PO 2026-0177 Amendment Tracker

Regional Policy Committee – November 5, 2026

Amd No.	First Page & Line No.	Sponsor	Addt'l Mttg Materials Folder Page	Amendment Description
1	Att A, Page 1, Line 1	von Reichbauer	3	• Replaces Attachment A with a new Attachment A that does the following: • Require reporting on data to be broken down by city as well as Council District and ZIP code. • Replace the term "shall" with "should", in reference to the amount of money to be invested in EA Goal 1 from 2028 through 2034. • Replace the phrase "is expected to" with "shall", in reference to incorporating quantitative and qualitative data in performance measurement. • Require a new procurement progress report be transmitted in 2028, 2029, and 2030. • Require that the biennial report, procurement progress reports, pre-procurement notifications, and substantial adjustments to the financial plan notifications that are transmitted to Council also be transmitted to the Regional Policy Committee. • Require that the pre-procurement notification report include specificity for performance metrics and remove permissive language. • Make technical edits.

Last updated 11/2/2026

Amd No.	First Page & Line No.	Sponsor	Addt'l Mttg Materials Folder Page	Amendment Description
2 to Amd 1	Att A, Page 6, Line 201	Balducci	129	• Would include reference to outcomes throughout the plan and establish an initial outcomes measurement plan to be transmitted to Council and the Regional Policy Committee.
3 to Amd 1	Att A, Page 39, Line 1397	von Reichbauer	132	• Would correct three references in the plan to reflect that the logic models appear in Section XI.
4 to Amd 1	Att A, Page 51, Line 1905	Balducci	133	• Would expand the content of the early year progress reports to include reporting on the programs that are still in operation in 2028 and 2029, in addition to reporting on the progress of procurements for new Bridge programs.

1

October 21, 2026
Chair's Amendment

Sponsor: Von Reichbauer

[S. Porter]

Proposed No.: 2026-0177

AMENDMENT TO PROPOSED ORDINANCE 2026-0177, VERSION 2

Strike Attachment A, King County Behavioral Health Bridge Implementation Plan 2028-2034, Dated October 2026, and insert Attachment A, King County Behavioral Health Bridge Implementation Plan 2028-2034 Phase 1: Transition Strategic Framework, Dated November 2026"

EFFECT prepared by *S. Porter*: *The amendment would:*

- ***Replace the term "shall" with "should", in reference to the amount of money to be invested in EA Goal 1 from 2028 through 2034.***
- ***Replace the phrase "is expected to" with "shall", in reference to incorporating quantitative and qualitative data in performance measurement.***
- ***Require reporting on data to be broken down by city as well as Council District and ZIP code.***
- ***Require a new procurement progress report be transmitted in 2028, 2029, and 2030.***
- ***Require that the biennial report, procurement progress reports, pre-procurement notifications, and substantial adjustments to the financial plan***

notifications that are transmitted to Council also be transmitted to the Regional Policy Committee.

- ***Require that the pre-procurement notification report include specificity for performance metrics and remove permissive language.***
- ***Make technical edits.***

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

November 2026



I. Contents

I. Contents **2**

II. Executive Summary **4**

III. Background **9**

A. The King County Behavioral Health Bridge 9

B. Primary purpose 10

C. A new name and a new process to meet current needs 10

D. Overview of DCHS and community behavioral health services 12

IV. The process to develop the Behavioral Health Bridge Implementation Plan, Phase 1 **14**

A. Behavioral health policy and funding changes 14

B. Changes in regional behavioral health needs 14

C. Community and subject matter expert engagement 16

V. A renewed King County Behavioral Health Bridge **18**

A. Equity framework 19

B. Phased, competitive procurement and base budget analyses 20

C. Advisory Committee 23

VI. Investments across the five strategy areas **25**

A. Care Transitions and Diversion Services (CTD) 25

B. Substance Use Disorder Treatment and Recovery (SUD) 28

C. Equitable Access to Behavioral Health Care (EA) 31

D. Child, Youth, and Young Adult Mental Wellbeing (CYYA) 33

E. Behavioral Health Workforce Development (WF) 36

VII. Measurement and evaluation **39**

A. Overarching principles 39

B. Performance measurement and evaluation framework 41

VIII. Reporting for continuous improvement and accountability **49**

IX. Financial plan and policies **52**

A. Overview 52

B. Financial plan 53

C. Fiscal policies 57

X. Inflation rate adjustment policy analysis **59**

A. How the inflation policy was determined to be applicable to the King County Behavioral Health Bridge 59

B. Analysis of the effect of the inflation rate adjustment policy on the Behavioral Health Bridge and risk of a structural gap 59
C. Process for mitigating fund shortfalls or structural gaps 60
XI. Requesting Implementation Plan Phase 2: Pre-Procurement Development Plan and Council Notifications 63
D. Pre-procurement Council and Regional Policy Committee notification 63
E. Council engagement opportunities and notification of awards 64
F. Anticipated procurement timeline 64
G. Examples of anticipated activities to be procured for the five strategy areas 65
H. Logic model and anticipated activities for Care Transitions and Diversion Strategy Area 65
I. Logic model and anticipated activities for Substance Use Disorder Treatment and Recovery Strategy Area 70
J. Logic model and anticipated activities for Equitable Access to Behavioral Health Care Strategy Area 74
K. Logic model and anticipated activities for Child, Youth, Young Adult Mental Wellbeing Strategy Area 77
L. Logic model and anticipated activities for the Behavioral Health Workforce Development Strategy Area 80
XII. Conclusion 84
XIII. Appendices 85
A. Appendix A. Behavioral Health Bridge investments in DCHS and other County agencies 85
B. Appendix B. Community engagement activities and results 86
C. Appendix C. Crosswalk of strategy areas and community engagement themes 94
D. Appendix D. Multi-sector subject matter expert process 95
E. Appendix E. Implementation examples of the five equity pillars 104
XIV. Endnotes 106

II. Executive Summary

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

The primary purpose of the King County 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.

A new name

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

Context and need

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

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, city, and Council District, the number of individuals receiving services by strategy area and by ZIP code, city, and Council District, and summaries of evaluation findings by strategy area and by ZIP code, city, and 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.[6]

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.

III. Background

A. The King County Behavioral Health Bridge

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

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

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

The flexibility in state law has allowed King County to invest in programs and services that collectively reduce reliance on jails, emergency rooms, and hospitals, and create engagement in and connections to community-based behavioral health treatment for King County residents most in need. In the 2026-2027 biennium, about 25 percent of Bridge[22] funds are managed by other King County agencies, 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 (see Figure 34 in Appendix A). DCHS also currently manages some community contracts for behavioral health services that are connected to programs primarily operated by other County agencies.

Programs funded by MIDD in 2017-2025 reached over 20,000 people each year through more than 50 initiatives.[23] MIDD programs and initiatives since 2017 were organized under the following strategy areas:

- Recovery and Reentry

- 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.[24]

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.[25]

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

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 Health 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.[26]

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

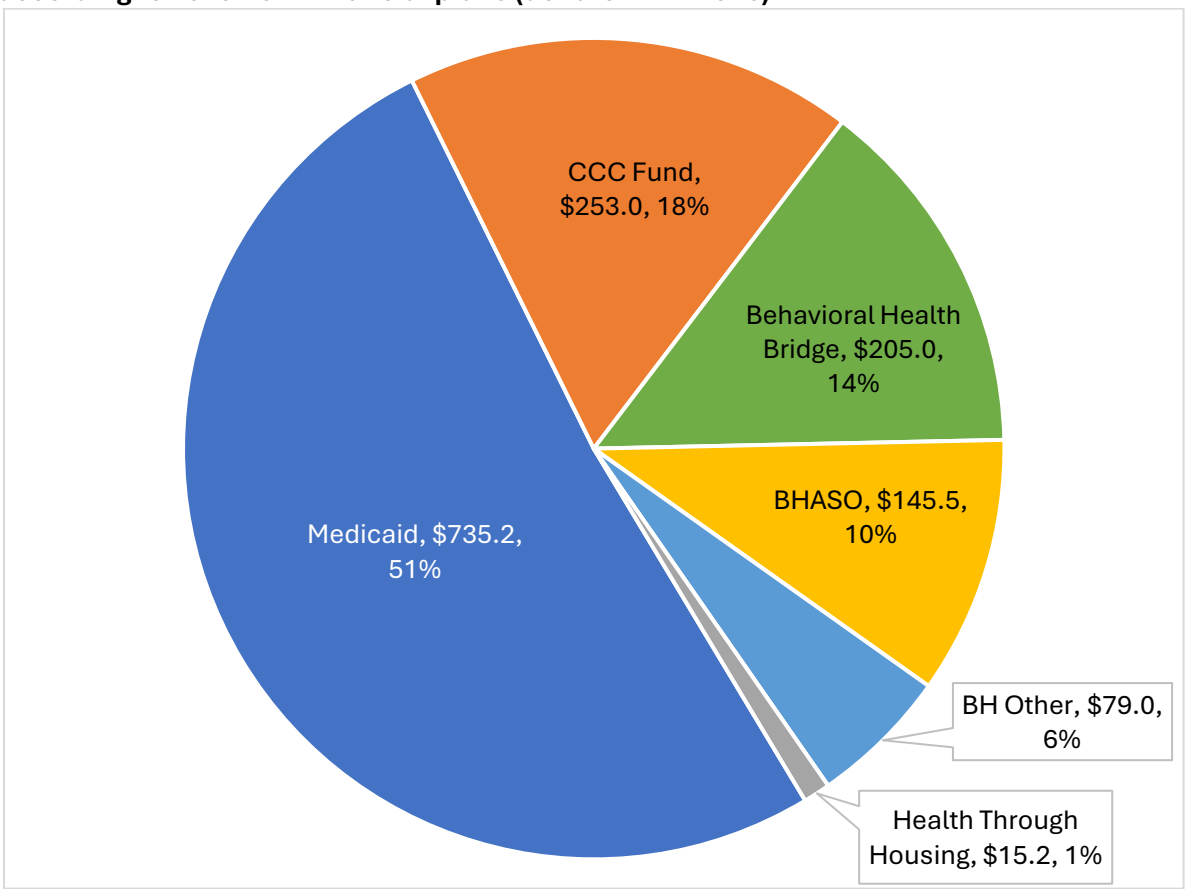
DCHS' Behavioral Health and Recovery Division (BHRD) oversees the public behavioral health system in King County, which includes managing and implementing the Behavioral Health Bridge sales tax and the Crisis Care Centers (CCC) Levy. In addition to the Behavioral Health Bridge sales tax and the CCC Levy, 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).[27] 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)[28]



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

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

The development of the Phase 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.[29]

- **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).[30, 31, 32, 33]
- **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.[34, 35, 36, 37]
- **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.[38, 39, 40]

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 a substance use disorder (SUD) concern did not have a follow-up outpatient visit within 30 days.[41] In addition, analysis shows that people who died from overdose in King County had engaged with a

variety of public services such as jails, emergency departments, homeless services, or mental health care in the year before their death.[42] However, fewer than half (48 percent) had been receiving publicly funded SUD services during that time.[43] 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.[44] 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.[45] 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.[46] In addition, the proportion of unhoused, unsheltered people with SUD has increased from 29 percent in 2017 to 41 percent in 2026.[47,48] 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).[49] Further, one in four County residents is an immigrant, and almost one third report speaking a language other than English at home.[50,51] Decades of research demonstrate racial and ethnic inequities in access to behavioral health care, and King County is no exception.[52] 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.[53] Lesbian, gay, bisexual and transgender adults are two to three times as likely to experience frequent mental distress as their cisgender and heterosexual peers.[54] 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.[55] 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.[56] 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.[57] In 2025, approximately one in 12 King County eighth and tenth graders reported considering suicide during the previous year.[58] 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.[59] 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.[60,61] 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.[62,63] In 2025, KCICN provider agencies had an overall vacancy rate of nearly 10 percent, equating to 414 open positions.[64] The persistent workforce shortage means that treatment needs go unmet and

care is delayed.[65] 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.[66]

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.[67]

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.[68]

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.

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 Plan comply with the supplantation restrictions in RCW 82.14.460(4) that were in effect at the time of plan adoption.[69] 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 coverage or another fund source. Instead, the Bridge is uniquely positioned to fund programs and services beyond the limited scope of federal, state, or other local funding.

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.

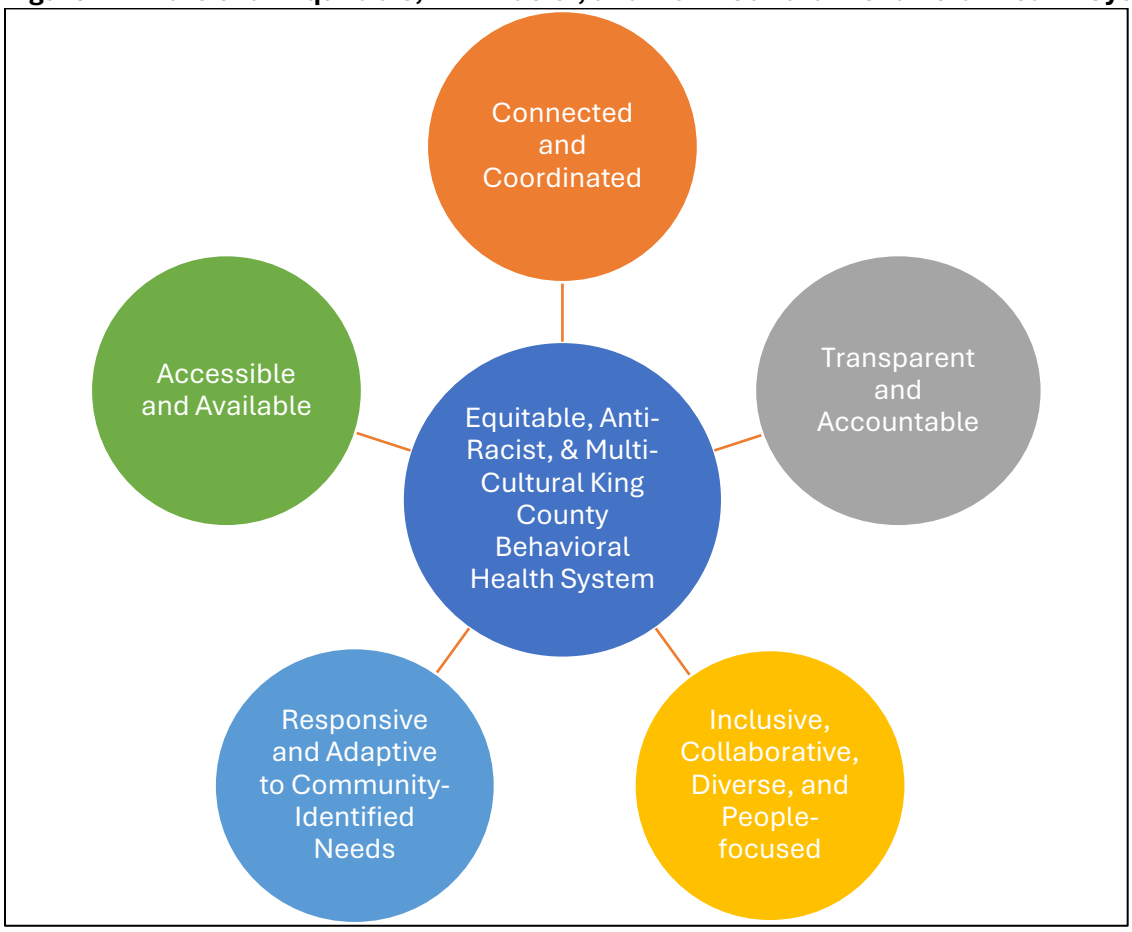
BIPOC, refugee and immigrant, LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual), and disability communities, as well as survivors of trauma or domestic, sexual, and gender-based violence, are more likely to struggle with behavioral health conditions and less likely to access supportive 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[70,71]

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

behavioral health sales tax.[72,73] 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).[74] 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)
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 (CYYA)	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 complementary 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 to 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.[75] 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

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.[76,77] Following conversations throughout 2025, the AC agreed that the core functions of the committee as outlined in Ordinance 18452 remain constant.[78] Proposed legislation transmitted concurrently with this Phase 1 Implementation Plan updates the name of the committee from the King County MIDD Advisory Committee to the Behavioral Health Bridge Advisory Committee, consistent with the broader name change discussed in Subsection III.C. 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 Behavioral Health Bridge Advisory Committee will 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.

VI. Investments across the five strategy areas

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

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

Section XI provides logic models for each of the strategy areas to show how Behavioral Health Bridge investments will drive towards the outcomes and goals for that identified area along with activities that are anticipated to be procured under each goal area.

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.[79] Bridge programs combine supports related to behavioral health, housing stabilization, and reentry in order to break cycles of homelessness, crisis, and incarceration or hospitalization.[80]

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 will 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
Goal 1	$25.8*	$24.0	$24.6	$25.1	$25.7	$26.2	$26.8
Goal 2	$5.7*	$5.0	$5.1	$5.3	$5.4	$5.5	$5.7
Goal 3	$5.2*	$3.5	$3.6	$3.7	$3.8	$4.2	$4.5
Total	**$36.7***	**$32.5**	**$33.3**	**$34.1**	**$34.9**	**$35.9**	**$36.9**

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

**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
Anticipated Activities	$25.8*	$24.0	$24.6	$25.1	$25.7	$26.2	$26.8

**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.[81] Although the Behavioral Health Bridge focuses on behavioral health services, housing that is connected to

behavioral health services is a permissible expenditure under RCW 82.14.460(3).[82] 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.[83] 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.[84]

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
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.[85] 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
Anticipated Activities	$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
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**

^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
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.[86] 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
Anticipated Activities	$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."[87] People in recovery need housing, employment, and social supports to maintain the gains they earned during treatment.[88] 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.[89] 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
Anticipated Activities	$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.[90] 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.[91,92,93] 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.[94] The administrative tasks required to stay enrolled in Medicaid may be especially difficult for people with behavioral health conditions.[95] 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**

^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 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.

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 should 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
Anticipated Activities	$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.[96,97,98] 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.[99] 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 of 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, people living unsheltered, 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
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.*

D. 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.

CYYA strategy area summary

King County is committed to providing equitable opportunities for all children to progress through childhood happy, healthy, safe, and thriving.[100] 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.[101] 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
Goal 1	$3.5*	$4.0*	$4.5	$4.6	$4.7	$4.9	$5.0
Goal 2	$5.2*	$4.9*	$4.7	$4.8	$5.0	$5.1	$5.2
Goal 3	$2.6*	$2.8*	$3.0	$3.1	$3.1	$3.5	$3.8
Total	**$11.2***	**$11.7***	**$12.2**	**$12.5**	**$12.8**	**$13.4**	**$13.9**

^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 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."[102] 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.[103]

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
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.[104] In 2025, 2,095 juvenile cases were referred by law enforcement to the King County Prosecuting Attorney's Office.[105] 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.[106] 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
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, 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.[107] In King County in 2025, about half of LGBTQ+ youth in King County experienced depression.[108]

- 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.[109]
- 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.[110]

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
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.*

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.[111] In 2025, the King County Integrated Care Network (KCICN) had an overall vacancy rate of nearly 10 percent, equivalent to 414 open positions.[112] 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.[113]

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**

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

**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.[114] 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.[115,116] 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.[117,118] SUD Professional trainees (SUDPts) also had a very high vacancy rate of 16 percent.[119]

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.[120] 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.[121] 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
Anticipated Activities	$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
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.*

VII. Measurement and evaluation

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

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

A. Overarching principles

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

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

Transparent: To foster public accountability and transparency, King County regularly shares performance measurement and evaluation outcomes, methods, and data sources with the public via annual dashboards and biennial reports, which are described further in Section VIII.[128] King County evaluation staff will also regularly review data and outcomes with program managers and contracted service providers to ensure that information received by King County is accurate, reliable, and valid.

Outcomes-driven: Assessment and evaluation of data are essential tools for understanding what 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 shall 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.[129] 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[130]. 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

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.[131] 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 shall be both qualitative and quantitative. 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 ZIP code, city, and 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, city, and Council District

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, city, and Council District for each program or strategy. Data will be reported using maps or other visualizations to aid interpretation of the data. All reporting 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, city or Council District 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 ZIP code, city, and 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.[132] 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.[133] 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.[134,135] This effort resulted in the consolidated DCHS Dashboard.[136] 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.[137] 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

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.[138]

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, city, and Council District in King County as described in Subsection VII.B.;
- The number of participants receiving Behavioral Health Bridge-supported services by strategy area by ZIP code, city, and Council District 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, reported by ZIP code, city, and Council District;
- Reporting on standardized outcome measures by ZIP code, city, and 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 and the Regional Policy Committee, the Executive shall electronically transmit to the Council and the Regional Policy Committee 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.

Additionally, annually by August 31st in 2028 through 2030, the Executive shall electronically transmit to the Council and the Regional Policy Committee a procurement progress report that provides the following information:

1. A summary of all procurements conducted and planned to be conducted for the current calendar year;
2. The names of contracted service providers that submit an application for each procurement and the amount of funding requested; and
3. The name of the contracted service provider (or providers) who are awarded funding for each conducted procurement, their associated funding level, and the expected evaluation performance measures to be collected.

The procurement progress report for 2030 may, at the discretion of the Executive, be incorporated into the first biennial report due to be transmitted to the Council by August 31, 2030, rather than as a standalone report. The Executive will accompany each procurement progress 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 procurement progress report to inform the Council's consideration of this motion.

IX. Financial plan and policies

A. Overview

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

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

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

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

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

B. Financial plan

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

Projected Beginning Fund Balance	**$19.5**	**$23.4**	**$20.4**	**$19.0**	**$18.8**	**$19.2**	**$19.8**	
Behavioral Health Bridge Sales Tax Projected Revenue (2028 - 2034)								
	2028	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**Total**
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**
Total Revenue	**$108.3**	**$104.5**	**$109.4**	**$113.6**	**$116.8**	**$121.2**	**$124.8**	**$798.6**

Behavioral Health Bridge Sales Tax Approximate Allocation by Strategy (2028 - 2034)								
	2028	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**Total**
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	$14.9	$15.9	$16.9	$17.8	$18.6	$19.6	$20.7	**$124.4**
Strategy Area 3: Equitable Access to Behavioral Health Care	$20.7	$20.8	$20.9	$21.1	$21.2	$21.6	$21.9	**$148.2**
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	$1.3	$6.6	$6.8	$7.0	$7.1	$7.6	$8.0	**$44.3**

Workforce Development								
Technical Assistance & Capacity Building	$0.5	$0.5	$0.5	$0.6	$0.6	$0.6	$0.60	**$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**
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.*

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.

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

Administration and compliance

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

Performance measurement and evaluation

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

Behavioral Health Fund transfer

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

Sustainability reserve

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

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.[147] 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.[148]

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 and the Regional Policy Committee 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 (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.)

X. Inflation rate adjustment policy analysis

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

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

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

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

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

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

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

During the 2028-2034 implementation period, the Behavioral Health Bridge is expected to continue reflecting inflation adjustments for contracted behavioral health program services, tracking the CPI-U Seattle BFPA inflation rate. If CPI-U inflation assumptions continue 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 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.[155]
- 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.[156]

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.[157]

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[158]	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:

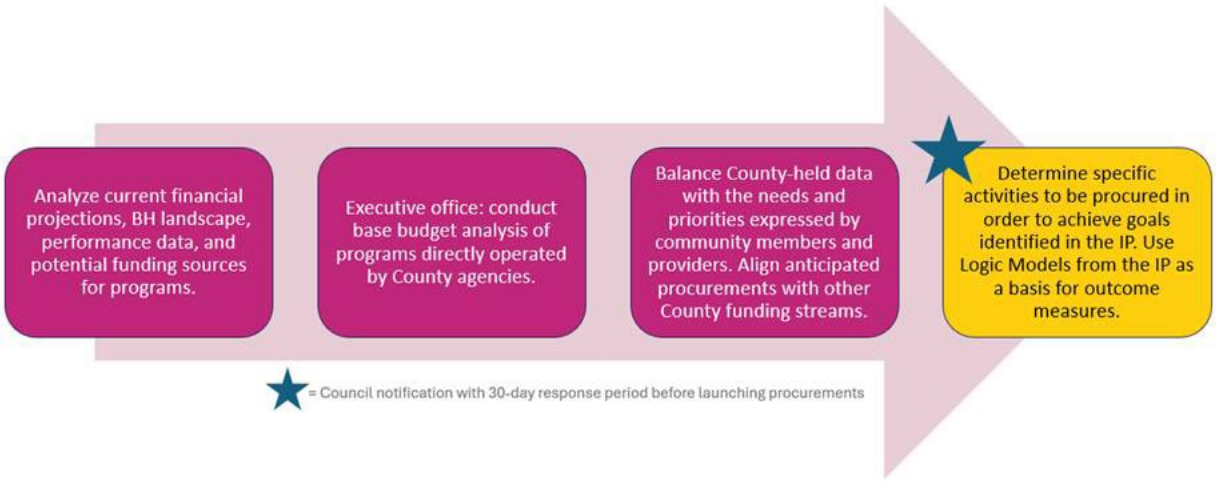
- **Forgo program expansions and investments in new programs.** Priority will be given to maintaining existing programs and service levels, except for reducing or sunsetting programs for other policy reasons.
- **Prohibit or cap future provider inflation rate increases.** DCHS may suspend or reduce inflation 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.[159]

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

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

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 and the Regional Policy Committee 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



D. Pre-procurement Council and Regional Policy Committee 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 soliciting service providers for a particular Behavioral Health Bridge strategy area, the Executive will transmit a notification letter to the Council and the Regional Policy Committee 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,

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 that will 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;
- 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 and members of the Regional Policy Committee. 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.

E. 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.

F. 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

SUD Treatment and Recovery (SUD)	Q2 2027	Q3 2027	End of Q4 2027	Q1 & Q2 2028	Q3 2028
Equitable Access to Behavioral Health Care (EA)	Q2 2027	Q3 2027	End of Q4 2027	Q1 & Q2 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 (CYYA)	Q2 2028	End of Q3 2028	End of Q4 2028	Q1 & Q2 2029	Q3 2029

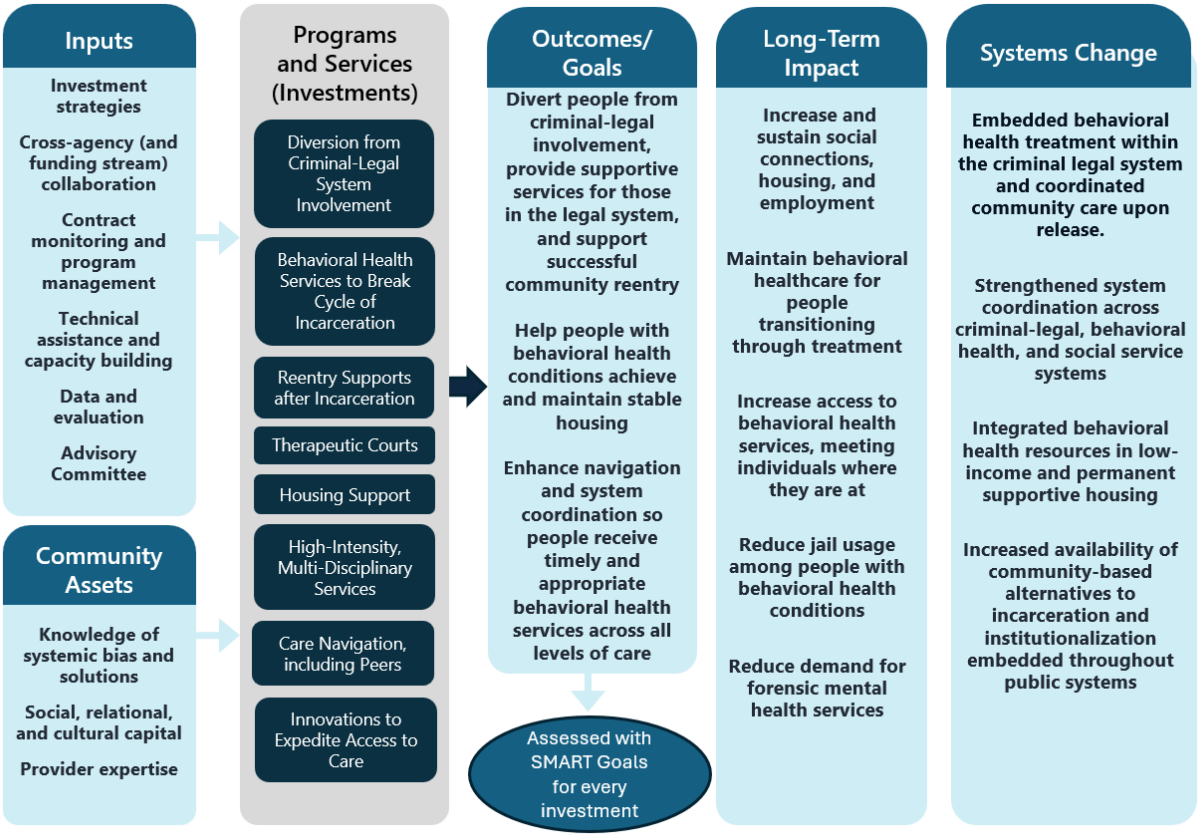
G. Examples of anticipated activities to be procured for the five strategy areas

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.

H. 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 Services (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.[160] Further

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.[161]

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.[162,163] 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

residents in King County's Health Through Housing sites accessed behavioral health care services.[164] 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.[165,166] 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.[167,168] 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 closed-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.[169] 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:

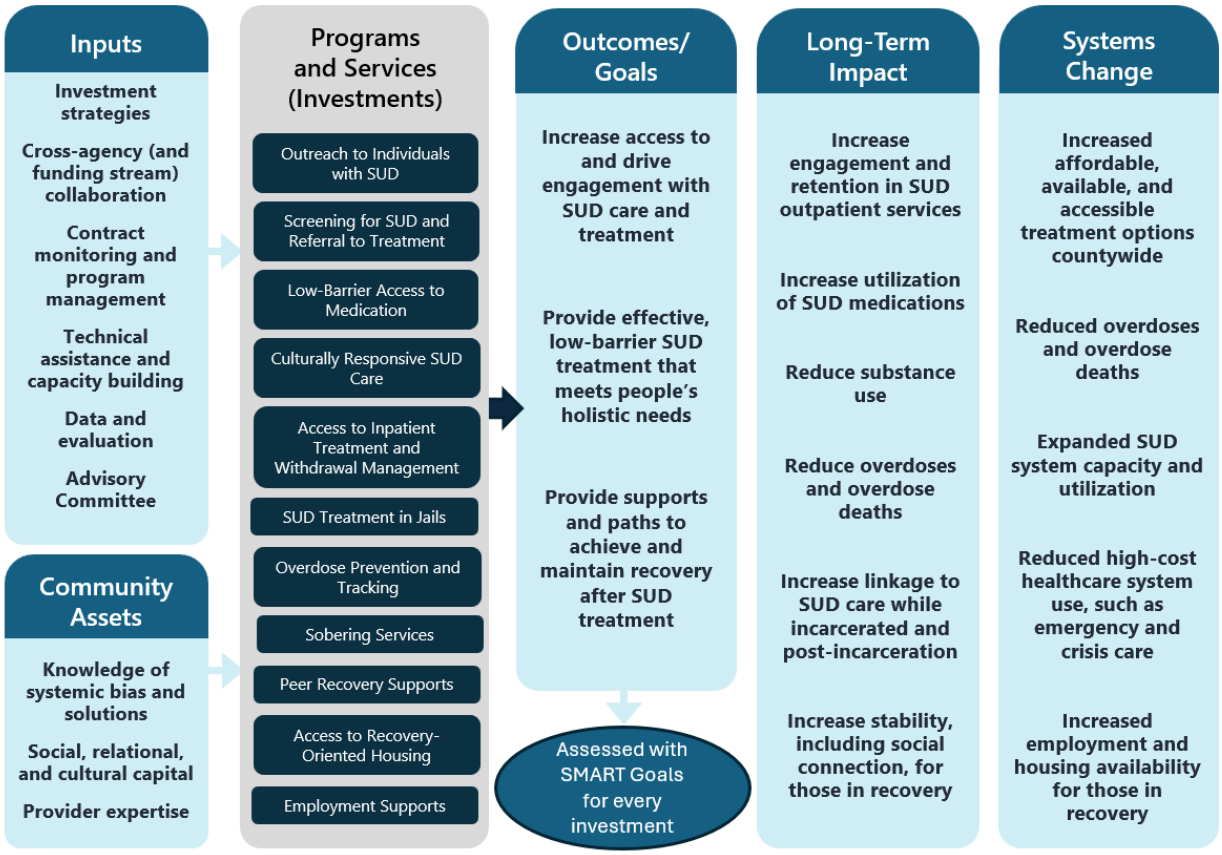
- Same-day or next-day initiation of outpatient treatment for youth and adults.

- 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.

I. 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.[170] 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.[171] 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.[172] 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.[173,174] 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.[175,176] 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.[177,178,179] 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.[180] 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).[181]

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.[182,183,184] 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.[185,186] Increasing culturally responsive options for people with SUD is a key way to address inequitable outcomes across King County communities.

The Executive will use 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.[187] 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.[188] 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

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."[189,190] 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.

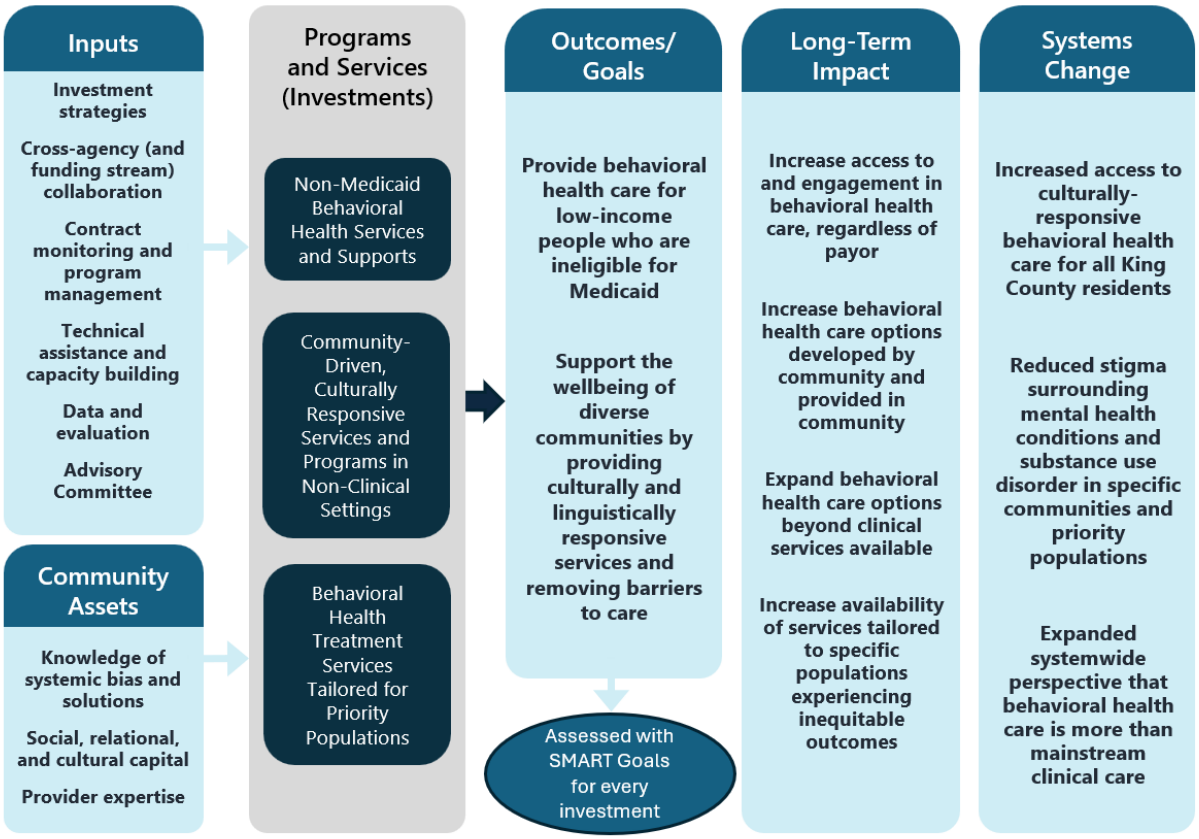
Activity: Employment supports

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.

J. 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.[191] 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.[192,193]

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:

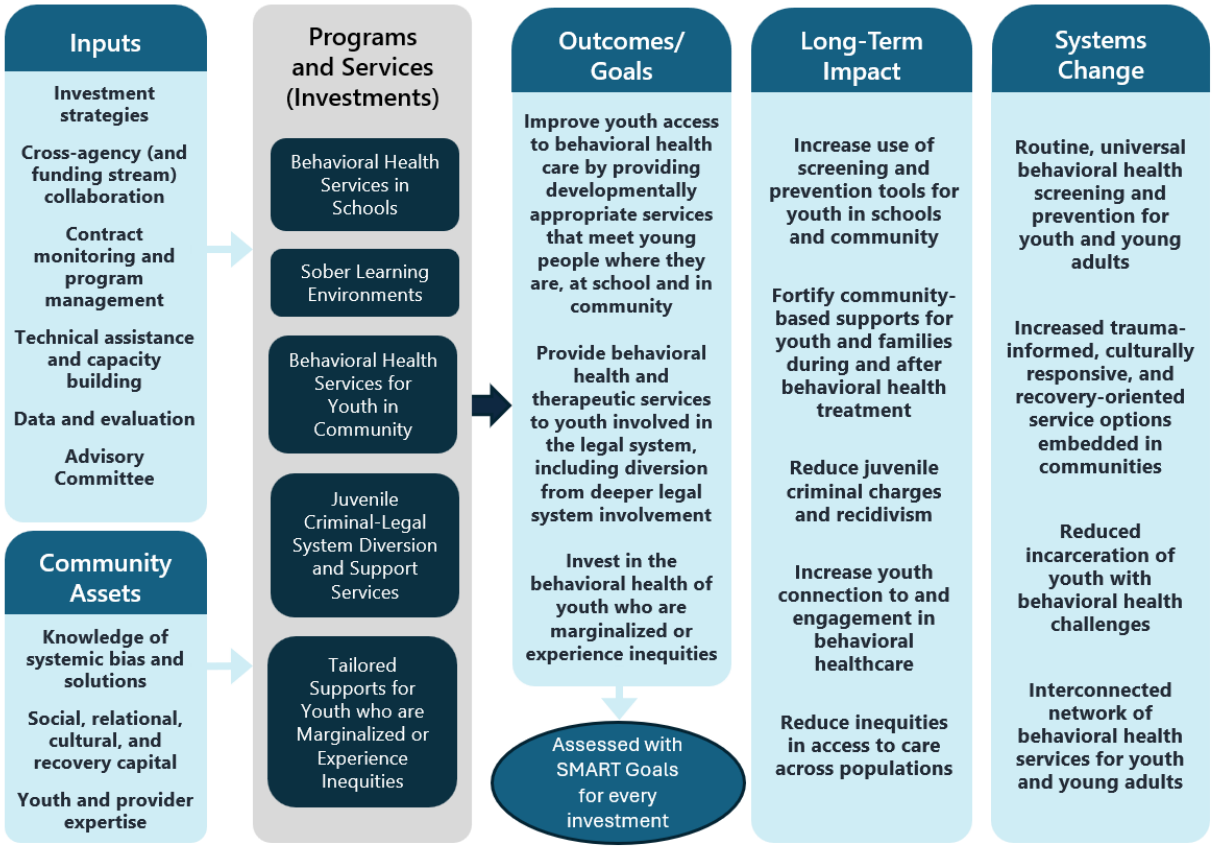
- Tailored therapies for LGBTQIA+ people facing behavioral health challenges.
- Behavioral health treatment and enhanced care navigation for survivors of trauma or domestic, sexual, and gender-based-violence, including flexible financial assistance where material barriers interfere with behavioral health 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.

K. 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 (CYYA) 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.[194] 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.[195] At the Recovery High School, however, 67 percent of students earned or are working toward a high school diploma.[196] After enrolling in the program, 53 percent of IRC students have more than one year of recovery.[197] 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.[198] 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.[199] 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.[200,201,202] 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.

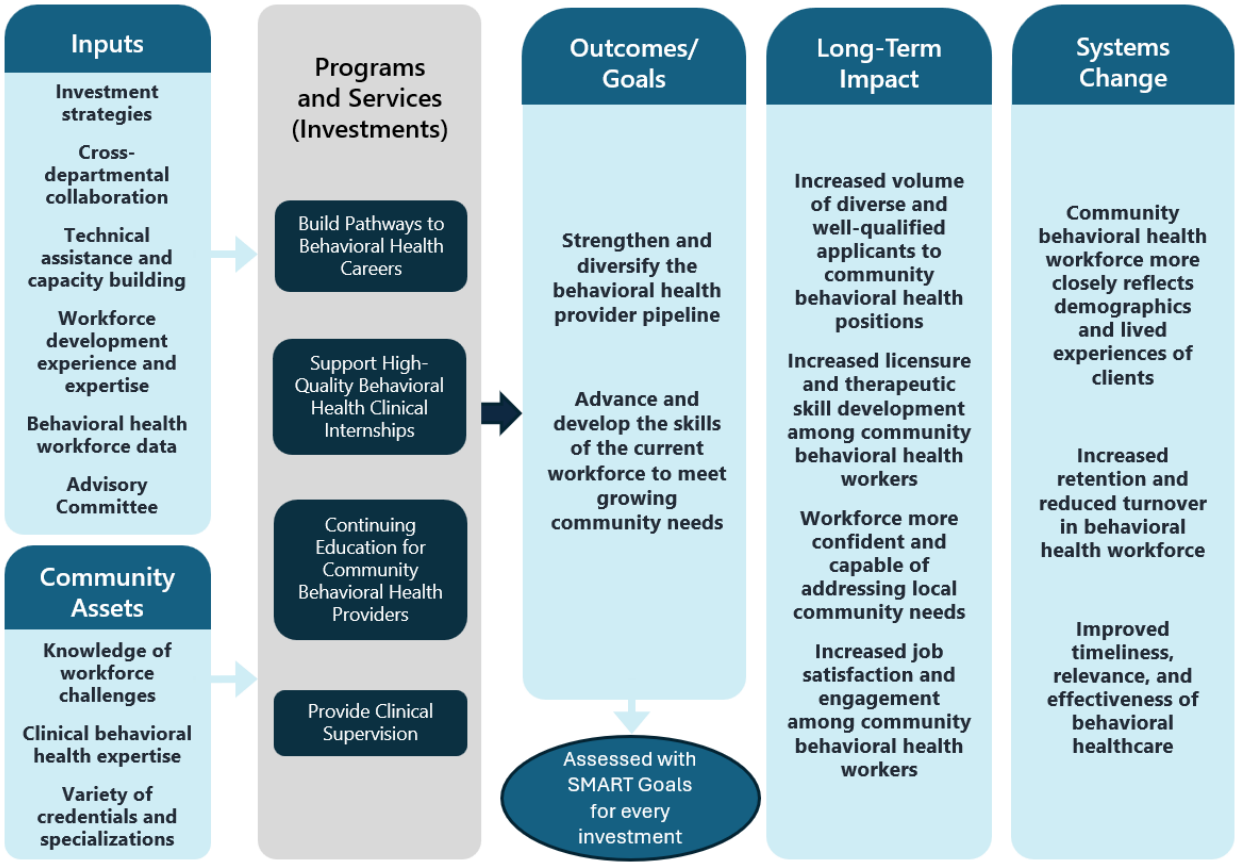
During the procurement process, King County plans to evaluate proposals from community organizations that are already known and respected by the families this goal is intended to serve, which may include KCICN providers. Providers should have training on the unique confidentiality, safety, caregiver 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.

L. 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.

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.[203]

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.[204] The cost of paying to receive clinical supervision is a barrier for providers' career advancement and disproportionately affects low-income and BIPOC individuals.[205] 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

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.[206] 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.[207] 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.

XII. Conclusion

The Behavioral Health Bridge Implementation Plan 2028-2034 contains an approach to developing an equity-driven set of investments to strengthen King County's behavioral health system in a time of profound community need. Grounded in extensive community engagement, informed by multidisciplinary expertise, and aligned to complement the County's other behavioral health and human services funding sources, this plan sets a direction toward a behavioral health system that is more available, accessible, effective, and equitable.

The Behavioral Health Bridge Implementation Plan features investments across five strategy areas: 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 investments in the Behavioral Health Bridge Implementation Plan are expected to help break the cycle of crisis, homelessness, incarceration, and hospitalization by helping people receive the right treatment and support at the right time. Strategy areas, goal areas, and anticipated activities are designed not only to meet immediate needs but also to strengthen community behavioral health care against potential shifts in funding, workforce capacity, and service demand that are expected in the coming years.

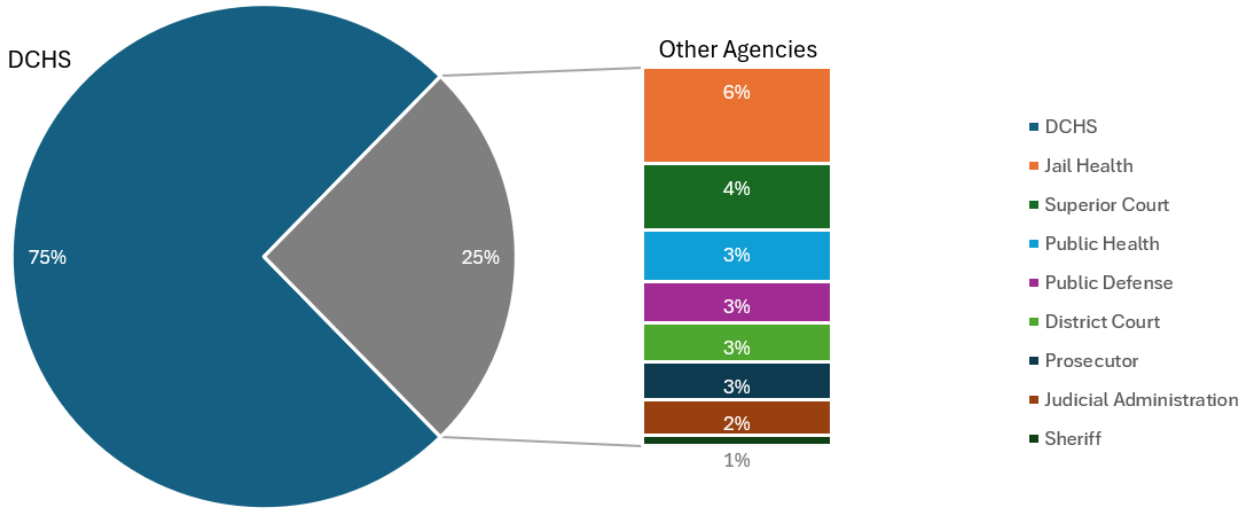
Successful implementation will depend on continued partnership with community-based organizations, behavioral health service providers, people with lived experience, and across County agencies. Ongoing evaluation, transparent reporting, and a phased procurement approach will help deliver a smooth transition from the current set of investments to the planned Behavioral Health Bridge investments.

With the Behavioral Health Bridge Implementation Plan, King County reaffirms its commitment to enabling all residents, especially those most impacted by inequities, to access effective, high-quality behavioral health care and pursue long term recovery, stability, and wellbeing.

XIII. Appendices

A. Appendix A. Behavioral Health Bridge investments in DCHS and other County agencies

Figure 33: 2026-2027 adopted Behavioral Health Bridge budget by King County agency



B. Appendix B. Community engagement activities and results[208]

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

Council District	Date (2024-2025)	Location
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

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
Total number of community members engaged	**2226**

In addition, BHRD staff conducted 33 virtual listening sessions from a wide range of King County organizations (Figure 37).

Figure 36: Virtual listening sessions and organizations engaged

Partner Engagement July 2024 – October 2025
Virtual Listening Sessions (2024-2025)
• Behavioral Health Advisory Board [BHAB] Listening Session • Community-based Organization Listening Session (4 sessions) • General Public Listening Session (3 sessions) • HCHN Governance Council Listening Session • King County Alliance for Human Services (KCAHS) Listening Session • King County Employees Listening Session (2 sessions) • King County Rural Behavioral Health Collaborative Listening Session • MIDD Advisory Group Listening Session • MIDD Community Owned Behavioral Health Collaborative Listening Session • MIDD Leads Listening Session • One-on-one Virtual Interview (Consejo Counseling) • One-on-one Virtual Interview (Interagency Schools) • One-on-one Virtual Interview (Kent Youth & Family Services) • One-on-one Virtual Interview (Mental Health Policy Roundtable) • One-on-one Virtual Interview (King County Drug Diversion Court) • Peer Listening Session (3 sessions) • Provider Listening Session (4 sessions) • Rural Community Listening Session (2 sessions) • SB SBIRT Listening Session • Sound Cities Association Listening Session • Vocal-WA Virtual Listening Session

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 Brillance (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

- 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.[209]

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]
Total individuals:	**2226**

* 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%)
Total individuals that were part of a priority population	**1161 (52.1%)**

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)

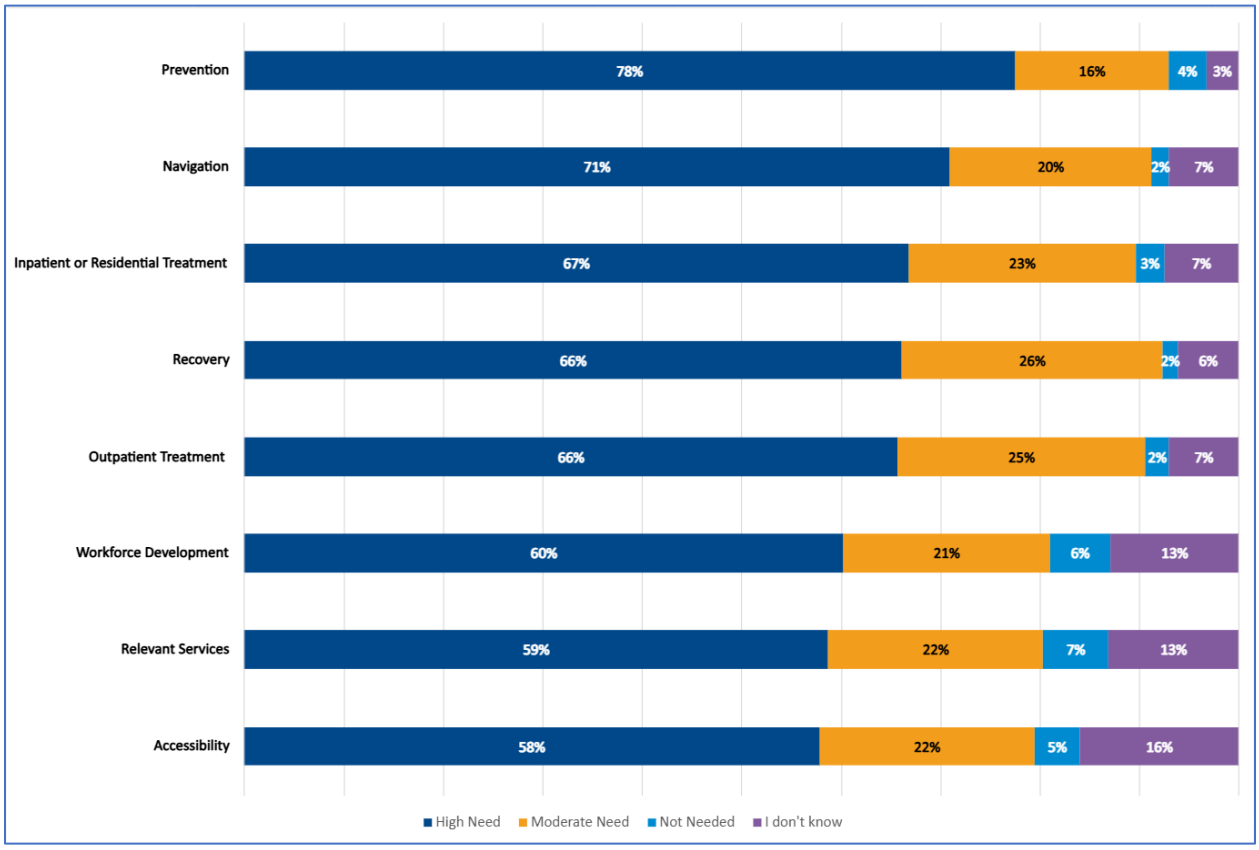
Affiliation or self-identification of attendees	Number of people engaged
LGBTQIA+ community members	23 (3%)
Behavioral health providers	72 (9%)
City government agencies	50 (7%)
Community-based organizations (CBOs)	62 (8%)
Correctional officers	15 (2%)
Incarcerated adults	99 (13%)
Incarcerated youth	27 (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%)
Total individuals who provided affiliation data	**763**

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.

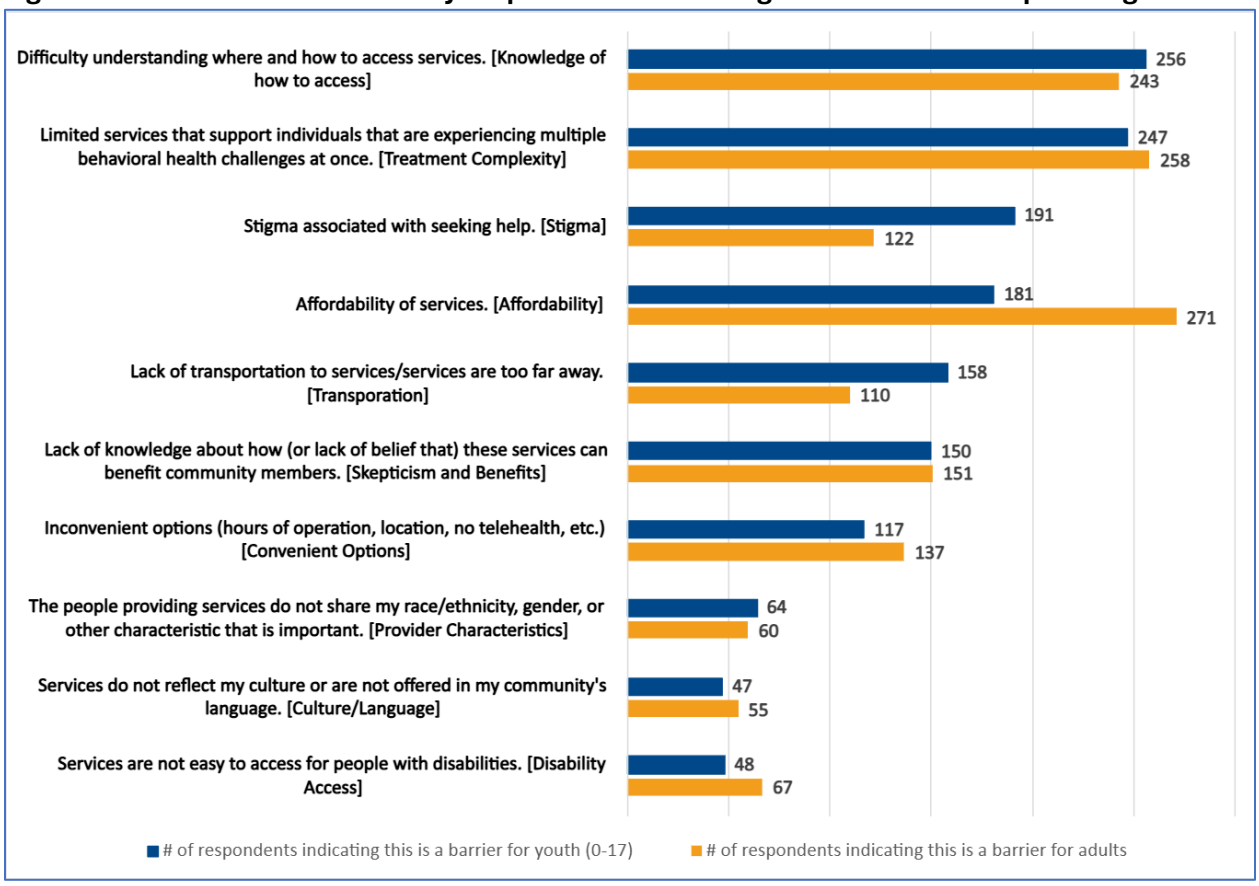
Figure 40: Online survey respondents' rating of behavioral health system barriers



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
Care Transitions and Diversion Services	• **Reduce system fragmentation and improve service coordination** (subthemes: struggles with system navigation; transitional service gaps) • **Strengthen wraparound services** (subthemes: crisis diversion and harm reduction; housing crisis; aftercare for those leaving incarceration or inpatient settings)
Substance Use Disorder Treatment and Recovery	• **Reduce system fragmentation and improve service coordination** (subthemes: SUD struggles with system navigation; SUD service gaps) • **Strengthen and expand the behavioral health workforce** (subthemes: SUD peer support models) • **Strengthen wraparound services that use team-based care and connect people to basic needs** (subthemes: crisis diversion and harm reduction; housing crisis; support for community-based organizations to address SUD)
Equitable Access to Behavioral Health Care	• **Increase access and reduce barriers** (subthemes: lack of affordable care; insurance barriers; transportation barriers) • **Strengthen culturally relevant and responsive care** (subthemes: provider diversity and cultural responsiveness; unique trauma and stressors; language access)
Child, Youth, and Young Adult Mental Wellbeing	• **Strengthen and increase services for children, youth, and young adults** (subthemes: support for parents/caregivers; crafting safe spaces; increase awareness and decrease stigma) • **Priority population: LGBTQIA+** (heightened concern for queer and trans youth in current sociopolitical climate) • **Priority population: Youth** (more attention to young people with co-occurring mental health and SUD conditions, as well as those involved in the criminal justice system)
Behavioral Health Workforce Development	• **Strengthen and expand the behavioral health workforce** (subthemes: staffing shortages and high turnover; career development and advancement; peer support models) • **Strengthen culturally relevant and responsive care** (subthemes: provider diversity and cultural responsiveness; language access)

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
CTD Goal 1. Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.	From the SUD group: • Scale and strengthen established diversion frameworks that feature a workforce emphasizing those with lived experience, including certified peers. • Medications and other forms of treatment and support for people in jail, both before and after release. • Tailored navigation and wraparound services (transportation, housing) for people with SUD leaving incarceration. • Low-barrier places to stay with behavioral health supports for people leaving incarceration.
CTD Goal 2. Help people with behavioral health conditions achieve and maintain stable housing.	From the CTD group: • 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. From the SUD group: • Wraparound services connecting people to housing and other supports when accessing SUD care (and vice versa).
CTD Goal 3. Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.	From the CTD group: • 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. • Benefit and resource navigators (for people exiting incarceration, among others). • Care navigation programs. • Benefit navigators to help people get food, housing, legal help, medical care, etc. From the SUD group: • Enhance coordination and support services for people moving between withdrawal management and inpatient programs, as well as between inpatient and outpatient providers

Implementation plan goal	SME suggestions that informed the anticipated activities for each goal
	• Technology that allows real-time tracking of available supports, facilitates warm handoffs, and streamlines linkage to care (community information exchange). • Reimagine SUD Next Day Appointments (NDA) for youth and young adults. From the EA group: • Low-barrier case management and robust behavioral health services for people with low incomes who are uninsured, underinsured, or unhoused. From the CYYA group: • Coordinated, high-quality, billable navigation and case management to help families find and coordinate multiple types of services at once • Funding technology to alleviate administrative burdens. From the WF group: • Leverage technology as appropriate to reduce administrative burdens.
SUD Goal 1. Drive engagement and retention in SUD care.	From the SUD group: • Outreach strategies that are delivered in a non-mobile setting, such as emergency departments and primary care.
SUD Goal 2. Provide effective, low-barrier SUD treatment that meets people's holistic needs.	From the SUD group: • 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. • Increased access to medication for substance use disorders (MSUD), including through innovative strategies like long-acting injectables • Low-barrier harm reduction services • Medications and other forms of treatment and support for people in jail, both before and after release. • 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.
SUD Goal 3. Support paths to achieve and maintain recovery after treatment.	From the SUD group: • 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.

Implementation plan goal	SME suggestions that informed the anticipated activities for each goal
EA Goal 1. Provide behavioral health care for low-income people who are ineligible for Medicaid.	From the SUD group: • Clinical treatment and case management for people not covered by Medicaid that are tailored to the needs of the people being served. • Medicaid services for non-Medicaid youth, such as outpatient, intensive outpatient, and residential treatment From the EA group: • Language access/Language justice.
EA Goal 2. Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.	From the SUD group: • Non-clinical services and supports that are not covered by Medicaid and are tailored to the needs of the people being served From the EA group: • Fund culturally centered organizations to develop and provide community-based programs that address community-identified needs. • 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. • Affirming services for LGBTQIA+ communities. • Services by and for rural communities. • Trauma-informed and trauma-responsive care.
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.	From the SUD group: • School-based SBIRT. • Recovery High Schools for a safe and sober environment where students pursue academic and career goals. • Mobile MSUD and intensive case management for youth and young adults who are experiencing homelessness. • Increased withdrawal management and MOUD treatment options for youth. From the CYYA group: • Universal screenings and tiered response with brief intervention. • School-based health services that include SUD as well as mental health. • Mobile therapy
CYYA Goal 2. Provide behavioral health and therapeutic services to youth involved in the legal system, including	From the CYYA group: • 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.

Implementation plan goal	SME suggestions that informed the anticipated activities for each goal
diversion from deeper legal system involvement	• Innovative community-based programs that engage youth who are involved or at risk of being involved in the criminal-legal system in healthy activities.
CYYA Goal 3. Invest in the behavioral health of youth who are marginalized or experience inequities.	From the CYYA group: • Ensure that youth with complex needs can have their needs met, regardless of acuity. • Fund culturally centered organizations to incorporate behavioral health supports into existing youth-focused programming. • Targeted, identify-affirming supports for LGBTQIA+ youth.
WF Goal 1. Strengthen and diversify the behavioral health provider pipeline.	From the CTD group: • Grow the non-clinical workforce (peers, CHWs, wellbeing specialists, care navigators, benefit navigators, non-clinical case managers, etc.), which can act as trusted supports. From the SUD group: • Support workforce development for peer and non-clinical providers From the EA group: • 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. From the CYYA group: • Recruitment and retention programs that attract providers from diverse backgrounds and communities, especially multilingual providers. From the WF group: • Fund well-supported internships to bolster a diverse provider pipeline. • Recruitment and training in clinical and non-clinical provider roles, such as peers, mental health care practitioners (MHCPs), etc. • Programs in diverse middle and high schools to increase BH career awareness and pathways among BIPOC youth.
WF Goal 2. Advance and develop the skills of the current workforce to meet growing community needs.	From the CTD group: • Training and development to implement best practices in crisis, navigation, and transition services, such as implementing peer supports and meeting basic needs first • Additional support for supervision and internship with a particular focus on diversifying the workforce. From the CYYA group: • Training and workforce support to ensure there are enough providers who can successfully work with high-acuity youth.

Implementation plan goal	SME suggestions that informed the anticipated activities for each goal
	• Develop pathways to multi-licensure or team-based care to enable providers to better serve youth with complex needs. From the WF group: • Increase support for clinical supervision. • Training curricula that better prepare students for the realities of the job. • Support clinical competency by offering ongoing clinical supervision and support. • Trainings on cultural humility and trauma-informed care, including funding to access trainings and replace lost income from billable activities. • Create training programs in evidence-based practices (EBPs) within community behavioral health settings. • Programs that help mental health practitioners become licensed for SUD, and vice versa. • Training pathways on specialized skills for serving children, youth, and young adults, including those with developmental disabilities.

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

- Chloe Gale, ETS/REACH
- Christina Mason, King County Adult Drug Diversion Court (delegate of Catherine Cornwall*)
- Dominique Davis, Community Passageways/Choose 180
- Emily Shapiro, DESC
- Freyton Castillo, King County DCHS
- Jennifer McPherson, Pioneer Human Services
- Jessica Rosado, Valley Cities
- Jim Conroy, King County ASD Veterans Reentry Program
- Jose "Neaners" Garcia, Second Chance Outreach
- Joshua Thorne, King County DCHS
- Kate Anderson, DCYF
- Kate Tramontana, King County District Court – Therapeutic Courts
- Kimberly Hardy, Regional Crisis Response (RCR)
- Kimmy Reedy, Peer Washington
- LaTrecia Smith, King County DCHS
- Lt. Jeff Gepner, SCorE
- Dr. Matthew Goldman, King County DCHS, Crisis Systems Medical Director
- Megan Murphy, King County Jail Health Services
- Owen Riley, Harborview
- Rachel Dryden, King County Department of Public Defense
- Rheanell Roberts, King County DCHS
- Stacey Devenney, Harborview*
- Sue Rash, YMCA Mobile Crisis Team

Substance Use Disorder Treatment and Recovery (SUD)

Steering committee:

- Brad Finegood, Public Health – Seattle & King County*
- Dan Floyd, King County DCHS
- David Perlmutter, King County DCHS
- Dedra Barrow, Public Health – Seattle & King County
- Delton Mosby, King County DCHS
- Ericka Turley, Public Health – Seattle & King County
- Ileana Janovich, King County DCHS
- Jennifer Wyatt, King County DCHS
- Robyn Smith, King County DCHS

Workgroup:

- Angie Thompson, St Frances, St Anne, and St Elizabeth Hospitals
- Apoorva Mallya, Hepatitis Education Project
- Elsa Tamru, Harborview
- Esther Lucero, Seattle Indian Health Board
- Harumi Hashimoto, Asian Counseling and Referral Service (ACRS)
- Hussein Ugas, Rahma Recovery Center
- James Lovell, Chief Seattle Club

- Jessica Levy, Interagency Academy/Recovery High School
- Joe Barsana, King County Drug Diversion Court
- Johnny Ohta, Ryther
- Joshua Wallace, Peer Washington*
- Laura Quinn, King County Community Prevention and Wellness Initiative
- Leslie Enzian, UW Medicine
- Lisa Rogers, Sound
- Malika Lamont – Purpose Dignity Action / LEAD
- Manuela Raunig-Berho, ETS/REACH
- Mark Varela, Coordinated Care Washington
- Mary Hatch – UW Addictions, Drug, and Alcohol Institute
- Monika Whitfield, Washington Recovery Alliance
- Nicole Davis-Westbrook, WA Recovery Helpline and Crisis Connections
- Sabrina de la Fuente, Consejo Counseling and Referral Services
- Scott Reding, Integrative Counseling Services
- Taylor Richards, Recovery Beyond
- Thea Oliphant-Wells, Public Health – Seattle & King County
- Vania Rudolph – Swedish Recovery Services
- Vicki Brinigar – Valley Cities

Equitable Access to Behavioral Health Care (EA)

Steering committee:

- Anne-Marie Bishop, King County DCHS
- Idabelle Fosse, King County DCHS
- Karen Spoelman, King County DCHS
- Makayla Wright, Public Health – Seattle & King County
- Robin Pfohman, King County DCHS
- Tyler Corwin, King County DCHS
- Ziying Hu, King County DCHS

Workgroup:

- Amarinthia Torres, Coalition Ending Gender-Based Violence
- Bonnie Wang, Asian Counseling and Referral Service (ACRS)
- Candace Hunsucker, Community Health Plan of Washington
- Carline Stephens, King County DCHS
- David Bulindah, Wakulima
- David Coffey, Recovery Café
- Eben Pobee, CharmD Behavioral Health
- Fartun Mohamed, Somali Health Board*
- Jade Park, Harborview
- Jams Stuivenga, Sound Generations
- Jessica Knaster Wasse, Public Health – Seattle & King County
- Lea Aromin, Coalition Ending Gender-Based Violence
- Marc Oommen, NAMI Eastside*

- Nimo Abdullahi, Peer Community
- Rashaun Renggli, The DOVE Project
- Rosario Lopez, Super Familia
- Someireh Amirfaiz, New American Alliance for Policy and Research*
- Thyda Chhom, Khmer Community of Seattle – King County
- Wilbur Klein, King County DCHS

Child, Youth, and Young Adult Mental Wellbeing

Steering committee:

- Caress Piña, King County DCHS
- Delaney Knottnerus, King County DCHS
- Fatima Al-Shimari, King County DCHS
- Jim Ott, King County DCHS
- Latonya Rogers, King County DCHS
- Nacoubi Jiles, King County DCHS
- Rebekah Woods, King County DCHS
- Sarah Wilhelm, Public Health – Seattle & King County

Workgroup:

- Anthony Austin, Southeast Youth and Family Services*
- Connie Gonzales, Guided Pathways for Youth and Families
- Dianne Boyd, Children's Crisis Outreach Response (CCORS) for Developmental Disabilities
- Emmy Bell, Vashon Youth & Family Services
- Eric Mayne, Therapeutic Health Services
- Hodan Mohamed, Washington Multicultural Services Link
- Jeni Johnson, Vashon Youth & Family Services*
- Jorene Reiber, Family Court (King County Superior Court)*
- Kashi Arora, Seattle Children's Hospital
- Kate Garvey, King County Sexual Assault Resource Center
- Kristen Prentice, SeaMar
- Letha Fernandez, Sound
- Libby Hein, Molina Healthcare
- M'Liss Moon, Empower Youth Network
- Martha Aguiniga, Mente Counseling and Consulting
- Megan Walsh, Encompass
- Robert Gant, Juvenile Court Services (King County Superior Court)
- Sarah Burdell, International Community Health Services (ICHS)
- Sarah Walker, UW CoLab for Community & Behavioral Health Policy
- Sarah Wilhelm, Best Starts for Kids (Public Health – Seattle & King County)
- William Hairston, Center for Children and Youth Justice

Behavioral Health Workforce Development

Steering committee:

- Brandon Paz, King County DCHS

- David Perlmutter, King County DCHS
- Jessamyn Findlay, King County DCHS
- Karen Manuel, King County DCHS
- Lisa Floyd, King County DCHS
- Margaret Soukup, King County DCHS
- Molly Bauer, King County DCHS
- Sarah Boye, King County DCHS

Workgroup:

- Adrian Lopez Romero, Public Health – Seattle & King County
- Anna Duncan, UW CoLab for Community & Behavioral Health Policy
- Dr. Brian Allender, King County Chief Medical Officer
- Dan Ferguson, Washington State Allied Health Center of Excellence
- Danie Eagleton, Seattle University
- Elizabeth Schaumberg, Crisis Connections
- Erin Lloyd, Valley Cities
- Genell Hennings, YMCA Heritage Masters Program
- Jackie Bui, Youth Eastside Services
- Jasmeet Singh, Crisis Text Line*
- Laura Knapp, Seattle Children's Hospital
- Mario Paredes, Consejo Counseling and Referral Services*
- Melody McKee, SEIU Healthcare Training Fund
- Renee Fullerton, Washington Training & Education Coordinating Board
- Robyn Smith, King County DCHS
- Sachi Horback, United Healthcare
- Shaena Spoor, Deconstructing the Mental Health System
- Stacey Lopez, Sound
- Stephanie Lane, Peer Washington
- Tavish Donahue, Healthier Here

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
Connected and coordinated	- 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. - 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).
Transparent and accountable	- Renewal process: DCHS published community engagement results online in 2024 and 2025. - Behavioral Health Bridge 2028-2034: The implementation plan includes crosswalks showing how community feedback was incorporated (see Appendix C and Appendix D). - Behavioral Health Bridge 2028-2034: Robust evaluation will ensure transparency and accountability, including through disaggregation of performance data by race, ethnicity, and language.
Inclusive, collaborative, diverse, and people-focused	- Renewal process: Translated written materials and provided language interpretation at community listening sessions to ensure inclusivity and language access. - Renewal process: Included people with lived experience in the subject matter expert workgroups that developed recommendations for behavioral health sales tax investments. - Behavioral Health Bridge 2028-2034: Outcome evaluation will use participatory and community-based models when appropriate and feasible.
Responsive and adaptive to community-identified needs	- Renewal process: Incorporated community and subject matter expert feedback into the implementation plan. - 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). - 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.
Accessible and available	- 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). - 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.

XIV. Endnotes

[1] 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]

[2] RCW 82.14.460. [https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460]

[3] 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]

[4] 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]

[5] 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]

[6] DCHS' communication channels include, but are not limited to, the Cultivating Connections department blog and department social media accounts.

[7] 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]

[8] RCW 82.14.460. [https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460]

[9] K.C.C. 4A.500.315. [https://aqua.kingcounty.gov/council/clerk/code/07_Title_4A.htm#_Toc54697846]

[10] RCW 82.14.460. [https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460]

[11] Ordinance 15949 (2007). [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=554785&GUID=D03F4D6D-19CA-4973-AB42-558B5BAC250E]

[12] Ordinance 18333 (2016). [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=2745995&GUID=70E5373E-EAD8-4E04-8470-ADF157652B25]

[13] Ordinance 19976 (2025). [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7477276&GUID=C9F88779-E410-4BF9-9D6C-1E5CF80E02DE]

[14] Ordinance 19976 (2025). [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7477276&GUID=C9F88779-E410-4BF9-9D6C-1E5CF80E02DE]

[15] 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]

[16] 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]

[17] 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]

[18] 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]

[19] 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]

[20] RCW 82.14.460. [https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460]

[21] RCW 82.14.460. [https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460]

[22] 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.

[23] MIDD 2 Initiative Descriptions. [https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-behavioral-health-tax/initiatives]

[24] These outcomes describe the experiences of individuals enrolled in relevant MIDD initiatives between 2017 and 2022, three years following program participation.

[25] 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.

[26] 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]

[27] 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=c5a838bfcbda42a590b5dd1d078bc0d8&hash=DA4ADD564B01D20B4402B3C3D424F07B]

[28] 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.

[29] Motion 15093. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=3119993&GUID=ABA47252-DF74-49B5-A4DA-C5391A5F71CD]

[30] 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=c5a838bfcbda42a590b5dd1d078bc0d8&hash=DA4ADD564B01D20B4402B3C3D424F07B]

[31] King County DCHS. *Crisis Care Centers Initiative*. [https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/crisis-care-centers-levy]

[32] King County DCHS. *Health Through Housing Initiative*. [https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/health-through-housing]

[33] 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]

[34] 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]

[35] Washington State Health Care Authority. *Medicaid Transformation Project (MTP)*. [https://www.hca.wa.gov/about-hca/programs-and-initiatives/medicaid-transformation-project-mtp]

[36] 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/]

[37] 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).

[38] 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.

[39] 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]

[40] 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/]

[41] 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]

[42] 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/department/documents/FINAL_integrated_overdose_brief.ashx?la=en]

[43] 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/department/documents/FINAL_integrated_overdose_brief.ashx?la=en]

[44] 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/]

[45] 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.

[46] 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]

[47] 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]

[48] 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/]

[49] Communities Count. *King County Population Dashboard*. [https://www.communitiescount.org/population-dashboard]

[50] Public Health – Seattle & King County. *Community Health Needs Assessment*. [https://kingcounty.gov/en/dept/dph/about-king-county/about-public-health/chna]

[51] 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/]

[52] 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/]

[53] 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.

[54] Communities Count. *Frequent Mental Distress*. [https://www.communitiescount.org/frequent-mental-distress]

[55] 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]

[56] 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]

[57] 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]

[58] Washington State Healthy Youth Survey. [https://www.askhys.net/SurveyResults/FactSheets]

[59] Youth.gov. *Behavioral Health*. [https://youth.gov/youth-topics/homelessness-and-housing-instability/behavioral-health]

[60] 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]. The 2017 MIDD 2 Implementation Plan noted that "the behavioral health workforce is in crisis."

[61] 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/]

[62] King County. KCICN Workforce Survey 2021.

[63] 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]

[64] King County. KCICN Workforce Survey 2025.

[65] 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]

[66] 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=3EDD11B4F9CAF6A7C4BDDCB16EAFF1FD]

[67] 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]

[68] 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]

[69] RCW 82.14.460(4). [https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460]

[71] 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]

[72] Heinz A., Liu S. (2022). Challenges and chances for mental health care in the 21st century. *World Psychiatry* (8;21(3)), 423-424. [https://pmc.ncbi.nlm.nih.gov/articles/PMC9453898/]

[73] Recovery.com. (2024). *Timeline: History of Addiction Treatment*. [https://recovery.org/drug-treatment/history/]

[74] 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]

[75] 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]

[76] Ordinance 16077. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=555168&GUID=59A067B4-E1D8-4A40-9775-50FA651696E1]

[77] Ordinance 18452. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=2819659&GUID=43729153-15C2-4825-89CD-C8885F90D04B]

[78] 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].

[79] 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]

[80] 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]

[81] King County Regional Homelessness Authority. (2026). *Point-in-Time Count*. [https://kcrha.org/community-data/king-county-point-in-time-count/]

[82] RCW 82.14.460. [https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460]

[83] 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]

[84] 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]

[85] 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-medicaids-administrative-burdens-to-advance-health-and-racial]

[86] 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/]

[87] 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]

[88] 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/]

[89] 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/]

[90] The Agency for Healthcare Research and Quality (AHRQ). *Six Domains of Health Care Quality*. [https://www.ahrq.gov/talkingquality/measures/six-domains.html]

[91] 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/]

[92] 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.

[93] 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/]

[94] 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]

[95] 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]

[96] 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/]

[97] 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]

[98] 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/]

[99] 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/]

[100] 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]

[101] 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/]

[102] Motion 16966. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7760680&GUID=69D1C7DC-BC39-4093-BC56-3B473E58E1B7]

[103] Consistent with all Behavioral Health Bridge investments, services provided by this goal are not intended to replace Medicaid payment for equivalent services.

[104] 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/]

[105] 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]

[106] 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*czE3OTA3MTEzMDgkbzEkZzEkdDE3OTA3MTEzNTAkajE4JGwwJGgw]

[107] Washington State Healthy Youth Survey. [https://www.askhys.net/SurveyResults/FactSheets]

[108] Washington State Healthy Youth Survey. [https://www.askhys.net/SurveyResults/FactSheets]

[109] 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]

[110] Washington State Healthy Youth Survey. [https://www.askhys.net/SurveyResults/FactSheets]

[111] Health Resources and Services Administration. *Behavioral Health Workforce Projections.* [https://data.hrsa.gov/topics/health-workforce/workforce-projections]

[112] King County. KCICN Workforce Survey 2025.

[113] 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.

[114] 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."

[115] 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/]

[116] 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]

[117] King County. KCICN Workforce Survey 2025.

[118] 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]

[119] King County. KCICN Workforce Survey 2025.

[120] King County. KCICN Workforce Survey 2025.

[121] King County. KCICN Workforce Survey 2025.

[122] 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]

[123] 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]

[124] 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]

[125] Clear Impact. *What is Results-Based Accountability?* [https://clearimpact.com/results-based-accountability/]

[127] 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]

[128] 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]

[129] 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]

[130] 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.

[131] Clear Impact. *What is Results-Based Accountability?* [https://clearimpact.com/results-based-accountability/].

[132] 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.

[133] King County DCHS. *Measuring DCHS' Impact*. [https://kingcounty.gov/en/dept/dchs/about-king-county/about-dchs/data-reports]

[134] 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.

[135] 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.

[136] King County DCHS. *Explore the Data*. [https://kingcounty.gov/en/dept/dchs/about-king-county/about-dchs/data-reports/impact-dashboard]

[137] 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].

[139] State of Washington. (2026). *ESSB 6346*. [https://app.leg.wa.gov/BillSummary/?BillNumber=6346&Year=2025]

[140] 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]

[141] 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]

[142] 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]

[143] 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.

[144] 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=f11305dd68fd4c29af2a8ca 8e60145a5&hash=95EA94BF839EAEDF42E3EDA908D8368F]

[145] 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/]

[146] 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.

[147] King County. *King County Comprehensive Financial Management Policies*. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=5122778&GUID=EA35F767-889C-4ADA-A720-6342044F7413]

[148] 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.

[149] 2026-2027 King County Biennial Budget. November 18, 2025. [https://mkcclegisearch.kingcounty.gov/LegislationDetail.aspx?ID=7680373&GUID=B4E9E09C-A982-4A8C-A0DA-6CC195D69EE0]

[150] 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]

[151] 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.

[152] 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]

[153] King County. *King County Budget and Financial Planning Assumptions Dashboard*. [https://app.powerbigov.us/groups/me/reports/b97a6283-2b3f-4a50-8f6d-c5d0d601df05/ReportSection3c4f835a513e65de275e]

[154] 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]

[155] 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]

[156] 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]

[157] 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]

[158] King County. *King County Budget and Financial Planning Assumptions Dashboard*. [https://app.powerbigov.us/groups/me/reports/b97a6283-2b3f-4a50-8f6d-c5d0d601df05/ReportSection3c4f835a513e65de275e]

[159] 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]

[160] King County DCHS. *Familiar Faces Data Packet*. [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.

[161] Therapeutic court services provided by the Juvenile Response and Accountability Court – Behavioral Health Response (JTRAC-BHR) are addressed under CYYA Goal 2.

[162] U.S. Department of Housing and Urban Development. *Homelessness Management Information System*. [https://www.hudexchange.info/programs/hmis/]

[163] 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]

[164] 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]

[165] 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]

[166] 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]

[167] 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]

[168] Eliacin J., Burgess D., Rollins A.L., Patterson S., Damush T., Bair M.J., Salyers M.P., Spoont 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]

[169] 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.

[170] 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/]

[171] King County DCHS. (2026, April). *Internal analysis of Medicaid claims data, Washington State Health Care Authority*.

[172] 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]

[173] Reed, M.K., Smith, K.R., Ciocco, F. *et al.* (2023). Sorting through life: evaluating patient-important measures of success in a medication for opioid use disorder (MOUD) treatment program. *Substance Abuse Treatment Prevention Policy,* 18, 4. [https://link.springer.com/article/10.1186/s13011-022-00510-1]

[174] Wakeman S.E., Larochelle M.R., Ameli O., et al. (2020). Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. *JAMA Network Open*, 3(2). [https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032]

[175] Johns Hopkins Bloomberg School of Public Health. (2023, May). *Fentanyl, Heroin Use Substantially Decline in Patients Receiving Methadone Treatment for Opioid Use Disorder During First Year*. [https://publichealth.jhu.edu/2023/fentanyl-heroin-use-substantially-decline-in-patients-receiving-methadone-treatment-for-opioid-use-disorder-during-first-year]

[176] Kiley, B. (2023, June). Walk the beat with an outreach worker helping people who live on Seattle streets. *The Seattle Times*. [https://www.seattletimes.com/pacific-nw-magazine/walk-the-beat-with-an-outreach-worker-helping-people-who-live-on-seattle-streets/]

[177] University of Washington School of Nursing and Research with Expert Advisors on Drug Use (READU). (2023). *Opioid Settlement Stakeholder Feedback: Recommendations for the use of opioid settlement funds allocated to Seattle & King County*. [https://cdn.kingcounty.gov/-/media/king-county/depts/dph/documents/safety-injury-prevention/overdose-prevention/opioid-settlement-stakeholder-feedback.pdf?rev=a3ec346155a74f509ffc4e8c70005518&hash=2A4DB44D762FAED01ADE3F5791A83B4A]

[178] Addictions, Drug & Alcohol Institute. (2024). *Results from the 2023 WA State Syringe Services Program Health Survey*. [https://adai.uw.edu/wordpress/wp-content/uploads/dlm_uploads/ssp-health-survey-2023.pdf]

[179] Fockele C.E., Duber H.C., Finegood B., Morse S.C., Whiteside L.K. (2021). Improving transitions of care for patients initiated on buprenorphine for opioid use disorder from the emergency departments in King County, Washington. *J Am Coll Emerg Physicians Open,* 23;2(2). [https://pmc.ncbi.nlm.nih.gov/articles/PMC7987236/]

[180] Harborview Injury Prevention & Research Center at the University of Washington. (2024). *NEW Tele-buprenorphine Hotline now serving King County*. [https://hiprc.org/blog/telebup-hotline/]

[181] U.S. Department of Justice Civil Rights Division. ADA.gov: Opioid Use Disorder. [https://www.ada.gov/topics/opioid-use-disorder]

[182] Banks D.E., Brown K., Saraiya T.C. (2023). Culturally Responsive Substance Use Treatment: Contemporary Definitions and Approaches for Minoritized Racial/Ethnic Groups. *Curr Addict Rep*, 10(3):422-431. [https://pmc.ncbi.nlm.nih.gov/articles/PMC12834561/]

[183] Yoon-Hendricks, A. (2023). How Native WA communities are fighting the fentanyl crisis. *The Seattle Times*. [https://www.seattletimes.com/seattle-news/how-native-wa-communities-are-fighting-the-fentanyl-crisis/]

[184] Guerrero E.G., Khachikian T., Kim T., Kong Y., Vega W.A. (2013). Spanish language proficiency among providers and Latino clients' engagement in substance abuse treatment. *Addictive*

Behaviors, 38(12):2893-2897. [https://www.sciencedirect.com/science/article/abs/pii/S0306460313002451]

[185] 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]

[186] 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=3EDD11B4F9CAF6A7C4BDDCB16EAFF1FD]

[187] 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/]

[188] Recovery Research Institute. *What is the evidence for peer recovery support services?* [https://www.recoveryanswers.org/research-post/what-is-the-evidence-for-peer-recovery-support-services/]

[189] Johns Hopkins Bloomberg School of Public Health blog. *How Stable Housing Supports Recovery from Substance Use Disorders*. [https://opioidprinciples.jhsph.edu/how-stable-housing-supports-recovery-from-substance-use-disorders/]

[190] National Academies of Sciences, Engineering, and Medicine. (2016, September). Measuring Recovery from Substance Use or Mental Disorders: Workshop Summary. *National Academies Press (US)*. [https://www.ncbi.nlm.nih.gov/books/NBK390393/]

[191] King County DCHS. (2025, January). *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]

[192] Morales-Garzón S., Parker L.A., Hernández-Aguado I., González-Moro Tolosana M., Pastor-Valero M., Chilet-Rosell E. (2023, April). Addressing Health Disparities through Community Participation: A Scoping Review of Co-Creation in Public Health. *Healthcare (Basel)*,11(7):1034. [https://pmc.ncbi.nlm.nih.gov/articles/PMC10094395/]

[193] Chen D., Watson R.J., Caputi T.L., Shover C.L. (2021). Proportion of U.S. Clinics Offering LGBT-Tailored Mental Health Services Decreased Over Time: A Panel Study of the National Mental Health Services Survey. *Ann LGBTQ Public Popul Health*. [https://pmc.ncbi.nlm.nih.gov/articles/PMC8659117/]

[194] Seattle Public Schools' Interagency Recovery Campus: Washington's Only Sober Public High School. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-

recovery/youth/01-interagency-recovery-campus-enrollment-brochure-06-2025-final.pdf?rev=deeb06b6eedd4d5abac0b65cc15072ad&hash=8E56135EABBF1E42430F890384FDC2A6]

[195] Kohlenberg E., Lucenko B., Mancuso D., He L., Coker L., Liu Q., Felver, B. (2013). *Behavioral Health Needs and School Success: Youth with Mental Health and Substance Abuse Problems are at Risk for Poor High School Performance*. [https://www.dshs.wa.gov/sites/default/files/rda/reports/research-11-194.pdf]

[196] Seattle Public Schools. *Report 2: Student Characteristics and Outcomes*. [https://interagency.seattleschools.org/about/campus-locations/interagencys-recovery-campus/student-characteristics-outcomes/]

[197] Loeb, H., Wyatt, J. G., Sandoval, N. (2025). *Seattle Public Schools' Interagency Recovery Campus Brief Series*. Renton, WA: Puget Sound Education Service District Strategy, Evaluation and Learning Department and Seattle, WA: King County Department of Community and Human Services, Behavioral Health and Recovery Division. [https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/youth/2025-interagency-recovery-campus-intro-data-experiences-briefs-combined.pdf?rev=9fb0274d1cfa46dd9e191a90ab64263a&hash=14924D4E89E63B2B07B565551EF8F547]

[198] Hill E., Bond L., Weisz J.R., Patel V. (2025). Addressing the Adolescent Mental Health-Care Gap in the United States. *Journal of Adolescent Health*, 77, 1014-1016. [https://www.jahonline.org/article/S1054-139X(25)00370-2/fulltext]

[199] This number reflects youth served through the following MIDD 2 initiatives: CD-02A: Youth Connection Services, CD-02B: Family Court Services (FCS) Behavioral Health Program, CD-13: Family Intervention Restorative Services (FIRS), and PRI-02: Juvenile Justice Youth Behavioral Health Assessments (JJYBHA).

[200] Ngo V.K., Asarnow J.R., Lange J., Jaycox L.H., Rea M.M., Landon C., Tang L., Miranda J. (2009, October). Outcomes for Youths from Racial-Ethnic Minority Groups in a Quality Improvement Intervention for Depression Treatment. *RAND. Psychiatric Services*, v. 60, no. 10. [https://www.rand.org/pubs/external_publications/EP20091015.html]

[201] Center for the Study of Social Policy. (2025, May). *Using Culture to Promote Youth Mental Health and Well-being: Lessons from Community Providers*. [https://cssp.org/resource/using-culture-to-promote-youth-mental-health-and-well-being/]

[202] Bochicchio, L., Reeder, K., Ivanoff, A., Pope, H., Stefancic, A. (2022). Psychotherapeutic interventions for LGBTQ + youth: a systematic review. *Journal of LGBT Youth*, *19*(2), 152–179. [https://doi.org/10.1080/19361653.2020.1766393]

[203] Washington Council for Behavioral Health. (2024). *Behavioral Health Teaching Clinic Designation and Enhancement Rate Demonstration Project – Stakeholder Report*. [https://www.thewashingtoncouncil.org/wp-content/uploads/2025/01/BH-Teaching-Clinic-Final-Report-Dec.-2024.pdf]

[204] Washington State Department of Health. *Mental Health Counselor – Licensing Requirements*. [https://doh.wa.gov/licenses-permits-and-certificates/professions-new-renew-or-update/mental-health-counselor/licensing-requirements]

[205] Washington Council for Behavioral Health. (2024). *Behavioral Health Teaching Clinic Designation and Enhancement Rate Demonstration Project – Stakeholder Report*. [https://www.thewashingtoncouncil.org/wp-content/uploads/2025/01/BH-Teaching-Clinic-Final-Report-Dec.-2024.pdf]

[206] King County. KCICN Workforce Survey 2025.

[207] Seattle YMCA. (2026). *The Y + Heritage University Master's in Mental Health Counseling Program* [https://www.seattleymca.org/blog/y-heritage-university-masters-mental-health-counseling-program]

[208] 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=3EDD11B4F9CAF6A7C4BDDCB16EAFF1FD]

[209] Communities Count. *Communities Count Population Dashboard*. [https://www.communitiescount.org/population-dashboard]; As of 2024, 48.2 percent of King County residents identified as BIPOC.

November 4, 2026
Outcomes

2 to 1

Sponsor: Balducci

[S. Porter]

Proposed No.: 2026-0177

AMENDMENT TO AMENDMENT 1 TO PROPOSED ORDINANCE 2026-0177,

VERSION 2

In Attachment A, on page 6, line 201, after "outcomes." insert "This will include an outcome measurement plan for high-level outcomes that are anticipated to be achieved through the investments using Behavioral Health Bridge funding."

In Attachment A, on page 10, line 325, after "systems" insert "and, as a result, achieve better mental health and wellness among King County residents."

In Attachment A, on page 43, after line 1589 insert:
"**Outcomes**

In order to require the Executive to identify and define outcomes in advance of procuring programs, an outcomes measurement plan shall be transmitted to Council to identify the high-level outcomes that are anticipated to be achieved through the investments using Behavioral Health Bridge funding. This shall include the overarching outcomes for the program and the resulting improved behavioral health outcomes from these investments, such things could include, but not be limited to, decreased criminal legal system involvement, decreased emergency psychiatric hospitalizations, and improved engagement with behavioral health treatment that King County is attempting to achieve with this suite of programs. Outcomes shall be identified and quantified in advance of procuring and implementing new programs, so that progress towards these outcomes can be tracked and reported. The outcomes measurement plan will identify the data sources and timeframes (i.e., monthly, quarterly, or annually) that will be used for tracking and future reporting."

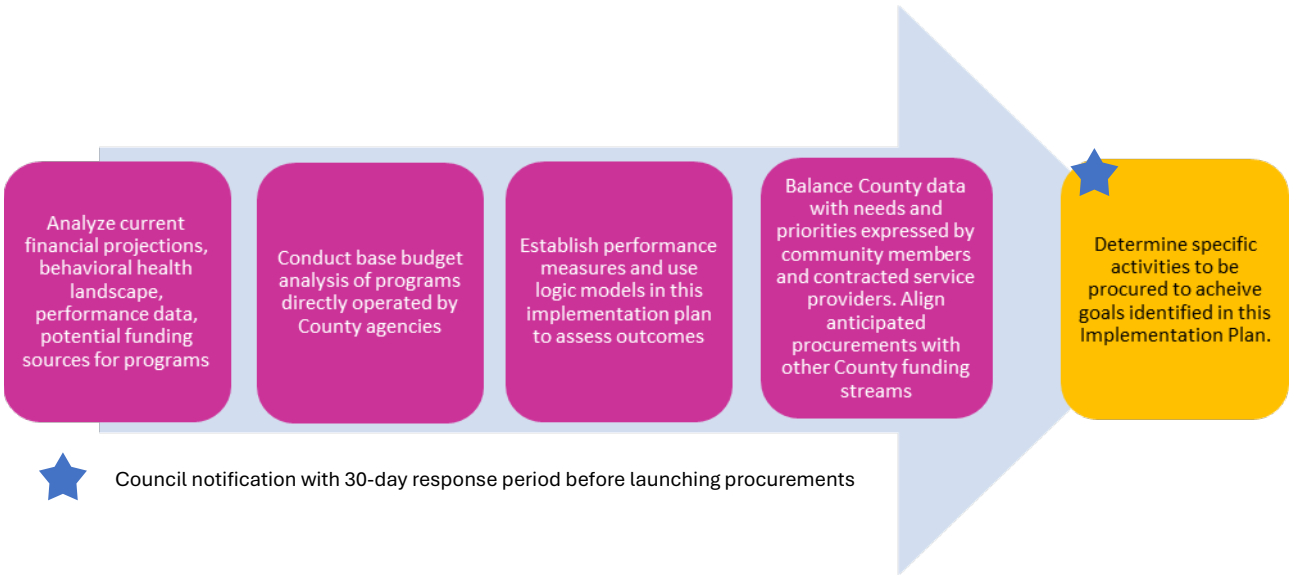
In Attachment A, on page 50, after line 1874 insert: "

- Status of progress on the measurements identified approved as part of the initial outcomes measurement plan described in Section XI of this plan;"

In Attachment A, on page 63, line 2280, after "**2:**" insert "**Overarching Outcomes,**"

In Attachment A, on page 63, beginning on line 2291, strike line 2291 through 2293 and insert:

"**Figure 1: Anticipated Steps to Procurement**



A. Initial outcomes measurement plan

In order to require the Executive to identify and define outcomes in advance of procuring Behavioral Health Bridge programs, no later than January 31, 2027, the Department shall transmit a proposed high-level outcomes measurement plan that describes outcomes that are anticipated to be achieved through the investments using Behavioral Health Bridge funding. The proposed plan should include overarching outcomes for the program and the resulting improved behavioral health outcomes from these investments, such things could include, but not be limited to, decreased criminal legal system involvement, decreased emergency psychiatric hospitalizations, and improved engagement with behavioral health treatment that King County is attempting to achieve with this suite of programs. Outcomes shall be identified and quantified in advance of procuring and implementing new programs so that progress towards these outcomes can be tracked and reported. The outcomes measurement plan should identify the data sources and intervals (i.e. monthly, quarterly, annually) that will be used for tracking and future reporting. The proposed outcome measurement plan shall be provided along with an accompanying motion for consideration and approval by the Council. The Executive shall electronically transmit the outcomes measurement plan and accompanying motion with the clerk of the Council, who will retain an electronic copy and provide an electronic copy to all Councilmembers and members of the Regional Policy Committee. Once approved, status of progress on the measurements will be provided as part of the biennial reporting due by August 31 every other year, starting in 2030."

Renumber the remaining subsections consecutively and correct any internal references accordingly.

The clerk of the council is instructed to engross changes from any adopted amendments, correct any scrivener's errors, and if applicable, to update the tables of contents in the

attachment and correct any internal hyperlinks, in accordance with any adopted amendments.

EFFECT prepared by *S. Porter:* ***Would include reference to outcomes throughout the plan and establish an initial outcomes measurement plan to be transmitted to Council and the Regional Policy Committee by January 31, 2027.***

November 4, 2026
Logic models in Section XI

3 to 1

Sponsor: von Reichbauer

[S. Porter]

Proposed No.: 2026-0177

AMENDMENT TO AMENDMENT 1 TO PROPOSED ORDINANCE 2026-0177,

VERSION 2

In Attachment A, on page 39, line 1397, after "as shown in" strike "Section VI" and insert "Section XI"

In Attachment A, on page 40, line 1433, after "logic models" strike "throughout this Phase 1 Implementation Plan" and insert "in Section XI"

In Attachment A, on page 42, line 1538, after "goals identified" strike "in the logic models in Section VI and Section XI" and insert "in Section VI and the logic models in Section XI"

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

EFFECT prepared by *S. Porter: Would correct references in the plan to reflect that the logic models appear in Section XI.*

November 4, 2026
Progress reports

4
to 1

Sponsor: Balducci

[S. Porter]

Proposed No.: 2026-0177

AMENDMENT TO AMENDMENT 1 TO PROPOSED ORDINANCE 2026-0177,

VERSION 2

In Attachment A, on page 51, line 1905, after "Committee a" strike "procurement"

In Attachment A, on page 51, after line 1913, insert:
"Additionally, the progress reports shall include information regarding ongoing programing that occurred during the current calendar year. This could include, but not be limited to:

A. Performance measurement and outcome data, for each program funded through Bridge dollars;
B. Program utilization statistics;
C. Geographic distribution of sales tax expenditures across the county, including by ZIP code, city, and Council District; and
D. Summary of cumulative calendar year data."

In Attachment A, on page 51, line 1914, after "The" strike "procurement"

In Attachment A, on page 51, line 1916, after "report." insert " "

In Attachment A, on page 51, line 1916, after "each" strike "procurement"

In Attachment A, on page 51, line 1918, after ", on the" strike "procurement"

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

EFFECT prepared by *S. Porter: Expands the content of the progress reports to include reporting on the programs that are still in operation in 2028 and 2029, in addition to reporting on the progress of procurements for new Bridge programs.*

Crisis Care Center Levy 2025 Annual Report

Regional Policy Committee – November 5th, 2026

Denille Bezemer – BHRD Interim Deputy Division Director

Mark Cooke – Crisis Care Center Community Impact Project Manager

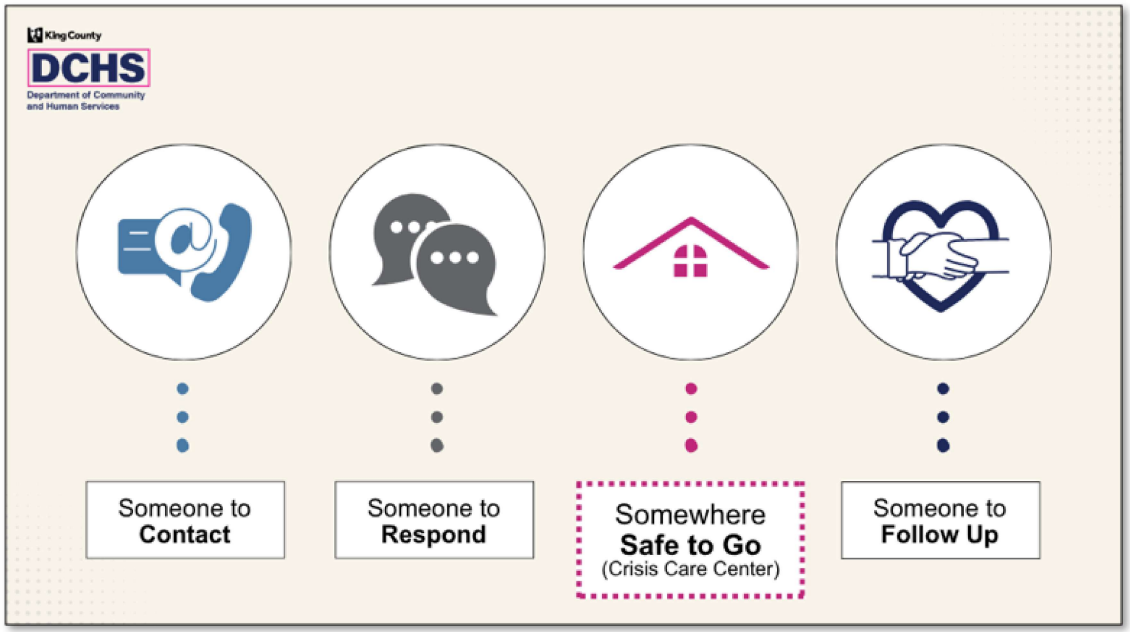
King County

DCHS

Department of Community and Human Services

Crisis Care Centers initiative

In 2023, voters **approved** the Crisis Care Center levy.



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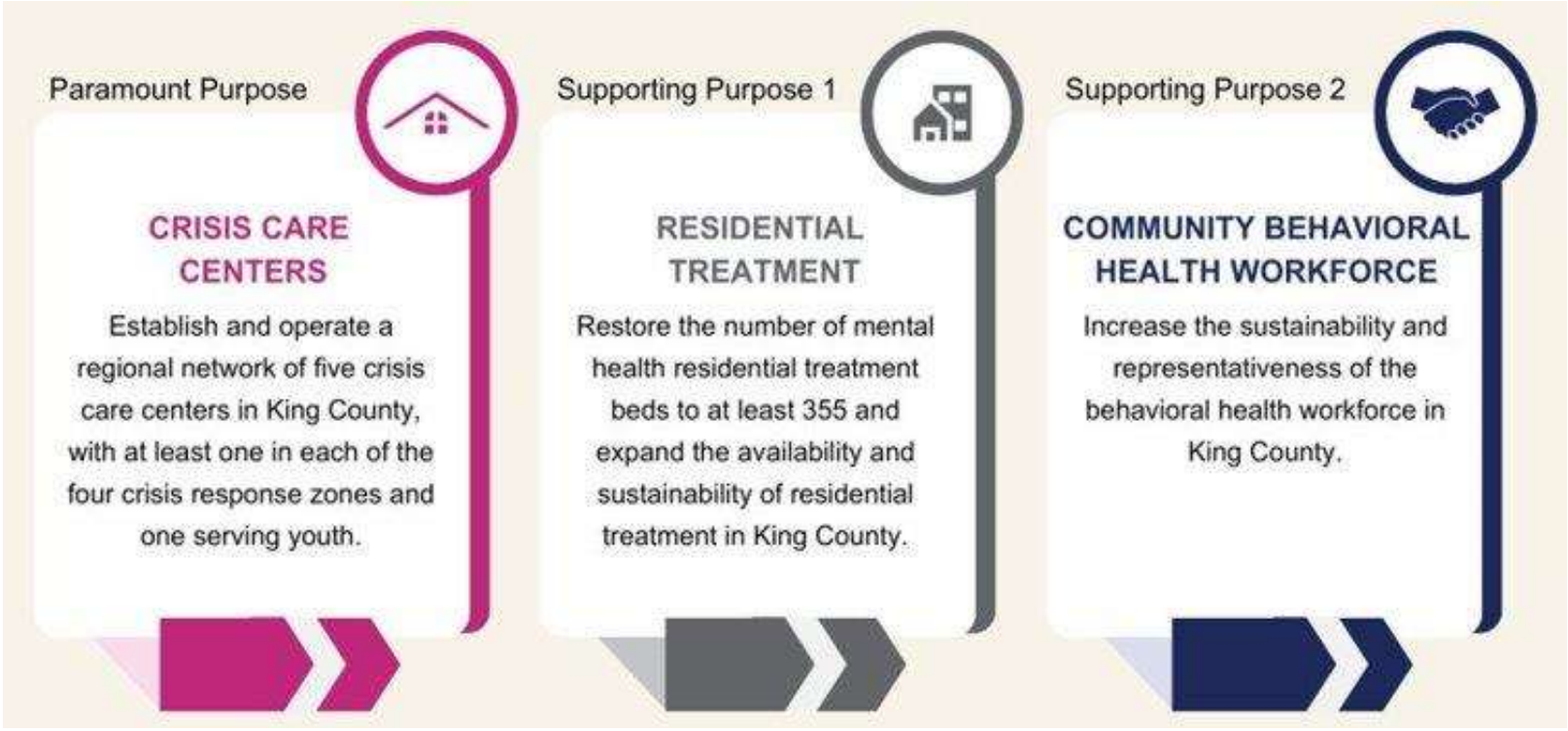
Levy Purposes



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4
Early Crisis Response Investments
5
Capacity Building and Technical Assistance
3
Strengthen Workforce
6
Evaluation and Performance Measurement
2
Expand Treatment Capacity
7
Levy Administration
8
Crisis Care Centers
Levy Strategies
1
Create Five Centers
8
Levy Reserves
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Timeline

- 2023:
  - April: Levy approved
  - December: Implementation Plan transmitted
- 2024:
  - June: CCC Levy Implementation **Plan adopted** by Ordinance 19783
  - July: **Implementation Begins**
- 2025:
  - January: First full year of Levy implementation



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2025 Highlights

- North Regional CCC in Kirkland: youth behavioral health urgent care service begins and becomes licensed for withdrawal management services.
- Central CCC in Seattle: sited at a building purchased by King County. Connections awarded as operator.
- $12.4 million spent on workforce initiatives to strengthen, stabilize, and increase representativeness of community behavioral health workforce.



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2025 Highlights

Early Investments

- Expanded number of youth and adult mobile crisis teams.
- Increased resources for opioid overdose crisis response – naloxone vending machines and overdose reduction supply distribution at permanent supportive housing, low-income housing, emergency shelters, day centers, and food banks.



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2025 Highlights: Data

- **3,669 individuals** served through 5,425 visits at the North Regional Crisis Care Center.
- **3,686 staff** benefited from Career Pathways investments, including 833 staff who obtained or renewed a license.
- **3,000 kits** distributed through the five vending machines.
- Crisis Connections dispatched Mobile Rapid Response Crisis Teams (MRRCT) for adults **5,676 times**.
- Mobile Response and Stabilization Services (MRSS) for youth increased the number of **teams from 3 to 9** on weekdays and **2 to 6** on weekends.

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2025 Highlights

Released and closed seven procurements:

- North and Central Crisis Care Centers
- Post-Crisis Follow-Up Services
- Funds for Jurisdictions
- Crisis Training Academy
- Residential Treatment Capital Development
- Residential Treatment – Capital Rehab and Maintenance



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Community Engagement

Engagement efforts reached a broad cross-section of King County communities, ensuring meaningful participation and input on crisis care and Levy implementation.

- 66 community partnership presentations
- 22 community conversations
- 25 tours, listening sessions, and provider meetings

Emphasis on populations experiencing behavioral health inequities.

Used a variety of communications strategies to keep community and stakeholders informed (newsletter, blog posts, social media, advertising, etc.)



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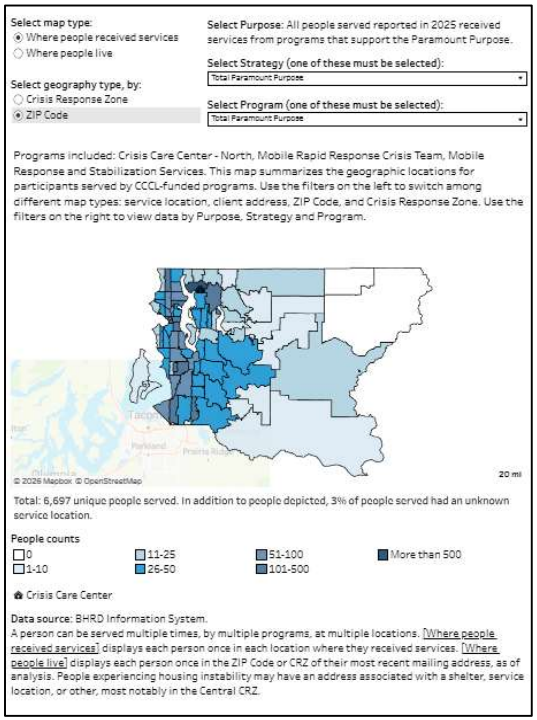
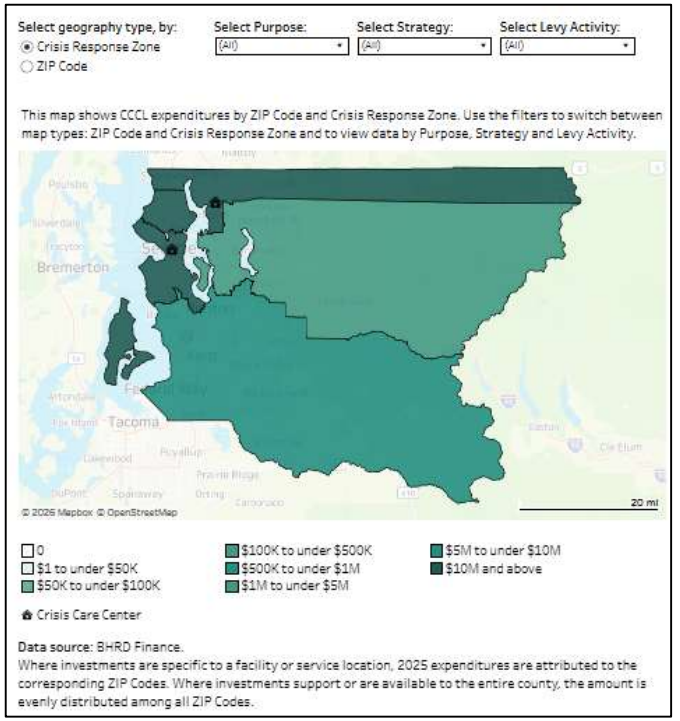
2025 Financial Information

Purpose	Strategy	Activity	2025 CCC Levy Expenditures	2025 CCC Levy Budget
Crisis Care Centers	1. Create and Operate Five Crisis Centers	Crisis Care Centers – Central and North	$39,978,676	$59,888,000
Residential Treatment	2. Restore, Expand, and Sustain Treatment Capacity	Residential Treatment	$1,679,625	$33,340,000
Community Behavioral Workforce	3. Strengthen the Community Behavioral Workforce	Apprenticeship, Career Pathways, Labor Management Partnership Training	$12,404,973	$11,849,000
Crisis Care Centers	4. Early Crisis Response Investments	911 Diversion, Overdose Prevention Supplies and Resources, Mobile Rapid Response Crisis Team, Pioneer Square Client Engagement	$2,985,027	$6,290,000
Supports All Purposes	5. Capacity Building and Technical Assistance	Capacity Building and Technical Assistance Total	$96,902	$2,029,000
Supports All Purposes	6. Evaluation and Performance Measurement	Evaluation and Performance Measurement Total	$806,408	$1,099,000
Supports All Purposes	7. CCC Levy Administration	CCC Levy Administration Total	$6,049,033	$7,581,000
			2025 Levy Total Spent: $64,000,643	**2025 Levy Budget Total: $122,077,000**

King County DCHS Department of Community and Human Services

2025 geographic service and fiscal expenditure data





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2026 Preview



- Progress on awards and contracts for the South, East, and Youth Crisis Care Centers;
- Launch of three PCFU teams providing culturally and linguistically appropriate services;
- New procurements, awards, and expenditures to restore, expand, and sustain residential treatment facilities;
- Maintaining workforce development initiatives through new funding opportunities, and initiating the Crisis Training Academy;
- Continuing investments for community-based crisis response programs, reducing overdoses, and facilities offering substance use disorder services;
- Continued technical assistance and capacity building funding to support providers and jurisdictions siting facilities and responding to procurements;
- Measuring, analyzing, and reporting on the impact of the CCC Levy; and
- Releasing procurement to build a Crisis Care Coordination Platform.

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Instagram

Blog

YouTube

Website

Data Dashboard