBB0C57A7E9BF1](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/170804_midd_evaluation_plan.pdf?la=en&rev=85c9a05460084507a190c1ce943d57b1&hash=6E4F1C75BCAC13288FBBB0C57A7E9BF1)]

<sup>124</sup> Ordinance 18407. [[https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/ordinance\\_18407.pdf?la=en&rev=5867c9491f1344488211221b2fd7fda8&hash=08258AC12F55E0E731E8DB355A154182](https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/ordinance_18407.pdf?la=en&rev=5867c9491f1344488211221b2fd7fda8&hash=08258AC12F55E0E731E8DB355A154182)]

<sup>125</sup> Clear Impact. *What is Results-Based Accountability?* [<https://clearimpact.com/results-based-accountability/>]

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 124

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<sup>127</sup> Substance Abuse and Mental Health Services Administration. (2024). *Developing Goals and Measurable Objectives*. [<https://www.samhsa.gov/grants/how-to-apply/forms-and-resources/developing-goals-measurable-objectives>]

<sup>128</sup> King County DCHS. *MIDD Behavioral Health Sales Tax dashboard, Plans, Reports, and Briefing Papers*. [<https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-behavioral-health-tax/midd-behavioral-health-sales-tax-dashboard/past-reports>]

<sup>129</sup> WestEd Justice & Prevention Research Center for the Annie E. Casey Foundation. (2019). *Reflections on Applying Principles of Equitable Evaluation*. [<https://www.aecf.org/resources/reflections-on-applying-principles-of-equitable-evaluation>]

<sup>130</sup> Implementation of a revised approach to performance metrics has begun in 2026. After reviewing best practices across many Departments, work has begun to start integrating performance metrics into the DNA of how the County does business. The Executive Office is standardizing an approach that will be extended across all Departments and will also be working on additional best practices with the Departments who are doing these processes today to continue with operational excellence work. This approach will eventually include monthly business reviews for every department and quarterly business reviews with the Executive Office.

<sup>131</sup> Clear Impact. *What is Results-Based Accountability?* [<https://clearimpact.com/results-based-accountability/>].

<sup>132</sup> Motion 15081. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=3307620&GUID=D5F273E9-C87F-40F1-97FE-C668F5DAA261&Options=Advanced&Search=https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=3307620&GUID=D5F273E9-C87F-40F1-97FE-C668F5DAA261>]. Motion 15081 accepted a report on consolidated human services reporting, as required by Ordinance 18409, Section 66, Proviso P2.

<sup>133</sup> King County DCHS. *Measuring DCHS' Impact*. [<https://kingcounty.gov/en/dept/dchs/about-king-county/about-dchs/data-reports>]

<sup>134</sup> Motion 15081. [<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=3307620&GUID=D5F273E9-C87F-40F1-97FE-C668F5DAA261&Options=Advanced&Search=https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=3307620%20&GUID=D5F273E9-C87F-40F1-97FE-C668F5DAA261>]; Motion 15081 accepted a report on consolidated human services reporting, as required by Ordinance 18409, Section 66, Proviso P2.

<sup>135</sup> Multiple data system improvements support this data collection and reporting, including investments in data systems and infrastructure, performance measurement and evaluation staff to manage and analyze large amounts of data from hundreds of providers. DCHS partnered with PHSKC and KCIT to build an Integrated Data Hub that deduplicates service participants across a

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 125

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wide variety of programs and supports cross-systems analysis. DCHS also developed and implemented a first-of-its kind data system, known as the Client Outcomes Reporting Engine (CORE), to efficiently manage large volumes of data submissions from providers that enables consistent measures and transparent reporting.

<sup>136</sup> King County DCHS. *Explore the Data*. [<https://kingcounty.gov/en/dept/dchs/about-king-county/about-dchs/data-reports/impact-dashboard>]

<sup>137</sup> King County DCHS. *MIDD Behavioral Health Sales Tax dashboard*. [<https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-behavioral-health-tax/midd-behavioral-health-sales-tax-dashboard>].

<sup>139</sup> State of Washington. (2026). *ESSB 6346*. [<https://app.leg.wa.gov/BillSummary/?BillNumber=6346&Year=2025>]

<sup>140</sup> Office of Economic and Financial Analysis. *March 2026 King County Economic and Revenue Forecast*. [[https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026\\_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99](https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99)]

<sup>141</sup> King County DCHS. (2024). *DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy>]

<sup>142</sup> King County Executive Order, “Breaking the Cycle.” Document Code ACO-8-34-EO. March 31, 2026. [<https://cdn.kingcounty.gov/-/media/king-county/depts/executive-services/policies/documents/ACO-8-34-EO.pdf>]([https://content.govdelivery.com/attachments/WAKING/2026/03/31/file\\_attachments/3602521/Breaking%20the%20Cycle%20Executive%20Order%20Final.pdf](https://content.govdelivery.com/attachments/WAKING/2026/03/31/file_attachments/3602521/Breaking%20the%20Cycle%20Executive%20Order%20Final.pdf))

<sup>143</sup> One Big Beautiful Bill Act, H.R.1, 119th Congress (2025-2026). [<https://www.congress.gov/bill/119th-congress/house-bill/1>]; Federal legislation requires states to implement work requirements and 6-month reauthorizations for Medicaid enrollment as soon as 2027.

<sup>144</sup> Section 6. Reviewing and Prioritizing Base Budgets. King County Executive Order, “Better Governance and Financial Management.” Document Code ACO-8-33-EO. March 4, 2026. [<https://cdn.kingcounty.gov/-/media/king-county/depts/executive-services/policies/documents/aco-8-33-eo-03-04-2026.pdf?rev=f11305dd68fd4c29af2a8ca8e60145a5&hash=95EA94BF839EAEDF42E3EDA908D8368F>]

<sup>145</sup> King County DCHS. (2025). *An Update: Responding to the Audit*. *DCHS Blog: Cultivating Connections*. [<https://dchsblog.com/2025/12/11/an-update-responding-to-the-audit/>]

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 126

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<sup>146</sup> Motion 16975. (2026).

[<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7965836&GUID=74EC9640-4DB4-4562-BF46-E39FCCC6E8AE&Options=Advanced&Search=https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7965836&GUID=74EC9640-4DB4-4562-BF46-E39FCCC6E8AE>] Motion 16975 accepts the Report on the Status of Activities Related to Contract Management and Compliance Reporting Protocols.

<sup>147</sup> King County. *King County Comprehensive Financial Management Policies*.

[<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5122778&GUID=EA35F767-889C-4ADA-A720-6342044F7413&Options=Advanced&Search=https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5122778&GUID=EA35F767-889C-4ADA-A720-6342044F7413>]

<sup>149</sup> The 10 percent threshold for notification letters will be applied to the annual allocation for the strategy area, as adjusted through any prior changes if applicable. Prior changes may include substantive changes that have been summarized in past notification letters to the Council like those described in this section; proceeds not spent within a strategy area in the originally planned year but retained within the same strategy area for use in a subsequent year; other non-substantive adjustments that do not meet the notification threshold; or changes that may have been initiated by the Council through a budget ordinance.

<sup>150</sup> 2026-2027 King County Biennial Budget. November 18, 2025.

[<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7680373&GUID=B4E9E09C-A982-4A8C-A0DA-6CC195D69EE0&Options=Advanced&Search=&FullText=https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7680373&GUID=B4E9E09C-A982-4A8C-A0DA-6CC195D69EE0>]

<sup>151</sup> King County DCHS. DCHS Inflation Rate Adjustment Policy for Human Services Contracts.

(2024). [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policyhttps://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy>]

<sup>152</sup> Ordinance 19364, Section 44, Proviso P3.

[<https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5153492&GUID=83A03492-A721-4832-BA46-BCD9D2951C3D&Options=Advanced&Search=&FullText=https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5153492&GUID=83A03492-A721-4832-BA46-BCD9D2951C3D>]; This proviso language was later amended to remove the report requirement.

<sup>153</sup> King County DCHS. (2024). *DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy>]

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 127

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<sup>154</sup> King County. *King County Budget and Financial Planning Assumptions Dashboard*. [<https://app.powerbigov.us/groups/me/reports/b97a6283-2b3f-4a50-8f6d-c5d0d601df05/ReportSection3c4f835a513e65de275e>]

<sup>155</sup> Office of Economic and Financial Analysis. *March 2026 King County Economic and Revenue Forecast*. [[https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026\\_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99](https://cdn.kingcounty.gov/-/media/king-county/independent/governance-and-leadership/government-oversight/forecasting/documents/march2026_pdfadopted.pdf?rev=6cdf6650ea2d492abfc50bb439636bf8&hash=A27D47D6291478774123E825A1084F99)]

<sup>156</sup> King County DCHS. (2024). *Section 6.3 of DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy>]

<sup>157</sup> King County DCHS. (2024). *Section 6.7 of DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy>]

<sup>158</sup> King County DCHS. (2024). *Section 6.7 of DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy>]

<sup>159</sup> King County. *King County Budget and Financial Planning Assumptions Dashboard*. [<https://app.powerbigov.us/groups/me/reports/b97a6283-2b3f-4a50-8f6d-c5d0d601df05/ReportSection3c4f835a513e65de275e>]

<sup>160</sup> King County DCHS. (2024). *Section 6.1 of DCHS Inflation Rate Adjustment Policy for Human Services Contracts*. [<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/ASD/DCHS%20Inflation%20Policy>]

<sup>161</sup> King County DCHS. *Familiar Faces Data Packet*. [[https://www.naco.org/sites/default/files/event\\_attachments/Familiar%20Faces%20Data%20Packet.pdf](https://www.naco.org/sites/default/files/event_attachments/Familiar%20Faces%20Data%20Packet.pdf)]; This source provides and internal analysis of jail bookings in King County Correctional Facility, Maleng Regional Justice Center, South Correctional Entity, and municipal jails for the Cities of Enumclaw, Issaquah, Kent, and Kirkland.

<sup>162</sup> Therapeutic court services provided by the Juvenile Response and Accountability Court – Behavioral Health Response (JTRAC-BHR) are addressed under CYYA Goal 2.

<sup>163</sup> U.S. Department of Housing and Urban Development. *Homelessness Management Information System*. [<https://www.hudexchange.info/programs/hmis/>]

<sup>164</sup> King County Executive Order, “Breaking the Cycle.” Document Code ACO-8-34-EO. March 31, 2026. [<https://cdn.kingcounty.gov/-/media/king-county/depts/executive-services/policies/documents/ACO-8-34-EO.pdf>][https://content.govdelivery.com/attachments/WAKING/2026/03/31/file\\_attachments/3602521/Breaking%20the%20Cycle%20Executive%20Order%20Final.pdf](https://content.govdelivery.com/attachments/WAKING/2026/03/31/file_attachments/3602521/Breaking%20the%20Cycle%20Executive%20Order%20Final.pdf)]

King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 128

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<sup>165</sup> King County DCHS. (2024). *2023 Health Through Housing Annual Report*.  
[<https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/housing/health-through-housing/annual-reports/2023-health-through-housing-annual-report.pdf?rev=508110d4a6d4939b9925e2af0f3caf1&hash=6B38F2613B8573DCA8E926227019C3C7>]

<sup>166</sup> Kelly E., Fulginiti A., Pahwa R., et al. (2014). A Pilot Test of a Peer Navigator Intervention for Improving the Health of Individuals with Serious Mental Illness. *Community Ment Health J* 50, 435–446. [<https://link.springer.com/article/10.1007/s10597-013-9616-4>]

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King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 130

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Page | 131

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King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 132

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King County Behavioral Health Bridge Implementation Plan 2028-2034 [Phase 1: Transition Strategic Framework](#)

Page | 133

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