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

King County

Meeting Agenda

Regional Policy Committee

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

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

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

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

9:00 AM **Thursday, November 5, 2026** **Hybrid Meeting**

SPECIAL MEETING

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

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

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

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

1. Call to Order

2. Roll Call

3. Approval of Minutes p. 4-9

Minutes of September 30 and October 14, 2026 meetings.

Consent

4. Proposed Motion No. 2026-0206 p. 10

A MOTION approving the 2025 annual mental illness and drug dependency annual summary report.

Sponsors: Mosqueda

Sam Porter, Council staff

Discussion and Possible Action

5. Proposed Substitute Ordinance No. 2026-0174.2 p. 66

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

Sponsors: Mosqueda

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Sam Porter, Council staff
All versions of Proposed Ordinance 2026-0174 are before the committee for consideration and are available on Legisearch

6. Proposed Substitute Ordinance No. 2026-0177.2 **p. 91**

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

Sponsors: Mosqueda

Sam Porter, Council staff
All versions of Proposed Ordinance 2026-0177 are before the committee for consideration and are available on Legisearch

Briefing

7. Briefing No. 2026-B0128 **p. 545**

Crisis Care Centers Levy 2025 Annual Report

Jenny Giambattista, Council staff

Adjournment

Sign language and interpreter services can be arranged given sufficient notice (206-848-0355).
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King County

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Meeting Minutes

Regional Policy Committee

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Alt: Dionne Foster, Alexis Mercedes Rinck

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

3:00 PM **Wednesday, September 30, 2026** **Hybrid Meeting**

DRAFT MINUTES -SPECIAL MEETING

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1. Call to Order

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

2. Roll Call

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

Excused: 3 - Juarez, Pavone and Robinson

3. Approval of Minutes

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

Briefing

4. Briefing No. 2026-B0112

King County's Energy Resilience

This matter was Presented

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

Discussion and Possible Action

5. Proposed Motion No. 2026-0159

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

Sponsors: Mosqueda

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

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

Excused: 4 - Juarez, Pavone, Perry and Robinson

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

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

Votes: Yes: 8 von Reichbauer, Barón, Arnold, Backus, Ralph and Lin
Excused: Juarez, Pavone, Robinson and Perry

Briefing

6. Briefing No. 2026-B0087

Best Starts for Kids 2025 Annual Report.

This matter was Presented

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

Adjournment

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

Approved this _____ day of _____

Clerk's Signature

King County

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

Meeting Minutes

Regional Policy Committee

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Alternates: Dana Ralph, Kent; Jim Ribail, Carnation

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

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

3:00 PM **Wednesday, October 14, 2026** **Hybrid Meeting**

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1. Call to Order

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

2. Roll Call

Present: 6 - Arnold, Backus, Pavone, von Reichbauer, Barón and Perry

Excused: 3 - Juarez, Robinson and Lin

3. Approval of Minutes

The meeting minutes were held.

Discussion Only

4. Proposed Ordinance No. 2026-0174

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

Sponsors: Mosqueda

This matter was Deferred

Sam Porter, Council staff, briefed the Committee on the legislation and answered questions from members. Also present were Isabel Jones, Interim Director, Behavioral Health and Recovery Division (BHRD), Department of Community and Human Services (DCHS), Laura Smith, MIDD Renewal Manager, BHRD, DCHS, Susan Mclaughlin, Director, DCHS and Liz Arjun, Behavioral Health Policy Lead, Office of the Executive.

5. Proposed Ordinance No. 2026-0177

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

Sponsors: Mosqueda

This matter was Deferred

Sam Porter, Council staff, briefed the Committee on the legislation and answered questions from members. Also present were Isabel Jones, Interim Director, Behavioral Health and Recovery Division (BHRD), Department of Community and Human Services (DCHS), Laura Smith, MIDD Renewal Manager, BHRD, DCHS, Susan Mclaughlin, Director, DCHS and Liz Arjun, Behavioral Health Policy Lead, Office of the Executive.

Other Business

There was no other business to come before the Committee.

Adjournment

The meeting was adjourned at 3:29 p.m.

Approved this _____ day of _____

Clerk's Signature

Metropolitan King County Council
Staff Report

Committee:	Health, Housing, and Human Services Committee		
Agenda Item:	4	**Analyst(s):**	Sam Porter
Proposed No.:	2026-0206	**Meeting Date:**	November 5, 2026

OVERVIEW

TOPIC: Proposed Motion 2026-0206 that would approve the 2025 Mental Illness and Drug Dependency annual report.

LEGISLATION SUMMARY

The 2025 Mental Illness and Drug Dependency (MIDD) Annual Report is Attachment A to Proposed Motion 2026-0206, which would approve the report. The requirements for the MIDD annual report are outlined in King County Code (K.C.C.) 4A.500.309 and include performance measurement statistics, utilization statistics, expenditure status updates, and progress reports on evaluation and implementation. The MIDD Advisory Committee reviewed the 2025 MIDD annual report at their meeting on June 4, 2026. Proposed Motion 2026-0206 is a nonmandatory dual referral to both the Health, Housing, and Human Services Committees and to the Regional Policy Committee. The Regional Policy Committee was briefed on this item at their August 26, 2026, meeting.[1] The Health, Housing, and Human Services Committee (HHHS) was briefed at the October 6, 2026, meeting. The proposed motion was introduced at the October 6, 2026, Full Council meeting, and acted on by HHHS at their November 3, 2026 meeting. This item is on the consent agenda for action today.

This Annual Report appears to meet the K.C.C. requirements.

KEY ISSUES FROM THE ANALYSIS

No key issues were identified for this legislation.

BACKGROUND & TIMING CONSIDERATIONS

↑ BACK TO TOP

State Authorizes Sales Tax. In 2005, the Washington State Legislature authorized counties to implement a one-tenth of one percent sales and use tax to support new and expanded

[1] Briefing No. 2026-B0088, King County - File #: 2026-B0088

chemical dependency and mental health treatment programs and services, and for the operation of new or expanded therapeutic court programs and services.

King County Authorizes Sales Tax. In 2007, the King County Council adopted Ordinance 15949 authorizing the first Mental Illness and Drug Dependency (MIDD) sales tax.[2] Ordinance 15949 established the expiration date of MIDD 1 as January 1, 2017. Subsequent ordinances established the MIDD Oversight Committee (April 2008)[3] and the MIDD implementation Plan and MIDD Evaluation Plan (October 2008).[4]

King County Council Approved Extension of the MIDD Sales Tax in August 2016. On August 22, 2016, the King County Council passed Ordinance 18333, extending collections of the MIDD sales tax through 2025. MIDD 2 became effective on January 1, 2017. Ordinance 18333 set forth the following five policy goals for the MIDD:

1. Divert individuals with behavioral health needs from costly interventions such as jail, emergency rooms and hospitals.
2. Reduce the number, length, and frequency of behavioral health crisis events.
3. Increase culturally-appropriate, trauma-informed behavioral health services.
4. Improve the health and wellness of individuals living with behavioral health conditions.
5. Explicit linkage with, and furthering the work of, King County and community initiatives.

MIDD Renewal. The MIDD Sales Tax was renewed in 2025 through Ordinance 19976 and the 1/10th of one penny sales tax is currently projected to generate approximately $998 million over the nine-year collection period.

MIDD Renaming and Bridge Implementation Plan. Proposed legislation to rename the MIDD the "Behavioral Health Bridge"[5] and adopt the Bridge implementation plan[6] are mandatory dual referrals to the Health, Housing and Human Services Committee and to the Regional Policy Committees. The current schedule contemplates final action on the

[2] In 2005, the Washington state legislature authorized counties to implement a one-tenth of one percent sales and use tax to support new or expanded chemical dependency or mental health treatment programs and services and for the operation of new or expanded therapeutic court programs and services.
[3] The MIDD Oversight Committee was established in Ordinance 16077 and is an advisory body to the King County Executive and the Council. The purpose of the Oversight Committee is to ensure that the implementation and evaluation of the strategies and programs funded by the tax revenue are transparent, accountable, and collaborative.
[4] In October 2008, the Council adopted the MIDD 1mplementation Plan and the MIDD Evaluation Plan via Ordinance 16261 and Ordinance 16262.
[5] Proposed Ordinance 2026-0174
[6] Proposed Ordinance 2026-0177

regular course on November 17, 2026. For more information about the implementation plan and renaming legislation please refer to the staff reports for Proposed Ordinances 2026-0174 and 2026-0177.

ANALYSIS

↑ BACK TO TOP

The 2025 MIDD annual report appears to meet the requirements of K.C.C. 4A.500.309. The services and programs funded by the MIDD are evaluated by staff in King County's Department of Community and Human Services (DCHS) based on data submitted by providers. King County Code 4A.500.309.D.1 requires that the annual summary evaluation report shall include at a minimum the following:

A. Performance measurement statistics;

B. Program utilization statistics;

C. Request for proposal and expenditure status updates;

D. Progress reports on evaluation implementation;

E. Geographic distribution of the sales tax expenditures across the county, including collection of residential ZIP Code data for individuals served by the programs and strategies;

F. Updated performance measure targets for the following year of MIDD initiatives, programs and services;

G. Recommendations on either program changes or process changes, or both, to the funded programs based on the measurement and evaluation data; and

H. Summary of cumulative calendar year data.

According to the report, the MIDD Advisory Committee reviewed and endorsed the 2025 Annual Report at their June 4, 2026, meeting.

Table 1 below provides the page numbers for specific sections of the report. Additional information provided through the web-based 2025 MIDD Data Dashboard can be found at this address: https://kingcounty.gov/MIDDdashboard

Table 1. 2025 MIDD Annual Report Sections

Section	Page
2025 Results	3-8
Participants	9-10
Geographic Distribution of Participants	10
Evaluation and Continuous Improvement	10-11
2025 Procurement Update	11-12
Fiscal Information	12-13
2025 Continuous Improvement and Data Informed Implementation Adjustments	Appendix A
Updates to Performance Measure Targets	Appendix B
Reporting Elements Table and MIDD Online Reporting Guide	Appendix C
2025 MIDD Investments	Appendix D
2025 MIDD Partners	Appendix E

Items of note in the 2025 MIDD annual report:

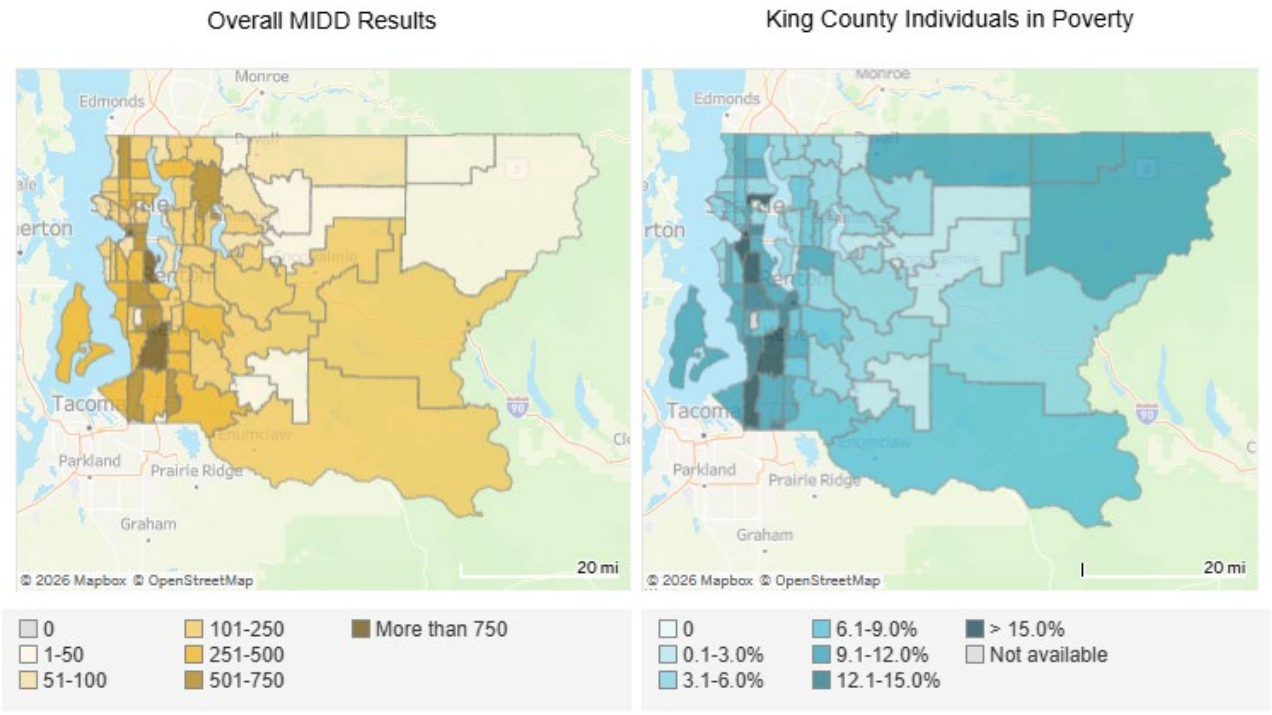
- In 2025, total MIDD expenditures were approximately $115.8 million.[7]
- There were 30,139 people served by MIDD programs in 2025; approximately 2,000 more than the previous year. Of those, according to the dashboard, 10 percent were youth ages 0 to 17, 60 percent were adults ages 18-54, and 29 percent were age 55 and over.[8]
- In 2025, there were 52 active MIDD initiatives, 166 partner organizations, and 312 active contracts.
- Outcomes for MIDD participants in 2025 include:
  - 63% long-term decrease in crisis service episodes among adults;
  - 33% long-term decrease in jail bookings among adults;
  - 29% long-term decrease in emergency department admissions;
  - 41% long-term decrease in psychiatric inpatient admissions;
  - 50% of participants were linked with publicly funded behavioral health treatment;

[7] 2025 MIDD Data Dashboard, accessed August 4, 2026. https://kingcounty.gov/MIDDdashboard and 2025 MIDD Annual Report, page 33.
[8] 2025 MIDD Data Dashboard, "How much do we invest?" accessed August 4, 2026. https://kingcounty.gov/MIDDdashboard

    - 89% of youth had no additional crisis services episodes after connecting with MIDD services;
    - 67% of participants had no substance use after enrollment; and
    - 80% of participants had reduced substance use after enrollment.
- MIDD Strategy RR-11A: Peer Bridger Programs served 224 individuals in 2025. Of those, 67% of participants were linked to publicly-funded behavioral health treatment, and participants experienced a 70% decrease in psychiatric hospitalizations over the long term.[9]
- MIDD Strategy RR-01: Housing Support Services supported behavioral health services for 1,361 permanent supportive housing residents across the county. According to the annual report, " residents receiving these services experienced a 53% decrease in psychiatric inpatient hospitalizations and a 71% decrease in adult jail bookings over the long term."[10]
- Appendix A summarizes continuous improvement and data informed implementation adjustments that occurred in 2025.
- Appendix B states that in 2025, no MIDD initiatives adjusted their performance measurement targets. First-time targets were established in 2025 for initiatives CD-02A: Youth Detention Prevention Behavioral Health Engagement and CD-02B Family Court Services Behavioral Health Program.
- Figure 1 provides information about the geographic distribution of people served in 2025.[11]
- Figure 2 provides information about additional demographics of people served in 2025.[12]

[9] 2025 MIDD Annual Report, page 5
[10] 2025 MIDD Annual Report, page 7
[11] 2025 MIDD Annual Report, page 10
[12] 2025 MIDD Annual Report, page 9

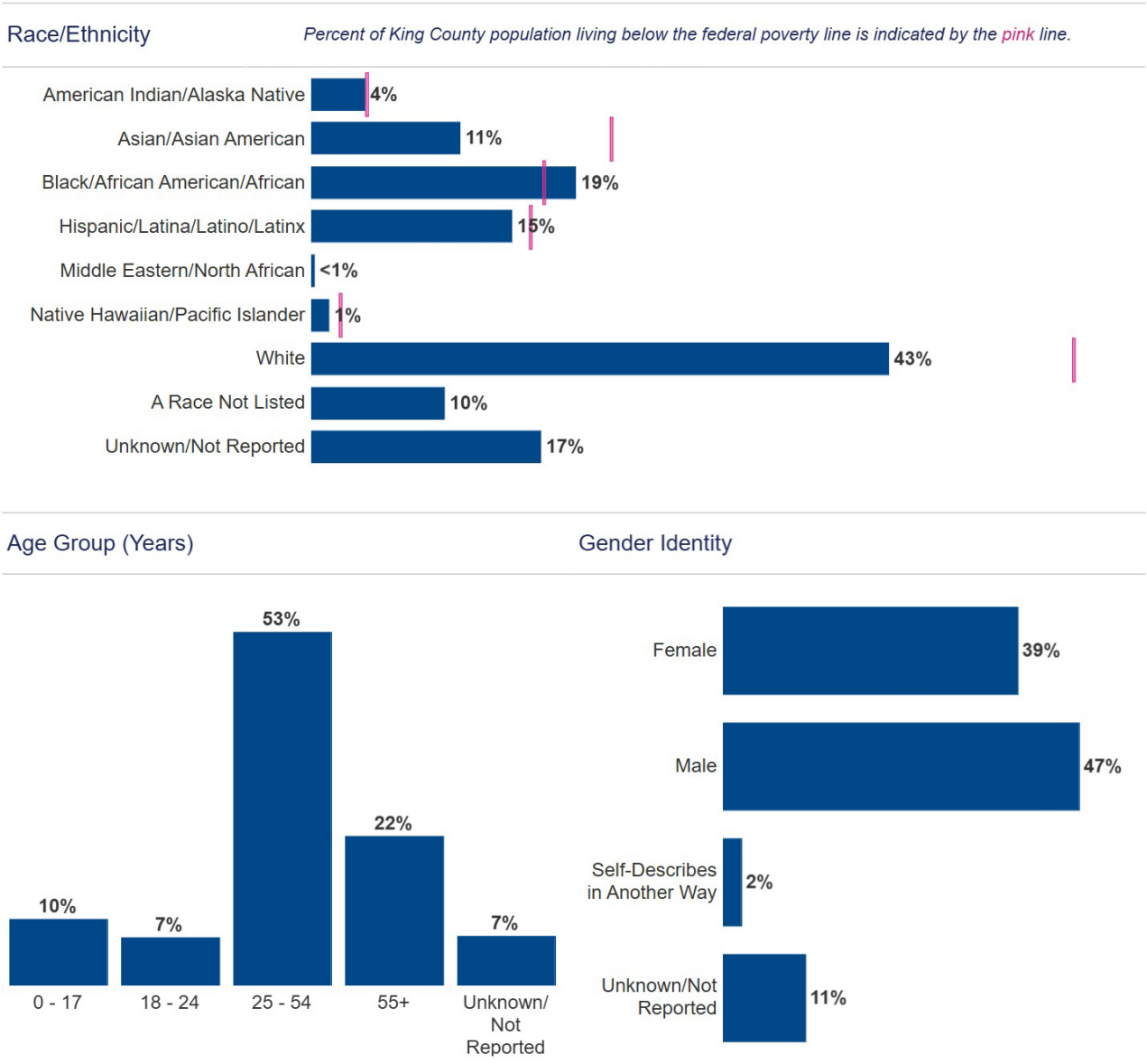
Figure 1. Residential ZIP Code of People Served Through MIDD in 2025 Compared to the Percent of Individuals Whose Income is Below the Federal Poverty Line by ZIP Code[13]



The two maps of King County display the number of individuals served by MIDD (left) and the percent of individuals living in poverty (right) by ZIP Code. ZIP Codes are color-coded, with darker shading indicating a greater number of individuals served or a greater percentage of individuals living in poverty.

[13] 2025 MIDD Annual Report, page 10

Figure 2. Additional Demographics of People Served by MIDD, 2025[14]



ATTACHMENTS

1. Proposed Motion 2026-0206 (and its attachment)
2. Transmittal Letter
3. Executive Staff PowerPoint Presentation, August 26, 2026

[14] 2025 MIDD Data Dashboard, "Who do we serve?" accessed August 4, 2026. https://kingcounty.gov/MIDDdashboard

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

Motion

Proposed No. 2026-0206.1 **Sponsors** Mosqueda

A MOTION approving the 2025 annual mental illness and drug dependency annual summary report.

WHEREAS, in 2005, the state Legislature authorized counties to implement a one-tenth of one percent sales and use tax to support new or expanded chemical dependency or mental health treatment programs and services and for the operation of new or expanded therapeutic court programs and services, and

WHEREAS, in 2007, Ordinance 15949 authorized the levy collection of and legislative policies for the expenditure of revenues from an additional sales and use tax of one-tenth of one percent for the delivery of mental health and chemical dependency services and therapeutic courts, and

WHEREAS, in 2016, Ordinance 18333 extended the expiration date of this sales and use tax to January 1, 2026, and

WHEREAS, the council called for and approved in 2016 and 2018 a service improvement plan, an implementation plan, and an evaluation plan to guide the investment of renewed mental illness and drug dependency sales tax revenue, and

WHEREAS, in 2025, Ordinance 19976 extended the expiration date of the sales and use tax to January 1, 2035, and

WHEREAS, in the 2026-2027 Biennial Budget Ordinance 20023, Section 70, Expenditure Restriction ER6, the council called for expenditures through 2027 to continue

to be consistent with the 2016 and 2018 plans' processes and practices, and

WHEREAS, the mental illness and drug dependency fund's processes and practices under the 2016 and 2018 plans include annual reports that are submitted to the Council by August 1 of each year, for council review and approval by motion, and

WHEREAS, the 2025 mental illness and drug dependency behavioral health sales tax fund annual summary report, which is Attachment A to this motion, has been developed in coordination with the mental illness and drug dependency advisory committee and is supported by the committee;

NOW, THEREFORE, BE IT MOVED by the Council of King County:

The 2025 mental illness and drug dependency behavioral health sales tax fund annual summary report is hereby approved.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____

Sarah Perry, Chair

ATTEST:

_____

Melani Pedroza, Clerk of the Council

APPROVED this _____ day of _____, _____.

_____

Girmay Zahilay, County Executive

Attachments: A. 2025 MIDD Behavioral Health Sales Tax Fund Annual Summary Report

2025 MIDD Behavioral Health Sales Tax Fund Annual Summary Report

July 31, 2026

King County

I. Summary

Building on its record of strengthening King County's behavioral health system, the region's 0.1 percent behavioral health sales tax remains a flexible and impactful local funding source. Authorized under RCW 82.14.460 and KCC 4A.500.300, the tax supports mental health and substance use treatment, recovery services, crisis diversion, outreach, workforce development, and prevention programs throughout King County. These investments are designed to break cycles of crisis, incarceration, hospitalization, and homelessness by addressing root causes, expanding access to care, and supporting long-term stability.

For nearly two decades, MIDD has helped counter chronic underinvestment in behavioral health at the state and federal levels by providing a stable local funding stream that strengthens provider capacity and system coordination. MIDD works alongside other King County, state, and federal resources to expand access to care, support innovative approaches, and respond to emerging community needs. In 2025, MIDD investments focused on prevention and early intervention, crisis diversion, recovery and reentry, system improvement, and therapeutic courts. This flexibility allows King County to fill critical gaps – including programs that are not Medicaid-billable and services for residents who are not Medicaid-eligible – while improving outcomes and reducing downstream costs.

In 2025 alone, MIDD-funded initiatives served 30,139 residents through 52 programs delivered by 166 community partners. These investments increased access to mental health and substance use care, strengthened outreach and crisis response capacity, and supported a more stable behavioral health workforce. As reflected in 2025 performance data, MIDD program participants experienced measurable improvements in health and stability, including increased engagement in services, reduced crisis system involvement, and stronger connections to community-based supports.

II. Background

King County's 0.1 percent behavioral health sales tax is a unique local funding source authorized under RCW 82.14.460 and KCC 400.5A.300 that improves access to mental health and substance use treatment, recovery, and prevention services.[1,2] The Behavioral Health and Recovery Division (BHRD) within the Department of Community and Human Services (DCHS) administers the fund and partners with community-based organizations to deliver services across the full continuum of care. Since its inception in 2007, the fund has been known in King County as MIDD.

Since 2008, MIDD investments have supported behavioral health services that cannot be billed to Medicaid, and services for people who are ineligible for Medicaid. MIDD helps interrupt cycles of crisis and systems involvement by ensuring people can access the right support at the right time. By investing in outreach teams, crisis response infrastructure, diversion programs, workforce capacity, and innovative service models, MIDD demonstrates what coordinated, outcomes-driven local government can achieve. As a reliable and adaptable revenue source, MIDD not only addresses immediate needs, it has the potential to build a more affordable, resilient, and sustainable behavioral health system for the long term.

In 2025, the King County Council unanimously adopted Ordinance 19976 to renew the sales tax through 2034.[3] Ordinance 20023, Section 70, Expenditure Restriction ER6 directed MIDD expenditures to continue in 2026-27 according to plans in place for 2017-25, while the Executive branch prepared an updated Implementation Plan.[4] Ordinance 20023, Section 70, Proviso P1, called for the Executive to deliver an updated Implementation Plan for the fund by July 1, 2026.[5] The Executive transmitted the plan for the fund through 2034 to the Council in July 2026. At the time of this report, the Implementation Plan was under consideration by the Council.

While the tax 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. In response to community and provider feedback, in the proposed implementation plan for 2028-2034 and associated legislation that were before Council at the time of this report, the Executive has proposed 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 a bridge between people experiencing behavioral health conditions, community behavioral health treatment, the criminal-legal system, and pathways to recovery.

Despite the proposed name change, this report still primarily uses the name "MIDD" because it reports retrospectively on activities and outcomes from 2025.

III. Report Requirements

This annual report summarizes the activities of the MIDD Behavioral Health Sales Tax Fund for 2025. It also includes links to the online MIDD Dashboard, which provides a more in-depth review of the MIDD's 2025 outcomes.

Additional Information Available in the MIDD Dashboard
Significant additional information about MIDD initiatives is online in the MIDD Dashboard available at https://kingcounty.gov/MIDDdashboard. For example, the dashboard includes:

- additional data specific to each MIDD initiative,
- additional context and discussion of initiative activities and performance in 2025,
- customizable views of MIDD data,
- greater background on participant demographics,
- more information about how MIDD and its partners are working to support the behavioral health of residents.

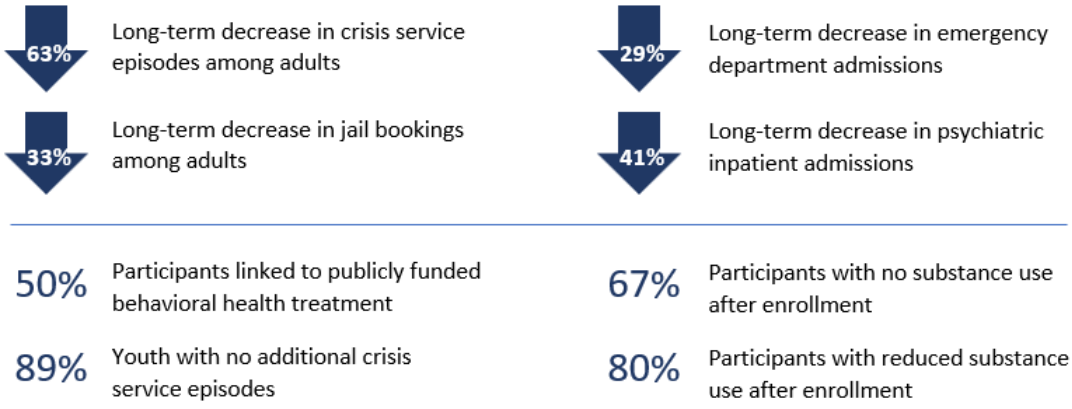
A. MIDD Implementation and Results in 2025

MIDD investments across a wide array of initiatives in 2025 contributed to ensuring effective, equitable, and accessible behavioral health care, and helped to break the cycle of repeated crisis, incarceration, hospitalization, and homelessness by connecting residents to timely, community-based support. In 2025, MIDD served 30,139 people across 52 initiatives, an increase of seven

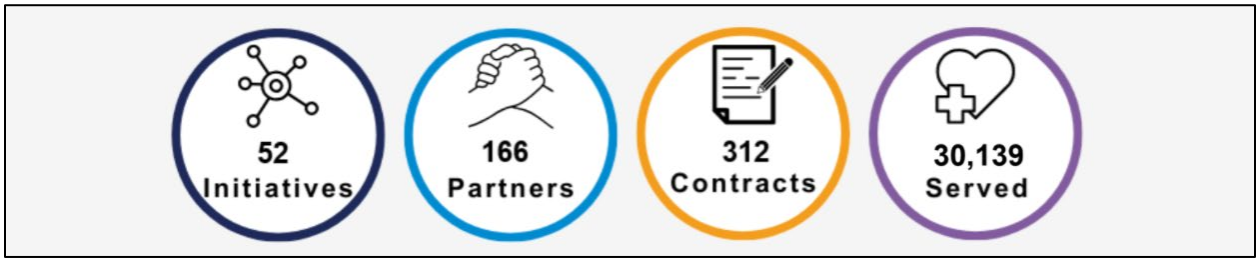
percent over the 28,113 served in 2024.[6] The figure below displays key short- and long-term outcomes among participants in MIDD programs.[7]

Key MIDD Outcomes in 2025

Participants in MIDD programs showed increased access to care for mental health and substance use conditions, fewer trips to jails and hospitals, and more connections to treatment and services in their communities. These outcomes reflect meaningful progress toward breaking recurring cycles of crisis and system involvement that drive poor health outcomes and high system costs.



MIDD achieved these results in partnership with 166 community-based entities operating community-informed programs under an umbrella of 52 initiatives.



MIDD investments in 2025 were guided by the MIDD 2 Implementation Plan and responded to emerging community needs to the degree possible within currently funded initiatives.[8] Key areas of focus featured in this report include MIDD-funded work to:

- Respond to emerging behavioral health needs;
- Work across systems to deliver coordinated, effective care; and
- Leverage local funding to improve and innovate services in the behavioral health system.

Key Area of Focus: Responding to Emerging Behavioral Health Needs

The purpose of King County's behavioral health sales tax is to invest in the long-term availability, accessibility, and effectiveness of the behavioral health system, especially where people are falling through the cracks of existing services and cycling through multiple systems. The behavioral health sales tax's flexibility allows King County to respond to emerging behavioral health needs and fill critical gaps in services that neither Medicaid nor the State fund. By focusing on low-income

residents with mental health and substance use conditions, particularly those facing marginalization or intersectional inequities, the County directs these resources where need is greatest and impact is most meaningful.

The examples below highlight MIDD-funded programs that address behavioral health needs when other funding falls short.

- In 2025, **CD-01: Law Enforcement Assisted Diversion (LEAD)** served 1,121 individuals in King County utilizing a case management model which tailors care plans to each client's self-identified needs. Individuals who are unhoused, use substances, or have untreated mental health conditions frequently encounter law enforcement due to behaviors that constitute low-level law violations, such as sex work, trespassing, disorderly conduct, or public intoxication. LEAD diverts individuals from arrest and incarceration, which can exacerbate behavioral health conditions and bear significant costs to the individual and King County. Participants in LEAD experienced a 52 percent reduction in jail bookings over the long term (three years after program enrollment). Flexible funding also allows case managers to use small but meaningful engagement tools, such as sharing a meal, to establish relationships with clients who may be skeptical of engaging with a service system that has historically harmed and mistreated segments of the population.

- **RR-11A: Peer Bridger Programs** served 224 individuals in 2025, increasing engagement in treatment and recovery programs by assisting participants with their transition out of institutional settings such as inpatient hospitalization and into outpatient behavioral health care. The flexibility of MIDD funding allows program staff to provide not only the core program components of discharge planning and system navigation but also concrete, basic needs assistance, such as clothing, bus tickets, and other essentials. This approach eases a difficult transition for many patients during a particularly vulnerable period when many individuals lapse in their behavioral health care. Sixty-seven percent of participants in Peer Bridgers Programs were linked to publicly-funded behavioral health treatment following enrollment in the program, and participants experienced a 70 percent decrease in psychiatric inpatient hospitalizations over the long term. **RR-11B: Substance Use Disorder (SUD) Peer Support** similarly uses a peer support network to meet people in community settings, connect them to local services, and support individuals on their journey to stability.



Peer Washington / Peer Kent provides navigation supports to community members, frequently meeting participants in community locations such as King County Libraries.
Source: Peer Washington and King County Library System

- **PRI-11A: Community-Based Behavioral Health Treatment** engaged 3,365 individuals, who have low incomes but are not eligible for Medicaid, in outpatient mental health and substance use treatment in 2025. This program aims to provide necessary services and treatment to all low-income King County residents needing services by reaching individuals with behavioral health needs unaddressed by other publicly funded behavioral health services. This critical

resource prevents the necessity for more costly treatment and intervention among King County residents. For example, participants in MIDD-funded Community-Based Behavioral Health Treatment services experienced a 34 percent decrease in psychiatric inpatient hospitalizations and a 25 percent decrease in jail bookings over the long term.

The programs highlighted above show how the behavioral health sales tax fund's flexibility helps interrupt the cycle of incarceration, untreated behavioral health conditions, and system disengagement for people with behavioral health conditions. The fund expands healthcare access for the uninsured and fills critical service gaps during transitions between providers, when individuals in need often disengage from care. Because other state and federal fund sources typically do not support these behavioral health services, these local funds are an essential resource to build an integrated system of care.

Key Area of Focus: Work Across Systems to Deliver Coordinated, Effective Care

Local behavioral health sales tax investments strengthen King County's behavioral health system by supporting coordination across County departments and partner systems, demonstrating what effective government looks like when agencies work together toward shared outcomes. DCHS collaborates with partners in public health, education, the legal system, child welfare, and housing to expand behavioral health support in community and non-clinical settings.
MIDD also aligns with other County initiatives, such as Best Starts for Kids and the Crisis Care Centers Levy, as well as state and federal resources that support King County's role as the region's Behavioral Health Administrative Services Organization (BHASO). This coordinated approach maximizes impact and enables individuals with behavioral health needs to receive more holistic, connected care across programs and service settings.

The examples below illustrate MIDD-funded efforts that enhance coordination and address behavioral health needs when the broader system falls short.

- Some of King County's most vulnerable residents are individuals with behavioral health conditions who are recently released from incarceration into homelessness. This is a vulnerable point in time for individuals – they often leave jail needing continued behavioral healthcare, medications and housing, but their connections to these supports can be lost. DCHS works with the Department of Adult and Juvenile Detention and Jail Health Services of Public Health Seattle-King County to deliver **RR-06B: Jail Coordinated Discharge** to break the cycle of homelessness and incarceration among individuals with behavioral health conditions. This program provided release planning to 2,631 individuals leaving King County jails in 2025. Participants received a supply of medication, linkages to care, next day appointments for SUD treatment, and re-entry items.

- Early identification of issues and intervention with youth and young adults, particularly those with behavioral health conditions, saves lives by creating pathways to treatment in a non-stigmatizing manner. **PRI-05: School-Based Screening, Brief Intervention, and Referral to treatment/services (School-Based SBIRT)** program uses a secure survey – available in 22 languages including English – to provide instant, personal feedback to teenagers, promoting social and emotional health. Over a dozen King County school districts have partnered with MIDD and the Best Starts for Kids Levy (BSK) to integrate this tool into their curriculum.[9] Based on students' responses to the questionnaire, the survey platform refers students to counselors or support groups. In 2025, the School-Based SBIRT survey screened 14,311 students across

13 school districts and one private school, referring over 3,000 students to needed services. In the 2024-2025 school year, 2,845 students identified a new need previously unknown to school staff.

- Permanent Supportive Housing (PSH) provides long-term, onsite services for people experiencing homelessness, including many who have behavioral health conditions. Through **RR-01: Housing Support Services**, MIDD funds behavioral health services for 1,361 PSH residents across the county. Residents receiving these services experienced a 53 percent decrease in psychiatric inpatient hospitalizations and a 71 percent decrease in adult jail bookings over the long term.
- **TX-SMC: Seattle Municipal Mental Health Court** funds a position, known as a competency boundary spanner, who partners with jail staff and prosecuting attorneys to refer individuals in jail custody to the Legal Intervention and Network of Care (LINC) program. Individuals booked into jail on misdemeanor charges who are at risk of, or have a history of, having their competency to stand trial questioned may enroll in the LINC program in lieu of prosecution. The LINC program provides behavioral health treatment, peer support, respite beds, case management, and legal coordination to support over 100 individuals annually through MIDD funding and state investment. A 2022 state report found that LINC and two other prosecutorial diversion programs significantly reduced rearrests, jail days, and state psychiatric hospital stays.[10] Participants in LINC that were referred via the competency boundary spanner experienced a 61 percent decrease in jail bookings over the long term.

Concerted partnerships and working across systems are critical to delivering accessible and appropriate services that improve client outcomes.

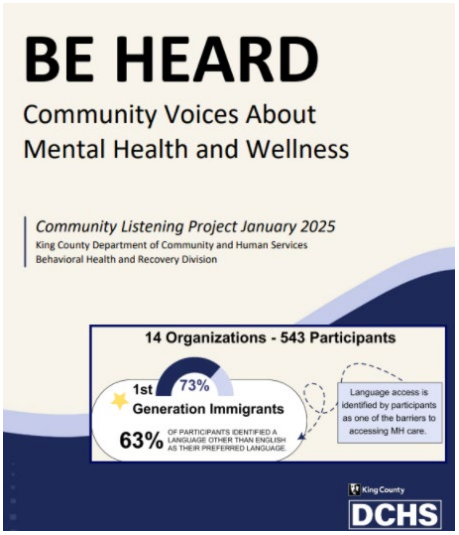
Key Area of Focus: Leverage Local Funding to Improve and Innovate the Behavioral Health System

As King County continues to respond to rising behavioral health needs, the behavioral health sales tax remains one of the region's most important tools for strengthening and evolving the system. Its local flexibility allows the County to respond to emerging challenges, pilot innovative approaches, and support services that expand and enhance the broader behavioral health continuum. Working in coordination with other County, state, and federal resources, this funding helps advance new models, strengthen connections across systems, and improve access to timely, community-centered care. The examples below highlight how MIDD-funded initiatives invested in innovation, best practices, and collaborative programs that strengthen behavioral healthcare in King County.

- **CD-11: Children's Crisis Outreach Response System** (CCORS) provides crisis response services to children, youth, and families who are disconnected from publicly funded behavioral health services yet affected by interpersonal conflict or severe emotional or behavioral concerns. MIDD funding for CCORS acts as a critical reinforcement to outreach services for behavioral healthcare engagement by providing mobile crisis outreach and crisis stabilization services to help families support their child to stay in their home. CCORS was expanded in 2025 to cover all of King County regardless of insurance status and to transition to an evidence-based model required by the state, called Mobile Response and Stabilization Services (MRSS). The geographic expansion enabled CCORS to decrease its response time for emergent outreach to

less than an hour. Participants engaged in services through CCORS experienced a 50 percent reduction in emergency department visits over the long term.

- **SI-01: Community Driven Behavioral Health Grants** supported the *Be Heard: Community Voices about Mental Health and Wellness Community Listening Project* and resulting report. This project funded 14 culturally centered, community-based organizations to host 106 listening sessions about mental health with 543 individuals.[11] This report shows varying degrees of knowledge and stigma across communities, the trauma and stressors unique to different communities, and the many barriers to care faced by immigrants, refugees, and other marginalized groups, and highlighted the importance of culturally responsive and community-driven behavioral health education, resources, and treatment. These findings informed the 2025 competitive procurement for culturally-focused behavioral health services, as well as the development of the proposed implementation plan for the behavioral health sales tax. In 2025, eight partner organizations funded through the same initiative engaged 756 participants in culturally relevant services, including healing circles and art therapy. These organizations also held 177 community events and 235 support groups.



Be Heard: Community Voices about Mental Health and Wellness: Community Listening Project January 2025. *King County Department of Community and Human Services.*

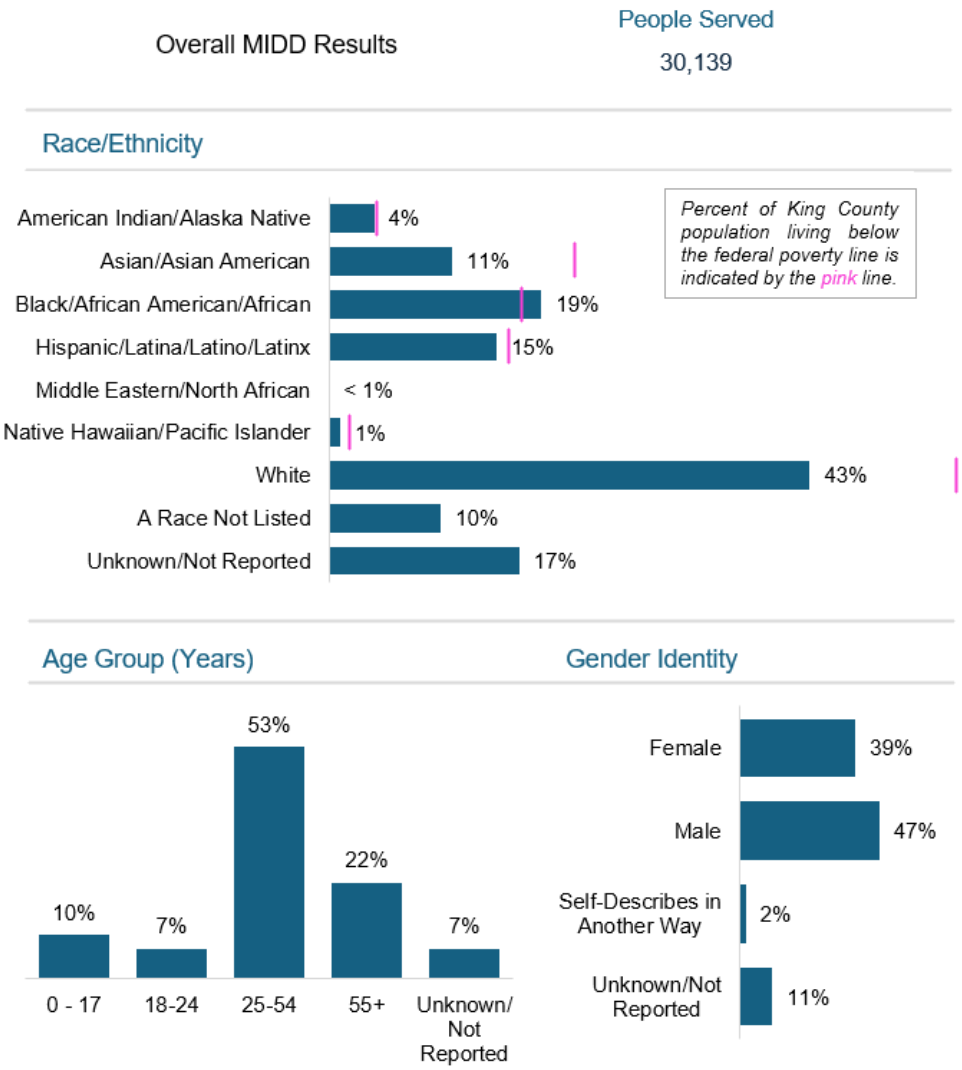
- **SI-04: Behavioral Health Workforce Development** provided training to 103 staff members at nine behavioral health agencies in Dialectical Behavioral Therapy (DBT) and 84 staff at five behavioral health agencies in Cognitive Behavioral Therapy for Psychosis (CBTp). Further, 15 staff at six behavioral health agencies received training in the Seven Challenges, a treatment model for adolescents and young adults with substance use disorders, and 108 staff utilized a MIDD-funded on-demand training platform with integrated feedback to support quality improvement in behavioral health care. This initiative also funded the Centering Diverse Healers collaborative project with Public Health-Seattle & King County and Best Starts for Kids levy. By providing training in best practices and traditional healing, the project supports the availability of high-quality and effective care. In 2025, Centering Diverse Healers engaged 177 individuals in trainings, internships, or supervision with over 87 percent reporting an increase in skills and competencies.

Through these and other local investments, King County pilots new approaches to behavioral healthcare, improving the access, affordability, and appropriateness of services.

B. MIDD Participants

King County supports the health and well-being of King County residents by investing MIDD resources in programs that deliver services across the behavioral health continuum, including prevention and early intervention, crisis diversion, treatment, community reentry, and recovery services. Services funded by MIDD reached a total of 30,139 people in 2025.

Figure 1: Demographic Characteristics of People Served Through MIDD in 2025



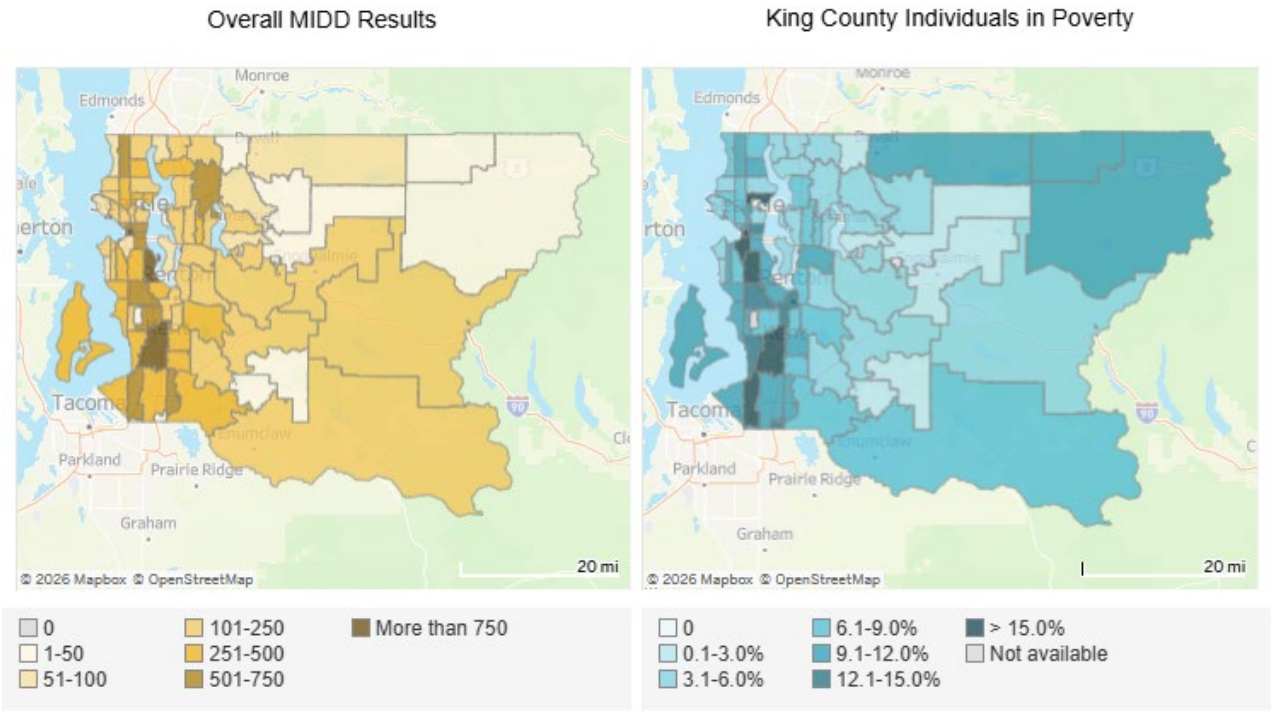
King County's behavioral health sales tax creates services that are responsive to the unique needs of the region's geographic, cultural, and ethnic communities.[12] To promote equitable access to essential behavioral health services, it has invested in programs that meet emergent needs of under-resourced populations. Figure 1 displays the demographic information of people served by MIDD initiatives in 2025. While some racial/ethnic groups, such as individuals identifying as Black (or African-American or African) are overrepresented when compared to the general population of

King County, other racial/ethnic groups, such as individuals identifying as Asian or Asian-American, are underrepresented.

More detailed information on the people served by individual MIDD initiatives is available on the MIDD data dashboard (https://kingcounty.gov/MIDDdashboard). The dashboard includes demographic information disaggregated by MIDD initiative.

The maps displayed in Figure 2 show the number of people served by MIDD initiatives in 2025 and the percentage of individuals whose income is below the federal poverty line (FPL) in each King County ZIP code. As Figure 2 demonstrates, in 2025, people served by MIDD initiatives more often lived in ZIP codes with a higher percentage of individuals living below the poverty line, consistent with MIDD's focus on reaching underserved populations throughout the county.

Figure 2: Residential ZIP Code of People Served Through MIDD in 2025 Compared to the Percent of Individuals Whose Income is Below the Federal Poverty Line by ZIP Code



The two maps of King County display the number of individuals served by MIDD (left) and the percent of individuals living in poverty (right) by ZIP Code. ZIP Codes are color-coded, with darker shading indicating a greater number of individuals served or a greater percentage of individuals living in poverty.

More detailed information on where people served by MIDD initiatives live can be found on the MIDD Dashboard, including geographic information disaggregated by MIDD initiative.

C. Evaluation and Continuous Improvement

Consistent with the direction from Ordinance 20023, Section 70, Expenditure Restriction ER6, each MIDD initiative was evaluated in 2025 relative to one or more of the policy goals outlined in the 2017 MIDD Implementation Plan.[13] Additional proximal measures reflect specific program activities and their impact. This approach recognizes the unique, direct impact each initiative has

on participants receiving services, as well as the collective impact MIDD programming creates across multiple initiatives and participants. An example of this is the combined impact of more than 20 initiatives on overall jail bookings across thousands of MIDD participants.

MIDD evaluation uses a Results-Based Accountability (RBA) framework, which asks questions about the quantity, quality, and impact of services:

- How much did we do?
- How well did we do it?
- Is anyone better off?

This framework supports understanding how MIDD programs contribute to breaking cycles of incarceration, hospitalization, and other system involvement over time. See Section A above ("MIDD Implementation and Results in 2025") for overarching results across the fund, as well as example outcomes for specific MIDD initiatives.

MIDD uses data about its programs to make improvements when needed. Appendix A summarizes data-informed implementation adjustments that occurred for MIDD-funded services during 2025. Appendix B reviews the status of changes to performance measure targets during the year. This information is also available on the MIDD Dashboard.

D. 2025 Procurement Update

King County DCHS's Behavioral Health & Recovery Division (BHRD) contracts with community-based organizations to deliver culturally responsive services, promote coordination across funding sources, and expand access to behavioral health services among underserved populations. BHRD released six MIDD-funded competitive procurements in 2025, for the following investments:

- **CD-07: Multipronged Opioid Strategies** to fund contingency management for stimulant use disorder and to implement an opioid medication adherence collaborative.
- **RR-03: Housing Capital and Rental** to create 20 permanent supportive housing units for individuals with chronic behavioral health needs.
- **SI-01: Community Driven Behavioral Health** to deliver culturally-tailored behavioral health supports by organizations embedded in Black, Indigenous, and People of Color (BIPOC) communities.
- **SI-02**: **Behavioral Health Services in Rural King County** to expand the availability of behavioral health services in rural communities which are often isolated from behavioral health supports.
- **SI-04: Workforce Development** led two procurements in 2025 to fund training opportunities for King County Integrated Care Network (KCICN) community behavioral health providers, delivered through a Training



MIDD awarded Consejo Counseling & Referral Services funding through SI-02 for its mobile van, allowing Consejo to keep a van purchased with federal COVID-19 funding on the road, and delivering much needed behavioral health services to residents living in rural King County. Source: King County

Academy model: Dialectical Behavior Therapy (DBT) Training and Cognitive Behavioral Therapy for psychosis (CBTp).

- **TX-RMHC: Regional Mental Health Court and Regional Veterans Court** procured urinalysis testing services delivered through a trauma-informed care lens.

Additional detail on procurements is available on the MIDD Dashboard.

E. MIDD Fiscal Information

The environment surrounding MIDD entering 2025 brought a complex mix of economic and fiscal considerations which influenced its investment approach for 2025.

As the COVID-19 pandemic concluded, DCHS invested unspent MIDD funds in one-time capital investments and time-limited program expansion to support needed activities without increasing ongoing programmatic costs for MIDD. Entering 2025, the United States and greater Puget Sound region were experiencing continued and significantly elevated inflation rates. The cumulative effect of this environment was higher costs, particularly for labor. As most MIDD programs are labor-intensive, this created increasing financial pressures on the MIDD fund and program operations.

Actual revenue collections for 2025 were largely in line with forecasts, ending the year just 1.1 percent higher than budgeted. Actual expenditures in 2025 were 90 percent of budgeted amounts. One-time capital projects accounted for nearly half of MIDD's under-expenditure, due to challenges providers faced executing capital and facility projects within the year. Despite these challenges, MIDD ended 2025 with its reserve levels reduced to near normal levels.

Entering the 2026-2027 biennium and the next implementation planning period, the fund faces several financial challenges. Contracted service providers and the County continue to face inflationary pressures that increase the cost to deliver funded services. Also, the Washington State Legislature expanded the MIDD tax base through Engrossed Substitute Senate Bill (ESSB) 5814 in 2025, only to roll back the expansion in 2026 with ESSB 6346, with corresponding reductions in anticipated collections effective 2029.[14,15] The volatility of sales tax as a revenue source also presents ongoing challenges, with program service demands often climbing at times when tax collections are falling. Finally, the federal policy environment presents substantial uncertainty which may place future service demands on the fund as early as 2027.

Figure 3: Breakdown of MIDD Budget and Actual Expenditures in 2025.

STRATEGY AREA	2025 Budget	2025 Actuals	Percent Spent
Prevention & Early Intervention[16, 17]	$ 25,081,572	$ 25,887,580	103%
Crisis Diversion[14,18]	$ 31,818,512	$ 28,105,437	88%
Recovery & Reentry[16]	$ 28,949,015	$ 26,634,407	92%
System Improvement[16]	$ 9,161,476	$ 7,545,969	82%
Therapeutic Courts	$ 15,123,302	$ 13,943,763	92%
Special Projects[15,19]	$ 12,171,300	$ 8,708,390	72%
Administration & Evaluation	$ 5,942,077	$ 5,000,624	84%
Total[20]	**$ 128,247,254**	**$ 115,826,170**	**90%**

F. MIDD Dashboard

The MIDD Dashboard is the primary source of detailed data and information on MIDD initiative performance and outcomes. The dashboard contains nine tabs which, respectively, provide information on:

- 2025 highlights;
- Who MIDD serves;
- Exploring how MIDD participants self-identify;
- Where MIDD participants live;
- Measures of MIDD performance;
- MIDD long-term outcomes;
- How MIDD is improving;
- What MIDD invests in; and
- How MIDD is evaluated.

While this report contains summary information about 2025 MIDD investments, the dashboard contains additional demographic information, geographic data, performance measures, long-term outcomes, 2025 procurements, data-informed implementation adjustments, performance relative to targets, changes to targets, and expenditures by initiative.

MIDD Advisory Committee

The MIDD Advisory Committee is an advisory body to the King County Executive and King County Council that seeks to ensure that the implementation and evaluation of MIDD is transparent, accountable, collaborative, equity-focused, and effective. The MIDD Advisory Committee reviewed and endorsed this Annual Report at the June 4, 2026 meeting.

A list of MIDD Advisory Committee Members and the agencies and subject matter expertise they bring to the Advisory Committee is available on the MIDD webpage.[21]

IV. Conclusion/Next Actions

Local behavioral health sales tax funding remains essential to the health of King County residents who need behavioral health support. This fund helps to break cycles of crisis, incarceration, hospitalization, and homelessness to ensure that more people receive the right support at the right time, promoting recovery, stability, and reduced crisis or system involvement. In 2025, MIDD-funded programs reached thousands of residents; increased access to mental health and substance use care; strengthened outreach, and crisis response; and reinforced a more coordinated continuum of care across the region.

This fund continues to be one of King County's most effective tools for improving and innovating the behavioral health system and community-based supports. Its flexibility allows the County to respond to emerging needs, invest upstream, and support services that would not otherwise exist, while working across systems and partnering with other local, state, and federal resources to deliver coordinated, effective, and community-centered care. A core strength of the fund is its ability to help break cycles of crisis, hospitalization, incarceration, and homelessness through sustained, targeted investment in the programs that make the greatest impact.

The renewal of the behavioral health sales tax in September 2025 ensures that it will remain a stable and flexible funding source for years to come. The Executive transmitted a proposed updated implementation plan to the King County Council in July 2026. The proposed plan, under Council consideration at the time of this report, introduces a streamlined framework that supports competitive procurement, alignment with emerging community needs, and ongoing assessment of program outcomes. This next phase of these investments is expected to continue to strengthen the behavioral health system by promoting innovation, improving coordination, and leveraging local resources to meet the community's evolving behavioral health needs.

Appendix A: 2025 Continuous Improvement and Data Informed Implementation Adjustments

Every year, MIDD initiatives work to make improvements to program implementation based on opportunities identified by program partners and informed by data. Examples of continuous improvement efforts undertaken by MIDD-funded programs in 2025 included:

- A chart review of patients receiving mental health care through **CD-03: Outreach and In-Reach Systems of Care** revealed that patients often receive their medical care and mental health care at separate Harborview clinics. Patient care coordinators expanded the chart review process to identify patterns of service duplication, streamline support to patients, and reduce costs to the healthcare system.

- After tracking outreach and referral trends throughout 2025, the Mobile Rapid Response Crisis Team (MRRCT), funded through **CD-06 Crisis Diversion Services**, aligned staffing and standardized workflows to improve the crisis team's responsiveness. Using revised protocols for transportation to emergency departments and improved coordination, MRRCT reduced wait times that sometimes exceeded 12 hours to a consistent average of 4 hours. As outreach and referral workflows improved, crisis bed utilization increased throughout the year.

- In response to caregiver feedback, **CD-13: Family Intervention and Restorative Services (FIRS)** revised family contact policies and procedures to improve transparency and alignment with family needs. Dialectical Behavioral Therapy groups were also implemented within the FIRS Center to enhance youth capacity for emotion regulation and distress tolerance. Additionally, the program added clinical interns to the FIRS team to expand service availability.

- **PRI-02: Juvenile Justice Assessment Team (JJAT)** monitored referral volumes, assessment timelines, and service outcomes to inform the way they triage referrals and prioritize time-sensitive cases. This monitoring helped JJAT implement necessary updates to the assessment format and procedures, improving the usefulness of reports for court decision making and treatment planning.

- In coordination with Evergreen Treatment Services (ETS), the **RR-08: Hospital Re-entry Respite Beds** program updated policies and procedures for on-site methadone dosing, prioritizing patient safety and secure medication storage. Staff note that these improvements decrease on-site drug use and overdose risk.

- **RR-12 Jail-Based SUD Treatment** implemented a new appointment reminder process that increased participation and maintained communication with the Jail Release Planning Team to coordinate discharges. The program also expanded the treatment team to include staff with lived experience.

- In response to community feedback highlighting youth suicide prevention as an urgent priority, six of the eight funded programs under **SI-02: Behavioral Health Services in Rural King County** implemented a dedicated youth suicide prevention strategy and ensured coverage across five rural areas: SE King County (e.g., Enumclaw), NE King County (e.g., Duvall/Carnation), Vashon Island, Bear Creek, and Snoqualmie Valley.

Examples of MIDD initiatives that used data to inform program implementation and process adjustments in 2025 included:

- Program staff for **CD-07: Multipronged Opioid Strategies** used overdose response data, including overdose locations, frequency, and fatality to increase Narcan distribution in neighborhoods experiencing higher rates of overdose. This data also helped the Street Medicine Team make decisions regarding where to prioritize the co-location of clinical services in their new service model.

- After assessing survey data and analyzing recidivism among program participants, **CD-17: Young Adult Crisis Stabilization** strengthened after hours and weekend support and implemented a follow-up plan for participants between two to four weeks after program exit. This enables program staff to identify individuals who were struggling to connect to long-term support and re-engage them before they return to acute crisis.

- **PRI-03: Prevention and Early Intervention Behavioral Health for Adults Over 50** used depression screening scores to better triage individuals into the program and ensure individuals with indicated levels of depressive symptoms were connected to appropriate, structured support. The program also developed new protocols for scheduling appointments with clients, sending reminders, and setting expectations with clients around attendance.

- Partners for **RR-06A: Jail Reentry System of Care** reviewed reentry data and found that when care coordinators engaged participants early and more frequently, trust, rapport, and outcomes improved. The program built new partnerships to proactively identify and engage individuals showing early signs of losing contact after enrollment.

- Jail Health Services (JHS), the provider of **RR-06B: Jail Coordinated Discharge**, analyzed retrospective data across key points in a person's jail stay to examine who was offered buprenorphine at booking, whether people of color were initiated at the same rate as white patients, whether discontinuation of medication rates during custody were comparable across groups, and whether individuals received medication at jail release at similar rates. This analysis helped JHS identify inequities in access to treatment and informed the rollout of long-acting injectable buprenorphine, the structure of patient outreach, and communication strategies for different patient groups.

- Program data revealed a pattern of early disengagement from **RR-11B: SUD Peer Support**, particularly among participants working with newer coaches. In response, the provider delivered a division-wide Motivational Interviewing (MI) training to reinforce engagement, rapport-building, and participant-centered practices across all coaching staff. They also launched a new "Coaching 101" training focused on providing newer coaches with concrete tools to sustain participant connection during the most vulnerable phase of early engagement.

Additional examples and further detail on continuous improvement activities and data informed adjustments are available online on the MIDD Dashboard.

Appendix B: Updates to Performance Measure Targets

The implementation and evaluation of MIDD funded programs require occasional modifications as new information becomes available. Performance targets regarding the number of people to be served are established during early program planning, around the time of the MIDD 2 Implementation Plan for most initiatives, preceding current system challenges. Targets are not typically adjusted from year to year to account for external system challenges but are maintained as a measure of initiative performance. However, BHRD adjusts performance targets when clear evidence shows that the original target was an over or underestimation of feasible service delivery.

In 2025, no MIDD initiatives adjusted their targets. First-time targets were established in 2025 for initiatives **CD-02A: Youth Detention Prevention Behavioral Health Engagement** and **CD-02B Family Court Services Behavioral Health Program**.

Twenty-five of the 43 MIDD initiatives with established targets for the number of people served exceeded their target numbers. Initiatives that did not meet their target number for the year cited several factors that impacted the number of people served, including changes in program referral patterns, staffing challenges, changes to program workflows, miscommunication regarding program eligibility and processes, restrictive local policies (limited jail access, municipal banishment practices such as Stay Out of Drug Areas (SODA) or Stay Out of Areas of Prostitution (SOAP), challenges navigating the emergency shelter system, and the increased potency of drugs).[22] As described in Appendix A, MIDD initiatives are revisiting program operations and processes and leveraging partnerships and external resources to address these challenges. Additional detail on program performance relative to targets and updates to performance measurement targets in 2025 are available on the MIDD Dashboard.

Appendix C: Reporting Elements Table and MIDD Online Reporting Guide

Reporting Element Language	See Section(s) of This Report	See Also MIDD Online Dashboard Tab(s)[23]
Performance measurement statistics	Report Requirements: • Subsection A: MIDD Implementation and Results in 2025, Key MIDD Outcomes, Pages 3-4.	"Measuring MIDD Performance" tab
Program utilization statistics	Report Requirements: • Subsection A: MIDD Implementation and Results in 2025, Pages 3-8. • Subsection B: MIDD Participants Pages 9-10.	• "Who MIDD serves" tab • "Where MIDD participants live" tab • "Measuring MIDD performance" tab
Request for proposal and expenditure status updates	Report Requirements: • Subsection D: 2025 Procurement Update, Pages 11-12. • Subsection E: MIDD Fiscal Information, Pages 12-13	"What MIDD invests in" tab
Progress reports on evaluation implementation	Report Requirements • Subsection C: Evaluation and Continuous Improvement, Pages 10-11.	• "Measuring MIDD performance" tab • "How MIDD is evaluated" tab
Geographic distribution of the sales tax expenditures across the county, including collection of residential ZIP code data for individuals served by the programs and strategies	Report Requirements • Subsection B: Residential Zip Codes Page 10.	• "Who MIDD Serves" tab • "Where MIDD participants live" tab
Summary of cumulative calendar year data	Report Requirements • Subsection A: MIDD Implementation and Results in 2025, Pages 3-8. • Subsection B: MIDD Participants, Pages 9-10.	"Measuring MIDD performance" tab

Reporting Element Language	See Section(s) of This Report	See Also MIDD Online Dashboard Tab(s)[23]
By late 2020, DCHS anticipates being able to make available maps and/or data summaries showing the distribution of Best Starts, MIDD, and VSHSL human services by service participant ZIP code, with high-level summaries included in the initiatives' annual reports.	Report Requirements (MIDD) • Subsection A: MIDD Implementation and Results in 2025, Pages 3-8. • Report Requirements Subsection B: Figure 2: Residential ZIP codes of People Served Through MIDD, Page 10.	"Where MIDD participants live" tab
Recommendations on either program changes or process changes, or both, to the funded programs based on the measurement and evaluation data	Report Requirements Appendix A: Continuous Improvement and Data Informed Adjustments, Pages 15-16.	"How MIDD is improving" tab
Updated performance measure targets for the following year of the mental illness and drug dependency initiatives, programs and services	Report Requirements Appendix B: Updates to Performance Measurement Targets, Page 17.	"How MIDD is improving" tab

Appendix D: MIDD Investments in 2025

Appendix D provides a table of 2025 MIDD strategies sorted by initiatives. These strategies and initiatives map to the 2016 policy goals outlined in the MIDD Service Improvement Plan.[24] Initiative names and numbering below may reflect changes from the Service Improvement Plan and Implementation Plan, with changes made when initiative names were formally updated or programs were added via budget ordinances or Advisory Committee actions.

The strategies and goal areas of an updated behavioral health sales tax is under consideration by the King County Council at the time of this report, and will replace these initiatives upon the Plan's adoption and subsequent procurements.

Prevention and Early Intervention (PRI)	
PRI initiatives help people stay healthy and keep behavioral health concerns from escalating. Programs include early assessment and brief therapies, as well as expanded access to outpatient care for those without Medicaid coverage. Programs equip clinicians, first responders, and community members with tools and resources to identify people who are at risk of behavioral health conditions and to respond in a culturally responsive way to those who need support for substance use or mental health concerns. Collectively, these programs reduce potential for harm and connect individuals with resources and services.	
Initiative Code	**MIDD Initiatives in 2025**
PRI-01: Screening, Brief Intervention and Referral to Treatment (SBIRT)	SBIRT provides people with individualized feedback about their alcohol and drug use. Alongside doctors and nurses in two local emergency departments, SBIRT clinicians enhance a person's motivation to change their alcohol and drug use while respecting their individual goals, values, and culture. Clinicians work with people to reduce harm from substance use, consider options for alcohol and drug treatment and recovery, and connect people to other needed services such as mental health treatment, vocational services, and housing.
PRI-02: Juvenile Justice Youth Behavioral Health Assessments (JJYBHA)	JJYBHA addresses the behavioral health needs of individuals who are involved with the juvenile legal system. The initiative relies on a team approach to screening, assessment, and referral with the goal of diverting youth with behavioral health needs from initial or continued legal involvement. JJYBHA teams help families connect to behavioral health and other support services, resulting in a warm hand-off between the legal and behavioral health systems.
PRI-03: Prevention and Early Intervention Behavioral Health for Adults Over 50	Prevention and Early Intervention Behavioral Health for Adults Over 50 ensures that integrated behavioral health services are available in primary care settings for older adults. The goal is to enable providers to prevent acute illnesses, high-risk behaviors and substance use, and to address mental and emotional disorders. MIDD funding is blended with funding from the Veterans, Seniors, and Human Services Levy to expand the initiative's reach in specific target populations.
PRI-04: Older Adult Crisis Intervention / Geriatric Regional	Older Adult Crisis Intervention/GRAT Team supports a home visiting team of intervention experts to provide engagement, clinical assessment, and early intervention to isolated older adults who might be at risk for a crisis. With a focus on communities of color and communities who face barriers to

Assessment Team (GRAT)	accessing publicly funded behavioral health care services, this program seeks to prevent inappropriate or avoidable institutionalization and/or harm to selves or others. MIDD funding is blended with funding from the Veterans, Seniors, and Human Services Levy.
PRI-05: School-Based Screening, Brief Intervention and Referral to Service / Treatment (School-Based SBIRT)	School-Based SBIRT provides a structured approach to promoting social and emotional health and strives to prevent substance use among middle and high school students. School staff and counselors offer screening, brief interventions, referrals, case management, and behavioral health support groups. These enhanced behavioral health prevention services reached a total of 60 middle and high schools across 13 different school districts and one private school in King County. School-Based SBIRT uses a secure and teen-friendly digital screener that is tailored to include cultural considerations and designed to provide instant, personalized feedback. The screener is translated into 21 different languages other than English. MIDD funding is blended with funding from the Best Starts for Kids Levy.
PRI-07: Mental Health First Aid (MHFA)	MHFA prepares people and communities to assist individuals experiencing mental health issues or crises and reduces the stigma associated with behavioral health issues by training community-based organizations, professionals, and the general public. MHFA addresses risk factors and warning signs for mental health and substance use issues and provides guidance on listening, offering support and identifying appropriate professional help.
PRI-08: Crisis Intervention Training (CIT)-First Responders	CIT for First Responders trains police, fire, and emergency medical services personnel and other first responders across King County to safely de-escalate difficult situations, improving responses to individuals experiencing behavioral health crises. CIT prepares first responders to intervene effectively in crisis situations and to coordinate with behavioral health providers, connecting affected individuals with the services they need.
PRI-09: Sexual Assault Behavioral Health Services	Sexual Assault Behavioral Health Services provides brief, early, evidence-based and trauma-specific interventions, and advocacy to survivors of sexual assault. By providing intensive treatment and supports, the initiative seeks to reduce the impact of trauma, assist survivors in building healthy coping skills, and decrease the need for longer-term behavioral health treatment.
PRI-10: Domestic Violence and Behavioral Health Services and System Coordination	Domestic Violence Behavioral Health Services and System Coordination supports co-location of mental health professionals within community-based domestic violence advocacy programs throughout King County. Mental health professionals provide treatment interventions and supports to assist survivors in addressing the impact of trauma and build healthy coping skills. The initiative also supports domestic violence, sexual assault, and behavioral health organizations in building and strengthening bridges between disciplines through training, relationship building, and consultation so that survivors experience more holistic and responsive services.
PRI-11 Community Based Behavioral Health Treatment	Community Behavioral Health Treatment Mental Health provides outpatient mental health and substance use treatment services for people who have low incomes but are not eligible for Medicaid. This includes immigrants and refugees, people on Medicare, and people who are pending Medicaid

	coverage, so that they can access a similar level of services available to Medicaid recipients. Additionally, this initiative supports culturally specific and responsive organizations to provide behavioral health programming with a therapeutic intent to individuals and/or communities that are not well served by the behavioral health system.

Crisis Diversion (CD)	
CD initiatives help people in crisis avoid unnecessary hospitalization or incarceration. Programs help people stabilize and get connected with community services, including expedited access to outpatient care, multidisciplinary community-based outreach teams, crisis facilities, and alternatives to incarceration.	
Strategy Code	**MIDD Initiatives in 2025**
CD-01: Law Enforcement Assisted Diversion (LEAD)	Through LEAD, law enforcement officers divert adults engaged in low-level drug involvement or sex work away from the criminal legal system and toward intensive, flexible, community-based services. A collaborative community safety effort, the program includes 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.
CD-02A: Youth Connection Services	The Youth Connection Services program is part of King County's coordinated and expanded approach to supporting young people who are experiencing behavioral health concerns and are involved with, or at risk of involvement with, the juvenile legal system. MIDD funding supports a program director, two parent partners, and two youth peers to provide short-term, community-based behavioral health support and system navigation to young people and their families.
CD-02B: Family Court Services (FCS) Behavioral Health Program	The FCS Behavioral Health program is part of King County's coordinated and expanding approach to preventing young people from becoming involved with, or becoming at risk of prolonged involvement with, the juvenile legal system as result of a BECCA petition filing. FCS partners with the Institute for Family Development (IFD) to provide short-term, community-based behavioral health supports and system navigation to young people and their families.
CD-03: Outreach & In-Reach System of Care	Outreach and In-Reach System of Care delivers community-based outreach and engagement services to individuals experiencing homelessness with behavioral health conditions in downtown Seattle and south and east King County. The initiative works with contracted agencies to remove barriers to care and provide integrated physical and behavioral health care to reduce participants' reliance on crisis services, emergency departments, crisis facilities, and psychiatric hospitals, as well as their engagement with the criminal legal system.
CD-05: High Utilizer Care Teams	High Utilizer Care Teams offer flexible and individualized services in emergency departments to individuals who have complex needs, including those who have physical disabilities, mental health conditions, and/or are experiencing homelessness. Teams provide intensive support in times of crisis and follow up to connect individuals to appropriate and supportive

	community resources. The program prioritizes people who have frequent emergency department or psychiatric emergency visits.
CD-06: Crisis Diversion Services	Crisis Diversion Services provide voluntary community-based interventions to adults who are experiencing an emotional or behavioral health crisis. This initiative includes three program components: the Crisis Diversion Facility, Crisis Diversion Interim Services (collectively called Crisis Diversion Beds), and the Mobile Rapid Response Crisis Teams (MRRCTs). The goal of MRRCTs is to reduce dependency on and involvement of emergency responders and to decrease the likelihood of involuntary processes, including detaining individuals under the Washington State Involuntary Treatment Act (ITA).
CD-07: Multipronged Opioid Strategies	Multipronged Opioid Strategies implements recommendations made by a regional task force on opioid use disorder, with a focus on user health. Services include primary prevention, treatment service expansion, outreach to unhoused individuals in shelters and encampments, and overdose prevention. This collaboration between King County, advocates, and community providers leverages MIDD funds to support treatment programs that provide low-barrier buprenorphine and MOUD.
CD-08: Children's Domestic Violence Response Team (CDVR)	CDVRT provides behavioral health treatment, linkage to resources, and advocacy for children, families, and caregivers who have experienced domestic violence. Through intensive cross-system collaboration and supports, the program helps children and families navigate multiple complex systems, including the legal, housing, and school system.
CD-10: Next Day Crisis Appointments (NDAs)	NDAs divert people experiencing behavioral health crises from psychiatric hospitalization or jail by providing crisis response within 24 hours. Services include crisis intervention and stabilization, psychiatric evaluation and medication management, benefits counseling and enrollment, and linkages for ongoing behavioral health care.
CD-11: Children's Crisis Outreach and Response System (CCORS)	CCORS provides countywide crisis response to children, youth, and their families who are affected by interpersonal conflict or severe emotional or behavioral concerns, and whose living situations may be at imminent risk of disruption. CCORS teams respond in a time sensitive manner to homes, schools, and community settings, and can provide short-term intensive interventions to stabilize crises and coordinate services across systems.
CD-12: Parent Partners Family Assistance	Parent Partners Family Assistance helps youth – and their caregivers – who are experiencing behavioral health challenges obtain services, navigate complex health and service systems, and meet basic needs required to maintain well-being and resilience. This initiative also supports social events, advocacy opportunities, skill building, and individualized support to youth and caregivers.
CD-13: Family Intervention Restorative Services (FIRS)	FIRS offers a community-based, non-secure alternative to court involvement and secure detention for youth who have been violent toward a family member. Specialized juvenile probation counselors and social workers guide youth through a risk and needs assessment and help them develop a family safety plan. FIRS staff offer de-escalation counseling to safely reunite youth with their families. Families are offered in-home family counseling, mental

	health services, drug and alcohol services, and the Step-Up Program, which specifically addresses adolescent family violence.
CD-14: Involuntary Treatment Triage	Involuntary Treatment Triage provides initial assessments for individuals with severe and persistent mental health conditions who have been incarcerated for serious misdemeanor offenses, who have been found not competent to assist in their own defense, and who cannot be restored to competency to stand trial. Behavioral health professionals evaluate participants to determine whether they meet the criteria for involuntary civil commitment and refer them to services to address their behavioral health needs. This approach decreases the need for emergency departments and crisis responders to carry out assessments and significantly expedite evaluations.
CD-15: Wraparound Services for Youth	Wraparound Services for Youth engages children, youth, and their families in a team process that builds on family, community strengths, and cultures to support youth to succeed in their homes, schools, and communities. MIDD funding provides wraparound services to children and families who are not eligible for Medicaid.
CD-17: Young Adult Crisis Facility (CORS-YA)	Young Adult Crisis Stabilization provides community-based behavioral health supports to housing providers for young adults (ages 18 to 24 years), including those experiencing their first psychotic break. Mobile response teams serve young adults in transitional housing, rapid rehousing, permanent housing, and shelters, working to meet the unique needs of young adults and supporting shelter staff in responding to crisis events.
CD-18A: Regional Crisis Response System (RCR)	RCR is a behavioral health first response model in which crisis responders, who are mental health professionals, deploy through the 911/public safety system to provide de-escalation and connect individuals experiencing behavioral health crises to appropriate services. RCR seeks to decrease police response to people in behavioral health crisis, reduce inappropriate use of emergency services, and improve outcomes for people in crisis.
CD-18B: Therapeutic Response Unit (TRU)	TRU, operated by the King County Sheriff's Office, partners sheriff deputies with mental health professionals (MHPs) to co-respond to calls for service involving mental health, substance use, social service deficits, behavioral health triage, de-escalation, and service referrals that intersect with public safety.

Recovery and Reentry (RR)	
RR initiatives help people become healthy and reintegrate into the community safely after a crisis. Services focus on the needs of the whole person to support recovery and sustain positive change. Programming includes providing stable housing, services for people experiencing homelessness, employment support services, peer-based recovery supports, and community reentry services after incarceration.	
Strategy Code	**MIDD Initiatives in 2025**
RR-01: Housing Supportive Services	Housing Supportive Services braids MIDD resources with other King County investments and funding from federal, state, and local sources, including housing authorities, to serve adults who are experiencing chronic homelessness and who have been unsuccessful in maintaining housing due to ongoing behavioral health challenges.

RR-02: Behavioral Health Services at Community Center for Alternative Programs	Community Center for Alternative Programs provides mental health services for non-Medicaid-enrolled participants with co-occurring mental health and substance use disorders and criminal legal system involvement.
RR-03: Housing Capital and Rental	Housing Capital and Rental invests in the construction and preservation of housing units for individuals with behavioral health conditions and very low incomes (at or below 30 percent of area median income). This initiative also invests in the improvement, repair, renovation, and expansion of behavioral health facilities.
RR-04: Rapid Rehousing-Oxford House Model	The Rapid Rehousing Oxford House Model voucher program offers affordable clean-and-sober housing for people in early recovery who are either experiencing homelessness or at risk of becoming homeless. By pairing a proven housing program with rapid access to housing, this initiative aims to prevent and decrease homelessness through improved self-reliance.
RR-05: Housing Vouchers for Adult Drug Court (ADC)	Housing Vouchers for ADC seeks to disrupt the cycle of homelessness and substance use by supporting recovery-oriented transitional housing units and case management services. On-site case management focuses on long-term stability and helps participants establish a positive rental history, engage in treatment, and obtain employment and next-step housing when they complete ADC.
RR-06A: Jail Reentry System of Care	Jail Reentry System of Care funds reentry case management services providing linkages to behavioral health treatment, public benefits, and access to basic needs for unstably housed adults not enrolled in other services. It provides these services to those who are transitioning out of municipal jails in south and east King County, the Maleng Regional Justice Center and other partner programs, and are reentering back into the community.
RR-06B: Jail Coordinated Discharge	Jail Coordinated Discharge provides timely, complex release planning and coordination of community services for people with moderate to high needs to ensure lifesaving continuity of care at release. The program serves those with any behavioral health condition, young adults (18-24), and people experiencing homelessness. Upon release, individuals receive a supply of medications, culturally appropriate linkages to care, next day appointments for substance use disorder (SUD) treatment, and re-entry items (identification, phone, clothing, hygiene kits, transportation, Medicaid enrollment, etc.). Participant follow-up, transportation, and incentives are provided for attending up to five SUD treatment visits post-release.
RR-07: Behavioral Health Risk Assessment Tool for Adult Detention	Behavioral Health Risk Assessment Tool for Adult Detention addresses the behavioral health needs of incarcerated individuals. Individuals help create a personalized treatment plan based on a comprehensive assessment of risks and needs. The tool is intended to decrease their likelihood of further criminal legal system involvement through an evidence-based approach to reentry.
RR-08: Hospital Re-entry Respite Beds	Hospital Re-entry Respite Beds, part of a hospital-based medical respite program, offers recuperative physical and behavioral healthcare to individuals

	currently experiencing homelessness who need additional healthcare services to support their stability when they are discharged from the hospital.
RR-09: Recovery Café	Recovery Café is a community space where people can access support, resources, and a community of care to help stabilize their physical and behavioral health; receive assistance with housing, relationship, and employment support; and participate in opportunities for volunteer service.
RR-10: Behavioral Health Employment Services and Supported Employment	Behavioral Health Employment Services and Supported Employment provides evidence-based and intensive supported employment services for people living with mental health conditions and those living with both mental health and substance use conditions. The program helps people find, obtain, and maintain competitive, integrated employment throughout King County.
RR-11A: Peer Bridger Programs	Peer Bridger Programs offer transition assistance to adults being discharged from King County psychiatric hospitals. Peer Bridgers use their lived experience and skills to collaborate with inpatient treatment teams, assist in discharge planning and transition, and partner with program participants post-discharge to ensure connections are made to outpatient behavioral health care, primary care, and other natural supports.
RR-11B: Substance Use Disorder (SUD) Peer Support	SUD Peer Support connects people with substance use disorders to peer specialists whose lived experiences and skills support participants' ability to maintain recovery. Peers are deployed to recovery organizations to help participants engage with ongoing treatment services and other supports, strengthening efforts to divert them from criminal legal entanglement and emergency medical settings.
RR-12: Jail-based Substance Use Disorder Treatment	Jail-Based Substance Use Disorder Treatment provides substance use disorder treatment services to adult men at the Maleng Regional Justice Center. The initiative also provides comprehensive release planning and connections to appropriate community-based services for participants re-entering the community.
RR-13: Deputy Prosecuting Attorney for Familiar Faces	Deputy Prosecuting Attorney for Familiar Faces funds prosecutorial resources to help track and, when possible, resolve outstanding warrants and criminal cases for individuals who have high utilization of the King County Correctional Facility. With this support, participants can remain in the community and connect with therapeutic interventions and other resources, such as permanent supportive housing. This integrated, community-based approach to serving people at the intersection of behavioral health and the criminal legal system promotes recovery, public safety, and reduces harm.
RR-15: Pretrial Assessment and Linkage Services (PALS)	The PALS program provides substance use disorder assessments and outpatient behavioral health services to non-Medicaid-enrolled pretrial individuals whose criminal cases are assigned to the Maleng Regional Justice Center and the Federal Way Municipal Court. Individualized, culturally responsive, trauma-informed services include substance use disorder assessments, outpatient treatment, and linkages to other community-based services.

System Improvements (SI)	
SI initiatives strengthen access to the behavioral health system and equip providers to be more effective. Programs build the behavioral health workforce, improve the quality and availability of core services, and support community-initiated behavioral health projects. SI initiatives strengthen King County's behavioral health system through several channels: community-designed, culturally and linguistically appropriate services; greater reach into rural unincorporated communities; implementation of quality improvement programming; and workforce development to support behavioral health countywide. Together, these initiatives improve the quality and availability of behavioral health services for all King County residents.	
Strategy Code	**MIDD Initiatives in 2025**
SI-01: Community-Driven Behavioral Health Grants	Community Driven Behavioral Health Grants increase access to culturally and linguistically appropriate behavioral health services. By directly funding community-based organizations to design and implement service approaches that meet their needs, this initiative seeks to overcome barriers to behavioral health service participation and recovery programming experienced by Black, Indigenous, and People of Color (BIPOC) in King County and other marginalized communities.
SI-02: Behavioral Health Services in Rural King County	Behavioral Health Services in Rural King County funds programming that improves the health and wellness of residents by promoting access to services and community self-determination in rural areas of King County that face barriers to accessing behavioral health care.
SI-03: Quality Coordinated Outpatient Care	Quality Coordinated Outpatient Care promotes integration of behavioral and physical health services across King County, with the goal of improving access to treatment and recovery support. This initiative funds strategic investments in King County's outpatient community behavioral health continuum to provide broader access to treatment, better treatment services, and recovery support services.
SI-04: Workforce Development	Workforce Development supports providers to receive specialized training in clinical skills, such as Dialectical Behavior Therapy. This initiative also funds the annual umbrella license for SUD youth treatment providers to implement the evidence-based program, Seven Challenges. It also supports Seven Challenges national trainers to work with the agencies by facilitating quarterly meetings and an annual fidelity meeting.

Therapeutic Courts (TX)	
TX initiatives serve people with behavioral health conditions involved with the legal system. Programs offer an alternative to traditional proceedings and support participants to achieve stability and avoid further legal system involvement.	
Strategy Code	**MIDD Initiatives in 2025**
TX-ADC: Adult Drug Court	ADC offers structured court supervision and access to services for eligible individuals charged with felony drug and property crimes. Services offered include comprehensive behavioral health treatment and housing services, employment and education support, and peer services. The program is designed to foster a stronger connection between drug court participants and the community, and to support participants' increased ownership of their recovery.

TX-CC: Community Court	Community Court offers an alternative approach for individuals who come into the criminal legal system with significant needs but are at low risk for violent offense. Community Resource Centers, a component of the program and open to the community at large, provide information and navigation assistance for housing, financial, education, employment, and behavioral health services.
TX-FTC: Family Treatment Court (FTC)	FTC is a recovery-based child welfare court intervention. FTC focuses on children's welfare and families' recovery from substance use through evidence-based practices to improve child well-being, family functioning, and parenting skills. Strong agency partnerships enable FTC to maintain maximum capacity to serve children in north and south King County.
TX-JTRAC-BHR: Juvenile Therapeutic Response and Accountability Court-Behavioral Health Response	Juvenile Therapeutic Response and Accountability Court-Behavioral Health Response provides an incentive-driven program to help youth involved in the criminal legal system who are struggling with substance use, and who have criminal offenses, reduce the likelihood of continued legal system involvement. The initiative's holistic continuum of care model takes a culturally responsive approach and supports completion.
TX-RMHC: Regional Mental Health and Veterans Court	The Regional Mental Health and Veterans Court serves people with behavioral health conditions during their involvement with the criminal legal system. This initiative provides a therapeutic response that helps defendants recover, while addressing the underlying issues that can contribute to criminal legal issues. The programs are based on a collaborative, team-based approach, supplemented by judicial monitoring.
TX-SMC: Seattle Municipal Mental Health Court	Seattle Municipal Mental Health Court provides referrals to services for individuals who are booked into jail on misdemeanor charges and at risk of, or have a history of, having their competency to stand trial questioned. By integrating court-based staff into a community-based diversion program, the initiative enables close coordination between behavioral health, housing, and other social services, increasing the number of people with behavioral health conditions who are routed to treatment and out of criminal legal entanglements.

Appendix E: MIDD Partners in 2025

In 2025, MIDD services were carried out in collaboration with 166 partners, represented below:

Affect Therapeutics, Inc.	Evergreen Treatment Services
Alimentando al Pueblo	Filipino Community of Seattle
Aristo Behavioral Health	Friends of Youth
Asian Counseling and Referral Service	Guided Pathways
Association of Zambians Seattle	Harborview
Atlantic Street Center	Harborview Abuse and Trauma Center (HATC)
Auburn School District	Harborview Allied and Ambulatory Services
Ayan Maternity Health Care Services	Harborview Behavioral Health Services
Black Star Line (PH/BSK)	Harborview Housing First
Catholic Community Services of Western WA	Harborview Medical Center
Center for Human Services	Harborview Outpatient MH and Addiction Services
Charmd Behavioral Health	HealthPoint
Children's Home Society of WA (SYP)	Hearing, Speech & Deafness Center (KCICN TA)
CHOOSE 180	Hepatitis Education Project
City of Bellevue	HERO House NW
City of Bothell	Highline School District
City of Kenmore	Holman Recovery Center
City of Kent	IKRON
City of Kirkland	IACS (Indian American Community Services)
City of Lake Forest Park	Institute for Family Development
City of Seattle	Integrative Counseling Services
City of Shoreline	Intercept Associates
Coalition Ending Gender Based Violence	International Community Health Services
Communities of Rooted Brilliance	King County Sexual Assault Resource Center
Community House MH Agency	Kennedy Catholic High School
Congolese Integrated Network	Kent School District
Consejo Counseling and Referral Service	Kent Youth and Family Services
Crisis Connections	Khmer Community of Seattle King County
DAWN - Domestic Abuse Women's Network	King County Council
Diaspora Family Healing Network (Sustainable Seatle)	King County DCHS Housing & Community Development
Downtown Emergency Service Center	King County Department of Adult & Juvenile Detention
Empower Youth Network	King County Department of Judicial Administration
Encompass NW	King County Department of Public Defense
Enumclaw School District	King County District Court
Eritrean Association in Greater Seattle	King County Executive Office
Ethiopian Community in Seattle	King County Family Treatment Court

King County Family Treatment Court	RISE (Resilient In Sustaining Empowerment)
King County Judicial Admin Drug Court	RI International (Outpatient)
King County Prosecuting Attorney's Office	Ryther
King County Public Hospital District	Sea Mar Community Health Centers
King County Sexual Assault Resource Center	Seattle Children's Hospital
King County Sheriff's Office	Seattle Drug & Narcotic Center Inc
King County Superior Court	Seattle Public Schools
Korean Community Service Center	Second Chance Outreach
Lake Washington School District	Seneca Family Of Agencies
LIHI (Low Income Housing Institute	Seven Challenges
LingualLinx Language Solutions (KCICN TA)	Skykomish School District
Lutheran Community Services Northwest	Snoqualmie Valley School District
Lyssn (KCICN Training Academy)	Sobering Center
Mercer Island School District	Somali Health Board
Multicare Health System	Sound
Nami Eastside	Sound Generations
National Council for Behavioral Health	Southwest Youth and Family Services
Navos	St Anne Hospital
Neighborcare Health	St. Francis Community Hospital
Neighborhood House	Sustainable Seattle
New Americans Alliance for Policy & Research	Tacoma Pierce County Health Department
New Beginnings	Tahoma School District
New Traditions	The DOVE Project
New Way Treatment	The Garage, A Teen Café
Northshore School District	The Goodfoot Arts Collective
Oxford House	The Trail Youth
Path with Art	Therapeutic Health Services
PDA (Purpose Dignity Action)	Ticket Health
Peer Bridger Program	Transitional Resources
Peer Washington	Tukwila School District
Pioneer Human Services	Ukrainian Community Center of Washington
Public Health - Seattle & King County	Unified Outreach
Puget Sound Educational Service District - 121	University of Washington Medical Center
REST (Real Escape from the Sex Trade)	University of Washington School of Social Work
Recovery Beyond	University of Washington Training Academy
Recovery Café	Unkitawa
Refugee Women's Alliance	UTOPIA
Regional Crisis Response Agency	Valley Cities Counseling and Consultation
Renton School District	Vashon Island School District
Rescue Agency Public Benefit	Vashon Youth & Family Services

Vietnamese Health Board	Washington State University
WA Alliance for Better Schools	WCHS Inc
WA Criminal Justice Training Commission	We Are Comunidad
WA Therapy Fund Foundation	Weld Seattle
Wakulima USA	YMCA of Greater Seattle
WAPI	Yoga Behind Bars
Washington Recovery Alliance	Youth Eastside Services
Washington State Hospital Association	

End Notes

[1] RCW 82.14.460, 2005. [LINK https://app.leg.wa.gov/rcw/default.aspx?cite=82.14.460]

[2] King County Ordinance 18407, November 2016. [LINK https://aqua.kingcounty.gov/council/clerk/OldOrdsMotions/Ordinance%2018407.pdf]

[3] King County Ordinance 19976, September 2025. [LINK https://kingcounty.legistar.com/View.ashx?M=F&ID=14848457&GUID=54F7EDF4-4858-4ECE-A2B0-EFFE42FFBCBE]

[4] King County Ordinance 20023, September 2025. [LINK https://mkcclegisearch.kingcounty.gov/View.ashx?M=F&ID=14986044&GUID=63D9EB5A-A59A-4DCD-80E8-A23B2FDB6F27]

[5] King County Ordinance 20023, September 2025. [LINK https://mkcclegisearch.kingcounty.gov/View.ashx?M=F&ID=14986044&GUID=63D9EB5A-A59A-4DCD-80E8-A23B2FDB6F27]

[6] MIDD Dashboard. [LINK https://kingcounty.gov/MIDDdashboard]

[7] Between 2022-2024. short-term outcomes are measured one year following MIDD program enrollment whereas long-term outcomes are measured at one, two, and three years following MIDD program enrollment. The results displayed below represent the third-year outcomes for the most recent cohort for which these measures are available: the 2022 MIDD cohort. Participant outcome measures summarized in this report apply to MIDD initiatives that identify the measure as an intended outcome. Here, and throughout this report, "long-term" changes refer to the third year following baseline measurement.

[8] MIDD 2 Implementation Plan, June 2017. [LINK 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]

[9] PRI-05: School-Based Screening, Brief Intervention, and Referral to treatment/services (School-Based SBIRT holds agreements with school districts in King County for the 2025 Contract Year: Auburn School District, Enumclaw School District, Highline School District, Kennedy Catholic High School, Kent School District, Mercer Island School District, Northshore School District, Renton School District, Seattle School District, Skykomish School District, Snoqualmie Valley School District, Tahoma School District #409, Tukwila School District, and Vashon Island School District.

[10] The Impact of Prosecutorial Diversion Programs on Behavioral Health Service Use and Criminal Justice System Involvement: An Evaluation of DSHS-Contracted Diversion Programs, March 2022. [LINK https://www.dshs.wa.gov/sites/default/files/rda/reports/research-11-260.pdf]

[11] Be Heard Community Voices About Mental Health and Wellness, January 2025. [LINK https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/MIDD/Be-Heard-Community-Listening-Report]

[12] MIDD 2 Implementation Plan, June 2017. [LINK

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]

[13] MIDD 2 Implementation Plan, June 2017. [LINK 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]

[14] Washington State Engrossed Substitute Senate Bill ESSB 5814, [LINK https://lawfilesext.leg.wa.gov/biennium/2025-26/Pdf/Bills/Senate%20Passed%20Legislature/5814-S.PL.pdf?q=20260521095641

[15] Washington State Engrossed Substitute Senate Bill ESSB 6346, [LINK https://lawfilesext.leg.wa.gov/biennium/2025-26/Pdf/Bills/Senate%20Passed%20Legislature/6346-S.PL.pdf?q=20260521100215

[16] These MIDD Strategies contain initiatives that combine MIDD revenue with other local, state, or federal funding. For these strategies, charges to MIDD may be deferred in favor of other term limited funds. This can mean that MIDD funding that remains committed to particular initiatives may be expended later than initially planned or budgeted.

[17] MIDD leadership briefed the MIDD Advisory Committee at its December 2025 meeting on a plan to direct $1.5 million in underspend toward PRI-11: Community Behavioral Health Treatment. The addition of $1.5 million remained within appropriated amounts for the MIDD fund, and allowed DCHS to provide continued access to treatment for individuals who were losing access to Medicaid coverage they had during the COVID-19 pandemic.

[18] This MIDD Strategy had lower actual expenditures than originally budgeted, due to timing of startup, staffing challenges, rollout of programming components, and/or procurement of services.

[19] The Special Projects Strategy contains initiatives committing funds to long-term capital projects. While MIDD appropriation authority is limited to the current year, DCHS expects and plans for the appropriation of these funds to follow these capital projects until completion.

[20] King County Office of Economic Forecast and Analysis reported final revenue collections for 2025 of $94,375,903. In 2025, all new 2025 MIDD revenue was expended, plus $21,450,267 carried forward from previous years, for total expenditures in 2025 of $115,826,170.

[21] MIDD Webpage, MIDD Advisory Committee Membership Roster. [LINK https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/midd-behavioral-health-tax/midd-committee]

[22] City of Seattle, Ordinance 127085, September 2024. [LINK https://seattle.legistar.com/LegislationDetail.aspx?ID=6818970&GUID=4293EDC6-B550-494D-A215-9026FFD7CB42&Options=ID|Text|&Search=120835]

[23] MIDD Dashboard. [LINK https://kingcounty.gov/en/legacy/depts/community-human-services/mental-health-substance-abuse/midd/reports]

[24] MIDD Service Improvement Plan, November 2016. [LINK https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd/documents/161221_approved-midd_2-sip.pdf?la=en&rev=1f3adfcf23184a49b3f4cbc5a7009111&hash=3F0198C878A04D8FC57DDC775BBB5DB3]

King County | Office of the Executive

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

July 31, 2026

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

Dear Councilmember Perry:

This letter transmits the 2025 MIDD Behavioral Health Sales Tax Fund Annual Summary Report, and a proposed Motion that would, if enacted, approve the report. This report describes evaluation results for the programs and services supported by King County's dedicated 0.1 percent behavioral health sales tax that has been known as MIDD. In addition, the report provides information about implementation of the programs and services supported by MIDD during 2025.

In response to community and provider feedback, in the proposed implementation plan for 2028-2034 and associated legislation that were before Council at the time of this report, I have proposed to rename MIDD as the King County Behavioral Health Bridge, or "the Bridge." Despite the proposed name change, this report still primarily uses the name "MIDD" because it reports retrospectively on activities and outcomes from 2025.

MIDD investments across a wide array of initiatives in 2025 contributed to ensuring effective, equitable, and accessible behavioral health care, and helped to break the cycle of repeated crisis, incarceration, hospitalization, and homelessness by connecting residents to timely, community-based support. MIDD supports equitable opportunities for health, wellness, connection to community, and recovery for King County residents living with or at risk of behavioral health conditions. Its programs are designed to improve access to behavioral health treatment and therapeutic court services through a continuum of care that includes prevention, early intervention, crisis diversion, recovery and reentry, and system improvement.

The 2025 report showcases key outcomes and themes in MIDD's implementation in 2025, including but not limited to data showing that participants in MIDD programs experienced

increased access to care for mental health and substance use conditions, fewer trips to jails and hospitals, and more connections to treatment and services in their communities. The report also links to the online MIDD Data Dashboard, an interactive tool that allows users to explore MIDD data and outcomes. The dashboard provides fiscal information on MIDD investments, plus demographic and outcomes data for the fund overall and by initiative.

The 2025 report illustrates the behavioral health sales tax fund's critical role in reinforcing King County's behavioral health system and highlights MIDD's effectiveness amid ongoing challenges. Key areas of focus featured in this report include MIDD-funded work to:

- Respond to emerging behavioral health needs;
- Work across systems to deliver coordinated, effective care; and
- Leverage local funding to improve and innovate services in the behavioral health system.

The MIDD Advisory Committee reviewed and supported the enclosed report at its June 4, 2026 meeting. A draft copy of the report was distributed to committee members in advance and comments from members were incorporated into the final report.

Thank you for your consideration of this report and for King County Council's continued partnership in strengthening the behavioral health system by promoting innovation, improving coordination, and leveraging local resources to meet the community's evolving behavioral health needs.

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

Sincerely,



for

Girmay Zahilay
King County Executive

Enclosure

cc: King County Councilmembers
ATTN: Stephanie Cirkovich, Chief of Staff
Melani Hay, Clerk of the Council
Karan Gill, Deputy Executive, Office of the Executive
Jasmin Weaver, Chief of Staff, Office of the Executive
Hyeok Kim, Chief Operating Officer, Office of the Executive
Sierra Howlett Browne, Director of Government Relations, Office of the Executive
Garrett Holbrook, Council Relations Manager, Office of the Executive
Dr. Susan McLaughlin, Director, Department of Community and Human Services

MIDD 2025 Summary Report

Isabel Jones, Acting Director, Behavioral Health and Recovery Division, DCHS
Robin Pfohman, Special Projects Manager, Behavioral Health and Recovery Division, DCHS

Regional Policy Committee

August 26, 2026

King County
MIDD Supporting behavioral health and recovery

2025 Report as Context for Renewal

2008 - MIDD sales tax launched to counter chronic state and federal underinvestment in behavioral health programming, providing a stable local funding stream that strengthens provider capacity and system coordination.

MIDD 1 & 2 Implementation Plans - Investments historically focused on prevention and early intervention, crisis diversion, recovery and reentry, system improvement, and therapeutic courts.

September 2025 - The King County Council voted to extend MIDD for an additional nine years through 2034.

July 2026 - The Executive transmitted a new Implementation Plan that reflects extensive community engagement and proposes a new name: the King County Behavioral Health Bridge.

The Bridge Implementation Plan introduces a streamlined framework that supports competitive procurement, alignment with emerging community needs, and ongoing assessment of program outcomes. If approved by the King County Council this fall, the plan would guide investments from 2028 through 2034.

2025 Key MIDD Accomplishments

63% Long-term decrease in crisis service episodes among adults

29% Long-term decrease in emergency department admissions

33% Long-term decrease in jail bookings among adults

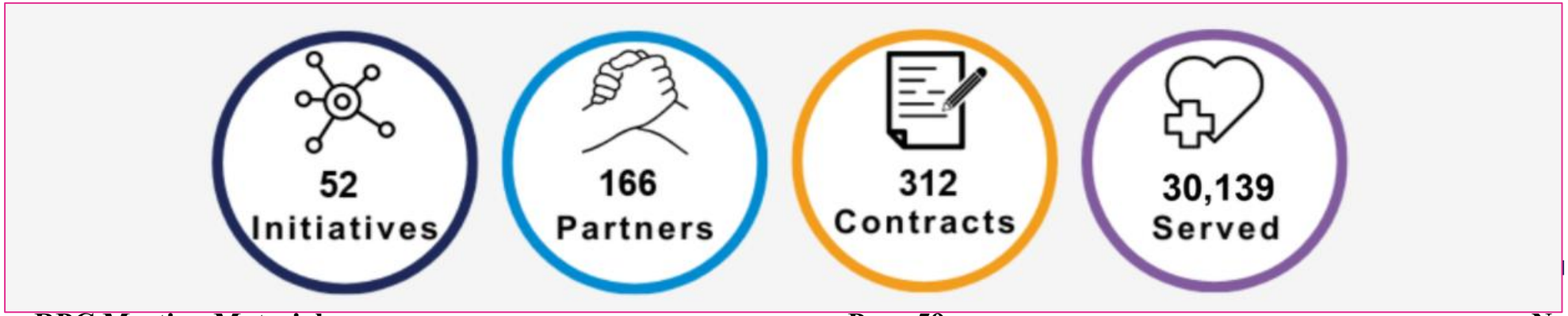
41% Long-term decrease in psychiatric inpatient admissions

50% Participants linked to publicly funded behavioral health treatment

67% Participants with no substance use after enrollment

89% Youth with no additional crisis service episodes

80% Participants with reduced substance use after enrollment

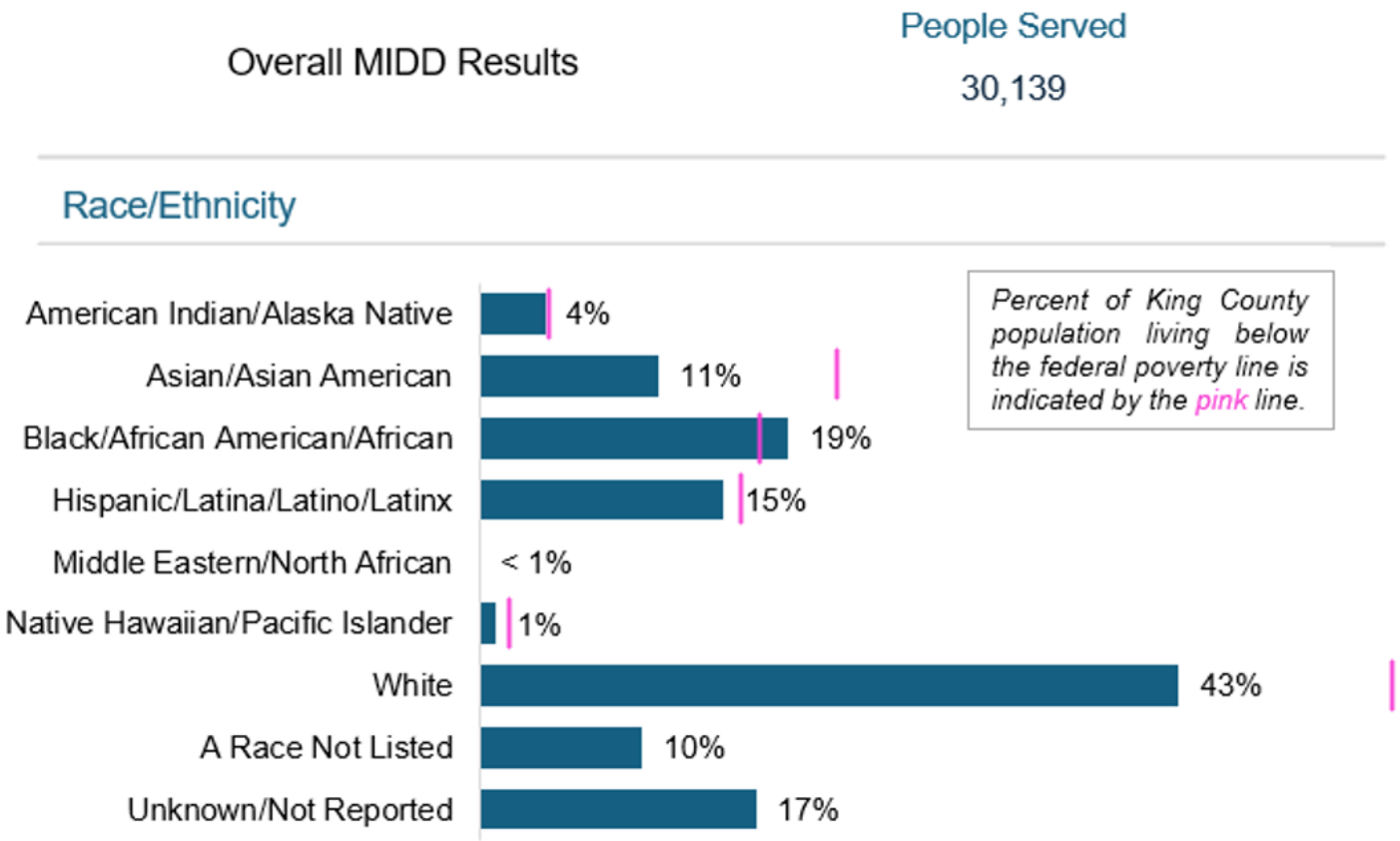


King County MIDD Supporting behavioral health and recovery

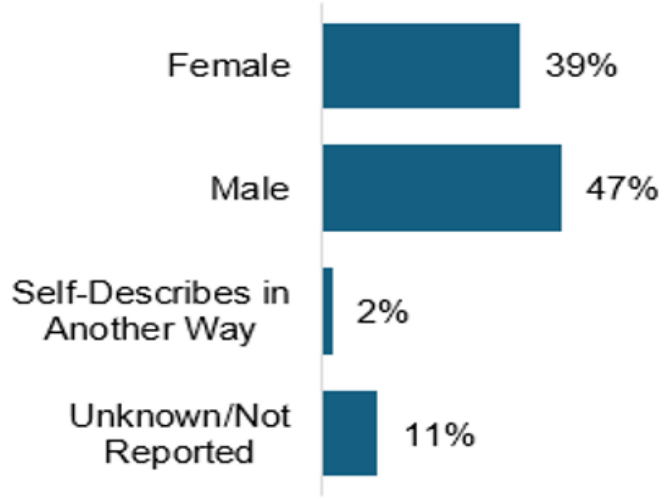
Who MIDD Served in 2025

TOTAL SERVED: 30,139

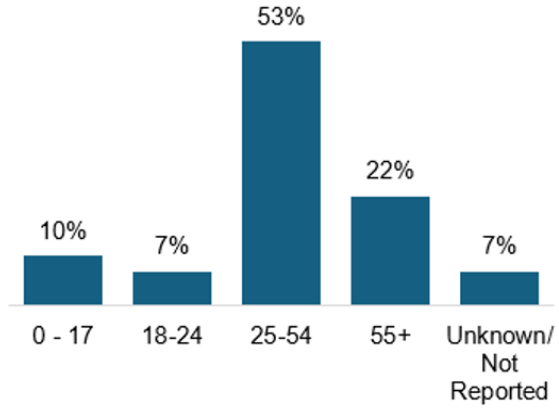
Race/Ethnicity



Gender Identity



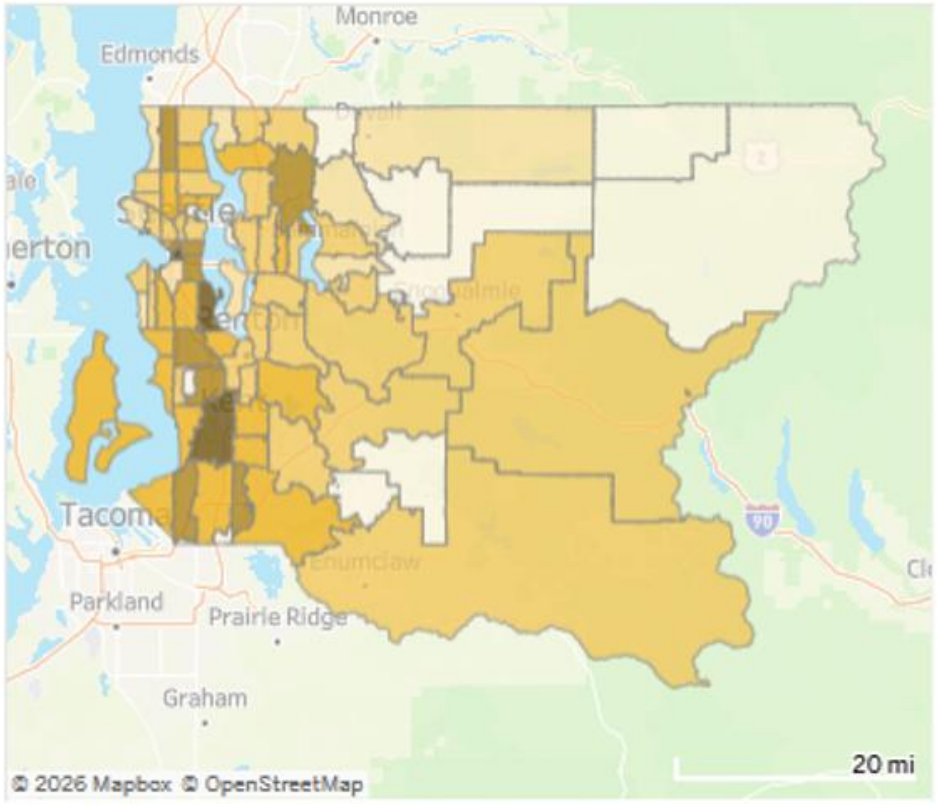
Age Group (Years)



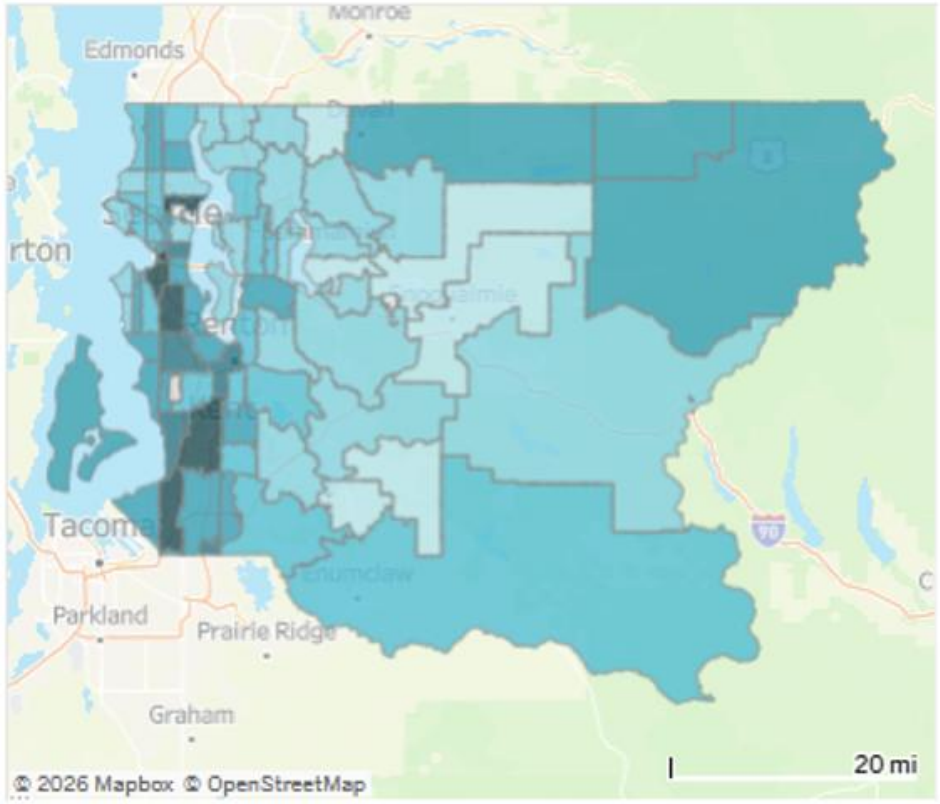
King County
MIDD Supporting behavioral health and recovery

Where MIDD Participants Live

Overall MIDD Results



King County Individuals in Poverty



King County MIDD Supporting behavioral health and recovery

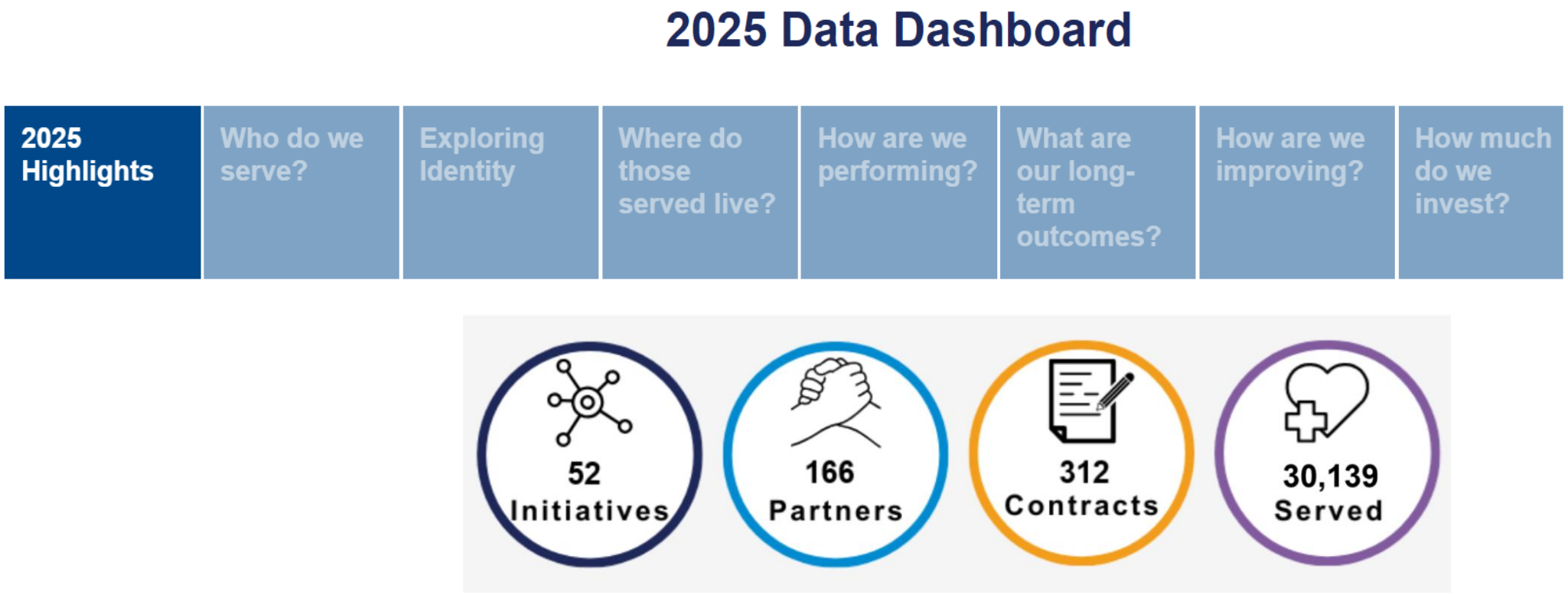
2025 Financial Report

STRATEGY AREA	2025 Budget	2025 Actuals	Percent Spent
Prevention & Early Intervention	$ 25,081,572	$ 25,887,580	103%
Crisis Diversion	$ 31,818,512	$ 28,105,437	88%
Recovery & Reentry	$ 28,949,015	$ 26,634,407	92%
System Improvement	$ 9,161,476	$ 7,545,969	82%
Therapeutic Courts	$ 15,123,302	$ 13,943,763	92%
Special Projects	$ 12,171,300	$ 8,708,390	72%
Administration & Evaluation	$ 5,942,077	$ 5,000,624	84%
Total	**$ 128,247,254**	**$ 115,826,170**	**90%**

King County MIDD Supporting behavioral health and recovery

2025 Data Dashboard

To fully explore MIDD's overall results, visit: **https://kingcounty.gov/MIDDdashboard**



How the Behavioral Health Bridge builds on MIDD 2 learnings

- **Strengthens data, reporting, and accountability** by aligning performance expectations within each of the 5 new strategy areas.
- **Emphasizes alignment and integration across service areas,** increasing coordination and cross-system connectivity.
- **Continues to invest where needs are greatest** according to data, community engagement, and subject matter input.

King County

DCHS

Department of Community and Human Services

Instagram

Blog

YouTube

Website

Data Dashboard

King County

Metropolitan King County Council
Staff Report

Committee:	Regional Policy Committee		
Agenda Item:	5	**Analyst(s):**	Sam Porter Jenny Ngo
Proposed No.:	2026-0174.2	**Meeting Date:**	November 5, 2026

OVERVIEW

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

LEGISLATION SUMMARY

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

It is important to note that transmitted in tandem with this item is Proposed Ordinance 2026-0177, which would adopt the Behavioral Health Bridge Implementation Plan. Proposed Ordinance 2026-0177 is a mandatory dual referral to the Regional Policy Committee. These ordinances are anticipated to be taken up on the same schedule (refer to Table 12 of the staff report for Proposed Ordinance 2026-0177 for schedule information).

KEY ISSUES FROM THE ANALYSIS

A. Duty Changes. Proposed Ordinance 2026-0174 would change the duties of the Advisory Committee from "review and report to the Executive and Council" to "review and provide guidance on Behavioral Health Bridge annual reports."

B. Membership Changes. Proposed Ordinance 2026-0174 would change two representatives of behavioral health consumer interests and community interests to two positions representing behavioral health consumer interests who have lived experience with behavioral health conditions.

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

Action in the Health, Housing, and Human Services Committee, October 6, 2026

- **Striking Amendment S1 was adopted by the HHHS Committee on October 6, 2026 to:**
  - Add a position on the Behavioral Health Bridge Advisory Committee for a youth representative with lived experience of behavioral health conditions.
  - Establish compensation for Bridge Advisory Committee members who are serving in positions representing lived experience and provide recruitment assistance for prospective applicants.
  - Remove "annual" in reference to reports that would receive Bridge AC review and guidance.
  - Make technical edits to correct drafting.

BACKGROUND & TIMING CONSIDERATIONS

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

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

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

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

[1] Ordinance 18406
[2] Motion 15093
[3] Motion 15058

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

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

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

ANALYSIS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Council's legal counsel has reviewed the proposed ordinance.

Action at the Health, Housing, and Human Services Committee on October 6, 2026. The HHHS Committee adopted Striking Amendment S1 on October 6, 2026 to:

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

INVITED

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

ATTACHMENTS

1. Proposed Ordinance 2026-0174 .2
2. Transmittal Letter
3. Fiscal Note

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

Ordinance

Proposed No. 2026-0174.2 **Sponsors** Mosqueda

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

STATEMENT OF FACTS:

1. The one-tenth of one percent sales and use tax supporting behavioral health programs and services and therapeutic court programs and services authorized by RCW 82.14.460 and K.C.C. 4A.500.315, which has been known in King County as the mental illness and drug dependency ("MIDD") sales and use tax, generates significant local revenue each year to support behavioral health care in the county.

2. For more than eighteen years, this tax has helped make behavioral health treatment and related services more available, accessible, and effective for King County residents.

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

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

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

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

BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:

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

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

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

2. The advisory committee shall:

a. review and provide written recommendations to the executive and the council on the implementation and effectiveness of the county's sales tax funded

programs in meeting the ((~~goals~~)) purpose established in ((~~Ordinance 15949, Section 3, as amended, and K.C.C. 4A.500.300 through 4A.500.340~~)) K.C.C. 4A.500.315 and the goals described in implementation plans that guide the uses of the behavioral health bridge fund;

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

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

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

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

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

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

1. The council;

2. The executive;

3. The superior court;

4. The district court;

5. The prosecuting attorney's office;

6. The sheriff's office;

7. The department of public health;

8. The department of judicial administration;

9. The department of adult and juvenile detention;

10. The department of community and human services;

11. A provider of both mental health and chemical dependency services in King County;

12. A provider of culturally specific mental health services in King County;

13. A provider of culturally specific chemical dependency services in King County;

14. A representative of an organization with expertise in helping individuals with behavioral health needs in King County get jobs and live independent lives;

15. A provider of domestic violence prevention services in King County;

16. A provider of sexual assault victim services in King County;

17. An agency providing mental health and chemical dependency services to youth;

18. Harborview Medical Center;

19. ((~~All Home~~)) An entity serving individuals experiencing homelessness in King County;

20. King County systems integration initiative, which is an ongoing work group established by the executive for addressing juvenile justice matters;

21. The Community Health Council;

22. The Washington State Hospital Association, representing King County hospitals;

23. The Sound Cities Association;

24. The city of Seattle;

25. The city of Bellevue;

26. Labor representing a bona fide labor organization;

27. The office of the public defender;

28. The National Alliance on Mental Illness;

29. Puget Sound educational services district;

30. A representative of a philanthropic organization;

31. The King County behavioral health advisory board;

32. A representative of an organization with expertise in recovery;

33. A representative of the five managed care organizations operating in King County;

34. ((~~An~~)) Two individuals representing behavioral health consumer interests ((~~from the mental illness and drug dependency advisory committee's consumers and communities ad hoc work group;~~

~~35. An individual representing community interests from the mental illness and drug dependency advisory committee's consumers and communities ad hoc work group~~)) who have lived experience with behavioral health conditions;

((~~36.~~)) 35. A representative of a grassroots organization serving a cultural population or cultural populations; ((~~and~~))

((~~37.~~)) 36. A representative of unincorporated King County; and

37. A youth representative who shall be a person who is twenty-four years of age or under, who has lived experience with behavioral health conditions.

D.1. Separately elected officials and King County agency directors or their designees are not required to be appointed or confirmed.

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

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

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

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

2. The committee shall elect a chair or cochairs.

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

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

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

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

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

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

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

J. The department of community and human services shall provide recruitment assistance for positions representing lived experience. Recruitment assistance shall consist of actively recruiting and supporting candidates as they go through the application process. The assistance may include such things as posting vacancies on relevant

communications platforms, such as King County blogs or email listservs, or connecting with peer networks and community-based organizations to notify partners of vacancies. The notifications should use plain language application materials as should King County staff providing technical assistance to applicants to complete the application paperwork as needed.

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

A. For the purposes of this section:

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

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

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

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

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

2. Serve as the Best Starts for Kids children and youth strategies oversight and advisory body, including making recommendations on and monitoring the distributions of levy proceeds described in Ordinance 19267, Section 4.C.1. and 2., Section 4.D. and Section 4.E..

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

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

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

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

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

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

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

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

1. Advise on development of indicators and targets for Best Starts for Kids children and youth strategies;

2. Monitor the distribution of best starts for kids levy proceeds;

3. Work in collaboration with executive staff on any recommended changes to the children and youth strategies in the Best Starts for Kids implementation plan; and

4. Consult on and review annual reports to the council and community that demonstrate transparency regarding the expenditure of levy proceeds and the effectiveness of the best starts for kids children and youth strategies in meeting the goals and outcomes established in Ordinance 19267.

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

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

1. Review and advise the executive and council on emerging and evolving best and promising practices to improve the health and well-being of children and youth;

2. Coordinate with other county boards and groups including, but not limited to, the steering committee to address juvenile justice disproportionality, the ((~~mental illness~~

~~and drug dependency oversight board~~)) behavioral health bridge advisory committee, ((~~the regional human services levy citizen oversight board,~~)) and the veterans, seniors, and human services levy advisory ((~~citizen oversight~~)) board, to maximize the impact of the county's children and youth services;

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

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

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

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

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

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

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

K. In accordance with K.C.C. 2.28.006, youth members aged twenty-four years old and younger of the board who are neither employees of King County nor employees of other municipal governments shall receive compensation. The initial compensation shall be one hundred twenty-five dollars per meeting and shall not exceed one hundred twenty-five dollars per month before December 31, 2022. Beginning January 1, 2023,

the compensation amount per meeting and the maximum compensation amount per month shall be automatically adjusted annually, and every year thereafter, at the rate equivalent to the twelve-month change in the U.S. Department of Labor, Bureau of Labor Statistics Consumer Price Index for All Urban Consumers for the Seattle-Tacoma-Bellevue Statistical Metropolitan Area, which is known as "the CPI-U." However, if the twelve-month change in the CPI-U is negative, there shall not be an adjustment.

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

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

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

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

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

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

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

E.((~~1. In accordance with K.C.C. chapter 4.33, t~~))The proceeds of the sales tax shall be used solely for the purpose of providing new or expanded chemical dependency or mental health treatment services and for the operation of new or expanded therapeutic

court programs and shall not be used to supplant existing funding for these purposes, except as authorized in RCW 82.14.460(4).

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

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

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

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

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

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

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

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

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____

Sarah Perry, Chair

ATTEST:

_____

Melani Pedroza, Clerk of the Council

APPROVED this _____ day of _____, _____.

_____

Girmay Zahilay, County Executive

Attachments: None

King County | Office of the Executive

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

July 1, 2026

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

Dear Councilmember Perry:

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

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

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

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

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

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

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

Sincerely,



for

Girmay Zahilay
King County Executive

Enclosure

cc: King County Councilmembers
ATTN: Stephanie Cirkovich, Chief of Staff
Melani Hay, Clerk of the Council
Karan Gill, Deputy Executive, Office of the Executive
Jasmin Weaver, Chief of Staff, Office of the Executive
Hyeok Kim, Chief Operating Officer, Office of the Executive
Sierra Howlett Browne, Director of Government Relations, Office of the Executive
Garrett Holbrook, Council Relations Manager, Office of the Executive
Dr. Susan McLaughlin, Director, Department of Community and Human Services

2026 FISCAL NOTE

Ordinance/Motion:	Ordinance
Title:	An ordinance renaming and revising the mental illness and drug dependency fund and the mental illness and drug dependency advisory committee; amending Ordinance 16077, Section 4, as amended, and K.C.C. 2.130.010, Ordinance 18217, Section 2, as amended, and K.C.C. 2A.300.510, Ordinance 15955, Section 2, as amended, and K.C.C. 4A.200.430, and Ordinance 16693, Section 3, as amended, and K.C.C 24.22.020, adding a new section to K.C.C. chapter 4A.200, and recodifying K.C.C. 4A.200.430.
Affected Agency and/or Agencies:	DCHS
Note Prepared By:	Scott Miller
Date Prepared:	6/3/2026
Note Reviewed By:	Kevin Lo
Date Reviewed:	6/3/2026

Description of request:

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

Revenue to:

Agency	Fund Code	Revenue Source	2026-2027	2028-2029	2030-2031
TOTAL			**0**	**0**	**0**

Expenditures from:

Agency	Fund Code	Department	2026-2027	2028-2029	2030-2031
TOTAL			**0**	**0**	**0**

Expenditures by Categories

	2026-2027	2028-2029	2030-2031
TOTAL	**0**	**0**	**0**

Does this legislation require a budget supplemental? No.

Notes and Assumptions:

Metropolitan King County Council
Staff Report

Committee:	Regional Policy Committee		
Agenda Item:	6	**Analyst(s):**	Sam Porter Miranda Leskinen Jenny Ngo
Proposed No.:	2026-0177	**Meeting Date:**	November 5, 2026

OVERVIEW

TOPIC: An ordinance adopting the "Behavioral Health Bridge" Implementation Plan.

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

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

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

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

A summary of proposed amendments for consideration at today's special RPC meeting is provided on page 28 of this staff report.

[1] Ordinance 18406
[2] Motion 15093
[3] Motion 15058

Timing Considerations. There is no mandated deadline by which the legislation must be adopted. Executive staff initially expressed their desire to have the legislation adopted in October but have since agreed to final adoption by the end of 2026.
It is important to note that transmitted in tandem with the implementation plan is Proposed Ordinance 2026-0174, which proposes to rename MIDD the "Behavioral Health Bridge" and update the Advisory Committee. Proposed Ordinance 2026-0174 is a mandatory dual referral to the Regional Policy Committee. Both ordinances are anticipated to be taken up on the same schedule.

KEY ISSUES FROM THE ANALYSIS

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

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

BACKGROUND & TIMING CONSIDERATIONS

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

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

was adopted by Motion 15093 in March 2018. The MIDD II evaluation plan was approved by Motion 15058 in February 2018.

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

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

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

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

Table 1. 2026-2034 MIDD Estimated Collections

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

[4] Ordinance 18406
[5] Motion 15093
[6] Motion 15058
[7] This is approximately $27 million less than was projected by the March 2026 OEFA forecast.
[8] The forecast accounts for adjusted tax base expansion under ESSB 5814 and the tax base reduction from 2029 and beyond under ESSB 6346. Table 1 has been updated from the July 23, HHHS Committee Staff report which was based on the March 2026 OEFA forecast.

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

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

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

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

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

ANALYSIS

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

- Implementation plan overview
    - Primary purpose
    - Five strategies and 13 goals
- Community engagement

[9] RCW 82.14.460

- Equity framework
- Advisory Committee
- Phased, competitive procurement and base budget analysis
- Measurement and evaluation
- Reporting
- Financial plan and policies for underspend and deficit
- Inflation rate adjustment policy proviso response
- Potential policy issues
- Next steps and key dates

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[12] Behavioral Health Bridge Implementation Plan, page 21.
[13] Behavioral Health Bridge Implementation Plan, page 19.

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

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

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

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

Table 3. Timeline of Phased Procurement

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

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

[14] Behavioral Health Bridge Implementation Plan, page 20.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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
Activity	Services for people with behavioral health conditions who have cycled repeatedly through the criminal-legal system
Activity	Supports for people to reenter the community after incarceration
Activity	Behavioral health services and supports for people involved in the legal system, including therapeutic courts.
Goal 2	**Help people with behavioral health conditions achieve and maintain stable housing.**
Activity	Behavioral health services in permanent supportive housing
Activity	High-intensity services for people with behavioral health conditions leaving institutional settings who are experiencing or at risk of homelessness
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
Activity	Technology investments to facilitate care coordination across all levels of care
Activity	Promoting timely access to appropriate care

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

Goal 1	**Drive engagement and retention in SUD care.**
Activity	Proactive outreach to people with SUD, especially those experiencing homelessness
Activity	Screening and referrals integrated into multiple settings
Activity	Sobering services
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
Activity	Provision of mobile and in-community services
Activity	SUD treatment for incarcerated people
Activity	Alleviating barriers to enter inpatient SUD treatment and withdrawal management
Activity	Culturally and linguistically responsive SUD care
Activity	Overdose prevention and tracking
Goal 3	**Support paths to achieve and maintain recovery after treatment.**
Activity	Peer recovery services

Activity	Access to housing that supports recovery
Activity	Employment supports

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

Goal 1	**Provide behavioral health care for low-income people who are ineligible for Medicaid.**
Activity	Non-Medicaid behavioral health services and supports
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
Activity	Behavioral health treatment services tailored for priority populations

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

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
Activity	Sober learning environments
Activity	Youth behavioral health services in community
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
Goal 3	**Invest in the behavioral health of youth who are marginalized or experience inequities.**
Activity	Tailored supports for youth who are marginalized or experience inequities

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

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

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

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

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

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

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

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

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

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

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

Biennial Behavioral Health Bridge reports would include the following:

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

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

Financial policies.

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

[15] Bridge Implementation Plan, p. 50.

Table 10. Bridge Projected Revenue in Millions, 2028-2034[16]

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

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

	2028	2029	2030	2031	2032	2033	2034
Strategy 1: Care Transitions and Diversion							
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**
Strategy 2: Substance Use Disorder Treatment and Recovery							
Goal 1	$1.7*	$2.2	$2.3	$2.4	$2.4	$2.5	$2.5
Goal 2	$15.6*	$16.3	$16.8	$17.3	$17.7	$18.1	$18.5
Goal 3	$2.1*	$1.6	$1.7	$1.7	$1.8	$2.1	$2.4
Total	**$19.5***	**$20.2**	**$20.8**	**$21.4**	**$21.9**	**$22.6**	**$23.3**
Strategy 3: Equitable Access to Behavioral Health Care							
Goal 1	$12.0	$12.3	$12.7	$13.0	$13.3	$13.6	$13.9
Goal 2	$4.1*	$4.2	$4.3	$4.5	$4.6	$5.0	$5.3
Total	**$16.1***	**$16.5**	**$17.0**	**$17.5**	**$17.9**	**$18.6**	**$19.2**
Strategy 4: Child, Youth, and Young Adult Mental Wellbeing							
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**
Strategy 5: Behavioral Health Workforce Development							
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

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

Total	**$1.3***	**$6.6**	**$6.8**	**$7.0**	**$7.1**	**$7.6**	**$8.0**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Potential policy issues. Staff have identified some potential policy issues as summarized below. The issues all represent policy choices for the committees to consider.
1. Proposed new priorities. The transmitted plan replaces the MIDD 2 strategies with five new strategies to address care transitions and diversion services; substance use disorder treatment and recovery; equitable access to behavioral health care; child, youth, and young adult mental wellbeing; and behavioral health workforce development. Whether to accept these new strategies in the implementation plan as proposed present policy choices.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Council's legal counsel has reviewed the implementation plan.

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

Striking Amendment S1 made the following changes to the legislation:

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

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

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

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

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

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

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

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

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

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

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

PROPOSED RPC AMENDMENTS Á BACK TO TOP

The following amendments to Proposed Ordinance 2026-0177.2 are publicly available as of October 30, 2026, and attached to this staff report. Additional amendments may be released prior to the committee meeting.

Amendment	Sponsor	Effect Statement
1	von Reichbauer	Amendment 1 would: • 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.

INVITED

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

ATTACHMENTS

1. Proposed Ordinance 2026-0177.2 (and its attachment A, Dated October 2026)
2. Transmittal Letter
3. Fiscal Note
4. Financial Plan
5. Behavioral Health Bridge and MIDD Strategy Crosswalk
6. Q&A in response to the July 23rd HHHS Committee meeting
7. Behavioral Health Bridge and MIDD Strategy Financial Crosswalk (updated 8/31/26)
8. Current MIDD Initiative Reference for Attachment 7
9. Executive Staff PowerPoint Presentation
10. AMD1 to 2026-0177.2_RPC Chair’s Amendment (and its attachment A, Dated November 2026)
11. Redline copy of Attachment A, Dated November 2026 (for illustrative purposes only)

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

Ordinance

Proposed No. 2026-0177.2 **Sponsors** Mosqueda

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

STATEMENT OF FACTS:

1. In 2005, the state Legislature authorized counties to implement a one-tenth of one percent sales and use tax to support new and expanded behavioral health programs, as described in RCW 82.14.460.

2. The behavioral health sales and use tax, originally enacted in King County in 2007 through Ordinance 15949, was extended in 2016 through Ordinance 18333. Ordinance 19976, Section 2, which is codified as K.C.C. 4A.500.315, provided for the continued collection of the sales and use tax without interruption and at the same rate through January 1, 2035.

3. The tax, originally known in King County by the mental illness and drug dependency ("MIDD") name, is renamed through Ordinance XXXXX (Proposed Ordinance 2026-0174), the King County behavioral health bridge ("the bridge").

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

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

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

7. The bridge sales tax continues to fill critical gaps in the availability of behavioral health care in King County, including paying for behavioral

health care for low-income people not eligible for Medicaid and whose services are not covered by state funding. Bridge-funded programs and services also complement and strengthen the investments of other county funding streams, such as the Crisis Care Centers Levy and Health Through Housing, by paying for services and programs that those targeted local moneys do not support.

8. The King County Behavioral Health Bridge Implementation Plan 2028-2034, Phase 1: Transition Strategic Framework invests where the need is greatest and where dollars can make the most meaningful impact. The plan 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. The plan promotes holistic and high-quality behavioral health care for years to come by addressing long-term workforce shortages and the youth behavioral health crisis. The plan invests strategically to improve the availability, accessibility, effectiveness, and equity of behavioral health care in King County across five interconnected strategy areas, which are: care transitions and diversion services; substance use disorder treatment, and recovery; equitable access to behavioral health care; child, youth, and young adult mental well-being; and behavioral health workforce development.

9. The 2026-2027 Biennial Budget Ordinance, Ordinance 20023, Section 70, Expenditure Restriction ER6, restricts nearly all behavioral health sales and use tax revenues in 2026 and 2027 to be expended or encumbered consistent with the processes and practices established in Ordinance 18406 and Motions 15093 and 15058. As a result, the King County Behavioral Health Bridge Implementation Plan 2028-2034, Phase 1: Transition Strategic Framework encompasses the years 2028 through 2034.

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

BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:

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

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

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

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____

Sarah Perry, Chair

ATTEST:

_____

Melani Pedroza, Clerk of the Council

APPROVED this _____ day of _____, _____.

_____

Girmay Zahilay, County Executive

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

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

October 2026

King County

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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, the number of individuals receiving services by strategy area and by ZIP code, and summaries of evaluation findings by strategy area and by ZIP code or Council district when available. The biennial report will include descriptions of specific actions to improve programs based on reporting and evaluation and inform potential investment changes that the Executive may include in budget proposals. The Executive will make the biennial reports widely available to the Council, the Regional Policy Committee, and the community through DCHS' communication channels.[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 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

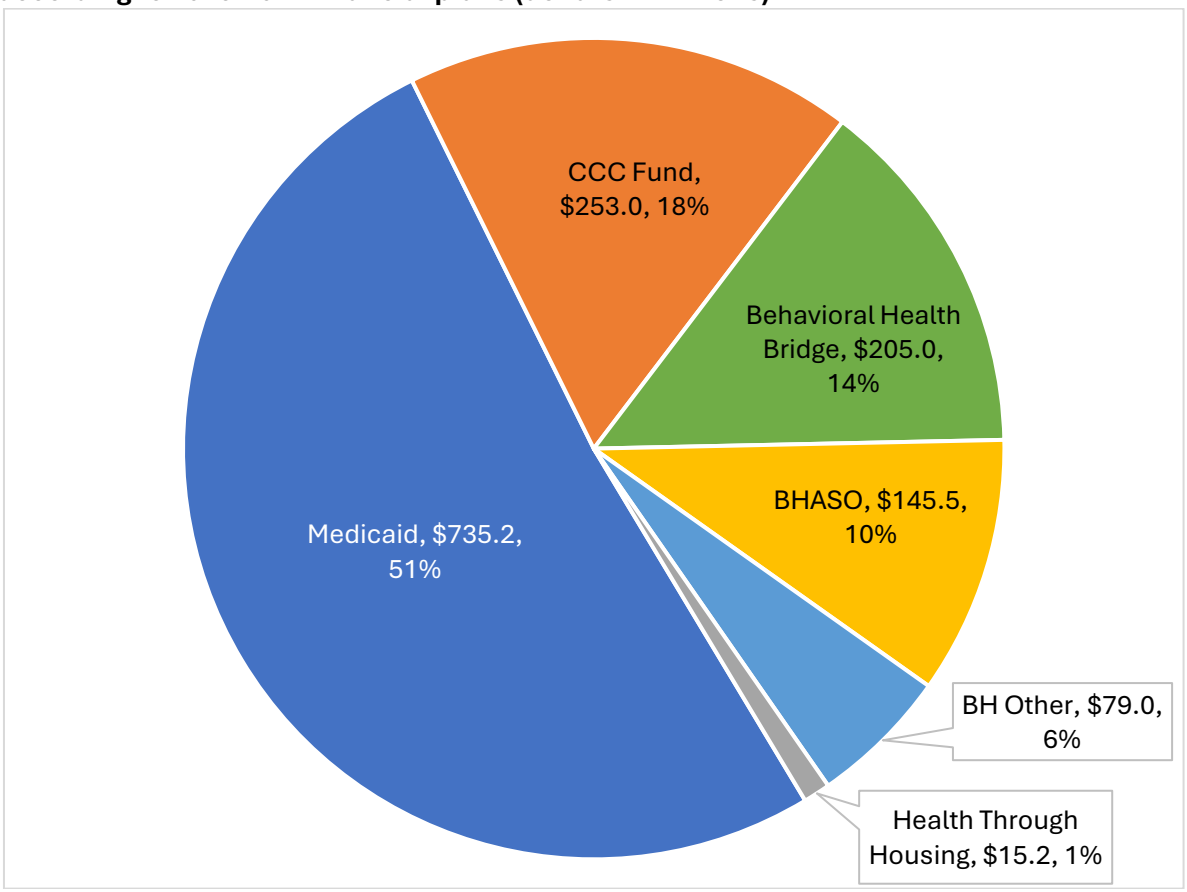
DCHS' Behavioral Health and Recovery Division (BHRD) oversees the public behavioral health system in King County, which includes managing and implementing the Behavioral Health Bridge sales tax and the Crisis Care Centers (CCC) Levy. In addition to the Behavioral Health Bridge sales tax and the CCC Levy,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

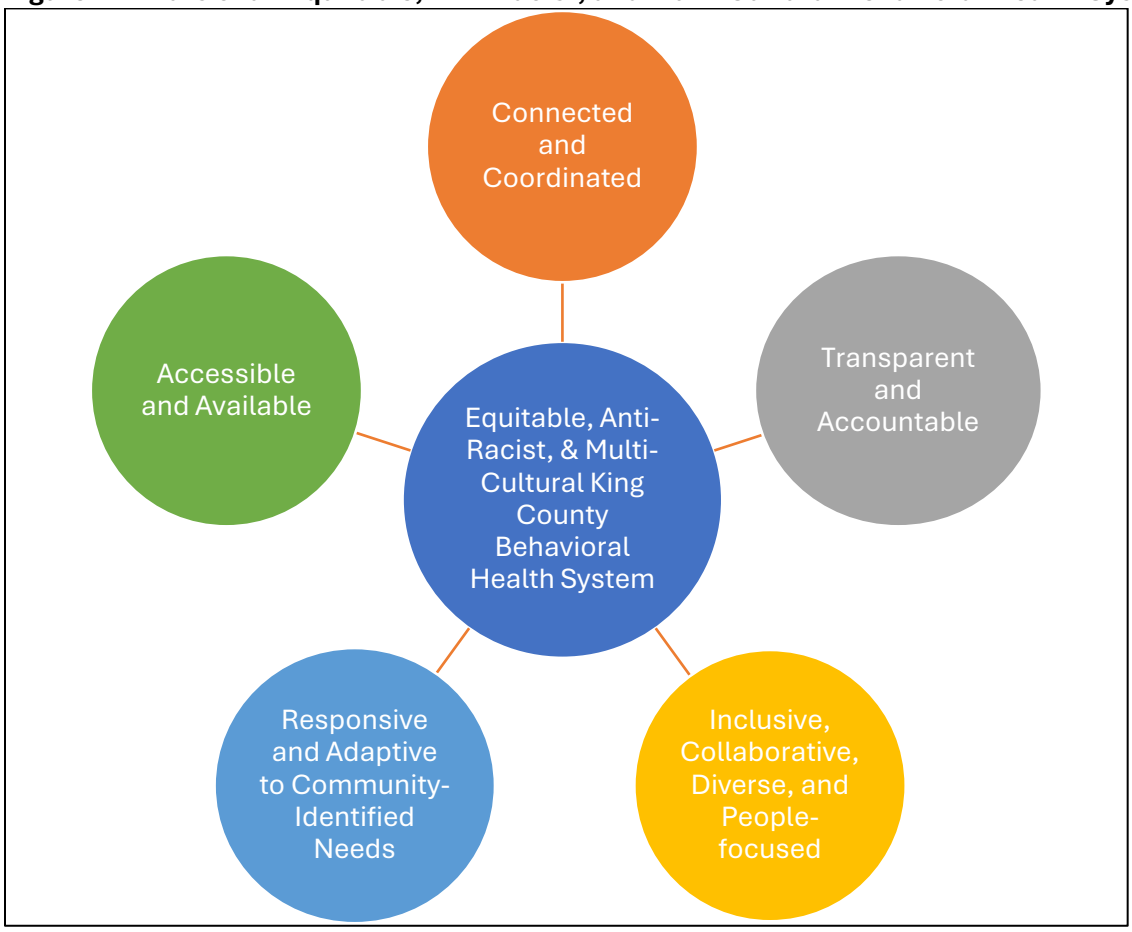
BIPOC, refugee and immigrant, LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual), and disability communities, as well as survivors of trauma or domestic, sexual, and gender-based violence, are more likely to struggle with behavioral health conditions and less likely to access supportive 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 complimentary and not duplicative, and invest in a continuum of care that best serves youth and families. If the Best Starts levy is not approved by voters, DCHS will reevaluate optimal investments of the Behavioral Health Bridge for children, youth, and young adults to reflect that substantial loss of services for youth and families.

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

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

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

Updated landscape and population needs assessment

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

Base budget analysis

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

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

The Executive Office will coordinate with DCHS on base budget analyses for all Bridge-funded programs that are managed or administered by King County agencies outside DCHS.[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 to maintain its strong commitment to centering the expertise and lived experience of its members, engaging them as deeply as possible so they stay well-informed, connected, and meaningfully involved.

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 provide 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 shall invest no less than $16.6 million annually in EA Goal 1 services from 2028 through 2034.

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

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

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

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

	2028	2029	2030	2031	2032	2033	2034
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 complex behavioral health care needs present themselves across provider sites over time.

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

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

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

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

	2028	2029	2030	2031	2032	2033	2034
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 is expected to incorporate quantitative and qualitative data and will include demographic information to ensure service recipients are reflective of the community. Qualitative data will include participant experiences and should be meaningfully incorporated alongside quantitative measures whenever possible. King County staff regularly review data and performance measures to inform program or contract modifications, repurposing of funds, and future procurement of services.

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

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

Figure 22: Example performance measures

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

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

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

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

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

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

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

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

Data collection

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

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

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

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

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

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

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

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

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

Disaggregation by demographic characteristics

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

Behavioral Health Equity Highlight

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

Measuring the King County Behavioral Health Bridge's collective impact

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

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

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

Reporting methodology to show geographic distribution by ZIP code

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

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

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

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

Aligning performance measurement with other dedicated human services initiatives

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

In response to a 2018 budget proviso, DCHS invested heavily in data systems and infrastructure to responsibly collect, manage, and share information, with the goal to make data widely accessible and to direct programming and policy decisions.[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 in King County as described in Subsection VII.B.;
- The expenditure of Behavioral Health Bridge proceeds by strategy area by ZIP code in King County as described in The number of participants receiving Behavioral Health Bridge-supported services by strategy area by ZIP code where the individuals reside at the time of service as described in Subsection VII.B.;
- A map or summary describing the Behavioral Health Bridge's geographic distribution, including by Council District;
- Reporting on standardized outcome measures by Council District, whenever possible, so the collective impact of Bridge activities can be assessed by strategy area and across the county; and
- Summaries of findings from in-depth evaluations related to Behavioral Health Bridge programs, and actions taken or planned based on those findings in years where such findings are available.

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

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

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

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

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 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:

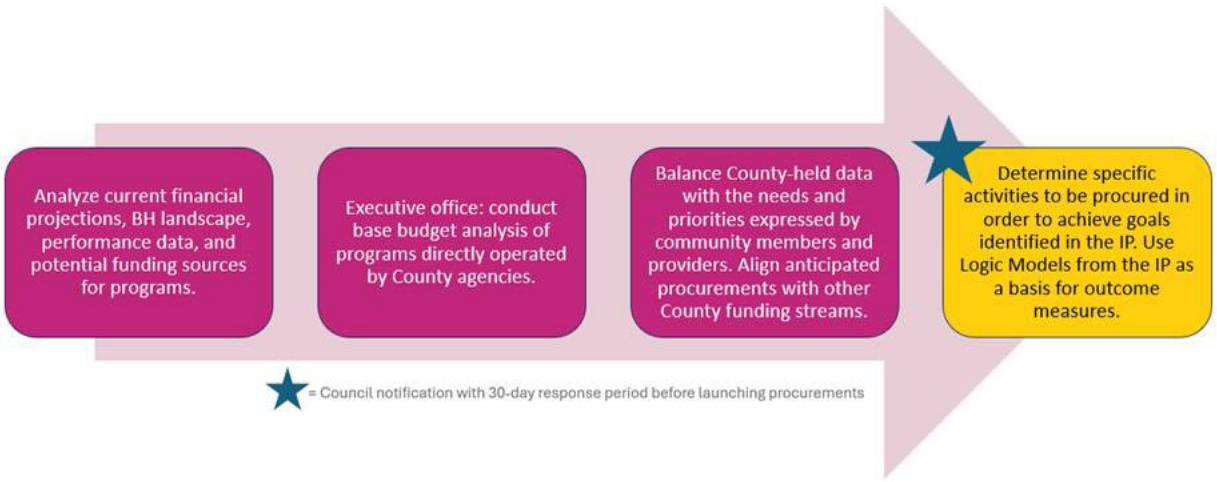
- **Forgo program expansions and investments in new programs.** Priority will be given to maintaining existing programs and service levels, except for reducing or sunsetting programs for other policy reasons.
- **Prohibit or cap future provider inflation rate increases.** DCHS may suspend or reduce inflation 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 will be notified and engaged in the procurement process, and anticipated activities to be procured for in each strategy area.

Figure 25: Anticipated Steps to Procurement



A. Pre-procurement Council notification

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

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

identification of the service provider contracts affected, and information regarding how many people the contracts served in the prior year;

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

The Executive may address multiple strategy areas in a single letter, if appropriate. The Executive will electronically file the letter with the clerk of the Council, who will retain an electronic copy and provide an electronic copy to all Councilmembers. Unless the Council passes a motion rejecting the plans within 30 days of the Executive's transmittal, the Executive may proceed with the programs and identified procurements as set forth in the notification letter.

B. Council engagement opportunities and notification of awards

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

C. Anticipated procurement timeline

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

Figure 26: Procurement Steps and Anticipated Timelines

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

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

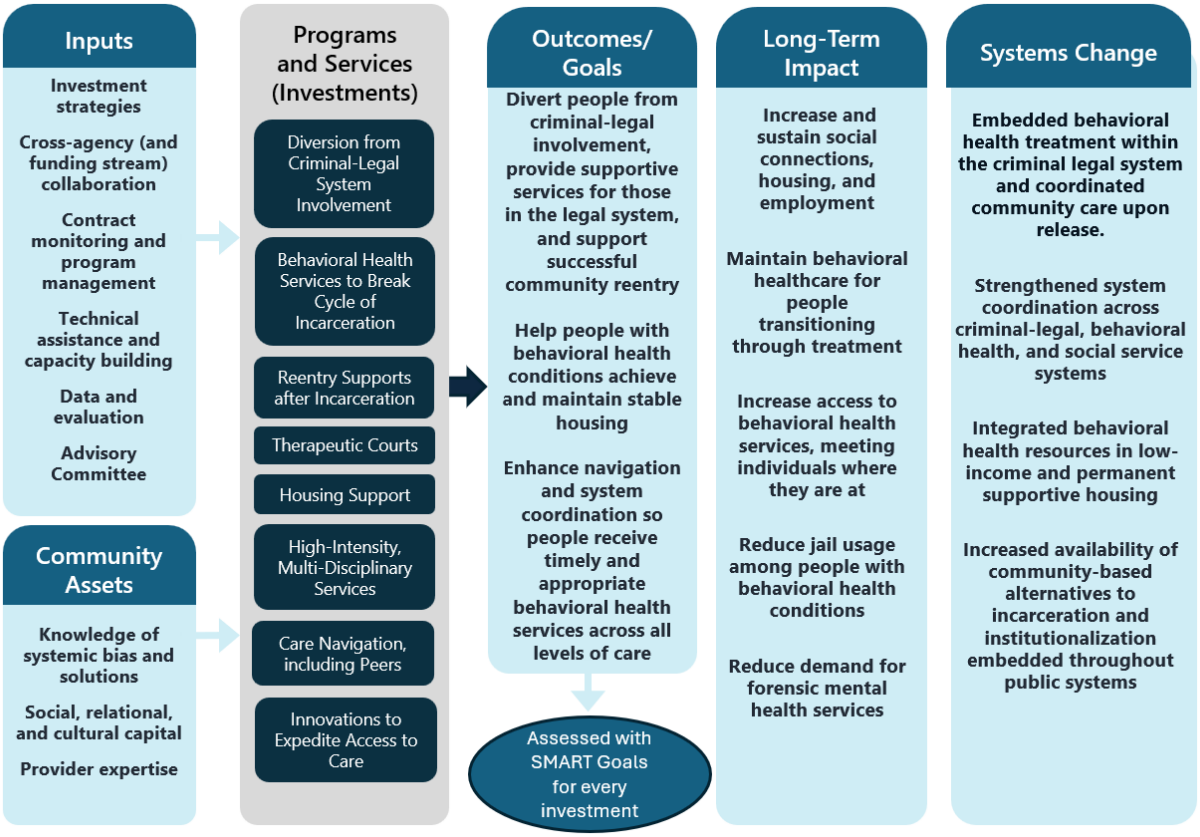
D. Examples of anticipated activities to be procured for the five strategy areas

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

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

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

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



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

Activity: Diversion from criminal-legal system involvement

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

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

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

Recent DCHS analysis of jail data reveal that nearly 1,400 individuals in King County are regularly cycling through County and municipal jails, meaning they are being booked into a correctional facility located in King County four or more times per year in two of the past three years.[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 recouperation 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 close-loop referral systems to help providers see what services someone is already engaged in, identify available resources, and connect them seamlessly while keeping patient data secure.

In an era of extraordinary technological advances, more can be done to streamline connections between systems and make it easier for people to get the care they need. Subject matter experts requested technology that would allow service providers and provider networks to easily see what services a participant is already engaged in, identify available resources that meet their needs, and connect them to care as quickly and seamlessly as possible. There is also a need for technology solutions and support staff that identify when someone has been referred and to ensure that the linkage was made. If the connection does not occur as planned, technology can make it easier to initiate additional outreach and engagement to support successful connections to care for those who may be at risk of falling through the cracks. Contracted service providers that maintain closed-loop referral systems and information-share with other providers help community organizations by presenting a whole-person snapshot of need across a complete trajectory of care. Closed-loop referrals allow case managers to send and receive status updates about participants between organizations through inter-organizational data management systems. This requires adequate staff and reliable data infrastructure to maintain patient records and document the patient experience at each step in the care process.

Activities under this goal will support contracted service providers in implementing systems for HIPAA-compliant status reporting and referrals between local service providers, based on a whole-person care model (proactive case management to ensure access to services that address the social determinants of health outside of clinical settings), thereby reducing redundancy through cross-organizational transparency and accountability.

Several technology supports designed to facilitate better behavioral health care navigation already exist in King County, such as the BHRD Quality and Care Coordination Resources SharePoint.[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:

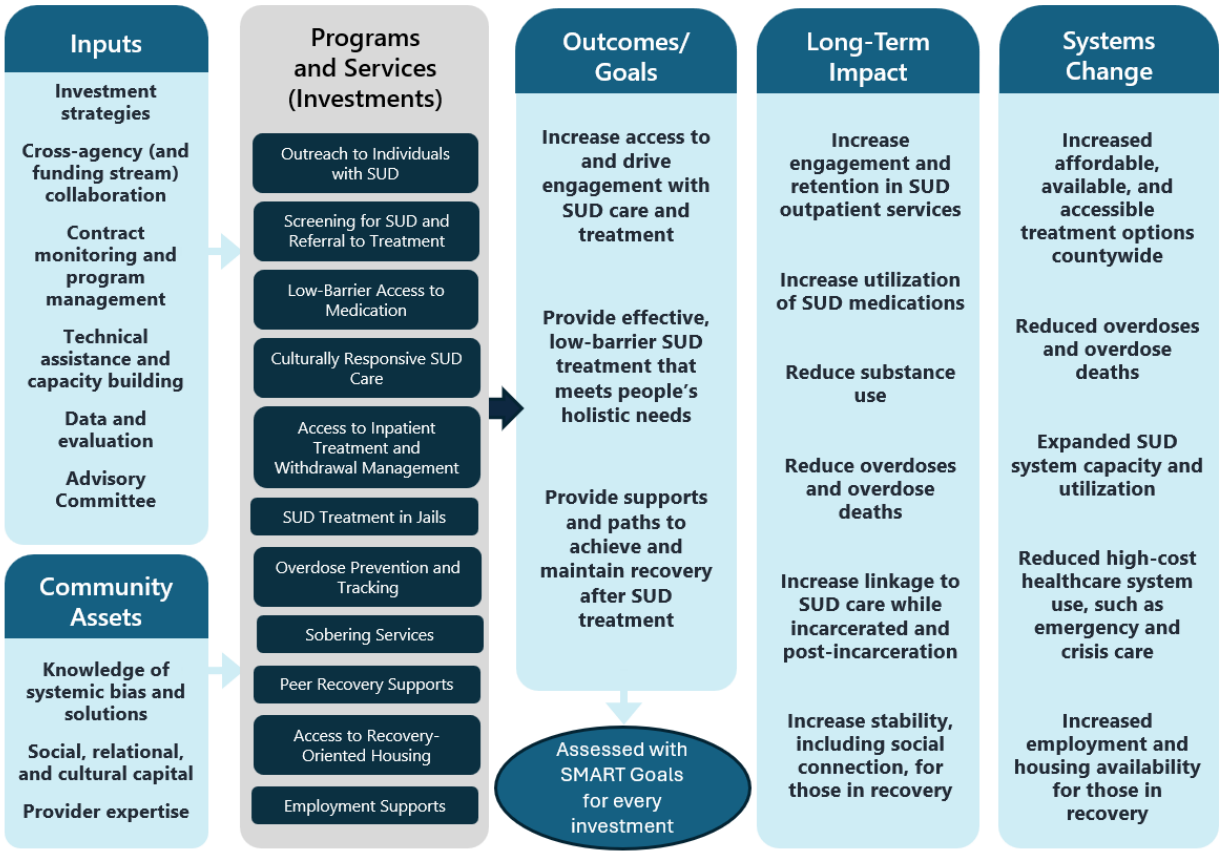
- Same-day or next-day initiation of outpatient treatment for youth and adults.

- 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.

F. Logic model and anticipated activities for Substance Use Disorder Treatment and Recovery Strategy Area

Additional detail about the SUD Treatment and Recovery strategy area, including descriptions of each goal and financial estimates, can be found in Section VI.B.

Figure 29: Logic model for the Substance Use Disorder Treatment and Recovery (SUD) strategy area



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

Activity: Proactive outreach to people with SUD, especially those experiencing homelessness

Decades of research, as well as feedback from community members and subject matter experts, show that outreach is a key part of connecting people to care, especially for people with substance use disorders who are experiencing homelessness.[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 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.

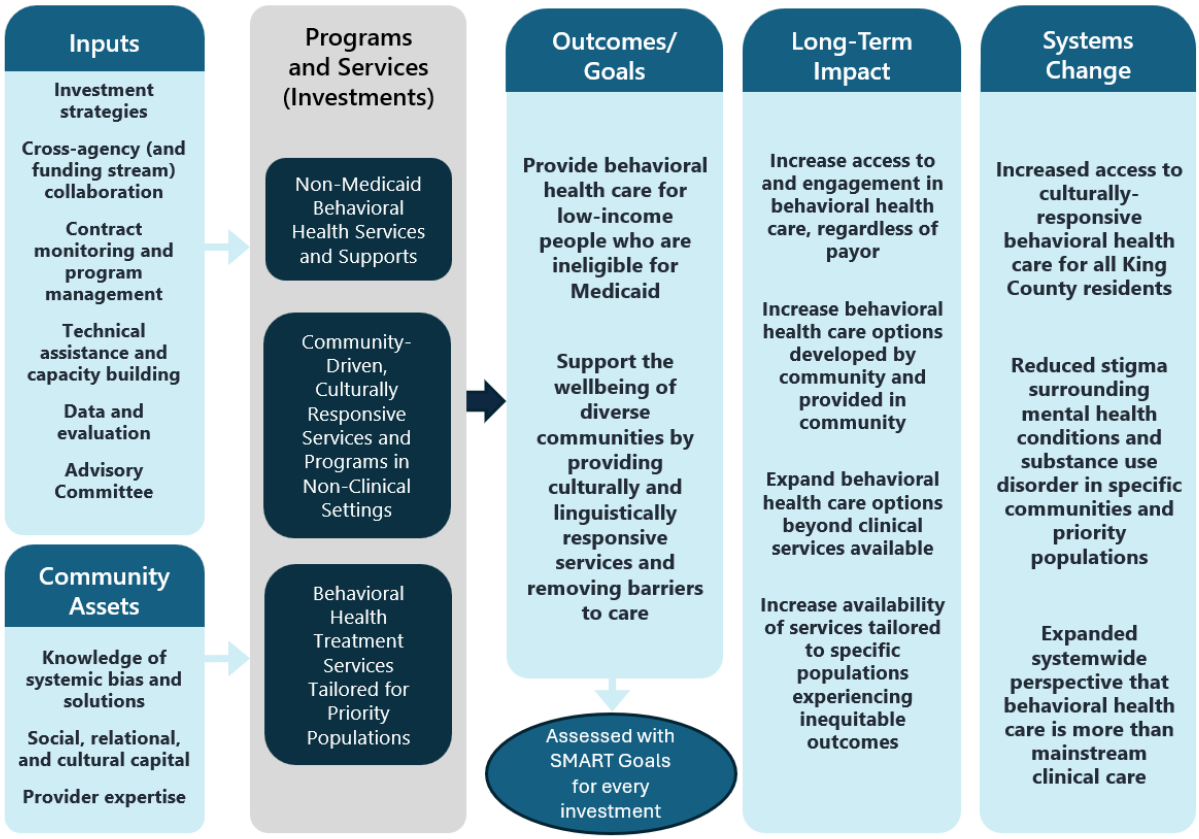
Activity: Employment supports

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.

G. Logic model and anticipated activities for Equitable Access to Behavioral Health Care Strategy Area

Additional detail about the Equitable Access to Behavioral Health Care strategy area, including descriptions of each goal and financial estimates, can be found in Subsection VI.C.

Figure 30: Logic model for the Equitable Access to Behavioral Health Care strategy area



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

Activity: Expanded funding stream designated for behavioral health services for people not covered by Medicaid

In its next iteration, the behavioral health sales tax will continue to pay for behavioral health services for low-income uninsured or underinsured King County residents who are ineligible for Medicaid coverage.

Since its inception, the behavioral health sales tax has provided access to behavioral health treatment services for uninsured low-income people. Every year since 2008, this program has served between 3,000 and 4,000 uninsured people with outpatient mental health and substance use treatment services, including immigrants and refugees, people on Medicare, and people who are pending Medicaid coverage. This funding addresses inequities for these populations by enabling them to access safety-net behavioral health treatment that would otherwise be out of reach. Supporting access to low-barrier, preventative treatment services helps keep people from delaying needed treatment and accessing higher levels of care at a later time. The Behavioral Health Bridge will sustain this important program in 2028-2034 to continue supporting treatment equity between people with insurance coverage and those who lack access due to coverage gaps, income, immigration status or other barriers to care (such as transportation or language). In addition, the Executive plans to use the Bridge to pay for translation and interpretation services and connection to culturally responsive healthcare practices for people receiving outpatient treatment through this program who speak a language other than English.

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

Activity: Community-driven culturally and linguistically responsive services and programs that support behavioral health outside of clinical settings

Community engagement participants and subject matter experts were clear that community-based organizations are better positioned to address the needs of their communities than well-intentioned outsiders. Services procured under this goal can directly fund community-based organizations to increase access to culturally and linguistically appropriate prevention, early intervention, care navigation, and recovery supports for BIPOC, immigrant or refugee, LGBTQIA+, and rural King County residents. By working with communities to design and implement service approaches that meet their needs, this goal directly addresses race- and place- based inequities and promotes King County's commitment to equity as a core value.

DCHS shall release one or more RFPs to identify organizations that can provide tailored supports to populations that experience behavioral health inequities, such as those who:

- Identify as Black, Indigenous, or people of color.
- Are immigrants, refugees, or asylees.
- Identify as LGBTQIA+.
- Live in rural areas.
- Are survivors of trauma or domestic, sexual, and gender-based violence.
- Live unsheltered.

Examples of the types of programs that could be procured to further this goal include:

- Behavioral health education paired with culturally responsive programming such as sweat lodges or art therapy.
- Community conversations focused on de-stigmatization and healing, including cross-generational programming.
- Queer-affirming suicide prevention provided by an LGBTQIA+ organization.
- Wellness programs in safe spaces that build strong community connections.
- Mental health awareness and education, in preferred languages by trusted organizations.

Activity: Behavioral health treatment services tailored for at-risk populations

Participants in the Be Heard: Community Voices About Mental Health and Wellness project shared that culture, beliefs, values, race, language, and personal identity affect perspectives on mental health and substance use.[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:

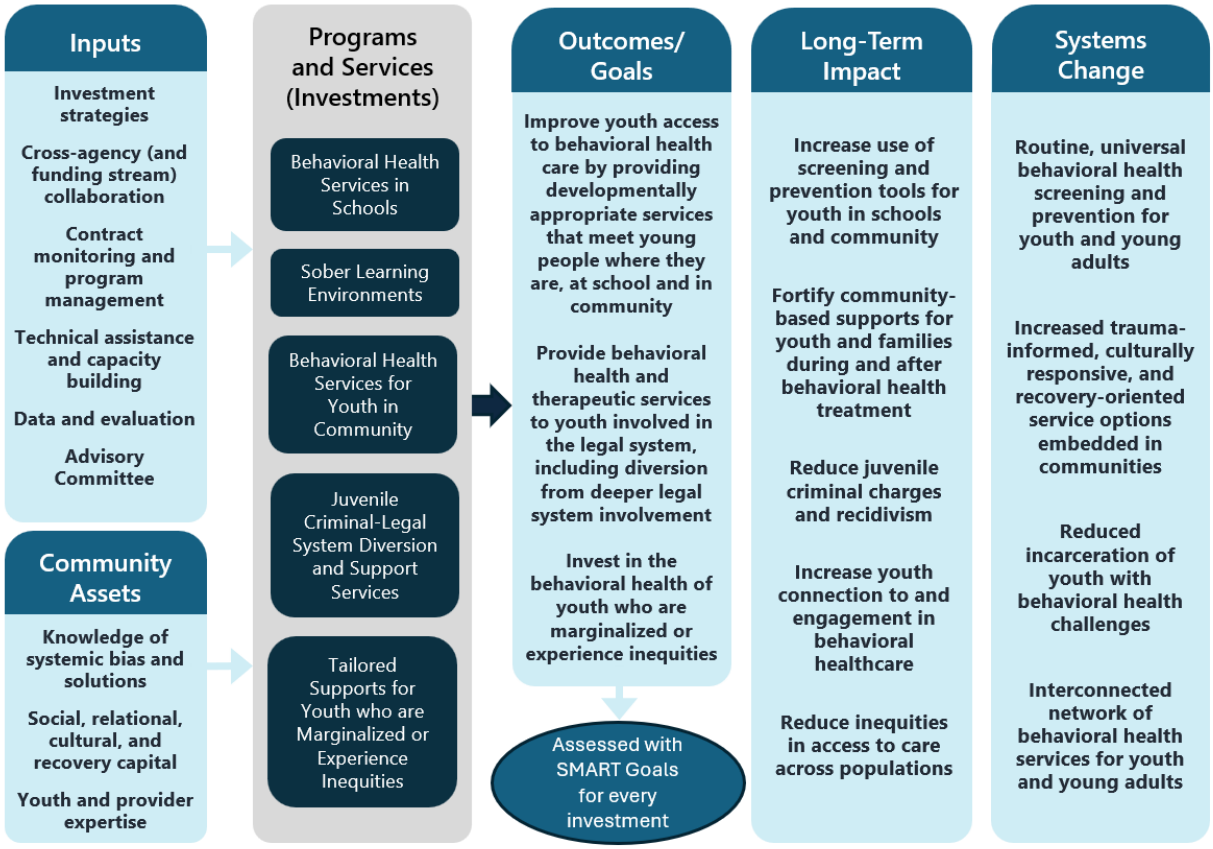
- Tailored therapies for LGBTQIA+ people facing behavioral health challenges.
- Behavioral health treatment and enhanced care navigation for survivors of trauma or domestic, sexual, and gender-based-violence, including flexible financial assistance where material barriers interfere with behavioral health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

H. Logic model and anticipated activities for Child, Youth, Young Adult Mental Wellbeing Strategy Area

Additional detail about the Child, Youth, and Young Adult Mental Wellbeing strategy area, including descriptions of each goal and financial estimates, can be found in Subsection VI.D.

Figure 31: Logic model for the Child, Youth, and Young Adult Mental Wellbeing (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.

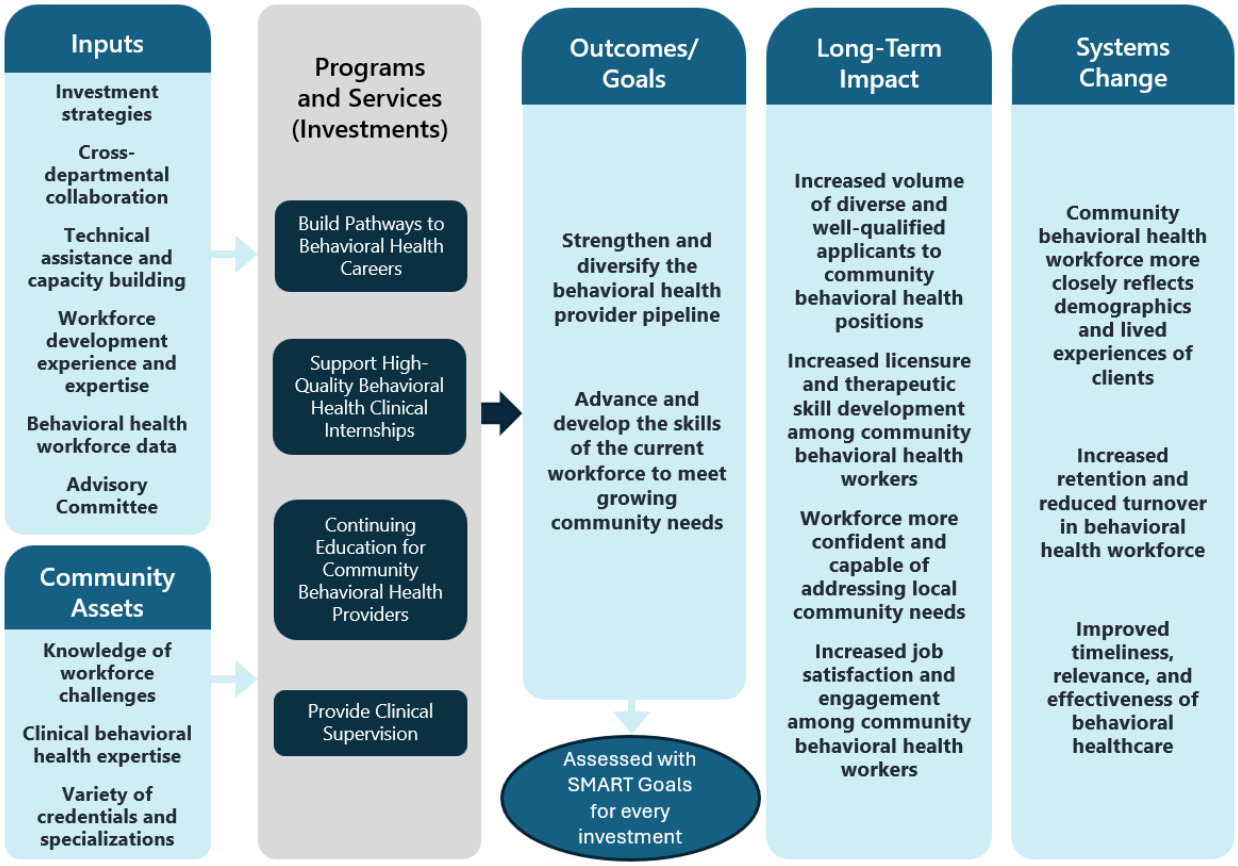
During the procurement process, King County plans to evaluate proposals from community organizations that are already known and respected by the families this goal is intended to serve, which may include KCICN providers. Providers should have training on the unique confidentiality, safety, caregiver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

I. Logic model and anticipated activities for the Behavioral Health Workforce Development Strategy Area

Additional detail about the Behavioral Health Workforce Development strategy area, including descriptions of each goal and financial estimates, can be found in Subsection VI.E.

Figure 32: Logic model for the Behavioral Health Workforce Development (WF) strategy area



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

Activity: Building pathways to behavioral health careers

The Executive intends for the Behavioral Health Bridge to fund programs and activities that bring people into the provider pipeline, with a focus on recruiting a representative workforce, including by raising awareness of behavioral health career opportunities, preparing people for jobs in the field, and connecting people to careers in behavioral health. The Executive will invest in activities such as:

- Educating under-resourced communities on non-clinical and clinical career pathways and ways to access free or no-cost trainings.
- Delivering programs in diverse middle and high schools to increase behavioral health career awareness among BIPOC youth.
- Building "connection to industry" through hands-on learning, job shadowing, career tours, and clinical simulations.
- Sponsoring Behavioral Health Career Pathways Fairs in collaboration with community-based organizations that serve underrepresented populations, including youth.
- Continuing summer programs for youth interested in pursuing behavioral health careers.
- Expanding existing relationships with technical colleges and skills centers.
- Targeted outreach to individuals enrolled in higher education behavioral health programs, highlighting benefits of working in community behavioral health, diversity of careers available, and opportunities for career growth within the behavioral health system.

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.

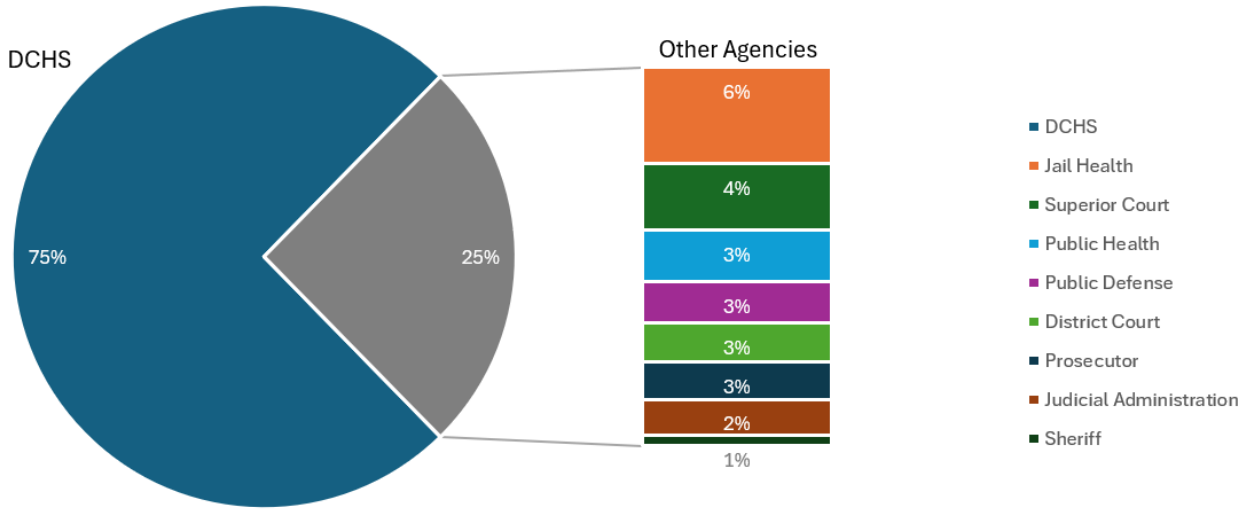
Successful implementation will depend on continued partnership with community-based organizations, behavioral health service providers, people with lived experience, and across County agencies. Ongoing evaluation, transparent reporting, and a phased procurement approach will help deliver a smooth transition 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)

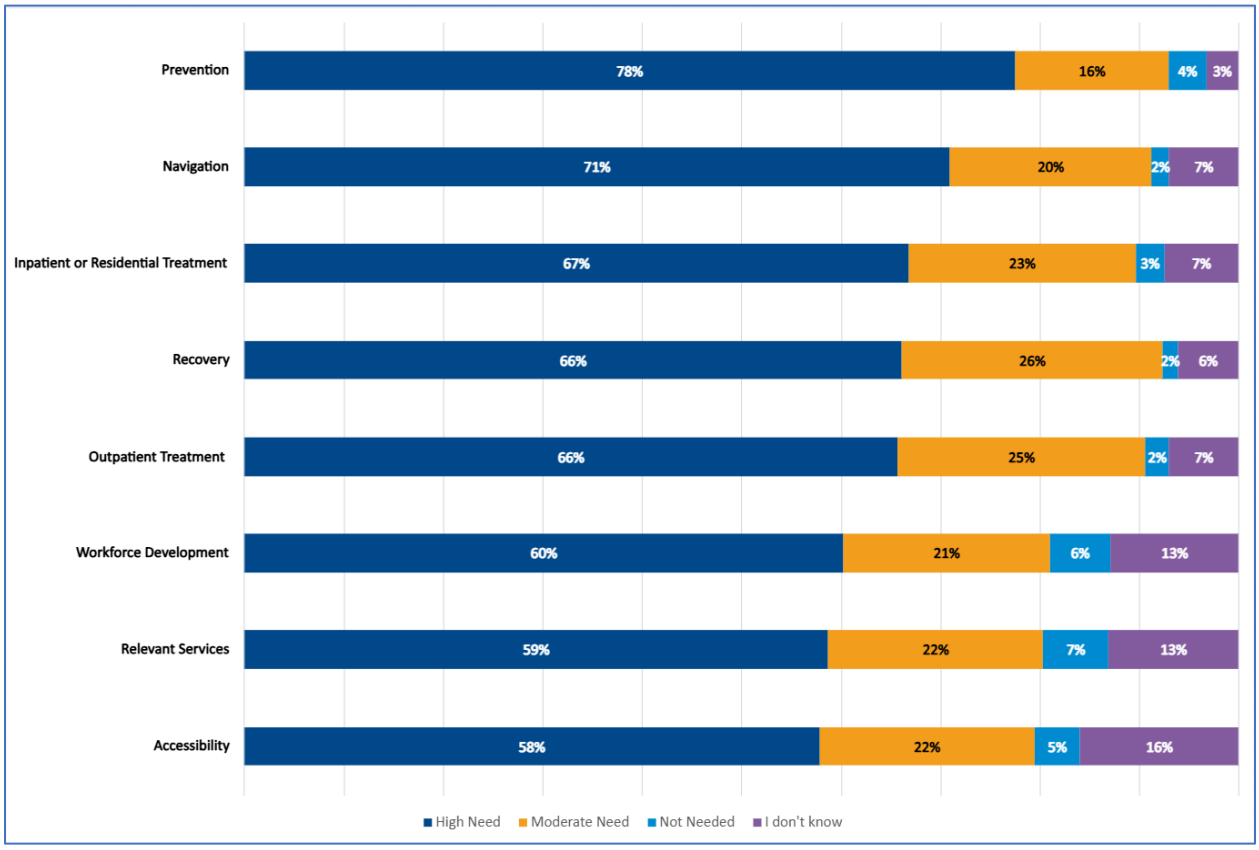
Affiliation or self-identification of attendees	Number of people engaged
LGBTQIA+ community members	23 (3%)
Behavioral health providers	72 (9%)
City government agencies	50 (7%)
Community-based organizations (CBOs)	62 (8%)
Correctional officers	15 (2%)
Incarcerated adults	99 (13%)
Incarcerated youth	27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

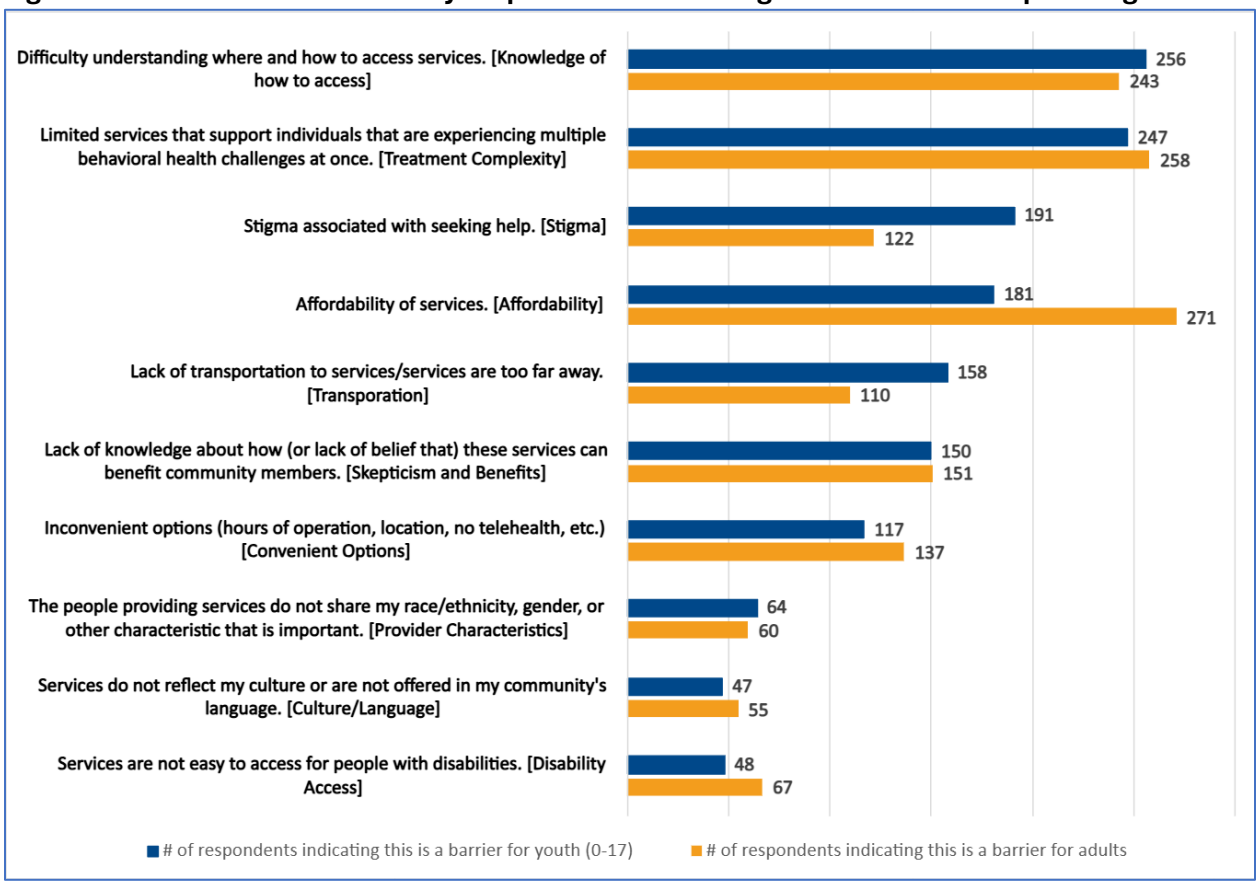
Figure 40: Online survey respondents' rating of behavioral health system barriers



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

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

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

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[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]

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[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.

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[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]

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[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].

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and-ethnic-disparities-in-mental-health-care-findings-from-the-kff-survey-of-racism-discrimination-and-health/]

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[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]

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[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]

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[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]

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[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.

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[121] King County. KCICN Workforce Survey 2025.

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[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]

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[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]

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King County | Office of the Executive

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

July 1, 2026

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

Dear Councilmember Perry:

This letter transmits the King County Behavioral Health Bridge Implementation Plan 2028-2034, which responds to Ordinance 20023, Section 70, Proviso P1, and a proposed Ordinance that would, if enacted, adopt the implementation plan. Adoption of this proposed legislation would reaffirm the County's commitment to high-quality, accessible , effective, and equitable behavioral health care in King County.

The "King County Behavioral Health Bridge" ("the Bridge") represents a new name for this plan and its programs, reflected in a separate proposed Ordinance, to replace the "Mental Illness and Drug Dependency" (MIDD) name that has been used for this fund and its programs and advisory committee since 2007. Responsive to community feedback, the King County Behavioral Health Bridge name emphasizes the role of sales tax-funded programs in creating a bridge between people experiencing behavioral health conditions and community behavioral health treatment, other systems people interact with including the criminal-legal system, and pathways to recovery.

Under its former name MIDD, this fund supported programs that served over 130,000 unduplicated King County residents between 2017 and 2025. These investments make programs possible that improve health and wellness, recovery, and connection to community, especially for people most affected by inequities related to race, income, housing status, and access to health care.

The King County Behavioral Health Bridge is projected to generate nearly $800 million for behavioral health care in King County between 2028 and 2034. The proposed King County Behavioral Health Bridge Implementation Plan 2028-2034 invests strategically to break the cycle

and prevent incarceration, hospitalization, homelessness, and crisis for low-income people with mental health and substance use conditions. The plan builds on past successes while strategically tackling the most pressing behavioral health issues in King County communities through investments in five interconnected strategy areas:

- Care transitions and diversion services.
- Substance use disorder prevention, treatment, and recovery.
- Equitable access to behavioral health care.
- Child, youth, and young adult mental wellbeing.
- Behavioral health workforce development.

The proposed plan invests where the need is greatest and where dollars can make the most meaningful impact. It describes the forecasted expenditure of revenues in the five strategy areas to achieve the King County Behavioral Health Bridge's identified goals. It includes activities in which the County anticipates investing to reduce behavioral health system fragmentation, improve service availability, and align with other funding sources such as Medicaid and local funds. The plan also describes a performance measurement and evaluation framework to assess and report on how well Bridge investments are achieving desired results, and describes plans for regular reporting to the Council and community.

This plan and its five strategy areas are the product of an intensive engagement process that began in June 2024 and concluded in March 2026. The strategy areas, goals, and activities were informed by community engagement with over 2,200 King County residents, an extensive multi-sector process involving over 100 subject matter experts, and the most current available county-level data on needs and outcomes. Community engagement activities included participation from behavioral health agencies, people with lived experience of behavioral health, incarcerated people with behavioral health conditions, scholars, advocates, representatives of the legal system, the MIDD Advisory Committee, elected officials, and other community partners. Feedback from these diverse individuals significantly informed the investments described in this plan, and will inform future procurement and operational phases of the Behavioral Health Bridge.

The King County Behavioral Health Bridge Implementation Plan 2028-2034 and its programs will enable the County to continue to break cycles of incarceration, hospitalization, and homelessness and build toward a future of available, accessible, effective, and equitable behavioral health care. I look forward to working with the Council to provide access to high-quality behavioral health care that enables residents to pursue long term recovery, stability, and wellbeing. Thank you for your consideration of this important Plan and proposed Ordinance.

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

Sincerely,



for

Girmay Zahilay
King County Executive

Enclosure

cc: King County Councilmembers
ATTN: Stephanie Cirkovich, Chief of Staff
Melani Hay, Clerk of the Council
Karan Gill, Deputy Executive, Office of the Executive
Jasmin Weaver, Chief of Staff, Office of the Executive
Hyeok Kim, Chief Operating Officer, Office of the Executive
Sierra Howlett Browne, Director of Government Relations, Office of the Executive
Garrett Holbrook, Council Relations Manager, Office of the Executive
Dr. Susan McLaughlin, Acting Director, Department of Community and Human Services

2026 FISCAL NOTE

Ordinance/Motion:	Ordinance
Title:	An ordinance adopting the King County behavioral health bridge implementation plan, required by the 2026-2027 Biennial Budget Ordinance, Ordinance 20023, Section 70, Proviso P1, to govern the expenditure of proceeds from 2028 through 2034 of the behavioral health sales and use tax authorized by RCW 82.14.460 and K.C.C. 4A.500.315.
Affected Agency and/or Agencies:	DCHS
Note Prepared By:	Scott Miller
Date Prepared:	6/3/2026
Note Reviewed By:	Kevin Lo
Date Reviewed:	6/3/2026

Description of request:

The proposed ordinance would adopt the King County Behavioral Health Bridge Implementation Plan 2028-2034 to govern the expenditure of proceeds from 2028 through 2034 of the behavioral health sales and use tax authorized by RCW 82.14.460 and K.C.C. 4A.500.315.

Revenue to:

Agency	Fund Code	Revenue Source	2028-2029	2030-2031	2032-2033
DCHS	1135	Sales Tax	211,280,000	221,610,000	236,730,000
DCHS	1135	Interest Earnings	1,510,000	1,330,000	1,270,000
TOTAL			**212,790,000**	**222,940,000**	**238,000,000**

Expenditures from:

Agency	Fund Code	Department	2028-2029	2030-2031	2032-2033
DCHS	1135	BHRD	211,910,000	224,580,000	236,990,000
TOTAL			**211,910,000**	**224,580,000**	**236,990,000**

Expenditures by Categories

	2028-2029	2030-2031	2032-2033
Strategy Area 1: Care Transitions and Diversion Services	69,180,000	67,460,000	70,810,000
Strategy Area 2: SUD Treatment and Recovery	39,650,000	42,120,000	44,510,000
Strategy Area 3: Equitable Access to Behavioral Health Care	32,630,000	34,520,000	36,530,000
Strategy Area 4: Child, Youth, and Young Adult Mental Wellbeing	22,910,000	24,750,000	26,250,000
Strategy Area 5: Behavioral Health Workforce Development	7,870,000	13,730,000	14,700,000
Technical Assistance & Capacity Building	1,060,000	1,110,000	1,180,000
Administration	17,270,000	18,290,000	19,240,000
Performance Measurement & Evaluation	5,080,000	5,380,000	5,660,000
Behavioral Health Fund Transfer	16,260,000	17,220,000	18,110,000
TOTAL	**211,910,000**	**224,580,000**	**236,990,000**

Does this legislation require a budget supplemental? No. Fiscal impacts begin in the 2028-29 budgetary biennium.

Notes and Assumptions:

Biennial amounts are rounded to nearest $10,000.

Behavioral health provider contract budgets assume inflationary increases based on BFPA rates (Seattle Consumer Price Index).

Financial Plan - King County Behavioral Health Bridge Implementation Plan 2028-2034
Behavioral Health Bridge / 1135

Category	2028-2029 Projected	2030-2031 Projected	2032-2033 Projected	2034 Projected
Beginning Fund Balance	**$ 19,550,000**	**$ 20,430,000**	**$ 18,790,000**	**$ 19,800,000**
Revenues				
Local Sales Tax	211,280,000	221,610,000	236,730,000	124,180,000
Other/Interest	1,510,000	1,330,000	1,270,000	660,000
Total Revenues	**$ 212,790,000**	**$ 222,940,000**	**$ 238,000,000**	**$ 124,840,000**
Expenditures				
Strategy Area 1: Care Transitions and Diversion Services	69,180,000	67,460,000	70,810,000	36,900,000
Strategy Area 2: SUD Treatment and Recovery	39,650,000	42,120,000	44,510,000	23,350,000
Strategy Area 3: Equitable Access to Behavioral Health Care	32,630,000	34,520,000	36,530,000	19,230,000
Strategy Area 4: Child, Youth, and Young Adult Mental Wellbeing	22,910,000	24,750,000	26,250,000	13,920,000
Strategy Area 5: Behavioral Health Workforce Development	7,870,000	13,730,000	14,700,000	7,960,000
Technical Assistance & Capacity Building	1,060,000	1,110,000	1,180,000	620,000
Administration	17,270,000	18,290,000	19,240,000	9,950,000
Performance Measurement & Evaluation	5,080,000	5,380,000	5,660,000	2,930,000
Behavioral Health Fund Transfer	16,260,000	17,220,000	18,110,000	9,360,000
Total Expenditures	**$ 211,910,000**	**$ 224,580,000**	**$ 236,990,000**	**$ 124,220,000**
Estimated Under expenditures	-	-	-	-
Other Fund Transactions	-	-	-	-
Total Other Fund Transactions	**$ -**	**$ -**	**$ -**	**$ -**
Ending Fund Balance	**$ 20,430,000**	**$ 18,790,000**	**$ 19,800,000**	**$ 20,420,000**
Reserves				
Rainy Day Reserve	17,420,000	18,460,000	19,480,000	20,420,000
Sustainability Reserve	3,010,000	330,000	320,000	-
Total Reserves	**$ 20,430,000**	**$ 18,790,000**	**$ 19,800,000**	**$ 20,420,000**
Reserve Shortfall	-	-	-	-
Ending Undesignated Fund Balance	**$ -**	**$ -**	**$ -**	**$ -**

Financial Plan Notes

All financial plans have the following assumptions, unless otherwise noted in below rows:
- Outyear projections columns: revenue and expenditure inflation assumptions are consistent with figures provided by the Executive Budget Team's BFPA guidance and the agency's internal assumptions and methodology.
- Biennial amounts are rounded to nearest $10,000.
- Beginning fund balance for 2028 is based on projections from the MIDD Fund Q1 2026 Financial Monitoring plan from March 2026.

Revenue Notes:

- Revenue amounts are based on March 2026 economic forecast for sales tax, and updated planning assumptions for interest earned.

Expenditure Notes:

- Projected amounts assume the King County Behavioral Health Bridge will implement the King County Behavioral Health Bridge Implementation Plan 2028-2034 as proposed, with expenditures grouped into the categories shown in this table and aligned to expected revenues for the plan period.

Reserve Notes:

- 2028-2034 Rainy Day reserves are based on 60 days of expenditures.

Former MIDD Program and Number	Aligned "Bridge" Anticipated Activity	Notes
PRI-01 Screening, Brief Intervention and Referral to Treatment-SBIRT	SUD Goal 1 - activity: Screening and referrals integrated into multiple settings	
PRI-02 Juvenile Justice Youth Behavioral Health Assessments	CYYA Goal 2 - activity: Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system	
PRI-03: Prevention and Early Intervention Behavioral Health for Adults Over 50	n/a	Funding ending 12/31/26 per Council-adopted biennial budget
PRI-04 older Adult Crisis Intervention/Geriatric Regional Assessment Team	n/a	Funded by VSHSL-only in 2027
PRI-05 Collaborative School Based Behavioral Health Services: Middle and High School Students	CYYA Goal 1: Youth behavioral health services in schools	
PRI-06: Zero Suicide Initiative Pilot	n/a	Already ended (before 2026-2027 biennium)
PRI-07: Mental Health First Aid	EA Goal 2: activity: Community-driven culturally and linguistically responsive services and programs that support behavioral health outside of clinical settings	
PRI-08: Crisis Intervention Training – First Responders	CTD Goal 1 - activity: Diversion from criminal-legal system involvement	
PRI-09: Sexual Assault Behavioral Health Services	EA Goal 2: activity: BH treatment services tailored for priority populations	
PRI-10: Domestic Violence Behavioral Health Services and System Coordination	EA Goal 2: activity: BH treatment services tailored for priority populations	
PRI-11: Community Behavioral Health Treatment	EA Goal 1: activity: Non-Medicaid behavioral health services and supports	
CD-01: Law Enforcement Assisted Diversion	CTD Goal 1 - activity: Diversion from criminal-legal system involvement	
CD-02: Youth and Young Adult Homelessness Services	CYYA Goal 2 - activity: Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system	
CD-03: Outreach and In Reach System of Care	SUD Goal 1 - activity: Proactive outreach to people with SUD, especially those experiencing homelessness	
CD-04: South County Crisis Diversion Services/Center	n/a	Rolled into CD-06 several years ago
CD-05: High Utilizer Care Teams	n/a	No longer MIDD-funded (was moved to Harborview bond before 2026-2027 biennium)
CD-06: Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team	n/a	Intended to shift to CCC before 2028
CD-07: Multipronged Opioid Strategies	SUD Goal 2 - activity: Low-barrier access to medications for substance use disorder and medication-first treatment approachesSUD Goal 2 - activity: SUD treatment for incarcerated peopleSUD Goal 2 - activity: overdose prevention and tracking	Current activities of CD-07 align with multiple anticipated future activities within SUD Goal 2

Former MIDD Program and Number	Aligned "Bridge" Anticipated Activity	Notes
CD-08: Children's Domestic Violence Response Team	CYYA Goal 3 - activity: Tailored supports for youth who are marginalized or experience inequities	
CD-09: Behavioral Health Urgent Care Walk-In Clinic	n/a	Already ended (before 2026-2027 biennium)
CD-10: Next-Day Crisis Appointments	CTD Goal 3 - activity: Promoting timely access to appropriate care	
CD-11: Children's Crisis Outreach Response System	n/a	Intended to shift to CCC before 2028
CD-12: Parent Partners Family Assistance	CYYA Goal 3 - activity: Tailored supports for youth who are marginalized or experience inequities	
CD-13: Family Interventions Restorative Services	CYYA Goal 2 - activity: Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system	
CD-14: Involuntary Treatment Triage	CTD Goal 1 - activity: Services for people with behavioral health conditions who have cycled repeatedly through the criminal-legal system	
CD-15: Wraparound Services for Youth	CYYA Goal 3 - activity: Tailored supports for youth who are marginalized or experience inequities	
CD-16: Youth Behavioral Health Alternatives to Secure Detention	n/a	Already ended (before 2026-2027 biennium)
CD-17: Young Adult Crisis Facility	CYYA Goal 1: Youth behavioral health services in community	
CD-18: RCR/TRU	CTD Goal 1 - activity: Diversion from criminal-legal system involvement	
RR-01: Housing Supportive Services	CTD Goal 2 - activity: Behavioral health services in permanent supportive housing	
RR-02: Behavior Modification Classes at Community Center for Alternative Programs	n/a	Intended to shift to General Fund before 2028
RR-03: Housing Capital and Rental	n/a	The Bridge IP reflects DCHS' plans to cease this transfer to HCD at the time that the CTD area is reprocured (2029)
RR-04: Rapid Rehousing Oxford House Model	SUD Goal 3 - activity: Access to housing that supports recovery	
RR-05: Housing – Adult Drug Court	n/a	Modeled as part of Adult Drug Court beginning in 2028 (continuing, but not as a standalone program)
RR-06: Jail Reentry System of Care	CTD Goal 1 - activity: Supports for people to reenter the community after incarceration	
RR-07: Behavioral Health Risk Assessment Tool for Adult Detention	n/a	Already ended (before 2026-2027 biennium)
RR-08: Hospital Reentry Respite Beds	CTD Goal 3 - activity: Promoting timely access to appropriate care	
RR-09: Recovery Café	SUD Goal 3 - activity: Peer recovery services	
RR-10: Behavioral Health Employment Services and Supported Employment	SUD Goal 3 - activity: Employment supports	
RR-11: Peer Bridgers and Peer Support Pilot	CTD Goal 3 - activity: Care navigation, including peer navigation and care coordination SUD Goal 3 - activity: Peer recovery services	Peer Bridgers (RR-11A) fits under CTD Goal 3 and SUD Peer Support (RR-11B) fits under SUD Goal 3

Former MIDD Program and Number	Aligned "Bridge" Anticipated Activity	Notes
RR-12: Jail-Based Substance Abuse Treatment	SUD Goal 2 - activity: SUD treatment for incarcerated people	
RR-13: Deputy Prosecuting Attorney for Familiar Faces	CTD Goal 1 - activity: Services for people with behavioral health conditions who have cycled repeatedly through the criminal-legal system	
RR-14: Shelter Navigation Services	n/a	Already ended (before 2026-2027 biennium)
RR-15: PreTrial Assessment and Linkage Services (PALS)	n/a	Intended to shift to General Fund before 2028
SI-01: Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities	EA Goal 2: activity: Community-driven culturally and linguistically responsive services and programs that support behavioral health outside of clinical settings EA Goal 2: activity: BH treatment services tailored for priority populations	Current activities of SI-01 that are more upstream in nature would fall under the first activity ("outside of clinical settings"), while treatment services would fall under the second activity.
SI-02: Behavioral Health Services in Rural King County	EA Goal 2: activity: Community-driven culturally and linguistically responsive services and programs that support behavioral health outside of clinical settings EA Goal 2: activity: BH treatment services tailored for priority populations	Current activities of SI-02 that are more upstream in nature would fall under the first activity ("outside of clinical settings"), while treatment services would fall under the second activity.
SI-03: Quality Coordinated Outpatient Care	CTD Goal 3 - activity: Technology investments to facilitate care coordination across all levels of care	
SI-04: Workforce Development	WF Goal 2 - activity: continuing education for community behavioral health providers	
TX-ADC: Adult Drug Court	CTD Goal 1 - activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts	
TX-FTC: Family Treatment Court	CTD Goal 1 - activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts	
TX-JTRAC-BHR: Juvenile Therapeutic Response and Accountability Court - Behavioral Health Response	CYYA Goal 2 - activity: Diversion and supportive services for youth involved, or at-risk of involvement, in the criminal-legal system	
TX-RMHC: Regional Mental Health Court	CTD Goal 1 - activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts	
TX-SMC: Seattle Mental Health Municipal Court	CTD Goal 1 - activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts	
TX-CCPL: Community Court Planning	CTD Goal 1 - activity: Behavioral health services and supports for people involved in the legal system, including therapeutic courts	

ATTACHMENT 6: JULY 23RD HEALTH, HOUSING, AND HUMAN SERVICES COMMITTEE Q&A

1. Please provide a summary of existing funding levels for MIDD II programs and strategies (annual and/or to date).

While the Bridge implementation plan calls for a more strategic and aligned approach to funding priorities, it is anticipated that many of the services currently provided under MIDD 2 initiatives programming will continue through updated procurements. Attachment 7 to the staff report provides an overview of current investments in services aligned with the Bridge strategy areas and shows those investments from 2026-2034.

The MIDD 2 to BH Bridge Comparison (Attachment 7 to the staff report) compares funding levels for current 2026-27 services with the planned investments under each Bridge Implementation Plan goal area.

Shifts from current funding amounts to planned investment under the Bridge Implementation Plan are summarized below:

- **Care Transitions and Diversion:** The slight reduction in Care Transitions and Diversion reflects a planned shift as some existing programs move to other funding streams, specifically CD-06, Crisis Diversion Services, and CD-11, Children's Crisis Outreach and Response System.
- **SUD Treatment and Recovery:** Increasing SUD investment is essential because growing overdose risks demand more effective, low-barrier care, including significant added funding to expand legally-mandated access to MOUD for people in custody in King County jails. Increased funding in this strategy area will strengthen early intervention and engagement, expand access to a full continuum of treatment, and enhance long-term recovery supports.
- **Equitable Access to BH Care:** A reduction in equitable access funding relative to 2026-2027 reflects a planned shift in the non-Medicaid outpatient benefit payment model and eligibility process while still prioritizing culturally responsive care for communities facing the greatest barriers. These changes are expected to support the non-Medicaid benefit program to support the same amount or more individuals within the proposed budget.
- **Children, Youth, and Young Adults:** Increasing investment in children and youth is critical because rising behavioral health needs in this population require earlier, developmentally tailored supports.

- **Workforce:** Investment is increasing to address persistent recruitment and retention challenges, stabilize provider capacity, and ensure the behavioral health system can effectively implement and sustain the plan's strategies and services.

2. How did the data from MIDD 2 inform the Bridge plan and process?

DCHS reviewed data on enrollment patterns, outcomes, spending, and implementation challenges for MIDD 2 programs during the renewal process. DCHS will incorporate this information, along with assessment data for the current behavioral health landscape**,** along with an analysis of updated population trends and performance indicators and outcome data from MIDD 2 programs, into the procurement development phase. This process will help determine which existing service types and program models are best suited to continue (with updates to align under the Bridge Implementation Plan's strategy areas, goals, and evaluation approach), versus where new or revised models may be procured to meet emerging community needs.

DCHS intentionally refrained from asking the multidisciplinary subject matter expert workgroups that supported the Bridge Implementation Plan's program design to begin their process by evaluating current MIDD programming. This approach allowed workgroups to start from a blank slate**,** generating input based on community identified needs, updated behavioral health data, and the broader system challenges described in the Bridge Implementation Plan, to create a forward-looking investment framework that reflects the needs and priorities of King County residents. Later, during procurement, more recent MIDD program data will be integrated where applicable to align future investments with the proposed Implementation Plan's strategy areas and goals.

3. Please explain how decisions about what does/doesn't get funding are made (e.g., informed by MIDD II data/evaluation or community feedback)?

Building on the process outlined in the Implementation Plan and in the question above that shaped the design of the Bridge Implementation Plan's strategy areas and goals, DCHS intends to continue to use data and feedback to inform the process of procuring and contracting for Bridge-funded services. Procurement development will integrate updated performance information, population level trends, and outcome data from existing MIDD programs. This analysis will help to determine which existing services and program models are strong candidates to continue as Bridge-funded programs (with updates to align under the Bridge Implementation Plan's strategy areas, goals, and evaluation approach); which may be better aligned with other funding sources such as Medicaid or the Crisis Care Centers Levy; and where new or revised models may be required to meet emerging community needs. The renewed process emphasizes the interconnectedness of the proposed goals, alignment with the broader behavioral health system, and responsiveness to significant changes in the funding landscape.

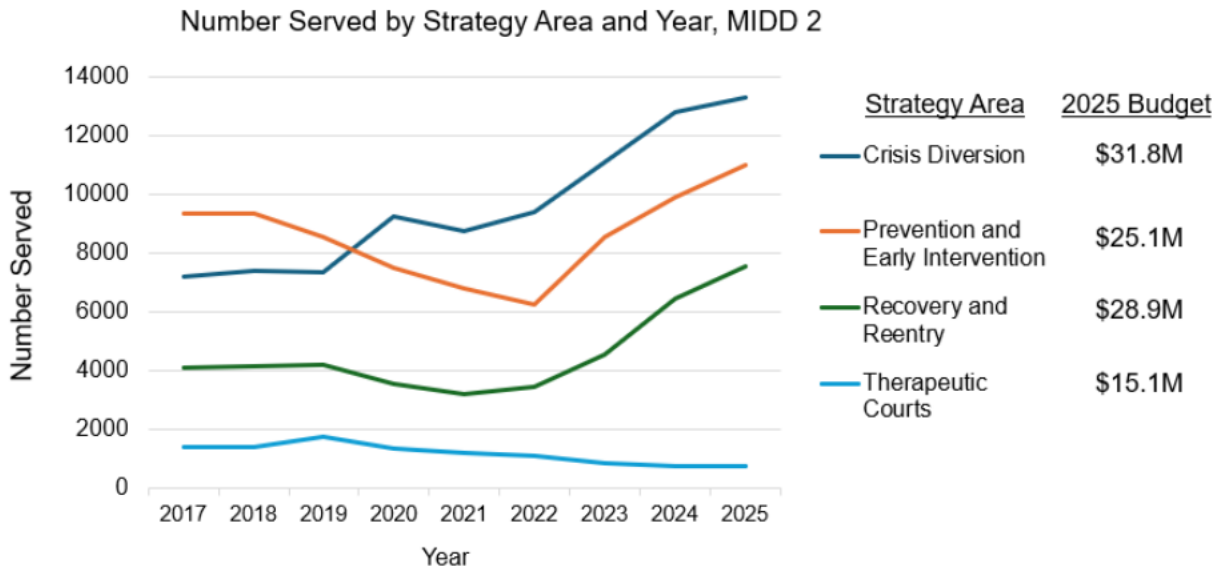
Community feedback also plays a central role in determining funding priorities. Engagement with more than 2,200 residents and providers directly informed the identification of the five strategy areas, the definition of community needs, and the elevation of equity issues across the system. Recommendations from multisector subject matter experts and community participants shaped the strategic direction rather than evaluations of existing services, ensuring that decisions reflect community identified priorities rather than legacy investments. Combined with data analysis, and attention to forthcoming shifts in state and federal funding streams, this ensures that funding decisions remain both evidence informed and responsive to evolving behavioral health needs in King County. Together, community identified needs and subject matter expert insights shaped the Bridge's strategy areas by pinpointing where investments can have the greatest impact in the behavioral health system. As described in the Implementation Plan, Bridge investments will directly impact these areas.

4. Please provide available quantitative data that informed policy decisions in transmitted plan, generally speaking (tables, charts etc. that could be shared with providers) by 7/31.

To inform future investments and strategy areas, DCHS staff conducted an extensive look back at the MIDD 2 implementation and the over 100,000 King County residents who were served since 2017. Staff identified successes and challenges of MIDD implementation, changes to community behavioral health needs over the past decade, and changes in the funding landscape (local, State, and Federal).

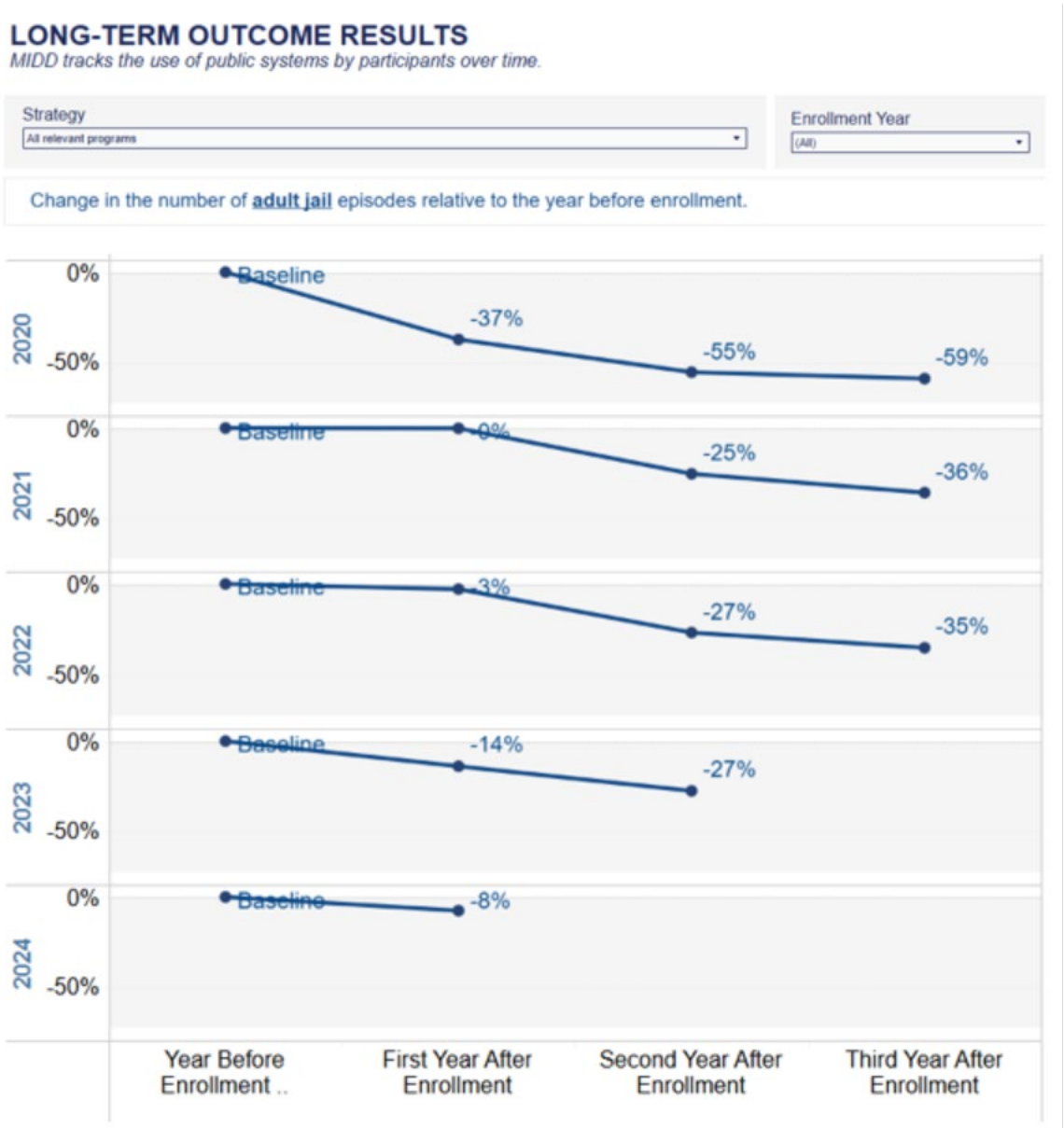
Staff assessed the number of County residents served by MIDD 2 within each strategy area, demographics characteristics of those served, program costs, geographic reach, and outcome data, all within the context of the current behavioral health landscape. The figure below displays the trends in the number of MIDD participants, organized by MIDD 2

strategy area, from 2017-2025.

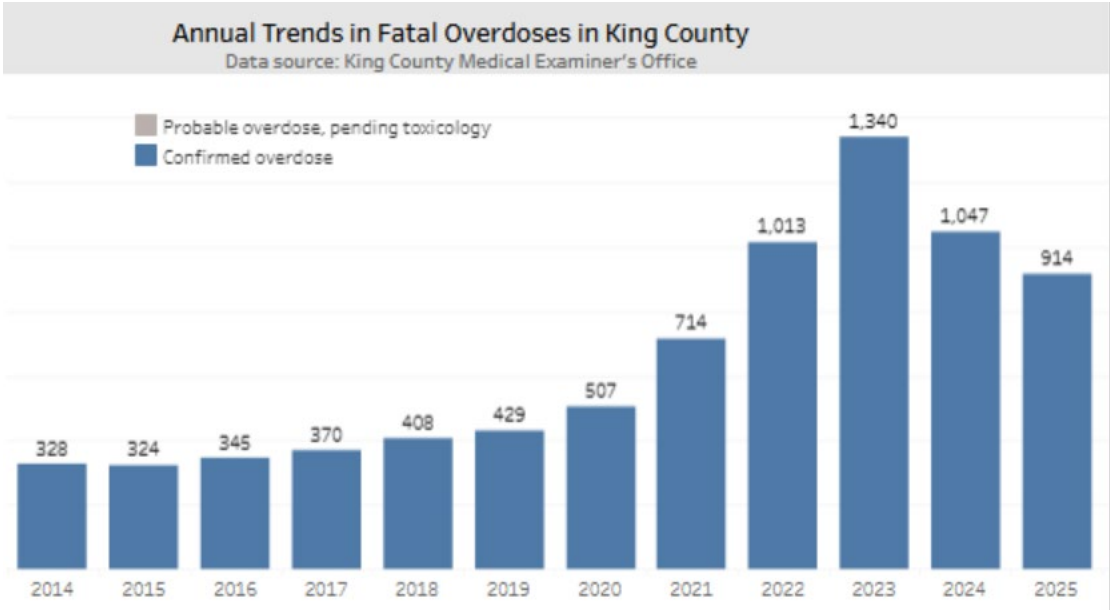


Every year, the MIDD Annual Report Data Dashboard[1] provides detailed information on each initiative that uses sales tax revenue. Long-term outcomes related to crisis episodes, emergency department visits, jail bookings, and psychiatric hospitalizations are displayed on the dashboard and can be filtered to the specific initiatives to which these outcomes pertain. See the example below of jail booking outcome data across the entire MIDD, which shows consistent reductions in jail bookings over the long-term for individuals participating in relevant MIDD programs. These outcomes are assessed over time by cohort (i.e., year) of MIDD 2 program participants. The example below illustrates that among individuals enrolled in relevant MIDD programs in 2020; jail bookings went down by 59% by the third year following their participation. Among individuals enrolled in relevant MIDD programs in 2021, jail bookings went down by 36% by the third year following their participation. This information demonstrates a consistent pattern, year-over-year, of the long-term outcomes for individuals participating in MIDD programs. The data is purely descriptive, however, and the new evaluation framework in the Bridge Implementation Plan will add the ability to assess relative impact across programs and the potential to assess program efficacy. DCHS staff used MIDD 2 data like this, at the strategy area and initiative level, to inform the development of the Bridge Implementation Plan, including its proposed strategy areas and goals and the anticipated activities that DCHS plans to procure.

[1] MIDD Annual Report Data Dashboard, https://kingcounty.gov/MIDDdashboard



In addition to assessing patterns in outcome data for MIDD 2 programming, DCHS staff also assessed the existing behavioral health landscape using available data from Public Health – Seattle and King County (PHSKC) and other entities. For example, as shown below and summarized in the Implementation Plan, fatal overdose rates have increased and remain substantially higher than 2018 levels. This pattern in King County necessitates a renewed focus of behavioral health investments aimed at substance use. Patterns, such as those displayed below, informed the creation of the Substance Use Disorder Treatment and Recovery strategy area and the anticipated activities therein.



Source: Overdose deaths data dashboard, Public Health – Seattle & King County. [LINK]

Further, DCHS staff engaged over 2,200 community members to inform the creation of the Bridge Implementation Plan and identify needs and gaps in the King County behavioral health system (for more detail, see the Phase One Community Engagement Report[2]). This engagement process sought insight into how the Bridge might enhance behavioral health care for community members, reduce substance use risks (including overdose), improve the behavioral health workforce, and support integrated care. Community members who participated represented every King County Council district. The most oft-cited recommendations from community members were collapsed into major themes and summarized as follows:

1. Increase Access & Reduce Barriers
2. Strengthen Culturally Relevant & Responsive Care
3. Reduce System Fragmentation & Improve Service Coordination
4. Strengthen and Increase Services for Children, Youth, and Young Adults
5. Strengthen and Expand the Behavioral Health Workforce
6. Strengthen Wraparound Services

5. What is the proportion of funding going to different strategies under exec's proposed IP?

[2] Phase One Community Engagement Report, https://cdn.kingcounty.gov/-/media/king-county/depts/dchs/behavioral-health-recovery/midd/midd-renewal-community-engagement-report-final-2025.pdf?rev=158a78c33eab4cdda443da39d874f040&hash=3EDD11B4F9CAF6A7C4BDDCB16EAFF1FD

The figure below shows each strategy area and the total amount of Bridge revenue to be invested in each area during the 2028-34 implementation period.

Behavioral Health Bridge Sales Tax Approximate Allocation by Strategy (2028 - 2034)		Percentage of funding invested
	Total (millions)	
Strategy Area 1: Care Transitions and Diversion Services	**$244.4**	31%
Strategy Area 2: SUD Treatment and Recovery	**$149.6**	19%
Strategy Area 3: Equitable Access to Behavioral Health Care	**$122.9**	15%
Strategy Area 4: Child, Youth, and Young Adult Mental Wellbeing	**$87.8**	11%
Strategy Area 5: Behavioral Health Workforce Development	**$44.3**	6%
Technical Assistance & Capacity Building	**$4.0**	1%
Administration & Compliance	**$64.8**	8%
Performance Measurement & Evaluation	**$19.0**	2%
Behavioral Health Fund Transfer:	**$60.9**	8%
Total Behavioral Health Bridge Sales Tax Costs	**$797.7**	

NOTE: Numbers above may not sum exactly due to rounding.
To see a breakdown of the investments by year, please see the Implementation Plan, page 50, Figure 23.

6. What are trade-offs of new funding strategies, what are we potentially not funding; explanation of why we are prioritizing some areas over others.

The Behavioral Health Bridge Implementation Plan generally organizes the services supported by the fund to align under new strategy areas and goals, without excluding types of services funded under MIDD 2 from eligibility for future funding. Most service types funded under MIDD 2 align with the Behavioral Health Bridge strategy areas and goals. To

ensure an equitable and accountable process, most Bridge services will be competitively reprocured starting in 2028, with the exception of services directly operated by King County, such as therapeutic courts and some public health programs.

As described further in the Implementation Plan Section IV, page 13-16 and in the responses to Batch 2 questions 1, 2, and 4[3], the selected strategy areas are prioritized because they emerged from an 18-month, comprehensive process that included a thorough behavioral health landscape assessment, extensive community engagement, and consultation with subject matter experts. This deliberate approach ensured that priorities in the Implementation Plan reflect the most pressing community needs. This process helped identify strategies that are positioned to create meaningful improvement on key issues and needs in behavioral health in King County, given the limited amount of funding available through the Bridge.

7. Please provide more information about what programs utilize braided funds (and rationale for combined funding approach) and the rationale for 'unbraiding' some program funding for the Bridge.

Historically, services have been structured with braided funding when the County wished to respond to an urgent or newly emerging community need, but no single funding stream had sufficient funding available to fund the requested program or service in its entirety. As the County has added or renewed several local funding streams in human services and behavioral health since the 2017 renewal of the MIDD fund, the Bridge renewal presents an opportunity to start to shift programs to single sources of local funding where possible. This approach is intended to streamline administration and oversight while enhancing transparency and accountability. It also supports the Executive's priority of shifting from a collection of disparate programs to a thoughtfully planned and integrated system.

The chart below shows the MIDD 2 investments that have associated braided funding in 2026-27, with information about what other funding streams currently support each service.

At this time, DCHS does not have information about the presence or absence of braided funding in programs that receive direct appropriations from Council and are administered by courts or other criminal legal system agencies.

[3] These are questions 2, 3, and 4 in Attachment 6.

MIDD Initiative	Program Title- Official	Managing Division/ Department	Type of funding								OTHER - NON STATE, NON LOCAL [includes Juul/Atria settlement, Raikes Foundation, Opioid settlement]
			OTHER FEDERAL	MEDICAID	BHASO	OTHER STATE	CCC	BSK	VSHSL	OTHER LOCAL	
TX-ADC	Adult Drug Court	BHRD			Yes						
RR-02	Community Center for Alternative Programs (CCAP)	BHRD				Yes					
CD-10	Emergency Telephone Services - Regional Crisis Line	BHRD		Yes	Yes						
SP-14 & RR-13	Familiar Faces Intensive Case Management (VITAL)	BHRD			Yes						
CD-13	Family Intervention Restorative Services	BHRD								Yes	
CD-13	Functional Family Therapy (FFT)	BHRD				Yes				Yes	
RR-12	Jail SUD Assessment Services	BHRD			Yes						
PRI-02	Juvenille Justice Youth Behavioral Health Assessments	BHRD				Yes					
RR-01	KC Housing and Recovery Through Peer Services (HARPS)	BHRD	Yes		Yes	Yes					
CD-01	Law enforcement Diversion (LEAD)	BHRD								Yes	
TX-SMC	Legal Intervention & Network of Care (LINC)	BHRD			Yes	Yes					
CD-13	Multisystemic Therapy (MST)	BHRD				Yes				Yes	
CD-10	Next Day Appointments (MH)	BHRD			Yes	Yes					
PRI-04	Geriatric Regional Assessment Team	BHRD							Yes		
PRI-11	Older Adult Substance Use Disorder Services	BHRD								Yes	
RR-11A	Peer Bridger	BHRD				Yes					
SI-03	Program for Assertive Community Treatment (PACT)	BHRD	Yes		Yes	Yes				Yes	
SP-09	Recovery High School	BHRD			Yes			Yes			
SP-09	Recovery Navigator Program	BHRD			Yes						
PRI-11	RSN Clubhouse Services	BHRD		Yes							
PRI-05	School-based SBIRT	BHRD						Yes			
PRI-11	Sobering Services	BHRD	Yes								
PRI-11	Standard Supportive Housing	BHRD		Yes							
CD-11	Youth Mobile Crisis Team (MRSS)	BHRD	Yes	Yes	Yes		Yes			Yes	
SP-01	Youth Support Services	BHRD			Yes					Yes	
CD-07H	Jail-based Methadone Dosing	PHSKC				Yes					
CD-03	Healthcare for the Homeless Network (HCHN)	PHSKC	Yes	Yes		Yes				Yes	Yes
CD-14	Opioid-Related Surveillance & Evaluation	PHSKC	Yes								Yes
CD-07	Street Medicine Team - Behavioral Health Specialist	PHSKC	Yes								

8. What's the proportion of administration funding under MIDD II compared to the Bridge proposal?

The figure below shows the proportion of administration funding reflected in the Bridge Implementation Plan in comparison to MIDD 2026-27 administration funding for MIDD 2 in 2026-27.

	Time Period	*Approximate Proportion*	*Total Amount*	*Average Annual Amount*
MIDD 2 (current budget)	2026-27	6%	$15M over 2 years	$7.5M
Bridge (implementation plan)	2028-34	8%	$64.8M over 7 years	$9.3M

In 2026-27, MIDD funding for administration is just above 6%, excluding evaluation functions. Under the Bridge Implementation as proposed, administration constitutes just below 8% of total planned expenditures for the 7-year planning period. The new implementation plan increases allocations to ensure the Bridge has sufficient staffing and systems capacity to meet audit aligned standards of oversight, strengthen contract monitoring, and improve data measurement and evaluation consistent with Better Government priorities. This includes expanding administrative and evaluation infrastructure to support a more rigorous procurement process, enhanced fiscal controls, continuous quality improvement, and expanded cross agency coordination.

9. Please provide a comparison between current and proposed workforce investments and corresponding dollar amounts.

MIDD/Bridge Workforce Investments Comparison			
Initiative/ Funding Stream	**Dollar Amount**	**Investment Period**	**Investment Description**
MIDD Sales Tax	$6.7M	2017-2027	**SI-04: Workforce Development** • Workforce Development supports providers to receive specialized training in clinical skills, such as Dialectical Behavior Therapy. This initiative also funds the annual umbrella license for SUD youth treatment providers to implement the evidence-based program, Seven Challenges. It also supports Seven Challenges national trainers to work with the

			agencies by facilitating quarterly meetings and an annual fidelity meeting.
BRIDGE Sales Tax *Proposed*	$36.4M	2028-2034	**Goal 1: Strengthen and diversify the behavioral health provider pipeline** • Activity: Build pathways to behavioral health careers • Activity: Support high-quality behavioral health clinical internships **Goal 2: Advance and develop skills of the current workforce to meet growing community needs** • Activity: Clinical supervision • Activity: Continuing education for community behavioral health providers, including expansion of King County Integrated Care Network (KCICN) Training Academy in Evidence-Based Practices and other culturally relevant clinical modalities effective for BHRD population

10. Undesignated fund balance – please provide more information on what the proposal is for dealing with undesignated fund balance and alternative policy options.

Section IX.C of the Bridge Implementation Plan addresses priorities for allocating undesignated fund balance, including how such allocations remain subject to the County's budget process. The relevant section of the plan is excerpted below.

Priorities for allocating undesignated fund balance

This part of this subsection describes the process for prioritizing allocations of undesignated fund balance. Undesignated fund balance may result from circumstances such as, but not limited to, Behavioral Health Bridge revenue exceeding this plan's revenue projections or Bridge revenue becoming available because other funding sources (including federal, state, or philanthropic sources) are contributing funding toward Bridge strategy areas and goals at a higher level than anticipated. Expenditures of Behavioral Health Bridge revenues allocated through this prioritization remain subject to the appropriation limits authorized through the County's budget process. Any proposals requiring additional appropriation will be proposed by the Executive in budget ordinances and be subject to County Council deliberation and adoption. The Executive will assess whether undesignated fund balance is the result of one-time fund availability or represents an opportunity for long-term, sustainable investment.

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

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

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

11. Regarding the timeline for making decisions, is there a need to implement some strategies prior to the 2-year extension?

The Executive requests that Expenditure Restriction ER6 governing expenditures during 2026-2027 be left in place, and that the Bridge Implementation Plan go into effect at the beginning of 2028 as proposed. As discussed further below, retaining the proposed Implementation Plan time period would enable the Executive branch to begin planning for the renewed Bridge, including its phased procurements, during 2027 ahead of the plan's effective date.

The Executive supports any Council consideration timeline for the Bridge Implementation Plan that results in adoption by December 31, 2026, provided staffing for the renewed Bridge that is needed in 2027 to plan for procurements is adopted through the 2nd omnibus supplemental budget that will be transmitted to the Council this fall.

To support the procurement strategy that is necessary to carry out the strategies in the Implementation Plan, the Executive anticipates proposing additional staffing for Bridge

implementation planning through the 2nd omnibus, to begin in 2027. Section V.B of the plan describes the design of the procurement process, including planned phases and anticipated development and implementation steps. The procurement process will follow standard departmental procurement procedures, including new safeguards that DCHS is implementing to respond to the results of a 2025 KCAO audit of the department. As also described in the response to Batch 2 question 9[4], procurements for each strategy area are anticipated to be publicly announced approximately one year in advance of the launch of new or reprocured programs within that strategy area. This timeline allows time for an application period, review period, transition or ramp-down period where applicable, and the thoughtful transfer of program participants to new providers as necessary.

12. Please summarize any providers feedback about changing the procurement process for the Bridge and need for more measurable outcomes.

Providers played an important role in shaping the planned shift to competitive procurement during the renewal process. Through listening sessions and SME workgroups, providers emphasized that the provider landscape has shifted over the years and that there is a need for transparent and equitable procurement processes and expressed support for revisiting longstanding program models to better reflect current behavioral health needs. Providers also called for using data to determine the services to provide which directly informed the Implementation Plan's strengthened performance measurement approach, including logic models, goals, and outcomes.

13. How many contracts does MIDD currently have and how many contracts is the Bridge aiming to have?

In 2025, MIDD's 52 initiatives involved 312 contracts across 166 different partners. DCHS anticipates conducting an average of 2-3 procurements per Bridge goal in 2028-2029, using the phased procurement approach outlined in the Implementation Plan. The number of applicants, the number of provider partners necessary to deliver a sufficient scope and range of services, and the amounts that applicants request will all be factors in determining the number of Bridge contracts in 2028-34.

14. How is the provider community being made aware of the changes proposed by the new implementation plan, such as RFP/procurement approach and transition timing for new/continuing and noncontinuing programs from MIDD II? Please provide information about your communications plan.

[4] This is question 15 in Attachment 6.

The Bridge serves as a hub across the region for behavioral health providers, and throughout the process of extending the MIDD behavioral health sales tax and developing the implementation plan, the planning team has engaged providers in every step of the process. In 2027, DCHS will develop a plan to engage the provider community. The plan is expected to build on measurable outcomes and community engagement strategies that informed the sales tax extension, which include:

- Engaging with the MIDD Advisory Board, Behavioral Health Advisory Board, and the King County Integrated Care Network to bring providers along in the planning, procurement process, and forthcoming procurement timelines per the implementation plan.
- Partnering with regionally based behavioral health providers and human services coalitions (e.g. King County Human Services Alliance) and partner groups to host planning session on "what to expect" for upcoming procurement opportunities.
- Facilitating workgroups, which may consist of providers, County staff, and Councilmembers on specific topics to help inform upcoming procurements and inform the provider community about the rounds of procurements by quarter as outlined in the implementation plan.
- Sharing data with KCICN providers (who are also Bridge providers) to illustrate the needs and impacts of Bridge investments across the strategy areas.
- Conducting surveys to ensure provider voices are incorporated throughout the procurement process
- Providers will be informed about changes through DCHS' communication channels, which include, but are not limited to, the Cultivating Connections department blog, department social media accounts, and email lists specific to MIDD renewal community engagement and MIDD renewal updates.

15. Will providers know in advance if their work was going to continue under the Bridge?

In preparing for the transition to the Behavioral Health Bridge, DCHS will continue sharing information about the strategy areas, goals, and anticipated activities. This information will help providers understand what goal areas are most relevant to the work they do and when those procurement processes open. When procurements are announced for each strategy area, current providers will be able to evaluate whether their current services are a good fit for the planned RFPs or not. DCHS intends to fund the availability of technical assistance to all potential applicants for Bridge funds, to help providers understand the scope of the procurement and any differences from the services they currently provide. In cases where current programs are not a strong match to a Bridge procurement, providers may choose to apply with modified programming approaches, parameters, or focus populations, or

they may opt to seek funding elsewhere. DCHS intends to announce Bridge procurements a year in advance of planned program launch, so that providers who choose not to apply or who are not selected in the Bridge procurement have enough time to identify other funding or prepare to ramp down their programs if needed.

16. Please provide the rationale for switching from an annual to a biennial reporting cadence.

The proposed transition to biennial narrative reports is intended to redirect Executive branch staff resources to increase continuous improvement and taking action to use information on program performance and outcomes to make adjustments when needed. However, the shift to biennial transmitted reports does not replace annual monitoring or accountability. The proposed implementation plan continues the same frequency of accountability and transparency by complementing transmitted reports with annual dashboard updates accompanied by Council briefings each year.

17. Can you confirm that it is the intention of the Exec to align the procurement process with the anticipated activities in the logic models?

Yes, this is the Executive branch's intention. Procurements will align with the plan's strategy areas, goals, and anticipated activities, as outlined in the logic models. In some cases, a single procurement may encompass multiple related activities to best support the goals of the strategy area.

18. Are there Bridge programs that are operated by DCHS? If so, are they not planned to receive a base budget analysis?

DCHS staff do not provide direct services in any current MIDD programs. All County agencies, including DCHS, are expected to participate in the Executive Office's base budget analysis process described in Executive Order "Better Governance and Financial Management" from March 4, 2026. The program level base-budget analyses planned for non-DCHS managed MIDD/Bridge programs are also responsive to the Executive Order but will provide more specialized and detailed analysis.

Strategy Area	Goal	MIDD 2 Initiatives currently aligned with anticipated activities	2026	2027	2028	2029	2030	2031	2032	2033	2034
Care Transitions and Diversion Services (CTD)	CTD 1. Divert people from criminal-legal involvement, provide supportive services for those involved in the legal system, and support successful community reentry.	CD-01, CD-14, CD-18A, CD-18B , RR-06A, RR-06B, RR-13, PRI-08, TX-ADC (including RR-05), TX-SMHC, TX-RMHC, TX-FTC, TX-CC	$27.2	$27.3	$25.8	$24.0	$24.6	$25.1	$25.7	$26.2	$26.8
	CTD 2. Help people with behavioral health conditions achieve and maintain stable housing.	RR-01, RR-03	$5.9	$6.1	$5.7	$5.0	$5.1	$5.3	$5.4	$5.5	$5.7
	CTD 3. Enhance navigation and system coordination so that people receive timely and appropriate behavioral health services across all levels of care.	RR-11A, RR-08, CD-10, SI-03	$6.8	$7.2	$5.2	$3.5	$3.6	$3.7	$3.8	$4.2	$4.5
	CTD Total		$39.8	$40.5	$36.7	$32.5	$33.3	$34.1	$34.9	$35.9	$36.9
SUD Treatment and Recovery (SUD) Strategy Area	SUD 1. Drive engagement and retention in SUD care.	PRI-01, CD-03	$1.3	$1.4	$1.70	$2.2	$2.3	$2.4	$2.4	$2.5	$2.5
	SUD 2. Provide effective, low-barrier SUD treatment that meets people's holistic needs.	CD-07, RR-12	$7.9	$8.1	$15.60	$16.3	$16.8	$17.3	$17.7	$18.1	$18.5
	SUD 3. Support paths to achieve and maintain recovery after treatment.	RR-04, RR-09, RR-10, RR-11B	$2.8	$2.9	$2.10	$1.6	$1.7	$1.7	$1.8	$2.1	$2.4
	SUD Total		$12.0	$12.3	$19.50	$20.2	$20.8	$21.4	$21.9	$22.6	$23.4
Equitable Access to Behavioral Health Care (EA) Strategy Area	EA 1. Provide behavioral health care for low-income people who are ineligible for Medicaid.	PRI-11	$16.0	$16.6	$12.0	$12.3	$12.7	$13.0	$13.3	$13.6	$13.9
	EA 2. Support the wellbeing of diverse communities by providing culturally and linguistically responsive services and removing barriers to care.	SI-01, SI-02, PRI-07, PRI-09, PRI-10	$4.2	$4.4	$4.1	$4.2	$4.3	$4.5	$4.6	$5.0	$5.3
	EA Total		$20.3	$21.0	$16.1	$16.5	$17.0	$17.5	$17.9	$18.6	$19.2
Child, Youth, and Young Adult Mental Wellbeing (CYYA) Strategy Area	CYYA 1. Improve youth access to behavioral health care by providing developmentally appropriate services that meet young people where they are, at school and in community	PRI-05, CD-17	$3.6	$3.7	$3.5	$4.0	$4.5	$4.6	$4.7	$4.9	$5.0
	CYYA 2. Provide behavioral health and therapeutic services to youth involved in the legal system, including diversion from deeper legal system involvement.	CD-02A, CD-02B, CD-13, PRI-02, TX-JTRAC-BHR	$5.3	$5.5	$5.2	$4.9	$4.7	$4.8	$5.0	$5.1	$5.2
	CYYA 3. Invest in the behavioral health of youth who are marginalized or experience inequities.	CD-08, CD-12, CD-15	$2.9	$2.7	$2.6	$2.8	$3.0	$3.1	$3.1	$3.5	$3.8
	CYYA Total		$11.8	$12.0	$11.2	$11.7	$12.2	$12.5	$12.8	$13.4	$13.9
Behavioral Health Workforce Development (WF) Strategy Area	WF 1. Strengthen and diversify the behavioral health provider pipeline.		$0.0	$0.0	$0.0	$2.5	$2.5	$2.6	$2.7	$2.9	$3.0
	WF 2. Advance and develop the skills of the current workforce to meet growing community needs.	SI-04	$1.4	$1.4	$1.3	$4.1	$4.2	$4.4	$4.5	$4.7	$4.9
	WF Total		$1.4	$1.4	$1.3	$6.6	$6.8	$7.0	$7.1	$7.6	$8.0

Consistent with the King County Behavioral Health Bridge Implementation Plan, amounts in this table are rounded to the nearest $100,000.

ATTACHMENT 8: MIDD 2 INITIATIVE REFERENCE FOR ATTACHMENT 7

This attachment provides a list of MIDD 2 initiatives as a reference to the information provided in Attachment 7. Initiatives that are aligned with anticipated Bridge activities as indicated in Attachment 7 are indicated with an asterisk. Initiatives that are not listed as aligned with Bridge activities in Attachment 7 are indicated with a light gray highlight.

Prevention and Early Intervention Initiatives

PRI-01: Screening, Brief Intervention and Referral to Treatment*

PRI-02: Juvenile Justice Youth Behavioral Health Assessments*

PRI-03: Prevention and Early Intervention Behavioral Health for Adults Over 50

PRI-04: Older Adult Crisis Intervention/Geriatric Regional Assessment Team

PRI-05: Collaborative School Based Behavioral Health Services: Middle and High School Students*

PRI-06: Zero Suicide Initiative Pilot

PRI-07: Mental Health First Aid*

PRI-08: Crisis Intervention Training – First Responders*

PRI-09: Sexual Assault Behavioral Health Services*

PRI-10: Domestic Violence Behavioral Health Services and System Coordination*

PRI-11: Community Behavioral Health Treatment*

Crisis Diversion Initiatives

CD-01: Law Enforcement Assisted Diversion*

CD-02A: Youth Connection Services*

CD-02B: Family Court Services Behavioral Health Program*

CD-03: Outreach and In Reach System of Care*

CD-04: South County Crisis Diversion Services/Center

CD-05: High Utilizer Care Teams

CD-06: Adult Crisis Diversion Center, Respite Beds, and Mobile Behavioral Health Crisis Team

CD-07: Multipronged Opioid Strategies*

CD-08: Children's Domestic Violence Response Team*

CD-09: Behavioral Health Urgent Care Walk-In Clinic

CD-10: Next-Day Crisis Appointments*

CD-11: Children's Crisis Outreach Response System

CD-12: Parent Partners Family Assistance*

CD-13: Family Interventions Restorative Services*

CD-14: Involuntary Treatment Triage*

CD-15: Wraparound Services for Youth*

CD-16: Youth Behavioral Health Alternatives to Secure Detention

CD-17: Young Adult Crisis Facility*

CD-18A: Regional Crisis Response*

CD-18B: Therapeutic Response Unit*

Recovery and Reentry Initiatives

RR-01: Housing Supportive Services*

RR-02: Behavior Modification Classes at Community Center for Alternative Programs

RR-03: Housing Capital and Rental*

RR-04: Rapid Rehousing Oxford House Model*

RR-05: Housing – Adult Drug Court*

RR-06A: Jail Reentry System of Care*

RR-06B: Jail Coordinated Discharge*

RR-07: Behavioral Health Risk Assessment Tool for Adult Detention

RR-08: Hospital Reentry Respite Beds*

RR-09: Recovery Café*

RR-10: Behavioral Health Employment Services and Supported Employment*

RR-11A: Peer Bridger Programs*

RR-11B: Substance Use Disorder Peer Support*

RR-11C: Peer Respite

RR-12: Jail-Based Substance Abuse Treatment*

RR-13: Deputy Prosecuting Attorney for Familiar Faces*

RR-14: Shelter Navigation Services

RR-15: Pretrial Assessment and Linkage Services (PALS)

System Improvement Initiatives

SI-01: Community-Driven Behavioral Health Grants for Cultural and Ethnic Communities*

SI-02: Behavioral Health Services in Rural King County*

SI-03: Quality Coordinated Outpatient Care*

SI-04: Workforce Development*

SI-05: Emerging Issues

Therapeutic Court Initiatives

TX-ADC: Adult Drug Court*

TX-FTC: Family Treatment Court*

TX-JTRAC-BHR: Juvenile Therapeutic Response and Accountability Court - Behavioral Health Response*

TX-RMHC: Regional Mental Health Court*

TX-SMC: Seattle Mental Health Municipal Court*

TX-CC: Community Courts*

Behavioral Health Bridge Briefing

Liz Arjun, Behavioral & Public Health Policy Advisor, King County Executive Office
Susan McLaughlin, Director, DCHS
Isabel Jones, Acting Director, Behavioral Health and Recovery Division, DCHS

Regional Policy Committee

August 26, 2026

King County
DCHS
Department of Community and Human Services

Agenda

- Development of the Implementation Plan
  - Community engagement behind the plan
- What's Different
  - Updated 5 strategy areas
  - Procurement for DCHS
  - One County Approach to Outcomes, Measures, and Accountability
- Procurement Timeline and Process
- Inflation Analysis

Implementation Plan Development Steps

Behavioral Health Landscape Assessment
Identified successes, gaps, and areas of concern

Multi-Sector Subject Matter Expert Workgroups
Explored potential investments and provided recommendations

Executive Office Alignment
Developed a package of anticipated investments that sustains past successes and meets current and future community needs

Community Engagement
Identified themes related to community members' concerns over 18 months (June 2024-November 2025.)

DCHS Subject Matter Expert Workgroups
Evaluated recommendations to assess feasibility, cost, equity, and alignment with the County's broader vision for behavioral health

MIDD Advisory Committee Engagement Throughout

Community and Subject Matter Expert Engagement

King County

DCHS

Department of Community and Human Services

Community Engagement Overview

- Over 2200 people engaged over 18 months through listening sessions, community events, and an online survey in 21 languages.
- Half of people engaged were BIPOC, including Black, Latinx, AAPI, Middle Eastern, and Native/Indigenous.
- Significant engagement from youth, elders, LGBTQIA+ people, people with lived experience, and people who are incarcerated.

Engagement took place across all 9 districts of King County from June 2024 to November 2025.

Engaging Subject Matter Experts

Multi-sector subject matter expert (SME) workgroups

- One workgroup for each strategy area, consisting of **over 100 subject matter experts.**
- They produced a set of **preliminary goals and investment ideas** to improve behavioral health for King County residents.
- Staff at DCHS, Public Health, and the Executive Office **evaluated and refined** the results.

The result: An implementation plan with 13 goals and a set of anticipated activities that respond to the most pressing needs in King County's behavioral health system.

Executive Office Alignment & Priorities

- **Implement a countywide approach with an emphasis on integration** of behavioral health services and crisis response systems, as well as services for people who are incarcerated, hospitalized, or unhoused.
- **Promote overall accountability across county investments** that will respond to behavioral health needs across different systems, through competitive procurements and other accountability mechanisms.
- **Make stronger investments with data-driven decisions** that have clear performance goals across multiple systems, including the criminal-legal system.

King County DCHS Department of Community and Human Services

What's New

King County

DCHS

Department of Community and Human Services

BH Bridge Investment Considerations

- Investments respond to changing fiscal projections throughout implementation in 2028-2034.
- Introduction of a reserve to create flexibility during anticipated sales tax volatility.
- Strengthen monitoring and compliance by right-sizing staffing to support the investment of $100M per year.

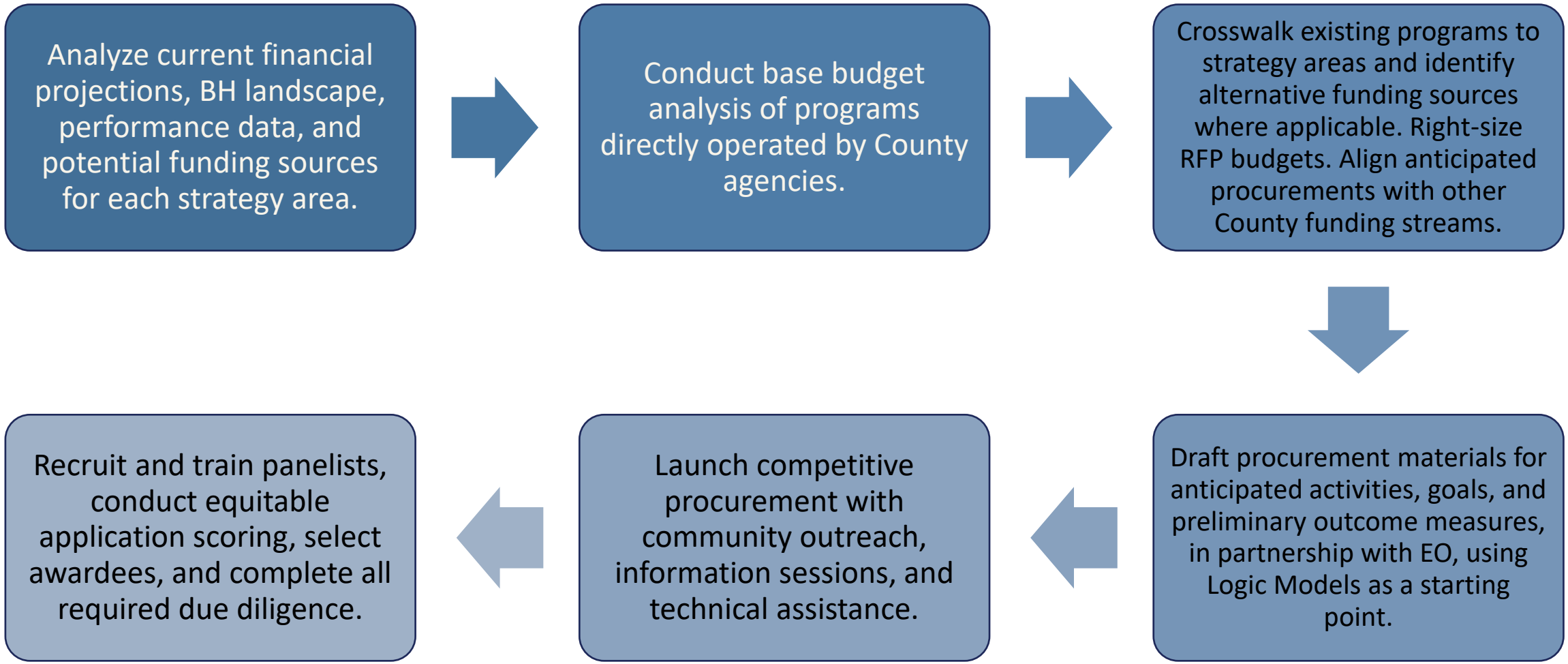
BH Bridge Strategy Areas

1. Care Transitions & Diversion Services
2. Substance Use Disorder Treatment and Recovery
3. Equitable Access to Behavioral Health Care
4. Child, Youth, and Young Adult Mental Wellbeing
5. Behavioral Health Workforce Development

Countywide Approach to Accountability and Outcomes

- Five strategy areas with specific goals and identified measures.
- Competitive procurement process for DCHS programs.
- One County approach with Executive Office to measure, monitor and support accountability.

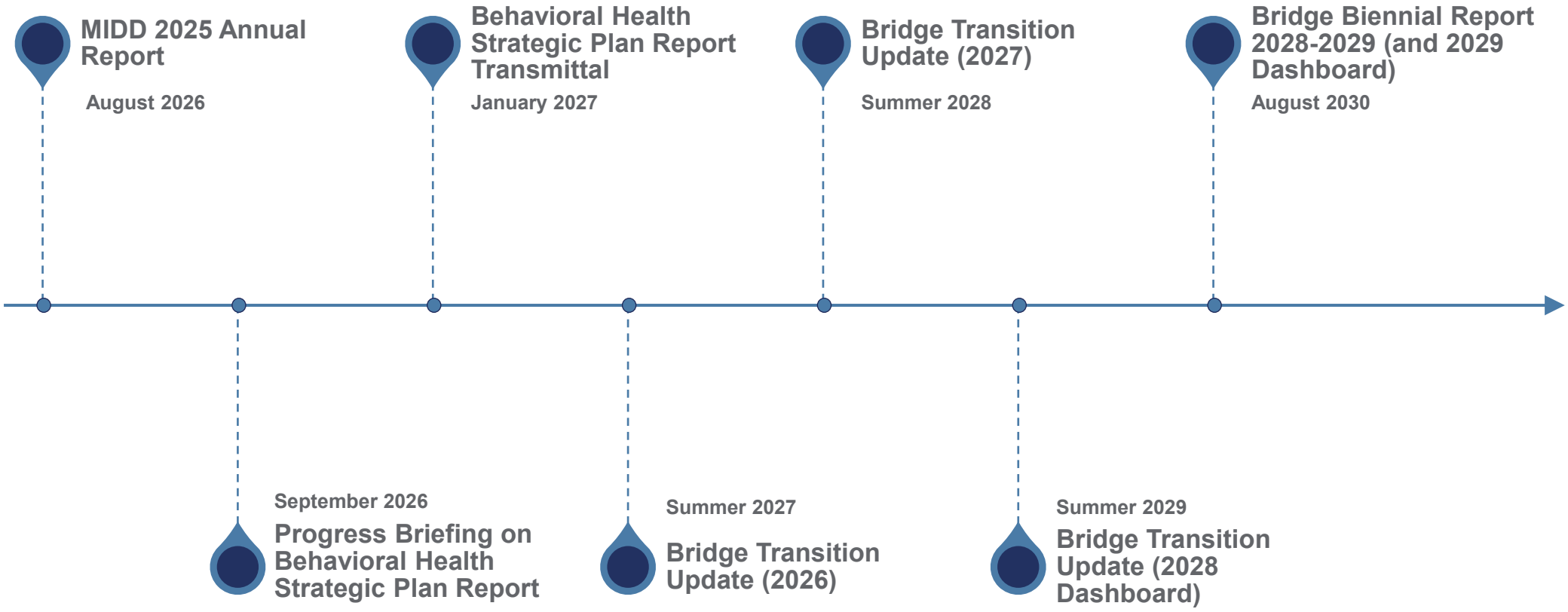
Anticipated Steps to Procurement



Estimated Timeline for Phased Procurements and Non-Funded Program Ramp-Down

Strategy area	Procurements announced	Applications due & Selection process	Successful applicants announced	Ramp down for MIDD 2 programs no longer receiving funding	Anticipated launch of programs (reprocured or with new base budget)
SUD Treatment and Recovery (SUD)	Q2 2027	Q3 2027	End of Q4 2027	Q 1& 2 of 2028	Q3 of 2028
Equitable Access to Behavioral Health Care (EA)	Q2 2027	Q3 2027	End of Q4 2027	Q 1& 2 of 2028	Q3 of 2028
Care Transitions and Diversion Services (CTD)	Q4 2027	End of Q1 2028	End of Q2 2028	Q 3 & 4 of 2028	Q1 of 2029
Behavioral Health Workforce Development (WF)	Q4 2027	End of Q1 2028	End of Q2 2028	Q 3 & 4 of 2028	Q1 of 2029
Child, Youth, and Young Adult Mental Wellbeing (CYYA)	Q2 2028	End of Q3 2028	End of Q4 2028	Q 1 & 2 of 2029	Q3 of 2029

Upcoming Reports and Briefings



Inflation Analysis

King County

DCHS

Department of Community and Human Services

Inflation Analysis in this Plan

Responsive to Council Budget Proviso

- DCHS integrates provider inflation rate adjustments into implementation plans and budget proposals for local funds to:
  - Support human services providers to maintain service levels/retain workers.
- Expenditure growth is predicted to outpace revenue growth.
- Implementation plan establishes sustainable Bridge spending for 2028-34 by:
  - Planning expenditures to fit within anticipated 7-year revenue total
  - Reducing inflation adjustments when a revenue drop is anticipated (2029) but maintaining them otherwise.

Frequently Asked Questions

King County

DCHS

Department of Community and Human Services

Frequently Asked Questions

- **Will the Bridge invest equitably across the County?**
  - Future Bridge investments are expected to maintain or improve behavioral health service availability across the County through countywide services and targeted investments in both urban and rural areas.
- **Why shift from annual to biennial narrative reports?**
  - The proposed IP continues annual dashboard updates accompanied by Council briefings each year. The proposed transition to biennial narrative reports is intended to redirect Executive branch staff resources to increase continuous improvement.

King County DCHS Department of Community and Human Services

Questions?

King County

DCHS

Department of Community and Human Services

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

King County

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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

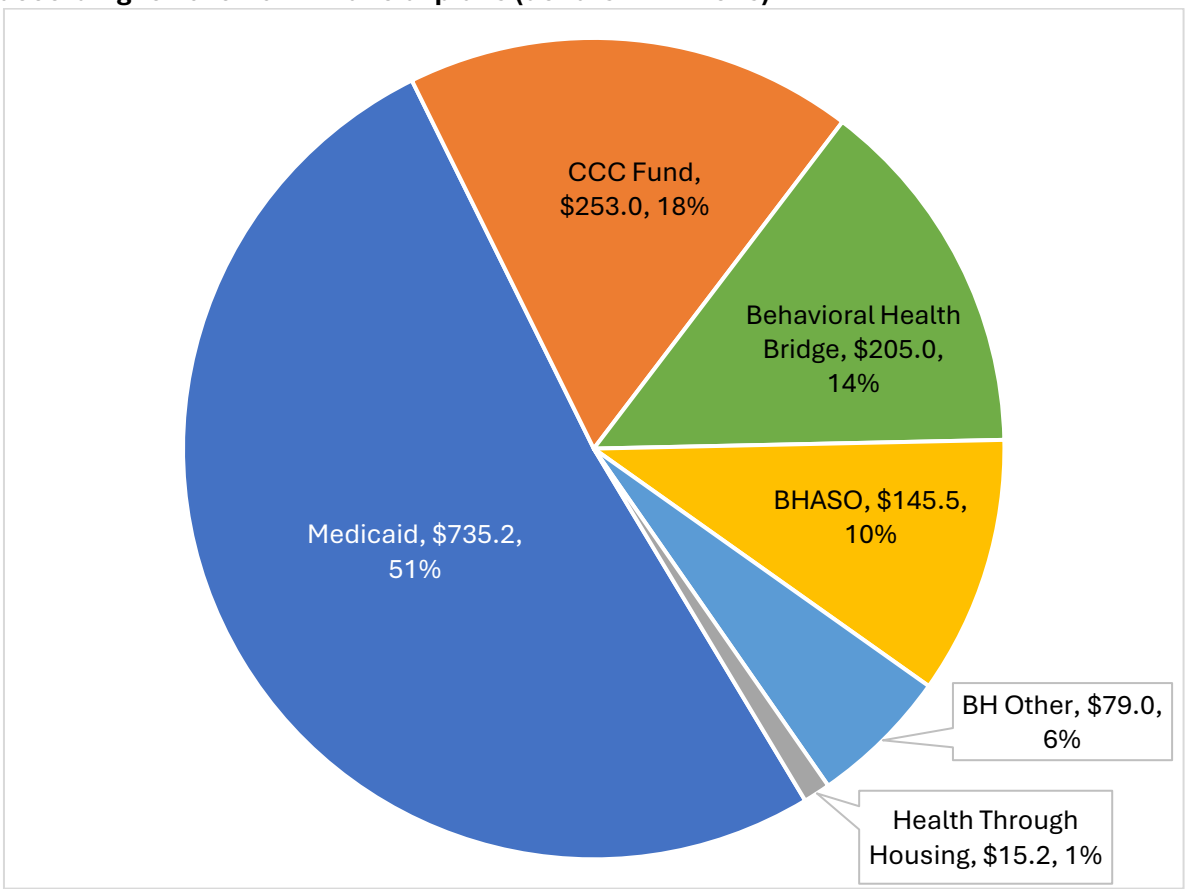
DCHS' Behavioral Health and Recovery Division (BHRD) oversees the public behavioral health system in King County, which includes managing and implementing the Behavioral Health Bridge sales tax and the Crisis Care Centers (CCC) Levy. In addition to the Behavioral Health Bridge sales tax and the CCC Levy,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

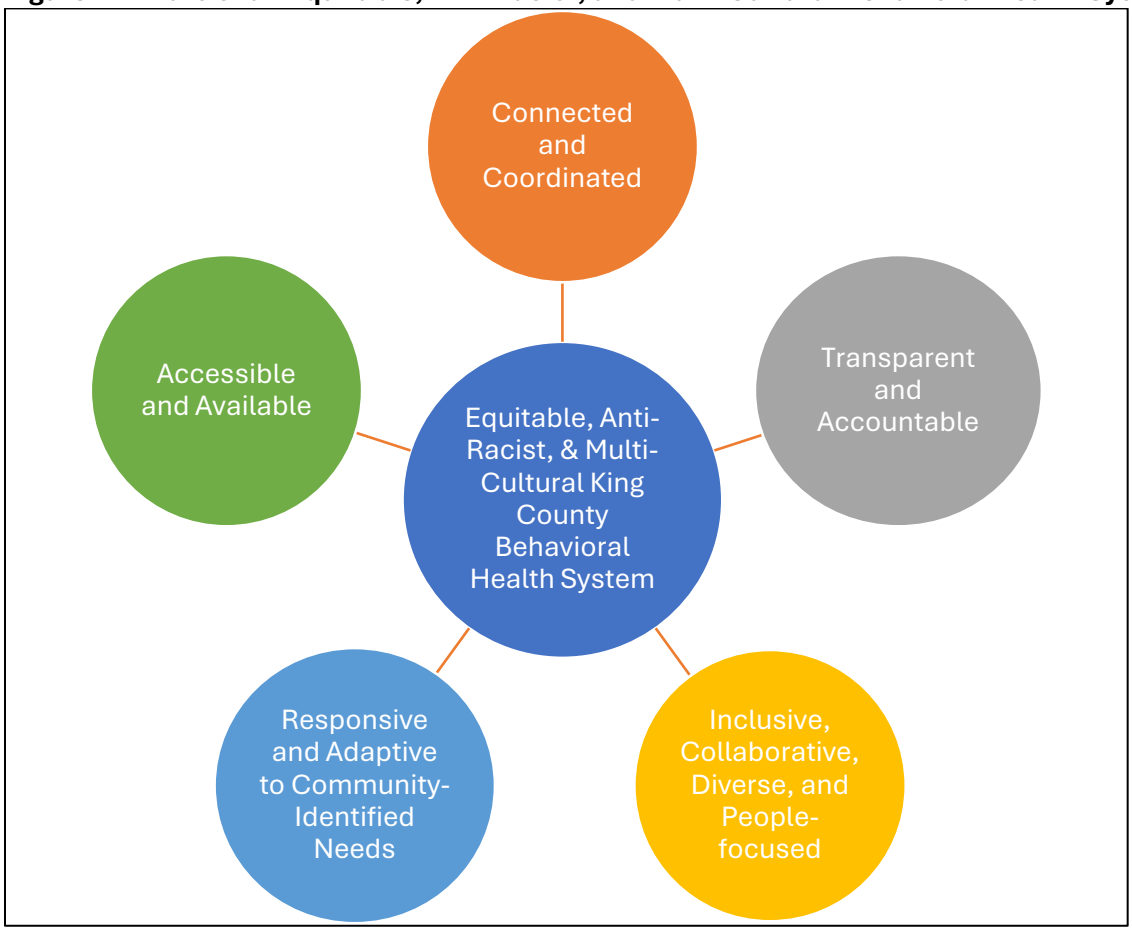
BIPOC, refugee and immigrant, LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual), and disability communities, as well as survivors of trauma or domestic, sexual, and gender-based violence, are more likely to struggle with behavioral health conditions and less likely to access supportive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

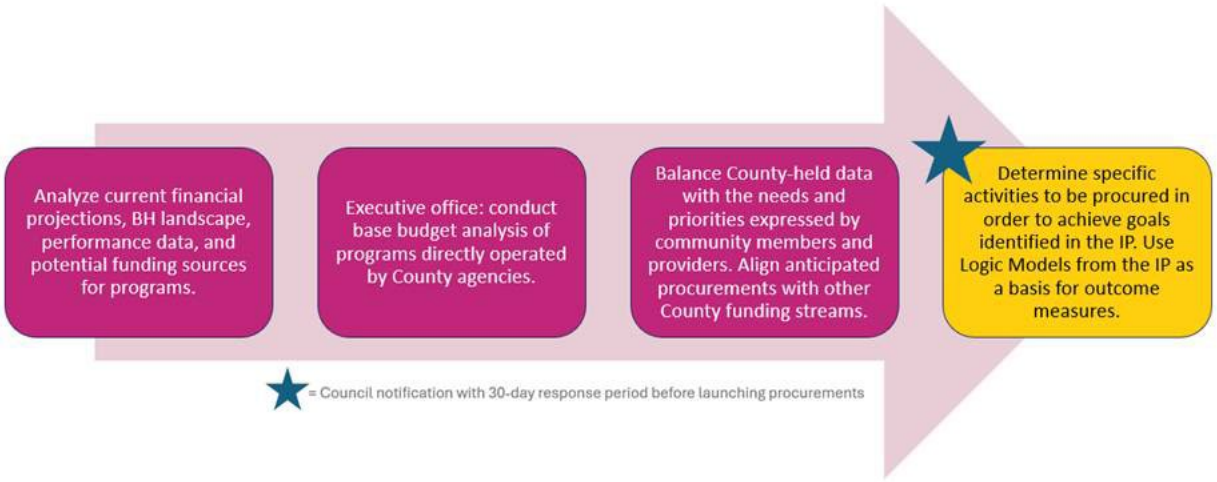
- **Forgo program expansions and investments in new programs.** Priority will be given to maintaining existing programs and service levels, except for reducing or sunsetting programs for other policy reasons.
- **Prohibit or cap future provider inflation rate increases.** DCHS may suspend or reduce inflation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

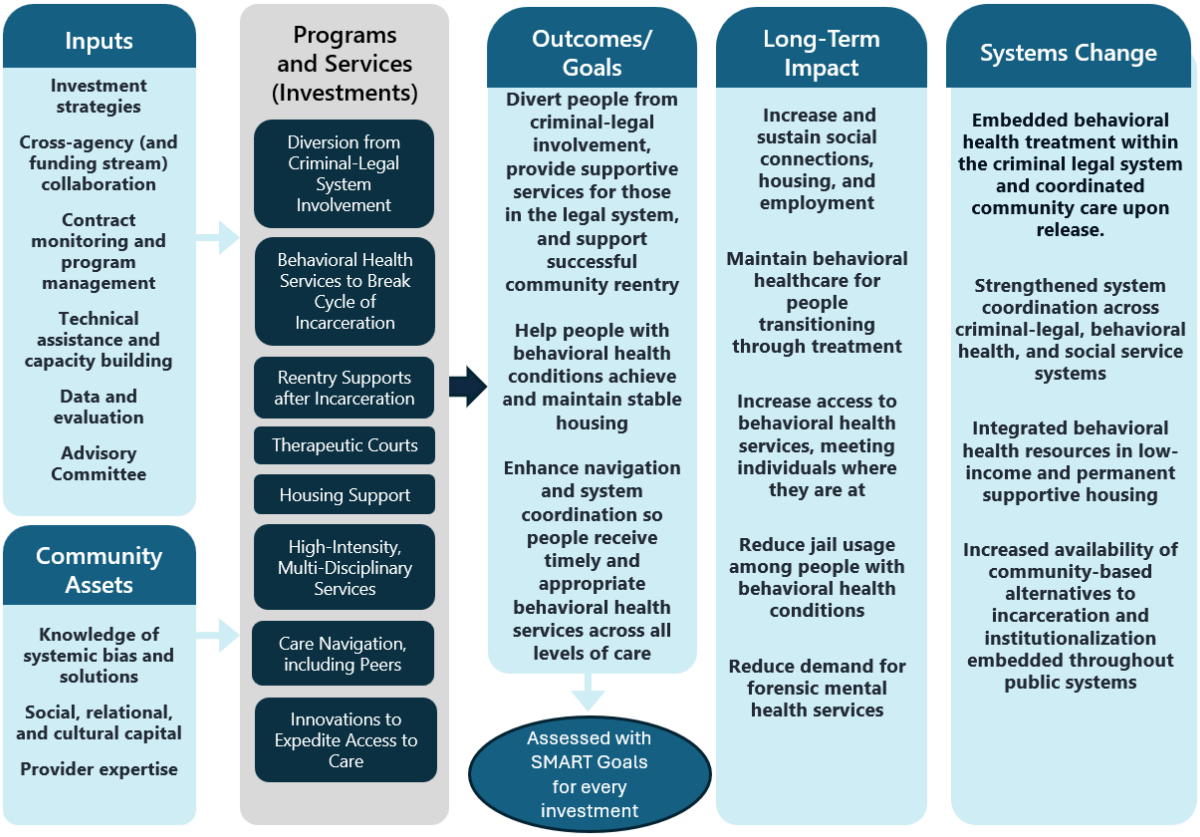
G. Examples of anticipated activities to be procured for the five strategy areas

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:

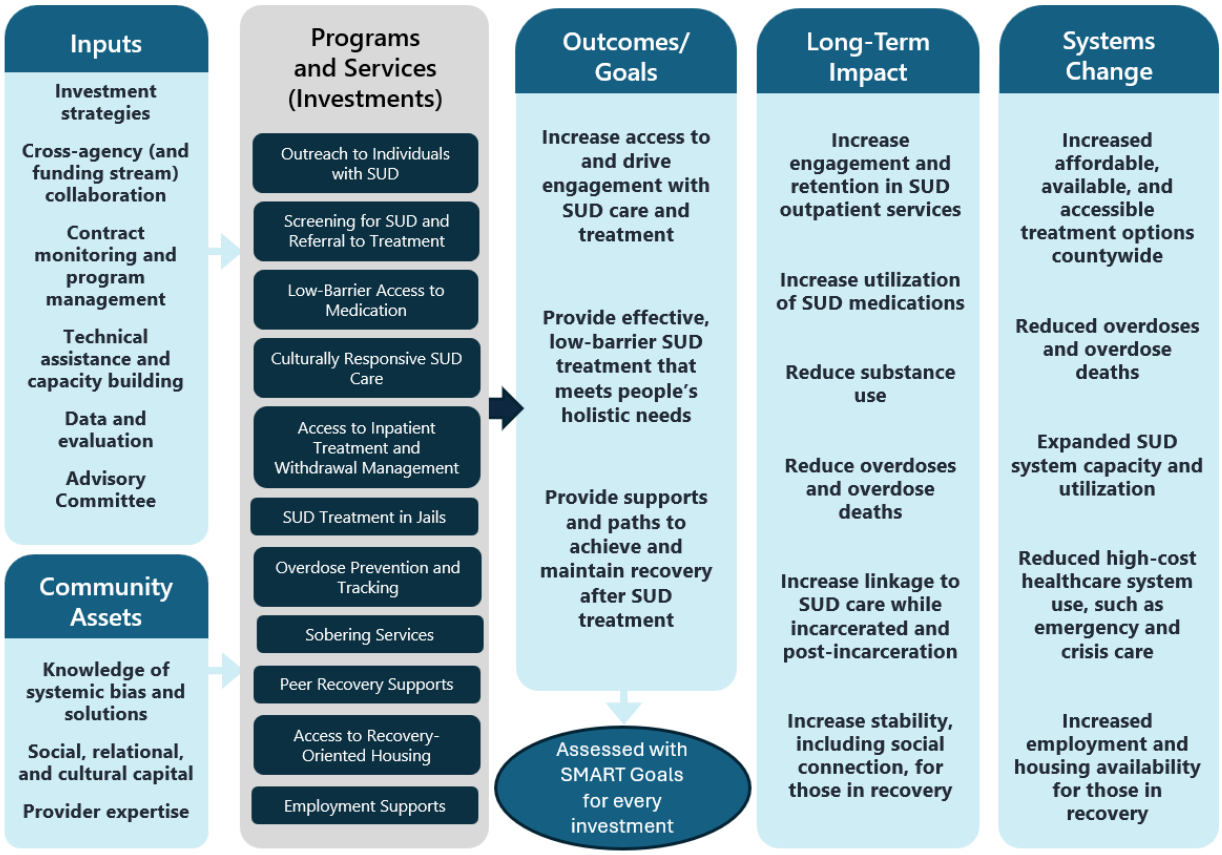
- Same-day or next-day initiation of outpatient treatment for youth and adults.

- 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.

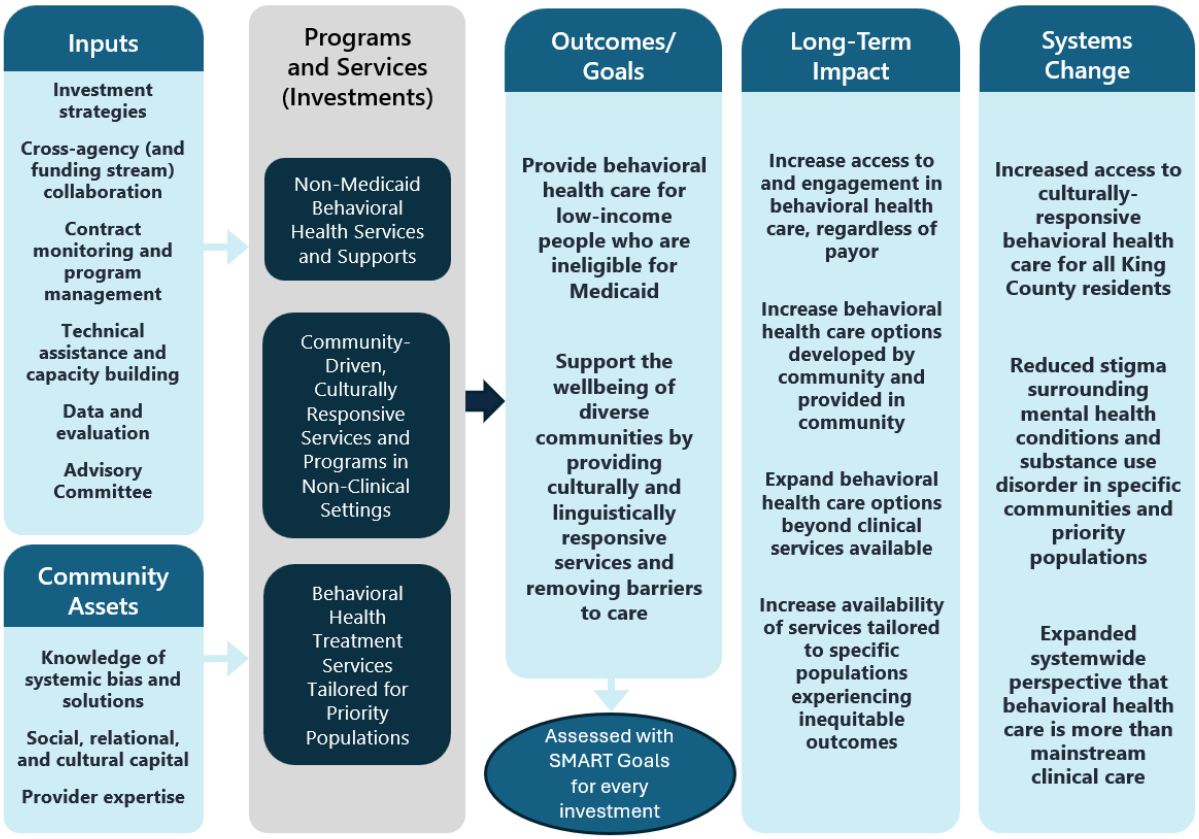
Activity: Employment supports

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:

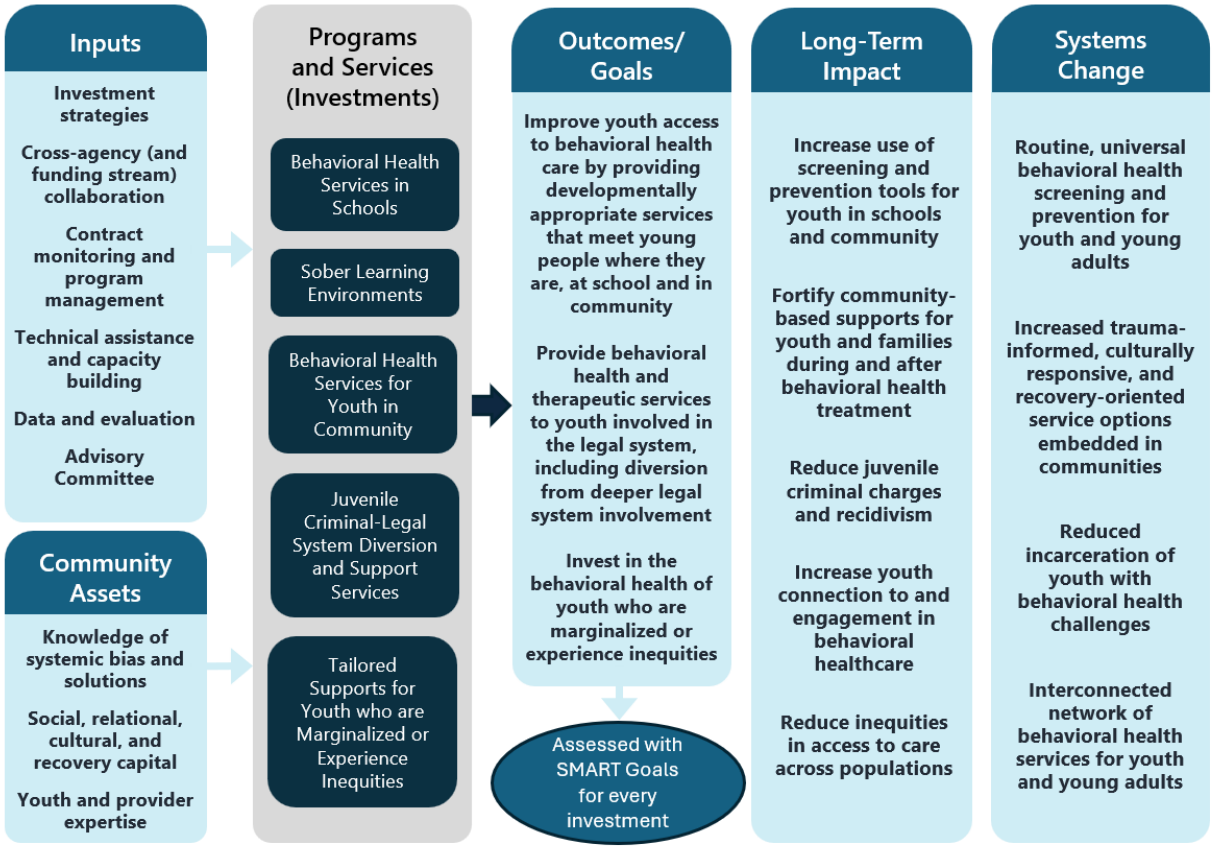
- Tailored therapies for LGBTQIA+ people facing behavioral health challenges.
- Behavioral health treatment and enhanced care navigation for survivors of trauma or domestic, sexual, and gender-based-violence, including flexible financial assistance where material barriers interfere with behavioral health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

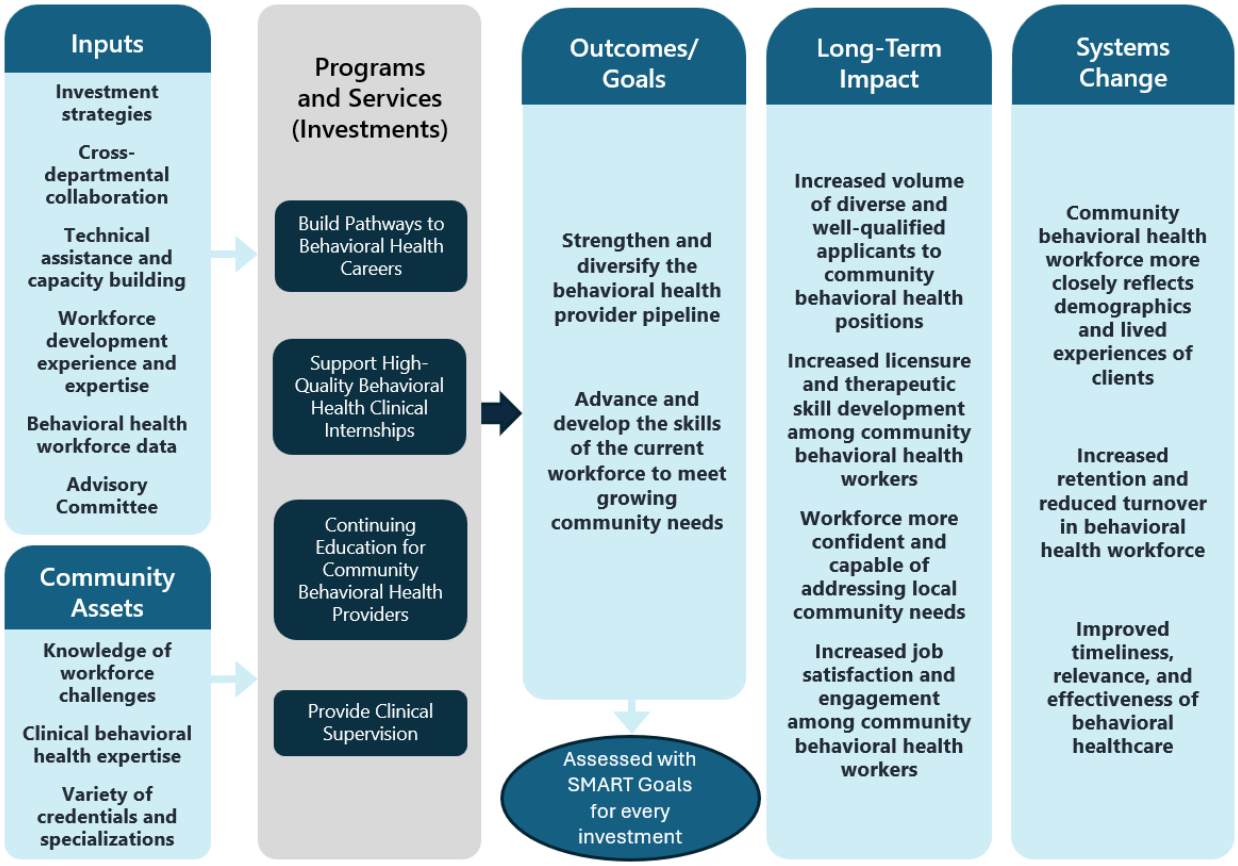
During the procurement process, King County plans to evaluate proposals from community organizations that are already known and respected by the families this goal is intended to serve, which may include KCICN providers. Providers should have training on the unique confidentiality, safety, caregiver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

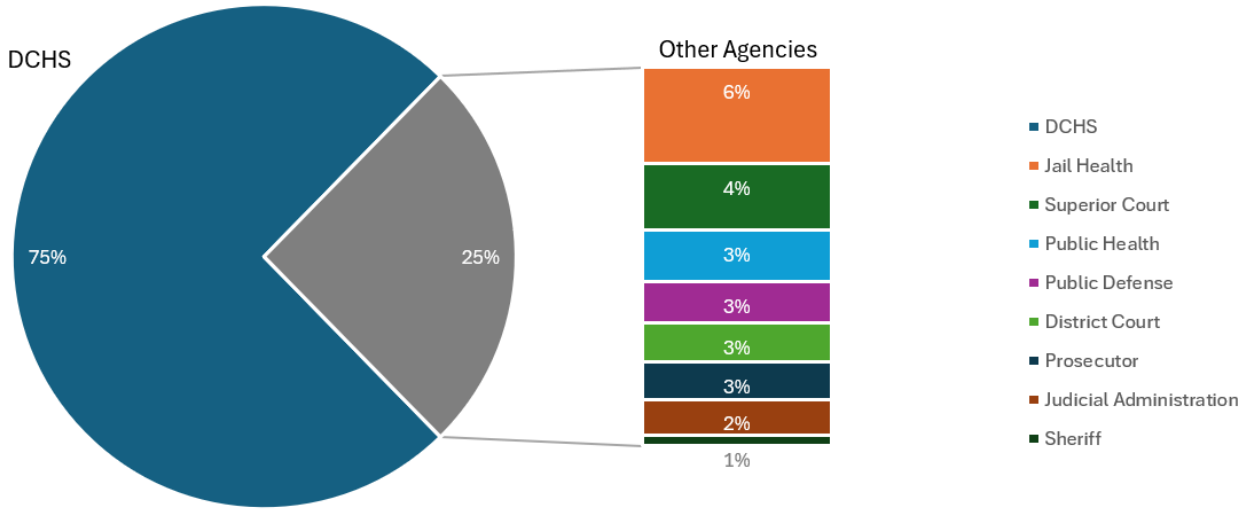
Successful implementation will depend on continued partnership with community-based organizations, behavioral health service providers, people with lived experience, and across County agencies. Ongoing evaluation, transparent reporting, and a phased procurement approach will help deliver a smooth transition 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)

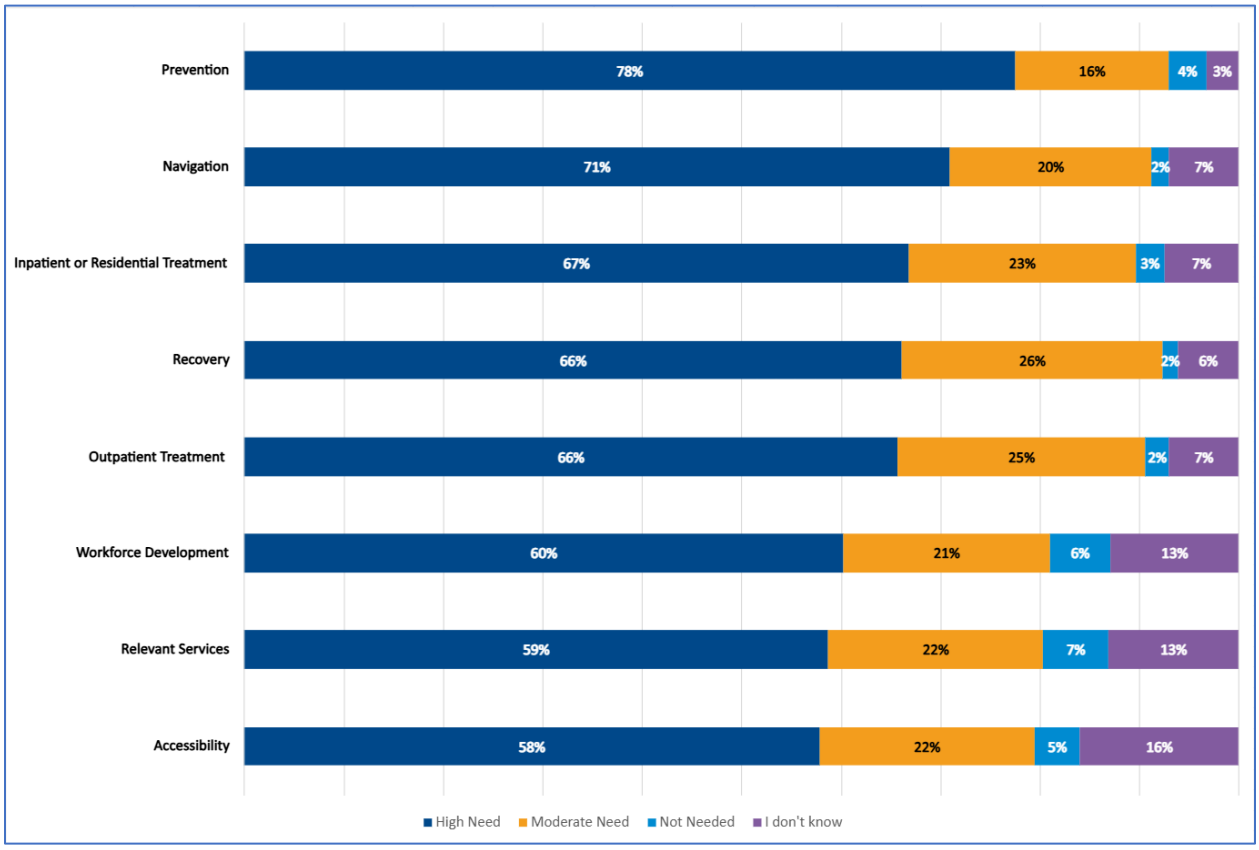
Affiliation or self-identification of attendees	Number of people engaged
LGBTQIA+ community members	23 (3%)
Behavioral health providers	72 (9%)
City government agencies	50 (7%)
Community-based organizations (CBOs)	62 (8%)
Correctional officers	15 (2%)
Incarcerated adults	99 (13%)
Incarcerated youth	27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

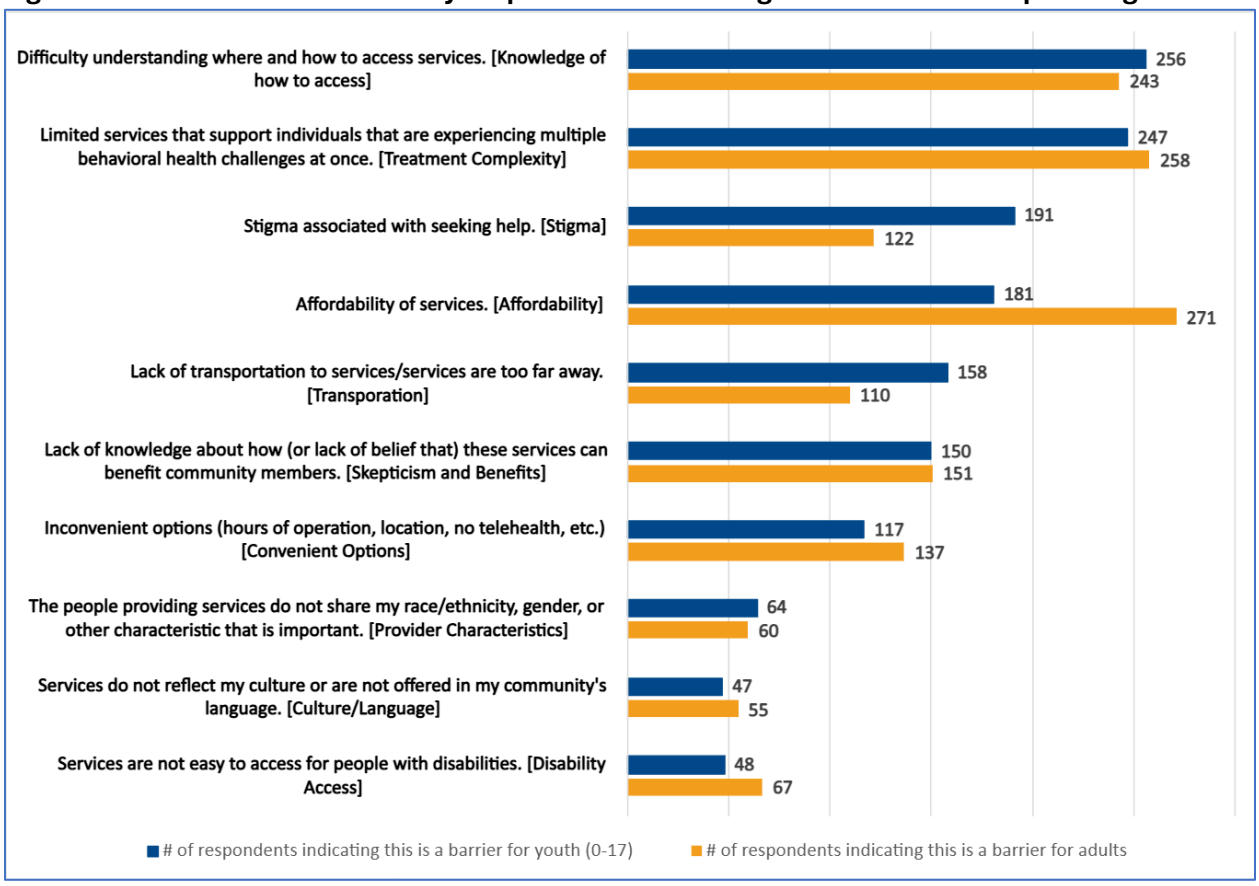
Figure 40: Online survey respondents' rating of behavioral health system barriers



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

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[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]

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[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]

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[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.

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[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]

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[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]

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

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[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]

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[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/]

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and-ethnic-disparities-in-mental-health-care-findings-from-the-kff-survey-of-racism-discrimination-and-health/]

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[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]

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[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]

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[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]

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[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."

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[117] King County. KCICN Workforce Survey 2025.

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[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]

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

~~October~~ November 2026



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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 ~~or~~ Council district when available. The biennial report will include descriptions of specific actions to improve programs based on reporting and evaluation and inform potential investment changes that the Executive may include in budget proposals. The Executive will make the biennial reports widely available to the Council, the Regional Policy Committee, and the community through DCHS' communication channels.[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

Commented [PS1]: Change requested to replace "or" with "and"

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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

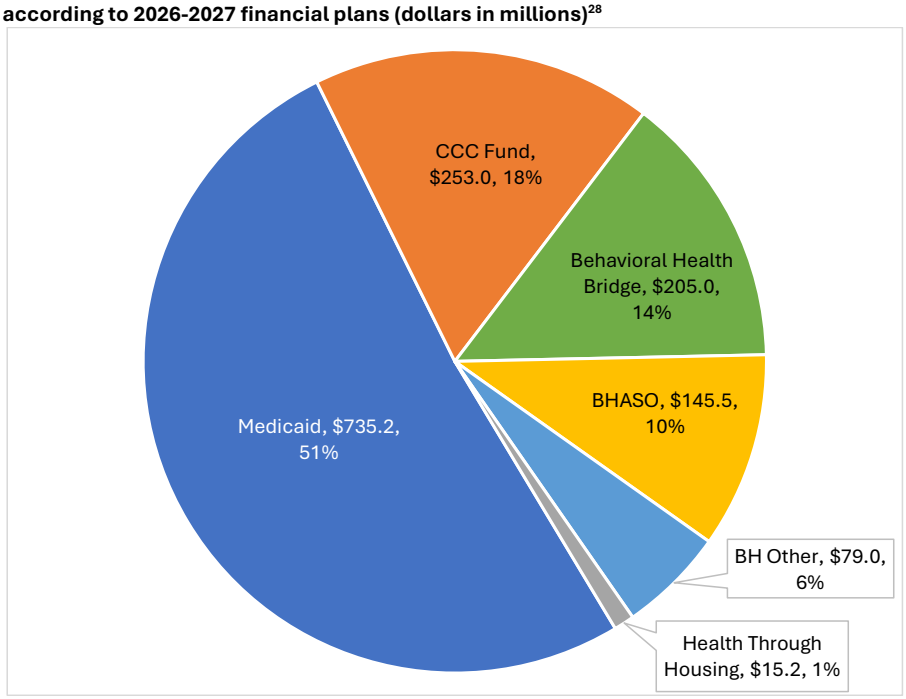
DCHS' Behavioral Health and Recovery Division (BHRD) oversees the public behavioral health system in King County, which includes managing and implementing the Behavioral Health Bridge sales tax and the Crisis Care Centers (CCC) Levy. In addition to the Behavioral Health Bridge sales tax and the CCC Levy,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

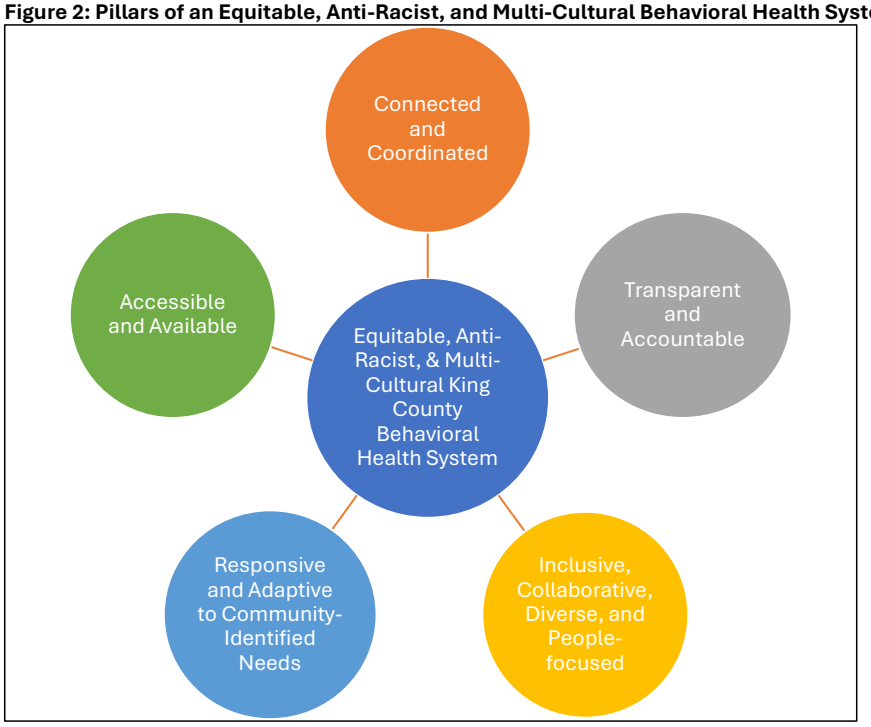
BIPOC, refugee and immigrant, LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual), and disability communities, as well as survivors of trauma or domestic, sexual, and gender-based violence, are more likely to struggle with behavioral health conditions and less likely to access supportive 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 ~~complimentary~~ 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 ~~to~~ maintain its strong commitment to centering the expertise and lived experience of its members, engaging them as deeply as possible so they stay well-informed, connected, and meaningfully involved.

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 ~~shall~~ should invest no less than $16.6 million annually in EA Goal 1 services from 2028 through 2034.

Commented [SP3]: Change from "shall" to "should" allows the Executive to potentially change this amount in the future should it be needed (change to federal policy regarding Medicaid, etc.). A substantial adjustment notification would be required if the adjustment meets that threshold.

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.

Commented [PS4]: Add reference to people living unsheltered to reflect this reference on line 1212 in this section.

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~~is expected to~~ incorporate quantitative and qualitative data and will include demographic information to ensure service recipients are reflective of the community. Qualitative data will include participant experiences and should be meaningfully incorporated alongside quantitative measures whenever possible. King County staff regularly review data and performance measures to inform program or contract modifications, repurposing of funds, and future procurement of services.

Commented [PS5]: Change requested to require that performance measures include both qualitative and quantitative data.

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

Commented [PS6]: Change requested to require that performance measurements include both qualitative and quantitative data.

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.

Commented [PS7]: Change requested to include ZIP code and city

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. ~~ZIP code~~ Dd~~d~~ata will be reported using maps or other visualizations to aid interpretation of the data. All reporting ~~by ZIP code~~ will continue to abide by privacy and confidentiality guidelines to ensure individuals cannot be identified.

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

Collection of program participant ZIP code, 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.

Commented [PS8]: Change requested to include ZIP code and city

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 expenditure of Behavioral Health Bridge proceeds by strategy area by ZIP code in King County as described in~~ The number of participants receiving Behavioral Health Bridge-supported services by strategy area by ZIP code, 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, ~~including~~ reported by ZIP code, city, and ~~by~~ 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.

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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.

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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**	

2026
2027

**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.

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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:

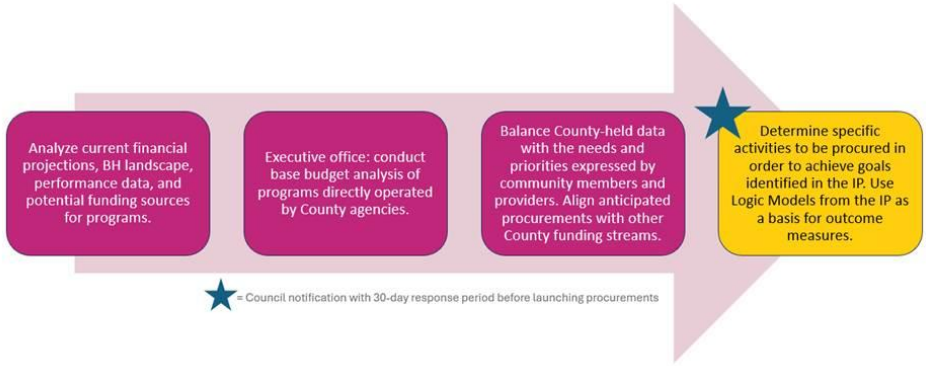
- **Forgo program expansions and investments in new programs.** Priority will be given to maintaining existing programs and service levels, except for reducing or sunsetting programs for other policy reasons.
- **Prohibit or cap future provider inflation rate increases.** DCHS may suspend or reduce inflation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

Commented [PS15]: Including the Regional Policy Committee in the notifications for pre-procurement plans

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~~anticipated to~~ be applicable to each activity and applied to each contracted service provider, including definitions for baseline metrics, equity-specific metrics, youth-specific metrics, SUD retention metrics, and standardized anticipated reporting cycles~~, to the degree known at the time of the letter~~;
- a description of how the strategy area's planned procurements will further the goals and recommendations from the Executive's Breaking the Cycle workgroup, where applicable;
- a description of how the strategy area's planned procurements relate to the Behavioral Health Strategic Plan report called for by Ordinance 20086, Section 39, Proviso P1;
- a description of how community engagement and service provider input informed the formation of the strategy area's planned procurements; and
- any feedback from the Behavioral Health Bridge Advisory Committee regarding the strategy area's planned procurements.

The Executive may address multiple strategy areas in a single letter, if appropriate. The Executive will electronically file the letter with the clerk of the Council, who will retain an electronic copy and provide an electronic copy to all Councilmembers 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.

Commented [PS16]: Changes requested to ensure that specificity about performance metrics are reported on in the pre-procurement reports transmitted to Council.

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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

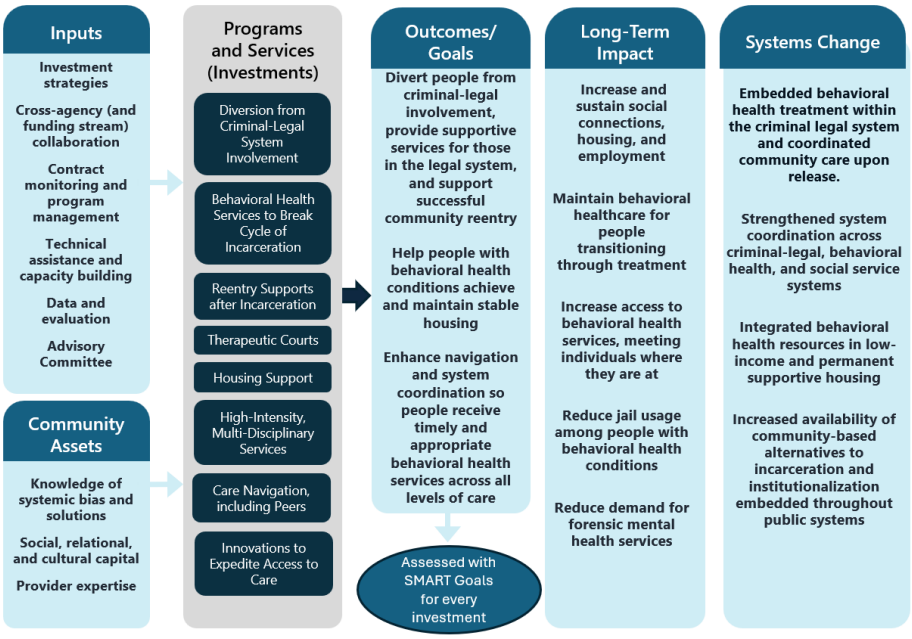
G. Examples of anticipated activities to be procured for the five strategy areas

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 ~~Servies~~ 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 ~~recouperation~~ 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:

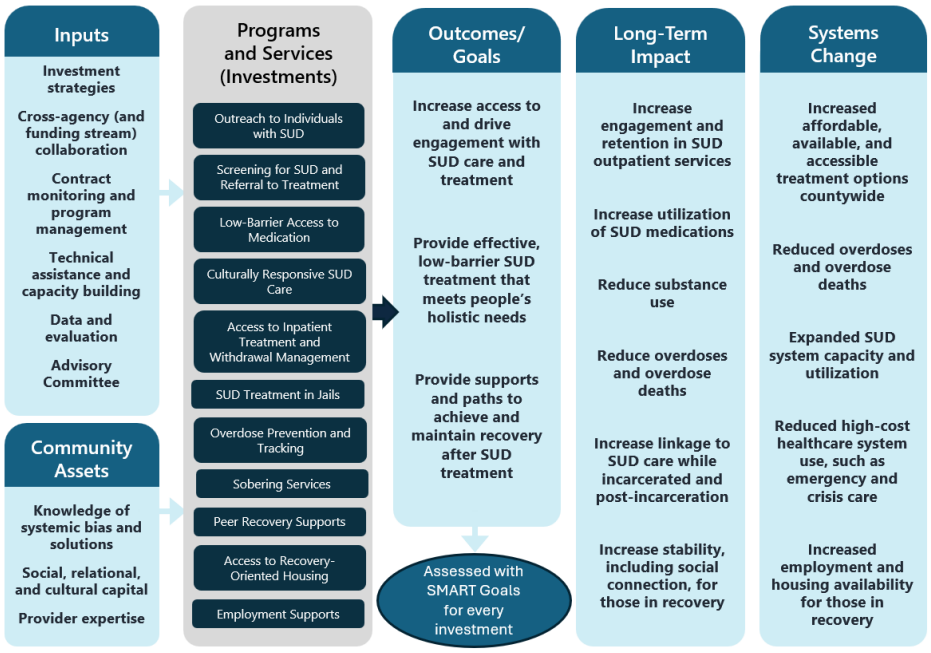
- Same-day or next-day initiation of outpatient treatment for youth and adults.

- 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 292929: 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.

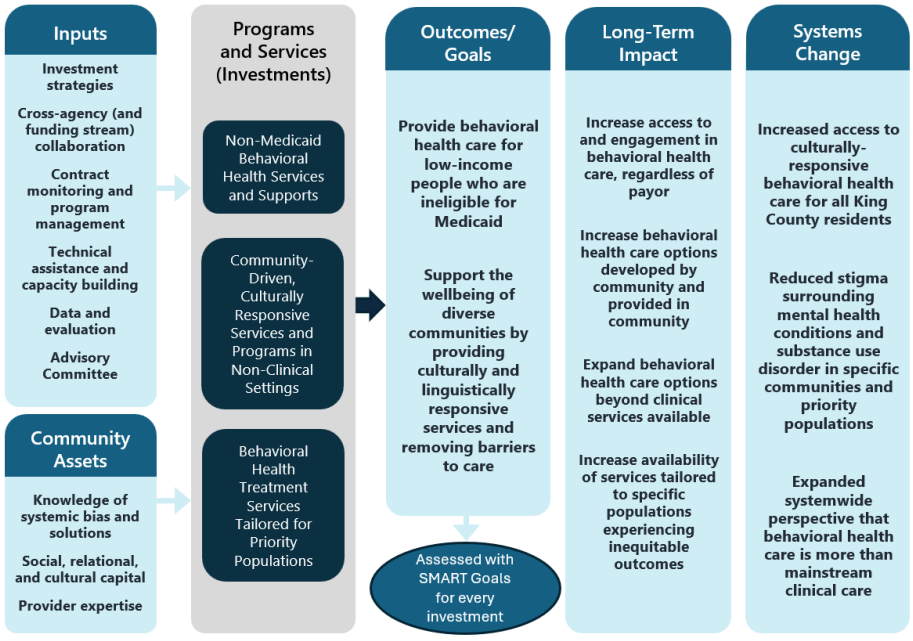
Activity: Employment supports

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~~31: Logic model for the Equitable Access to Behavioral Health Care strategy area



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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:

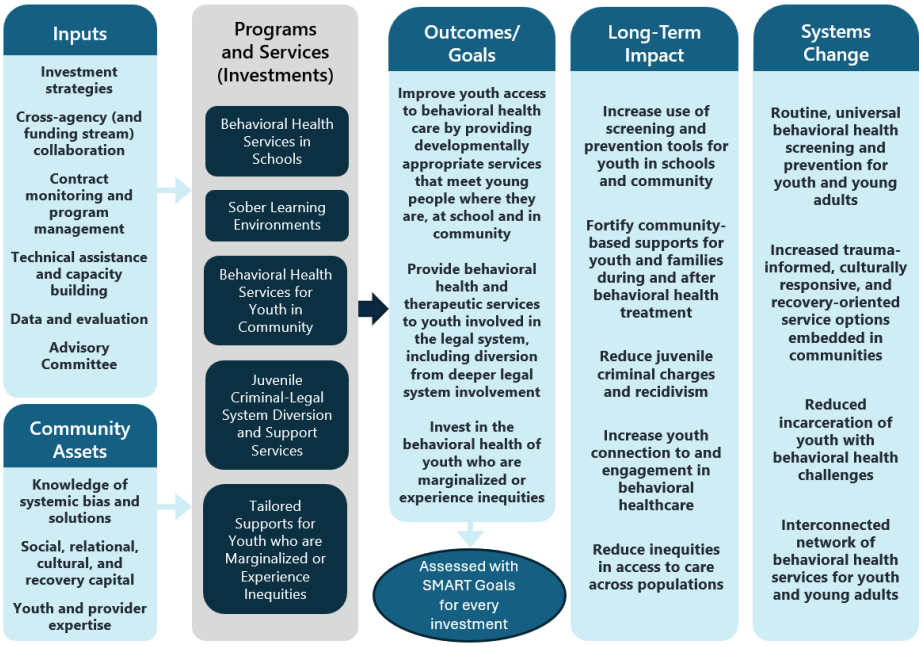
- Tailored therapies for LGBTQIA+ people facing behavioral health challenges.
- Behavioral health treatment and enhanced care navigation for survivors of trauma or domestic, sexual, and gender-based-violence, including flexible financial assistance where material barriers interfere with behavioral health 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 3132: 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.

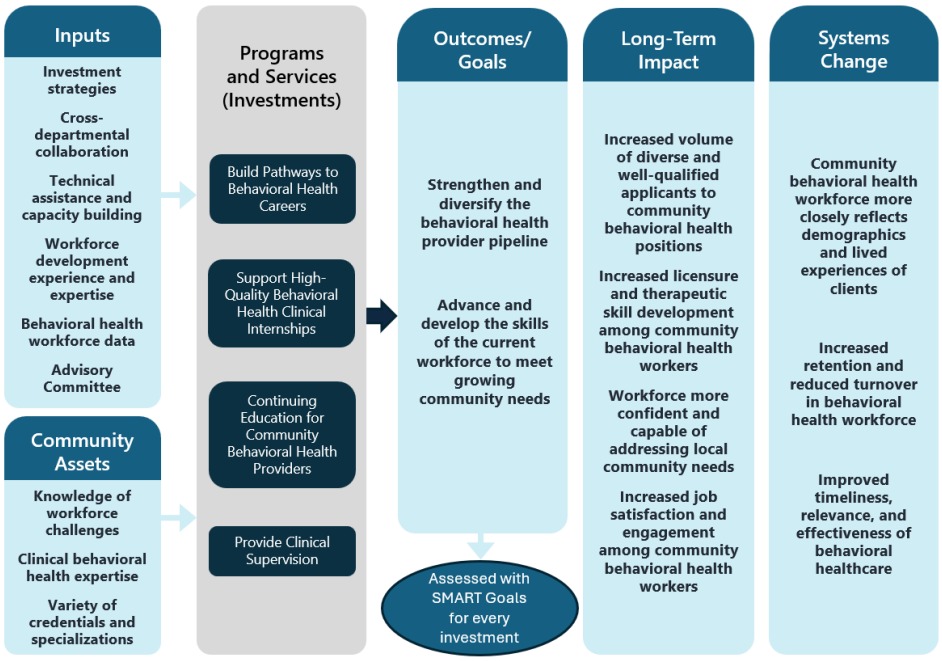
During the procurement process, King County plans to evaluate proposals from community organizations that are already known and respected by the families this goal is intended to serve, which may include KCICN providers. Providers should have training on the unique confidentiality, safety, caregiver 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 3233: 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.

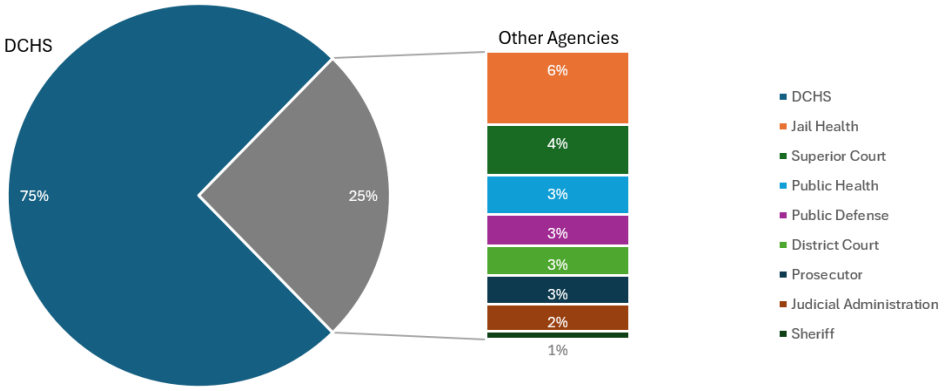
Successful implementation will depend on continued partnership with community-based organizations, behavioral health service providers, people with lived experience, and across County agencies. Ongoing evaluation, transparent reporting, and a phased procurement approach will help deliver a smooth transition 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 3334: 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~~35: 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 3536: 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 3637: 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~~38: 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 3839: 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 3940: 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**

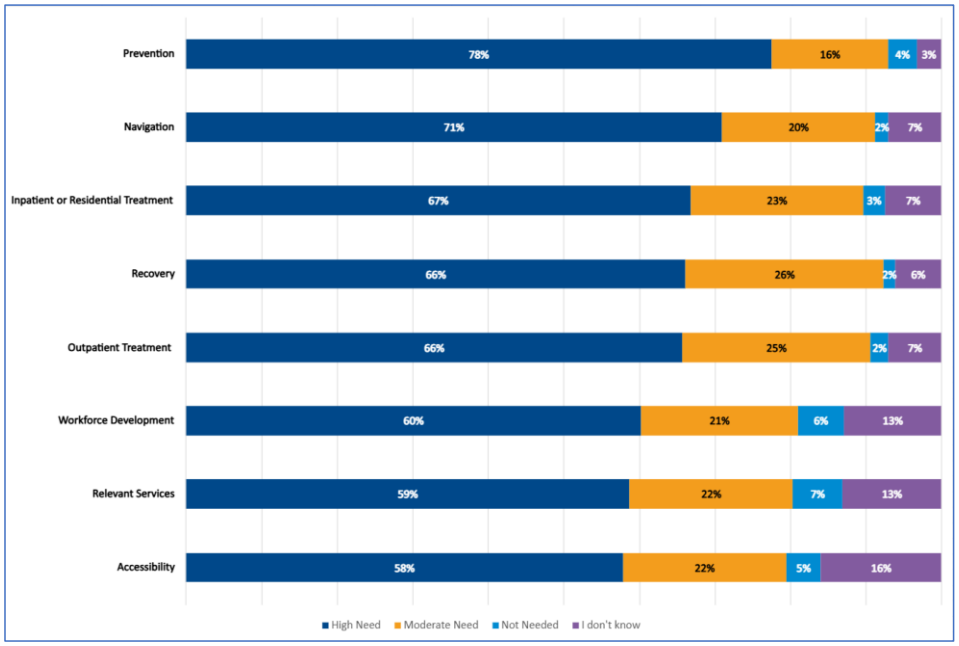
Δ Number of participants is suppressed when less than ten to protect privacy.

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.

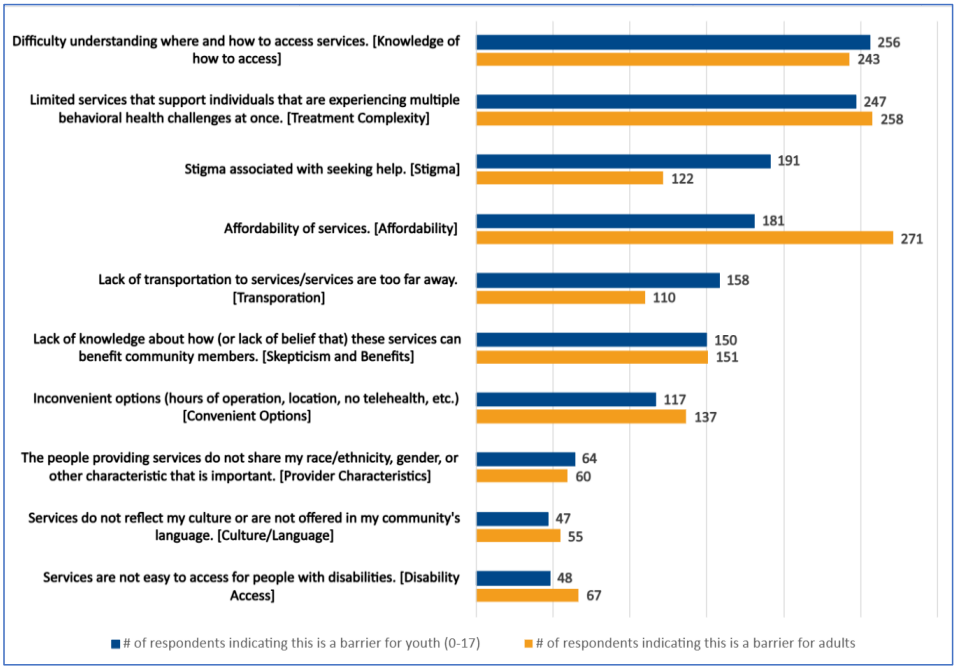
Figure ~~4041~~: Online survey respondents' rating of behavioral health system barriers



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 4142: 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~~43: 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~~44: 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~~45: 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]

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[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/]

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[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.

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[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]

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[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/]

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[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/]

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[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]

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[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]

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[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]

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Metropolitan King County Council
Staff Report

Committee:	Regional Policy Committee		
Agenda Item:	7	**Analyst(s):**	Jenny Giambattista Andrea Brudnicki
Proposed No.:	2026-B0128	**Meeting Date:**	November 5, 2026

OVERVIEW

TOPIC: A briefing on the proposed motion (Proposed Motion 2026-0223) acknowledging receipt of the 2025 Crisis Care Centers (CCC) Annual Report and summary letter required by the Crisis Care Center Levy Implementation Plan for 2024-2032.

LEGISLATION SUMMARY

The 2025 Crisis Care Centers (CCC) Annual Report is linked in the transmittal letter to Proposed Motion 2026-0223 which also serves as the annual Summary Letter.[1] The 2025 Annual Report can be found at this webpage: https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/crisis-care-centers-levy/annual-report.

The requirements for the 2025 Annual Report and Summary Letter are set forth in the CCC Levy Implementation Plan adopted by Ordinance 19783, which passed in June 2024.[2] The Annual Report is required to include information about expenditures, utilization data, CCC operator awards made to date and progress on each award, CCC Levy accomplishments, and performance measurement information.

The 2024 Annual Report was transmitted on August 15, 2025, and Council passed Motion 2025-0252 acknowledging receipt of the Summary Letter and completion of the Annual Report requirement on May 26, 2026.[3]

Proposed Motion 2026-0223 is a nonmandatory referral to the Regional Policy Committee and the Health, Housing, and Human Services Committee.

[1] 2025 CCC Annual Report Summary Letter, View.ashx.
[2] Ordinance 19783, King County - File #: 2024-0011.
[3] Motion 2025-0252, King County - File #: 2025-0252.

KEY ISSUES FROM THE ANALYSIS

No issues have been identified. The 2025 Annual Report appears to comply with the requirements set forth in the Implementation Plan. Additionally, the Summary Letter includes all the necessary information as required by the Implementation Plan.[4]

BACKGROUND & TIMING CONSIDERATIONS

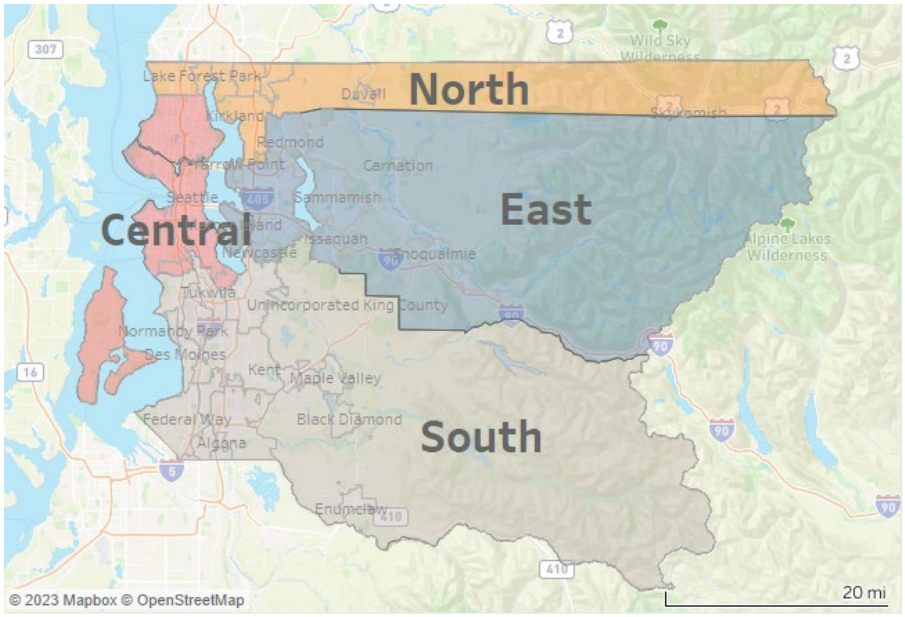
BACK TO TOP

Crisis Care Centers Levy. On April 25, 2023, voters approved a new nine-year Crisis Care Centers (CCC) Levy (2024-2032) to support the creation of five new regional CCC facilities distributed throughout the County, with one Center serving youth by 2032.[5] The CCC Levy also prioritizes the restoration of behavioral health residential treatment capacity and expansion of treatment availability and sustainability in King County as well as supporting behavioral health workforce needs. The initial CCC Levy rate is $0.145 per $1,000 of assessed value in 2024 and at the time it was projected to generate a total of approximately $1.157 billion. According to a July 2026 forecast from the King County Office of Economic and Financial Analysis (OEFA), the total revenue projection is now $1.172 billion during the nine-year Levy period, a $14 million increase from the 2024 projection.[6]

Ordinance 19572 states that one CCC must be located in each of the four Crisis Response Zones (CRZ).[7] Figure 1 shows the boundaries of each CRZ and Attachment A lists the cities and unincorporated parts of King County located within each CRZ.[8] The purpose of the CRZ creation is to ensure geographic distribution of care across King County and anyone seeking care can access a facility in any CRZ.

[4] 2025 CCC Annual Report Summary Letter, View.ashx.
[5] King County Elections, April 25, 2023, Official Final Elections Results, https://aqua.kingcounty.gov/elections/2023/april-special/results.pdf.
[6] Revenue estimate according to a July 2026 forecast from the King County Office of Economic and Financial Analysis (OEFA). The original projected revenue according to the Implementation Plan was $1.157 billion, a $14 million decrease from the most recent July 2026 projection.
[7] Ordinance 19572, Ordinance 19572.pdf.
[8] Ordinance 19783, King County - File #: 2024-0011.

Figure 1. Crisis Response Zone Map[9]



Crisis Care Center (CCC) Levy Implementation Plan 2024-2032 Annual Report Requirements. The CCC Levy Implementation Plan sets forth the requirements for the Annual Report including that the Report be made available online no later than August 15 and include:

1. Total expenditure of Levy proceeds by service category and geographic distribution;
2. Number of people served by service category and geographic distribution;
3. An overview of CCC facility utilization data;
4. CCC operator awards made and progress on each awarded operator contract during the reporting period;
5. An overview of CCC Levy accomplishments during the previous calendar year, and changes DCHS intends to make or direct to improve performance in the following year, when applicable;
6. Transportation data;
7. Assessment of Residential Treatment Financial Plan;
8. The CCC Levy's fiscal and performance measurement during the applicable calendar year; and
9. A map or summary describing the geographic distribution of the CCC Levy.

[9] This Figure was taken from the CCC Levy Implementation Plan, Ordinance 19783, King County - File #: 2024-0011.

Annual Summary Letter. The CCC Levy Implementation Plan requires an annual Summary Letter to confirm availability of the Annual Report with a web link, identify how the report meets the requirements of Ordinance 19572, and summarize the key data and conclusions from the annual report. The 2025 Annual Report Summary Letter was transmitted to the Council on August 14, 2026.[10]

CCC Advisory Board. King County Code 2A.300.050 provides that the King County Behavioral Health Advisory Board (BHAB) serves as the CCC Levy Advisory Body and report on the CCC Levy to Council and the Community through online annual reports. The BHAB reviewed and certified the 2025 Annual Report at their August 6, 2026 meeting.

ANALYSIS

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The 2025 Annual Report appears to meet the reporting requirements set forth in the CCC Levy Implementation Plan. Additionally, the Summary Letter includes all the necessary information as required by the Implementation Plan.[11] The 2025 Annual Report also links to a table prepared by DCHS that states where in the report each reporting requirement from the Implementation Plan is addressed.[12]

Reporting Requirements. As discussed in the Background section of this staff report, the Implementation Plan includes specific reporting requirements for the Annual Report. Each reporting requirement is discussed below.

CCC Levy Accomplishments and Performance Improvements. The Implementation Plan requires an overview of CCC Levy accomplishments during the previous calendar year, and changes DCHS intends to make or direct to improve performance in the following year, when applicable.

CCC Levy Accomplishments – 2025 Highlights

The 2025 Annual Report includes an overview of CCC Levy accomplishments, categorized by eight strategies outlined in the Implementation Plan.[13] DCHS expenditures totaled $64 million for 2025. Key accomplishments in 2025 for each of the strategies as shown in the Annual Report include:

- Strategy 1: *Create and Operate Five Crisis Care Centers*

[10] 2025 CCC Annual Report Summary Letter, View.ashx.
[11] 2025 CCC Annual Report Summary Letter, View.ashx.
[12] 2025 Crisis Care Centers Levy Annual Reporting Requirements Table, reporting-requirements-crosswalk-table-1.pdf.
[13] The eight strategies listed in the Implementation Plan are used to categorize how funds will be invested to accomplish the Levy's goals.

- The first Regional Crisis Center in Kirkland, the North Crisis Response Zone (CRZ) began operating, and the County purchased a site and selected an operator for the Crisis Care Center in the Central CRZ.

- Strategy 2: *Restore, Expand, and Sustain Residential Treatment Capacity*
  - Awarded $20.9 million in capital funds to support residential treatment capacity:
    - $13 million to Aristo Healthcare Services to support a new 16 bed mental health residential treatment center in Renton.
    - $7.9 million to the Seattle Indian Health Board for the Thunderbird Treatment Center on Vashon Island to support its new 92-bed substance use treatment facility.
  - Awarded $15 million in capital funds for improvements across six behavioral health treatment facilities in King County.
- Strategy 3: *Strengthen the Community Behavioral Health Workforce*
  - Spent $6.9 million on Career Pathways investments that supported 35 King Conty community behavioral health agencies to recruit, retain, and increase workforce representation. Overall, the report indicates that 3,686 staff benefited from this investment.
  - Spent $5.5 million on several labor-management partnership training initiatives that advanced career and educational growth.
  - DCHS awarded $2.5 million to the Behavioral Health Institute at Harborview Medical Center to launch a Crisis Training Academy in 2026.
- Strategy 4: *Early Crisis Response Investments*
  - Continued to expand crisis response capacity with ongoing early investments including mobile crisis service expansion for both youth and adults.
  - Expanded Mobile Rapid Response Crisis Teams so programs were operating at full capacity to cover 24/7 shifts by the end of 2025.
  - Increased Mobile Rapid Response Crisis Teams for Youth so that by end of 2025 the program is serving all children, youth and families in King County 24/7. The number of youth teams increased from three to nine on weekdays and two to six on weekends.
- Strategy 5: *Capacity Building and Technical Assistance*
  - Funded capacity building and technical assistance contracts with three consultant agencies to provide targeted technical assistance to potential Behavioral Health Agencies applying for CCC levy funding opportunities.

- Released a Request for Proposal (RFP) offering resources to local jurisdictions for capital facility siting and for Crisis Care Center operators

- Strategy 6: *Evaluation and Performance Measurement*
  - Measured, analyzed, and reported on the impact of the CCC Levy to inform quality improvement initiatives and for reporting purposes.
- Strategy 7: *CCC Levy Administration*
  - Promoted accountability to the community through community engagement and quality assurance initiatives.
- Strategy 8: *CCC Levy Reserves*
  - Maintained the Levy fund reserve requirement.

Intended Changes to Improve Performance

The CCC Levy Implementation Plan requires the Annual Report to include any, if any, changes DCHS intends to make or direct to improve performance in the following year, when applicable. As shown in the quote below from the section of the Annual Report describing the intended changes, DCHS describes the approach to improving performance, rather than specific changes DCHS intends to make.

> *"The Crisis Care Centers initiative made progress in 2025, including negotiating contracts and launching services. Since most CCC programs were in the early stages of operation during this first full year of implementation, DCHS focused on ways to identify areas for improved performance. For example, as described in the Accomplishments Section, Facility Utilization, the performance of the North Regional Crisis Care Center is being monitored closely, including through annual program monitoring and oversight beginning in 2026. These program reviews will help refine clinical practices to ensure the Crisis Care Center complies with their contact and meeting community needs. Findings will be used to identify and respond to emerging trends, service gaps, and unmet needs that may influence utilization patterns.*
>
> *As levy programs are implemented and more data becomes available, DCHS will continue to assess performance and make necessary adjustments to ensure service quality and effectiveness."*

Expenditure of CCC Levy Proceeds. The CCC Levy Implementation Plan requires reporting of total expenditures of Levy proceeds by CRZ, crisis care center, purpose, strategy, activities related to crisis care center post-crisis stabilization, and activities related to expanding mobile crisis services, reported by King County ZIP Code where the

services were received. The Annual Report includes an interactive map and a link to a table to report spending by geography. For both the table and interactive map, where expenditures support or are available to the entire county, for reporting purposes the amount is evenly distributed among all ZIP Codes. Totals by geographic area are provided on the interactive map only.

The Annual Report map allows users to search by the required categories, and the results are displayed on the map. This interface is intended to allow readers to see total expenditures by ZIP Code or CRZ. Some readers may find it difficult to distinguish between the shades of green to identify the spending amount for a particular ZIP Code or CRZ. Readers may find it easier to display totals by hovering their cursor over the map and reading the total amount displayed in a pop up for each area.

As shown in Table 1, $64.0 million was expended of the $122.1 million overall 2025 Levy budget. The Report explains that the difference between budgeted amounts and expenditures was primarily due to timelines pushing longer than anticipated for capital projects that extend beyond 2025 in Strategy 1 and Strategy 2.[14]

Table 1. Financial Expenditures in 2025[15]

Strategy	2025 CCC Levy Expenditures	2025 CCC Levy Budget
Strategy 1: Create and Operate Five Crisis Care Centers	$39,978,676	$59,888,000
Strategy 2: Restore, Expand, and Sustain Treatment Capacity	$1,679,625	$33,340,000
Strategy 3: Strengthen the Community Behavioral Health Workforce	$12,404,973	$11,849,000
Strategy 4: Early Crisis Response Investments	$2,985,027	$6,290,000
Strategy 5: Capacity Building and Technical Assistance	$96,902	$2,029,000

[14] The 2025 CCC Annual Report states that, "Awarded amounts for Strategy 2 exceeded the 2025 budgeted amount because there was additional funding available from unawarded 2024 CCC Levy Strategy 2 dollars."
[15] Data taken from the 2025 Crisis Care Centers Annual Report, 2025 Crisis Care Centers Annual Report - King County, Washington.

Strategy	2025 CCC Levy Expenditures	2025 CCC Levy Budget
Strategy 6: Evaluation and Performance Management	$806,408	$1,099,000
Strategy 7: CCC Levy Administration	$6,049,033	$7,581,000
Levy Total	**$64,000,643**	**$122,077,000**

Using Figure 15 from the 2025 Annual Report, the following are the total expenditures for each CRZ:

- **Central CRZ**: $31. 3 million
- **North CRZ**: $21.7 million
- **South CRZ**: $6.7 million
- **East CRZ**: $4.2 million

According to DCHS, the reason for the larger amounts for the Central CRZ was driven by the purchase of the future CCC building in Seattle, and for the North CRZ by operating costs and capital improvements for the Kirkland CCC.

Number of People Served in 2025. The Implementation Plan requires reporting on the number of individuals receiving levy-funded behavioral health care services by CRZ, crisis care center, purpose, strategy, activities related to crisis care center post-crisis stabilization, and activities related to expanding mobile crisis services, reported by the ZIP Code where the individuals resided at the time of services and by the King County ZIP Code where the services were received, provided that individually protected information is not disclosed.

The transmitted 2025 Annual Report meets the reporting requirement by including an interactive online map and a link to a table showing the number of unique people served by CCC programs by ZIP Code and CRZ. All levy-funded programs with expenditures in 2025 and that served people in 2025 are reported and include: Crisis Care Center North, Mobile Rapid Response Crisis Team, Mobile Response and Stabilization Services, Pioneer Square Client Engagement, and 911 Diversion.

The total number of people by geographic area is only available using the online map rather than the table provided in the link. Users may find it helpful to view totals by geographic

area by placing their cursor on the map and reading the total amounts displayed in each area. Readers may view the map of people served by where they received services or by where they lived. When looking at where people received services, the map counts people once in each location where they received services. When looking at where people lived, the map counts each person only once overall at their last address.

According to the transmitted Report, 6,697 unique people received services from either the Crisis Care Center or mobile crisis teams in 2025. This number includes individuals living outside of King County and unhoused people. This number excludes individuals served only by 911 Diversion and Pioneer Square Client Engagement because these services are "low barrier" services for which DCHS states there is not sufficient data collected on an individual's identity to allow for de-duplication[16] of the data when totaling with other program areas.

Where Do People Live

As shown below, the majority of people receiving services lived in the Central and South CRZs, which have the largest total population. The numbers below exclude the nine percent of people who did not live in King County or with no known address. For purposes of tracking where people lived, DCHS does not have data from Pioneer Square Client Engagement and 911 Diversion.

- **Central CRZ**: 3,037 people
- **North CRZ**: 806 people
- **South CRZ**: 1,544 people
- **East CRZ**: 628 people

Overview of CCC Facility Utilization Data. The Implementation Plan requires each Annual Report to include an overview of CCC facility utilization data. At the time of the 2025 Annual Report, there is only one CCC in operation. The Implementation Plan states that DCHS intends to require CCC operators to report on wait times, length of stay, occupancy, and other measures to ensure that people move efficiently through the clinical components of a facility. According to the 2025 Annual Plan, a total of 3,669 people were served through 5,425 visits to the three clinics at the North Regional Crisis Care Center (which includes behavioral health urgent care, 23-hour observation, and crisis stabilization units). DCHS anticipates future reports to include further performance data as more CCCs open and continuous quality improvement efforts are made.

[16] De-duplication refers to the process of ensuring each individual is only counted once, regardless of how many different programs in which they participated.

Crisis Care Center Operator Awards. The Implementation Plan requires reporting on CCC operator awards made, and progress on each awarded operator contract during the reporting period. Updates are broken down below by CRZ:

Central CRZ: In 2025, DCHS purchased the former Polyclinic building on Broadway in First Hill and selected Connections Health Solutions as the operator.[17] DCHS selected a property management company to manage the building and contracted with an architecture and engineering firm to design the interior. Renovations are projected to begin in late 2026 and be completed in late 2027.

North CRZ: In August 2025, the first Regional CCC operated by Connections Health Solutions began operating in Kirkland.

South CRZ: DCHS considered proposals for the South CCC in 2025 and announced MultiCare as the operator in early 2026.

East CRZ: DCHS performed pre-procurement activities in 2025 including meetings with potential providers and engagement with community organizations. Response to flooding in late 2025 delayed DCHS's opening of the Round Two CCC RFP (which focused on proposals to operate the East Regional CCC). As of the 2025 Annual Report drafting, DCHS was evaluating operator proposals.

Youth-Focused Facility: DCHS performed pre-procurement activities in 2025 including answering questions for potential providers and engaged jurisdictions for potential sites in anticipation of a procurement in 2026.

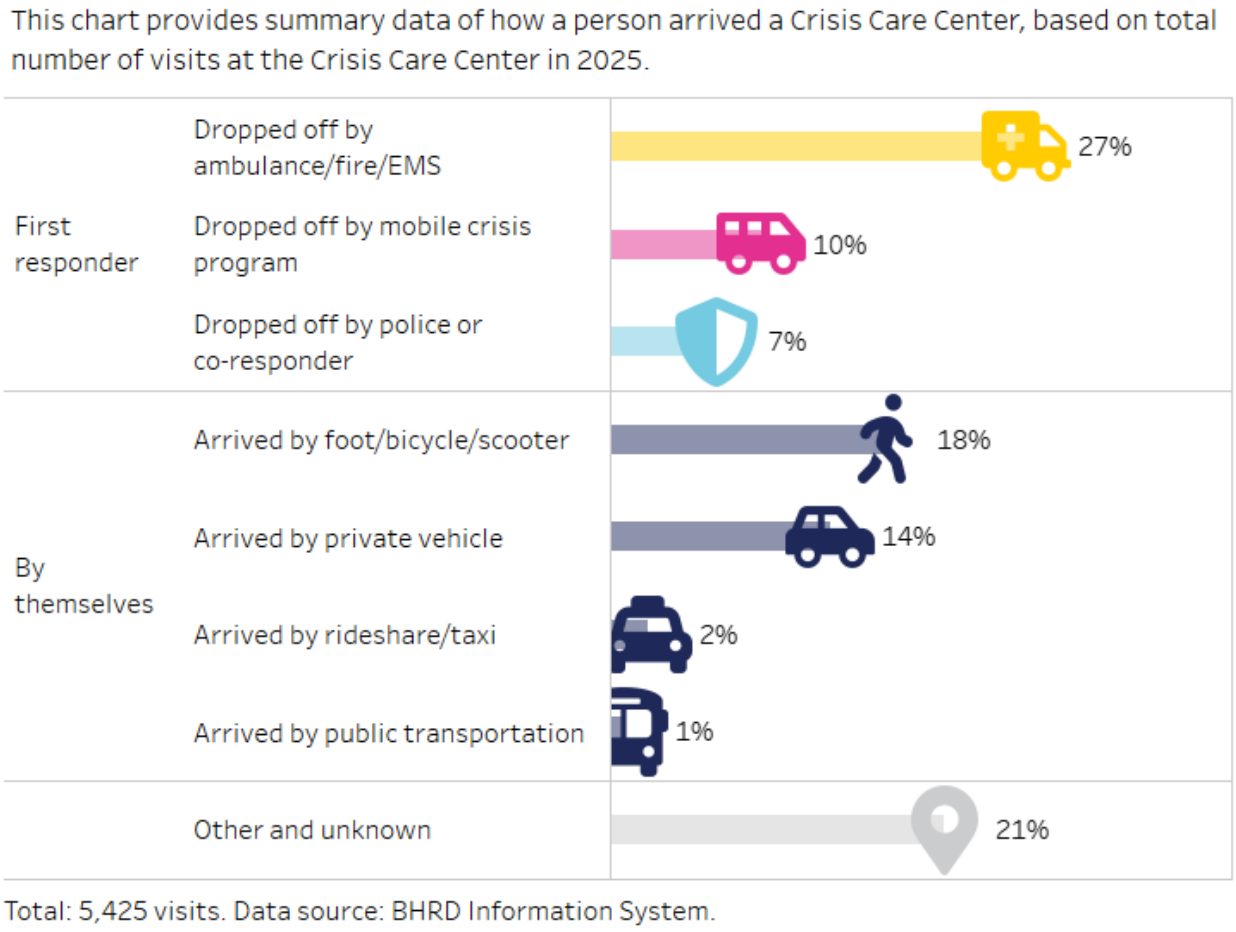
2026 Proposal Updates: The CCC Proposal Update Summary Letter, transmitted in October 2026, includes updates to CCC awards and contracts.[18] The County has started work to renovate the Central CRZ facility. Additionally, the County is working with the South CRZ operator to locate a viable site for that facility. The County has not yet selected operators for the East CRZ and youth-focused CCCs.

Transportation Data. The CCC Levy Implementation Plan requires reporting on how a patient was transported to a CCC as well as their insurance status. Data must be specifically disaggregated for each crisis center. According to the Behavioral Health and Recovery Division Information System, approximately 27% of visits to the North Regional CCC were from individuals who were dropped off by ambulance, fire, or emergency medical services (EMS). The second most frequent arrival mode was by foot, bicycle, or scooter (totaling 18% of visits). DCHS notes the 21% unknown number reflects the early

[17] The location of this CCC is 1145 Broadway and DCHS refers to this location as the "Broadway Facility".
[18] CCC Proposal Update Summary letter, October 2026, King County - File #: 2026-RPT0116.

data collection process and according to the 2025 Annual Report, DCHS expects that 2026 data will more fully reflect mode-of-arrival patterns, with a substantially lower "other/unknown" count.[19] Figure 2 (taken from the 2025 Annual Report) shows a breakdown of modes of transportation to the North Regional CCC.

Figure 2. Crisis Care Center Mode of Transportation[20]



Reporting on Assessment of Residential Treatment Financial Plan. The Implementation Plan also requires reporting on whether the CCC financial plan remains on target for residential treatment capacity investments. According to the 2025 Annual Report, the CCC Levy maintains the financial capacity to restore, expand, and sustain mental health residential treatment to 355 beds countywide. In response to Council staff questions, DCHS reports that the number of treatment beds at the end of 2025 is 240, unchanged from 2024.

[19] 2025 Crisis Care Centers Annual Report, 2025 Crisis Care Centers Annual Report - King County, Washington.
[20] This Image was taken from the 2025 Crisis Care Centers Annual Report, 2025 Crisis Care Centers Annual Report - King County, Washington.

Fiscal and Performance Measurement. The Implementation Plan also requires reporting on the CCC Levy's fiscal and performance measurement during the applicable calendar year.

Fiscal Measurement

The 2025 Annual Report includes tables on financial expenditures in 2025 and an explanation of the difference between budgeted and actual expenditures in each Strategy.

Performance Measurement

The Implementation Plan does not include detailed reporting requirements for what type of information is to be reported for performance measurement in the Annual Report. The 2025 CCC Annual Report includes a brief discussion on performance measurement activities.

In additional information provided to Council staff, DCHS noted performance measures are documented in the Performance Measurement plans for many levy-funded programs and that they are shared regularly with providers and partners during program discussions and meetings. Many of the data points from the Performance Measurement Plans quantifying services provided are included throughout the report. This includes: the number of behavioral health counselors embedded in 911 call centers, number of mobile rapid response crisis team responses, number of instances of Pioneer Square Client Engagement, and number of overdose prevention supplies and resources distributed.

Additionally, DCHS noted, there is an online data source available to explore outcomes across DCHS programs: DCHS Explore the data - King County, Washington.

Geographic Distribution. The CCC Levy Implementation Plan requires a map or summary describing the Levy's geographic distribution. This requirement appears to be met with the online geographic interface showing distribution of expenditures by ZIP Code. Additionally, the Implementation Plan requires DCHS, in consultation with cities, to develop strategies for ZIP Code reporting for the Levy's Supporting Purpose Two, workforce development and include a plan for annual reporting of this information in the Executive's 2026 career pathways notification letter. DCHS transmitted this notification letter on May 28, 2026, and according to the letter DCHS intends to report these ZIP Code metrics in the Annual Report beginning in 2027.

Year-Over-Year Comparison Data. The Implementation Plan requires DCHS, in consultation with Cities and the Sound Cities Association, to provide historical and current data in a manner that can be used to analyze services and to make year-over year comparisons. As noted in the 2025 Annual Report, DCHS is in the process of consulting with the Sound Cities Association to incorporate year-over-year comparison data for Levy-

funded programs as well as rolled up across Levy strategies, starting with the 2026 Annual Report.

INVITED

- Mark Cooke, CCC Community Impact Project Manager, DCHS Behavioral Health and Recovery Division
- Denille Bezemer, Acting Deputy Division Director, DCHS Behavioral Health and Recovery Division

ATTACHMENTS

1. Proposed Motion 2026-0223
2. 2025 CCC Annual Summary Letter
3. Cities and Unincorporated Parts of King County Located Within Each CRZ

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

Motion

Proposed No. 2026-0223.1 **Sponsors**

A MOTION acknowledging receipt of the summary letter and completion of the online annual report requirement for the Crisis Care Centers Levy, in accordance with Ordinance 19572, Section 7.C.9, and Attachment A to Ordinance 19783, Section VIII.A.

WHEREAS, in 2023, King County enacted Ordinance 19572 to provide for the submission to voters of a property tax levy in excess of the levy limitation contained in chapter 84.55 RCW, for the nine-year period of 2024 through 2032, for regional behavioral health services and capital facilities to establish and operate a regional network of behavioral health crisis care centers; to preserve, expand and maintain residential treatment facilities; to provide behavioral health workforce supports; to provide mobile crisis care and post-discharge stabilization; to pay, finance or refinance costs of those projects; and for administration, coordination, implementation and evaluation of levy activities, and

WHEREAS, King County voters considered the levy as Proposition No. 1 as part of the April 2023 special election, and fifty-seven percent of voters approved it, and

WHEREAS, Ordinance 19572, Section 7.C.9, requires online annual reports on the levy's progress over the previous year beginning in 2025, and

WHEREAS, on December 29, 2023, in accordance with Ordinance 19572, the executive transmitted to the council for review and adoption an implementation plan that described the purposes, strategies, financial plan, and reporting requirements for the levy from 2024 through 2032, and

WHEREAS, Ordinance 19783, Section 1, adopted the implementation plan in June 2024, and

WHEREAS, consistent with Ordinance 19572, the implementation plan requires the executive to make the online annual report available to the council, the regional policy committee, and the public, by August 15 of each year, and

WHEREAS, Section VIII.A of the implementation plan requires the executive to transmit to the council a summary of the online annual reporting in the form of a letter, and a motion to acknowledge receipt of the summary letter and completion of the online annual report requirement, by August 15 of each year, and

WHEREAS, the 2025 online annual report has been made available to the council, the regional policy committee, and the public, and

WHEREAS, the summary letter summarizing the 2025 online annual report, is submitted by the executive;

NOW, THEREFORE, BE IT MOVED by the Council of King County:

The receipt of the summary letter summarizing the 2025 online annual report and completion of the online annual report requirement on the Crisis Care Centers Levy, in

accordance with Ordinance 19572, Section 7.C.9., and Attachment A to Ordinance 19783, Section VIII A., is hereby acknowledged.

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

_____

ATTEST:

_____

APPROVED this _____ day of _____, _____.

_____

Attachments: None

King County | Office of the Executive

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

August 14, 2026

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

Dear Councilmember Perry:

In accordance with Ordinance 19572, Ordinance 19783, and the Crisis Care Centers (CCC) Levy Implementation Plan 2024-2032, this letter summarizes the CCC Levy's 2025 online annual report, which is available here: https://kingcounty.gov/en/dept/dchs/human-social-services/community-funded-initiatives/crisis-care-centers-levy/annual-report. Accompanying this letter is a Motion that, if enacted, would acknowledge receipt of the summary letter and completion of the online annual report requirement.

Reporting Requirements
The online annual report and this letter summarize the activities of the CCC Levy Initiative through the end of 2025 and fulfills the Initiative's annual reporting requirements per Ordinance 19572. Specifically, it includes summaries of the accomplishments of the expenditure of CCC Levy sales tax proceeds in 2025 as well as financial information and geographic distribution data. On August 6, 2026, the Behavioral Health Advisory Board reviewed and certified the online annual report.

The online annual report includes an overview of accomplishments, highlighting major milestones, service delivery innovations, and progress in improving behavioral health crisis care across King County. It also includes a review of fiscal and performance management, explaining expenditure alongside measurable impacts stemming from Levy funding. The report further provides details on the expenditure of Levy proceeds by crisis response zone (CRZ), strategy, and Levy purpose by King County ZIP code, and summarizes the geographic distribution of CCC Levy funding and distribution of individuals served across King County. This information is presented in greater depth within the online report. The online report also includes other information such as updates on Crisis Care Center siting, operator selection, and contracting; facility utilization;

transportation data; and updates on other Levy-funded strategies including but not limited to mobile crisis investments, residential treatment, and workforce programming. A crosswalk of how the report addresses each reporting requirement is also included in the online report.

Overview of Accomplishments and Progress

In 2025, King County continued to implement the CCC Levy, making it possible for more people to access crisis care services in King County than ever before. Amid a shifting local, state, and federal landscape, King County built on a strong foundation of early investments and program start up from 2024 by working diligently in 2025, the first full year of Levy implementation, to expand and launch new programs across Levy strategies. The Department of Community and Human Services (DCHS) drove measurable progress by establishing Crisis Care Centers and residential treatment facilities, strengthening the behavioral health workforce, and bringing more low-barrier crisis services online. Community engagement was a priority across all CCC Levy activities, to inform implementation and to hear from community members about what is working and what needs improvement. In total, DCHS invested about $64 million in 2025 across Levy strategies.

Key 2025 accomplishments across levy strategies include:

- **Strategy 1: Create and Operate Five Crisis Care Centers:** The first Regional Crisis Care Center in Kirkland, the North CRZ, began operating, and the County purchased a site and selected an operator for the Crisis Care Center in the Central CRZ.
- **Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity:** Awarded capital funds to support residential treatment capacity.
- **Strategy 3: Strengthen the Community Behavioral Health Workforce:** Invested across three initiatives to strengthen the behavioral health workforce.
- **Strategy 4: Early Crisis Response Investments:** Continued to expand crisis response capacity with ongoing early investments including mobile crisis service expansion for both youth and adults.
- **Strategy 5: Capacity Building and Technical Assistance:** Funded capacity building and technical assistance contracts with three consultant agencies.
- **Strategy 6: Evaluation and Performance Management:** Measured, analyzed, and reported on the impact of the CCC Levy to inform quality improvement initiatives and for reporting purposes.
- **Strategy 7: CCC Levy Administration:** Promoted accountability to the community through community engagement and quality assurance initiatives.
- **Strategy 8: CCC Levy Reserves:** Maintained the Levy fund reserve requirement.

The CCC Levy Implementation Plan prioritizes community engagement to inform implementation, and to engage community around Crisis Care Center openings and new available services. In 2025, DCHS participated in over 100 community engagement activities, with an emphasis on interacting with populations experiencing behavioral health inequities.

Fiscal and Performance Measurement

Financial Expenditures

In 2025, DCHS implemented and refined financial systems and internal capacity needed to oversee the CCC Levy and meet long-term goals. The CCC Levy's 2025 budget was $122.1 million, while actual spending totaled $64 million. The online annual report includes a detailed table of actual levy expenditures in 2025. The difference between budgeted amounts and expenditure was primarily due to capital project spending timelines extending beyond 2025 in two Levy strategies.

Strategy 1, Create and Operate Five Crisis Care Centers, had a budget of $59.9 million in 2025, and $40 million was spent. The $19.9 million difference reflects deferred expenditures for Crisis Care Center capital projects. As future Crisis Care Center locations and related capital projects are identified, the budgeted capital costs for renovation and conversion will be expended.

Strategy 2, Restore, Expand, and Sustain Residential Treatment Capacity, used its 2025 budget of $33.3 million to secure $35.9 million in awards, with $1.7 million expended. Capital activities often face longer timelines for expenditure due to issues such as siting, construction limitations, and decision-making across multiple levels of government. As more Residential Treatment Facilities come online and capital awardees draw down funds, annual funding is expected to more closely match budgeted amounts.

Performance Measurement

In 2025, performance measurement efforts continued building the evaluation and performance measurement framework outlined in the CCC Levy Implementation Plan. DCHS continued partnering with providers in 2025 to establish data collection and performance measures, including with Crisis Care Center operators, mobile crisis service providers, and behavioral health workforce programs. Community input also helped identify measures of success that are important to the community, such as an emphasis on documenting demographic data to identify potential disparities and to measure equity impacts on the effectiveness of services.

DCHS will continue refining the performance measurement evaluation framework to meet other requirements in future annual reports, such as consultation with cities and the Sound Cities Association about year-over-year comparisons and aligning CCC Levy performance measurement and reporting with other dedicated human services funding initiatives.

Geographic Distribution

Distribution of Expenditures by ZIP Code

In 2025, CCC Levy investments continued to support the entire county, with some programmatic investments connected to specific facilities or service areas. For example, investments in strengthening the behavioral health workforce, mobile crisis response, and overdose prevention supplies and resources were available to the entire county. For several programs, including establishing a network of regional Crisis Care Centers, DCHS awarded Levy funds to projects in specific locations, which provide services to county residents regardless of where they live. More

information on the distribution of expenditures, including data for each ZIP Code or CRZ by purpose, strategy, and CCC Levy activity, is available through the online annual report.

Distribution of Individuals Served
In 2025, CCC Levy funded programs served people across the entire county. Specifically, 6,697 people who live across the four CRZs received Levy-funded crisis care from a Crisis Care Center or mobile crisis services. The majority of these people lived in the Central and South CRZs, which have the largest total population. The online annual report contains comprehensive data on the geographic distribution of individuals served.

Looking Ahead

In its second year of implementation, the CCC Levy helped more people access crisis care services in King County than ever before. The County contracted and began promoting the first regional Crisis Care Center, awarded critical funding for residential treatment, and expanded mobile crisis response services. Procurements for additional Crisis Care Center operators and investments in the behavioral health workforce in 2025 also advanced the paramount and supporting purposes of the Levy. As DCHS continues to focus on meeting the goals of the CCC Levy Implementation Plan in partnership with providers and community members, the CCC Levy is well positioned to continue building and operating a behavioral health crisis system that offers timely, compassionate, and effective care to all residents and is a key component of the effort to Break the Cycle.

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

Sincerely,



for

Girmay Zahilay
King County Executive

Enclosure

cc: King County Councilmembers
ATTN: Stephanie Cirkovich, Chief of Staff
Melani Hay, Clerk of the Council
Karan Gill, Deputy Executive, Office of the Executive
Jasmin Weaver, Chief of Staff, Office of the Executive
Hyeok Kim, Chief Operating Officer, Office of the Executive
Sierra Howlett Browne, Director of Government Relations, Office of the Executive
Garrett Holbrook, Council Relations Manager, Office of the Executive
Dr. Susan McLaughlin, Director, Department of Community and Human Services

Table 1. Cities and Unincorporated Parts of King County Located Within Each CRZ[1]

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

[1] This Table was taken from the CCC Levy Implementation Plan, Ordinance 19783, King County - File #: 2024-0011.