



KING COUNTY

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Signature Report

Ordinance 19783

Proposed No. 2024-0011.3

Sponsors von Reichbauer, Zahilay and Mosqueda

1 AN ORDINANCE adopting the crisis care centers levy
 2 implementation plan, required by Ordinance 19572, Section
 3 7.A., to govern the expenditure of crisis care centers levy
 4 proceeds from 2024 to 2032 to create a regional network of
 5 five crisis care centers, restore and expand residential
 6 treatment capacity, and increase the sustainability and
 7 representativeness of the behavioral health workforce in
 8 King County.

9 **STATEMENT OF FACTS:**

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

15 2. Among people enrolled in Medicaid in King County in 2022, 45,000
 16 out of 88,000, which is 51 percent, of adults with an identified mental
 17 health need did not receive treatment, and 21,000 of 32,000, which is 66
 18 percent, of adults with an identified substance use need did not receive
 19 treatment.

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20 3. The gap in accessing behavioral health services is not evenly
21 experienced across King County's population. There are significant
22 inequities in service access and utilization among historically and
23 currently underserved communities. Black, Indigenous, and People of
24 Color populations are more frequently placed in involuntary treatment
25 while having the least access to routine behavioral health care.

26 4. The scale of suffering related to mental health conditions and substance
27 use remains persistently elevated. 1,229 people died by suicide in
28 Washington in 2021, equivalent to 15.3 out of every 100,000 people,
29 which is the 27th highest rate nationally. 292 people died by suicide in
30 King County in 2021. Suicide deaths increased nationally by 2.6 percent
31 from 2021 to 2022. Youth are especially impacted. According to the
32 2021 Healthy Youth Survey, 18.6 percent of King County's 8th graders
33 considered suicide in past year, and 8.8 percent made attempts. Among
34 Washington's 10th graders in 2021, 51.6 percent of gender-diverse youth
35 and 42.4 percent of youth identifying as LGBTQIA+ considered suicide,
36 and 22.7 percent and 17.9 percent attempted suicide, respectively.

37 5. Deaths related to drug overdose are increasing at unprecedented rates.
38 The annual number of overdose deaths in King County have nearly
39 doubled in just three years, from 508 deaths in 2020 to 1,001 in 2022, and
40 the number of fatal overdoses in 2023 has already exceeded that total.
41 There are significant disparities in overdose deaths by race and ethnicity.
42 The age-adjusted rate of fatal overdoses in King County is the highest in

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43 the American Indian/Alaska Native community and is five times higher
44 than non-Hispanic White King County residents.

45 6. The Federal Substance Abuse and Mental Health Services
46 Administration ("SAMHSA") released its National Guidelines for
47 Behavioral Health Crisis Care in 2020. Those guidelines call for the
48 creation of crisis facilities, referred to by SAMHSA as "somewhere to go"
49 for people in crisis to seek help. SAMHSA's guidelines envision crisis
50 facilities as part of a robust behavioral health crisis system that also
51 includes the 988 Suicide and Crisis Lifeline, referred to as "someone to
52 call," and mobile crisis teams, described as "someone to respond."

53 7. As of December 2023, the Crisis Solutions Center, operated by
54 Downtown Emergency Service Center and requiring mobile team, first
55 responder or hospital referral for entry, is the only voluntary behavioral
56 health crisis facility for the entirety of King County, and a walk-in urgent
57 care behavioral health facility does not exist in King County. For youth in
58 King County, there is not a crisis facility option at all.

59 8. King County's behavioral health crisis service system relies heavily on
60 phone support and outreach services, with very few options of places for
61 persons to go for immediate, life-saving care when in crisis.

62 9. A coalition of community leaders and behavioral health providers
63 issued recommendations to Seattle and King County in an October 13,
64 2021, letter that included recommendations to "expand places for people

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65 in crisis to receive immediate support" and "expand crisis response and
66 post-crisis follow up services."

67 10. Multiple behavioral health system needs assessments have identified
68 the addition of crisis facilities as top priorities to improve community-
69 based crisis services in King County. Such assessments include the 2016
70 recommendations of the Community Alternatives to Boarding Task Force
71 called for by Motion 14225, a Washington state Office of Financial
72 Management behavioral health capital funding prioritization and
73 feasibility study in 2018, and a Washington state Health Care Authority
74 crisis triage and stabilization capacity and gaps report in 2019.

75 11. King County is losing mental health residential treatment capacity that
76 is essential for persons who need more intensive supports to live safely in
77 the community due to rising operating costs and aging facilities that need
78 repair or replacement. As of October 2023, King County had a total of
79 240 mental health residential beds for the entire county, down 115 beds, or
80 nearly one third, from the capacity in 2018 of 355 beds.

81 12. As of October 2023, King County residents who need mental health
82 residential services must wait an average of 25 days before they are able to
83 be placed in a residential facility.

84 13. The 2023 King County nonprofit wage and benefits survey found that
85 employee compensation is a key factor contributing to nonprofit
86 employees leaving the sector, even though they are satisfied with their
87 jobs overall.

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88 14. A 2023 King County survey of member organizations of the King
89 County Integrated Care Network found that found that there were
90 approximately 600 staff vacancies across the agencies that responded to
91 the survey, a 16-percent total vacancy rate at King County community
92 behavioral health agencies, and there is still a need to hire more behavioral
93 health workers to support the growing behavioral health care needs in the
94 community.

95 15. In September 2022, alongside a broad coalition of elected officials,
96 behavioral health workers and providers, emergency responders, and
97 businesses, the executive announced a plan to address King County's
98 behavioral health crisis and improve the availability and sustainability of
99 behavioral health care in King County through a nine-year property tax
100 levy known as the crisis care centers levy.

101 16. On February 9, 2023, King County adopted Ordinance 19572 to
102 provide for the submission of the crisis care centers levy to the voters of
103 King County.

104 17. King County voters considered the levy as Proposition No. 1 as part
105 of the April 25, 2023, special election, and fifty-seven percent of voters
106 approved it.

107 18. The passage of Proposition No. 1 authorized the crisis care centers
108 levy that will raise proceeds from 2024 to 2032 to create a regional
109 network of five crisis care centers, restore and expand residential

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110 treatment capacity, and increase the sustainability and representativeness
111 of the behavioral health workforce in King County.

112 19. Ordinance 19572, Section 7.A., requires the executive to develop and
113 transmit for council review and adoption by ordinance an implementation
114 plan for the crisis care centers levy. The implementation plan, once
115 effective, will govern the expenditure of the levy's proceeds until the crisis
116 care centers levy expires in 2032. The required implementation plan is
117 Attachment A to this ordinance.

118 20. Ordinance 19572, Section 7.C., enumerates specific requirements for
119 the implementation plan. The crisis care centers levy implementation plan
120 2024-2032, Attachment A to this ordinance, responds to the requirements
121 set out by Ordinance 19572, Section 7.C., by: describing the purposes of
122 the levy; describing the strategies and allowable activities to achieve the
123 levy's purposes; describing the financial plan to direct the use of levy
124 proceeds; describing how the executive will seek and incorporate federal,
125 state, philanthropic and other resources when available; describing the
126 executive's assumptions about the role of Medicaid funding in the
127 financial plan; describing the process by which King County and partner
128 cities will collaborate to support siting of new capital facilities that use
129 proceeds from the levy for such facilities' construction or acquisition;
130 describing a summary and key findings of the community engagement
131 process; describing the process to make adjustments to the financial plan;
132 describing the advisory body for the levy; describing measurable results

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133 and a coordinated performance monitoring and reporting framework;
134 describing how the levy's required online annual report will be provided to
135 councilmembers, the regional policy committee or its successor, and the
136 public; and describing how crisis response zones described in the levy will
137 promote geographic distribution of crisis care centers.

138 BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:

139 SECTION 1. The crisis care centers levy implementation plan 2024-2032,


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140 Attachment A to this ordinance, is hereby adopted to govern the expenditure of crisis care
141 centers levy proceeds as authorized under Ordinance 19572.

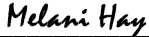
Ordinance 19783 was introduced on 1/16/2024 and passed by the Metropolitan King County Council on 6/18/2024, by the following vote:

Yes: 9 - Balducci, Barón, Dembowski, Dunn, Mosqueda, Perry, Upthegrove, von Reichbauer and Zahilay

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON

DocuSigned by:

E76CE01F07B14EF...
Dave Upthegrove, Chair

ATTEST:

DocuSigned by:

8DE1BB375AD3422...
Melani Hay, Clerk of the Council

APPROVED this _____ day of 7/1/2024, _____.

DocuSigned by:

4FBCAB8196AE4C6...
Dow Constantine, County Executive

Attachments: A. Crisis Care Centers Levy Implementation Plan 2024-2032, dated June 2024

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**Crisis Care Centers Levy
Implementation Plan 2024-2032**

June 2024



King County

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164

165

166 **II. Executive Summary**

167 The Crisis Care Centers (CCC) Levy is a once-in-a-generation opportunity to transform how people
 168 experiencing behavioral health crises can access specialized behavioral health care. This nine-year
 169 property tax levy will create a countywide network of five crisis care centers, restore residential
 170 treatment capacity, and strengthen King County’s community behavioral health workforce. The CCC
 171 Levy is authorized by King County Ordinance 19572 (see [Appendix A: Crisis Care Centers Levy Ordinance](#)
 172 [19572 Text and hereinafter referred to as Ordinance 19572](#)).
 173

174 **Crisis Care Centers Levy Purposes**

175 Ordinance 19572 defines the CCC Levy’s Paramount Purpose and two Supporting Purposes, which are
 176 more fully described in Figure 1.
 177

178 *Figure 1. Summary of Crisis Care Centers Levy Purposes*

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

179
 180 **Background**
 181

182 **Unmet Behavioral Health Needs in King County**

183 As more developed at [Section III.C. Key Historical and Current Conditions](#) of this CCC Levy
 184 Implementation Plan, federal and state investments in public behavioral health systems have been
 185 inadequate for decades.¹ As funding for behavioral health services has remained inadequate, the needs
 186 of people living with mental health and substance use conditions, generally referred to in this Plan
 187 either singularly or collectively as behavioral health conditions, have grown. The gap between
 188 behavioral health needs and available services is widening. Importantly, this gap is not evenly
 189 experienced across King County’s population. There are significant inequities in service access and
 190 utilization among historically and currently underserved communities.
 191

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

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

195 [Need for Crisis Care Centers](#)

196 The creation of specialized crisis facilities is frequently identified as a key strategy in the crisis service
197 continuum.² These facilities facilitate diverting people from emergency department and carceral settings
198 and serving people in higher quality specialized settings that can provide care using trauma-informed,
199 recovery oriented, and cultural humility best practices.³ Establishing and operating a regional network
200 of five crisis care centers in the County is the paramount purpose to be funded by the CCC Levy.

201
202 [Reduction in Residential Treatment Capacity](#)

203 Residential treatment is a community-based behavioral health treatment option for people who need a
204 higher level of care than outpatient behavioral health services can provide.⁴ As of October 2023, King
205 County had a total of 240 mental health residential treatment beds for the entire county, a decrease of
206 115 beds, down nearly one third from the capacity of 355 beds in 2018.⁵ One of the supporting purposes
207 to be funded by the CCC Levy is to restore the number of residential treatment beds to 355.

208
209 [Behavioral Health Workforce Needs](#)

210 The other supporting purpose to be funded by the CCC levy is to increase the number and diversity of
211 behavioral health workers. There is evidence that improving diversity among behavioral health workers
212 to better reflect the communities they serve may help reduce behavioral health disparities.⁶
213 Concomitant with developing a representative workforce must be the retention of those workers.

214
215 [Crisis Care Centers Levy Implementation Plan Methodology](#)

216 The CCC Levy Implementation Plan (Plan) is the product of an intensive process that began in June 2023
217 and concluded in December 2023. DCHS’s planning activities included engaging community partners,
218 soliciting of formal requests for information (RFIs), engaging with various Washington State
219 departments, consulting with national subject matter experts, coordinating with other County partners,
220 and convening internal workgroups within DCHS.

221
222 [Community Engagement Summary](#)

223 DCHS staff engaged community partners to inform this Plan, including participation from behavioral
224 health agencies, people with lived experiences of behavioral health crises, and frontline behavioral
225 health workers. See [Appendix F: Community Engagement Activities](#) Appendix F: Community Engagement
226 Activities Appendix F: Community Engagement Activities for a complete list of community engagement
227 activities. Engagement activities are summarized in [E. Community Engagement Summary](#). Figure

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

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

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

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

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

228 Behavioral Health Equity Framework

229 The success of the CCC Levy hinges not only on increasing access to behavioral health crisis services but
 230 also on reducing inequities in who can access that care. Inequities in who can access behavioral health
 231 care at the time of this Plan’s drafting are described in [Section III.C. Who Experiences Behavioral Health](#)
 232 [Inequities](#). During this Plan’s community engagement process, DCHS received extensive feedback from
 233 community partners about the importance of centering health equity in this Plan. In response, this Plan
 234 contains a behavioral health equity framework that will guide DCHS’s implementation of the CCC Levy.
 235 This framework is more fully described at [Section III.F. Behavioral Health Equity Framework](#).

237 Crisis Care Centers Levy Strategies

238 Ordinance 19572 requires this Plan to define strategies for how CCC Levy funds will be invested between
 239 2024 and 2032 to achieve the Levy’s purposes. This Plan’s strategies reflect Ordinance 19572
 240 requirements and input from community partners, subject matter experts, and DCHS staff. Figure 2
 241 summarizes the CCC Levy strategies. These strategies are more fully developed in [Section V. Crisis Care](#)
 242 [Centers Levy Strategies and Allowable Activities](#) of this Plan.

243 *Figure 2. Summary of the CCC Levy Strategies*

Summary of the CCC Levy Strategies	
Strategy	Summary Description
Strategy 1 Create and Operate Five Crisis Care Centers	<ul style="list-style-type: none"> • Capital funding to create and maintain five crisis care centers • Operating funding to support crisis care center personnel costs, operations, services, and quality improvement • Post-crisis follow-up for people after leaving a crisis care center
Strategy 2 Restore, Expand, and Sustain Residential Treatment Capacity	<ul style="list-style-type: none"> • Capital resources to restore mental health residential treatment capacity to at least 355 beds in King County • Capital resources to expand and sustain residential treatment capacity
Strategy 3 Strengthen the Community Behavioral Health Workforce	<ul style="list-style-type: none"> • Resources to expand community behavioral health career pathways, including investments to strengthen and sustain King County’s community behavioral health workforce and increase workforce representativeness • Resources to expand and sustain labor-management workforce development partnerships, including support for apprenticeships • Resources to support the development of the region’s behavioral health crisis workforce, including crisis care center workers
Strategy 4 Early Crisis Response Investments	<ul style="list-style-type: none"> • Resources to expand community-based crisis service capacity starting in 2024, before crisis care centers are open • Resources starting in 2024 to respond faster to the overdose crisis
Strategy 5 Capacity Building and Technical Assistance	<ul style="list-style-type: none"> • Resources to support the implementation of CCC Levy strategies • Support for capital facility siting • Build capacity for culturally and linguistically appropriate services
Strategy 6 Evaluation and Performance Measurement	<ul style="list-style-type: none"> • Resources to support CCC Levy data collection, evaluation, and performance management • Analyses of the CCC Levy’s impact on behavioral health equity

Summary of the CCC Levy Strategies	
Strategy	Summary Description
Strategy 7 CCC Levy Administration	<ul style="list-style-type: none"> Investments in CCC Levy administration, community engagement, information technology systems infrastructure, and designated crisis responder (DCR) accessibility⁷
Strategy 8 CCC Levy Reserves	<ul style="list-style-type: none"> Provide for and maintain CCC Levy reserves^{8,9}

245

246 **Crisis Care Centers Implementation Timeline**

247 DCHS intends to prioritize opening five crisis care centers as quickly as possible to meet the urgent
 248 needs of people experiencing behavioral health crises. DCHS plans to select crisis care center operators
 249 through an annual competitive procurement process starting in 2024. The first procurement round in
 250 2024 will prefer crisis care center proposals that can be developed and begin serving people rapidly.

251

252 **Restore, Expand, and Sustain Residential Treatment Capacity**

253 Supporting Purpose 1 of the CCC Levy, to restore, expand, and sustain residential treatment capacity
 254 will be implemented through Strategy 2. Sustaining residential treatment capacity means investing in
 255 existing residential treatment capital facilities to help prevent further facility closures. King County has
 256 lost one-third of its mental health residential treatment capacity since 2018. Strategy 2 funds and
 257 activities will be prioritized to support existing residential treatment operators to prevent further facility
 258 closures and restore King County's mental health residential capacity to at least the 2018 level of 355
 259 beds.¹⁰

260

261 **Strengthen the Community Behavioral Health Workforce**

262 It takes people to treat people. Supporting Purpose 2 will be implemented through Strategy 3, by
 263 investing in activities to strengthen King County's community behavioral health workforce. This strategy
 264 also directly supports the CCC Levy's Paramount Purpose to establish and operate five crisis care centers
 265 by investing in the development of King County's behavioral health crisis workforce, including crisis care
 266 center workers. Strategy 3's workforce activities focus on helping more people get hired and make a
 267 career in community behavioral health.

268

269 **Financial Plan**

270 The financial plan is more fully described at the Plan's Section VI.B. Financial Plan. It includes the CCC
 271 Levy's expected annual revenues and expenditures between 2024 and 2032, with the projected
 272 amounts of annual investment for each of the CCC Levy's strategies. The financial plan includes health
 273 insurance revenue assumptions, which account for the share of crisis care center expenses that are
 274 projected to be paid for by health insurance, including Medicaid. CCC Levy reserves are also depicted in
 275 the financial plan.

⁷ King County Crisis and Commitment Services offers evaluation of people with behavioral health disorders for involuntary detention in psychiatric and secure withdrawal facilities according to Washington law. The law for adults is RCW 71.05. [\[LINK\]](#) For youth 13 through 17 years of age the law is RCW 71.34. [\[LINK\]](#) Crisis and Commitment staff who perform these duties are referred to as Designated Crisis Responders (DCRs). [\[LINK\]](#)

⁸ Ordinance 19704 created the crisis care center fund to account for CCC Levy proceeds. [\[LINK\]](#)

⁹ This strategy creates a fund reserve equal to 60 days of budgeted expenditures, less capital expenses, consistent with King County Comprehensive Financial Management Policies (2016). [\[LINK\]](#)

276 **Evaluation and Performance Measurement**

277 The CCC Levy requires evaluation and performance measurements. This Plan focuses on reporting
278 measures relevant to monitoring performance of the CCC Levy, advancing continuous quality
279 improvement, and generating clear and actionable evaluation products for the public. It is critical that
280 the crisis services system can grow and evolve by building on what works well and improving what does
281 not. This process should be continuously informed by performance metrics, outcome data, client
282 experiences, and other relevant information. See

283 [VII. Evaluation and Performance Measurement](#) for more information about the CCC Levy’s evaluation
284 and performance measurement plan.

285

286 **Crisis Care Centers Annual Reporting**

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

296

297 **Crisis Care Centers Levy Advisory Body**

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

304

305 **Conclusion**

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

314

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

317 **III. Background**

318 **A. Department of Community and Human Services**

319 **Department Overview**

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

- 328 • Best Starts for Kids (BSK) voter-approved property tax levy;¹¹
- 329 • Health Through Housing (HTH) initiative funded through a County Council-adopted sales tax;¹²
- 330 • MIDD behavioral health sales tax fund adopted by the County Council;¹³
- 331 • Veterans, Seniors, and Human Services Levy (VSHSL) voter approved property tax levy,¹⁴ and,
- 332 • The Crisis Care Centers (CCC) Levy, a voter approved property tax levy.¹⁵

333

334 **Behavioral Health and Recovery Division**

335 [DCHS's Behavioral Health and Recovery Division \(BHRD\)](#) is responsible for managing and funding
336 behavioral health services and programs for King County residents enrolled in Medicaid and other
337 people with low incomes,¹⁶ as well as all residents in need of behavioral health crisis services.
338 Approximately 70,000 County residents annually receive services through BHRD programs. BHRD
339 primarily contracts with community behavioral health agencies¹⁷ to provide a full continuum of services.
340 However, in some cases, like involuntary commitment services, BHRD-employed staff provide services
341 directly.¹⁸

342

343 **B. The Crisis Care Centers Levy and King County Ordinance 19572**

344 Ordinance 19572 defines the CCC Levy's paramount and supporting purposes , which are summarized in
345 Figure 3 and further described in [Section IV. Crisis Care Centers Levy Purposes](#). A crosswalk matrix

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

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

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

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

¹⁵ King County Ordinance 19572 [\[LINK\]](#)

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

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

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

346 detailing how this Implementation Plan (Plan) addresses each of Ordinance 19572’s Plan requirements is
 347 included in [Appendix B: Crosswalk of Implementation Plan Requirements from King County Ordinance](#)
 348 19572. The background section provides additional context about the CCC Levy, including:
 349

- Context about King County’s behavioral health system;
- The current and historical conditions that created the need for the CCC Levy;
- The methodology used to develop this Plan;
- The community engagement process that helped inform this Plan’s recommendations, and,
- Behavioral health equity framework to guide the implementation of this Plan.

 354

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

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

356
 357 **C. Key Historical and Current Conditions**

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

363
 364 **Behavioral Health Service Funding Limitations and Opportunities**

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

371
 372 Medicaid, which combines state and federal resources and is subject to federal regulations, is
 373 administered in Washington by the Health Care Authority (HCA) and locally by the KCICN. Medicaid is an
 374 essential funding source, but it features two significant shortcomings:

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

- 375
- 376
- 377
- 378
- 379
- 380
- Medicaid reimburses less than care costs. King County’s analysis of preliminary results from a Washington State rate comparison study conducted by an actuarial firm determined that Medicaid payment rates in King County fall significantly short of provider costs to deliver care.²⁰
 - Medicaid does not reimburse at all for many essential costs. Medicaid is highly regulated and limits how and for whom funds may be used, including restrictions on important types of staff activities and creating new facilities through capital investments.²¹

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

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

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

	King County Integrated Care Network (KCICN)	Behavioral Health Administrative Services Organization (BH-ASO)	MIDD Behavioral Health Sales Tax	Other Behavioral Health Funding
Funding Source	Medicaid (federal and state)	State general funds; federal mental health and substance abuse block grants, and state funds for specific programs	King County’s 0.1 percent MIDD Behavioral Health Sales Tax Fund ²²	Other funds from local and state governments. These include a mix of state grants, levy funds, and local taxes, and contracts with other local governments.
Proportion of Behavioral Health Funding	About 56 percent	About 11 percent	About 20 percent	About 13 percent
Administration	BHRD administers the KCICN and receives funding from HCA via five Medicaid managed care organizations ²³	HCA contracts with BHRD to administer the BH-ASO; HCA mandates investment priorities ²⁴	BHRD administers funds to complement Medicaid and state funding ²⁵	BHRD administers funds in compliance with specific grant and contract requirements, as applicable.
Systems and Services Funded	Over 40 behavioral health agencies provide integrated direct services across the behavioral health continuum, and partner with King County to create access to a high-quality, coordinated system of care ²⁶	Provides for regional crisis services for all residents through mobile crisis and regional crisis lines; covers services for people who are not eligible for Medicaid; staff to carry out the State’s involuntary commitment statutes; and additional programs ²⁷	52 initiatives including prevention and early intervention; crisis diversion including King County’s only crisis facility; recovery and reentry services; system improvements to expand access to care, and therapeutic courts.	Other funds primarily provide dedicated support for specific purposes, as identified by the revenue source’s grantor or governing authority. A portion of these other funds are flexible and can be used generally for behavioral health programs and services.

382

²² MIDD is referred to in King County Code and related legislation as the mental illness and drug dependency fund, tax, or levy. KCC 4A.500.300 and 4A.500.309 [LINK]. See also the MIDD Behavioral Health Sales Tax Fund website [LINK].

²³ The KCICN Improves Access to Behavioral Health Care for Residents Furthest from Care. (2023) [LINK]

²⁴ Washington State Health Care Authority Behavioral Health Administrative Services Organization (BH-ASO) fact sheet [LINK]

²⁵ MIDD Implementation Plan [LINK]

²⁶ King County Integrated Managed Care (IMC) and Integrated Care Network (KCICN) Overview [LINK]

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

383 Additional federal block grant and state general funds distributed from HCA to King County through the
 384 BH-ASO come with prescriptive requirements. Between 2019 and 2022, Washington State’s BH-ASO
 385 funding provided approximately \$24 million less in total than King County’s costs to fulfill its state-
 386 mandated crisis service obligations during that period.²⁸ As a result, the County subsidizes state-required
 387 BH-ASO functions with local MIDD Behavioral Health Sales Tax funds.²⁹

388
 389 Years of consistently paying less in Medicaid and BH-ASO funds than it costs to provide care have
 390 created a chronically underfunded behavioral health system that is challenged to meet growing needs or
 391 make long term investments. The focus on funding services rather than facilities has been made worse
 392 by limited state capital investment in community behavioral health facilities and workforce
 393 development.^{30,31,32} These factors have combined to cause a loss of facilities and workforce and have
 394 inhibited new facility-based capacity at the scale that King County needs. Despite these barriers, King
 395 County is leading the state in regional service delivery innovation by creating the KCICN to make care
 396 more integrated and effective and by braiding Medicaid, BH-ASO, and MIDD funds.

397

398 [Unprecedented Rates of Suicide and Overdose Deaths](#)

399 The scale of suffering related to behavioral health conditions remain persistently elevated. A total of
 400 1,229 people died by suicide in Washington in 2021, equivalent to 15.3 out of every 100,000 people,
 401 which is the 27th highest rate nationally.³³ King County accounted for 292 deaths by suicide in 2021.³⁴
 402 Suicide deaths increased nationally by 2.6 percent from 2021 to 2022.³⁵ In the State of Washington,
 403 suicide is the seventh leading cause of years of potential life lost, surpassing liver disease, diabetes, and
 404 HIV.³⁶

405

406 Youth are especially impacted. According to the 2021 Healthy Youth Survey, 18.6 percent of King
 407 County’s 8th graders considered suicide in past year, and 8.8 percent made attempts.³⁷ Among
 408 Washington’s 10th graders in 2021, 51.6 percent of gender-diverse youth and 42.4 percent of youth

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

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

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

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

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

³³ Centers for Disease Control - Suicide Rates by State [\[LINK\]](#)

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

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

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

³⁷ Washington State Healthy Youth Survey fact sheets [\[LINK\]](#)

409 identifying as LGBTQIA+ considered suicide, and 22.7 percent and 17.9 percent attempted suicide,
410 respectively.^{38,39}

411
412 Deaths related to drug overdose are increasing at unprecedented rates. The annual number of overdose
413 deaths in King County have nearly doubled in just three years, from 508 deaths in 2020 to 1,001 in 2022,
414 and the number of fatal overdoses in 2023 has already exceeded this total.⁴⁰ Additionally, there are
415 significant disparities in overdose deaths by race and ethnicity. The age-adjusted rate of fatal overdoses
416 in King County is the highest in the American Indian/Alaska Native community and is five-times higher
417 than non-Hispanic White King County residents.⁴¹

418

419 [Unmet Behavioral Health Service Needs](#)

420 As funding for behavioral health services has remained inadequate, the needs of people with behavioral
421 health conditions, have only grown. The gap between behavioral health needs and available services is
422 widening. Importantly, this gap is not evenly experienced across King County's population. There are
423 significant inequities in service access and utilization among historically and currently underserved
424 communities, as described in the next subsection (see [Section III.C. Who Experiences Behavioral Health
425 Inequities](#)).

426

427 The National Council for Mental Wellbeing's 2022 access to care survey found that 43 percent of U.S.
428 adults who say they need care for behavioral health conditions did not receive that care due to
429 numerous barriers to accessing and receiving needed treatment.⁴² According to the 2021 National
430 Survey on Drug Use and Health (NSDUH), 1.06 million of the 1.18 million Washingtonians with substance
431 use disorders (90 percent) needed but did not receive treatment, including 51,000 of the 65,000
432 adolescents (79 percent), respectively.⁴³ The 2021 NSDUH also found that 1.2 million adults in
433 Washington received mental health services, which is 75 percent of the 1.6 million Washington adults
434 who were living with a mental health condition.⁴⁴

435

436 The national problem exists locally. Among people enrolled in Medicaid in King County in 2022, 45,000
437 out of 88,000 of adults with an identified mental health need did not receive treatment (51 percent),
438 and 21,000 of 32,000 adults with an identified substance use disorder need did not receive treatment
439 (66 percent).⁴⁵

440

441 Among Medicaid-enrolled children in Washington, 87,000 of the 223,000 children with mental health
442 treatment needs do not receive mental health treatment services (39 percent), and 27,000 of the 33,000

³⁸ Washington Department of Health - Adolescent Mental Health: Significant Challenges and Strategies for Improvement in Washington State [\[LINK\]](#)

³⁹ "LGBTQIA+" is an abbreviation for lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and other sexual orientations or gender identities.

⁴⁰ Washington State Department of Health – Opioid Data [\[LINK\]](#)

⁴¹ PHSKC Overdose Death Report (2022) [\[LINK\]](#)

⁴² National Council for Mental Wellbeing - 2022 Access to Care Survey - [\[LINK\]](#)

⁴³ 2021 National Survey on Drug Use and Health (NSDUH): State-Specific Tables [\[LINK\]](#)

⁴⁴ 2021 National Survey on Drug Use and Health (NSDUH): State-Specific Tables [\[LINK\]](#)

⁴⁵ Washington State Department of Social and Health Services, Cross-System Outcome Measures for Adults Enrolled in Medicaid [\[LINK\]](#)

443 children with substance use disorders (including those with co-occurring mental health disorders) do not
 444 receive behavioral health treatment services (81 percent).⁴⁶

445
 446 In 2022, there were 25,576 behavioral health crisis interactions with in-person crisis intervention and
 447 stabilization programs in King County.⁴⁷ This is substantially less than the approximately 63,000
 448 estimated crisis episodes that would typically occur in a population of approximately 2.3 million,
 449 suggesting a lack of access to these essential services.⁴⁸

450
 451 **Who Experiences Behavioral Health Inequities**
 452 Behavioral health inequities include disparities in how mental health and substance use impact specific
 453 populations and how well those populations can access behavioral health services.⁴⁹ It is also important
 454 to consider how those populations that experience such disparities are impacted by social determinants
 455 of behavioral health such as homelessness.⁵⁰

456
 457 **Given the breadth and complexity of these challenges, this section describes “populations experiencing**
 458 **behavioral health inequities,” which is the term this Plan uses in subsequent sections**
 459 **Key Findings of Community Engagement Process**

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

464 **Figure 6. Summary of Community Engagement Themes**

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

⁴⁶ Washington State Department of Social and Health Services, Behavioral Health Treatment Needs and Outcomes among Medicaid-Enrolled Children in Washington State, November 2023 [\[LINK\]](#)

⁴⁷ King County Behavioral Health Crisis Service Utilization Data Sheet, December 2023.

⁴⁸ The Crisis Resource Need Calculator [\[LINK\]](#). The calculator estimates 230 monthly crisis episodes per population of 100,000, based on an analysis that examined national crisis care claims from Truven Commercial, Truven Medicaid, Medicare Limited Data Set 2018, as well as the estimated number of episodes served by first responders that do not lead to care according to the Treatment Advocacy Center’s Road Runners report.

⁴⁹ American Psychiatric Association - Mental Health Disparities: Diverse Populations [\[LINK\]](#)

⁵⁰ Compton, M. T., & Shim, R. S., The Social Determinants of Mental Health, 2015, FOCUS, 13(4), 419–425. [\[LINK\]](#); Fountain House, From Harm to Health: Centering Racial Equity and Lived Experience in Mental Health Crisis Response, 2021. [\[LINK\]](#)

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

465

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

467 Community partners offered substantial input on the following topics, all focused on how to design a
 468 crisis care center clinical model that works as well as possible. These recommendations are reflected in
 469 the best practices described in [Appendix G: Clinical Best Practices in Behavioral Health Crisis Services](#)
 470 that inform the crisis services described in [A. Strategy 1: Create and Operate Five Crisis Care Centers](#).

471 [Welcoming and Safe](#)

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

480

481 [Person-Centered and Recovery-Oriented Care](#)

482 Community partners described the importance of ensuring that crisis care centers provide
483 person-centered and recovery-oriented care. Peer specialists and people with lived experience
484 of a behavioral health conditions emphasized the importance of keeping people in control of
485 their care as much as possible. They also emphasized minimizing care transitions, maximizing
486 continuity of care, and following up after discharge to start ongoing care.

487

488 [Culturally and Linguistically Appropriate Services](#)

489 Community partners advocated for ensuring that crisis care centers provide culturally and
490 linguistically appropriate services. Such services combine typical clinical best practices with
491 specially trained, often culturally concordant providers who incorporate cultural practices and
492 shared experience into the treatment and relationship with clients. This Plan incorporates this
493 input in:

- 494 • [Crisis Care Center Clinical Program Overview](#)A. Strategy 1: Create and Operate Five Crisis
495 Care Centers, which defines the crisis care center clinical model and post-crisis
496 stabilization resources;
- 497 • [Capacity Building for Providers with Expertise in Culturally and Linguistically Appropriate
498 Services](#), which will invest in capacity building for crisis care centers operators to further
499 enhance their capacity to deliver culturally and linguistically appropriate services, and
- 500 • [A. Evaluation and Performance Measurement Principles](#), which will measure how well
501 crisis care centers are meeting these needs to hold DCHS accountable for implementing
502 and improving upon culturally and linguistically appropriate services.

503 [Integrate Care for People Who Use Substances](#)

504 Community members identified substance use services as an essential resource to include in
505 crisis care centers because so many people in a mental health crisis have co-occurring substance
506 use or their crisis is primarily related to substance use. Service provider partners emphasized
507 that the model should include medication for opioid use disorder (MOUD), withdrawal
508 management (sometimes referred to as “detox”), substance use counseling, distribution of
509 overdose prevention supplies like naloxone, and testing for HIV and Hepatitis C.

510

511 [Least Restrictive Care](#)

512 Community partners, especially peer specialists and people with lived experience of a behavioral
513 health condition, frequently voiced a preference for crisis care center services to be voluntary as
514 much as possible. Some community partners acknowledged that state regulations, as well as
515 rare uncontrollable circumstances, such as when someone is refusing help even when their life
516 is in danger, might require involuntary interventions such as detention by a law enforcement
517 officer, placement of Involuntary Treatment Act (ITA) holds by a designated crisis responder
518 (DCR), involuntary medications, seclusions, and restraints. Most community partners agreed
519 that involuntary interventions should be minimized by proactively engaging someone in
520 treatment decisions whenever possible in the least restrictive setting. Furthermore, community
521 partners expressed consensus that use of involuntary interventions should be a focus of
522 monitoring and accountability for crisis care centers.

523

524 [Special Considerations for Serving Children, Youth, and Young Adults in Crisis](#)

525 Youth, parents, and providers serving youth clearly stated that behavioral health services for
526 youth differ from adult services in many important ways, and that these differences need to be
527 reflected in the youth crisis care center model. Youth behavioral health service providers
528 explained that adolescents’ needs differ from the needs of young children (up to approximately
529 age 12), and very young children (up to age 6) and have their own special needs during a
530 behavioral health crisis. Multiple community partners, including youth, also emphasized the
531 unique needs of transition age youth (ages 18-24), also known as young adults, who may not be
532 well served in a combined crisis care center setting with more mature adults. The needs of
533 families, caregivers, and unaccompanied youth also emerged as important factors. Community
534 members also described the high likelihood that young people with intellectual and
535 developmental disabilities (IDD) will present to crisis care centers. They emphasized the
536 importance of having staff who are specially trained to meet these unique needs. These
537 recommendations were critical to informing the clinical model for the youth crisis care center
538 described in [Clinical Model for Youth Crisis Care Center](#).

539

540 [Additional Clinical and Support Considerations](#)

541 Community members discussed the importance of childcare for parents in a behavioral health
542 crisis, care for pets, safe storage of belongings, nutrition and meal services, full-scope
543 medication formulary, basic laboratory testing, and transportation. Though many of these
544 recommendations are beyond the strategic scope of this Plan, DCHS will take this community
545 feedback into account for future procurement and operational phases of crisis care center
546 services.

547

548 *Theme B: Increase Access to Care for Populations Experiencing Behavioral Health Inequities*

549 Communities repeatedly voiced an absence of suitable or equitable care access points for when
 550 someone is in a behavioral health crisis. The service gaps described previously in Section III.C. Need for
 551 Places to Go in a Crisis have real impacts on communities. Community partners reported that existing
 552 conditions of limited access to real-time behavioral health crisis services leave people suffering without
 553 the care they need and at high risk of their crisis becoming significantly worse. Community members
 554 identified that this pattern is particularly prominent among Black, Indigenous, and People of Color
 555 (BIPOC) communities.

556

557 *Desirable Location Attributes*

558 Community members, especially people living in rural areas, shared that a critical need is for
 559 facilities to be located in places that are easy to access and close to multiple forms of
 560 transportation. Geographic and transportation accessibility are critical both for people who seek
 561 services themselves as well as for people who are dropped off by first responders. Community
 562 members also identified that County-funded transportation should be flexible with reduced
 563 barriers such as having costs covered, so that people can come to crisis care centers with
 564 confidence that they'll be able to get back to places such as their home or an appropriate clinical
 565 care setting. This input informed the capital facility siting requirements described in [Crisis Care
 566 Center Capital Facility Development](#).

567

568 *Community Outreach among Populations Experiencing Behavioral Health Inequities*

569 Community partners urged the County to promote the launch of crisis care centers. They said
 570 that the County should emphasize conducting outreach about the opening of crisis care centers
 571 to promote awareness within populations that experience behavioral health inequities (see
 572 Section III.C. Who Experiences Behavioral Health Inequities). Community members advocated
 573 for an advertising effort to increase awareness about these new resources, particularly in
 574 communities that have historically been marginalized and/or under-served. They also cautioned
 575 that word of mouth will be powerful, with the possibility of community members either avoiding
 576 services based on negative reports, or greater utilization based on positive experiences.
 577 [Community Engagement](#) includes funding of ongoing community engagement to increase
 578 awareness of crisis care center services and associated resources across communities in King
 579 County. The goal of this public education work is to increase access to care for populations
 580 experiencing behavioral health inequities. To promote equitable access to crisis care centers,
 581 there will be a requirement for crisis care center operators to assess the potential equity
 582 impacts of their proposed facility as described in [Crisis Care Center Capital Facility Development](#)
 583 describing the capital facility siting process.

584

585 *Theme C: Challenges of Community Resource Limitations*

586 Though the CCC Levy is primarily focused on creating capacity for a front door to care, community
 587 partners raised important questions about the back door to ongoing community-based services after a
 588 person leaves a crisis care center.

589

590 *Need to Build a "Bridge to Somewhere"*

591 People with lived experience and behavioral health providers shared the viewpoint that the
 592 period immediately following a crisis episode is a high-risk period for negative outcomes, and
 593 that it is important to create pathways so that a crisis service is not a "bridge to nowhere," but

594 instead can link a person to resources to continue to recover, such as primary care services,
 595 behavioral health services, social services, and housing resources. Providers with experience
 596 operating acute care facilities shared concerns about how limitations of housing resources and
 597 outpatient behavioral health services can cause bottlenecks that make it difficult to discharge
 598 people from crisis settings, which in turn can impact facility capacity. Community partners also
 599 expressed concerns that crisis services that do not bridge to other supports could risk cycling
 600 people through crisis systems in a way that is just as problematic as emergency or jail settings.
 601 Community members and providers alike advocated to increase access to resources for people
 602 in the immediate aftermath of a crisis episode, including access to housing resources. This Plan
 603 describes post-crisis stabilization resources in [Post-Crisis Stabilization Activities](#) that were
 604 directly informed by this community feedback.

605 606 [Care Coordination and Peer Engagement](#)

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

621 622 [Theme D: Interim Solutions While Awaiting Crisis Care Centers](#)

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

627 628 [Importance of Community-Based Response](#)

629 Some community members, especially parents of young people who had been in crisis,
 630 advocated for expanding community-based response resources, such as mobile crisis services.
 631 Though crisis facilities may present a front door to care that is not widely available at the time of
 632 this Plan's drafting, many people shared during community meetings that they would prefer to
 633 be served in their own environment by an outreach or mobile crisis team. [Increase Community-
 634 Based Crisis Response Capacity](#) describes ways that DCHS aims to respond to this community
 635 feedback by investing in an expansion of community-based crisis services beginning in 2024.

636 637 [Urgency of the Opioid Overdose Crisis](#)

638 Another matter of urgency that community members frequently mentioned during engagement
 639 was the opioid overdose crisis. Though there is access to some substance use services and harm
 640 reduction approaches, particularly in downtown Seattle, many community members expressed

641 ongoing concern about lack of access to essential resources such as the opioid overdose reversal
642 medication naloxone. An early crisis response investment in [Reduce Fatal Opioid Overdoses by](#)
643 [Expanding Low Barrier Opioid Reversal Medication](#) would aim to reduce overdoses beginning in
644 2024.

645
646 *Theme E: Residential Treatment Facility Preservation and Expansion*

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

656
657 Residential treatment facility operators shared their challenges operating residential facilities, including
658 historic underinvestment in residential treatment facility capital and maintenance funding. For example,
659 aging facilities require ongoing and often increasing maintenance expenses. Due to inflation and rising
660 costs, operators shared that they do not have enough funding to pay for maintenance and other repairs.
661 Operators expressed that with additional funding, they would be able to address building maintenance
662 to make necessary repairs to facilities. This includes renovations to address health and safety issues,
663 facility improvements such as HVAC repairs, renovations to community spaces, and facility expansion.

664
665 Residential treatment facility operator feedback helped to define the allowable activities that are
666 described in Section V.B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity.
667 Activities include both preservation of existing residential treatment facilities and expansion of
668 residential treatment facilities.

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

673
674 *Theme F: Behavioral Health Workforce Development*
675 Community engagement related to behavioral health workforce needs included both systemwide
676 community behavioral health workforce issues and needs specific to the crisis care center workforce.
677 DCHS gathered input from subject matter expert groups, listening sessions, and community engagement
678 events. Feedback highlighted the workforce shortage as a key factor in the success of the crisis care
679 centers. Community members stressed the importance of providing culturally congruent care by having
680 a workforce reflective of the communities that workforce will serve. Direct line workers provided
681 feedback regarding workforce challenges such as low wages, lack of opportunities for career
682 advancement, and burnout. These themes are described in greater detail below and reflected in the
683 design of Section V.C. Strategy 3: Strengthen the Community Behavioral Health Workforce.

684
685 *Low Wages*
686 Community partners identified that strengthening the behavioral health workforce is important
687 in increasing behavioral health service access. Behavioral health agencies shared they struggle
688 to provide care because workers are not entering the behavioral health workforce due to low
689 wages. Front line workers shared that low wages impact their quality of life, including
690 preventing workers from being able to afford to live in the communities where they work.
691 Workers shared that when they are unable to live in the same communities where they work,
692 they often experience long commutes, which in turn contributes to job dissatisfaction and the
693 decision to seek employment in jobs that pay a higher wage or are located closer to home.
694 Workers also identified that low wages are also a constant challenge for people who need to pay
695 for childcare or family care expenses.

696
697 *Barriers to Entering the Behavioral Health Workforce*
698 Higher education is often a requirement for positions within the behavioral health workforce.
699 Community partners shared that this is often a barrier for people to enter the behavioral health
700 workforce, especially for populations that have been disproportionately marginalized and have
701 faced barriers to accessing higher education. Community members identified activities such as
702 loan repayment, tuition assistance, assistance with professional licensure fees, and stipends for
703 books and other supplies as examples of activities that reduce barriers for people to enter and
704 remain in the behavioral health workforce.

705
706 *Worker Retention and Professional Development*
707 Front line behavioral health workers shared their experiences with work burnout and how it
708 impacts their longevity in the community behavioral health field. Workers shared they
709 sometimes experience burnout in their roles, don't have skills to move into a different role, and
710 don't have the resources to access professional development and training to advance their
711 careers. Workers shared that professional development opportunities, more robust clinical
712 supervision, and additional support at work would help them feel valued and would help them
713 grow professionally.

714 [Limited Collaboration Between Community Behavioral Health and Schools](#)
715 During listening sessions, front line behavioral health workers shared feedback about their
716 professional pathway entering community behavioral health. Workers expressed concerns
717 about the lack of formal career pathways between schools that train behavioral health
718 professionals and community behavioral health agencies. Additionally, clinical supervisors
719 shared the need to increase awareness among students and workers about the various
720 behavioral health career opportunities and pathways available within community behavioral
721 health agencies.

722
723 [Importance of Workforce Representation](#)
724 Community members participating in engagement activities shared that a more diverse
725 behavioral health workforce is needed, for both future crisis care centers and existing
726 community behavioral health agencies. During focus groups, community members stated that
727 when someone is seeking care, a behavioral health professional with similar lived experiences
728 helps to increase the level of comfort for the person accessing care. Community members also
729 shared that a more representative workforce, at both the frontline and leadership levels, can
730 influence practices and conditions within behavioral health agencies to be more inclusive of the
731 different cultures and identities of people seeking behavioral health care.

732
733 Feedback solicited through community engagement helped define the allowable funding activities
734 described in [C. Strategy 3: Strengthen the Community Behavioral Health Workforce](#) . Activities funded in
735 this Plan address both the workforce at crisis care centers and the systemwide community behavioral
736 health workforce.

737
738 [Theme G: Accountability Mechanisms and Ongoing Community Engagement](#)
739 Throughout the implementation planning process, community partners expressed appreciation for being
740 included in the early planning of the CCC Levy. They also voiced a strong preference to continue to be
741 involved in future phases of the CCC Levy, including monitoring CCC Levy outcomes.

742
743 [Defining Measures of Success](#)
744 Community partners demonstrated an interest in being involved in County processes to define
745 measures of success of the CCC Levy. Measures of interest include rates of improvement in
746 regard to a person's behavioral health condition, as well as overall quality of life. Measures of
747 equity across outcomes were also described as a priority. These topics are addressed in

748 [VII. Evaluation and Performance Measurement](#), which describes the evaluation and
749 performance management plan for the CCC Levy.

750

751 [Community Engagement During Future Planning Phases](#)

752 Community partners voiced strong interest in being included during future planning phases. In
753 particular, partners expressed interest in providing ongoing input on the clinical implementation
754 of CCC Levy services and engaging around the opening of each crisis care center. [Community](#)
755 [Engagement](#) includes activities related to crisis system administration and includes long-term
756 community engagement as a key focus.

757 F. Behavioral Health Equity. Background research and available literature described in this section
 758 highlights behavioral health inequities based on factors that include, but are not limited to, race and
 759 ethnicity, sexual orientation, gender identity, language preference, disability, housing status, living in a
 760 rural region, and experiential communities such as persons with legal system involvement, military
 761 veterans, immigrants, and refugees.

762
 763 There are significant racial and ethnic disparities in access to behavioral health services. Black,
 764 Indigenous, and People of Color (BIPOC) populations are more frequently placed in involuntary
 765 treatment while having the least access to routine behavioral health care.⁵¹ People who identify as being
 766 two or more races (24.9 percent) are more likely to report any mental illness within the past year than
 767 any other race/ethnic group, followed by American Indian/Alaska Natives (22.7 percent), White (19
 768 percent), and Black (16.8 percent).⁵² Among adults living with mental illness in 2021, White (52.4
 769 percent) or Multiracial adults (52.2 percent) were more likely than Black (39.4 percent), Hispanic (36.1
 770 percent), or Asian adults (25.4 percent) to have received any mental health services in the past year.⁵³

771
 772 Emergency departments exhibit similar disparities, with Black populations waiting longer for care. In jails
 773 and prisons, recidivism is significantly more likely among Black populations living with serious mental
 774 health conditions.^{54,55} Nearly one quarter of people killed by police displayed signs of a mental illness,
 775 with significantly higher rates among the Black population.⁵⁶ People who are involved in the criminal
 776 legal system more broadly are also more likely to be living with mental health and substance use
 777 conditions, yet they have less access to community behavioral health services.⁵⁷

778
 779 Within King County, individuals identifying as Black, African, or African American represented 20 percent
 780 of people who received BHRD crisis services and 17 percent of people who died by overdose in 2022,
 781 both of which are higher than the seven percent of people identifying as Black, African, or African
 782 American in King County.^{58,59} In contrast, people identifying as Asian or Asian American represented nine
 783 percent of individuals receiving BHRD crisis services and 13 percent of people receiving routine
 784 behavioral health care in 2022, both of which are lower than the 21 percent of people in the King
 785 County population who identify as Asian or Asian American.⁶⁰

786

⁵¹ Shea T, Dotson S, Tyree G, Ogbu-Nwobodo L, Beck S, Shtasel D. Racial and Ethnic Inequities in Inpatient Psychiatric Civil Commitment. *Psychiatr Serv.* 2022 Dec 1;73(12):1322-1329. [\[LINK\]](#)

⁵² American Psychiatric Association - Mental Health Disparities: Diverse Populations, 2017. [\[LINK\]](#)

⁵³ 2021 National Survey on Drug Use and Health (NSDUH) Annual National Report [\[LINK\]](#)

⁵⁴ Opoku ST, Apenteng BA, Akowuah EA, Bhuyan S. Disparities in Emergency Department Wait Time Among Patients with Mental Health and Substance-Related Disorders. *J Behav Health Serv Res* 2018;45(2):204–18. [\[LINK\]](#)

⁵⁵ Veeh CA, Tripodi SJ, Pettus-Davis C, Scheyett AM. The interaction of serious mental disorder and race on time to reincarceration. *Am J Orthopsych* 2018;88(2):125-31. [\[LINK\]](#)

⁵⁶ Saleh AZ, Appelbaum PS, Liu X, Scott Stroup T, Wall M. Deaths of people with mental illness during interactions with law enforcement. *Int J Law Psychiatry.* 2018 May-Jun;58:110-116. [\[LINK\]](#)

⁵⁷ Bonfine N, Wilson AB, Munetz MR. Meeting the Needs of Justice-Involved People With Serious Mental Illness Within Community Behavioral Health Systems. *Psychiatr Serv.* 2020 Apr 1;71(4):355-363. [\[LINK\]](#)

⁵⁸ King County Behavioral Health Crisis Service Utilization Data Sheet, December 2023.

⁵⁹ Public Health Seattle & King County - Overdose deaths data dashboard [\[LINK\]](#)

⁶⁰ King County Department of Community and Human Services - Data Dashboard [\[LINK\]](#)

787 Immigrants are at higher risk of experiencing mental health conditions, which is due to factors such as
 788 higher acculturative stress, pre-migration experiences, discrimination, racism, economic hardship, and
 789 stigmatization.⁶¹ Access to care among immigrant populations is also limited, particularly in areas with
 790 higher concentration of Latin American immigrants.⁶² Similar trends have been observed in refugee
 791 populations, with lack of access to mental health services despite higher rates of common mental health
 792 conditions such as depression, anxiety, and post-traumatic stress disorder among migrants exposed to
 793 adversity and refugees than among host populations.⁶³ Furthermore, language access has been shown
 794 to impede access to mental health services. Among those who were likely to receive specialty mental
 795 health services, people who preferred speaking Spanish had a significantly lower rate of mental health
 796 care use.⁶⁴

797
 798 Among people identifying as lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, or
 799 other sexual orientations or gender identities (LGBTQIA+), studies have shown that depression, anxiety,
 800 and substance use are two and a half times higher than the general population.⁶⁵ Fear of discrimination
 801 may lead to some people avoiding care due to common experiences of providers denying care, using
 802 harsh language, or blaming the patient’s sexual orientation or gender identity as the cause for an
 803 illness.⁶⁶

804
 805 Of the approximately 36,000 people who have severe, chronic intellectual and developmental
 806 disabilities (IDD) in King County, an estimated one third have a co-occurring mental health condition.⁶⁷
 807 However, in 2022 the Washington State Department of Social and Health Services reported that people
 808 with IDD and their families have difficulty accessing behavioral health services due to a lack of resources,
 809 communication barriers, and inadequate training among behavioral health providers.⁶⁸

810
 811 Access to behavioral health services is also limited among people experiencing homelessness. A recent
 812 survey found that only 18 percent of people experiencing homelessness had received either mental
 813 health counseling or medications in the prior 30 days despite 66 percent reporting current mental
 814 health symptoms.⁶⁹ The same survey describes barriers such as lacking access to a phone, needing to

⁶¹ Markova V, Sandal GM, Pallesen S. Immigration, acculturation, and preferred help-seeking sources for depression: comparison of five ethnic groups. *BMC Health Serv Res.* 2020 Jul 11;20(1):648. [\[LINK\]](#)

⁶² Jing F, Li Z, Qiao S, Ning H, Zhou S, Li X. Association between immigrant concentration and mental health service utilization in the United States over time: A geospatial big data analysis. *Health Place.* 2023 Sep;83:103055. [\[LINK\]](#)

⁶³ World Health Organization, “Mental health and forced displacement,” 31 August 2021 [\[LINK\]](#)

⁶⁴ Byhoff E, Dinh DH, Lucas JA, Marino M, Heintzman J. Mental Health Care Use by Ethnicity and Preferred Language in a National Cohort of Community Health Center Patients. *Psychiatr Serv.* 2023 Oct 26. [\[LINK\]](#)

⁶⁵ Kates, J., Ranji, U., Beamesderfer, A., Salganicoff, A., & Dawson, L. (2016). Health and access to care and coverage for lesbian, gay, bisexual, and transgender individuals in the U.S. [\[LINK\]](#)

⁶⁶ Kates, J., Ranji, U., Beamesderfer, A., Salganicoff, A., & Dawson, L. (2016). Health and access to care and coverage for lesbian, gay, bisexual, and transgender individuals in the U.S. [\[LINK\]](#)

⁶⁷ The Arc of King County – What is IDD? [\[LINK\]](#)

⁶⁸ Developmental Disabilities Administration, Washington State Department of Social and Health Services, Best practices for co-occurring conditions: Serving people with intellectual and developmental disabilities and mental health conditions, October 1, 2022. [\[LINK\]](#)

⁶⁹ Kushel, M., Moore, T., et al. (2023). Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness. UCSF Benioff Homelessness and Housing Initiative. [\[LINK\]](#)

815 stay with belongings to prevent theft, and avoiding services due to past experiences of traumatic or
816 unsupportive interactions with health care providers.

817
818 Among U.S. military veterans who experience depression and PTSD, disparities in access to mental
819 health services have been described as a major factor contributing to the high suicide rates among
820 veterans.⁷⁰ People living in rural areas in the U.S. also experience significant disparities in mental health
821 outcomes despite having similar prevalence of mental illness to those living in metropolitan areas.⁷¹
822

823 [Need for Places to Go in a Crisis](#)

824 With so many people unable to access treatment when they need it, crisis care centers and similar
825 facilities can help. The Federal Substance Abuse and Mental Health Services Administration (SAMHSA)
826 released its National Guidelines for Behavioral Health Crisis Care in 2020.⁷² These guidelines call for the
827 creation of crisis facilities, referred to by SAMHSA as “somewhere to go,” for people in crisis to seek
828 help. SAMHSA’s guidelines envision crisis facilities as part of a robust behavioral health crisis system that
829 also includes the 988 Suicide and Crisis Lifeline, referred to as “someone to call,” and mobile crisis
830 teams, described as “someone to respond.”⁷³

831 King County's behavioral health crisis service system relies heavily on phone support and mobile
832 response, with very few options for people to go for immediate, life-saving care when in crisis. At the
833 time of this Plan’s drafting, King County has just one behavioral health crisis facility, called the Crisis
834 Solutions Center (CSC) in Seattle.⁷⁴ With a limited capacity of 46 beds across two levels of care, this
835 facility is only able to accept referrals through mobile crisis teams, first responders, and hospitals. For
836 youth in King County, there is no crisis facility option at all.

837
838 With no specialty behavioral health setting in King County to walk in and receive care if a person is
839 experiencing a behavioral health crisis, the front door to crisis services at the time of this Plan’s drafting
840 is typically hospital emergency departments, where people seeking help for a behavioral health crisis
841 may often spend hours or even days waiting for care.⁷⁵ People experiencing a crisis, especially those in

⁷⁰ Hester RD. Lack of access to mental health services contributing to the high suicide rates among veterans. *Int J Ment Health Syst.* 2017 Aug 18;11:47. [\[LINK\]](#)

⁷¹ Morales DA, Barksdale CL, Beckel-Mitchener AC. A call to action to address rural mental health disparities. *J Clin Transl Sci.* 2020 May 4;4(5):463-467. [\[LINK\]](#)

⁷² Substance Abuse and Mental Health Services Administration. (2020). National Guidelines for Behavioral Health Crisis Care - Best Practice Toolkit. [\[LINK\]](#);

⁷³ Substance Abuse and Mental Health Services Administration. (2020). National Guidelines for Behavioral Health Crisis Care - Best Practice Toolkit. [\[LINK\]](#); Substance Abuse and Mental Health Services Administration: National Guidelines for Child and Youth Behavioral Health Crisis Care. Publication No. PEP22-01-02-001 Rockville, MD: Substance Abuse and Mental Health Services Administration, 2022. [\[LINK\]](#)

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

⁷⁵ Esmey Jimenez, “King County mental health facilities still reject a quarter of patients, report shows.” *The Seattle Times*, September 5, 2023. [\[LINK\]](#)

842 public spaces, are frequently engaged by law enforcement and may end up in jail if they have committed
843 a crime while in distress.⁷⁶

844
845 The creation of specialized crisis facilities is frequently identified as a key strategy in the crisis service
846 continuum. These facilities enable diverting people from emergency department and carceral settings
847 and serving people in a higher quality specialized settings that can provide care using trauma-informed,
848 recovery oriented, and cultural humility best practices.^{77, 78, 79} Multiple local behavioral health system
849 needs assessments have arrived at a similar conclusion. The 2016 recommendations of the King County
850 Community Alternatives to Boarding Task Force called for by Motion 14225 included a recommendation
851 to expand crisis diversion capacity.⁸⁰ Similar conclusions were reached in needs assessments by the
852 Washington State Office of Financial Management behavioral health capital funding prioritization and
853 feasibility study in 2018, a Washington State Health Care Authority crisis triage and stabilization capacity
854 and gaps report in 2019, and the Initial Assessment of the Behavioral Health Crisis Response and Suicide
855 Prevention Services from the Crisis Response Improvement Strategy (CRIS) Committee in 2021.^{81,82,83}
856 Federal and state legislation have rapidly advanced the implementation of crisis services across the
857 United States.⁸⁴ Expanding access to crisis response services has been a recent focus of the Washington
858 Legislature. This includes its first-in-the-nation support of the implementation and expansion of 988 and
859 other crisis services, with its passage of Engrossed Second Substitute House Bill 1477 in 2021.⁸⁵
860 Additional legislation, including Engrossed Second Substitute House Bill (E2SHB) 1134 in and Second
861 Substitute Senate Bill (2SSB) 5120 in 2023, have further demonstrated the state’s commitment to these
862 services.^{86,87} The 23-hour Crisis Relief Centers established under 2SSB 5120, which are undergoing
863 Washington State Department of Health and Health Care Authority rulemaking into 2024, will establish
864 important frameworks for licensure and Medicaid payment that will inform the future development of
865 crisis care centers.
866

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

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

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

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

⁸⁰ Community Alternatives to Boarding Task Force - King County, Washington [\[LINK\]](#)

⁸¹ 2018 Behavioral Health Capital Funding Prioritization and Feasibility Study [\[LINK\]](#);

⁸² Crisis Stabilization Services - HCA Report to the Legislature [\[LINK\]](#)

⁸³ Crisis Response Improvement Strategy (CRIS) Committee - Initial Assessment of the Behavioral Health Crisis Response and Suicide Prevention Services in Washington and Preliminary Funding Recommendations [\[LINK\]](#)

⁸⁴ National Alliance for Mental Illness - Reimagine Crisis Response - 988 Crisis Response State Legislation Map [\[LINK\]](#)

⁸⁵ 2SSB 1477 (2021). 2SHB 1477’s scope included RCW chapters 71.24, 48.43, 43.06, and 82.86. [\[LINK\]](#).

⁸⁶ E2SHB 1134 (2023). E2SHB 1134’s scope included RCW chapters 71.24, 43.06, 82.86, 43.70, and 38.60. [\[LINK\]](#)

⁸⁷ 2SSB 5120 (2023) 2SSB 5120’s scope included RCW chapters 71.05, 71.34, 71.24, 10.31, 10.77, and 48.43. [\[LINK\]](#)

867 In light of the behavioral health funding crisis, the scale of unmet need, and the opportunity presented
 868 by this national and statewide momentum around expanding crisis services, a coalition of community
 869 leaders and behavioral health providers issued recommendations to Seattle and King County in a letter
 870 on October 13, 2021. The letter included recommendations to "expand places for people in crisis to
 871 receive immediate support" and "expand crisis response and post-crisis follow up services."⁸⁸ The CCC
 872 Levy carries these efforts forward, as outlined in this Plan.

873

874 [Need for Post-Crisis Stabilization Services](#)

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

880

881 Despite the benefits of follow-up during this high-risk post-crisis period, in 2021 only 58.7 percent of
 882 people with Medicaid received follow-up within 30 days of discharge from a psychiatric hospitalization.⁹¹
 883 Among youth and young adults, who visited the emergency room for a mental health reason, the rate is
 884 even worse, with only 46.4 percent receiving follow-up care within 30 days.⁹² Furthermore, Black
 885 populations receive lower rates of outpatient treatment during the 30-day period after discharge
 886 compared with White populations.⁹³

887

888 SAMHSA considers post-crisis stabilization services to be an essential element of responding to a
 889 behavioral health crisis and addressing the person's unmet needs.⁹⁴ Studies have shown that prior
 890 outpatient engagement is the most important predictor of follow-up after hospitalization, which is
 891 indicative of two key factors: the importance of reconnecting people back to prior providers, and the
 892 need to dedicate additional resources to connect people to care when they are otherwise without
 893 services.⁹⁵ Culturally appropriate interventions that link people to outpatient follow-up are also

⁸⁸ 2022 Priority Budget Recommendations to Seattle and King County to Strengthen Continuum of Behavioral Health Crisis Services. October 13, 2021.

⁸⁹ Olfson M, Wall M, Wang S, Crystal S, Liu SM, Gerhard T, Blanco C. Short-term Suicide Risk After Psychiatric Hospital Discharge. *JAMA Psychiatry*. 2016 Nov 1;73(11):1119-1126. [\[LINK\]](#)

⁹⁰ Smith TE, Corbeil T, Wall MM, Tang F, Essock SM, Frimpong E, Goldman ML, Mascayano F, Radigan M, Wang R, Rodgers I, Dixon LB, Olfson M, Lewis-Fernández R. Community, Hospital, and Patient Factors Contributing to Ethnoracial Disparities in Follow-Up After Psychiatric Hospitalization. *Psychiatr Serv*. 2023 Jul 1;74(7):684-694. [\[LINK\]](#)

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

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

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

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

⁹⁵ Smith TE, Haselden M, Corbeil T, Wall MM, Tang F, Essock SM, Frimpong E, Goldman ML, Mascayano F, Radigan M, Schneider M, Wang R, Rodgers I, Dixon LB, Olfson M. The Effectiveness of Discharge Planning for Psychiatric

894 identified as a strategy to reduce racial-ethnic disparities in outpatient mental health treatment
895 following acute treatment.⁹⁶

896
897 A 2017 study of a post-discharge peer support program demonstrated positive outcomes for
898 participants in terms of recovery, wellbeing, and hospital avoidance.⁹⁷ The peer approach has been
899 taken up in Washington State through peer bridger programs, which HCA implemented as required by
900 Second Engrossed Substitute House Bill (2ESHB) 2376 from the 2016 Washington State legislative
901 session.⁹⁸ Peer bridgers assist with community reintegration planning activities and promote service
902 continuity with the goal of enhancing long-term recovery and reducing hospital readmissions.⁹⁹

903
904 The peer bridger program model is implemented locally in King County for adults who have been
905 hospitalized psychiatrically at two community hospitals. This model is composed of teams of certified
906 peer specialists (paid staff who have lived experience with behavioral health conditions themselves)
907 working in coordination with inpatient treatment teams to develop individualized plans to promote each
908 person's successful transition to the community.¹⁰⁰ However, these post-crisis services are only available
909 in a small number of settings. Most people exiting hospitals, emergency rooms, crisis settings, and other
910 acute behavioral health settings do not receive dedicated services to support these critical care
911 transitions during these high-risk periods.

912

913 [Reduction in Residential Treatment Capacity](#)

914 Residential treatment is a community based behavioral health treatment option for people who need a
915 higher level of care than outpatient behavioral health services can provide.¹⁰¹ Residential treatment
916 programs provide people living with complex behavioral conditions with 24/7 intensive services in a

Inpatients With Varying Levels of Preadmission Engagement in Care. *Psychiatr Serv.* 2022 Feb 1;73(2):149-157.

[\[LINK\]](#)

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

[\[LINK\]](#)

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

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

⁹⁹ Washington State Health Care Authority - Peer Bridger Program [\[LINK\]](#)

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

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

917 licensed residential treatment facility. These programs are important options for people being
 918 discharged from inpatient behavioral health settings when outpatient services are not sufficient to meet
 919 their treatment needs. Residential treatment programs help people continue to recover and stabilize in
 920 a safe and supportive community-based setting.

921
 922 Residential treatment programs provide services for people experiencing severe and persistent mental
 923 illness to promote stability, community tenure, and movement toward the least restrictive community
 924 housing option.¹⁰² Programs provide residential stabilization and case management services that are
 925 strengths-based and promote recovery and resiliency. Such services provide symptom relief to assist
 926 clients to find what has been lost in their lives due to their illness, including the opportunity to make
 927 friends, use natural supports, make choices about their care, find and maintain employment, and
 928 develop personal strategies for coping and regaining independence.¹⁰³ Staff help clients to prepare for
 929 discharge by providing services that promote community integration and assistance with the transition
 930 to the least restrictive community housing option.¹⁰⁴

931
 932 Multiple mental health residential treatment facilities, which are a subset of residential treatment
 933 facilities, have closed in recent years due to rising operating and maintenance costs, aging
 934 infrastructure, and insufficient resources to repair facilities. The lack of resources to pay for capital
 935 facility improvements and maintain aging buildings has contributed to facility closures.¹⁰⁵ As of October
 936 2023, King County had a total of 240 mental health residential treatment beds for the entire county, a
 937 decrease of 115 beds, down nearly one third from the capacity of 355 beds in 2018.¹⁰⁶ The impact of
 938 reduced residential treatment facility capacity has impacted residential treatment wait times. For
 939 example, King County residents who needed residential treatment services in October 2023 had to wait
 940 an average of 25 days before they were admitted to a residential treatment facility.¹⁰⁷ The closing of
 941 residential treatment facilities highlights a gap in King County’s behavioral health continuum of care for
 942 people exiting inpatient behavioral health settings.¹⁰⁸

943

944 Behavioral Health Workforce Needs

945 It takes people to care for people, and King County is experiencing a behavioral health workforce
 946 shortage that is impacting people’s ability to access behavioral health care when they need it.¹⁰⁹ Similar

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

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

¹⁰⁴ BHRD Provider Manual, pages 119-123 [\[LINK\]](#)

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

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

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

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

¹⁰⁹ King County Community Behavioral Health Provider Survey, 2023.

947 behavioral health workforce shortages are occurring across the United States, according to the Federal
 948 Health Resources and Services Administration (HRSA).¹¹⁰ By the final year of the CCC Levy in 2032, HRSA
 949 projects the national behavioral health workforce will only have 69 percent of the number of mental
 950 health counselors, 62 percent of the number of substance use disorder counselors, 73 percent of the
 951 number of psychologists, and 54 percent of the number of psychiatrists that are needed to meet the
 952 demand for behavioral health care nationally.¹¹¹

953
 954 Within King County, a 2021 survey of community behavioral health agencies contracted with the KCICN
 955 identified that job vacancies at surveyed agencies were at least double what they were in 2019.¹¹² The
 956 survey also found that master-level licensed mental health clinicians are particularly difficult to
 957 recruit.¹¹³ A October 2023 survey of community behavioral health agencies contracted with the KCICN
 958 found that there are approximately 600 staff vacancies across the agencies that responded to the
 959 survey.¹¹⁴ This represents a 16 percent total vacancy rate at King County community behavioral health
 960 agencies, and there is still a need to hire more behavioral health workers to support the growing
 961 behavioral health care needs in the community.¹¹⁵

962
 963 In addition to staff vacancies, workforce retention is also a challenge for behavioral health providers. A
 964 February 2023 poll of members of three labor unions representing health care workers in Washington
 965 State, including behavioral health workers, found that 80 percent of health care workers reported
 966 feeling burned out by their jobs and 49 percent of workers reported they are likely to leave health care
 967 in the next few years.¹¹⁶ Rising housing and childcare costs are contributing to workers leaving the
 968 behavioral health workforce.¹¹⁷ In addition to high cost of living expenses, behavioral health workers
 969 often have student loan debt. For example, a National Council on Social Work Education report found
 970 that 73 percent of baccalaureate social work graduates and 76 percent of master's graduates have
 971 student loan debt.¹¹⁸ When community behavioral health agencies are not able to offer competitive
 972 wages and benefits, it is more challenging to recruit and retain employees, which contributes to
 973 chronically high vacancies and high turnover of staff.^{119,120} The KCICN's 2021 survey of King County
 974 community behavioral health agencies reinforced this dynamic. Survey respondents identified monetary
 975 incentives, loan repayments, professional fees and continuing education assistance, and employee
 976 wellbeing, as being impactful activities that could help retain workers.¹²¹
 977

¹¹⁰ Health Resources & Services Administration, Behavioral Health Workforce Projections [\[LINK\]](#)

¹¹¹ Health Resources & Services Administration, Behavioral Health Workforce Projections [\[LINK\]](#)

¹¹² KCICN Workforce Survey 2021

¹¹³ KCICN Workforce Survey 2021

¹¹⁴ KCICN Workforce Survey Data 2023

¹¹⁵ KCICN Workforce Survey Data 2023

¹¹⁶ 2023 poll of health care workers represented by SEIU Healthcare 1199NW, UFCW 3000, and WSNA conducted by GBAO [\[LINK\]](#)

¹¹⁷ 2023 King County Nonprofit Wage and Benefits Survey Report [\[LINK\]](#)

¹¹⁸ Student Loan Debt Relief for Social Workers [\[LINK\]](#)

¹¹⁹ Washington State Employment Security Department Supply and Demand Report [\[LINK\]](#)

¹²⁰ 2022 Behavioral Health Workforce Assessment [\[LINK\]](#)

¹²¹ KCICN Workforce Survey 2021

978 Increasing the representativeness of behavioral health workers is a critical component of strengthening
 979 King County’s community behavioral health workforce.¹²² Nationally, the behavioral health workforce
 980 does not reflect the demographics and identities of people receiving behavioral health services.^{123, 124}
 981 There is evidence that improving diversity among behavioral health workers so that workers better
 982 reflect the community they serve may help reduce behavioral health disparities.¹²⁵ For example,
 983 communication and trust is improved between behavioral health workers and people receiving services
 984 when there is cultural, linguistic, racial, or ethnic concordance between clinicians and clients.¹²⁶
 985 Developing a representative community behavioral health workforce will require intentional training,
 986 recruitment, and retention strategies. For example, BIPOC and LGBTQIA+ clinicians are often impacted
 987 by a lack of congruent mentorship in higher education, experiences of racism and discrimination.¹²⁷
 988

989 At a time when nearly one in five Americans lives with a mental health condition, and more people than
 990 ever are interested in seeking behavioral health support, the lack of access to diverse and qualified
 991 behavioral health professionals can serve as a barrier for accessing treatment to people and
 992 communities across the country and within King County.¹²⁸ Creative, local workforce investments are
 993 needed to complement Medicaid and state funds to provide for a stable workforce to deliver the high-
 994 quality community based behavioral health care that King County residents need and deserve.
 995

996 **D. Implementation Plan Methodology**

997 On April 25, 2023, King County voters approved Proposition No. 1, as called for by Ordinance 19572, to
 998 adopt the CCC Levy. Ordinance 19572 requires a CCC Levy Implementation Plan (Plan) be developed and
 999 transmitted by the King County Executive to King County Council by the end of December 2023. The
 1000 Plan's requirements are set out in Ordinance 19572, and [Appendix B: Crosswalk of Implementation Plan](#)
 1001 [Requirements from King County Ordinance 19572](#) describes how this Plan meets these requirements.
 1002

¹²² A focus of the Plan is to increase accessibility of behavioral health services, including crisis services funded by the CCC Levy, for all King County residents, including populations who experience behavioral health inequities. A consistent theme of community engagement was the importance for people seeking care of culturally and linguistically congruent services, staff with lived experience of behavioral health crises, and demographic representativeness. Establishing a workforce that is representative of King County's population, with particular care to representativeness for populations experiencing behavioral health inequities (see [Who Experiences Behavioral Health Inequities](#)), will ensure that more King County residents can choose to receive care from a provider with whom they are comfortable and is one of this Plan's strategies to ensure that all King County residents have meaningful access to CCC Levy-funded facilities and services.

¹²³ National Academy for State Health Policy State, Strategies to Increase Diversity in the Behavioral Health Workforce [\[LINK\]](#)

¹²⁴ Duffy FF, West JC, Wilk J, et al. Mental health practitioners and trainees. In RW Manderschild & MJ Henderson (Eds.), *Mental health, United States, 2002* (pp. 327-368; DHHS Publication No. SMA 04-3938). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2004

¹²⁵ Chao, P.J., Steffen, J.J., and Heiby, E.M. (2012). The effects of working alliance and client-clinician ethnic match on recovery status. *Community Mental Health Journal* (48), 91-97 [\[LINK\]](#)

¹²⁶ The Mental Health Needs and Statistics of the BIPOC Community [\[LINK\]](#)

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

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

1003 This Plan is the product of an intensive process that began in June 2023 and concluded in December
 1004 2023. Community engagement was a focus of implementation planning activities and is described in
 1005 detail in [E. Community Engagement Summary](#). Planning activities by DCHS also included solicitation of
 1006 formal requests for information (RFIs), engagement with various Washington State departments,
 1007 consultation with national subject matter experts, coordination with other County partners, and
 1008 convenings of internal workgroups within DCHS. These activities are described below and in this Plan's
 1009 appendices.

1010

1011 [Crisis Care Center Methodology](#)

1012 DCHS focused on four major areas to develop strategies in support of the CCC Levy's Paramount Purpose
 1013 to create a network of five crisis care centers:

- 1014 • Understanding and describing current community needs, service capacity, and system gaps
 1015 related to behavioral health care (as described in [Unmet Behavioral Health Service Needs](#));
- 1016 • Developing an approach to integrate substance use treatment services within the crisis care
 1017 center model;
- 1018 • Defining the related but distinct youth-focused crisis care center model, which addresses the
 1019 unique needs of children and adolescents, and
- 1020 • Integrating planning for the crisis care centers within regional contexts such as the existing
 1021 behavioral health crisis system, the behavioral health service continuum more broadly (as
 1022 described above in [C. Key Historical and Current Conditions](#)), criminal legal systems, health and
 1023 hospital systems, and additional community resources.

1024

1025 DCHS also undertook an in-depth process to establish procurement and siting processes for crisis care
 1026 centers. DCHS issued an RFI for the capital facility siting process to local jurisdictions, and a copy of the
 1027 RFI is included in [Appendix C: King County Local Jurisdiction Request for Information \(RFI\)](#).

1028

1029 Meetings with jurisdictions, behavioral health agencies, and other community partners were held for
 1030 DCHS to share updates on the CCC Levy planning process with interested parties and to learn about
 1031 provider, jurisdictional, and community partner needs and challenges. DCHS convened meetings with:

- 1032 • Subject matter experts internal to King County government, such as the Department of Natural
 1033 Resources and Parks, DCHS, Metro, and Public Health – Seattle & King County (see [Appendix D:
 1034 Coordination with State and County Partners](#) for a list of County partners);
- 1035 • Washington state partners, such as the Health Care Authority, the Department of Health, and
 1036 the Department of Social and Human Services (see [Appendix D: Coordination with State and
 1037 County Partners](#) for a list of meeting topics); and
- 1038 • Community partners, such as community members, people with lived experience of behavioral
 1039 health conditions, as well as their families and support systems, community-based
 1040 organizations, community behavioral health agencies, and others (see [Appendix F: Community
 1041 Engagement Activities](#) for details).

1042

1043 The DCHS planning team also made site visits to adult and youth crisis facilities in Washington, as well as
 1044 California and Arizona (see [Appendix E: Site and Field Visits](#)). ZiaPartners, a firm with experience
 1045 planning and implementing local and statewide behavioral health crisis system initiatives, consulted on

1046 crisis care center program model development and strategies for crisis system coordination and quality
 1047 improvement.¹²⁹

1048

1049 Residential Treatment Methodology

1050 Community partner engagement, subject matter expert consultation, and residential treatment
 1051 operator engagement informed the residential treatment recommendations in this Plan. DCHS BHRD
 1052 clinical staff with mental health residential subject matter expertise participated in an internal
 1053 workgroup to provide guidance on preserving and expanding residential treatment capacity. DCHS
 1054 planning staff met with leadership and frontline workers of agencies operating residential treatment
 1055 facilities to solicit feedback about residential treatment gaps and how to sustain and increase residential
 1056 treatment capacity. This included seven site visits to residential treatment facilities in King County,
 1057 which are listed in [Appendix E: Site and Field Visits](#). It also included an RFI soliciting information from
 1058 operators about residential treatment facility capital improvement funding needs. The RFI is included in
 1059 [Appendix G: Clinical Best Practices in Behavioral Health Crisis Services](#)
 1060

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

¹²⁹ ZiaPartners, Inc. [\[LINK\]](#)

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

1061
1062

1063 Appendix H: BHRD Capital Improvement Funding for Behavioral Health Facilities Request for Information
 1064 (RFI). Additionally, residential treatment topics were included in CCC Levy implementation planning
 1065 community engagement meetings and presentations to solicit feedback from a broader group of
 1066 community partners beyond the residential treatment sector. Community engagement is highlighted
 1067 below, and a list of community engagement activities is included in [Appendix F: Community Engagement](#)
 1068 [Activities](#).

1070 Workforce Methodology

1071 DCHS planning staff solicited feedback on how the CCC Levy can build, retain, and increase the
 1072 representativeness of the community behavioral health workforce.¹³⁰ Engagement on workforce issues
 1073 included focus groups with community members and focus groups with subject matter experts;
 1074 informational interviews with key personnel in community behavioral health agencies; and site visits in
 1075 San Diego, Arizona and Washington state. DCHS also engaged the University of Washington, Public
 1076 Health-Seattle and King County, and health care workforce training and apprenticeship programs to
 1077 inform strategy design. (See [Appendix F: Community Engagement Activities](#) for list of key informant
 1078 interviews and individual engagement meetings.) Community partner meetings included union-
 1079 represented and non-union represented provider staff.

1081 E. Community Engagement Summary

1082 DCHS staff engaged community partners to inform this Plan, including participation from behavioral
 1083 health agencies, people with lived experiences of behavioral health crises, and frontline behavioral
 1084 health workers. See [Appendix F: Community Engagement Activities](#) for a complete list of community
 1085 engagement activities. Engagement activities are summarized in Figure 5. In addition to informing the
 1086 strategies in this Plan, DCHS plans to take the community feedback into account during future
 1087 procurement and operational phases of the CCC Levy.

1088

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

1089 **Figure 5. Summary of Community Engagement Activities Conducted by DCHS Between June and**
 1090 **November 2023**



1091
 1092
 1093 **Key Findings of Community Engagement Process**

1094 This section summarizes community input from implementation planning activities, with supporting
 1095 details provided in the appendices as noted. DCHS organized community feedback into key themes that
 1096 informed this Plan. Figure 6 summarizes these key themes, with a more detailed description of each
 1097 theme below the table.

1098 **Figure 6. Summary of Community Engagement Themes**

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

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

1099

1100 *Theme A: Implement Clinical Best Practices in Crisis Services*

1101 Community partners offered substantial input on the following topics, all focused on how to design a
 1102 crisis care center clinical model that works as well as possible. These recommendations are reflected in
 1103 the best practices described in [Appendix G: Clinical Best Practices in Behavioral Health Crisis Services](#)
 1104 that inform the crisis services described in [A. Strategy 1: Create and Operate Five Crisis Care Centers](#).

1105 [Welcoming and Safe](#)

1106 Community members emphasized that people from their communities would only come to crisis
 1107 care centers if they were confident that they would be helped and not harmed during a crisis.
 1108 Community members defined safety differently: some people described feeling unsafe around
 1109 uniformed officers, while others said they prefer or even expect a uniformed officer to be
 1110 present to feel safe. Some people shared experiences of feeling trapped and unsafe in a locked
 1111 unit, while others said they would feel safer being in a secured environment. Many described
 1112 the importance of a comfortable physical space, but that it would be unacceptable to create a
 1113 superficially attractive space without having a welcoming and safe program to reinforce it.

1114
 1115 [Person-Centered and Recovery-Oriented Care](#)

1116 Community partners described the importance of ensuring that crisis care centers provide
 1117 person-centered and recovery-oriented care.^{131,132} Peer specialists and people with lived
 1118 experience of a behavioral health conditions emphasized the importance of keeping people in
 1119 control of their care as much as possible. They also emphasized minimizing care transitions,
 1120 maximizing continuity of care, and following up after discharge to start ongoing care.

1121
 1122 [Culturally and Linguistically Appropriate Services](#)

1123 Community partners advocated for ensuring that crisis care centers provide culturally and
 1124 linguistically appropriate services. Such services combine typical clinical best practices with
 1125 specially trained, often culturally concordant providers who incorporate cultural practices and
 1126 shared experience into the treatment and relationship with clients.¹³³ This Plan incorporates this
 1127 input in:

- 1128 • [Crisis Care Center Clinical Program Overview](#)A. Strategy 1: Create and Operate Five Crisis
 1129 Care Centers, which defines the crisis care center clinical model and post-crisis
 1130 stabilization resources;
- 1131 • [Capacity Building for Providers with Expertise in Culturally and Linguistically Appropriate
 1132 Services](#), which will invest in capacity building for crisis care centers operators to further
 1133 enhance their capacity to deliver culturally and linguistically appropriate services, and
- 1134 • [A. Evaluation and Performance Measurement Principles](#), which will measure how well
 1135 crisis care centers are meeting these needs to hold DCHS accountable for implementing
 1136 and improving upon culturally and linguistically appropriate services.

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

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

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

1137 [Integrate Care for People Who Use Substances](#)

1138 Community members identified substance use services as an essential resource to include in
 1139 crisis care centers because so many people in a mental health crisis have co-occurring substance
 1140 use or their crisis is primarily related to substance use.¹³⁴ Service provider partners emphasized
 1141 that the model should include medication for opioid use disorder (MOUD), withdrawal
 1142 management (sometimes referred to as “detox”), substance use counseling, distribution of
 1143 overdose prevention supplies like naloxone, and testing for HIV and Hepatitis C.

1144

1145 [Least Restrictive Care](#)

1146 Community partners, especially peer specialists and people with lived experience of a behavioral
 1147 health condition, frequently voiced a preference for crisis care center services to be voluntary as
 1148 much as possible. Some community partners acknowledged that state regulations, as well as
 1149 rare uncontrollable circumstances, such as when someone is refusing help even when their life
 1150 is in danger, might require involuntary interventions such as detention by a law enforcement
 1151 officer, placement of Involuntary Treatment Act (ITA) holds by a designated crisis responder
 1152 (DCR), involuntary medications, seclusions, and restraints.¹³⁵ Most community partners agreed
 1153 that involuntary interventions should be minimized by proactively engaging someone in
 1154 treatment decisions whenever possible in the least restrictive setting. Furthermore, community
 1155 partners expressed consensus that use of involuntary interventions should be a focus of
 1156 monitoring and accountability for crisis care centers.

1157

1158 [Special Considerations for Serving Children, Youth, and Young Adults in Crisis](#)

1159 Youth, parents, and providers serving youth clearly stated that behavioral health services for
 1160 youth differ from adult services in many important ways, and that these differences need to be
 1161 reflected in the youth crisis care center model. Youth behavioral health service providers
 1162 explained that adolescents’ needs differ from the needs of young children (up to approximately
 1163 age 12), and very young children (up to age 6) and have their own special needs during a
 1164 behavioral health crisis. Multiple community partners, including youth, also emphasized the
 1165 unique needs of transition age youth (ages 18-24), also known as young adults, who may not be
 1166 well served in a combined crisis care center setting with more mature adults.¹³⁶ The needs of
 1167 families, caregivers, and unaccompanied youth also emerged as important factors. Community
 1168 members also described the high likelihood that young people with intellectual and
 1169 developmental disabilities (IDD) will present to crisis care centers. They emphasized the
 1170 importance of having staff who are specially trained to meet these unique needs. These

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

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

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

1171 recommendations were critical to informing the clinical model for the youth crisis care center
1172 described in [Clinical Model for Youth Crisis Care Center](#).

1173

1174 [Additional Clinical and Support Considerations](#)

1175 Community members discussed the importance of childcare for parents in a behavioral health
1176 crisis, care for pets, safe storage of belongings, nutrition and meal services, full-scope
1177 medication formulary, basic laboratory testing, and transportation. Though many of these
1178 recommendations are beyond the strategic scope of this Plan, DCHS will take this community
1179 feedback into account for future procurement and operational phases of crisis care center
1180 services.

1181

1182 *Theme B: Increase Access to Care for Populations Experiencing Behavioral Health Inequities*

1183 Communities repeatedly voiced an absence of suitable or equitable care access points for when
1184 someone is in a behavioral health crisis. The service gaps described previously in [Section III.C. Need for](#)
1185 [Places to Go in a Crisis](#) have real impacts on communities. Community partners reported that existing
1186 conditions of limited access to real-time behavioral health crisis services leave people suffering without
1187 the care they need and at high risk of their crisis becoming significantly worse. Community members
1188 identified that this pattern is particularly prominent among Black, Indigenous, and People of Color
1189 (BIPOC) communities.

1190

1191 [Desirable Location Attributes](#)

1192 Community members, especially people living in rural areas, shared that a critical need is for
1193 facilities to be located in places that are easy to access and close to multiple forms of
1194 transportation. Geographic and transportation accessibility are critical both for people who seek
1195 services themselves as well as for people who are dropped off by first responders. Community
1196 members also identified that County-funded transportation should be flexible with reduced
1197 barriers such as having costs covered, so that people can come to crisis care centers with
1198 confidence that they'll be able to get back to places such as their home or an appropriate clinical
1199 care setting. This input informed the capital facility siting requirements described in [Crisis Care](#)
1200 [Center Capital Facility Development](#).

1201

1202 [Community Outreach among Populations Experiencing Behavioral Health Inequities](#)

1203 Community partners urged the County to promote the launch of crisis care centers. They said
1204 that the County should emphasize conducting outreach about the opening of crisis care centers
1205 to promote awareness within populations that experience behavioral health inequities (see
1206 [Section III.C. Who Experiences Behavioral Health Inequities](#)). Community members advocated
1207 for an advertising effort to increase awareness about these new resources, particularly in
1208 communities that have historically been marginalized and/or under-served. They also cautioned
1209 that word of mouth will be powerful, with the possibility of community members either avoiding
1210 services based on negative reports, or greater utilization based on positive experiences.
1211 [Community Engagement](#) includes funding of ongoing community engagement to increase
1212 awareness of crisis care center services and associated resources across communities in King
1213 County. The goal of this public education work is to increase access to care for populations
1214 experiencing behavioral health inequities. To promote equitable access to crisis care centers,
1215 there will be a requirement for crisis care center operators to assess the potential equity

1216 impacts of their proposed facility as described in [Crisis Care Center Capital Facility Development](#)
1217 describing the capital facility siting process.

1218

1219 *Theme C: Challenges of Community Resource Limitations*

1220 Though the CCC Levy is primarily focused on creating capacity for a front door to care, community
1221 partners raised important questions about the back door to ongoing community-based services after a
1222 person leaves a crisis care center.

1223

1224 *Need to Build a “Bridge to Somewhere”*

1225 People with lived experience and behavioral health providers shared the viewpoint that the
1226 period immediately following a crisis episode is a high-risk period for negative outcomes, and
1227 that it is important to create pathways so that a crisis service is not a “bridge to nowhere,” but
1228 instead can link a person to resources to continue to recover, such as primary care services,
1229 behavioral health services, social services, and housing resources. Providers with experience
1230 operating acute care facilities shared concerns about how limitations of housing resources and
1231 outpatient behavioral health services can cause bottlenecks that make it difficult to discharge
1232 people from crisis settings, which in turn can impact facility capacity. Community partners also
1233 expressed concerns that crisis services that do not bridge to other supports could risk cycling
1234 people through crisis systems in a way that is just as problematic as emergency or jail settings.
1235 Community members and providers alike advocated to increase access to resources for people
1236 in the immediate aftermath of a crisis episode, including access to housing resources. This Plan
1237 describes post-crisis stabilization resources in [Post-Crisis Stabilization Activities](#) that were
1238 directly informed by this community feedback.

1239

1240 *Care Coordination and Peer Engagement*

1241 In the aftermath of a behavioral health crisis, people may need to be connected to a range of
1242 health and social services such as outpatient care, primary care, housing resources, and public
1243 benefits enrollment. However, many barriers exist to successfully connecting with these
1244 resources. Community partners described barriers such as distrust of providers, concerns about
1245 cost of services, difficulties with transportation and making appointments (especially for those
1246 experiencing homelessness or housing instability), and stigma. Providers also described
1247 fragmented health records systems that prevent information sharing necessary to transition a
1248 person’s care, including when trying to re-connect someone with an existing provider. Among
1249 the peer-run organizations that participated in the CCC Levy planning process, one solution that
1250 was voiced often was the value of peer navigators and peer bridgers who can support people
1251 who were recently in crisis to access the resources they need. The post-crisis follow-up program
1252 described in [Post-Crisis Stabilization Activities](#), as well as the care coordination infrastructure
1253 investments in [Develop Data Systems Infrastructure and Technology](#), both aim to address these
1254 needs.

1255

1256 *Theme D: Interim Solutions While Awaiting Crisis Care Centers*

1257 Throughout the implementation planning process, there was a clear sense of urgency among community
1258 partners to invest in resources that can serve people as quickly as possible. Since it can take a long time
1259 for facilities to be constructed and initiate operations, community members advocated for expedited
1260 resources to be implemented while awaiting crisis care centers to come online.

1261

1262 [Importance of Community-Based Response](#)

1263 Some community members, especially parents of young people who had been in crisis,
1264 advocated for expanding community-based response resources, such as mobile crisis services.
1265 Though crisis facilities may present a front door to care that is not widely available at the time of
1266 this Plan’s drafting, many people shared during community meetings that they would prefer to
1267 be served in their own environment by an outreach or mobile crisis team. [Increase Community-
1268 Based Crisis Response Capacity](#) describes ways that DCHS aims to respond to this community
1269 feedback by investing in an expansion of community-based crisis services beginning in 2024.

1270

1271 [Urgency of the Opioid Overdose Crisis](#)

1272 Another matter of urgency that community members frequently mentioned during engagement
1273 was the opioid overdose crisis. Though there is access to some substance use services and harm
1274 reduction approaches, particularly in downtown Seattle, many community members expressed
1275 ongoing concern about lack of access to essential resources such as the opioid overdose reversal
1276 medication naloxone. An early crisis response investment in [Reduce Fatal Opioid Overdoses by
1277 Expanding Low Barrier Opioid Reversal Medication](#) would aim to reduce overdoses beginning in
1278 2024.

1279

1280 [Theme E: Residential Treatment Facility Preservation and Expansion](#)

1281 To understand the needs of the residential treatment sector, the CCC Levy planning team engaged in a
1282 series of conversations with residential treatment facility operators. These included key personnel
1283 informational interviews with leadership and front-line workers and onsite visits to facilities. See
1284 [Appendix E: Site and Field Visits](#) for a complete list of residential treatment facility site visits. Throughout
1285 this engagement, conversations centered around understanding the needs of residential treatment
1286 facilities for both adult and youth populations, with an emphasis on the loss of facilities in recent years
1287 and the resources needed to preserve existing facilities and to add more. Additionally, operators shared
1288 insights regarding the value of providing residential treatment services and impact that facility closures
1289 have had on the County’s overall behavioral health system.

1290

1291 Residential treatment facility operators shared their challenges operating residential facilities, including
1292 historic underinvestment in residential treatment facility capital and maintenance funding. For example,
1293 aging facilities require ongoing and often increasing maintenance expenses. Due to inflation and rising
1294 costs, operators shared that they do not have enough funding to pay for maintenance and other repairs.
1295 Operators expressed that with additional funding, they would be able to address building maintenance
1296 to make necessary repairs to facilities. This includes renovations to address health and safety issues,
1297 facility improvements such as HVAC repairs, renovations to community spaces, and facility expansion.

1298

1299 Residential treatment facility operator feedback helped to define the allowable activities that are
1300 described in [Section V.B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity](#).
1301 Activities include both preservation of existing residential treatment facilities and expansion of
1302 residential treatment facilities.

1303 Some feedback themes shared by community partners during engagement activities related to
1304 residential treatment services, including input about clinical care needs, are not addressed in this Plan
1305 because they fall outside of the scope of services that the CCC Levy is designed to address. This feedback
1306 will help inform future DCHS quality improvement activities outside of the CCC Levy.
1307

1308 *Theme F: Behavioral Health Workforce Development*

1309 Community engagement related to behavioral health workforce needs included both systemwide
1310 community behavioral health workforce issues and needs specific to the crisis care center workforce.
1311 DCHS gathered input from subject matter expert groups, listening sessions, and community engagement
1312 events. Feedback highlighted the workforce shortage as a key factor in the success of the crisis care
1313 centers. Community members stressed the importance of providing culturally congruent care by having
1314 a workforce reflective of the communities that workforce will serve. Direct line workers provided
1315 feedback regarding workforce challenges such as low wages, lack of opportunities for career
1316 advancement, and burnout. These themes are described in greater detail below and reflected in the
1317 design of [Section V.C. Strategy 3: Strengthen the Community Behavioral Health Workforce](#).
1318

1319 *Low Wages*

1320 Community partners identified that strengthening the behavioral health workforce is important
1321 in increasing behavioral health service access. Behavioral health agencies shared they struggle
1322 to provide care because workers are not entering the behavioral health workforce due to low
1323 wages. Front line workers shared that low wages impact their quality of life, including
1324 preventing workers from being able to afford to live in the communities where they work.
1325 Workers shared that when they are unable to live in the same communities where they work,
1326 they often experience long commutes, which in turn contributes to job dissatisfaction and the
1327 decision to seek employment in jobs that pay a higher wage or are located closer to home.
1328 Workers also identified that low wages are also a constant challenge for people who need to pay
1329 for childcare or family care expenses.
1330

1331 *Barriers to Entering the Behavioral Health Workforce*

1332 Higher education is often a requirement for positions within the behavioral health workforce.
1333 Community partners shared that this is often a barrier for people to enter the behavioral health
1334 workforce, especially for populations that have been disproportionately marginalized and have
1335 faced barriers to accessing higher education. Community members identified activities such as
1336 loan repayment, tuition assistance, assistance with professional licensure fees, and stipends for
1337 books and other supplies as examples of activities that reduce barriers for people to enter and
1338 remain in the behavioral health workforce.
1339

1340 *Worker Retention and Professional Development*

1341 Front line behavioral health workers shared their experiences with work burnout and how it
1342 impacts their longevity in the community behavioral health field. Workers shared they
1343 sometimes experience burnout in their roles, don't have skills to move into a different role, and
1344 don't have the resources to access professional development and training to advance their
1345 careers. Workers shared that professional development opportunities, more robust clinical
1346 supervision, and additional support at work would help them feel valued and would help them
1347 grow professionally.

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[Limited Collaboration Between Community Behavioral Health and Schools](#)

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

[Importance of Workforce Representation](#)

Community members participating in engagement activities shared that a more diverse behavioral health workforce is needed, for both future crisis care centers and existing community behavioral health agencies. During focus groups, community members stated that when someone is seeking care, a behavioral health professional with similar lived experiences helps to increase the level of comfort for the person accessing care. Community members also shared that a more representative workforce, at both the frontline and leadership levels, can influence practices and conditions within behavioral health agencies to be more inclusive of the different cultures and identities of people seeking behavioral health care.

Feedback solicited through community engagement helped define the allowable funding activities described in [C. Strategy 3: Strengthen the Community Behavioral Health Workforce](#) . Activities funded in this Plan address both the workforce at crisis care centers and the systemwide community behavioral health workforce.

Theme G: Accountability Mechanisms and Ongoing Community Engagement

Throughout the implementation planning process, community partners expressed appreciation for being included in the early planning of the CCC Levy. They also voiced a strong preference to continue to be involved in future phases of the CCC Levy, including monitoring CCC Levy outcomes.

[Defining Measures of Success](#)

Community partners demonstrated an interest in being involved in County processes to define measures of success of the CCC Levy. Measures of interest include rates of improvement in regard to a person's behavioral health condition, as well as overall quality of life. Measures of equity across outcomes were also described as a priority. These topics are addressed in

1382 [VII. Evaluation and Performance Measurement](#), which describes the evaluation and
1383 performance management plan for the CCC Levy.

1384
1385 [Community Engagement During Future Planning Phases](#)

1386 Community partners voiced strong interest in being included during future planning phases. In
1387 particular, partners expressed interest in providing ongoing input on the clinical implementation
1388 of CCC Levy services and engaging around the opening of each crisis care center. [Community](#)
1389 [Engagement](#) includes activities related to crisis system administration and includes long-term
1390 community engagement as a key focus.

1391 **F. Behavioral Health Equity Framework**

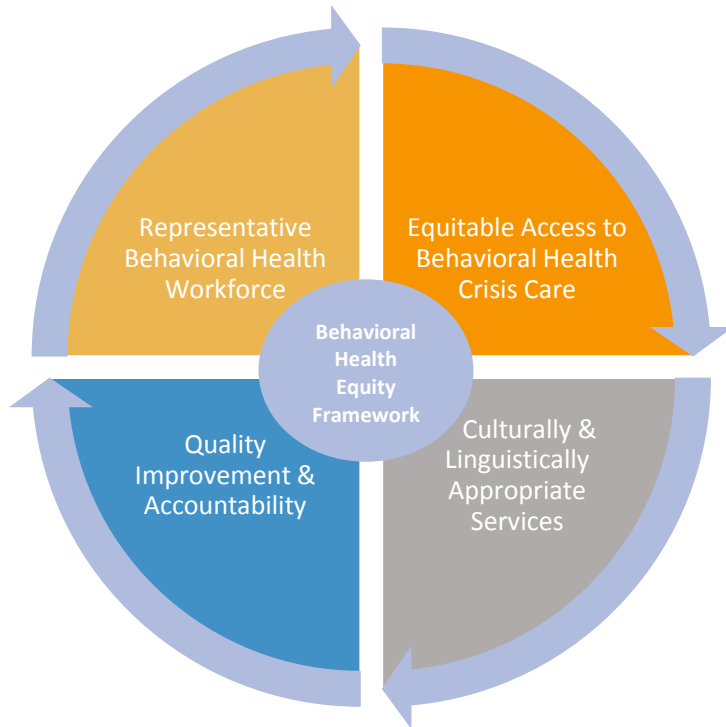
1392 The CCC Levy will not succeed if it increases access to behavioral health crisis services without also
1393 reducing inequities in who can access that care. Inequities in who can access behavioral health care at
1394 the time of this Plan’s drafting are described above in the section on [Section III.C. Who Experiences](#)
1395 [Behavioral Health Inequities](#). During this Plan’s community engagement process, DCHS received
1396 extensive community feedback from community partners about the importance of centering health
1397 equity in this Plan, as summarized in the previous section, [Section III.E. Key Findings of Community](#)
1398 [Engagement Process](#). Ordinance 19572 reinforces this approach by stating that a key function of
1399 behavioral health facilities, including crisis care centers, is to promote equitable and inclusive access to
1400 behavioral health services, including those in racial, ethnic, experiential, and geographic communities,
1401 which experience disparities in mental health and substance use conditions and outcomes.

1402
1403 This section synthesizes findings from research and community engagement into a behavioral health
1404 equity framework for the Plan, depicted in Figure 7, summarized in Figure 8, and described further in
1405 this subsection.
1406

Behavioral Health Equity Highlight

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

1407
1408 **Figure 7. CCC Levy Implementation Plan Behavioral Health Equity Framework**
1409



1430

1431 **Figure 8. CCC Levy Implementation Plan Behavioral Health Equity Framework Summary**

CCC Levy Implementation Plan Behavioral Health Equity Framework Summary		
Behavioral Health Equity Focus	Background and Community Engagement	CCC Levy Strategies and Activities
Increase equitable access to behavioral health crisis care	<ul style="list-style-type: none"> • Significant unmet behavioral health service needs in sociodemographic groups • Need to reach out to underserved communities 	<ul style="list-style-type: none"> • Reduce cost/insurance barriers • Increase geographic access 24/7 • Promote awareness and outreach to populations that disproportionately face barriers to access
Expand availability of culturally and linguistically appropriate behavioral health services	<ul style="list-style-type: none"> • Clinical best practice to offer culturally and linguistically appropriate services (CLAS)¹³⁷ • Community demand for increased access to CLAS 	<ul style="list-style-type: none"> • Require and support crisis care center operators to offer CLAS • Invest in providers with expertise in CLAS to expand services
Increase representativeness of the behavioral health workforce	<ul style="list-style-type: none"> • Culturally concordant care improves outcomes • Community feedback advocating for increased diversity in behavioral health workforce 	<ul style="list-style-type: none"> • Train, recruit and retain a more representative behavioral health workforce
Promote accountability to health equity	<ul style="list-style-type: none"> • Need to put accountability mechanisms in place • Ongoing community engagement is needed 	<ul style="list-style-type: none"> • Support community engagement throughout the CCC Levy period • Track outcomes within and between demographic subpopulations • Train providers on best practices for gathering demographic information needed to inform equity analyses

1432
1433 This Plan's behavioral health equity framework aligns closely with King County's historic investments in
1434 addressing inequities.¹³⁸ In 2016, the Executive released the King County Equity and Social Justice
1435 Strategic Plan.¹³⁹ The CCC Levy is highly aligned with the main approaches laid out in the Equity and
1436 Social Justice Strategic Plan and includes investments in upstream resources to: prevent inequities and
1437 injustices, foster community partnerships, support County employees, and develop mechanisms to
1438 ensure transparent and accountable leadership. This Plan describes activities that further the Equity and
1439 Social Justice Strategic Plan's priority domains for pro-equity policies, including leadership, operations
1440 and services; plans, policies and budgets; workforce and workplace; community partnerships;
1441 communication and education; and facility and system improvements.

1442 1443 **Equitable Access to Behavioral Health Crisis Care**

1444 As described in [Who Experiences Behavioral Health Inequities](#)
1445 , behavioral health services remain inaccessible to far too many people who need help. Community
1446 members and providers clearly articulated that people in a behavioral health crisis face many barriers

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

¹³⁸ King County Ordinance 16948 [\[LINK\]](#)

¹³⁹ King County Equity and Social Justice Strategic Plan [\[LINK\]](#)

1447 locally, as described in [Theme B: Increase Access to Care for Populations Experiencing Behavioral Health](#)
 1448 [Inequities](#).

1449
 1450 Public policies and social norms play a significant role in shaping social determinants of health that result
 1451 in behavioral health inequities. Studies have shown that the most significant barriers to accessing
 1452 behavioral health care are related to concerns about high costs and lack of health insurance.¹⁴⁰ These
 1453 concerns are particularly prevalent among BIPOC communities, in part due to social policies that
 1454 impeded generational accrual of wealth.¹⁴¹ The CCC Levy will increase access to behavioral health crisis
 1455 care by making services available regardless of insurance status or ability to pay, as described in [Crisis](#)
 1456 [Care Center Clinical Model](#) and [Crisis Care Center Post-Crisis Follow-Up Program](#). While waiting for the
 1457 crisis care centers to open, CCC Levy funds will also be used to invest funds starting in 2024 to expand
 1458 access to community-based resources for residents of King County, as described in [Increase Community-](#)
 1459 [Based Crisis Response Capacity](#), as well as substance use services, as described in [Reduce Fatal Opioid](#)
 1460 [Overdoses by Expanding Low Barrier Opioid Reversal Medication](#) and [Substance Use Facility](#)
 1461 [Investments](#).

1462 1463 [Culturally and Linguistically Appropriate Services](#)

1464 Access to, and engagement in, behavioral health care can also be impeded by a lack of cultural and
 1465 linguistic appropriate services among providers.¹⁴² These challenges are described in [Who Experiences](#)
 1466 [Behavioral Health Inequities](#)
 1467 and were also raised by community members, as described in [Culturally and Linguistically Appropriate](#)
 1468 [Services](#).

1469
 1470 Culturally and linguistically appropriate services best practices (CLAS) are nationally recognized as a way
 1471 to improve the quality of services provided to all individuals, which will ultimately help reduce health
 1472 disparities and promote health equity.¹⁴³ According to the U.S. Department of Health and Human
 1473 Services, which developed the CLAS standards, all aspects of a provider's and a client's cultural identity,
 1474 as depicted in Figure 9, influence the therapeutic process and are relevant to the expansion of CLAS as
 1475 described throughout this Plan.

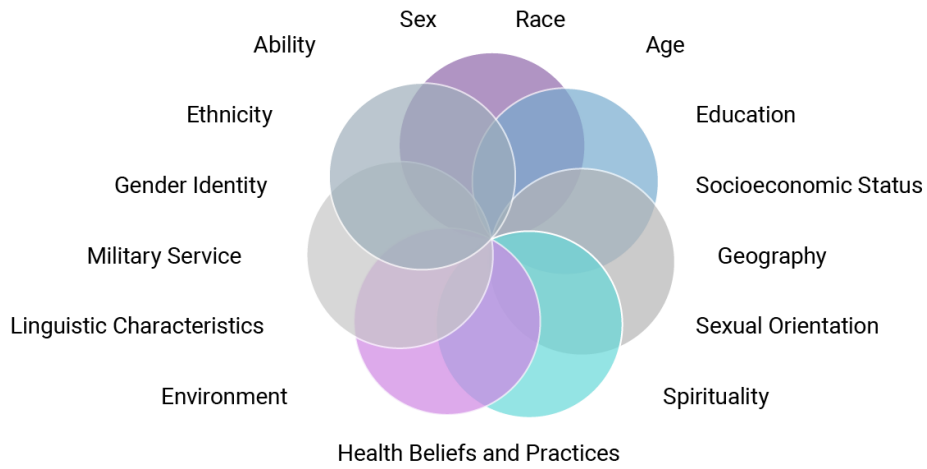
¹⁴⁰ Walker ER, Cummings JR, Hockenberry JM, Druss BG. Insurance status, use of mental health services, and unmet need for mental health care in the United States. *Psychiatr Serv.* 2015 Jun;66(6):578-84. [\[LINK\]](#)

¹⁴¹ Coombs NC, Meriwether WE, Caringi J, Newcomer SR. Barriers to healthcare access among U.S. adults with mental health challenges: A population-based study. *SSM Popul Health.* 2021 Jun 15;15:100847. [\[LINK\]](#)

¹⁴² Fountain House, *From Harm to Health: Centering Racial Equity and Lived Experience in Mental Health Crisis Response*, 2021. [\[LINK\]](#)

¹⁴³ National Culturally and Linguistically Appropriate Services (CLAS) Standards. Think Cultural Health, U.S. Department of Health & Human Services [\[LINK\]](#)

1476 **Figure 9. Aspects of Experience and Identity that Impact Behavioral Health¹⁴⁴**



1477
1478 *Image Source: U.S. Department of Health and Human Services, Think Cultural Health.*
1479

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

1480 The CCC Levy will increase availability of these clinical best practices by investing in crisis care centers
 1481 and post-crisis follow-up services that include CLAS, as described in [Crisis Care Center Clinical Model](#) and
 1482 [Culturally and Linguistically Appropriate Post-Crisis Follow-Up Services](#). CCC Levy funds will also be used
 1483 to support crisis care center operators with capacity building and technical assistance to ensure they are
 1484 positioned to meet DCHS's equity goals, as described in [Crisis Care Center Operator Regulatory and](#)
 1485 [Clinical Quality Activities](#). Finally, behavioral health providers with expertise in CLAS will be eligible to
 1486 receive funds to build their own capacity to better serve populations experiencing behavioral health
 1487 inequities, as described in [Capacity Building for Providers with Expertise in Culturally and Linguistically](#)
 1488 [Appropriate Services](#).
 1489

Behavioral Health Equity Highlight

[Culturally and Linguistically Appropriate Services](#) describes how access to behavioral health care can be impeded by a lack of cultural humility amongst providers and by language barriers.¹⁴⁵ These challenges are described in [Who Experiences Behavioral Health Inequities](#) and were also raised by community members, as described in [Culturally and Linguistically Appropriate Services](#).

Culturally and linguistically appropriate services (CLAS) are nationally recognized as a way to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and promote health equity.¹⁴⁶ The CCC Levy will increase availability of these clinical best practices by investing in crisis care centers that include CLAS, including interpretation and translation services. CCC Levy funds will be used to support crisis care center operators with capacity building and technical assistance to ensure they are positioned to meet DCHS's equity goals, as described in [Crisis Care Center Operator Regulatory and Clinical Quality Activities](#).

1490
 1491 [Representative Behavioral Health Workforce](#)
 1492 In addition to offering CLAS as part of clinical best practices, there is evidence that improving diversity
 1493 among behavioral health workers to better reflect the communities they serve may help improve
 1494 communication and trust while reducing behavioral health disparities.^{147,148} Based on both the
 1495 background in [Behavioral Health Workforce](#) and the community engagement described in [Importance](#)
 1496 [of Workforce Representation](#), there are investments to improve the representativeness of the
 1497 community behavioral health workforce, as described in [Error! Reference source not found.](#)
 1498 [Quality Improvement and Accountability](#)
 1499 The final behavioral health equity focus in this Plan relates to ensuring that equity objectives are realized
 1500 to both improve quality of care and hold the County and behavioral health providers accountable.
 1501 Community members provided this feedback prominently, as described in [Theme G: Accountability](#)
 1502 [Mechanisms and Ongoing Community Engagement](#). The CCC Levy's operations funding for crisis care
 1503 center operators includes funds to collect high quality data about client characteristics, as described in

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

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

1504 [Collect and Report High Quality Data](#), and then to use this information to implement continuous quality
1505 improvement activities that monitor and concerted aim to reduce observed disparities, as described in
1506 [Continuous Quality Improvement](#). The CCC Levy will further invest in community-based organizations or
1507 behavioral health providers with expertise in CLAS to provide subject matter expertise to the County to
1508 ensure that quality improvement activities are appropriately monitoring and advancing these equity
1509 goals, as described in [Expertise to Support Oversight of Behavioral Health Equity](#) . Additional
1510 accountability will occur through the formal evaluation of the CCC Levy, whose funded activities are
1511 described in [F. Strategy 6: Evaluation and Performance Measurement Activities](#) and details are provided
1512 in

1513 [VII. Evaluation and Performance Measurement](#). The annual reports will include information about these
1514 equity analyses, including information on geographic variations that may provide insights into serving
1515 rural communities, as described in [B. Reporting Methodology to Show Geographic Distribution by ZIP](#)
1516 [Code](#).

1517
1518 In addition to collecting, analyzing, and reporting on data and metrics in a way that accounts for this
1519 Plan’s behavioral health equity framework, DCHS will engage community partners in an ongoing
1520 manner, as described in [Community Engagement](#). The Behavioral Health Advisory Board, the advisory
1521 body of the CCC Levy, will also play an important role by providing a forum for people with
1522 demographics representative of King County, as well as lived experience of mental health and substance
1523 use conditions to advise DCHS on the CCC Levy implementation, as described in

1524 [IX. Crisis Care Centers Levy Advisory Body.](#)

1525 **IV. Crisis Care Centers Levy Purposes**

1526 Ordinance 19572 defines the Crisis Care Centers (CCC) Levy's Paramount Purpose and two Supporting
 1527 Purposes. The Paramount Purpose is to establish and operate a network of five crisis care centers in King
 1528 County. Supporting Purpose 1 is to restore and expand mental health residential treatment capacity and
 1529 Supporting Purpose 2 is to strengthen King County's community behavioral health workforce. The Levy's
 1530 purposes will significantly support King County residents' behavioral health. However, the CCC Levy
 1531 cannot transform or repair the region's entire system of behavioral health care. Attempting to do so
 1532 without first fulfilling the CCC Levy's required purposes risks dissipation of the CCC Levy's resources. To
 1533 promote focused and high-quality implementation of this initiative, this Plan prioritizes the three
 1534 mandatory, voter-approved purposes of the CCC Levy.

1535

1536 **Paramount Purpose**

1537 The Paramount Purpose of the CCC Levy is to create and support operations of a regional network of
 1538 five crisis care centers across King County, including at least one that specializes in serving youth. These
 1539 crisis care centers will strengthen this region's community behavioral health system by creating safe and
 1540 welcoming places for people experiencing an urgent behavioral health need to quickly access behavioral
 1541 health care, as described in detail in [A. Strategy 1: Create and Operate Five Crisis Care Centers](#). Crisis
 1542 care centers will promote continuity of care by connecting people to behavioral health and social service
 1543 resources to support ongoing recovery.

1544

1545 **Supporting Purpose 1**

1546 Supporting Purpose 1 will restore mental health residential beds lost in King County since 2018. During
 1547 this brief period, King County's mental health residential bed capacity has dropped by 115 beds, or
 1548 nearly one third. To restore this bed capacity to 355 beds as King County had in 2018, the CCC Levy will
 1549 fund capital and maintenance expenses to preserve existing and build new mental health residential
 1550 treatment beds in King County, as described in detail in [B. Strategy 2: Restore, Expand, and Sustain
 1551 Residential Treatment Capacity](#).

1552

1553 **Supporting Purpose 2**

1554 Supporting Purpose 2 addresses community behavioral health workforce shortages and the need to
 1555 grow and sustain the behavioral health workforce, including but not limited to the workforce at the
 1556 region's new crisis care centers. Investments related to this purpose are intended to increase the
 1557 sustainability and representativeness of the behavioral health workforce by expanding community
 1558 behavioral health career pathways, sustaining and expanding labor-management workforce
 1559 development partnerships, and supporting crisis workforce development.¹⁴⁹ These activities are
 1560 described in detail in [C. Strategy 3: Strengthen the Community Behavioral Health Workforce](#).

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

1561 **V. Crisis Care Centers Levy Strategies and Allowable Activities**

1562 Ordinance 19572 requires this Plan to define strategies for how CCC Levy funds will be invested between
1563 2024 and 2032 to achieve the Levy’s purposes. This Plan’s strategies reflect Ordinance 19572
1564 requirements and input from community partners, subject matter experts, and DCHS staff, as described
1565 in [D. Implementation Plan Methodology](#).

1566
1567 Figure 10 summarizes the strategies, and Figure 11 illustrates which strategies directly and indirectly
1568 support each of the CCC Levy’s purposes. Descriptions of each strategy and its allowable expenditures
1569 and activities follow the summary figures.
1570

1571 **Figure 10. Summary of the CCC Levy Strategies**

Summary of the CCC Levy Strategies	
Strategy	Summary Description
Strategy 1 Create and Operate Five Crisis Care Centers	<ul style="list-style-type: none"> Capital funding to create and maintain five crisis care centers Operating funding to support crisis care center personnel costs, operations, services, and quality improvement Post-crisis follow-up for people after leaving a crisis care center
Strategy 2 Restore, Expand, and Sustain Residential Treatment Capacity	<ul style="list-style-type: none"> Capital resources to restore mental health residential treatment capacity to at least 355 beds in King County Capital resources to expand and sustain residential treatment capacity
Strategy 3 Strengthen the Community Behavioral Health Workforce	<ul style="list-style-type: none"> Resources to expand community behavioral health career pathways, including investments to stabilize and sustain King County's community behavioral health workforce and increase workforce representativeness Resources to expand and sustain labor management workforce development partnerships, including support for apprenticeships Resources to support the development of the region's behavioral health crisis workforce, including crisis care center workers
Strategy 4 Early Crisis Response Investments	<ul style="list-style-type: none"> Resources to expand community-based crisis service capacity starting in 2024, before crisis care centers are open Resources starting in 2024 to respond faster to the overdose crisis
Strategy 5 Capacity Building and Technical Assistance	<ul style="list-style-type: none"> Resources to support the implementation of CCC Levy strategies Support for capital facility siting Build capacity for culturally and linguistically appropriate services
Strategy 6 Evaluation and Performance Measurement	<ul style="list-style-type: none"> Resources to support CCC Levy data collection, evaluation, and performance management Analyses of the CCC Levy's impact on behavioral health equity
Strategy 7 CCC Levy Administration	<ul style="list-style-type: none"> Investments in CCC Levy administration, community engagement, information technology systems infrastructure, and designated crisis responder (DCR) accessibility¹⁵⁰
Strategy 8 CCC Levy Reserves	<ul style="list-style-type: none"> Provide for and maintain CCC Levy reserves^{151,152}

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

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

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

1572 **Figure11. How Each Strategy Advances the CCC Levy’s Purposes**

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

1573
1574 **A. Strategy 1: Create and Operate Five Crisis Care Centers**

1575 **Overview**

1576 The Paramount Purpose of the CCC Levy is to create and operate a regional network of five crisis care
1577 centers across King County. The CCC Levy’s network of crisis care centers will create a new front door for
1578 people in crisis who need behavioral health services. Crisis care centers will help people by:

- 1579 • Providing in-person behavioral health services tailored to the needs of people in a behavioral
1580 health crisis;
- 1581 • Creating a dedicated place for people in crisis to receive effective care from specialized
1582 behavioral health providers;
- 1583 • Serving as a destination for first responders, including law enforcement, to bring people who
1584 need behavioral health care;
- 1585 • Expanding King County’s behavioral health continuum of care as a complement to services
1586 funded through the KCICN, BH-ASO, and MIDD (see [Behavioral Health Service Funding
1587 Limitations and Opportunities](#)), and

- 1588 • Reducing reliance on hospital emergency departments, hospitals, and jails as places that people
1589 go when in a behavioral health crisis.

1590

1591 This section provides an overview of the CCC Levy’s crisis care center program and the allowable
1592 activities within Strategy 1, including descriptions of:

- 1593 • The clinical model for the five crisis care centers, including the one dedicated to serving youth;
- 1594 • Post-crisis stabilization activities to support people after a crisis care center visit;
- 1595 • DCHS’s role to oversee and improve the quality of the crisis care centers;
- 1596 • Allowable operational and capital funding activities for crisis care centers;
- 1597 • Crisis care center capital facility requirements, and
- 1598 • The crisis care centers procurement and siting process.

1599

1600 [Crisis Care Center Clinical Program Overview](#)

1601 The purpose of this Plan is to guide DCHS in its administration and implementation of the CCC Levy. This
1602 section of the Plan describes the initial vision for crisis care centers operations to inform appropriate
1603 County-level guidance for levy-level administration activities such as procurements, contracting,
1604 performance measurement, and communications with communities. This Plan does not preempt
1605 relevant state or federal laws or regulations. It also is not intended to interfere with patient-level care
1606 decisions that are more appropriately governed outside of a County-level implementation plan.

1607

1608 DCHS will refine this clinical program and model during procurement and implementation phases based
1609 on improved understanding of community needs. Refinements are expected to incorporate rapid
1610 advancements in the evidence base for effective behavioral health care, satisfy future federal and state
1611 regulatory guidance and licensing rules, and use continuous quality improvement practices that respond
1612 to performance data and community accountability. (See more on [Section V.A. Strategy 1 Create and](#)
1613 [Operate Five Crisis Care Clinics: Oversight of Crisis Care Center Quality and Operations](#) later in this
1614 subsection).

1615

1616 The crisis care center clinical program model has four parts:

- 1617 1. **Clinical components,**
- 1618 2. **Services,**
- 1619 3. A **facility,** and
- 1620 4. An **operator.**

1621

1622 Specifically, the crisis care center clinical program has three **clinical components** (24/7 Behavioral Health
1623 Urgent Care, 23-Hour Observation Unit, and Crisis Stabilization Unit), in which **services** (assessment,
1624 triage, interventions, referrals) are provided at a sited **facility** (see [Section V.A. Strategy 1: Created and](#)
1625 [Operated Five Crisis Care Centers: Crisis Care Center Capital Facility Development](#)) by an **operator** that
1626 has been competitively selected by DCHS (see [Section V.A. Strategy 1: Created and Operated Five Crisis](#)
1627 [Care Centers: Crisis Care Center Procurement and Siting Process](#)).

1628

1629 This clinical program model is based on multiple inputs, including:

- 1630 • The core elements of crisis care centers as defined in Ordinance 19572 (see Figure 12).
- 1631 • SAMHSA’s National Guidelines for Behavioral Health Crisis Care, which call for the creation of
1632 crisis facilities (“somewhere to go”) for people in crisis to seek help as part of a robust
1633 behavioral health crisis system (see

- [Access to behavioral health services is also limited among people experiencing homelessness. A recent survey found](#) that only 18 percent of people experiencing homelessness had received either mental health counseling or medications in the prior 30 days despite 66 percent reporting current mental health symptoms. The same survey describes barriers such as lacking access to a phone, needing to stay with belongings to prevent theft, and avoiding services due to past experiences of traumatic or unsupportive interactions with health care providers.

Among U.S. military veterans who experience depression and PTSD, disparities in access to mental health services have been described as a major factor contributing to the high suicide rates among veterans. People living in rural areas in the U.S. also experience significant disparities in mental health outcomes despite having similar prevalence of mental illness to those living in metropolitan areas.

- Need for Places to Go in a Crisis);^{153,154}
- The CCC Levy community engagement process, which identified several clinical best practices that helped inform many of the clinical model components (see Theme A: Implement Clinical Best Practices in Crisis Services); Informational interviews with subject matter experts and other community partners, which helped tailor crisis care center services to local contexts and needs (see [Crisis Care Center Methodology](#)); and
- Site visits to 10 adult or youth behavioral health crisis facilities in Washington, California, and Arizona (see [Appendix E: Site and Field Visits](#)).

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

Crisis Care Center Definition
<p>"Crisis care center" means a single facility or a group of facilities that provide same-day access to multiple types of behavioral health crisis stabilization services, which may include, but are not limited to, those described in RCW 71.24.025(20), as amended.¹⁵⁵ A crisis care center shall endeavor to accept at least for initial screening and triage any person who seeks behavioral health crisis care.</p> <p>Among the types of behavioral health crisis stabilization services that a crisis care center shall provide are:</p> <ul style="list-style-type: none"> • A behavioral health urgent care clinic that offers walk-in and drop-off client screening and triage 24 hours per day, seven days per week; • Access to onsite assessment by a designated crisis responder; • A 23-hour observation unit or similar facility and service that allows for short-term, onsite stabilization of a person experiencing a behavioral health crisis; and • A crisis stabilization unit that provides short-term, onsite behavioral health treatment for up to 14 days or a similar short-term behavioral health treatment facility and service.

¹⁵³ Substance Abuse and Mental Health Services Administration. (2020). National Guidelines for Behavioral Health Crisis Care - Best Practice Toolkit. [\[LINK\]](#)

¹⁵⁴ Substance Abuse and Mental Health Services Administration: National Guidelines for Child and Youth Behavioral Health Crisis Care. Publication No. PEP22-01-02-001 Rockville, MD: Substance Abuse and Mental Health Services Administration, 2022. [\[LINK\]](#)

¹⁵⁵ RCW 71.24.025. [\[LINK\]](#)

A crisis care center shall be staffed by a multidisciplinary team that includes peer counselors. A crisis care center may incorporate pre-existing facilities that provide crisis stabilization services so long as their services and operations are compatible with this definition. Where a crisis care center is composed of more than one facility, those facilities shall either be geographically adjacent or shall have transportation provided between them to allow persons using or seeking service to conveniently move between facilities.

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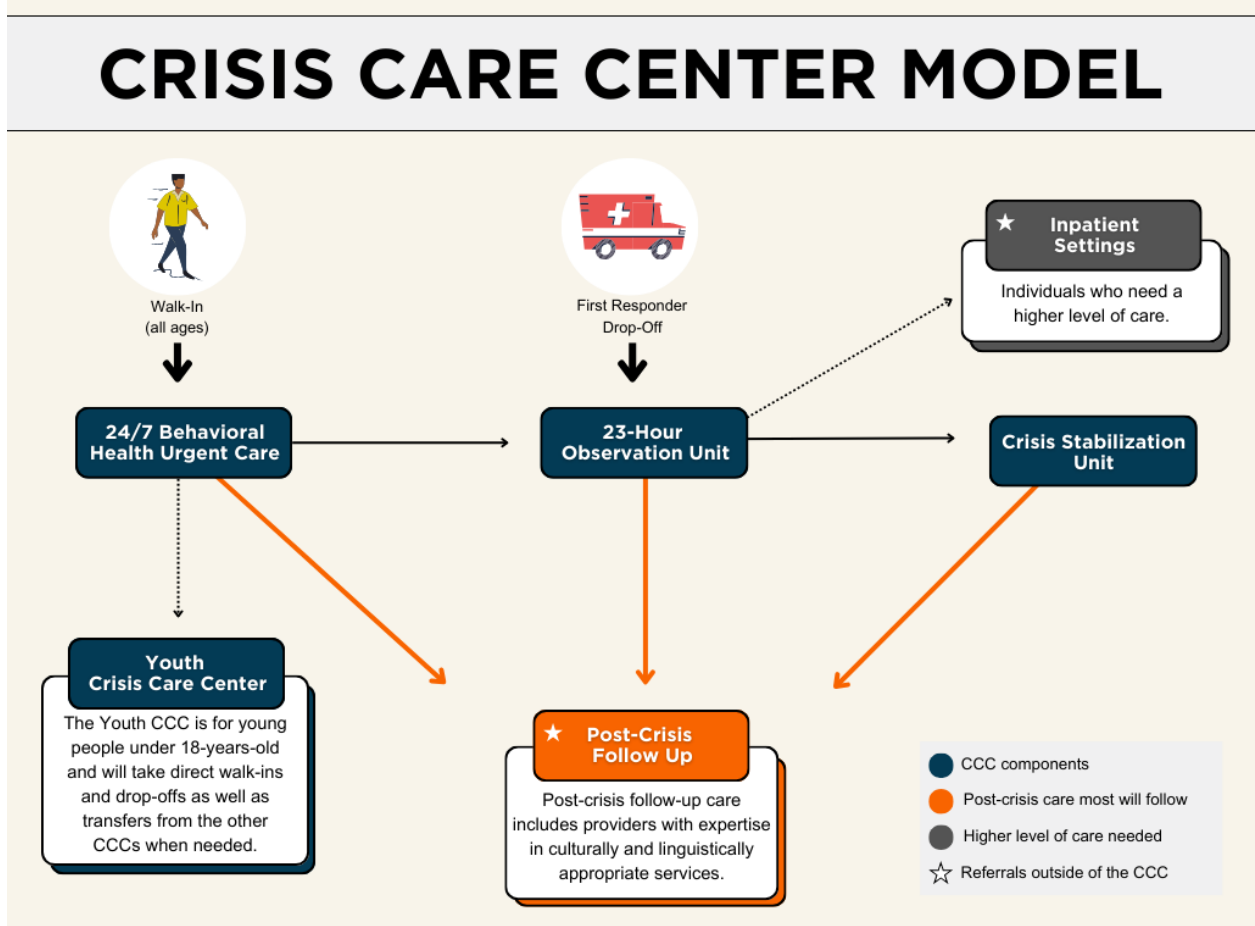
DCCHS intends for crisis care centers to incorporate clinical best practices, as described throughout the clinical model below. These best practices are summarized in [Appendix G: Clinical Best Practices in Behavioral Health Crisis Services](#) and include care that is trauma-informed, recovery-oriented, person-centered, culturally and linguistically appropriate, integrated, and delivered in the least restrictive setting. This Plan includes support for providers to implement these best practices through [Section V.E Strategy 5: Capacity Building and Technical Assistance](#). This model reflects high quality standards of compassionate and effective care in crisis settings.¹⁵⁶

Crisis Care Center Clinical Model

The crisis care center clinical model described in this subsection applies to the four crisis care centers that will primarily serve adults. Figure 13 depicts the model and Figure 14 **Error! Reference source not found.** describes the model in greater detail. This clinical model describes how at the time of this Plan’s transmittal, DCCHS expects crisis care centers will operate. All of the crisis care centers will offer the three clinical components (24/7 behavioral health urgent care, 23-hour observation, and crisis stabilization), which will provide different levels of care depending on each person’s needs. The centers will primarily provide accessible and efficient assessment, short-term stabilization, and triage to subsequent services and supports. The youth crisis care center clinical model is described in the next section.

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

1675 **Figure 13. Crisis Care Center Clinical Model**



1676
1677

1678 DCBS, in partnership with community behavioral health providers, will create crisis care centers that
1679 operate according to the clinical model depicted in Figure 13 above and described in Figure 14 below.

1680 **Figure14. Summary of the Crisis Care Center Clinical Model**

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

1681

1682 [Access to Crisis Care Centers](#)

1683 Crisis care centers are places to go in a crisis. People will primarily access care by self-presenting to the
1684 behavioral health urgent care clinic, which may include having another person like a service provider or
1685 family member bring the person. Just like a physical health urgent care clinic, people seeking same-day
1686 behavioral health care outside the traditional outpatient clinic setting should be able to access the
1687 behavioral health urgent care clinic as a “front door” to services.

1688
1689 Crisis care center operators shall work with relevant parties including community behavioral health
1690 providers, mobile crisis teams, co-responder teams, emergency medical services, or law enforcement to
1691 help facilitate transportation to crisis care center facilities from behavioral health provider locations as
1692 needed and subject to available resources.

1693
1694 Crisis care centers that operate either a crisis stabilization unit as defined in RCW 71.05.020, a 23-hour
1695 crisis relief center as defined in RCW 71.24.025, or both, shall accept individuals transported by law
1696 enforcement, in accordance with RCW 10.31.110, to those clinical components.

1697
1698 Crisis care centers will also receive drop-offs by first responders, which include, but are not limited to,
1699 mobile crisis teams, co-responder teams, emergency medical services, and law enforcement. First
1700 responder drop-offs will be made directly into the 23-hour observation unit through a dedicated first
1701 responder entrance. These drop-offs are expected be completed in an efficient manner so that first
1702 responders can return to their duties as quickly as possible.

1703
1704 Youth under age 18, including those who are unaccompanied by parents or caregivers as permitted by
1705 state law, will be able to seek behavioral health urgent care services in any of the crisis care centers,
1706 though the youth crisis care center detailed a later subsection will be tailored best to their needs (see
1707 [Section V.A. Strategy 1:Created and Operated Five Crisis Care Centers: Clinical Model for Youth Crisis
1708 Care Center](#)). Crisis care centers will follow the “no wrong door” approach, meaning individuals will be
1709 able to receive at least an initial screening and triage for all clinical needs.¹⁵⁷ Examples of “no wrong
1710 door” may include an individual facing their first behavioral health crisis episode, someone without
1711 regular access to behavioral health care, or an established client seeking services outside their
1712 outpatient clinic’s standard hours. Services will be available regardless of ability to pay and without an
1713 appointment.¹⁵⁸ DCHS will work with crisis care center operators, jurisdictions within the crisis response
1714 zone, and other crisis system partners to determine criteria and protocols to manage new admissions
1715 when a center is at full capacity.

1716
1717 Crisis care center operators are encouraged to become a Safe Place Site or Licensed Safe Place Agency.
1718

Behavioral Health Equity Highlight

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

¹⁵⁷ Substance Abuse and Mental Health Services Administration. (2020). National Guidelines for Behavioral Health Crisis Care - Best Practice Toolkit. [\[LINK\]](#)

¹⁵⁸ King County Ordinance 19572 [\[LINK\]](#)

1719 [Initial Screening and Triage](#)

1720 People coming to a crisis care center will receive an initial screening for mental health and substance use
 1721 service needs, social service needs, and medical stability. Peer specialists will engage with each person,
 1722 if appropriate, to help them feel welcome and safe. Based on feedback from community partners (see
 1723 [Theme A: Implement Clinical Best Practices in Crisis Services](#)), all team members engaging with people
 1724 experiencing a behavioral health crisis will be trained and supervised to use trauma-informed, recovery-
 1725 oriented, and culturally and linguistically appropriate approaches (see [Appendix G: Clinical Best Practices
 1726 in Behavioral Health Crisis Services](#)).

1727
 1728 The goal of the initial screening is for the clinical team to work with the person in crisis to make shared
 1729 decisions about what services and supports they may need. People who come to a crisis care center may
 1730 be triaged to a more appropriate setting when they do not meet criteria for medical stability or do not
 1731 have an active behavioral health crisis need, which DCHS will define with input from community
 1732 partners including first responders.¹⁵⁹ People who decline services will be treated respectfully so their
 1733 experience increases their likelihood of accepting services in the future.

1734
 1735 [Services Available at Crisis Care Centers](#)

1736 Some services will be available throughout a crisis care center, while others will be specific to certain
 1737 components identified in Figure 14. Regardless of how a person in a behavioral health crisis enters a
 1738 crisis care center or which component they are in, crisis care center operators may first address each
 1739 person’s basic needs by providing resources such as food and water, clean clothes, and a safe place to
 1740 rest. Peer specialists will work across the components to engage and support people to take steps
 1741 towards their recovery goals and access the services they need. Whenever possible, DCHS expects the
 1742 crisis care center operator to collaborate with outside service providers to promote continuity of care
 1743 and observe clinical best practices.

1744
 1745 Psychiatric providers will be available 24/7 to provide services that include, but are not limited to,
 1746 medication refills, administration of long-acting injectable medications, and initiation of medications for
 1747 psychiatric symptoms, opioid use disorder and substance use withdrawal.¹⁶⁰ Crisis care centers shall
 1748 ensure prompt access to substance use disorder treatment on-site. Social service providers will be
 1749 available to help access benefits and existing housing resources (see more on [Housing Stability
 1750 Resources](#) later in this subsection). Supports for people with co-occurring behavioral health needs and
 1751 intellectual and developmental disabilities will also be available at the centers.

1752
 1753 Crisis stabilization services will be offered only in the 23-hour observation units (up to 23 hours and 59
 1754 minutes, with possible exceptions depending on Washington State Department of Health regulations)
 1755 and crisis stabilization units.¹⁶¹ Services and methodologies in these components will include, but are not
 1756 limited to, maintaining a safe and healing environment, using de-escalation techniques, creating safety
 1757 plans and crisis plans, and providing evidence-based therapies and substance use counseling. DCHS

¹⁵⁹ First responders include, but are not limited to, mobile crisis teams, co-responder teams, emergency medical services, and law enforcement.

¹⁶⁰ Psychiatric providers include but are not limited to psychiatrists, psychiatric nurse practitioners, and psychiatric physician assistants.

¹⁶¹ Washington State Department of Health Proposal Statement of Inquiry CR-101 regarding WSR 23-13-017, to implement 2SSB 5120 (2023). [\[LINK\]](#)

1758 expects that the 23-hour observation unit to be equivalent to a psychiatric emergency service in its
 1759 ability to serve the full scope of mental health and substance use crises that people will present with at
 1760 the crisis care centers. This clinical component will also have the most staff working at any given time
 1761 compared to the other components of a crisis care center, including staff to implement a significant
 1762 focus on maintaining a safe and healing environment. In contrast, DCHS expects the crisis stabilization
 1763 unit to be a lower level of care, with a focus on problem solving around complex health and social
 1764 service needs and engaging in short-term counseling within a maximum stay of 14 days. Stabilization
 1765 beds may be dual licensed to also provide medically monitored withdrawal management services.¹⁶²
 1766

1767 In addition to services, the physical space of a crisis care center affects its function.¹⁶³ Though the
 1768 [Section V.A. Strategy 1: Created and Operated Five Crisis Care Centers: Site and Facility Requirements](#)
 1769 subsection later in address the detailed regulatory requirements for these facilities, this subsection
 1770 briefly describes the clinical importance of the physical space based on the community feedback
 1771 described in [Welcoming and Safe](#).
 1772

1773 DCHS envisions that the crisis care centers will have design features that include, but are not limited to:

- 1774 • a space that is both open and has flexible rooms to protect privacy when needed;
- 1775 • comfortable, private, and calming spaces;
- 1776 • a designated “swing” space to safely separate youth and other vulnerable populations;
- 1777 • spaces to accommodate outside service providers as well as family and caregivers;
- 1778 • sound suppression features to prevent echoes and minimize over-stimulation for people living
 1779 with intellectual or developmental disabilities;
- 1780 • a dedicated entrance for first responders for discrete and efficient drop-offs, and
 1781 • accessible outdoor space.

1782
 1783 DCHS will provide technical assistance and oversight of crisis care center operators to design facilities
 1784 that support the clinical model described above.
 1785

1786 [Triage to the Next Level of Care](#)

1787 DCHS anticipates that most people who come in through the behavioral health 24/7 urgent care clinic
 1788 will have their needs addressed in that setting with potential follow-up care (see [Section V. A. Post-Crisis
 1789 Stabilization Activities](#)), based on similar care models.¹⁶⁴ DCHS will establish triage criteria, with input
 1790 from crisis care center operators and other community partners, for entry to the 23-hour crisis
 1791 observation or crisis stabilization units, which will be consistent for adult centers and tailored for
 1792 children (see [Clinical Model for Youth Crisis Care Center later in this subsection](#)). The criteria will include
 1793 with factors that may assess risk of suicide or violence, behavioral distress, withdrawal from substances,
 1794 and likelihood of benefitting from a higher level of care. Anyone under age 18 who needs a higher level
 1795 of care may be transferred to the youth crisis care center, as capacity allows. If someone needs longer-
 1796 term services, the crisis care center team may initiate a referral to an appropriate care setting, such as a
 1797 mental health or substance use residential treatment setting.

¹⁶² Washington State Health Care Authority - Adult Withdrawal Management Services [\[LINK\]](#)

¹⁶³ Based on crisis center clinical leadership’s report during a DCHS staff site visit to crisis facilities listed in
[Appendix E: Site and Field Visits](#)

¹⁶⁴ Based on crisis center clinical leadership’s report during a DCHS staff site visit to a crisis facility in Phoenix, AZ.

1798 It is a priority of King County for behavioral health crisis care to be delivered in the least restrictive
1799 way.¹⁶⁵ This means that the person receiving services remains in control of their own care as much as
1800 possible. Community members provided clear support for this approach, as described in [Least](#)
1801 [Restrictive Care](#).

1802
1803 Only when a significant concern exists that a person meets statutory criteria for involuntary treatment
1804 and the person declines treatment, despite every effort to engage them in care voluntarily, DCHS
1805 anticipates that the crisis care center clinical staff will request an evaluation for potential involuntary
1806 treatment by a designated crisis responder (DCR), as required by the Involuntary Treatment Act.¹⁶⁶ A
1807 DCR would conduct a timely onsite evaluation at a crisis care center, as required by Ordinance 19572.¹⁶⁷
1808 [Designated Crisis Responder Accessibility](#) provides resources to help expedite designated crisis
1809 responder response times.

1810
1811 If a DCR determines that someone requires involuntary treatment in accordance with the Involuntary
1812 Treatment Act, then the crisis care center may continue to provide services up until transfer to the most
1813 appropriate alternative setting, such as a psychiatric hospital or evaluation and treatment (E&T) bed.¹⁶⁸
1814 DCHS will work with crisis care center operators to develop policies and procedures that minimize the
1815 use of involuntary interventions while remaining compliant with Washington State law. DCHS will
1816 require crisis care center operators to monitor and report on the use of involuntary interventions,
1817 including assessing for potential disparities by race and other demographics. Crisis care center operators
1818 will also be required to use widely recognized national best practices such as the Six Core Strategies to
1819 Reduce Seclusion and Restraint Use, which promotes alternative interventions such as prevention of
1820 escalation, trauma-informed and person-centered approaches, and de-escalation techniques like
1821 affording the person ample space and time.¹⁶⁹

1822
1823 DCHS expects that, when someone is ready for discharge from a crisis care center, crisis care center
1824 team members will work with each person to determine appropriate transitions to engage with

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

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

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

¹⁶⁸ RCW 71.05. [\[LINK\]](#)

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

1825 community-based health and social service resources. Resources include, but are not limited to,
 1826 reconnecting people with their existing providers, initiating new outpatient referrals, providing
 1827 prescription refills and medications for opioid use disorder, and linking people to post-crisis follow-up
 1828 care. (See more on [Section V.A. Strategy 1: Created and Operated Five Crisis Care Centers: Post-Crisis](#)
 1829 [Stabilization Activities](#)) To provide the clinical best practice of integrating behavioral health with physical
 1830 health care, as described in [Appendix G: Clinical Best Practices in Behavioral Health Crisis Services](#), crisis
 1831 care center operators may partner with primary care providers, including federally qualified health
 1832 centers (FQHCs) or similar programs, to facilitate referrals to primary care and access to low-cost
 1833 medications.¹⁷⁰

1834

1835 *Clinical Model for Youth Crisis Care Center*

1836 The youth crisis care center will be a specialized clinical setting designed to serve young people, as well
 1837 as their families and caregivers, in coordination with other youth behavioral health services available in
 1838 King County. This youth clinical model describes how at the time of this Plan’s transmittal DCHS expects
 1839 crisis care centers will operate, providing a level of detail beyond what is included in Ordinance 19572.

1840

1841 The County intends for the youth crisis care center to be like the other four centers in most ways,
 1842 including its three clinical components, approach to screening and triage, available services, and physical
 1843 environment. However, youth crisis care centers will be a specialized child and adolescent behavioral
 1844 health setting. At a minimum, the youth crisis care center will:

- 1845 • Offer services to and collaborate with the youth in a behavioral health crisis as well as their
 1846 families and caregivers.
- 1847 • Employ team members specially trained in youth behavioral health services and co-occurring
 1848 intellectual and developmental disabilities.
- 1849 • Employ peer specialists that include both young people and parent advocates with lived
 1850 experience of navigating youth behavioral health services.
- 1851 • Accommodate the unique needs of younger children and adolescents, such as the use of age-
 1852 specific stabilization units (for example, separate units for children 12 and under and for youth
 1853 ages 13 to 17), rather than distinct 23-hour observation and crisis stabilization units as in the
 1854 adult centers.¹⁷¹
- 1855 • Accept transfers when a young person seen at one of the other crisis care centers is determined
 1856 to meet criteria for facility-based care for reasons such as having a high risk of suicide, violence,
 1857 or behavioral distress.
- 1858 • Coordinate with the young person’s existing support systems such as school wellness centers,
 1859 child protective services, foster care, and juvenile justice systems.
- 1860 • Include spaces for youth service providers, family and caregivers to facilitate coordination and
 1861 engagement in care.

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

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

- 1862 • Provide youth in need of community-based services with specialized short-term post-crisis
1863 wraparound services as the youth is transitioning to ongoing care.

1864 **Crisis Care Center Operational Activities**

1865 Allowable activities under Strategy 1 include crisis care center operating and service costs. Allowable
1866 crisis care center operating activities are described below in Figure 15.

1867
1868 Crisis care centers will be funded to operate 24/7. DCHS anticipates that many of the services provided
1869 at crisis care centers will be covered by health insurance as described in [E. Health Insurance](#)
1870 [Assumptions](#). CCC Levy proceeds will pay for crisis care center operating and service costs that are not
1871 covered by health insurance or other sources, including the costs of services for people who are
1872 uninsured. Crisis care centers will welcome and serve people regardless of their insurance or
1873 immigration status and will also serve persons for whom confidentiality is important to their safety or
1874 willingness to seek care.¹⁷² Crisis care center operators will be eligible for workforce investments as
1875 described in [C. Strategy 3: Strengthen the Community Behavioral Health Workforce](#).

1876

Behavioral Health Equity Highlight

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

1877

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

1878 **Figure 15. Allowable Crisis Care Center Operations Activities**

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

1879

1880 **Post-Crisis Stabilization Activities**

1881 In addition to crisis care center operations, CCC Levy Strategy 1 funds will support people after they
 1882 have received services at a crisis care center. Community partners state that many people will likely
 1883 need additional community-based behavioral health services, health care, and social services after they
 1884 leave a crisis care center, to support their ongoing recovery and wellbeing. Need for Post-Crisis
 1885 Stabilization ServicesCommunity partners also shared during implementation planning process
 1886 engagement that significant supports are needed by people exiting the crisis care centers in the period
 1887 immediately following a crisis episode (see [Need to Build a "Bridge to Somewhere"](#)).

¹⁷³ Strategy 3 also includes resources for competitive wages in the crisis workforce, including at crisis care centers, that are better aligned with other sectors. See [C. Strategy 3: Strengthen the Community Behavioral Health Workforce](#) for more information about these CCC Levy workforce investments. See [Behavioral Health Workforce](#) for further discussion of historic underinvestment in behavioral health workers.

1888 Participants in community meetings and focus groups, including people who have experienced
 1889 behavioral health crises, discussed the profound benefits of having someone, especially a peer specialist,
 1890 continue to offer support and help connect to community-based care (see [Care Coordination and Peer](#)
 1891 [Engagement](#)). Evidence and research also identify the need for post-crisis stabilization services, as
 1892 discussed in [Need for Post-Crisis Stabilization Services](#). Despite their importance, existing post-crisis
 1893 follow up services in King County are inadequate to meet the need.

1894
 1895 Strategy 1 resources will be used to fund the activities described in Figure 16 to create a post-crisis
 1896 follow-up program that serves all five of the crisis care centers. These services may address three
 1897 important and interrelated objectives:

- 1898 1. Provide brief behavioral health interventions during the high-risk period immediately following a
 1899 discharge from a crisis care center;
- 1900 2. Engage people proactively to help them connect with community-based behavioral health,
 1901 health care, and social service resources that meet their needs and preferences, including
 1902 culturally and linguistically appropriate services and housing services; and
- 1903 3. Manage the capacity of crisis care centers by helping people connect to the intensity of services
 1904 that best meets their needs, including less intensive community-based services.

1905
 1906 **Figure 16. Allowable Crisis Care Center Post-Crisis Stabilization Activities**

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

1907
 1908 DCHS anticipates that the post-crisis stabilization resources within this strategy will be inadequate to
 1909 meet the behavioral health needs of all people who access King County’s crisis care centers.
 1910 Complementary investments from philanthropic partners and the state or federal governments will be
 1911 needed to bring the services to scale. Washington State must continue to be a primary funder of post-
 1912 crisis services, including through state funding for the Behavioral Health Administrative Services
 1913 Organizations (BHASOs), and enhanced Medicaid reimbursement for eligible clinical services. [D. Seeking](#)
 1914 [and Incorporating Federal, State, and Philanthropic Resources](#) describes how the Executive intends to
 1915 seek complementary funding opportunities to augment the impact of the CCC Levy.

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

1916

1917 *Crisis Care Center Post-Crisis Follow-Up Program*

1918 Strategy 1 will create a post-crisis follow-up program that serves people after they receive care at the
 1919 five crisis care centers. During this high-risk period, post-crisis follow-up services are essential to serving
 1920 as a bridge from crisis care centers to the next level of care. Services may include proactive contacts
 1921 after discharge, care coordination with new and existing providers, brief interventions to address acute
 1922 needs while awaiting linkage to additional services, and peer support to enhance engagement and
 1923 support people to access the services they need, similar to the promising but limited Peer Bridging
 1924 programs described in [Need for Post-Crisis Stabilization Services](#). Services will address both mental
 1925 health and substance use needs, as well as referrals to social services, including housing resources when
 1926 needed. Special considerations may be needed to tailor post-crisis follow-up services for youth and their
 1927 families and caregivers. Care should continue to be trauma-informed, recovery-oriented, person-
 1928 centered, culturally and linguistically appropriate, and aim to maintain people in the least restrictive
 1929 level of care possible, according to the crisis care center clinical best practices reviewed the [Crisis Care
 1930 Center](#) Clinical Program Overview in Appendix G: Clinical Best Practices in Behavioral Health Crisis
 1931 Services.

1932

1933 DCHS expects that these services will be provided by a multidisciplinary care team that includes peer
 1934 specialists and should be initiated in-person at a crisis care center prior to discharge before transitioning
 1935 to outpatient offices, outreach in community-based settings, or virtually through telehealth visits. All
 1936 individuals treated at a crisis care center shall have access to post-crisis follow-up treatment planning,
 1937 subject to available resources. Because demand for post-crisis stabilization services is likely to exceed
 1938 the capacity available through this strategy, DCHS may need to establish prioritization criteria in
 1939 partnership with post-crisis follow-up providers. For example, post-crisis stabilization resources may be
 1940 prioritized to support people who have the highest risk of not engaging in follow-up care, including
 1941 populations experiencing behavioral health inequities (see [Who Experiences Behavioral Health
 1942 Inequities](#)).¹⁷⁵

1943

1944 A specific focus of the post-crisis follow-up program will be to reach people who are experiencing
 1945 homelessness or are at risk of homelessness, given the significant barriers to accessing behavioral health
 1946 services described in [Unmet Behavioral Health Service Needs](#). Tailored approaches are often needed to
 1947 meet people in the community and create lower threshold entry points for people experiencing
 1948 homelessness to engage in care.¹⁷⁶ Therefore, the post-crisis follow-up program is expected to provide
 1949 outreach-based follow-up and linkages to existing housing and social service resources. This strategy's
 1950 activities may include short-term housing stability resources like hotel vouchers.

1951

1952 *Culturally and Linguistically Appropriate Post-Crisis Follow-Up Services*

1953 The availability of culturally and linguistically appropriate services during high-risk periods is essential, as
 1954 demonstrated in community feedback, research showing disparities in behavioral health services

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

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

1955 following a crisis, and the value of culturally congruent care. (See [Culturally and Linguistically](#)
1956 [Appropriate Services.](#)) Lack of culturally congruent care reduces engagement in behavioral health care,
1957 which this strategy aims to address. (See [Behavioral Health Workforce Needs.](#))

1958
1959 For these reasons, providers with expertise in offering culturally and linguistically appropriate services
1960 are well positioned to offer post-crisis follow-up services. DCHS will make funding available specifically
1961 for behavioral health agencies that demonstrate significant experience in providing culturally and
1962 linguistically appropriate services to provide post-crisis follow-up services. These post-crisis services will
1963 be prioritized for people who were seen in crisis care centers. These providers may support care
1964 continuity through longer-term services when appropriate so long as capacity is maintained for new
1965 post-crisis follow-up services.

1966
1967 The Strategy 1 investment activities described in Figure 16 are intended to increase the capacity of
1968 culturally and linguistically specialized service providers to provide post-crisis follow-up services. These
1969 funds will be made available prior to opening of the crisis care centers so that these providers can build
1970 capacity in time to receive referrals when the crisis care centers open. These investments will increase
1971 over time as crisis care centers become operational so that organizations have additional financial
1972 resources to serve new people who are referred from crisis care centers. DCHS intends to award funding
1973 for these activities to organizations that have expertise in providing culturally and linguistically
1974 appropriate or concordant behavioral health services through a competitive procurement process. Prior
1975 to the competitive procurement process, DCHS intends to solicit additional information from providers
1976 and community partners to inform how best to identify and select providers with expertise in culturally
1977 and linguistically appropriate services.

1978

Behavioral Health Equity Highlight

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

1979

1980 *Housing Stability Resources*

1981 Safe, healthy, and affordable housing is a critical resource and social determinant of health for people
1982 living with behavioral health conditions.^{177, 178} Housing stability is both a protective factor against future
1983 crises and an important component of post-crisis care and recovery.¹⁷⁹ Homelessness and housing

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

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

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

1984 instability can contribute to crises and undermine the care in settings like a crisis care center.¹⁸⁰ (See
1985 [Section III.C. Key Historical and Current Conditions: Who Experiences Behavioral Health Inequities.](#))

1986
1987 Understanding housing stability’s importance, crisis care center operators and post-crisis follow-up
1988 providers will connect clients with existing housing resources whenever possible. The CCC Levy’s
1989 regional network of crisis care centers and increased residential treatment capacity will also present
1990 housing providers with new resources to reinforce and complement existing housing services.

1991
1992 DCHS will collaborate with other governments and philanthropy to increase housing resources for King
1993 County residents, including people receiving CCC Levy-funded care (See [D. Seeking and Incorporating
1994 Federal, State, and Philanthropic Resources.](#)) DCHS will also coordinate its divisions’ work when possible
1995 to increase housing supports for people experiencing homelessness who receive care at crisis care
1996 centers.

1997
1998 In addition to the limited housing stability expenditures that this Plan authorizes, when necessary and
1999 available as part of post-crisis follow up activities, CCC Levy funds may be used for housing resources in
2000 accordance with this Plan’s priorities for increasing allocations due to additional funding. (See [F. Process
2001 to Make Substantial Adjustments to the Financial Plan](#)). These investments may include permanent and
2002 emergency housing stability resources like hotel vouchers, rapid rehousing funds, rental assistance,
2003 housing vouchers, other housing subsidies, and housing capital or housing operations costs that are
2004 otherwise eligible under Ordinance 19572.

2005
2006 [Oversight of Crisis Care Center Quality and Operations](#)

2007 The CCC Levy will establish an entirely new class of behavioral health facility in King County. DCHS will be
2008 responsible for ensuring that crisis care centers and related programs are functioning as described
2009 above in this Section V.A. Strategy 1:Created and Operated Five Crisis Care Centers: [Crisis Care Center
2010 Clinical Program Overview](#) and [Post-Crisis Stabilization Activities](#).

2011
2012 Ordinance 19572 directs this Plan to include "levy administration activities and activities that monitor
2013 and promote coordination, more effective crisis response, and quality of care within and amongst crisis
2014 care centers, other behavioral health crisis response services in King County, and first responders."
2015 These activities of the CCC Levy are aligned with the “accountable entity” concept defined by the
2016 National Council for Mental Wellbeing’s *Roadmap to the Ideal Crisis System* report as “a structure that
2017 holds the behavioral health crisis system accountable to the community for meeting performance
2018 standards and the needs of the population.”¹⁸¹ The CCC Levy provides a unique opportunity for DCHS to
2019 assume this critical oversight role within the scope of the crisis care centers and other related programs
2020 funded by the CCC Levy.

2021
2022 This subsection describes how DCHS will support crisis care center operators to engage with first

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

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

2023 responders and other behavioral health crisis service providers to coordinate policies and procedures,
 2024 improve quality of services, and collect and report high quality data, as directed by Ordinance 19572.¹⁸²

2025
 2026 DCHS shall collect and report detailed data about how individuals in behavioral health crisis arrive at the
 2027 24/7 Behavioral Health Urgent Care clinics and the 23-Hour Observation Units of each crisis care center.
 2028 DCHS should collaborate with first responders, Crisis Connections, and other entities in the crisis care
 2029 continuum in securing data. Transportation data must include but is not limited to people arriving in
 2030 bus, ambulance, police, fire, mobile crisis team, ride share, or private vehicle. Data must be
 2031 disaggregated for each crisis care center. Data collected for people using crisis care center services,
 2032 including those transported by first responders, shall include the person's insurance coverage status at
 2033 intake, including Medicaid, private insurance, other, or none, when such data is known to the crisis care
 2034 center operator. Aggregate data on people using crisis care center services who are known to operators
 2035 to have been transported by first responders without any insurance coverage must be included in the
 2036 annual report described in Section VIII of this Plan.

2037
 2038 Funding for DCHS to conduct this oversight is described in [G. Strategy 7: Crisis Care Centers Levy](#)
 2039 [Administration](#). Additional related CCC Levy investments include:

- 2040 • Crisis care center personnel costs, Health Information Technology, and other operating costs
 2041 described in Section V.A. Strategy 1: Created and Operated Five Crisis Care Centers: [Crisis Care](#)
 2042 [Center Operational Activities](#)
- 2043 • ;
- 2044 • Support for crisis care centers to implement continuous quality improvement practices, as
 2045 described in [Crisis Care Center Operator Regulatory and Clinical Quality Activities](#);
- 2046 • Resources for DCHS to engage community members in quality improvement processes, as
 2047 described in [Community Engagement](#);
- 2048 • Resources for DCHS to contract with community-based organizations and behavioral health
 2049 providers to inform quality improvement related to improving equity, as described in [Expertise](#)
 2050 [to Support Oversight of Behavioral Health Equity](#) ; and
- 2051 • Investments to enhance DCHS data systems and information technology needed to monitor and
 2052 promote coordination across crisis care centers, as described in [Develop Data Systems](#)
 2053 [Infrastructure and Technology](#).

2054 *Coordination Between Crisis Care Centers and Crisis System Partners*

2055 DCHS expects crisis care center operators to coordinate with regional partners including, but not limited
 2056 to, community-based organizations, behavioral health providers, hospital systems, first responders,
 2057 behavioral health co-responders, and the regional behavioral health crisis system coordinated by the
 2058 King County BH-ASO. DCHS will support operators to coordinate effectively. DCHS will collaborate with
 2059 first responders and other crisis system partners to develop policies and procedures for referrals from
 2060 outside facilities like hospitals and emergency departments, first responder drop-offs and medical
 2061 stability criteria at crisis care centers. DCHS anticipates developing protocols in collaboration with crisis
 2062 care center operators for when transfers between the centers are needed due to scenarios such as
 2063 reaching maximum occupancy or needing to transfer a child or adolescent to the youth crisis care
 2064 center. DCHS plans to further engage crisis care centers along with other crisis providers and first
 2065 responder agencies, such as crisis call lines, mobile crisis teams, co-responder programs, emergency

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

2066 medical services, and law enforcement agencies, to develop protocols, workflows, clinical convenings
 2067 about shared treatment plans, and other coordination activities.

2068
 2069 *Outreach to Increase Awareness*

2070 In addition to working with regional partners within crisis systems, DCHS expects and will support crisis
 2071 care center operators to promote awareness and outreach about crisis care center services to
 2072 populations experiencing behavioral health inequities (see [Who Experiences Behavioral Health](#)
 2073 [Inequities](#)) to be responsive to community feedback described in [Community Outreach among](#)
 2074 [Populations Experiencing Behavioral Health Inequities](#).

2075
 2076 *Continuous Quality Improvement and Quality Assurance*

2077 For a crisis system to function well, it must grow, evolve, and continuously improve by building on what
 2078 works well and strengthening what does not work well.¹⁸³ Continuous quality improvement is the
 2079 process by which performance metrics, outcomes data, individual experiences, and other relevant
 2080 information are regularly reviewed and analyzed to directly inform policies and procedures, with the
 2081 goal of improving outcomes in an ongoing, iterative manner.¹⁸⁴ Quality assurance includes functions
 2082 such as internal or external case review and compliance with licensing requirements.¹⁸⁵ Both quality
 2083 improvement and assurance are essential to advancing this Plan’s

2084 [Key Findings](#) of Community Engagement Process

2085 This section summarizes community input from implementation planning activities, with supporting
 2086 details provided in the appendices as noted. DCHS organized community feedback into key themes that
 2087 informed this Plan. Figure 6 summarizes these key themes, with a more detailed description of each
 2088 theme below the table.

2089 *Figure 6. Summary of Community Engagement Themes*

Summary of Community Engagement Themes	
Theme	Description
Theme A: Implement Clinical Best Practices in Crisis Services	Input on how best to design a crisis care center clinical model most likely to improve the health and wellbeing of people experiencing a behavioral health crisis in King County, including a welcoming and safe environment, person-centered and recovery-oriented care, culturally and linguistically appropriate services, integrated care for people who use substances, promoting least restrictive care, special considerations for serving youth and young adults, and additional clinical considerations.
Theme B: Increase Access to Care for Populations Experiencing Behavioral Health Inequities	Communities voiced the importance of having crisis care centers in desirable locations that are geographically accessible and accessible to transportation, as well as the importance of reaching out to diverse communities.

¹⁸³ Group for the Advancement of Psychiatry. (2021). Roadmap to the Ideal Crisis System: Essential Elements. Measurable Standards and Best Practices for Behavioral Health Crisis Response. National Council for Mental Wellbeing [\[LINK\]](#)

¹⁸⁴ The National Learning Consortium (2013). Continuous Quality Improvement (CQI) Strategies to Optimize your Practice: Primer. [\[LINK\]](#)

¹⁸⁵ Sherman, L. J., Lynch, S. E., Greeno, C. G. and Hoeffel, E. M. Behavioral health workforce: Quality assurance practices in mental health treatment facilities. The CBHSQ Report: July 11, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD. [\[LINK\]](#)

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

2090

2091 *Theme A: Implement Clinical Best Practices in Crisis Services*

2092 Community partners offered substantial input on the following topics, all focused on how to design a
 2093 crisis care center clinical model that works as well as possible. These recommendations are reflected in
 2094 the best practices described in [Appendix G: Clinical Best Practices in Behavioral Health Crisis Services](#)
 2095 that inform the crisis services described in [A. Strategy 1: Create and Operate Five Crisis Care Centers](#).

2096 [Welcoming and Safe](#)
2097 Community members emphasized that people from their communities would only come to crisis
2098 care centers if they were confident that they would be helped and not harmed during a crisis.
2099 Community members defined safety differently: some people described feeling unsafe around
2100 uniformed officers, while others said they prefer or even expect a uniformed officer to be
2101 present to feel safe. Some people shared experiences of feeling trapped and unsafe in a locked
2102 unit, while others said they would feel safer being in a secured environment. Many described
2103 the importance of a comfortable physical space, but that it would be unacceptable to create a
2104 superficially attractive space without having a welcoming and safe program to reinforce it.
2105

2106 [Person-Centered and Recovery-Oriented Care](#)
2107 Community partners described the importance of ensuring that crisis care centers provide
2108 person-centered and recovery-oriented care. Peer specialists and people with lived experience
2109 of a behavioral health conditions emphasized the importance of keeping people in control of
2110 their care as much as possible. They also emphasized minimizing care transitions, maximizing
2111 continuity of care, and following up after discharge to start ongoing care.
2112

2113 [Culturally and Linguistically Appropriate Services](#)
2114 Community partners advocated for ensuring that crisis care centers provide culturally and
2115 linguistically appropriate services. Such services combine typical clinical best practices with
2116 specially trained, often culturally concordant providers who incorporate cultural practices and
2117 shared experience into the treatment and relationship with clients. This Plan incorporates this
2118 input in:

- 2119 • [Crisis Care Center Clinical Program Overview](#)A. Strategy 1: Create and Operate Five Crisis
2120 Care Centers, which defines the crisis care center clinical model and post-crisis
2121 stabilization resources;
- 2122 • [Capacity Building for Providers with Expertise in Culturally and Linguistically Appropriate](#)
2123 [Services](#), which will invest in capacity building for crisis care centers operators to further
2124 enhance their capacity to deliver culturally and linguistically appropriate services, and
- 2125 • [A. Evaluation and Performance Measurement Principles](#), which will measure how well
2126 crisis care centers are meeting these needs to hold DCHS accountable for implementing
2127 and improving upon culturally and linguistically appropriate services.

2128 [Integrate Care for People Who Use Substances](#)

2129 Community members identified substance use services as an essential resource to include in
2130 crisis care centers because so many people in a mental health crisis have co-occurring substance
2131 use or their crisis is primarily related to substance use. Service provider partners emphasized
2132 that the model should include medication for opioid use disorder (MOUD), withdrawal
2133 management (sometimes referred to as “detox”), substance use counseling, distribution of
2134 overdose prevention supplies like naloxone, and testing for HIV and Hepatitis C.

2135
2136 [Least Restrictive Care](#)

2137 Community partners, especially peer specialists and people with lived experience of a behavioral
2138 health condition, frequently voiced a preference for crisis care center services to be voluntary as
2139 much as possible. Some community partners acknowledged that state regulations, as well as
2140 rare uncontrollable circumstances, such as when someone is refusing help even when their life
2141 is in danger, might require involuntary interventions such as detention by a law enforcement
2142 officer, placement of Involuntary Treatment Act (ITA) holds by a designated crisis responder
2143 (DCR), involuntary medications, seclusions, and restraints. Most community partners agreed
2144 that involuntary interventions should be minimized by proactively engaging someone in
2145 treatment decisions whenever possible in the least restrictive setting. Furthermore, community
2146 partners expressed consensus that use of involuntary interventions should be a focus of
2147 monitoring and accountability for crisis care centers.

2148
2149 [Special Considerations for Serving Children, Youth, and Young Adults in Crisis](#)

2150 Youth, parents, and providers serving youth clearly stated that behavioral health services for
2151 youth differ from adult services in many important ways, and that these differences need to be
2152 reflected in the youth crisis care center model. Youth behavioral health service providers
2153 explained that adolescents’ needs differ from the needs of young children (up to approximately
2154 age 12), and very young children (up to age 6) and have their own special needs during a
2155 behavioral health crisis. Multiple community partners, including youth, also emphasized the
2156 unique needs of transition age youth (ages 18-24), also known as young adults, who may not be
2157 well served in a combined crisis care center setting with more mature adults. The needs of
2158 families, caregivers, and unaccompanied youth also emerged as important factors. Community
2159 members also described the high likelihood that young people with intellectual and
2160 developmental disabilities (IDD) will present to crisis care centers. They emphasized the
2161 importance of having staff who are specially trained to meet these unique needs. These
2162 recommendations were critical to informing the clinical model for the youth crisis care center
2163 described in [Clinical Model for Youth Crisis Care Center](#).

2164
2165 [Additional Clinical and Support Considerations](#)

2166 Community members discussed the importance of childcare for parents in a behavioral health
2167 crisis, care for pets, safe storage of belongings, nutrition and meal services, full-scope
2168 medication formulary, basic laboratory testing, and transportation. Though many of these
2169 recommendations are beyond the strategic scope of this Plan, DCHS will take this community
2170 feedback into account for future procurement and operational phases of crisis care center
2171 services.

2172

2173 *Theme B: Increase Access to Care for Populations Experiencing Behavioral Health Inequities*

2174 Communities repeatedly voiced an absence of suitable or equitable care access points for when
 2175 someone is in a behavioral health crisis. The service gaps described previously in Section III.C. Need for
 2176 Places to Go in a Crisis have real impacts on communities. Community partners reported that existing
 2177 conditions of limited access to real-time behavioral health crisis services leave people suffering without
 2178 the care they need and at high risk of their crisis becoming significantly worse. Community members
 2179 identified that this pattern is particularly prominent among Black, Indigenous, and People of Color
 2180 (BIPOC) communities.

2181

2182 *Desirable Location Attributes*

2183 Community members, especially people living in rural areas, shared that a critical need is for
 2184 facilities to be located in places that are easy to access and close to multiple forms of
 2185 transportation. Geographic and transportation accessibility are critical both for people who seek
 2186 services themselves as well as for people who are dropped off by first responders. Community
 2187 members also identified that County-funded transportation should be flexible with reduced
 2188 barriers such as having costs covered, so that people can come to crisis care centers with
 2189 confidence that they'll be able to get back to places such as their home or an appropriate clinical
 2190 care setting. This input informed the capital facility siting requirements described in [Crisis Care
 2191 Center Capital Facility Development](#).

2192

2193 *Community Outreach among Populations Experiencing Behavioral Health Inequities*

2194 Community partners urged the County to promote the launch of crisis care centers. They said
 2195 that the County should emphasize conducting outreach about the opening of crisis care centers
 2196 to promote awareness within populations that experience behavioral health inequities (see
 2197 Section III.C. Who Experiences Behavioral Health Inequities). Community members advocated
 2198 for an advertising effort to increase awareness about these new resources, particularly in
 2199 communities that have historically been marginalized and/or under-served. They also cautioned
 2200 that word of mouth will be powerful, with the possibility of community members either avoiding
 2201 services based on negative reports, or greater utilization based on positive experiences.
 2202 [Community Engagement](#) includes funding of ongoing community engagement to increase
 2203 awareness of crisis care center services and associated resources across communities in King
 2204 County. The goal of this public education work is to increase access to care for populations
 2205 experiencing behavioral health inequities. To promote equitable access to crisis care centers,
 2206 there will be a requirement for crisis care center operators to assess the potential equity
 2207 impacts of their proposed facility as described in [Crisis Care Center Capital Facility Development](#)
 2208 describing the capital facility siting process.

2209

2210 *Theme C: Challenges of Community Resource Limitations*

2211 Though the CCC Levy is primarily focused on creating capacity for a front door to care, community
 2212 partners raised important questions about the back door to ongoing community-based services after a
 2213 person leaves a crisis care center.

2214

2215 *Need to Build a "Bridge to Somewhere"*

2216 People with lived experience and behavioral health providers shared the viewpoint that the
 2217 period immediately following a crisis episode is a high-risk period for negative outcomes, and
 2218 that it is important to create pathways so that a crisis service is not a "bridge to nowhere," but

2219 instead can link a person to resources to continue to recover, such as primary care services,
 2220 behavioral health services, social services, and housing resources. Providers with experience
 2221 operating acute care facilities shared concerns about how limitations of housing resources and
 2222 outpatient behavioral health services can cause bottlenecks that make it difficult to discharge
 2223 people from crisis settings, which in turn can impact facility capacity. Community partners also
 2224 expressed concerns that crisis services that do not bridge to other supports could risk cycling
 2225 people through crisis systems in a way that is just as problematic as emergency or jail settings.
 2226 Community members and providers alike advocated to increase access to resources for people
 2227 in the immediate aftermath of a crisis episode, including access to housing resources. This Plan
 2228 describes post-crisis stabilization resources in [Post-Crisis Stabilization Activities](#) that were
 2229 directly informed by this community feedback.

2230

2231 [Care Coordination and Peer Engagement](#)

2232 In the aftermath of a behavioral health crisis, people may need to be connected to a range of
 2233 health and social services such as outpatient care, primary care, housing resources, and public
 2234 benefits enrollment. However, many barriers exist to successfully connecting with these
 2235 resources. Community partners described barriers such as distrust of providers, concerns about
 2236 cost of services, difficulties with transportation and making appointments (especially for those
 2237 experiencing homelessness or housing instability), and stigma. Providers also described
 2238 fragmented health records systems that prevent information sharing necessary to transition a
 2239 person's care, including when trying to re-connect someone with an existing provider. Among
 2240 the peer-run organizations that participated in the CCC Levy planning process, one solution that
 2241 was voiced often was the value of peer navigators and peer bridgers who can support people
 2242 who were recently in crisis to access the resources they need. The post-crisis follow-up program
 2243 described in [Post-Crisis Stabilization Activities](#), as well as the care coordination infrastructure
 2244 investments in [Develop Data Systems Infrastructure and Technology](#), both aim to address these
 2245 needs.

2246

2247 *Theme D: Interim Solutions While Awaiting Crisis Care Centers*

2248 Throughout the implementation planning process, there was a clear sense of urgency among community
 2249 partners to invest in resources that can serve people as quickly as possible. Since it can take a long time
 2250 for facilities to be constructed and initiate operations, community members advocated for expedited
 2251 resources to be implemented while awaiting crisis care centers to come online.

2252

2253 [Importance of Community-Based Response](#)

2254 Some community members, especially parents of young people who had been in crisis,
 2255 advocated for expanding community-based response resources, such as mobile crisis services.
 2256 Though crisis facilities may present a front door to care that is not widely available at the time of
 2257 this Plan's drafting, many people shared during community meetings that they would prefer to
 2258 be served in their own environment by an outreach or mobile crisis team. [Increase Community-
 2259 Based Crisis Response Capacity](#) describes ways that DCHS aims to respond to this community
 2260 feedback by investing in an expansion of community-based crisis services beginning in 2024.

2261

2262 [Urgency of the Opioid Overdose Crisis](#)

2263 Another matter of urgency that community members frequently mentioned during engagement
 2264 was the opioid overdose crisis. Though there is access to some substance use services and harm
 2265 reduction approaches, particularly in downtown Seattle, many community members expressed

2266 ongoing concern about lack of access to essential resources such as the opioid overdose reversal
2267 medication naloxone. An early crisis response investment in [Reduce Fatal Opioid Overdoses by](#)
2268 [Expanding Low Barrier Opioid Reversal Medication](#) would aim to reduce overdoses beginning in
2269 2024.

2270

2271 *Theme E: Residential Treatment Facility Preservation and Expansion*

2272 To understand the needs of the residential treatment sector, the CCC Levy planning team engaged in a
2273 series of conversations with residential treatment facility operators. These included key personnel
2274 informational interviews with leadership and front-line workers and onsite visits to facilities. See
2275 [Appendix E: Site and Field Visits](#) for a complete list of residential treatment facility site visits. Throughout
2276 this engagement, conversations centered around understanding the needs of residential treatment
2277 facilities for both adult and youth populations, with an emphasis on the loss of facilities in recent years
2278 and the resources needed to preserve existing facilities and to add more. Additionally, operators shared
2279 insights regarding the value of providing residential treatment services and impact that facility closures
2280 have had on the County's overall behavioral health system.

2281

2282 Residential treatment facility operators shared their challenges operating residential facilities, including
2283 historic underinvestment in residential treatment facility capital and maintenance funding. For example,
2284 aging facilities require ongoing and often increasing maintenance expenses. Due to inflation and rising
2285 costs, operators shared that they do not have enough funding to pay for maintenance and other repairs.
2286 Operators expressed that with additional funding, they would be able to address building maintenance
2287 to make necessary repairs to facilities. This includes renovations to address health and safety issues,
2288 facility improvements such as HVAC repairs, renovations to community spaces, and facility expansion.

2289

2290 Residential treatment facility operator feedback helped to define the allowable activities that are
2291 described in Section V.B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity.
2292 Activities include both preservation of existing residential treatment facilities and expansion of
2293 residential treatment facilities.

2294 Some feedback themes shared by community partners during engagement activities related to
 2295 residential treatment services, including input about clinical care needs, are not addressed in this Plan
 2296 because they fall outside of the scope of services that the CCC Levy is designed to address. This feedback
 2297 will help inform future DCHS quality improvement activities outside of the CCC Levy.
 2298

2299 *Theme F: Behavioral Health Workforce Development*

2300 Community engagement related to behavioral health workforce needs included both systemwide
 2301 community behavioral health workforce issues and needs specific to the crisis care center workforce.
 2302 DCHS gathered input from subject matter expert groups, listening sessions, and community engagement
 2303 events. Feedback highlighted the workforce shortage as a key factor in the success of the crisis care
 2304 centers. Community members stressed the importance of providing culturally congruent care by having
 2305 a workforce reflective of the communities that workforce will serve. Direct line workers provided
 2306 feedback regarding workforce challenges such as low wages, lack of opportunities for career
 2307 advancement, and burnout. These themes are described in greater detail below and reflected in the
 2308 design of Section V.C. Strategy 3: Strengthen the Community Behavioral Health Workforce.
 2309

2310 *Low Wages*

2311 Community partners identified that strengthening the behavioral health workforce is important
 2312 in increasing behavioral health service access. Behavioral health agencies shared they struggle
 2313 to provide care because workers are not entering the behavioral health workforce due to low
 2314 wages. Front line workers shared that low wages impact their quality of life, including
 2315 preventing workers from being able to afford to live in the communities where they work.
 2316 Workers shared that when they are unable to live in the same communities where they work,
 2317 they often experience long commutes, which in turn contributes to job dissatisfaction and the
 2318 decision to seek employment in jobs that pay a higher wage or are located closer to home.
 2319 Workers also identified that low wages are also a constant challenge for people who need to pay
 2320 for childcare or family care expenses.
 2321

2322 *Barriers to Entering the Behavioral Health Workforce*

2323 Higher education is often a requirement for positions within the behavioral health workforce.
 2324 Community partners shared that this is often a barrier for people to enter the behavioral health
 2325 workforce, especially for populations that have been disproportionately marginalized and have
 2326 faced barriers to accessing higher education. Community members identified activities such as
 2327 loan repayment, tuition assistance, assistance with professional licensure fees, and stipends for
 2328 books and other supplies as examples of activities that reduce barriers for people to enter and
 2329 remain in the behavioral health workforce.
 2330

2331 *Worker Retention and Professional Development*

2332 Front line behavioral health workers shared their experiences with work burnout and how it
 2333 impacts their longevity in the community behavioral health field. Workers shared they
 2334 sometimes experience burnout in their roles, don't have skills to move into a different role, and
 2335 don't have the resources to access professional development and training to advance their
 2336 careers. Workers shared that professional development opportunities, more robust clinical
 2337 supervision, and additional support at work would help them feel valued and would help them
 2338 grow professionally.

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[Limited Collaboration Between Community Behavioral Health and Schools](#)

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

[Importance of Workforce Representation](#)

Community members participating in engagement activities shared that a more diverse behavioral health workforce is needed, for both future crisis care centers and existing community behavioral health agencies. During focus groups, community members stated that when someone is seeking care, a behavioral health professional with similar lived experiences helps to increase the level of comfort for the person accessing care. Community members also shared that a more representative workforce, at both the frontline and leadership levels, can influence practices and conditions within behavioral health agencies to be more inclusive of the different cultures and identities of people seeking behavioral health care.

Feedback solicited through community engagement helped define the allowable funding activities described in [C. Strategy 3: Strengthen the Community Behavioral Health Workforce](#) . Activities funded in this Plan address both the workforce at crisis care centers and the systemwide community behavioral health workforce.

Theme G: Accountability Mechanisms and Ongoing Community Engagement

Throughout the implementation planning process, community partners expressed appreciation for being included in the early planning of the CCC Levy. They also voiced a strong preference to continue to be involved in future phases of the CCC Levy, including monitoring CCC Levy outcomes.

[Defining Measures of Success](#)

Community partners demonstrated an interest in being involved in County processes to define measures of success of the CCC Levy. Measures of interest include rates of improvement in regard to a person's behavioral health condition, as well as overall quality of life. Measures of equity across outcomes were also described as a priority. These topics are addressed in

2373 [VII. Evaluation and Performance Measurement](#), which describes the evaluation and
2374 performance management plan for the CCC Levy.

2375
2376 [Community Engagement During Future Planning Phases](#)

2377 Community partners voiced strong interest in being included during future planning phases. In
2378 particular, partners expressed interest in providing ongoing input on the clinical implementation
2379 of CCC Levy services and engaging around the opening of each crisis care center. [Community](#)
2380 [Engagement](#) includes activities related to crisis system administration and includes long-term
2381 community engagement as a key focus.

2382 **F. Behavioral Health Equity Framework**

2383 [found at Section III. Background: F. Behavioral Health Equity Framework](#).¹⁸⁶ DCHS expects and will
 2384 support crisis care center operators to monitor and promote quality of care and to develop continuous
 2385 quality improvement practices. Contracts with crisis care center operators may include provisions that
 2386 tie payment to performance on quality measurements. CCC Levy funds will be used to support crisis care
 2387 centers to implement continuous quality improvement practices, as described in [Crisis Care Center](#)
 2388 [Operator Regulatory and Clinical Quality Activities](#).

2389
 2390 Ensuring that people efficiently move through the clinical components of a crisis care center will be an
 2391 important focus of continuous quality improvement and quality assurance activities. DCHS expects crisis
 2392 care center operators to facilitate timely access to behavioral health services while also meeting a wide
 2393 range of clinical and psychosocial needs as a “no wrong door” entry point for all. While it may be a sign
 2394 of a successful program for crisis care centers to operate at full capacity, crisis care center operators will
 2395 need to maintain available capacity for new people to be able to enter. DCHS intends to require and
 2396 support crisis care center operators to report near-real-time data on wait times, length of stay,
 2397 occupancy, and other measures of capacity and throughput to inform policies that can be adjusted to
 2398 ensure that crisis care centers are consistently accessible.

2399
 2400 DCHS will monitor utilization rates of crisis care centers and, if persistent underutilization is identified at
 2401 a particular center, DCHS will work with the provider to take appropriate steps, including but not limited
 2402 to, increased outreach and use of mobile services to address the needs of that particular center.

2403
 2404 *Collect and Report High Quality Data*

2405 Accurate and updated clinical records are essential for outcome metrics and quality improvement
 2406 activities to be accurate and meaningful. DCHS expects crisis care center operators to develop and
 2407 maintain high quality data collection practices and will support their efforts to do so. Crisis care center
 2408 operators should develop certified electronic health record systems that track standardized information,
 2409 automatically update and interface with care coordination and quality improvement platforms, and
 2410 utilize best practices for documentation, including approaches to gathering demographic information
 2411 needed to inform equity analyses.¹⁸⁷ Ensuring the reliability of data is necessary for the quality
 2412 improvement activities described above, as well as for meaningful evaluation and reporting as described
 2413 in

¹⁸⁶ Dzau VJ, Mate K, O’Kane M. Equity and Quality—Improving Health Care Delivery Requires Both. JAMA. 2022;327(6):519–520. [\[LINK\]](#)

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

2414 [VII. Evaluation and Performance Measurement](#) and

2415 [VIII. Crisis Care Centers Levy Annual Reporting.](#)
 2416

Behavioral Health Equity Highlight

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

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

2417
 2418 **Crisis Care Center Capital Facility Development**

2419 *Crisis Care Center Capital Activities*

2420 Strategy 1 investments will create a regional network of five crisis care centers in King County, including
 2421 one center specializing in serving children and youth, to fulfill the CCC Levy’s paramount purpose. King
 2422 County intends to contract with operators to develop, maintain, and operate crisis care centers. Crisis
 2423 care center operators will be selected through a competitive procurement process, which will begin in
 2424 2024 and is described in Section V.A. Strategy 1:Created and Operated Five Crisis Care Centers: [Crisis](#)
 2425 [Care Center Procurement and Siting Process](#). Once selected, operators will lead crisis care center capital
 2426 facility development in coordination with the County, the applicable local jurisdiction or jurisdictions,
 2427 and community partners. Strategy 1 investments that will be used to support crisis care center facility
 2428 capital development and maintenance activities are described in Figure 17.

2429
 2430 **Figure 17. Allowable Crisis Care Center Capital Development and Maintenance Activities**

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

2431
 2432 Crisis care center capital facilities funded with CCC Levy proceeds will be subject to the requirements
 2433 defined in this Plan, future procurement processes, and contracts. Procurements of crisis care centers
 2434 under Strategy 1 are intended to result in the combined characteristics and requirements described in
 2435 this section when the network of five crisis care centers are considered together.

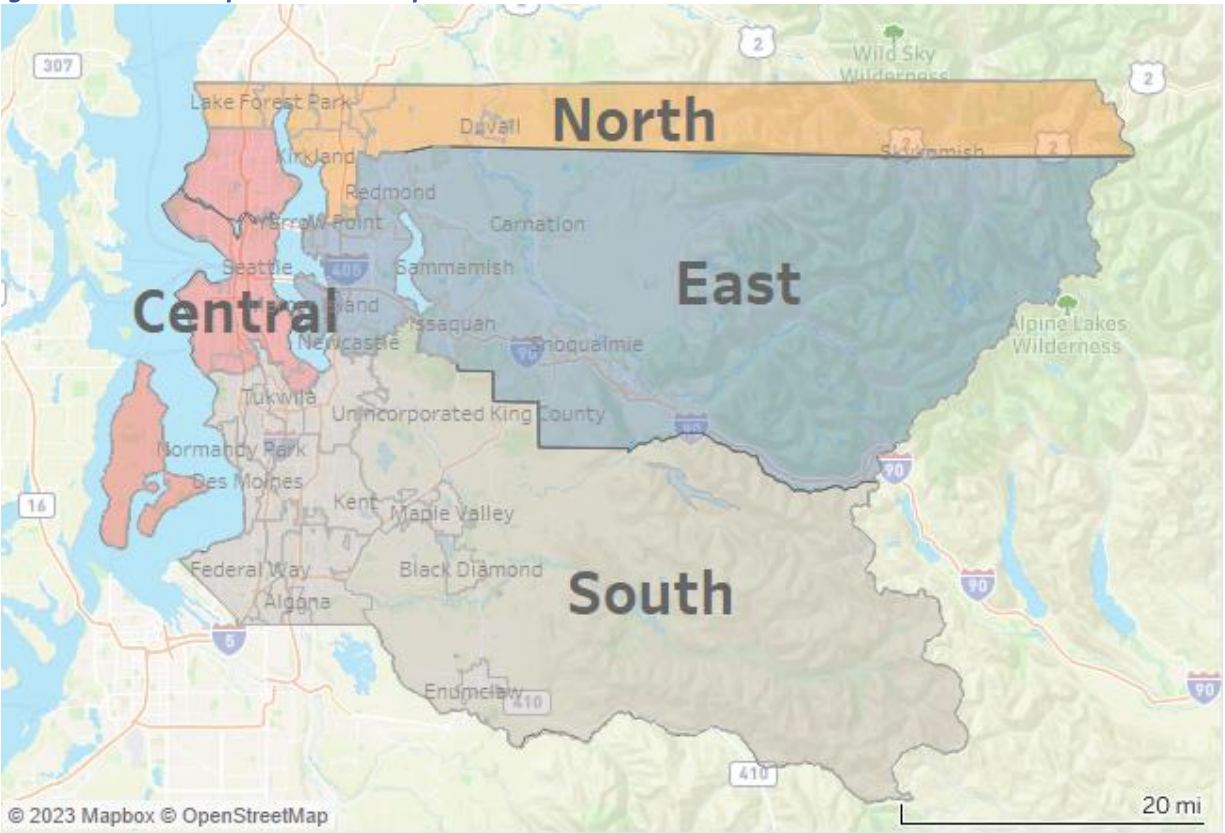
2436
 2437 *Crisis Response Zone Requirements*

2438 At least one crisis care center must be located within each of the four crisis response zones defined in
 2439 Ordinance 19572. Crisis response zone boundaries are depicted in Figure 18, and the cities and

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

2440 unincorporated regions of King County located within each zone are listed in Figure 19. The purpose of
2441 crisis response zones is to promote access by geographically distributing crisis care centers across King
2442 County. Crisis response zones do not restrict who can access crisis care centers. A person seeking
2443 services, or a first responder seeking to transport a person to receive services, can access a crisis care
2444 center in any zone.

2445 **Figure 18. Crisis Response Zone Map**



2446
2447

2448 **Figure 19. Cities and Unincorporated Parts of King County Located Within Each Crisis Response Zone**

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

2449

2450 *Public Interest Requirements*

2451 Crisis care center facilities will create long term crisis service capacity in King County. Any crisis care

2452 center facility that receives CCC Levy proceeds for capital development activities must meet the public

2453 interest requirements described in Figure 20 and requirements in future procurement processes and

2454 contracts. The purpose of these requirements is to ensure facilities receiving public capital resources are

2455 dedicated as crisis care centers for the life of the building or construction investments and that their

2456 development complies with County priorities.

2457 **Figure 20. Crisis Care Center Capital Facility Public Interest Requirements**

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

2458

2459 *Site and Facility Requirements*

2460 Crisis care center sites must meet the minimum requirements described in Figure 21. Minimum
 2461 requirements include sufficient size to deliver the crisis care center model's clinical components,

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

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

¹⁹¹ Green Building Ordinance - King County Code Chapter 18.17 [\[LINK\]](#)

2462 meaningful transportation access, accessibility and zoning requirements, and the ability to meet state
 2463 behavioral health facility licensure requirements. Additional requirements may be included in future
 2464 procurement processes and contracts to promote the goals and values described in this Plan.

2465

2466 **Figure 21. Crisis Care Center Site Requirements**

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

2467

2468 Crisis care center facility capital development may occur through a variety of potential scenarios,
 2469 described in Figure 22, that are each eligible for CCC Levy funding under Strategy 1. These scenarios
 2470 reflect the varied ways a facility could be developed while meeting all the crisis care center
 2471 requirements. Crisis care center sites and facilities must be able to accommodate the crisis care center
 2472 clinical model described in Section V.A. Strategy 1: Created and Operated Five Crisis Care Centers: [Crisis](#)
 2473 [Care Center Clinical Program Overview](#), modifications to that model that the County may make during
 2474 the levy period, and additional requirements described in future procurement processes and contracts.
 2475 This development model flexibility is allowed by Ordinance 19572. The purpose of this flexibility is to
 2476 accelerate creation of high-quality crisis care centers, further discussed in Section V.A. Strategy
 2477 1:Created and Operated Five Crisis Care Centers: [Sequence and Timing of Planned Expenditures and](#)
 2478 [Activities](#).

¹⁹² Ordinance 19572

¹⁹³ U.S. Department of Justice Civil Rights Division, The Americans with Disabilities Act [[LINK](#)]

¹⁹⁴ U.S. General Services Administration, Universal Design and Accessibility [[LINK](#)]

2479 **Figure 22. Allowable Crisis Care Center Capital Development Scenarios**

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

2480
 2481 Facility operators may co-locate within a crisis care center ancillary services or programs that
 2482 complement the crisis care center service model. Examples of such services or programs include, but are
 2483 not limited to:

- 2484 • Community health clinics;
- 2485 • Outpatient behavioral health clinics;
- 2486 • Sobering, metabolizing¹⁹⁵, and post-overdose recovery centers;
- 2487 • Substance use treatment programs;
- 2488 • Affordable housing and permanent supportive housing, and
- 2489 • Other services that support the health and wellbeing of people accessing crisis care center
 2490 services, their families, and their caregivers.

2491
 2492 DCHS may prefer in procurements proposals that promote co-locations of complementary programs or
 2493 services.

2494 2495 **Crisis Care Center Procurement and Siting Process**

2496 This subsection describes the crisis care center procurement and capital facility siting process,
 2497 summarized in Figure 23.

2498
 2499 Throughout the phases detailed in Figure 23, King County intends to support jurisdictions located within
 2500 specific crisis response zones to coordinate with potential facility operators and to identify and

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

2501 recommend crisis care center facility sites.¹⁹⁶ DCHS will ensure that activities King County may undertake
2502 to facilitate a potential crisis care center proposal do not inappropriately factor into consideration of
2503 crisis care center procurement.

2504
2505 In recognition that it is preferred to have host jurisdiction support for operator and siting decisions, it is
2506 important to have robust local jurisdiction participation in the process. Each competitive procurement
2507 process conducted for operators of crisis care centers shall include a scoring subject matter expert
2508 representative on the proposal review panel to foster collaboration and understanding of local factors
2509 between King County and cities within each crisis response zone, to ensure individual cities and each
2510 per-zone group have a voice in the decision processes. The representatives must recuse themselves
2511 from scoring for the remainder of the review process if there is an actual or perceived conflict of interest
2512 at any stage in the review process. The proposal review panel for each competitive procurement process
2513 shall include representatives as follows:

2514
2515 The proposal review panel for each competitive procurement process shall include representatives as
2516 follows:

- 2517 1. A North King County crisis response zone representative selected by the Sound Cities
2518 Association from cities as defined in Section 1.C.1 of Ordinance 19572 to review crisis care
2519 center operator proposals for the north King County crisis response zone.
- 2520 2. A Central King County crisis response zone representative selected by the Mayor and the
2521 Council of the City of Seattle to review crisis care center operator proposals for the central
2522 King County crisis response.
- 2523 3. A South King County crisis response zone representative selected by the Sound Cities
2524 Association from cities as defined in Section 1.C.3 of Ordinance 19572 to review crisis care
2525 center operator proposals for the south King County crisis response zone.
- 2526 4. An East King County crisis response zone representative selected by the Sound Cities
2527 Association from cities as defined in Section 1.C.4 of Ordinance 19572 to review crisis care
2528 center operator proposals for the east King County crisis response zone.
- 2529 5. One representative selected by the City of Seattle and Sound Cities Association to review
2530 youth crisis care center operator proposals.

2531 The City of Seattle and Sound Cities Association shall send the names of their representatives to the
2532 Director of the Department of Community and Human Services and the Director of the Behavioral
2533 Health and Recovery Division no later than September 1, 2024, for competitive procurements occurring
2534 in 2024, and by January 1 every year thereafter in which competitive procurements for crisis care center
2535 operators will take place. If the City of Seattle or Sound Cities Association has not yet sent the
2536 Department of Community and Human Services representatives for the proposal review panel by the
2537 dates identified in this section, then the Department may proceed with the procurement process
2538 without the representatives in order to avoid crisis care center timeline delays and the representative
2539 may join the review panel once selected.

2540
2541 When selecting a crisis care center site, each selected crisis care center operator shall work with the
2542 crisis response zone representative of the relevant jurisdiction in the site selection process.

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

2543 **Figure 23. Summary of Crisis Care Center Procurement and Siting Process**

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

2544
2545 The competitive procurement process shall include an evaluation of how operators will ensure a
2546 therapeutic milieu for individuals with disparate and often conflicting needs, especially age disparities
2547 between youth in the youth facility, age disparities between seniors and adults in the adult facilities,
2548 individuals with substance use needs, and people in active psychosis.
2549
2550 DCHS will prefer crisis care center procurement proposals that demonstrate support from a jurisdiction
2551 located within the crisis response zone where the facility is proposed. Jurisdictions can demonstrate
2552 support for a proposed site by providing a written statement as part of the procurement process that
2553 includes, but is not limited to, the following criteria:

- 2554 • Support for a crisis care center to be developed and operated by the proposed operator.
- 2555 • Support for the proposed crisis care center facility site and confirmation that the site meets or is
2556 likely to meet the jurisdiction’s zoning and other relevant local development requirements.¹⁹⁷
- 2557 • If a specific site is not yet identified, willingness to support the proposed operator in identifying
2558 a site that complies with the jurisdiction’s zoning and other local development requirements.
- 2559 • Commitment to supporting the proposed operator in engaging community members regarding
2560 the siting, development, and ongoing operations of a crisis care center facility.

2561
2562 Preference will be given to potential sites for crisis care centers with support from the host jurisdiction
2563 that also include, but are not limited to, the following:

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

- 2564 1. Existing facility or facilities that with retrofitting or remodeling will cost less than constructing a
- 2565 new facility.
- 2566 2. Sites that are bounded on all sides by rights-of-way and do not have any shared lot lines with
- 2567 adjacent properties or otherwise consistent with jurisdictional zoning and land use
- 2568 requirements.
- 2569 3. Sites with larger facilities that include potential expansion space and/or additional space for
- 2570 supporting service providers.
- 2571 4. Locations central to the community it will serve.
- 2572 5. Locations close to, or co-located with, existing community health facilities and hospitals for easy
- 2573 access and referral capabilities.
- 2574 6. Locations that provide easy access to bus, streetcar, light rail, and other forms of public transit.
- 2575 7. Facilities that have or would allow ample available onsite parking.
- 2576 8. Facilities that include existing infrastructure necessary to host a variety of medical related
- 2577 services.
- 2578 9. Facilities with multiple entrances that can be used to segregate portions of the facility into
- 2579 independent facilities.

2580 DCCHS will support the crisis care center facility siting process through CCC Levy funding as described in [E.](#)
 2581 [Strategy 5: Capacity Building and Technical Assistance](#). DCCHS will also support the siting process by
 2582 providing technical advice to jurisdictions and facility operators, supporting interjurisdictional
 2583 partnerships, supporting partnerships between facility operators and jurisdictions, supporting
 2584 community engagement, and creating and deploying communication content.

2585
 2586 **Siting a crisis care center will be a complex process involving review and approval by at least three**
 2587 **separate units of government** that only begins with Phases 1 and 2 in Figure 23. Once the King County-
 2588 administered procurement is complete and contracts with the selected crisis care center operators are
 2589 executed, Figure 23's Phase 3 requires an operator to complete at least two additional steps:

- 2590 • *Local Jurisdiction Zoning and Permitting:* First, an operator must satisfy land use, zoning, and
- 2591 permitting requirements of the host jurisdiction or jurisdictions. Each local jurisdiction defines
- 2592 its own land use, zoning, and permitting requirements and processes in accordance with state
- 2593 law. Historically, land use, zoning, and permitting decisions have often taken years, especially in
- 2594 conjunction with new construction or substantial capital rehabilitation for which some permits
- 2595 require a building or system to be built and then inspected while other types of permits must be
- 2596 acquired before or during construction.
- 2597 • *State-Level Facility and/or Operator Licensing:* Second, an operator must satisfy state-level
- 2598 Department of Health licensing requirements before a facility or its operator can begin providing
- 2599 certain types of behavioral health care that are required in the crisis care center clinical
- 2600 program. Other state-level licenses may also be necessary. It is common for Department of
- 2601 Health licensing requirements to take months, and they could take a year or more in some
- 2602 circumstances.

2603
 2604 This Plan recognizes the necessity of:

- 2605 • County-level procurement and contracting;
- 2606 • City or other local jurisdiction-level land use, zoning, and permitting; and
- 2607 • State-level licensing and their attendant requirements for public notice and potential review.

2608 **While recognizing the importance of these processes for effective facilities and operations, this Plan**
2609 **also acknowledges that in combination they have the potential to last for multiple years and**
2610 **constitute a substantial risk to the crisis care center capital development timelines that this Plan**
2611 **describes.**

2612
2613 [Crisis Care Center Procurement when a Facility or Site Is Purchased by King County](#)

2614 In exceptional circumstances, the County may be uniquely situated to purchase a site or an existing
2615 facility readily available for development of or conversion to a crisis care center. In such situations, to
2616 provide the County with the flexibility to move forward expeditiously, Strategy 1 funds may be used to
2617 purchase such a site or facility consistent with the following:

2618
2619 No earlier than 30 days from the date the Executive transmits the notification letter to the King County
2620 Council required by this section that identifies the proposed site or an existing facility to be purchased
2621 may the Executive proceed to close on the purchase and only if the King County Council has not passed a
2622 motion rejecting the purchase. The Executive shall electronically file the notification letter with the
2623 clerk of the Council, who will retain an electronic copy and provide an electronic copy to all
2624 councilmembers and all members of the Regional Policy Committee or its successor.

2625
2626 The Executive's notification letter shall include:

2627
2628 A copy of the purchase and sale agreement;

2629
2630 A copy of the written demonstration of the host jurisdiction's support of locating a crisis care center on
2631 the site or in the existing facility. Such demonstration may include, but not be limited to, the host
2632 jurisdiction's letter of support, memorandum of understanding, or legislation expressing support.

2633
2634 A description of the exceptional circumstances that makes the County uniquely situated to purchase the
2635 site or existing facility;

2636
2637 A description of how this purchase will accelerate the starting of crisis care center operations;

2638
2639 A description of the competitive procurement process to be used to select the operator of the crisis care
2640 center to be developed on the site or in the existing facility, including what if any consideration will be
2641 given for the selected operator to develop the site, convert the existing facility;

2642
2643 A description of the near and long term plans of the County retaining ownership or control of the
2644 property. If it is expected that the property will be ultimately transferred to the operator's ownership or
2645 control (i.e. lease), what conditions will be imposed on and/or considerations will be received from the
2646 operator in exchange for the property;

2647
2648 A description of all funding sources planned to be used for the purchase of the site or existing facility
2649 when colocation of other uses at the site or in the existing facility is expected or contemplated, and a
2650 breakdown of how much money is anticipated to be expended from each funding source on the
2651 purchase of the site or existing facility;

2652
2653 If the county will be responsible for developing the site or converting the existing facility, description of
2654 all funding sources planned to be used for developing the site or converting the existing facility, and a

2655 breakdown of how much money is anticipated to be expended from each funding source on the site or
2656 converting the existing facility;

2657
2658 If the county will be responsible for developing the site or converting the existing facility, then a
2659 description of the competitive process to be used to select the design and construction contractor or
2660 contractors (design-bid- build, design-build, GCCM, etc.) to develop the site or convert the existing
2661 facility to be used as a crisis care center, if known; and if not known, a description of the factors that
2662 need to be resolved to select a procurement process;

2663
2664 A description of how the proposed site or existing facility to be purchased by the County will satisfy the
2665 site or facility requirements and preferences listed in Section V.A. Strategy 1:Create and Operate Five
2666 Crisis Care Centers: Crisis Care Center Procurement and Siting Process;

2667
2668 A description of the current land use, zoning, and permitting requirements of the site or existing facility
2669 and if the crisis care center use is not allowed outright, the plan to obtain necessary local jurisdiction
2670 authorization to develop the site or convert the existing facility to be operated as a crisis care center;
2671 and

2672
2673 Identification if this purchase would result in the first crisis care center for the crisis response zone.

2674
2675 The Executive is encouraged to brief the King County Council, consistent with the open public meetings
2676 act, when considering such purchases prior to formalizing the purchase with a purchase and sale
2677 agreement.

2678
2679 **Alternative Siting Process**

2680 Ordinance 19572 requires a network of five crisis care centers by the end of 2032. Strong partnership
2681 between King County and cities or other local jurisdictions will produce the most rapid and effective
2682 accomplishment of this voter approved requirement. King County will encourage jurisdictions located
2683 within crisis response zones to coordinate with potential facility operators to identify and recommend
2684 crisis care center facility sites that meet the requirements defined in Ordinance 19572, this Plan, and
2685 future crisis care center procurement processes.

2686
2687 If, by December 31, 2026, King County does not yet have for any crisis response zone a viable proposal,
2688 with local jurisdiction support for an adult-focused crisis care center that meets the requirements
2689 defined in Ordinance 19572, this Plan, and future procurement processes, King County reserves all
2690 available rights, authorities, means, and abilities to proactively site and open an adult focused crisis care
2691 center within that crisis response zone.

2692
2693 If, by December 31, 2026, King County does not yet have a viable proposal that has host jurisdiction
2694 support for a youth-focused crisis care center that meets the requirements defined in King County
2695 Ordinance 19572, this Plan, and future procurement processes, King County reserves all available rights,
2696 authorities, means, and abilities to proactively site and open a youth focused crisis care center within
2697 King County.

2698
2699 The purpose of this alternative siting process is to prefer local jurisdiction supported crisis care center
2700 siting early in the CCC Levy period while ensuring that King County can fulfill the requirements of

2701 Ordinance 19572 as it was approved by a majority of King County voters in the April 2023 Special
2702 Election.

2703

2704 To best position crisis care centers for successful and timely siting in local jurisdictions, DCHS will
2705 maintain regular communications with stakeholders, including but not limited to the following:

- 2706 • Provide email updates to all King County Council offices, members and alternate members of
2707 the King County Regional Policy Committee or its successor, and Sound Cities Association when
2708 planning and releasing annual procurements and when announcing procurement results.
- 2709 • Incorporate updates on crisis care center operator awards and progress in each annual report.
- 2710 • For any crisis response zone that does not yet have a supported crisis care center operator after
2711 the 2024 and 2025 procurements, convene relevant jurisdictions to coordinate partnerships,
2712 provide technical assistance funding, and any other resources to help promote a successful
2713 procurement prior to 2027.
- 2714 • Create a list of steps needed to achieve a viable adult and youth crisis care center proposal, and
2715 by December 31, 2025, and prior to the release of the 2026 crisis care center operator
2716 procurement, and also at 30, 60, and 90 days prior to December 31, 2026, email an update to all
2717 King County Council offices, members and alternates of the King County Council Regional Policy
2718 Committee or its successor, and Sound Cities Association that summarizes steps remaining to
2719 achieve a viable proposal for each remaining unsited adult focused crisis care center or youth
2720 focused crisis care center, along with a red, yellow, or green milestone assessment of whether
2721 progress is on schedule to avoid an executive alternative siting process.

2722

2723 The Executive may only commence an alternative siting process authorized in this subsection after
2724 transmitting a notification letter to the King County Council describing the decision, issued no earlier
2725 than January 1, 2027. The Executive will electronically file the letter with the clerk of the Council, who
2726 will retain an electronic copy and provide an electronic copy to all councilmembers and all members of
2727 the Regional Policy Committee or its successor. Unless the Council passes a motion rejecting the
2728 commencement of the alternative siting process within 30 days of the Executive's transmittal, the
2729 Executive may proceed with the use of the alternative siting process.

2730

2731 [Sequence and Timing of Planned Expenditures and Activities](#)

2732 The process of developing and opening a crisis care center includes multiple parties and steps that have
2733 variable timelines. Before being able to open, any crisis care center would have had to satisfy at least
2734 the County-administered procurement and contracting process; a city or other local-jurisdiction defined
2735 land use, zoning, and/or permitting process; and a state department-defined licensing process. These
2736 necessary processes, administered by at least three separate levels of government, introduce
2737 substantial potential variability to the capital development timeline for a crisis care center.

2738

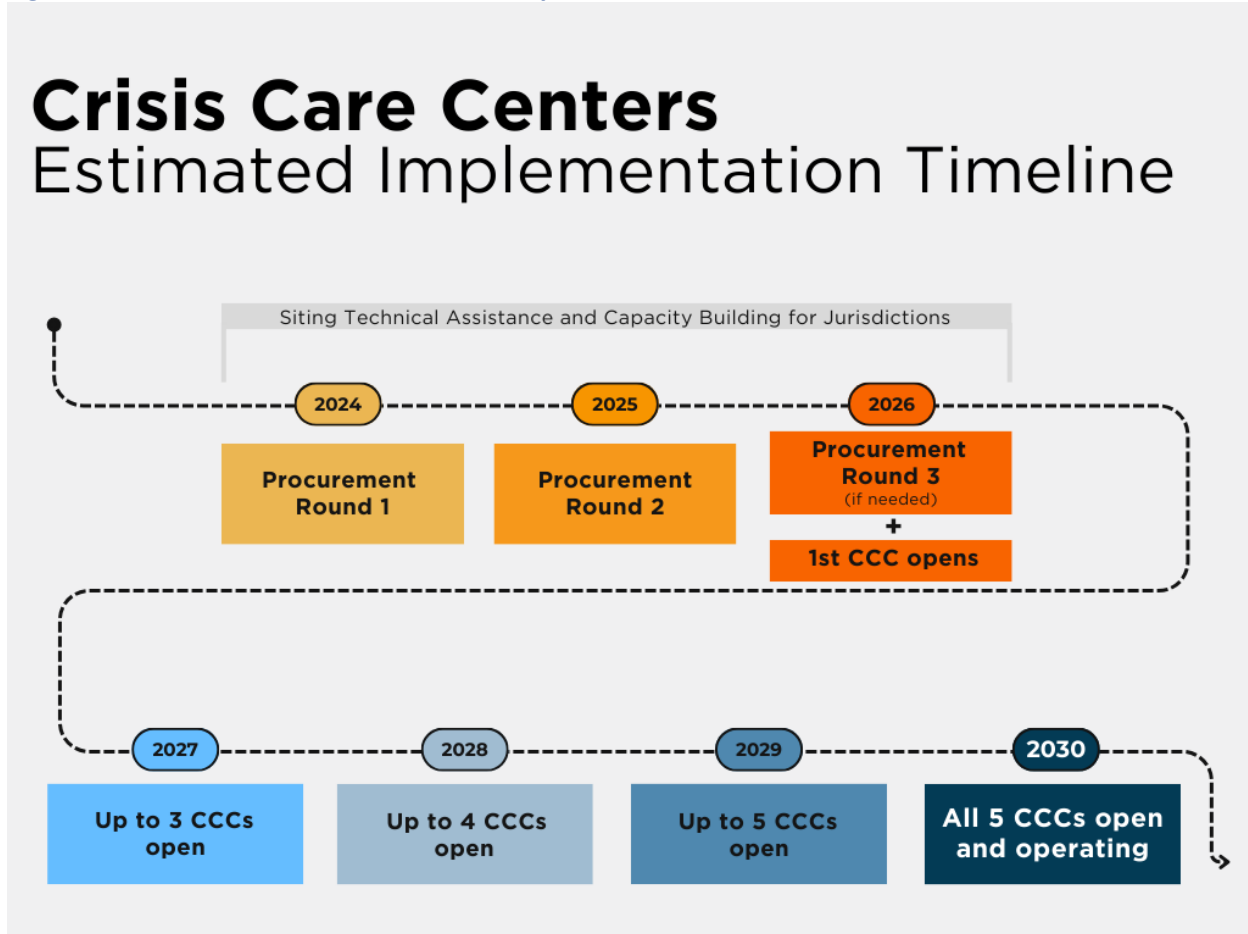
2739 This subsection describes the sequence and timing of expenditures and activities related to developing
2740 crisis care centers. It also describes when timelines may vary and how DCHS intends to work to mitigate
2741 these variables.

2742

2743 [Crisis Care Centers Implementation Timeline](#)

2744 DCHS intends to prioritize opening five crisis care centers as quickly as possible to meet the urgent
2745 needs of people experiencing behavioral health crises. DCHS plans to select crisis care center operators
2746 through an annual competitive procurement process starting in 2024, as depicted in Figure 24. The first

2747 procurement round in 2024 will prefer crisis care center proposals that can be developed and begin
2748 serving people rapidly. The 2024 round may include a single review deadline, multiple review deadlines,
2749 or a rolling review of applications, with the ability to make awards at different times within the round.
2750 The 2024 round will award contracts for a maximum of three centers. The purpose of this cap is twofold.
2751 First, it provides additional planning time for organizations that are interested in submitting a
2752 procurement proposal in 2025. The second purpose is to manage the timeline of expenditures against
2753 when CCC Levy proceeds are available. The 2025 procurement round will not have a cap on the number
2754 of awards, and a 2026 procurement round will only be held if operators for all five crisis care centers
2755 have not yet been selected.

2756 *Figure 24. Planned Crisis Care Center Development Timeline*2757
2758

2759 CCC Levy funding to support crisis care centers' capital facility development and operating costs are
 2760 planned to begin in 2025 and increase over time as crisis care centers are developed and become
 2761 operational. Figure 24 depicts the estimated opening timeline for the five crisis care centers that will be
 2762 funded with proceeds from the CCC Levy and described in this Plan. Strategy 1 funding levels as
 2763 described above in Section V.A. Strategy 1: Created and Operated Five Crisis Care Centers: [Crisis Care
 2764 Center Operational Activities](#) support this timeline.

2765
 2766 *Managing Development Timeline Variability*

2767 The crisis care center development timeline for individual facilities will likely differ due to the variability
 2768 in capital facility development approaches depicted in Figure 22, and potential external factors that
 2769 could impact the development timeline for a crisis care center during its siting, design, construction, or
 2770 facility activation phases. Examples of such factors are summarized in Figure 25. This Plan identifies the
 2771 factors and variety of responsible parties within Figure 25 to enable shared understanding between the
 2772 King County Executive, King County Council, Regional Policy Committee, and King County residents
 2773 about the importance of alignment to rapidly open crisis care centers, and about the substantial delays
 2774 that are possible if various responsible parties are misaligned on the development of a crisis care center.

2775 **Figure 25. Examples of Potential Factors that Could Impact Crisis Care Centers’ Development Timeline**

Examples of Potential Factors that Could Impact Crisis Care Centers’ Development Timeline		
Development Phase	Potential Factors Impacting Timeline	Responsible Parties
Siting	<ul style="list-style-type: none"> • Site identification and feasibility analysis • Community engagement • Environmental impact review • Zoning and permitting 	<ul style="list-style-type: none"> • Crisis care center operator • Local jurisdictions • DCHS supports community engagement
Design	<ul style="list-style-type: none"> • Programming and clinical processes • Schematic design and design development • WA Department of Health licensing review • Construction and permit documents • Design review process 	<ul style="list-style-type: none"> • Design team • Crisis care center operator • Local jurisdictions • King County • WA Department of Health
Construction	<ul style="list-style-type: none"> • Supply chains • Macroeconomic conditions • Certificate of occupancy inspections • Labor availability 	<ul style="list-style-type: none"> • Vendors and contractors • Crisis care center operator • Local jurisdictions
Facility Activation	<ul style="list-style-type: none"> • Equipment and furniture installation • IT installation and stocking supplies • Facility licensing • Labor supply • Staff onboarding and training 	<ul style="list-style-type: none"> • Crisis care center operator • Local jurisdictions • WA Department of Health • Other licensing entities

- 2776
- 2777 DCHS will work to mitigate potential timeline delays by:
- 2778
- 2779
- Accelerating the development steps managed by DCHS, including expediting the release of the crisis care centers procurement in 2024 after this Plan is adopted.
 - Striving to provide clear and transparent communication about CCC Levy implementation to support coordination and planning among parties involved in the development process;
 - Providing siting support to jurisdictions and crisis care center operators as described in [Local Jurisdiction Capital Facility Siting Support Activities](#) ;
 - Allowing existing facilities or facilities under development that are already sited and require minimal construction to be eligible to respond to crisis care center procurements, and,
 - Reviewing facility development plans during the crisis care centers procurement and giving preference to proposals that can be developed and operated more rapidly while still meeting crisis care center requirements defined in this Plan and future procurements and contracts.
- 2780
- 2781
- 2782
- 2783
- 2784
- 2785
- 2786
- 2787
- 2788
- 2789

2790 To ensure that five crisis care centers open by 2032, DCHS may choose to redistribute capital

2791 development funds, alter the siting location, and release additional procurements if DCHS determines

2792 that the development and opening timeline proposed by the selected crisis care center operator is no

2793 longer viable. Before exercising this option, DCHS will work closely with the selected operator and host

2794 jurisdiction to explore other paths to expedite the crisis care center development and opening.

2795 **B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity**

2796 **Overview**

2797 The CCC Levy’s Strategy 2 resources will restore, expand, and sustain residential treatment capacity in
 2798 furtherance of a CCC levy Supporting Purpose 1. Sustaining residential treatment capacity means
 2799 investing in existing residential treatment capital facilities to help prevent further facility closures. King
 2800 County has lost one-third of its mental health residential treatment capacity since 2018. This loss of
 2801 capacity has increased residential treatment wait times, made it more challenging for people to be
 2802 discharged from higher-intensity levels of care, and has impacted the capacity of other behavioral health
 2803 care settings because people cannot access the level of care that they need. Strategy 2 funds and
 2804 activities will be prioritized to support existing residential treatment operators to prevent further facility
 2805 closures and to restore King County’s mental health residential capacity to at least the 2018 level of 355
 2806 beds.¹⁹⁸

2807
 2808 Residential treatment provides important community-based treatment options for people who do not
 2809 need behavioral health inpatient care, but who need a higher level of care than behavioral health
 2810 outpatient services. Activities in Strategy 2 were developed as described in [Residential Treatment](#)
 2811 [Methodology](#) based on the background included in [Reduction in Residential Treatment Capacity](#) and
 2812 community engagement described in [Theme E: Residential Treatment Facility Preservation and](#)
 2813 [Expansion](#).

2814
 2815 **Activities to Restore, Expand, and Sustain Residential Treatment Capacity**

2816 Strategy 2 will fund residential treatment capital facility development and maintenance activities. These
 2817 activities are described in Figure 26. DCHS intends to distribute these resources to residential treatment
 2818 facility operators through competitive procurement processes. Funding from this strategy may also be
 2819 used to build additional residential treatment capacity beyond 355 beds.

2820 **Figure 26. Allowable Residential Treatment Facility Capital Development and Maintenance Activities**

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

2821

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

2822 **Residential Treatment Capital Facility Procurement and Siting Process**

2823 This subsection describes the procurement and siting process for residential treatment facilities that
2824 receive capital funding from the CCC Levy proceeds described in this Plan. CCC Levy proceeds dedicated
2825 to residential facility capital development will be awarded through competitive procurement processes
2826 beginning in 2024. The factors that DCHS may consider when awarding Strategy 2 funds include:

- 2827 • Whether a proposal increases local access to residential treatment beds throughout King County
2828 by opening or expanding new residential treatment capacity in areas where few or no similar
2829 residential treatment facilities exist;
- 2830 • Whether a proposal leverages a proposer's sited or licensed facility, thereby decreasing the cost
2831 or time necessary for starting new operations or continuing improved operations by proposing
2832 restoration, rehabilitation, or otherwise using a facility that is already licensed, already sited, or
2833 otherwise already meets regulatory requirements, or
- 2834 • Whether a proposal to increase residential treatment capacity also increases equity in
2835 behavioral health system access by proposing funding for an organization with expertise and
2836 experience providing culturally and linguistically appropriate services for populations
2837 experiencing behavioral health inequities (see [Who Experiences Behavioral Health Inequities](#)).

2838
2839 Organizations that are awarded capital resources to expand residential treatment facilities and thereby
2840 increase the number of treatment beds, must adhere to the relevant zoning and permitting laws and
2841 regulations of the jurisdiction within which residential treatment facilities are sited. These organizations
2842 must also satisfy licensing requirements from the state and additional requirements that King County
2843 may impose through contract.

2844
2845 **2024 Levy Funding Approach for Rapid Initial Progress on Residential Treatment**

2846 Strategy 2's 2024 allocation will support capital improvement and maintenance costs of existing
2847 residential treatment facilities and the development of new residential treatment facilities. DCHS
2848 intends to accelerate the distribution of resources to support existing residential treatment facilities by
2849 leveraging a broader behavioral health capital facility improvement procurement process that is planned
2850 for early 2024 and incorporates other funding sources, most notably MIDD.¹⁹⁹ The combined
2851 procurement process will begin in early 2024 to expedite awarding of these resources soon after this
2852 Plan is adopted. DCHS also plans to open a procurement in 2024 to distribute funds to support the
2853 capital development of new residential treatment facilities. Procurement awards will not be made until
2854 after this Plan is adopted. Figure 27Figure describes the anticipated timeline to distribute capital
2855 funding for residential treatment facilities in 2024.

2856

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

2857 **Figure 27. Timeline to Distribute CCC Levy Proceeds to Support Residential Treatment Facilities in 2024**

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

2858
 2859 **Initial Prioritization of Residential Treatment Capacity**
 2860 The financial plan as described in Figure 35 contains an approximate allocation for Strategy 2: Restore,
 2861 Expand, and Sustain Residential Treatment Capacity of \$48,575,000 in 2027 and \$1,464,000 in 2028,
 2862 with similar amounts thereafter. The Executive will assess the outcome of these investments and report
 2863 whether the financial plan remains on target for these investments as part of the annual report.

2864
 2865 **C. Strategy 3: Strengthen the Community Behavioral Health Workforce**

2866 **Overview**

2867 It takes people to treat people. Strategy 3 directly supports the CCC Levy’s Supporting Purpose 2 by
 2868 investing in activities to strengthen the community behavioral health²⁰⁰ workforce in King County. This
 2869 strategy also directly supports the CCC Levy’s Paramount Purpose to establish and operate five crisis
 2870 care centers by investing in the development of King County’s behavioral health crisis workforce,
 2871 including crisis care center workers.

2872
 2873 Strategy 3’s workforce activities focus on helping more people join and make a career in community
 2874 behavioral health. Allowable activities within Strategy 3 fall into three broad categories:

- 2875 • Career pathways for the broader community behavioral health workforce (called **community**
 2876 **behavioral health career pathways**): Resources such as training and paying licensing fees that
 2877 help workers join and progress within the community behavioral health workforce;
- 2878 • Labor-management partnerships on shared workforce development efforts for the broader
 2879 community behavioral health workforce (called **labor-management workforce development**
 2880 **partnerships**): Programs like apprenticeships and training funds, and
- 2881 • Workforce development efforts that are specific to the crisis response behavioral health
 2882 workforce (called **crisis workforce development**): Specialized training for crisis workers and
 2883 crisis settings.

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

2885 Figure 28 provides additional summary descriptions for each of Strategy 3’s broad categories, and each
 2886 is described in detail later in this section.

2887

2888 **Figure 28. Allowable Community Behavioral Health Workforce Activities**

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

2889

2890 **Community Behavioral Health Career Pathway Activities**

2891 Strategy 3 will fund career pathway activities to support the development of King County’s community
 2892 behavioral health workforce, as described in Figure 29 and Figure 30.²⁰² Career pathway resources will
 2893 support the recruitment, training, retention, and wellbeing of community behavioral health workers
 2894 through activities such as:

- 2895 • Tuition assistance;
- 2896 • Stipends for paid internships;
- 2897 • Clinical supervision costs;
- 2898 • Professional licensure fees;
- 2899 • Grants for community behavioral health agencies to promote the wellbeing of workers,²⁰³ and

²⁰¹ Post-crisis follow-up workers are behavioral health workers who provide post-crisis follow-up services for people who receive services at crisis care centers and are employed by agencies that are contracted to provide post-crisis follow-up services defined in [A. Strategy 1: Create and Operate Five Crisis Care Centers](#).

²⁰² Within the context of this Plan, “career pathways” means activities like training and recruiting that promote existing behavioral health workers’ professional development and support and incentivize new and existing workers to start and pursue long-term careers in community behavioral health.

²⁰³ Examples of activities that promote the wellbeing of community behavioral health workers include supervision and mentorship, covering staff time for self-directed program development and quality improvement initiatives, and access to mental health benefits.

- 2900 • Clinical training, including evidence-based practice training.

2901 DCHS will use at least 25 percent of the resources dedicated for community behavioral health career
2902 pathway activities for investments that are directly related to increasing the representativeness of King
2903 County’s community behavioral health workforce.²⁰⁴

2904
2905 DCHS intends to support community behavioral health agencies contracted with the King County
2906 Integrated Care Network (KCICN) for career pathway activities through the expansion of existing
2907 contracts, reimbursement for eligible activities through existing payment mechanisms, and possible
2908 competitive procurements. These investment approaches will be consistent with DCHS’s strategic
2909 community behavioral health workforce development plan, which will be approved by the County-
2910 provider Executive Committee of the KCICN and will be informed by significant and broad community
2911 engagement.

2912

2913 *Initial Prioritization and Assessment of Career Pathway Activities*

2914 Between 2024 and the end of 2026, as depicted in Figure 29, DCHS will fund career pathway activities to
2915 strengthen, support the development, and increase the representativeness of King County’s community
2916 behavioral health workforce. During 2024 and 2025, DCHS will assess the impact of activities by
2917 researching best and emerging community behavioral health workforce development practices and
2918 soliciting input from community partners, behavioral health workers, and community behavioral health
2919 agency leaders. This assessment will allow DCHS to refine the initial funding approach and improve
2920 activities to strengthen the community behavioral health workforce, increase the representativeness of
2921 behavioral health workers, and build the community behavioral health workforce pipeline.

2922

2923 As part of this assessment, DCHS will convene a workgroup with community partners that have subject
2924 matter expertise in behavioral health workforce development to inform proposed refinements and
2925 adjustments to the initial funding approach. The assessment will include reviewing the impact of career
2926 pathway activities on increasing the representativeness of community behavioral health workers.

2927 Workgroup membership will include, but is not limited to:

- 2928 • Representatives of workers, including representatives of labor-management workforce
2929 development partnerships;
- 2930 • Higher education training programs, including a community and technical college;
- 2931 • Community behavioral health agencies, including representation from both an agency that
2932 provides mental health services and an agency that provides substance use services, and
- 2933 • People with expertise in improving the representativeness of the behavioral health workforce,
2934 including workers who identify as members of populations experiencing behavioral health
2935 inequities (see [Who Experiences Behavioral Health Inequities](#)).

2936

2937 In 2026, prior to releasing funding for career pathway activities for 2027 to 2032, the Executive will
2938 transmit a notification letter to Council proposing refinements to career pathway activities and
2939 describing the community engagement process that informed the proposal. The Executive will
2940 electronically file the letter with the Clerk of the Council, who will retain an electronic copy and provide
2941 an electronic copy to all councilmembers, and members of the Regional Policy Committee. Unless the
2942 Council passes a motion rejecting the contemplated change within 30 days of the Executive’s transmittal

²⁰⁴ See [Who Experiences Behavioral Health Inequities](#)

2943 or funding has not yet been sufficiently appropriated, the Executive may proceed with the use of funds
2944 allocated for 2027 to 2032 as set forth in the notification letter. All CCC Levy proceeds will remain
2945 subject to Council appropriation.

2946
2947 **Figure 29. Community Behavioral Health Career Pathway Activities Timeline**



2948
2949
2950

2951 [VII. Evaluation and Performance Measurement](#) outlines DCHS’s expected performance measurement for
 2952 workforce investments. Where feasible, DCHS plans to use collected data to assess the
 2953 representativeness of workforce and effect of investments to increase the representativeness of
 2954 workers to better reflect the demographics of the people receiving community behavioral health
 2955 services.
 2956

Behavioral Health Equity Highlight

There is evidence that improving diversity among behavioral health workers to better reflect the communities they serve may help improve communication and trust while reducing behavioral health disparities. Community engagement further endorsed the importance of workforce representativeness. The activities referenced in this strategy to increase representativeness of the behavioral health workforce are central to meeting the goals described in [Representative Behavioral Health Workforce](#).

2957
 2958 While not Strategy 3’s focus, King County recognizes behavioral health wages as an important factor in
 2959 both recruitment and retention activities. CCC Levy resources are insufficient to increase wages
 2960 meaningfully and consistently across the region’s entire community behavioral health workforce. Even if
 2961 this were possible, doing so would substantially commit local funding where federal and state funding
 2962 should increase instead. Specifically, investing local funds to raise wages for the region’s entire
 2963 community behavioral health workforce could inhibit efforts to raise Medicaid rates that would
 2964 sustainably raise wages for the region’s behavioral health workforce with federal and state funds. One
 2965 exception to this general principle is that this Plan’s Strategy 3 authorizes and allocates funds to support
 2966 appropriate wages for the crisis care center workforce because these investments support the CCC
 2967 Levy’s Paramount Purpose. If funds become available through this Plan’s provisions to allocate
 2968 additional funds (see [F. Process to Make Substantial Adjustments to the Financial Plan](#)), this strategy
 2969 authorizes DCHS to develop and administer activities to increase wages for the broader behavioral
 2970 health workforce.
 2971

[Labor Management Workforce Development Partnership Activities](#)

2972 Labor management workforce development partnerships are activities that are supported by both
 2973 management and front-line workers, in this case community behavioral health agencies and workers,
 2974 including agencies that are represented by labor unions and agencies that are not represented.^{205,206}
 2975 Strategy 3 funds labor management workforce development partnership activities, including behavioral
 2976 health apprenticeships and other behavioral health worker training opportunities. These investments
 2977 are intended to help build a skilled and diverse community behavioral health care workforce in King
 2978 County in a way that incorporates workers’ voices in workforce development.
 2979
 2980

[Behavioral Health Apprenticeship Program Activities](#)

2981 Strategy 3 includes funding to sustain and expand a Washington State registered apprenticeship
 2982 program that offers behavioral health apprenticeships. Behavioral health apprenticeship programs are
 2983

²⁰⁵ Labor management partnerships are relationships between front line workers and management. It is a collaborative effort focused on common goals, relationship with unified mission, improve organizational performance and employee wellbeing. [\[LINK\]](#)

²⁰⁶ SEIU Healthcare 1199NW Multi-Employer Training Fund. [\[LINK\]](#)

2984 paid on the job training programs paired with technical instruction to train workers for behavioral health
2985 careers. These careers include but are not limited to peer counselors, substance use disorder
2986 professionals, and behavioral health technicians.
2987 Apprenticeship programs provide access to education and training for people who may be unable to
2988 afford college or significant classroom instruction time while working. The flexibility of apprenticeship
2989 programs can aid in recruitment of individuals from diverse backgrounds that historically have not had
2990 access to traditional higher education programs.²⁰⁷

2991
2992 Apprenticeships help workers and employers: Apprenticeship programs benefit workers by providing
2993 pay and benefits while pursuing a certification to advance their behavioral health careers.
2994 Apprenticeship programs benefit employers by building a skilled behavioral health workforce,
2995 promoting employee retention through professional development, and promoting increased workforce
2996 representation by reducing professional development barriers such as training costs.²⁰⁸

2997
2998 The apprenticeship programs funded by Strategy 3 will be available to community behavioral health
2999 agencies in King County and workers they employ to participate in behavioral health apprenticeships.
3000 Crisis care center operators funded with CCC Levy proceeds are among the eligible providers.
3001 Apprenticeships are managed by Washington State registered apprenticeship programs, and employers
3002 are responsible for hiring apprentices and mentors. Strategy 3 will sustain and expand DCHS's existing
3003 contract with a Washington State registered apprenticeship program. Eligible activities include, but are
3004 not limited to, apprenticeship program costs, eligible apprentice salary and benefit costs, employer and
3005 apprentice incentives, and program planning and recruitment costs.

3006
3007 *Labor Management Partnership Training Activities*
3008 Strategy 3 will also sustain and expand access to labor management partnership training activities for
3009 community behavioral health agencies in King County, including CCC levy-funded crisis care centers
3010 operators. Labor-management partnership training activities are developed in partnership between
3011 community behavioral health agency employers and frontline workers. DCHS intends to procure labor
3012 management training proposals and contract with community behavioral health agencies to pay for
3013 eligible activities. Eligible activities may include, but are not limited to, tuition assistance, professional
3014 development costs, professional certification fees, student supports, and career counseling. Community
3015 behavioral health agencies may use training resources for a labor-management partnership training
3016 fund in which they participate, or they may manage the training resources directly.²⁰⁹

3017
3018 **Crisis Workforce Development Activities**
3019 King County will need more people to join the region's community behavioral health workforce to staff
3020 CCC Levy-funded crisis care centers. Specific roles that crisis care centers need include, but are not
3021 limited to, peer specialists, substance use disorder professionals, mental health professionals,
3022 behavioral health technicians, nurses, nurse practitioners, and physicians. In addition to training and
3023 recruiting additional behavioral health workers, building a crisis workforce will require training existing
3024 workers to provide crisis services. Crisis services are unique clinical services that require specialized skills

²⁰⁷ Health Care Apprenticeship Consortium [\[LINK\]](#)

²⁰⁸ Health Care Apprenticeship Consortium [\[LINK\]](#)

²⁰⁹ Labor management partnership training funds are structures that support health care entities, including community behavioral health agencies, in investing in direct education and training benefits at no cost for their employees.

3025 in de-escalation, risk assessment, triage decision-making, and motivational interviewing. Strategy 3
 3026 invests resources to develop a crisis workforce in King County, which is described in the subsections
 3027 below.

3028 *Crisis Care Center and Post-Crisis Follow-Up Workforce Development Activities*

3029 Crisis care centers and post-crisis follow-up programs funded by CCC Levy proceeds, including
 3030 organizations with expertise in delivering culturally and linguistically appropriate services (see [Post-Crisis](#)
 3031 [Stabilization Activities](#)), will need to hire hundreds of behavioral workers to operate at their full capacity.
 3032 ²¹⁰ Eligible activities under this component of Strategy 3 will invest in these organizations to recruit,
 3033 train, retain, develop, and support the wellbeing of behavioral health crisis workers. Funds for these
 3034 activities will be distributed to both crisis care center operators and post-crisis follow-up providers
 3035 through a competitive procurement process and may be used to:

- 3036 • Increase wages for workers;
- 3037 • Improve benefits for workers;
- 3038 • Reduce the cost of living for workers, such as housing, education, or childcare;
- 3039 • Support the professional development of workers to improve service quality, and
- 3040 • Support worker wellbeing through activities such as supervision and mentorship, covering staff
 3041 time for self-directed program development and quality improvement initiatives, and access to
 3042 behavioral health benefits.

3043
 3044 *Crisis Workforce Training Activities*

3045 Strategy 3 also includes activities to strengthen King County’s community behavioral health crisis
 3046 workforce, including, but not limited to, crisis care centers funded by CCC Levy proceeds. DCHS will
 3047 procure one or more entities to develop crisis specialty training resources that will be made available for
 3048 behavioral health workers serving King County. Training resources will aim to build behavioral health
 3049 workers’ knowledge and skill of how to assess, triage, and provide behavioral health crisis stabilization
 3050 and treatment services for clients by using evidence-based and promising practices, culturally and
 3051 linguistically appropriate approaches, trauma-informed care, and care coordination best practices.
 3052 These training resources are intended to support behavioral health workers who work in specialty crisis
 3053 settings as well as behavioral health workers who work in other settings, such as outpatient settings,
 3054 who may benefit from developing their skills related to supporting a person experiencing a behavioral
 3055 health crisis.²¹¹ DCHS may invest in training opportunities that build the crisis skills of specific behavioral
 3056 health professions, such as specialty crisis internships, practicums, residencies, and fellowships for
 3057 behavioral health students and workers pursuing careers in behavioral health crisis services.
 3058

3059 **2024 Funding Approach for Rapid Initial Progress on Behavioral Health Workforce**

3060 DCHS intends to make rapid initial progress towards fulfilling Supporting Purpose 2 by allocating CCC
 3061 Levy proceeds through Strategy 3 in 2024. Early workforce investments planned for 2024 and depicted
 3062 in Figure 30 will help strengthen King County’s community behavioral health workforce, support the
 3063 development of the behavioral health worker pipeline, and prepare to build the crisis specialty skills of
 3064 behavioral health workers in King County. DCHS plans to begin the procurement and contract processes

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

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

3065 for these activities in early 2024 to expedite the distribution of these resources soon after this Plan is
3066 adopted. In this scenario, procurement awards will not be made until after the Plan is adopted.
3067

3068 **Figure 30. Strategy 3 Plans in 2024 to Make Rapid Progress Towards Fulfilling Supporting Purpose 2**

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

3069

3070 **D. Strategy 4: Early Crisis Response Investments**

3071 Crisis care centers are major capital facility projects that will take time to develop and will not open
 3072 immediately. The anticipated crisis care center opening timeline is described in [Sequence and Timing of](#)
 3073 [Planned Expenditures and Activities](#). Strategy 4’s early crisis system activities will bring additional
 3074 behavioral health crisis services and resources to King County beginning in 2024, particularly to increase
 3075 community-based crisis response capacity, reduce fatal opioid overdoses, and invest in substance use
 3076 capital facilities. Allowable activities are described in this section and are summarized in Figure 31.

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

3077 **Figure 31. Summary of Allowable Crisis Response Investment Activities Beginning in 2024**

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

3078

3079 **Increase Community-Based Crisis Response Capacity**

3080 Strategy 4 includes activities to increase the capacity of community-based crisis response programs.

3081 Community-based crisis response programs are services that can support a person experiencing a

3082 behavioral health crisis in a community-based setting. DCHS intends to expand the capacity of mobile

3083 crisis teams and a pilot program that redirects 911 calls to behavioral health specialists. These programs,

3084 which are described in more detail in the subsections below, will expand access to community-based

3085 crisis resources starting in 2024 before crisis care centers open. In addition, these investments will

3086 complement crisis care centers by increasing capacity to resolve a person's crisis in community-based

3087 settings whenever possible without a transfer to facility-based care at a crisis care center. These

3088 investments may help manage crisis care centers' capacity and client flow, which is further discussed in

3089 [Ensuring that people efficiently move through the clinical components of a crisis care center will be](#) an

3090 important focus of continuous quality improvement and quality assurance activities. .

3091

3092 **Expand Mobile Crisis Services**

3093 Mobile crisis services are provided by teams of behavioral health clinicians and peers who travel to

3094 community-based settings to support people experiencing behavioral health crises. Mobile crisis

3095 responders work to resolve a person's behavioral health crisis in the community by providing crisis

3096 assessments, brief clinical interventions, and immediate basic need supports. Mobile crisis services also

3097 provide referrals and arrange transportation to appropriate care settings when a crisis cannot be

3098 resolved in the community. Strategy 4 will expand the capacity of mobile crisis services in King County,

3099 including services for adults and youth, starting in 2024. DCHS intends to distribute these funds through

²¹³ Eligible site-based behavioral health facilities are defined in the [Substance Use Facility Investments](#).

²¹⁴ Eligible client engagement teams are defined in the subsection within this section titled [Substance Use Facility Investments](#).

3100 contract expansions with existing mobile crisis service providers and through a competitive procurement
 3101 process. This expansion will create additional crisis service capacity before crisis care centers open. It
 3102 will also complement crisis care centers once they open by addressing crises in community settings
 3103 whenever possible and serving as a key referral source when people need facility-based crisis care.
 3104

3105 Mobile crisis service funding is an investment area that the state has an opportunity to increase and
 3106 complement the CCC Levy. The state is responsible for funding mobile crisis services, including in King
 3107 County, but the level of state investment is not yet adequate to provide the scale of mobile crisis
 3108 services that is needed in King County. This means that people who could benefit from mobile crisis
 3109 services are unable to access care. If the state increases mobile crisis funding during the CCC Levy period
 3110 to a level that is better able to meet the needs of people living in King County, then DCHS may redirect
 3111 Strategy 4 funds for this activity to another use, according to the funding prioritization described in [F.
 3112 Process to Make Substantial Adjustments to the Financial Plan.](#)
 3113

3114 *Embed Behavioral Health Counselors in 911 Call Centers*

3115 When a person in King County is experiencing a behavioral health crisis and calls 911 seeking help, the
 3116 main ways to access behavioral health care are through first responders transporting the person to
 3117 emergency departments, or in limited cases, the Crisis Solution Center described in
 3118 [Access to behavioral health services is also limited among people experiencing homelessness. A recent
 3119 survey found](#) that only 18 percent of people experiencing homelessness had received either mental
 3120 health counseling or medications in the prior 30 days despite 66 percent reporting current mental
 3121 health symptoms. The same survey describes barriers such as lacking access to a phone, needing to stay
 3122 with belongings to prevent theft, and avoiding services due to past experiences of traumatic or
 3123 unsupportive interactions with health care providers.
 3124

3125 Among U.S. military veterans who experience depression and PTSD, disparities in access to mental
 3126 health services have been described as a major factor contributing to the high suicide rates among
 3127 veterans. People living in rural areas in the U.S. also experience significant disparities in mental health
 3128 outcomes despite having similar prevalence of mental illness to those living in metropolitan areas.
 3129

3130 Need for Places to Go in a Crisis. An innovative national program model is being piloted in King County
 3131 to co-locate trained behavioral health counselors in 911 call centers.^{215,216} This model makes it possible
 3132 to redirect behavioral health crisis calls to specialized behavioral health counselors in lieu of law
 3133 enforcement dispatch.²¹⁷ Once the call is redirected to a behavioral health counselor, the counselor
 3134 works to support the person over the phone or dispatches a mobile crisis team to respond to the
 3135 person. Given the limited first responder resources available, law enforcement agencies have supported

²¹⁵ The Council of State Governments Justice Center, Tips for Successfully Implementing a 911 Dispatch Diversion Program, October 2021. [\[LINK\]](#)

²¹⁶ The Washington State Department of Health (DOH) is collaborating with Washington's 988 Lifeline crisis centers and 911 call centers, including in King County, to pilot this model on a small scale. The Mental Health Crisis Call Diversion Initiative is funded by the Washington State Department of Health and is described in RCW 71.24.890(2)(a). [\[LINK\]](#)

²¹⁷ National Association of State Mental Health Program Directors, 988 Convening Playbook – Public Safety Answering Points (PSAPs). [\[LINK\]](#)

3136 this model to reduce strain on emergency services.²¹⁸ Strategy 4 invests funding to expand this King
3137 County pilot starting in 2024.
3138

Behavioral Health Equity Highlight

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

3139 **Reduce Fatal Opioid Overdoses by Expanding Low Barrier Opioid Reversal Medication**
3140 King County is experiencing an unprecedented number of opioid overdoses, as discussed in
3141 [Unprecedented Rates of Suicide and Overdose Deaths](#). Naloxone is a lifesaving opioid overdose reversal
3142 medication that can be safely administered in community-based settings to prevent opioid overdose
3143 deaths.²¹⁹ Expanding access to naloxone and other public health resources in community-based settings
3144 can help prevent fatal opioid overdoses and other negative health outcomes. Beginning in 2024,
3145 Strategy 4 will fund activities that aim to reduce fatal opioid overdoses, including expanding access to
3146 naloxone and other relevant public health supplies through vending machines and other community-
3147 based distribution mechanisms.²²⁰ The medication and public health supplies distributed through
3148 vending machines and other mechanisms will be provided at no cost to community members and may
3149 be managed by King County. A portion of these funds may be used for King County to administer the
3150 resources funded by this strategy and provide overdose prevention education. King County will prioritize
3151 increasing access to naloxone and other relevant public health supplies in settings and communities that
3152 are experiencing the highest opioid overdose rates and the greatest opioid overdose disparities. Public
3153 Health Seattle and King County (PHSKC) online overdose data dashboards provide information about
3154 communities in the greatest need.²²¹

Substance Use Facility Investments

3155
3156 Strategy 4 also includes capital facility funding for one or more site-based behavioral health facilities,
3157 especially those that are already permitted and can create faster in-person access to substance use crisis
3158 services, such as post-overdose recovery services, sobering services, and metabolizing services. Capital
3159 development activities may include, but are not limited to, facility renovation or expansion costs, new
3160 construction costs, and other capital development or capital improvement costs. One facility funded by
3161 Strategy 4 will include the 3rd Avenue post-overdose recovery center in Seattle. Strategy 4 may also
3162 include funding for the operations of a client engagement team to support people with behavioral
3163 health , health care, and social service needs in the immediate area surrounding a capital facility funded
3164 by this strategy if that client engagement team is operated by the same organization, or a subcontractor,
3165

²¹⁸ Police Executive Research Forum, Rethinking the Police Response to Mental Health-Related Calls Promising Models, October 2023. [\[LINK\]](#)

²¹⁹ Washington State Department of Health Naloxone Instructions [\[LINK\]](#)

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

²²¹ Seattle and King County Public Health online overdose data dashboards. [\[LINK\]](#)

3166 providing services within a capital facility funded by this strategy for the purpose of engaging persons in
3167 services or promoting a healthy environment in which to seek or receive services.

3168

3169 **E. Strategy 5: Capacity Building and Technical Assistance**

3170 The investments made by the CCC Levy represent a significant expansion in King County’s behavioral
3171 health services. Strategy 5 will provide funding for capacity building and technical assistance activities to
3172 support the implementation of the CCC Levy’s strategies described in this Plan. The allowable activities
3173 funded by Strategy 5 are summarized in Figure 32 and described in the subsections below.

3174 **Figure 32. Strategy 5 Capacity Building and Technical Assistance Activities**

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

3175

3176 **Facility Operator Capital Development Assistance Activities**

3177 Strategy 5 will support technical assistance and capacity building activities to support organizations in
 3178 developing behavioral health facilities funded by CCC Levy proceeds. Organizations that are applying for
 3179 or receiving CCC Levy capital funding will be eligible to apply for capacity building and technical
 3180 assistance funding during CCC Levy procurement processes related to developing residential treatment
 3181 facilities or crisis care center facilities. Activities funded by Strategy 5 include, but are not limited to,
 3182 capital facility predevelopment planning, capital financial planning, facility siting, facility design, facility
 3183 construction, and post-construction facility activation. DCHS may use a portion of these resources to
 3184 hire organizations or consultants with relevant subject matter expertise to provide capacity building and
 3185 technical assistance directly to individual facility operators or through learning collaboratives for
 3186 multiple facility operators to support the development of capital facilities funded by this Plan.

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

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

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

3187 [Crisis Care Center Operator Regulatory and Clinical Quality Activities](#)

3188 Crisis care centers are a new type of behavioral health facility in King County, and operators may need
3189 support to comply with regulations and provide high quality services. Strategy 5 will provide resources
3190 for technical assistance and capacity building activities to:

- 3191 • Support crisis care center operators to deliver high quality clinical services;
- 3192 • Provide inclusive care for populations experiencing behavioral health inequities (see [Who](#)
3193 [Experiences Behavioral Health Inequities](#)), and
- 3194 • Comply with regulatory requirements.²²⁵

3195 Activities related to assisting crisis care center operators to deliver high quality clinical services include,
3196 but are not limited to:

- 3197 • Developing clinical policies and procedures;
- 3198 • Implementing care coordination clinical workflows and technology;
- 3199 • Implementing evidence-based and promising clinical practices;
- 3200 • Adopting de-escalation and least restrictive care best practices;
- 3201 • Building capacity for clinical quality improvement activities;
- 3202 • Increasing specialization in serving youth and people living with intellectual and developmental
3203 disabilities, and
- 3204 • Implementing best practices to support workforce development and staff wellbeing.²²⁶

3205
3206 Activities related to providing inclusive care to populations experiencing behavioral health inequities
3207 include, but are not limited to:

- 3208 • Assisting crisis care center operators to institute CLAS best practices for providing culturally and
3209 linguistically appropriate services;
- 3210 • Providing cultural humility and health equity training for crisis care center staff²²⁷;
- 3211 • Providing organizational leadership training on best practices to advance health equity at an
3212 organizational level, and
- 3213 • Consulting with organizations with expertise in serving populations that experience behavioral
3214 health inequities (see [Section III.C. Key Historical and Current Conditions: Who Experiences](#)
3215 [Behavioral Health Inequities](#)) around adopting clinical best practices and supporting individual
3216 client case consultations when appropriate.²²⁸

3217
3218 Activities related to regulatory technical assistance and capacity building include, but are not limited to,
3219 assisting crisis care center operators to comply with applicable local, state, and federal regulatory rules,
3220 and licensing, auditing, and accreditation requirements.

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

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

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

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

3221 Crisis care center operators will be able to apply for technical and capacity building support related to
 3222 regulatory and quality assurance during crisis care center procurement processes. DCHS may use a
 3223 portion of these resources to hire organizations or consultants with relevant subject matter expertise to
 3224 provide the capacity building and technical assistance described in this subsection. Consultation may be
 3225 provided to individual crisis care centers or through learning collaboratives for multiple crisis care
 3226 centers.

3227
 3228 **Capacity Building for Providers with Expertise in Culturally and Linguistically Appropriate**
 3229 **Services**

3230 Funding through Section V.A. [Culturally and Linguistically Appropriate Post-Crisis Follow-Up Services](#) is
 3231 expected to increase the number of behavioral health organizations with expertise in culturally and
 3232 linguistically appropriate services to be well positioned to provide post-crisis follow-up services for
 3233 people who receive care at crisis care centers. Strategy 5 funding will support organizations with
 3234 expertise in culturally and linguistically appropriate services described under Strategy 1 to:

- 3235 • Build their organizational capacity to provide and secure payment for delivering post-crisis
 3236 follow-up and related services;
- 3237 • Strengthen organizational administrative infrastructure;
- 3238 • Enhance data and information technology systems;
- 3239 • Develop Medicaid and other health insurance billing infrastructure, and
- 3240 • Invest in workforce development, staff training, and worker wellbeing.²²⁹

3241

Behavioral Health Equity Highlight

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

3242

3243 **Local Jurisdiction Capital Facility Siting Support Activities**

3244 DCHS also plans to award grants under Strategy 5 to local jurisdictions to help offset a portion of
 3245 jurisdictions' costs that are directly related to siting behavioral health capital facilities funded by CCC
 3246 Levy proceeds and that are not recoverable under the jurisdiction's permitting process, such as meeting
 3247 facilitation, production of communication materials, and event costs and other expenses to complete
 3248 outreach and engagement. Grants will be prioritized for uses that expedite the opening of crisis care
 3249 center facilities funded in 2024, 2025, and 2026, which aligns with the preferred crisis care center siting
 3250 timeline and process described in [Crisis Care Center Procurement and Siting Process](#). Funding for
 3251 jurisdiction siting support activities may not be used to offset siting costs incurred by other parties or
 3252 other jurisdiction costs that cannot be directly attributed to siting capital facilities funded by CCC Levy
 3253 proceeds.

3254

3255 **DCHS Capital Facility Siting Technical Assistance**

3256 Strategy 5 also includes resources for DCHS to provide capital facility siting technical assistance to local
 3257 jurisdictions and operators of capital behavioral health facilities funded by CCC Levy proceeds. DCHS
 3258 technical assistance activities funded through Strategy 5 include, but are not limited to, creating and

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

3259 deploying communication content and supporting siting community engagement, interjurisdictional
3260 collaboration, and facility operator and jurisdictional partnerships. The community engagement
3261 activities funded by Strategy 5 are intended to augment the community engagement activities funded in
3262 [G. Strategy 7: Crisis Care Centers Levy Administration](#). They include, but are not limited to, costs related
3263 to engaging community members in capital facility siting processes and soliciting community input,
3264 communication costs, translation and interpretation costs, community engagement event costs, and
3265 costs to reduce barriers for community members to participate in related community engagement
3266 activities. DCHS may use a portion of these resources to fund organizations or consultants with relevant
3267 subject matter expertise to provide technical assistance directly to jurisdictions or capital facility
3268 operators to support the siting of capital facilities funded by this Plan.²³⁰

3269

3270 **F. Strategy 6: Evaluation and Performance Measurement Activities**

3271 DCHS will assess the impact of the CCC Levy through evaluation and performance measurement
3272 activities.

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

3273 [VII. Evaluation and Performance Measurement](#) details how DCHS will conduct evaluation and
3274 performance activities.

3275 [VIII. Crisis Care Centers Levy Annual Reporting](#) describes how the CCC Levy’s results will be reported to
3276 the public and policymakers annually. This subsection describes what activities will be funded with CCC
3277 Levy proceeds, which are summarized in Figure 33. DCHS will measure and evaluate data to assess the
3278 CCC Levy’s impact, report its results, and inform efforts to improve the quality of CCC Levy funded
3279 services. DCHS may also engage in more in-depth evaluation activities to complement regular
3280 performance measurement and deepen learnings about the effect of the CCC Levy and the services the
3281 CCC Levy funds.

3282 **Figure 33. Evaluation and Performance Measurement Activities**

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

3283

3284 **G. Strategy 7: Crisis Care Centers Levy Administration**

3285 Strategy 7 supports DCHS costs to manage the implementation of the CCC Levy over the nine-year Levy
 3286 period. These investments include using DCHS staff to support the implementation of this Plan, promote
 3287 accountability to the community, provide sufficient quality assurance and improvement oversight
 3288 infrastructure, and integrate CCC Levy services into existing continuums of care to improve how people
 3289 are able to access behavioral health services at crisis care centers and other community behavioral
 3290 health settings. Strategy 7 also funds costs related to community engagement, developing data systems
 3291 infrastructure and technology, and supporting the ability of designated crisis responders (DCRs) to serve
 3292 crisis care centers, which are further described later in this subsection.²³¹ These allowable activities
 3293 within Strategy 7 are described in Figure 34.

3294

3295 **Figure 34. CCC Levy Administration Activities**

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

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

3296 **Community Engagement**

3297 DCCHS intends to prioritize community engagement throughout the term of the CCC Levy to help inform
 3298 the ongoing implementation, quality improvement, evaluation and performance measurement, and
 3299 accountability of the Levy. In addition to its engagement related to ongoing implementation activities,
 3300 DCCHS plans to engage community members around the opening of crisis care centers to raise awareness
 3301 about these new services, including sharing information that is accessible in multiple languages and
 3302 formats. The importance of community engagement in an ongoing and meaningful way was a consistent
 3303 theme during implementation planning activities (see [Community Engagement During Future Planning](#)
 3304 [Phases](#)). DCCHS will engage community partners and community members impacted by the CCC Levy,
 3305 including populations experiencing behavioral health inequities (see [Who Experiences Behavioral Health](#)
 3306 [Inequities](#)).²³² Community partners also include, but are not limited to, people who have received CCC
 3307 Levy funded services, community-based organizations, contracted service providers, and elected officials
 3308 and policy makers. DCCHS intends to conduct listening sessions at least annually to solicit community
 3309 feedback about the CCC Levy implementation. After the siting and provider selection process is
 3310 completed, the selected crisis care center operator in each crisis response zone will create a "Good
 3311 Neighbor Policy" that proactively manages relationships with the neighboring community of each crisis
 3312 care center. The purpose of a Good Neighbor Policy is to identify ways that community stakeholders can
 3313 work together to address potential impacts of the crisis care center and to formalize a positive working
 3314 relationship between stakeholders for the benefits of all neighbors, including those being served by the
 3315 crisis care center. At minimum, the Good Neighbor Policy should address the process for communicating
 3316 with neighboring businesses and residents and policies and procedures for addressing neighborhood
 3317 concerns, both during construction and ongoing operations of the crisis care centers. DCCHS also intends
 3318 to engage community partners in the CCC Levy's performance measurement and evaluation activities by
 3319 publicly sharing and disseminating its annual reporting, and by soliciting provider feedback on
 3320 performance measurement to foster accountability and collaboration in the measurement of the CCC
 3321 Levy's progress.

3322 **Expertise to Support Oversight of Behavioral Health Equity**

3323 Measuring behavioral health equity is a complex and nuanced task, as described in [Quality Improvement](#)
 3324 [and Accountability](#). Convening community partners is important to helping inform a quality metric
 3325 selection process.²³³ DCCHS plans to contract with community-based organizations or behavioral health
 3326 agencies with expertise in culturally and linguistically appropriate services to help DCCHS define quality
 3327 standards and quality improvement activities to better serve people identified in this Plan's Background
 3328 Section as populations experiencing behavioral health inequities (see [Who Experiences Behavioral](#)
 3329 [Health Inequities](#)). This investment will help inform quality improvement priorities for crisis care center
 3330 operators and post-crisis follow-up providers.
 3331

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

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

Behavioral Health Equity Highlight

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

3332

3333 [Develop Data Systems Infrastructure and Technology](#)

3334 To advance the purposes of the CCC Levy, DCHS needs to have access to timely and accurate
3335 information and secure and reliable data systems. The CCC Levy will invest in data systems infrastructure
3336 and technology to improve service providers’ ability to coordinate care for people experiencing a
3337 behavioral health crisis and to support providers’ and DCHS’s operational and administrative activities
3338 associated with implementing this Plan. These enhancements would have the added benefit of
3339 strengthening the administration of the entire public behavioral health system in King County, in line
3340 with the activities described in

3341 [Oversight of Crisis Care Center Quality and Operations](#). Furthermore, these enhancements would
3342 provide more robust data to support DCHS’s performance measurement and evaluation activities,
3343 including internal and external-facing dashboards and annual reporting, as described in [Section VIII.](#)
3344 [Crisis Care Centers Levy Annual Reporting](#). CCC Levy investments in data systems infrastructure and
3345 technology may include upgrading outdated technology, redesigning databases to make them more
3346 efficient, and automating more data processing tasks and reports.

3347

3348 Care coordination is essential during a crisis encounter. Crisis service providers need to be able to
3349 efficiently access clinical information, such as a client’s prior use of clinical services, their responses to
3350 prior treatments, and their current active services. This kind of information is critical for informing the
3351 initial risk assessment and triage, discharge planning, and engagement in post-crisis follow-up services.
3352 It is equally as important for crisis service providers to communicate with other providers, including
3353 automated alerts when someone has entered an acute care setting and information sharing to inform
3354 warm handoffs as a client begins to transition to longer-term care.

3355

3356 At the time of this Plan’s drafting, providers in King County currently have limited access to relevant
3357 clinical and social services data, which is a common problem across the United States.²³⁴ The
3358 Washington State Health Care Authority and Department of Health are developing statewide crisis
3359 system data sharing platforms to support implementation of the 988 Suicide and Crisis Line and related
3360 crisis services, as required under E2SHB 1477.²³⁵ DCHS intends to coordinate with the state in these
3361 efforts to maximize the local benefits of these state investments. While these state activities are
3362 promising, there may remain a need for local investments in data systems and technology infrastructure
3363 if there is not full alignment with King County’s local needs or timelines. DCHS will assess its progress
3364 toward data system and technology infrastructure and technology goals periodically to determine if
3365 there is a need to focus also on data system improvements solely within King County government.

²³⁴ Goldman, M. L., Shoyinka, S., Allender, B., Balfour, M., Eisen, J., Hopper, K., Minkoff, K., Parks, J., Pinheiro, A., Rosa, D., & Shaw, B. (2023). Quality Measurement in Crisis Services. National Council for Mental Wellbeing. [\[LINK\]](#)

²³⁵ 2SSB 1477 (2021). 2SHB 1477’s scope included RCW chapters 71.24, 48.43, 43.06, and 82.86. [\[LINK\]](#)

3366 In addition to supporting clinical crisis care coordination, DCHS and crisis care center operators will need
 3367 robust data systems for operational and administrative functions. As the administrator of King County’s
 3368 Integrated Care Network (KICIN) and Behavioral Health Administrative Service Organization (BH-ASO),
 3369 DCHS already maintains a core administrative processing system to facilitate payments to providers,
 3370 reporting to the state and managed care organizations, and monitoring of provider and overall system
 3371 performance. However, the addition of CCC Levy-funded programs will further add to the demands on
 3372 the system. The CCC Levy presents a unique opportunity to expand and strengthen DCHS’s backbone
 3373 technologies to securely and reliably manage data that are essential to the success of the CCC Levy.
 3374

3375 [Designated Crisis Responder Accessibility](#)

3376 Ordinance 19572 requires crisis care centers to provide access to onsite assessment by a designated
 3377 crisis responder (DCR) when needed.²³⁶ A persistent feature of King County’s pre-CCC Levy behavioral
 3378 health system has been that wait times for a DCR evaluation in community settings have too often been
 3379 measured in days and weeks instead of minutes and hours.^{237,238} While immediately seeking an
 3380 involuntary commitment hold may, in rare cases, be appropriate, DCRs’ primary responsibility is to
 3381 conduct a DCR evaluation and make an initial legal determination about whether a person meets legal
 3382 criteria for detention under Washington’s Involuntary Treatment Act.²³⁹ DCRs are mental health
 3383 clinicians, but they do not provide treatment. DCRs are an essential part of the region’s behavioral
 3384 health crisis response system, but they should rarely be the first or only call a community member
 3385 makes in a crisis.
 3386

3387 The CCC Levy will create a regional network of crisis care centers that will enable treatment to become
 3388 the first response to a behavioral health crisis. The creation of 24/7 walk-in facilities that provide
 3389 specialized treatment for crises as they happen is central to the CCC Levy proposal. In addition to
 3390 increasing access to care, crisis care centers are a key part of DCHS’s strategy to reduce DCR response
 3391 times in community settings by reducing the number of calls that DCRs receive.
 3392

3393 During the implementation planning process, DCHS received feedback from community members that
 3394 timely access to a DCR evaluation is critical when needed, but that DCR access should be held in balance
 3395 with trying treatment first, promoting least restrictive care, and prioritizing voluntary services. DCHS will
 3396 address this feedback by investing in activities to expedite DCR assessments of a person who is
 3397 experiencing a behavioral health crisis at a crisis care center when clinically appropriate. These activities
 3398 are described in Figure 34 and include costs such as satellite DCR offices and transportation costs to
 3399 reduce response times. DCHS will work with crisis care center operators to prioritize least restrictive

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

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

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

²³⁹ RCW Chapters 71.05 [\[LINK\]](#) and 71.34 [\[LINK\]](#). King County BHRD Crisis and Commitment Services website. [\[LINK\]](#)

3400 care options whenever possible, thereby allowing DCRs to respond faster in crisis care centers and
3401 community settings to less frequent cases that have already exhausted less restrictive options for care.

3402

3403 **H. Strategy 8: Crisis Care Centers Levy Reserves**

3404 The CCC Levy will maintain fund reserves as directed by Ordinance 19572. The expenditure plan
3405 described in [Annual Expenditure Plan](#) includes a fund reserve equal to 60 days of budgeted
3406 expenditures, less capital expenses, consistent with King County Comprehensive Financial Management
3407 Policies.²⁴⁰ The purpose of the reserve is to ensure continuity of levy-funded operating activities for 60
3408 days if the CCC Levy is not renewed after 2032. The 60-day operating reserve will also help promote
3409 continuity of levy-funded activities in the event of fluctuations in CCC Levy revenue or strategy costs.

3410

3411 In addition, [A. Strategy 1: Create and Operate Five Crisis Care Centers](#) and [Section V. A. B. Strategy 2:](#)
3412 [Restore, Expand, and Sustain Residential Treatment Capacity](#) each reserve a portion of CCC Levy funding
3413 to help pay for ongoing capital maintenance costs of behavioral health capital facilities funded by Levy
3414 proceeds. These capital resources will promote the future sustainability of behavioral health capital
3415 facilities funded by this Plan.

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

3416 **VI. Financial Plan**

3417 **A. Overview**

3418 This section describes the CCC Levy's financial plan and other related financial considerations. These
 3419 considerations include the CCC Levy's approach to incorporating additional financial resources to
 3420 complement and augment CCC Levy proceeds, the role of health insurance funding, and the process to
 3421 makes substantial adjustments to the financial plan. The strategy to establish and maintain CCC Levy
 3422 reserves is described in [H. Strategy 8: Crisis Care Centers Levy Reserves](#).

3423

3424 **B. Financial Plan**

3425 **CCC Levy Annual Revenue Forecast**

3426 Figure 35 illustrates the CCC Levy's annual revenue forecast from January 1, 2024, to December 31,
 3427 2032. During 2024, the first year of the CCC Levy, the levy rate will be 14.5 cents per \$1,000 in assessed
 3428 property value. From 2025 to 2032, total levy collections may increase in accordance with Washington
 3429 State's levy limit, which at the time of this Plan's drafting was one percent annually plus the value of
 3430 new construction as determined by the King County Assessor.²⁴¹ The revenue forecast incorporated into
 3431 this Plan is from the King County OEFA August 2023 revenue forecast.²⁴² The revenue forecast depicted
 3432 in Figure 35 assumes a 99 percent revenue collection rate and an assumption that the CCC Levy's
 3433 proceeds will generate annual interest revenue at a rate of 0.5 percent.^{243,244}

3434

3435 **Annual Expenditure Plan**

3436 The CCC Levy's annual expenditure plan between 2024 and 2032 is described in Figure 35. The
 3437 expenditure plan includes annual investment amounts for each of the CCC Levy's strategies, which are
 3438 described in [V. Crisis Care Centers Levy Strategies and Allowable Activities](#)

²⁴¹ Municipal Research and Services Center (MRSC). *Levy Lid Lift*. [\[LINK\]](#)

²⁴² King County Office of Economic and Financial Analysis' (OEFA) economic forecasts [\[LINK\]](#)

²⁴³ King County Office of Economic and Financial Analysis' (OEFA) economic forecasts [\[LINK\]](#)

²⁴⁴ Fund revenues and corresponding cash balances accrue interest and County investment pool earnings, which are conservatively estimated at 0.5% of total collected revenues annually.

3439 Figure . The expenditure plan also includes one-time costs such as the election costs for King County
3440 Proposition 1 in April 2023 and initial planning costs permitted under Ordinance 19572.²⁴⁵ In addition to
3441 costs, the expenditure plan also includes health insurance funding assumptions, which account for the
3442 share of crisis care center expenses that are projected to be paid for by health insurance, including
3443 Medicaid. Additional information about the expenditure plan’s health insurance assumptions is
3444 described Section VI. Financial Plan: [E. Health](#) Insurance Assumptions. CCC Levy reserves are also
3445 depicted in the expenditure plan, and additional reserve information is described in [H. Strategy 8: Crisis](#)
3446 [Care Centers Levy Reserves](#).
3447

²⁴⁵ King County Elections. Ballot Measures: April 25, 2023 Special Election. King County Proposition No. 1: Crisis Care Centers Levy. [\[LINK\]](#)

3448 **Figure 35. Crisis Care Centers Levy Projected Revenue and Approximate Annual Allocations by Strategy, 2024-2032** ²⁴⁶

3449

Crisis Care Centers Levy Projected Revenue (2024 - 2032)										
	2024	2025	2026	2027	2028	2029	2030	2031	2032	Total
Projected CCC Levy Revenue	\$117,304,000	\$119,829,000	\$122,449,000	\$125,130,000	\$127,866,000	\$130,654,000	\$133,489,000	\$136,384,000	\$139,346,000	\$1,152,451,000
Projected Annual Interest	\$587,000	\$599,000	\$612,000	\$626,000	\$639,000	\$653,000	\$667,000	\$682,000	\$697,000	\$5,762,000
Total Revenue²⁴⁷	\$117,891,000	\$120,428,000	\$123,062,000	\$125,755,000	128,505,000	\$131,307,000	\$134,156,000	\$137,066,000	\$140,042,000	\$1,158,213,000

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

3450

²⁴⁶ The dollar amounts in this table are approximate and are rounded to the nearest thousand dollars.

²⁴⁷ The revenue forecast incorporated into this Plan is from the King County Office of Economic and Financial Analysis' August 2023 revenue forecast. [\[LINK\]](#)

The revenue forecast assumes a 99 percent revenue collection rate and an assumption that the CCC Levy's proceeds will generate annual interest revenue at a rate of 0.5 percent.

3451 **C. Sequencing and Timing of Planned Expenditures**

3452 Ordinance 19572 requires this Plan describe the sequence and timing of planned expenditures and
 3453 activities necessary to establish and operate a regional network of five crisis care centers. This
 3454 requirement is addressed in [Sequence and Timing of Planned Expenditures and Activities](#). DCHS plans to
 3455 open competitive procurement rounds in 2024, 2025, and 2026 if needed to select five crisis care center
 3456 operators.

3457
 3458 Ordinance 19572 also requires this Plan to describe how a portion of first year levy proceeds will be
 3459 allocated to make rapid initial progress towards fulfilling the CCC Levy's Supporting Purposes One and
 3460 Two. [2024 Levy](#) describes how progress will be made in 2024 towards fulfilling Supporting Purpose 1.
 3461 DCHS plans to open a competitive procurement in 2024 to award capital improvement funding for
 3462 resident treatment facility operators to help stabilize the sector and prevent additional closures and to
 3463 award capital funding for new residential treatment facility development. [2024 Funding Approach for
 3464 Rapid Initial Progress on Behavioral Health](#) describes how progress will be made in 2024 towards
 3465 fulfilling Supporting Purpose 2. DCHS plans to distribute resources to help strengthen and support the
 3466 development of King County's community behavioral health workforce through existing contracts with
 3467 organizations and new procurement processes.

3468

3469 **D. Seeking and Incorporating Federal, State, and Philanthropic Resources**

3470 The CCC Levy's financial plan is designed to advance the Paramount Purpose, Supporting Purpose 1, and
 3471 Supporting Purpose 2, within forecasted resources. Forecasted resources include projected CCC Levy
 3472 proceeds and health insurance funding. These funding assumptions are described in Section VI. B.
 3473 Financial Plan:[CCC Levy Annual Revenue Forecast](#) and Section VI.E [E. Health](#) Insurance Assumptions.

3474
 3475 In this Plan's financial plan, the Executive has not assumed federal, state, or philanthropic resources will
 3476 contribute to achieving the CCC Levy's purposes except for state and federal Medicaid funding based on
 3477 information available at the time of this Plan's drafting. While this Plan does not depend upon it,
 3478 government and philanthropic partners have a significant opportunity to bolster the impact of the CCC
 3479 Levy.

3480
 3481 Additional philanthropic and government investments in CCC Levy purposes could reduce the amount of
 3482 CCC Levy proceeds that are needed to fulfill this Plan's strategies. CCC Levy proceeds could then expand
 3483 funding for strategies through the uses described in Section VI. F. [F. Process to Make Substantial
 3484 Adjustments to the](#) Financial Plan. Government and philanthropic partners could also augment the
 3485 impact of the CCC Levy by investing in other parts of the behavioral health system or in other areas that
 3486 impact social determinants of health. For example, if federal and state partners invest in affordable
 3487 housing resources to meet the scale of housing needs of people living with behavioral health conditions
 3488 and housing instability in King County, individual experiences of behavioral health crises may be
 3489 reduced. The Executive will seek investments from government and philanthropic partners to augment
 3490 CCC Levy proceeds. Figure 36 describes examples of government and philanthropic investments that
 3491 could complement this Plan.

3492 **Figure 36. Federal, State, and Philanthropic Opportunities to Augment CCC Levy Proceeds**

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

3493
3494 Through King County’s annual legislative agenda and policymaker engagement activities, such as but not
3495 limited to briefings, work sessions, and public meetings, the Executive intends to seek federal and state
3496 government funding to complement the CCC Levy . DCHS will strive to coordinate the CCC Levy with
3497 federal and state crisis service initiatives and investments to maximize resource coordination and crisis
3498 system integration. As the state makes ongoing, state-wide investments in crisis facilities and programs,
3499 the Executive will continue to seek funds to augment the CCC Levy.

3500
3501 The Executive and DCHS also plan to seek philanthropic funding by sharing opportunities for
3502 philanthropic partners to amplify the impact of the CCC Levy proceeds with targeted funding support.
3503 Similar to state and federal initiatives, DCHS will strive to coordinate with existing philanthropic
3504 initiatives related to crisis services whenever feasible to maximize resource coordination across
3505 initiatives.

²⁴⁸ “Young adult,” also known as “transition age youth” means a person between eighteen and twenty-four years of age, per RCW 43.330.702 – Homeless youth—Definitions. [\[LINK\]](#)

²⁴⁹ Naloxone is a lifesaving opioid overdose reversal medication that can be safely administered in community-based settings. “MOUD” means medication for opioid use disorder and includes medications that are used to support people receiving treatment for opioid use.

3506 **E. Health Insurance Assumptions**

3507 **Medicaid Health Insurance**

3508 The CCC Levy financial plan assumes that Medicaid health insurance (“Medicaid”) will pay for
 3509 approximately 40 percent of the crisis care centers’ operating and service activities and approximately
 3510 40 percent of the post-crisis follow-up program’s operating and service activities that are described in [A.](#)
 3511 [Strategy 1: Create and Operate Five Crisis Care Centers](#). CCC Levy proceeds will be used to pay for the
 3512 remaining 60 percent of these activities’ operating and service costs that are expected not to be covered
 3513 by Medicaid.

3514
 3515 DCHS developed the 40 percent Medicaid assumption by analyzing King County’s historic crisis service
 3516 health insurance billing codes and utilization data, estimating the likely health insurance coverage payer
 3517 mix of people who may access crisis care centers, and reviewing Medicaid funding rates at comparable
 3518 facilities in Washington State. A review of crisis service health care billing codes and utilization rates
 3519 showed a range of 29 percent to 50 percent of the client population was covered by Medicaid,
 3520 depending on the service type, with a 34 percent average rate of people accessing behavioral health
 3521 crisis services. The crisis care centers’ payer mix will likely be higher than this 34 percent average rate
 3522 because crisis care centers are anticipated to disproportionately serve people who are eligible for
 3523 Medicaid. King County reviewed the share of costs Medicaid covered at two comparable crisis facilities
 3524 in Washington. Medicaid covered 24 percent of the operating and service costs at one facility and 86.5
 3525 percent of the operating and service costs at the second facility.²⁵⁰ This analysis, along with King
 3526 County’s commitment to maximize Medicaid billing through supporting Medicaid enrollment and billing
 3527 infrastructure, resulted in this Plan’s funding assumption reflecting a modest increase from Medicaid
 3528 utilization rates for crisis services that existed at the time of this Plan’s drafting, up to 40 percent
 3529 Medicaid funding.

3530
 3531 The actual Medicaid reimbursement amount, which may vary annually, may be higher or lower than this
 3532 40 percent projection based on the implementation of state law directing the state to maximize the use
 3533 of Medicaid for behavioral health services, including crisis services.²⁵¹ [Section VI. F. Process to Make](#)
 3534 [Substantial Adjustments to the Financial Plan](#) describes how excess funding or reduced funding,
 3535 including funding changes resulting from Medicaid assumptions, will be prioritized.

3536

3537 **Commercial Health Insurance**

3538 Recent state legislation regarding emergency health insurance coverage requires commercial health
 3539 insurance plans (“commercial plans”) to cover behavioral health crisis services at the same level as
 3540 physical health emergency services.²⁵² As a result of this legislation, beginning in 2024, commercial plans
 3541 will pay for the types of behavioral health crisis services that will be delivered at crisis care centers as
 3542 described in [A. Strategy 1: Create and Operate Five Crisis Care Centers](#). At the time of this Plan’s
 3543 transmittal, commercial plan payment rates were being negotiated and were unknown. Due to the
 3544 uncertainty regarding commercial plan rates, the CCC Levy’s financial plan does not assume any

²⁵⁰ The Crisis Solutions Centers in Seattle, WA has a 24 percent Medicaid reimbursement experience. The Spokane Regional Stabilization Center in Spokane, WA has an 86.5 percent Medicaid reimbursement experience.

²⁵¹ E2SSHB 1515 [\[LINK\]](#) and SSSB 5120 [\[LINK\]](#) both passed during the 2023 state legislative session and direct the Washington State Health Care Authority to maximize Medicaid billing for crisis services.

²⁵² Engrossed Second Substitute House Bill 1688 passed during the 2022 state legislative session and requires health insurance carriers to cover emergency services, including services provided at out-of-network facilities, up until the point of stabilization. [\[LINK\]](#)

3545 commercial plan funding. The actual commercial plan funding will likely be higher than zero dollars. The
 3546 real amount will be determined by the insurance coverage payer mix of people who receive services at
 3547 crisis care centers and the final negotiated commercial plan rates. Any future commercial insurance
 3548 payments will offset CCC Levy expenses and will allow for CCC Levy proceeds to be prioritized for uses
 3549 described in the next section, [Section VI. F. Process to Make Substantial Adjustments to the Financial](#)
 3550 [Plan](#).

3551

3552 **F. Process to Make Substantial Adjustments to the Financial Plan**

3553 **Overview**

3554 This section describes the process to communicate and make substantial adjustments to the CCC Levy's
 3555 financial plan. A substantial adjustment is a change or series of changes within the same calendar year
 3556 to a strategy's annual funding allocation by the greater of five percent or \$500,000.

3557
 3558 A change is not considered a substantial adjustment if it is due to additional CCC Levy revenue or other
 3559 funding sources becoming available. In this scenario, the additional CCC Levy revenue must be allocated
 3560 according to the priorities described later in this section and cannot reduce another strategy's
 3561 allocation. In addition, CCC Levy proceeds that are not spent within a strategy may be retained within
 3562 the same strategy for use in a subsequent year without being considered a substantial adjustment for
 3563 the purpose of this Plan.

3564
 3565 Potential causes for substantial adjustments to the financial plan may include, but are not limited to:

- 3566 • Macroeconomic conditions such as inflation being higher than expected;
- 3567 • CCC Levy generating less revenue than forecasted;
- 3568 • Health insurance funding being lower than projected;²⁵³
- 3569 • Additional funding contributions allowing CCC Levy proceeds to be reprioritized;
- 3570 • Unanticipated fluctuations or variations in program costs, and
- 3571 • Evolving needs, such as workforce conditions and capital project timeline changes.

3572
 3573 Expenditure of CCC Levy proceeds in any year remains subject to Council appropriation. Annual
 3574 reporting requirements directed by Ordinance 19572 and this Plan include annual financial reporting.

3575

3576 **Process for Communicating and Making a Substantial Adjustment**

3577 Substantial adjustments to the CCC Levy's financial plan will be communicated according to the process
 3578 defined in this subsection. If, without Council direction or concurrence, the Executive determines a
 3579 substantive adjustment to the funding allocations specified in the CCC Levy's financial plan is needed,
 3580 then the Executive will transmit a notification letter to Council detailing the scope of and rationale for
 3581 the changes. The Executive may only send such notification letters as frequently as twice per year when
 3582 needed. The Executive will electronically file the letter with the Clerk of the Council, who will retain an
 3583 electronic copy and provide an electronic copy to all councilmembers, the Council Chief of Staff, the lead
 3584 staff for the Committee of the Whole, or its successor, and the Regional Policy Committee. Unless the
 3585 Council passes a motion rejecting the contemplated change within 30 days of the Executive's
 3586 transmittal, the Executive may proceed with the change as set forth in the notification letter.

3587

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

3588 **Priorities for Reducing Allocations Due to Revenue that is Less than this Plan’s Projections**
 3589 This subsection describes the process for prioritizing substantial adjustments that reduce this Plan’s
 3590 annual allocations to one or more strategies. If the projected CCC Levy revenue or health insurance
 3591 funding assumptions are less than this Plan’s projections in any year, then it may be necessary to make a
 3592 substantial adjustment to an allocation amount in one or more strategies. If this occurs, the Executive
 3593 will identify necessary substantial adjustments according to the priorities described in Figure 37.
 3594

3595 **Figure 37. Funding Priorities if CCC Levy Proceed Allocations Must be Reduced Due to Funding that is**
 3596 **Less than Projected**

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

3597 **Priorities for Allocating Revenue in Excess of this Plan’s Original Allocations or to Reflect**
 3598 **Additional Funding from Other Sources**
 3599 This subsection describes the process for prioritizing allocations of CCC Levy revenue that exceed this
 3600 Plan’s revenue projections, or CCC Levy revenue that becomes available because other funding sources
 3601 are contributing funding toward this Plan’s strategies at a higher level than anticipated. Examples of
 3602 other funding sources could include but are not limited to higher than assumed health insurance
 3603 funding²⁵⁷ or complementary investments made by federal, state, and philanthropic partners to
 3604 augment the impact of the CCC Levy. Increases to a strategy’s allocation due to additional CCC Levy
 3605 revenue or funding secured for CCC Levy purposes from other sources that do not reduce another
 3606 strategy’s allocation and that comport with this subsection’s priorities do not constitute a substantial
 3607 adjustment for the purposes of this Plan. Expenditures of CCC Levy proceeds allocated through this
 3608 prioritization remain subject to Council appropriation. The Executive will apply the priorities described in
 3609 Figure 38 to allocate additional funding that becomes available because of higher CCC Levy revenue
 3610 projections or newly available funding from other sources.
 3611

²⁵⁴ Strategies with a direct link to accomplishing the CCC Levy’s paramount purpose include Strategy 1: Create and Operate Five Crisis Care Centers, Strategy 3: Strengthen the Community Behavioral Health Workforce, and Strategy 5: Capacity Building and Technical Assistance.

²⁵⁵ Strategy 3: Strengthen the Community Behavioral Health Workforce has a direct link to accomplishing the CCC Levy’s Supporting Purpose 2.

²⁵⁶ Strategies with a direct link to accomplishing Supporting Purpose 1 include Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity and Strategy 5: Capacity Building and Technical Assistance.

²⁵⁷ In this context, health insurance includes Medicaid and commercial health insurance.

3612 **Figure 38. Priorities for Increasing Allocations Due to Additional Funding**

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

3613

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

3614 **VII. Evaluation and Performance Measurement**

3615 This section describes how DCHS will approach evaluating and measuring the performance of the CCC
3616 Levy. This includes a description of the principles and framework that will guide evaluation and
3617 performance measurement activities. A description of how CCC Levy proceeds will be used to support
3618 evaluation and performance measurement activities is included in [F. Strategy 6: Evaluation and](#)
3619 [Performance Measurement Activities](#). A description of how community partners may be engaged in
3620 evaluation and performance measurement activities is included in [G. Strategy 7: Crisis Care Centers Levy](#)
3621 [Administration](#) . Lastly, DCHS will create and maintain an online annual report so the public and
3622 policymakers can review the performance of the CCC Levy. The CCC Levy’s annual report requirements
3623 and process are described in

3624 [VIII. Crisis Care Centers Levy Annual Reporting.](#)

3625

3626 **A. Evaluation and Performance Measurement Principles**

3627 The evaluation and performance measurement of the CCC Levy will be guided by the principles
 3628 described in Figure 39. Community engagement feedback and DCHS subject matter experts informed
 3629 these principles during the implementation planning process.

3630

3631 *Figure 39. CCC Levy Evaluation and Performance Measurement Principles*

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

3632

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

Behavioral Health Equity Highlight

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

3633

3634 **B. Evaluation and Performance Measurement Framework**

3635 The CCC Levy evaluation and performance measurement framework will focus on reporting measures
3636 relevant to monitoring performance of the CCC Levy, advancing continuous quality improvement, and
3637 generating clear and actionable evaluation products for the public. It is critical that the crisis services
3638 system can grow and evolve by building on what works well and improving what does not. This process
3639 should be continuously informed by performance metrics, outcome data, client experiences, and other
3640 relevant information, as described in [Error! Reference source not found.](#).

3641

3642 Evaluation of the CCC Levy will aim to inform strategic learning and accountability. Strategic learning is
3643 using data to understand which strategies are effective and why they are effective to inform continuous
3644 quality improvement activities.²⁶⁰ Data from evaluation also supports shared responsibility and
3645 accountability for CCC Levy activities between the County and community agencies. Providers are
3646 accountable for the activities they are funded to do, while the County is accountable for the overall
3647 results of the CCC Levy.

3648

3649 The scale and complexity of the CCC Levy requires an evaluation approach that encompasses a range of
3650 measurement techniques. The evaluation framework will therefore include three overall approaches:

- 3651 1. **Population Indicators:** DCHS will use population level measures to identify needs, characterize
3652 baseline conditions, and track trends.
- 3653 2. **Performance Measurement:** Performance measures are regularly generated and collected
3654 descriptors of program processes and outcomes that can be used to assess how well a strategy
3655 is working.
- 3656 3. **In-Depth Evaluation:** Additional evaluation activities will complement performance
3657 measurement to deepen learnings and understand selected CCC Levy investments’
3658 effectiveness. Approaches may include piloting new programs, developing new evaluation tools,
3659 and identifying areas that may benefit from new or deeper community supports. DCHS may
3660 contract with one or more third party, independent organization(s), or engage in public private
3661 partnerships to conduct in depth evaluations.

3662

3663 These three approaches are described in more in the following subsections.

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

3664 Population Indicators

3665 The CCC Levy will impact two priority populations, detailed in the list below, which reflect the two
 3666 facility-focused purposes of the CCC Levy. DCHS will focus on measuring how these populations change
 3667 over time in size and demographics. Where feasible, DCHS will disaggregate population indicator data by
 3668 demographic characteristics to advance King County’s equity goals, including evaluating
 3669 representativeness of services by comparing priority population demographics to regional population
 3670 demographics (see [Quality Improvement and Accountability](#)). DCHS will also measure how the CCC Levy,
 3671 as a part of the King County behavioral health system, provides services to these two priority
 3672 populations. Building on the King County Behavioral Health Data System, DCHS plans to use the
 3673 following definitions to provide estimates for following population indicators, which reflect the purposes
 3674 of the CCC Levy as noted in parentheses:

- 3675 1. People seeking immediate and in person crisis care through intervention and stabilization
 3676 services provided by County-contracted crisis services ([Paramount Purpose](#)); and
- 3677 2. People seeking residential treatment care and who have an open authorization to receive
 3678 residential treatment with County-contracted residential treatment providers ([Supporting
 3679 Purpose](#)).

3680

3681 While the goal is for the CCC Levy to contribute to population level outcomes in the long term, there are
 3682 multiple other sectors and community factors that are also responsible for countywide conditions and,
 3683 as a result, influence these measures. It is therefore difficult to attribute changes in population
 3684 indicators — positive or negative — to the CCC Levy itself.

3685

3686 Performance Measurement

3687 DCHS will measure and report on the impact of the CCC Levy in the three domains defined by Results
 3688 Based Accountability (RBA) framework, as appropriate.²⁶¹ The RBA framework describes performance
 3689 measurement by asking three key questions: how much did we do, how well did we do it, and is anyone
 3690 better off? The measurement framework will focus on reporting measures relevant to continuous
 3691 quality improvement and generating clear and actionable evaluation products to the public.

3692

3693 This approach to performance measurement will promote strategic learning and accountability through
 3694 transparency and collaboration with service providers funded through the CCC Levy. The RBA framework
 3695 also helps reduce data collection burden for providers and ensures that measurement reflects both
 3696 program and community definitions of progress. Consistent with standard practice for the department,
 3697 DCHS will give service providers the opportunity to inform final plans for performance measurement to
 3698 ensure they include meaningful measures and feasible reporting requirements.

3699

3700 For every strategy of the CCC Levy that is competitively procured, procurement materials such as
 3701 requests for proposal (RFPs) will include proposed performance measures to transparently
 3702 communicate contract expectations based on the CCC Levy’s intended impact and likely reporting
 3703 requirements. During the contract negotiation process, DCHS will engage with selected service providers
 3704 to finalize a performance measurement plan. The finalized performance measurement plan will capture
 3705 the individual program model’s unique aspects, while also adopting standardized measures to facilitate
 3706 measuring the CCC Levy’s collective impact.

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

3707 Performance measures across programs will vary based on the populations served, duration of services,
 3708 type of investment and activity, and funding duration. These measures can be quantitative or
 3709 qualitative. DCHS intends to require contracted service providers to regularly report data for CCC Levy
 3710 funded programs and strategies and will collect performance measurement data in a consistent manner.
 3711 The timeline for developing and reporting measures will be distinct for each program and will depend on
 3712 its implementation stage and data collection requirements. Specific measures will be finalized in
 3713 consultation with providers and refined periodically.

3714
 3715 For strategies that are investing in directly providing behavioral health services to clients, DCHS plans to
 3716 collect and monitor performance measures on individuals served, the nature of services provided, and
 3717 associated outcomes to support the implementation of [A. Strategy 1: Create and Operate Five Crisis](#)
 3718 [Care Centers](#) and [B. Strategy 2: Restore, Expand, and Sustain Residential](#) Treatment Capacity. Individual
 3719 level data may be collected on people receiving services to disaggregate measures by race, ethnicity, or
 3720 other demographic characteristics at both the program level and across programs for analysis within
 3721 strategies and result areas.

3722
 3723 For strategies that are investing in workforce or systems infrastructure, DCHS plans to collect and
 3724 monitor performance measures among community behavioral health providers that describe agency
 3725 attributes such as workforce characteristics, activities conducted, and associated outcomes to support
 3726 the implementation of [Section V.C. Strategy 3: Community Behavioral Health Workforce](#). Individual-level
 3727 data may be collected on a community behavioral health agency's staff to disaggregate measures by
 3728 race, ethnicity, or other demographic characteristics at both the program level and across programs for
 3729 analysis within strategies and result areas.

3730
 3731 Across all strategies, DCHS intends to continue expanding the ways in which populations experiencing
 3732 behavioral health inequities (see [Who Experiences Behavioral Health Inequities](#)) are visible in data and
 3733 are involved in decisions about what data are gathered and how it is interpreted. This may include
 3734 expanding the ways existing systems disaggregate data by race and ethnicity, developing new methods
 3735 for data collection, continuing to report on both numbers and stories to value participants' experiences,
 3736 increasing opportunities for community reflection and feedback on data analysis, and evaluating
 3737 representativeness by comparing demographics of people reached by CCC Levy strategies to regional
 3738 population demographics. A description of how community partners will be engaged in evaluation and
 3739 performance measurement activities is included in [G. Strategy 7: Crisis Care Centers Levy Administration](#)

3740 .
 3741
 3742 **In-Depth Evaluation**

3743 Performance measurement and evaluation activities may also include additional in-depth evaluations
 3744 that are more focused in scope, time, or substance to inform program decision making and to ensure
 3745 that the CCC Levy is functioning as intended. To conduct such evaluations for the CCC Levy, DCHS may
 3746 contract with external research partners or engage in public-private partnerships to augment its own
 3747 data collection, measurement, and evaluation work. Where feasible, DCHS will disaggregate in-depth
 3748 evaluation data by demographic characteristics to advance King County's equity goals.

3749
 3750 In collaboration with community partners, the CCC Levy plans to use the following criteria for selecting
 3751 priority areas for evaluation:

- 3752 1. **High interest from community partners.** Evaluations identified as being of critical need or
 3753 interest to King County Council, Cities and the Sound Cities Association, community-based

- 3754 organizations, providers, the King County Behavioral Health Advisory Board, and others
 3755 community partners as applicable.
- 3756 2. **High potential to improve equity.** Evaluations that focus on identifying disproportionalities in
 3757 services, or identifying whether there is improvement in servicing historically underserved
 3758 communities.
 - 3759 3. **High potential to improve quality of services.** Evaluation of programs or processes that are
 3760 integral to quality of care, and where findings can be used with partners for continuous quality
 3761 improvement.
 - 3762 4. **Provide new evidence.** Evaluation of new or existing programs that can fill a gap in the scientific
 3763 evidence base and enhance program learning and adaptation.
 - 3764 5. **High quality data.** Evaluations will be selected to leverage available robust, rigorous, and
 3765 sustainable data sources; results may also inform where further data infrastructure investments
 3766 are needed.

3768 The design of potential evaluations will be based on what is appropriate for the program’s stage of
 3769 implementation, and the existing evidence base for effectiveness of the selected program models.

3770 Options include, but are not limited to:

- 3771 • **Formative evaluation** to support innovation and decision making for a new program;
- 3772 • **Process evaluation** to support program implementation and improvements, and,
- 3773 • **Outcomes evaluation** to demonstrate whether the program is leading to the desired results.

3774
 3775 The timeline for completing in-depth evaluations will depend on when baseline data are available; the
 3776 point at which a sufficient number of individuals have reached the outcome to generate a statistically
 3777 reliable result; and the time needed for data collection, analyses, and interpretation of data.

3778
 3779 **C. Aligning CCC Levy Performance Measurement and Reporting with Other Dedicated Human**
 3780 **Services Funding Initiatives**

3781 DCHS intends to align CCC Levy performance measurement and reporting with other dedicated human
 3782 services funding initiatives where possible. Alignment is important because King County residents’
 3783 health and human services needs span the boundaries of federal, state, and local funding. Revenue from
 3784 the CCC Levy, along with the MIDD, Best Starts for Kids (BSK), the Veterans, Seniors, and Human Services
 3785 Levy (VSHSL), and Health Through Housing (HTH) constitutes a substantial portion of King County’s local
 3786 health and human service investments. Many of the County’s dedicated human services funding streams
 3787 are time-limited, requiring periodic renewal. MIDD (expires after 2025), BSK (expires after 2027), and
 3788 VSHSL (expires after 2029) will require renewal during the CCC Levy period to continue; and the County’s
 3789 updated implementation plan for HTH is due in 2027 also during the CCC Levy period. In the
 3790 development of this Plan, DCHS staff engaged across initiatives to coordinate planning efforts. These
 3791 overlapping funding timelines offer opportunities over the course of the CCC Levy to innovate, adapt,
 3792 and tune performance measurement and reporting in response to community needs.

3793
 3794 In response to a proviso included in King County’s 2017-2018 adopted budget, DCHS has invested
 3795 heavily in data systems and infrastructure to responsibly collect, manage, and share information, with
 3796 the goal to make data widely accessible and used to animate conversations, spark innovation, and direct
 3797 programming and policy decisions to benefit King County residents.²⁶² These investments have made

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

3798 possible new data products, including online dashboards, that provide insight on participants in
3799 programs and activities and how they access services, as well as how investments and services are
3800 geographically distributed. This information supports monitoring and evaluating the collective impact in
3801 communities and informs continuous improvement of service delivery. Using these tools, DCHS
3802 collaborates with program participants, contracted service providers, and its own direct services staff to
3803 collect high-quality data, review program performance, and develop and monitor quality improvement
3804 initiatives.

3805
3806 In July 2022, DCHS released a consolidated dashboard to report data on BSK, MIDD, and VSHSL funded
3807 services.²⁶³ In 2023, the dashboard added data for all programs and activities, including those that were
3808 federally funded, in the Behavioral Health and Recovery Division and the Developmental Disabilities and
3809 Early Childhood Supports Division. By 2025, expansion of this dashboard will include further information
3810 from all DCHS divisions to transparently share how the department works to help strengthen the
3811 communities of King County. By 2026, CCC Levy data will be included in this dashboard to transparently
3812 show how this initiative works to help strengthen the communities of King County.

²⁶³ The consolidated dashboard is titled *Measuring DCHS' Impact*. [\[LINK\]](#)

3813 **VIII. Crisis Care Centers Levy Annual Reporting**

3814 **A. Annual Reporting Process and Requirements**

3815 Beginning in 2025, and until 2033, DCHS staff will generate an annual report in alignment with reporting
3816 requirements of this Plan and Ordinance 19572. The report will then be reviewed and certified by the
3817 CCC Levy advisory body.²⁶⁴ By no later than August 15 of each year, the certified annual report will be
3818 made available online so that the community and all interested parties, including the King County
3819 Council and Regional Policy Committee or its successor, will have unfettered access.

3820
3821 The first year’s report will report on information from calendar year 2024. Subsequent certified, annual
3822 reports will report on the previous year, including updating the previous year’s data. In consultation
3823 with Cities and the Sound Cities Association, as part of the annual report, DCHS will provide historical
3824 and current data in a manner that can be used to analyze services and to make year-over-year
3825 comparisons.

3826
3827 Recognizing that the annual report reflects a collaborative commitment from DCHS to provide useful
3828 data at the local level for local jurisdiction partners in support of levy purpose outcomes, , each CCC Levy
3829 online annual report will, consistent with Ordinance 19572, include:

- 3830 1. Total expenditure of CCC Levy proceeds by crisis response zone, crisis care center, purpose,
3831 strategy, activities related to crisis care center post-crisis stabilization, and activities related to
3832 expanding mobile crisis services, reported by King County ZIP code where the services were
3833 received, and
- 3834 2. The number of individuals receiving CCC Levy funded behavioral health care services by crisis
3835 response zone, crisis care center, purpose, strategy, , activities related to crisis care center post-
3836 crisis stabilization, and activities related to expanding mobile crisis services, reported by the ZIP
3837 code where the individuals resided at the time of services and by the King County ZIP code
3838 where the services were received, provided that individually protected information is not
3839 disclosed.

3840
3841 In addition, DCHS will, in consultation with Cities, develop strategies for ZIP code reporting for the CCC
3842 Levy’s Supporting Purpose Two, workforce development, informed by evolving career pathways
3843 programming and data availability, and include in the Executive's 2026 career pathways notification
3844 letter a plan for annual reporting of this ZIP code data.

- 3845
3846 Additionally, each CCC Levy online annual report will include:
- 3847 3. An overview of CCC facility utilization data as described in the Continuous Quality Improvement
3848 and Quality Assurance subsection of Strategy 1 in this Plan;
 - 3849 4. Crisis care center operator awards made and progress on each awarded operator contract
3850 during the reporting period as required in the Alternative Siting Process section of Strategy 1 in
3851 this Plan;
 - 3852 5. An overview of CCC Levy accomplishments during the previous calendar year, and changes DCHS
3853 intends to make or direct to improve performance in the following year, when applicable;

²⁶⁴ Described in

[IX. Crisis Care Centers Levy Advisory Body](#)

- 3854 6. Transportation data required by Section V.A. Strategy 1: Collect and Report High Quality Data
3855 subsection;
- 3856 7. The assessment and reporting required by the Initial Prioritization of Residential Treatment
3857 Capacity of this Plan;
- 3858 8. The CCC Levy’s fiscal and performance measurement during the applicable calendar year, and
3859 9. A map or summary describing the CCC Levy’s geographic distribution.

3860
3861 No later than by August 15 of each year, the Executive will transmit directly to the Council, with a copy
3862 sent to the Regional Policy Committee, a summary of the online annual reporting in the form of a letter
3863 that:

- 3864 • Confirms availability of the online annual report and includes a web link or links;
- 3865 • Identifies how the online annual report meets the requirements of Ordinance 19572, and
- 3866 • Summarizes key data and conclusions in the five areas above, including an overview of
3867 accomplishments; fiscal and performance management; expenditure of levy proceeds by crisis
3868 response zone, strategy, and levy purpose by King County ZIP code; the number of individuals
3869 receiving levy-supported services by crisis response zone, strategy, and levy purpose by King
3870 County ZIP code; and a map or summary describing CCC Levy’s geographic distribution. This
3871 information will be described in greater detail within the online annual reporting.

3872
3873 The Executive will transmit with the summary letter a motion acknowledging receipt of the summary
3874 letter and completion of the online annual report requirement. The Executive will be prepared to
3875 present a briefing at the invitation of the King County Council or its committees, including the Regional
3876 Policy Committee, on the contents of the online annual report, to inform the Council's consideration of
3877 this motion.

3878
3879 **B. Reporting Methodology to Show Geographic Distribution by ZIP Code**
3880 Consistent with Ordinance 19572, each annual report shall provide total expenditures of CCC Levy
3881 proceeds by crisis response zone, purpose, and strategy by ZIP code in King County, reflecting the
3882 methodology and limitations described in this subsection. DCHS will also report the number of
3883 individuals receiving CCC Levy funded services by crisis response zone, purpose, and strategy by the ZIP
3884 code in King County where the individuals resided at the time of service, also reflecting the methodology
3885 and limitations described in this subsection. ZIP code data will be reported using maps or other
3886 visualizations to aid interpretation of the data.

3887
3888 **ZIP Code Reporting Methodology**
3889 DCHS intends to report expenditures by ZIP code data for all services that operate from a fixed brick and
3890 mortar location in each CCC Levy annual report, beginning with the inaugural 2025 report. DCHS intends
3891 to align methodology and dissemination practices for reporting program expenditures by ZIP code based
3892 on available data or modeling with approaches implemented in 2023 for Best Starts for Kids, and that
3893 are planned for the Veterans, Seniors, and Human Services Levy consistent with the adopted Veterans,
3894 Seniors, and Human Services Levy Implementation Plan for 2024-2029.²⁶⁵

3895
3896 DCHS evaluators may calculate expenditures by ZIP code through service provider location and program
3897 participant residence. Both approaches provide an understanding on the spread of expenditures across
3898 King County. For example, CCC Levy service providers may provide a mix of virtual, mobile, and in-

²⁶⁵ Best Starts for Kids Implementation Plan: 2022-2027. [\[LINK\]](#)

3899 person programs and services. Reporting by service provider location may not fully capture the service
3900 reach. Alternatively, reporting by program participant residence may not capture difficulties participants
3901 may have accessing services, including transportation. Many program participants access programs in
3902 more than one way. Using more than one methodology to assess expenditures by ZIP code can help
3903 deepen understanding of how programs are accessible to people throughout the County.
3904

3905 **ZIP Code Reporting Limitations**

3906 Collection of program participant ZIP code data may be limited for some programs in the following
3907 strategies found in Section V. A. Strategy 1: Create and Operate Five Crisis Care Centers, B. Strategy 2:
3908 Restore, Expand, and Sustain Residential Treatment Capacity, C. Strategy 3: Strengthen the Community
3909 Behavioral Health Workforce, D. Strategy 4: Early Crisis Response Investments, and E. Strategy 5:
3910 Capacity Building and Technical Assistance. The limitations include activities associated with, but not
3911 limited to, mobile programs or programs serving people experiencing homelessness, refugees, people
3912 experiencing acute behavioral health crisis, or people who are survivors of domestic violence.
3913 Geographic information may not be available or relevant for programs and strategies that invest in
3914 systems and environment change and strategies that support systemwide workforce capacity building.
3915 ZIP code collection may also not be possible for programs that are required to use an existing data
3916 system that the CCC Levy cannot revise, or when a legal framework prevents the sharing of these data.
3917 All reporting by ZIP code will continue to abide by privacy and confidentiality guidelines.

3918 **IX. Crisis Care Centers Levy Advisory Body**

3919 **A. Overview**

3920 This section describes the composition, duties of, and process to establish the CCC Levy’s advisory body,
 3921 consistent with Ordinance 19572, which allows for the CCC Levy’s advisory body to be a preexisting King
 3922 County board that has relevant expertise. This Plan identifies the [King County Behavioral Health](#)
 3923 [Advisory Board \(BHAB\)](#) to serve as the advisory body because it has the relevant expertise to advise the
 3924 Executive and the Council on matters relating to behavioral health care and crisis services in King
 3925 County.²⁶⁶ Ordinance XXXXX (Proposed Ordinance 2024-0013) that accompanies this Plan will expand
 3926 BHAB’s membership requirements and duties to include those set forth in Ordinance 19572.

3927 **B. BHAB Background and Connection to CCC Levy Purposes**

3928 Integrating the CCC Levy’s advisory body duties into the BHAB will help promote the coordination and
 3929 integration of crisis services across the continuum of behavioral health care managed by King County.
 3930 BHAB is the advisory body of the King County BH-ASO. The BH-ASO is the administrative entity within
 3931 King County BHRD that contracts with the Washington State HCA to manage non-Medicaid behavioral
 3932 health services, behavioral health block grants, and other behavioral health funds, with a significant
 3933 focus on crisis services. A significant portion of King County’s existing behavioral health crisis services are
 3934 administratively organized under the BH-ASO. As the advisory body of the BH-ASO, BHAB has relevant
 3935 expertise related to King County crisis services and is well positioned to advise the Executive and Council
 3936 regarding the CCC Levy. In addition to having the relevant expertise, centralizing advisory duties within
 3937 BHAB will ensure there is a single advisory body for King County’s continuum of crisis services. This
 3938 approach is intended to help avoid system fragmentation and to promote an integrated approach to
 3939 managing crisis services at the system level.

3940
 3941 Ordinance 19572 defines the CCC Levy advisory body’s membership requirements and duties, which
 3942 complement BHAB’s existing statutory and contractual requirements. BHAB membership requirements
 3943 and duties are established in the Revised Code of Washington (RCW) 71.24.300, Washington State
 3944 Administrative Code (WAC) 182-538C-252, King County’s BHASO contract with the HCA, and King County
 3945 Code 2A.300.050.^{267,268,269,270} Thus, an expansion of the BHAB’s board member composition
 3946 requirements and advisory duties to include advising on the CCC Levy will not conflict with its state
 3947 requirements.

3948
 3949 To reduce the potential of conflicts, the reader is directed to Ordinance XXXXX (Proposed
 3950 Ordinance 2024-0013), for the composition and duties to be fulfilled the BHAB serving as the CCC Levy
 3951 advisory body.

²⁶⁶ King County Behavioral Health Advisory Board [\[LINK\]](#)

²⁶⁷ RCW 71.24.300 [\[LINK\]](#)

²⁶⁸ WAC 182-538C-230 [\[LINK\]](#)

²⁶⁹ King County Code 2A.300.050 [\[LINK\]](#)

²⁷⁰ The 2023 HCA BH-ASO contract can be obtained from DCHS.

Behavioral Health Equity Highlight

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

3952

3953 [BHAB Member Recruitment Process](#)

3954 Members of the BHAB serving at the time of this Plan’s drafting will continue to serve their advisory
3955 board terms after the Plan and its accompanying advisory board ordinance are enacted. Upon adoption
3956 of Ordinance XXXXX (Proposed Ordinance 2024-0013), as necessary to meet the membership
3957 requirements for the CCC Levy advisory body, the Executive shall undertake a recruitment process to
3958 select for appointment new members that satisfy the CCC Levy advisory body qualifications, and subject
3959 to confirmation by the Council, in accordance with K.C.C. chapter 2.28. When BHAB seats become
3960 vacant, the Executive will appoint new BHAB members, informed by the composition requirements of
3961 Ordinance XXXXX (Proposed Ordinance 2024-0013), and subject to confirmation by the Council, in
3962 accordance with K.C.C. chapter 2.28. The Regional Policy Committee will be copied on the appointment
3963 transmittal to Council.

3964

3965 [BHAB Support](#)

3966 DCHS will provide staff support to BHAB and, in consultation with BHAB, will help BHAB fulfill its
3967 required CCC Levy duties described in this section. DCHS will work to remove barriers that may dissuade
3968 persons from seeking to join BHAB. Included in those strategies will be per diem compensation.

3969

3970 [D. Expansion of BHAB’s Duties to Include the CCC Levy](#)

3971 BHAB is responsible for advising the King County BH-ASO on the design and implementation of publicly
3972 funded behavioral health services.²⁷¹ This Plan and the accompanying of Ordinance XXXXX (Proposed
3973 Ordinance 2024-0013), expand the duties of BHAB to include the CCC Levy’s advisory body duties
3974 required in Ordinance 19572. These additional required duties include:

3975

- Advise the King County Executive and Council on matters affecting the CCC Levy;
- Visit each existing crisis care center annually to better understand the perspectives and priorities of crisis care center operators, staff, and clients, and
- Report on the CCC Levy to the Council and the community through annual online reports beginning in 2025, as described in

3976

3977

3978

3979

²⁷¹ King County Behavioral Health Advisory Board Bylaws [\[LINK\]](#)

- 3980 • [VIII. Crisis Care Centers Levy Annual Reporting.](#)

3981

3982 BHAB’s additional duties related to advising the CCC Levy will go into effect on the effective date of the
3983 of Ordinance XXXXX (Proposed Ordinance 2024-0013).

3984

3985 **E. Process to Update CCC Levy Advisory Body if Necessary**

3986 Existing BHAB membership requirements and duties defined by state law and state contracts may be
3987 updated during this Plan’s term. These potential changes could require adjustment of BHAB’s
3988 membership composition or duties that are described in this Plan and the accompanying of Ordinance
3989 XXXXX (Proposed Ordinance 2024-0013). If BHAB’s requirements are updated by the state in a way that
3990 is no longer compatible with the CCC Levy or if the Executive determines that a different CCC advisory
3991 body will better serve effective administration of the CCC Levy, then the Executive may propose an
3992 ordinance to the Council to update the CCC Levy’s advisory body structure, that will not require an
3993 amendment to this Plan. If the Executive proposes an ordinance to Council to update the CCC Levy's
3994 advisory board structure, the Executive will notify the Regional Policy Committee.

3995 **X. Conclusion**

3996 King County voters approved the Crisis Care Centers Levy on April 25, 2023. The nine-year levy begins on
 3997 January 1, 2024, starting an ambitious timeline to transform the region’s behavioral health crisis
 3998 response system, restore the region’s flagging mental health residential facilities, and reinforce the
 3999 workforce — the people — upon whom tens of thousands of King County residents depend for their
 4000 behavioral health. This Plan lays the path that King County, cities and other local jurisdictions, and
 4001 behavioral health providers must travel with urgency, common purpose, and strong partnership so that
 4002 future generations will have a safe, accessible, and effective place to go in a moment of mental health or
 4003 substance use crisis.

4004
 4005 **King County begins this levy at a critical moment.** The other systems upon which society depends —
 4006 schools, the legal system, housing providers, first responders, hospitals, employers, and so many more
 4007 — newly recognize that they cannot fully function if the people they serve cannot get behavioral health
 4008 care. Federal and state funding for behavioral health have not kept pace with needs, and local
 4009 communities, families, and individuals bear the results. Without better options, too many King County
 4010 residents experiencing a crisis have languished in a jail, emergency room, on the street, or alone in their
 4011 home when what they needed was a place they could get same-day care from a trained and supportive
 4012 professional in a setting that helps, instead of making symptoms or underlying conditions worse.

4013
 4014 **The Crisis Care Centers Levy also comes at a moment of new opportunity.** Other communities have
 4015 tested and proven models of care and facility types that help people get better. Mental health and
 4016 substance use treatments work when they are accessible and properly administered with dignity. The
 4017 new 988 crisis line gives people in crisis someone they can call. Governments at all levels are investing in
 4018 new teams and approaches that respond to more emergency calls with behavioral health clinicians.

4019
 4020 At this moment when long-forming needs meet new attitudes and infrastructures, people in crisis
 4021 increasingly have *someone they can call* and *someone to respond* to those calls. This Plan describes how
 4022 King County will focus new resources and efforts to create *somewhere for people to go* — and to know
 4023 that there will be providers there to help.

4024
 4025 **But plans do not by themselves make change.** Creating a regional network of crisis care centers,
 4026 restoring the region’s recently lost residential treatment capacity, and growing and better supporting a
 4027 more representative workforce in nine years will require King County, cities and other local jurisdictions,
 4028 and providers to work together in new ways. King County must fully resource and staff this Plan’s
 4029 strategies, maintaining disciplined prioritization — and avoiding diffusion — of the Levy’s proceeds and
 4030 staff capacity. Cities, other local jurisdictions, and communities must embrace and support development
 4031 of new behavioral health facilities. Providers will need to incorporate new practices, integrate services,
 4032 and coordinate care with new partners. All must communicate, collaborate, and be accountable with a
 4033 new commitment to creating a behavioral health system and model of cooperation that future
 4034 generations will be proud of and depend on.

4035
 4036 **The Crisis Care Centers Levy provides the resources. This Plan lays the path. The task is now to King**
 4037 **County, cities, and providers to make it happen.**

4038 **XI. Appendices**

4039 **Appendix A: Crisis Care Centers Levy Ordinance 19572 Text**

4040 AN ORDINANCE providing for the submission to the qualified electors of King County at a special election
4041 to be held in King County on April 25, 2023, of a proposition authorizing a property tax levy in excess of
4042 the levy limitation contained in chapter 84.55 RCW, for a consecutive nine-year period, at a first year
4043 rate of not more than \$0.145 per one thousand dollars of assessed valuation for collection beginning in
4044 2024, with the 2024 levy amount being the base for calculating increases in years two through nine
4045 (2025 - 2032) by the limit factor in chapter 84.55 RCW, as amended, for regional behavioral health
4046 services and capital facilities to establish and operate a regional network of behavioral health crisis care
4047 centers; to preserve, expand and maintain residential treatment facilities; to provide behavioral health
4048 workforce supports; to provide mobile crisis care and post-discharge stabilization; to pay, finance or
4049 refinance costs of those projects; and for administration, coordination, implementation and evaluation
4050 of levy activities.

4051

4052 STATEMENT OF FACTS:

- 4053 1. King County's behavioral health crisis service system relies heavily on phone support and outreach
4054 services, with very few options of places for persons to go for immediate, life-saving care when in crisis.
4055 2. As of September 2022, the Crisis Solutions Center, operated by Downtown Emergency Service Center
4056 and requiring mobile team, first responder or hospital referral for entry, is the only voluntary behavioral
4057 health crisis facility for the entirety of King County, and no walk-in urgent care behavioral health facility
4058 exists in King County.
4059 3. A coalition of community leaders and behavioral health providers issued recommendations to Seattle
4060 and King County in an October 13, 2021, letter that included recommendations to "expand places for
4061 people in crisis to receive immediate support" and "expand crisis response and post-crisis follow up
4062 services."
4063 4. Call volume to King County's regional behavioral health crisis line increased by 25 percent between
4064 2019 and 2021, from 82,523 calls in 2019 to 102,754 calls in 2021.
4065 5. The number of persons per year who received community-based behavioral health crisis response
4066 services in King County increased 146 percent between 2012 and 2021, from 1,764 persons served in
4067 2012 to 4,336 persons served in 2021.
4068 6. Referrals for mobile crisis outreach in King County grew 15 percent between 2019 and 2021, from
4069 4,030 referrals in 2019 to 4,648 referrals in 2021.
4070 7. King County's designated crisis responders conducted 14 percent more investigations for involuntary
4071 behavioral health treatment in 2021, when they investigated 9,189 cases, than in 2017 when they
4072 investigated 8,066 cases. There was a 10 percent increase in detentions or revocations for involuntary
4073 hospitalization during that same period, from 4,387 in 2017 to 4,806 in 2021.
4074 8. The wait time for a King County resident in behavioral health crisis in a community setting to be
4075 evaluated for involuntary behavioral health treatment tripled between January 2019 and June 2022,
4076 from 4 days to 12 days.
4077 9. The U.S. Department of Health and Human Services reported that in August 2022, the first full month
4078 that the new national 988 Suicide and Crisis Lifeline was operational, the overall volume of calls, texts
4079 and chats to the Lifeline increased by 152,000 contacts, or 45 percent, compared to the number of
4080 contacts to the National Suicide Prevention Lifeline in August 2021.
4081 10. The federal Substance Abuse and Mental Health Services Administration's ("SAMHSA's") National
4082 Guidelines for Behavioral Health Crisis Care, and its vision for the implementation of the new national

4083 988 Suicide and Crisis Lifeline, call for the development of safe places for persons in crisis to go for help
4084 as part of a robust behavioral health crisis system.

4085 11. In 2021, the Washington state Legislature passed Engrossed Second Substitute House Bill 1477,
4086 which became Chapter 302, Laws of Washington 2021, to support implementation of 988 in
4087 Washington, to further SAMHSA's overall vision and build on the crisis phone line change by expanding
4088 and transforming crisis services.

4089 12. RCW 71.24.025 defines crisis stabilization services to mean services such as 23-hour crisis
4090 stabilization units based on the living room model, crisis stabilization centers, short-term respite
4091 facilities, peer-operated respite services, and behavioral health urgent care walk-in centers, including
4092 within the overall crisis system components that operate like hospital emergency departments and
4093 accept all walk-ins, and ambulance, fire, and police drop-offs. Chapter 302, Laws of Washington 2021
4094 further expressed the state legislature's intent to expand the behavioral health crisis delivery system to
4095 include these components.

4096 13. Multiple behavioral health system needs assessments have identified the addition of crisis facilities
4097 as top priorities to improve community-based crisis services in King County. Such assessments include
4098 the 2016 recommendations of the Community Alternatives to Boarding Task Force called for by Motion
4099 14225, a Washington state Office of Financial Management behavioral health capital funding
4100 prioritization and feasibility study in 2018, and a Washington state Health Care Authority crisis triage
4101 and stabilization capacity and gaps report in 2019.

4102 14. King County is losing mental health residential treatment capacity that is essential for persons who
4103 need more intensive supports to live safely in the community due to rising operating costs and aging
4104 facilities that need repair or replacement. As of August 2022, King County had a total of 244 mental
4105 health residential beds for the entire county, down 111 beds, or nearly one third, from the capacity in
4106 2018 of 355 beds.

4107 15. As of July 2022, King County residents who need mental health residential services must wait an
4108 average of 44 days before they are able to be placed in a residential facility.

4109 16. Data from the U.S. Centers for Disease Control and Prevention, the U.S. Census Bureau and the
4110 Kaiser Family Foundation show that about three in ten adults in the United States reported symptoms of
4111 anxiety or depressive disorder in June 2022, up from one in ten adults who reported these symptoms in
4112 2019.

4113 17. The National Council for Mental Wellbeing's 2022 access to care survey found that 43 percent of
4114 U.S. adults who say they need mental health or substance use care did not receive that care, and they
4115 face numerous barriers to accessing and receiving needed treatment.

4116 18. According to the Washington state Department of Social and Health Services, the number of
4117 Medicaid enrollees in King County with an identified mental health need increased by approximately 34
4118 percent for adults and nine percent for youth between 2019 and 2021.

4119 19. The Washington state Department of Social and Health Services reports that in 2021, among those
4120 enrolled in Medicaid in King County, nearly half of adults and over a third of youth with an identified
4121 mental health need did not receive treatment.

4122 20. The Washington state Department of Social Health Services reports that in 2021, among those
4123 enrolled in Medicaid in King County, approximately 62 percent of adults and 80 percent of youth with an
4124 identified substance use disorder need did not receive treatment.

4125 21. SAMHSA's National Guidelines for Behavioral Health Crisis Care recommend including peers with
4126 lived experience of mental health conditions or substance use disorders on crisis response teams. Those
4127 guidelines also feature the living room model as an example of crisis service delivery innovation
4128 featuring peers.

4129 22. The 2021 King County nonprofit wage and benefits survey showed that many nonprofit employees
4130 delivering critical services earn wages at levels that make it difficult to sustain a career doing
4131 community-based work in this region.

4132 23. A 2021 King County survey of member organizations of the King County Integrated Care Network
4133 found that job vacancies at these community behavioral health agencies were at least double what they
4134 were in 2019. Providers cited professionals' ability to earn more in medical systems or private practice,
4135 and the high cost of living in the King County region, as the top reasons their workers were leaving
4136 community behavioral healthcare.

4137 24. The behavioral health workforce advisory committee to the state of Washington's Workforce
4138 Training and Education Coordinating Board found in 2021 that Washington continues to face a shortage
4139 of behavioral health professionals, while demand for services, and qualified workers to deliver them,
4140 continues to grow. The advisory committee also found that workers need increased financial support
4141 and incentives to remain in community behavioral health care.

4142

4143 BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:

4144 **SECTION 1. Definitions.** The definitions in this section apply throughout this ordinance unless the
4145 context clearly requires otherwise.

4146 A. "Crisis care center" means a single facility or a group of facilities that provide same-day access to
4147 multiple types of behavioral health crisis stabilization services, which may include, but are not limited to,
4148 those described in RCW 71.24.025(20), as amended. A crisis care center shall endeavor to accept at
4149 least for initial screening and triage any person who seeks behavioral health crisis care. Among the
4150 types of behavioral health crisis stabilization services that a crisis care center shall provide are a
4151 behavioral health urgent care clinic that offers walk-in and drop-off client screening and triage twenty-
4152 four hours per day, seven days per week; access to onsite assessment by a designated crisis responder; a
4153 twenty-three-hour observation unit or similar facility and service that allows for short-term, onsite
4154 stabilization of a person experiencing a behavioral health crisis; and a crisis stabilization unit that
4155 provides short-term, onsite behavioral health treatment for up to fourteen days or a similar short-term
4156 behavioral health treatment facility and service. A crisis care center shall be staffed by a
4157 multidisciplinary team that includes peer counselors. A crisis care center may incorporate pre-existing
4158 facilities that provide crisis stabilization services so long as their services and operations are compatible
4159 with this definition. Where a crisis care center is composed of more than one facility, those facilities
4160 shall either be geographically adjacent or shall have transportation provided between them to allow
4161 persons using or seeking service to conveniently move between facilities.

4162 B. "Designated crisis responder" has the same meaning as in RCW 71.05.020, as amended.

4163 C. "King County crisis response zone" means each of four geographic subregions of King County:

4164 1. North King County crisis response zone, which is the portion of King County within the boundaries of
4165 the cities of Bothell, Duvall, Kenmore, Kirkland, Lake Forest Park, Shoreline, Skykomish and Woodinville,
4166 plus the unincorporated areas within King County council district three as it is drawn on the effective
4167 date of this ordinance that are north or northeast of the city of Redmond;

4168 2. Central King County crisis response zone, which is the portion of King County within the boundaries
4169 of the city of Seattle, plus all unincorporated areas within King County council districts two and eight as
4170 they are drawn on the effective date of this ordinance;

4171 3. South King County crisis response zone, which is the portion of King County within the boundaries of
4172 the cities of Algona, Auburn, Black Diamond, Burien, Covington, Des Moines, Enumclaw, Federal Way,
4173 Kent, Maple Valley, Milton, Normandy Park, Pacific, Renton, SeaTac and Tukwila, plus all unincorporated
4174 areas within King County council districts five, seven and nine as they are drawn on the effective date of
4175 this ordinance; and

4176 4. East King County crisis response zone, which is the portion of King County within the boundaries of
4177 the cities of Beaux Arts, Bellevue, Carnation, Clyde Hill, Hunts Point, Issaquah, Medina, Mercer Island,
4178 Newcastle, North Bend, Redmond, Sammamish, Snoqualmie and Yarrow Point, plus the unincorporated
4179 areas within King County council district three as it is drawn on the effective date of this ordinance that
4180 are east or southeast of the city of Redmond, plus all unincorporated areas within King County council
4181 district six as it is drawn on the effective date of this ordinance.

4182 D. "Levy" means the levy of regular property taxes for the specific purposes and term provided in this
4183 ordinance and authorized by the electorate in accordance with state law.

4184 E. "Levy proceeds" means the principal amount of moneys raised by the levy and any interest earnings
4185 on the moneys and the proceeds of any interim or other financing following authorization of the levy.

4186 F. "Regional behavioral health services and capital facilities" means programs, services, activities,
4187 operations, staffing and capital facilities that: promote mental health and wellbeing and that treat
4188 substance use disorders and mental health conditions; promote integrated physical and behavioral
4189 health; promote and provide therapeutic responses to behavioral health crises; promote equitable and
4190 inclusive access to mental health and substance use disorder services and capital facilities for those
4191 racial, ethnic, experiential and geographic communities that experience disparities in mental health and
4192 substance use disorder conditions and outcomes; build the capacity of mental health and substance use
4193 disorder service providers to improve the effectiveness, efficiency, and equity, of their services and
4194 operations; provide transportation to care for persons receiving, seeking, or in need, of mental health or
4195 substance use disorder services; promote housing stability for persons receiving or leaving care from a
4196 facility providing mental health or substance use disorder services; promote service and response
4197 coordination, data sharing, and data integration amongst first responders, mental health and substance
4198 use disorder providers, and King County staff; promote community participation in levy activities,
4199 including payment of stipends to persons with relevant lived experience who participate in levy activities
4200 whose employment does not already compensate them for such participation; administer, coordinate
4201 and evaluate levy activities; apply for federal, state and philanthropic moneys and assistance to
4202 supplement levy proceeds; and promote stability and sustainability of the behavioral health workforce.

4203 G. "Residential treatment" means a licensed, community-based facility that provides twenty-four-hour
4204 on-site care for persons with mental health conditions, substance use disorders, or both, in a residential
4205 setting.

4206 H. "Strategy" means a program, service, activity, initiative or capital investment intended to achieve the
4207 purposes described in section 4 of this ordinance.

4208 I. "Technical assistance and capacity building" means assisting organizations in applying for grants
4209 funded by the levy and in implementing and improving delivery of a strategy or strategies for which levy
4210 moneys are eligible, and includes assisting community-based organizations in delivery of strategies to
4211 persons and communities that are disproportionately impacted by behavioral health conditions.

4212 **SECTION 2. Levy submittal.** To provide necessary moneys to fund, finance or refinance the purposes
4213 identified in section 4 of this ordinance, the King County council shall submit to the qualified electors of
4214 the county a proposition authorizing a regular property tax levy in excess of the levy limitation contained
4215 in chapter 84.55 RCW for nine consecutive years, with collection commencing in 2024, at a rate not to
4216 exceed \$0.145 per one thousand dollars of assessed value in the first year of the levy period. The dollar
4217 amount of the levy in the first year shall be the base upon which the maximum allowable levy amounts
4218 in years two through nine (2025-2032) shall be calculated using the limit factor in chapter 84.55 RCW, as
4219 amended.

4220 **SECTION 3. Deposit of levy proceeds.** The levy proceeds shall be deposited into the crisis care centers
4221 fund, or its successor.

4222 **SECTION 4. Levy purposes.**

4223 A. The paramount purpose of the levy shall be to establish and operate a regional network of five crisis
4224 care centers in King County, with each of the four King County crisis response zones containing at least
4225 one crisis care center and at least one of the five crisis care centers specializing in serving persons
4226 younger than nineteen years old.

4227 B. The levy's supporting purpose one shall be to restore the number of mental health residential
4228 treatment beds in King County to at least three hundred fifty-five beds and to expand the availability
4229 and sustainability of residential treatment in King County.

4230 C. The levy's supporting purpose two shall be to increase the sustainability and representativeness of
4231 the behavioral health workforce in King County by increasing recruitment and retention, and by
4232 improving financial sustainability for the behavioral health workforce through increased wages,
4233 apprenticeship programming and, where possible, reduction of costs such as costs of insurance, child
4234 care, caregiving and fees or tuition associated with behavioral health training and certification. This
4235 purpose shall promote workforce recruitment and retention for the region's behavioral health
4236 workforce while prioritizing increased wages and reduction of costs for the behavioral health workforce
4237 who are providing regional behavioral health services and capital facilities as a part of the levy's
4238 paramount purpose.

4239 D. The levy implementation plan required by section 7 of this ordinance may specify additional
4240 supporting purposes so long as those additional supporting purposes are not inconsistent with and are
4241 subordinate to the paramount purpose and supporting purposes one and two described in subsections
4242 A. through C. of this section.

4243 **SECTION 5. Eligible expenditures.**

4244 A. If approved by the qualified electors of the county, such sums from the first year's levy proceeds as
4245 are necessary may be used to provide for the costs and charges incurred by the county that are
4246 attributable to the election, and an amount from the first year's levy proceeds not to exceed one million
4247 dollars may be used for initial levy implementation planning activities.

4248 B. After the amounts authorized in subsection A. of this section, the remaining levy proceeds shall not
4249 be expended until King County enacts an ordinance adopting the implementation plan required by
4250 section 7 of this ordinance. The council's process to consider and adopt the levy implementation plan
4251 and any amendments shall include mandatory referral to the regional policy committee or its
4252 successor. After King County enacts an ordinance adopting the levy implementation plan, levy proceeds
4253 shall be expended in accordance with the implementation plan, as amended, and with this ordinance.

4254 C. Levy proceeds described in subsection B. of this section shall only be used to fund, finance or
4255 refinance costs to:

4256 1. Plan, site, construct, acquire, restore, maintain, operate, implement, staff, coordinate, administer
4257 and evaluate regional behavioral health services and capital facilities that achieve and maintain the
4258 paramount purpose, supporting purpose one, and supporting purpose two of the levy that are described
4259 in section 4. and as they may be further described in the implementation plan;

4260 2. Plan, site, construct, acquire, restore, maintain, operate, implement, staff, coordinate, administer
4261 and evaluate regional behavioral health services and capital facilities that achieve additional levy
4262 purposes that are included in the implementation plan, so long as those purposes are subordinate to
4263 and not inconsistent with the paramount purpose and supporting purposes one and two; and

4264 3. Provide for regional behavioral health services and capital facilities provided by metropolitan park
4265 districts, fire districts or local public hospital districts in King County in an amount up to the lost
4266 revenues to the individual district resulting from prorationing, as mandated by RCW 84.52.010, to the
4267 extent the levy was a demonstrable cause of the prorationing and only if the county council has
4268 authorized the expenditure by ordinance.

4269 D. Unless made otherwise eligible in subsection C. of this section, levy proceeds shall not be used to
4270 provide, supplant, replace or expand funding for non-behavioral health purposes including, but not
4271 limited to, jails, prisons, courts of law, criminal prosecution, criminal defense or law enforcement,
4272 except for costs that provide or coordinate regional behavioral health services and capital facilities
4273 within or between crisis care centers and other health care settings or that remove or reduce a barrier
4274 to receiving behavioral health services such as quashing a warrant. Nothing in this subsection shall be
4275 interpreted or construed to limit, discourage, or impede law enforcement agencies' or other first
4276 responders' coordination with, use of and access to crisis care centers for persons they encounter in the
4277 conduct of their duties.

4278 **SECTION 6. Call for special election.** In accordance with RCW 29A.04.321, the King County council
4279 hereby calls for a special election to be held on April 25, 2023, to consider a proposition authorizing a
4280 regular property tax levy for the purposes described in this ordinance. The King County director of
4281 elections shall cause notice to be given of this ordinance in accordance with the state constitution and
4282 general law and to submit to the qualified electors of the county, at the said special county election, the
4283 proposition hereinafter set forth. The clerk of the council shall certify that proposition to the director of
4284 elections in substantially the following form:

4285 PROPOSITION____: The King County Council passed Ordinance ____ concerning funding for
4286 mental health and substance use disorder services. If approved, this proposition would fund
4287 behavioral health services and capital facilities, including a countywide crisis care centers
4288 network, increased residential treatment; mobile crisis care; post-discharge stabilization; and
4289 workforce supports. It would authorize an additional nine-year property tax levy for collection
4290 beginning in 2024 at \$0.145 per \$1,000 of assessed valuation, with the 2024 levy amount being
4291 the base for calculating annual increases in 2025-2032 under chapter 84.55 RCW, and exempt
4292 eligible seniors, veterans, and disabled persons under RCW 84.36.381. Should this proposition
4293 be:

4294 Approved? _____

4295 Rejected? _____

4296 **SECTION 7. Implementation plan.**

4297 A. If voters approve the levy, the executive shall transmit by December 31, 2023, a proposed levy
4298 implementation plan for council review and adoption by ordinance. The proposed implementation plan
4299 shall direct levy expenditures from 2024 through 2032.

4300 B. The executive shall electronically file the implementation plan required in subsection A. of this
4301 section with the clerk of the council, who shall retain the original and provide an electronic copy to all
4302 councilmembers, the council chief of staff, the policy staff director and the lead staff for the law, justice,
4303 health and human services committee and the regional policy committee, or their successors. The
4304 implementation plan shall be accompanied by proposed ordinances that adopt the implementation plan
4305 and that establish or empower the advisory body, the description of which is set forth in subsection C.9.
4306 of this section.

4307 C. The implementation plan required in subsection A. shall include:

4308 1. A list and descriptions of the purposes of the levy, which must at least include and may not materially
4309 impede accomplishment of the paramount purpose and supporting purposes one and two described in
4310 section 4 of this ordinance;

4311 2. A list and descriptions of strategies and allowable activities to achieve the purposes described in
4312 subsection C.1. of this section, which strategies shall at least include:

4313 a. planning, capital, operations and services investments for crisis care centers, which may include
4314 construction of new or acquisition, renovation, updating or expanding existing buildings in whole or in
4315 part;

- 4316 b. capital and maintenance investments for mental health residential treatment capacity;
- 4317 c. investments to increase attraction to, retention in, and sustainability of the behavioral health
- 4318 workforce;
- 4319 d. establishment and maintenance of levy and capital reserves to promote continuity of levy-funded
- 4320 activities and prioritization of the paramount purpose and then supporting purposes one and two in the
- 4321 event of fluctuations in levy revenue or strategy costs;
- 4322 e. activities that promote post-crisis stabilization, including housing stability, for persons receiving or
- 4323 discharging from levy-funded services;
- 4324 f. a plan for the initial period of the levy prior to initiation of operations of the first crisis care center for
- 4325 the provision of mobile and site-based behavioral health activities that promote access to behavioral
- 4326 health services for persons experiencing or at risk of a behavioral health crisis;
- 4327 g. technical assistance and capacity building for organizations applying for or receiving levy funding,
- 4328 including a strategy or strategies to promote inclusive care at levy-funded facilities for racial, ethnic and
- 4329 other demographic groups that experience disproportionate rates of behavioral health conditions in
- 4330 King County;
- 4331 h. capital facility siting support, communication and city partnership activities;
- 4332 i. levy administration activities and activities that monitor and promote coordination, more effective
- 4333 crisis response, and quality of care within and amongst crisis care centers, other behavioral health crisis
- 4334 response services in King County, and first responders; and
- 4335 j. performance measurement and evaluation activities;
- 4336 3. A financial plan to direct the use of the proceeds for regional behavioral health services and capital
- 4337 facilities that achieve the purposes and strategies described in subsection C.1. and 2. of this section,
- 4338 which must at a minimum include:
- 4339 a. the forecast of annual revenue for each year of the levy;
- 4340 b. an annual expenditure plan for each year of the levy that allocates forecasted levy proceeds among
- 4341 the levy's strategies;
- 4342 c. a description of the sequence and timing of planned expenditures and activities to establish and
- 4343 operate the regional network of five crisis care centers required to satisfy the levy's paramount purpose;
- 4344 and
- 4345 d. a description of how a portion of first-year levy proceeds will be allocated to make rapid initial
- 4346 progress towards fulfilling supporting purposes one and two;
- 4347 4. A description of how the executive will seek and incorporate when available federal, state,
- 4348 philanthropic and other moneys that are not proceeds of the levy to accelerate, enhance, compliment or
- 4349 sustain accomplishment the levy's paramount purpose and supporting purposes one and two;
- 4350 5. A description of the executive's assumptions about the role of Medicaid funding in the financial plan
- 4351 and the executive's planned approach to billing eligible crisis care services to Medicaid or other sources
- 4352 of potential payment such as private insurance;
- 4353 6. A description of the process by which King County and partner cities shall collaborate to support
- 4354 siting of new capital facilities that use proceeds from the levy for such facilities' construction or
- 4355 acquisition;
- 4356 7. A summary of the process and key findings of the community and stakeholder engagement process
- 4357 that informs the proposed implementation plan;
- 4358 8. A process to make substantial adjustments to the financial plan required in subsection C.3. of this
- 4359 section, which process shall require notice to the council and provide for the council the ability to stop
- 4360 any substantial adjustment that the council does not support;
- 4361 9. A description of the composition, duties of, and process to establish the advisory body for the
- 4362 levy. The advisory body may be a preexisting King County board or commission that has relevant

4363 expertise or a new advisory body. The composition of the advisory body shall be demographically
4364 representative of the population of King County and shall include at least one resident of each King
4365 County crisis response zone, persons who have previously received crisis stabilization services, and
4366 persons with professional training and experience in the provision of behavioral health crisis care. The
4367 duties of the advisory body shall include advising the executive and council on matters pertaining to
4368 implementation of the levy, annually visiting each existing crisis care center and reporting annually to
4369 the council and community, through online annual reports beginning in 2025, on the levy's progress
4370 over the previous year towards accomplishing the levy purposes described in section 4 of this ordinance
4371 and on the levy's actual financial expenditures in the previous year relative to the financial plan required
4372 in subsection C.3. of this section that shall include, but not be limited to, the following:

4373 a. total expenditure of levy proceeds by crisis response zone, strategy, and levy purpose by ZIP Code in
4374 King County; and

4375 b. the number of individuals receiving levy-funded services by crisis response zone, strategy, and levy
4376 purpose by ZIP Code in King County of where the individuals reside at the time of service;

4377 10. A description of how the executive shall provide each online annual report described in subsection
4378 C.9. of this section to the clerk of the council, to all councilmembers and all members and alternate
4379 members of the regional policy committee, or its successor, including confirmation that the executive
4380 shall electronically file a proposed motion that shall acknowledge receipt of the report; and

4381 11. A description of how the purpose of the crisis response zones described in this levy will promote
4382 geographic distribution of crisis care centers so that they are accessible for walk-in and drop-off crisis
4383 care throughout King County, but that the crisis care zones shall not be used to limit the ability of any
4384 person in King County to use any particular crisis care center.

4385 **SECTION 8. Updating the definition of crisis care center.** If new research, changing best practices,
4386 updated federal or state regulations or other evidence-based factors cause this ordinance's definition of
4387 "crisis care center" to become infeasible, impracticable or inconsistent with the levy's paramount
4388 purpose, King County may, upon recommendation of the advisory body described in section 7.C.9. of
4389 this ordinance and with mandatory referral to the regional policy committee, update the definition of
4390 "crisis care center" through adoption of an ordinance to a definition substantially similar to what is
4391 recommended by the advisory body.

4392 **SECTION 9. Exemption.** The additional regular property taxes authorized by this ordinance shall be
4393 included in any real property tax exemption authorized by RCW 84.36.381.

4394 **SECTION 10. Ratification and confirmation.** Certification of the proposition by the clerk of the county
4395 council to the director of elections in accordance with law before the special election on April 25, 2023,
4396 and any other act consistent with the authority and before the effective date of this ordinance are
4397 hereby ratified and confirmed.

4398 **SECTION 11. Severability.** If any provision of this ordinance or its application
4399 to any person or circumstance is held invalid, the remainder of the ordinance or the application of the
4400 provision to other persons or circumstances is not affected.

4401

4402 **Appendix B: Crosswalk of Implementation Plan Requirements from King County Ordinance**
 4403 **19572**
 4404

Crosswalk of Implementation Plan Requirements from King County Ordinance 19572²⁷²	
King County Ordinance 19572 Requirements	Implementation Plan Section(s)
List and Descriptions of Purposes of the Levy	See Section(s)
1. A list and descriptions of the purposes of the levy, which must at least include and may not materially impede accomplishment of the paramount purpose and supporting purposes one and two described in section 4 of this ordinance;	<ul style="list-style-type: none"> • Section IV. Crisis Care Centers Levy Purposes
List and Descriptions of Strategies and Allowable Activities	See Section(s)
2. A list and descriptions of strategies and allowable activities to achieve the purposes described in subsection C.1. of this section, which strategies shall at least include:	<ul style="list-style-type: none"> • Section V. Crisis Care Centers Levy Strategies and Allowable Activities
<i>Crisis Care Centers</i>	See Section(s)
a. planning, capital, operations and services investments for crisis care centers, which may include construction of new or acquisition, renovation, updating or expanding existing buildings in whole or in part;	<ul style="list-style-type: none"> • Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers
<i>Mental Health Residential</i>	See Section(s)
b. capital and maintenance investments for mental health residential treatment capacity;	<ul style="list-style-type: none"> • Section V.B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity
<i>Behavioral Health Workforce</i>	See Section(s)
c. investments to increase attraction to, retention in, and sustainability of the behavioral health workforce;	<ul style="list-style-type: none"> • Section V.C. Strategy 3: Strengthen the Community Behavioral Health Workforce
<i>Reserves</i>	See Section(s)
d. establishment and maintenance of levy and capital reserves to promote continuity of levy-funded activities and prioritization of the paramount purpose and then supporting purposes one and two in the event of fluctuations in levy revenue or strategy costs;	<ul style="list-style-type: none"> • Section V.H. Strategy 8: Crisis Care Centers Levy Reserves
<i>Post-Crisis Stabilization/Discharge Resources incl Housing Stability</i>	See Section(s)
e. activities that promote post-crisis stabilization, including housing stability, for persons receiving or discharging from levy-funded services;	<ul style="list-style-type: none"> • Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers
<i>Plan for Initial Levy Period: Mobile and Site-Based BH Activities</i>	See Section(s)
f. a plan for the initial period of the levy prior to initiation of operations of the first crisis care center for the provision of mobile and site-based behavioral health activities that promote access to	<ul style="list-style-type: none"> • Section V.D. Strategy 4: Early Crisis System Investments

²⁷² King County Ordinance 19572 [[LINK](#)].

Crosswalk of Implementation Plan Requirements from King County Ordinance 19572²⁷²	
King County Ordinance 19572 Requirements	Implementation Plan Section(s)
behavioral health services for persons experiencing or at risk of a behavioral health crisis;	
<i>Technical Assistance and Capacity-Building</i>	<i>See Section(s)</i>
g. technical assistance and capacity building for organizations applying for or receiving levy funding, including ...	<ul style="list-style-type: none"> • Section V.E. Strategy 5: Capacity Building and Technical Assistance
... a strategy or strategies to promote inclusive care at levy-funded facilities for racial, ethnic and other demographic groups that experience disproportionate rates of behavioral health conditions in King County;	<ul style="list-style-type: none"> • Section V.E. Strategy 5: Capacity Building and Technical Assistance
<i>Capital Facility Siting Support, Communication, City Partnership</i>	<i>See Section(s)</i>
h. capital facility siting support, communication and city partnership activities;	<ul style="list-style-type: none"> • Section V.E. Strategy 5: Capacity Building and Technical Assistance
<i>Administration, Coordination, and Quality</i>	<i>See Section(s)</i>
i. levy administration activities and activities that monitor and promote coordination, more effective crisis response, and quality of care within and amongst crisis care centers, other behavioral health crisis response services in King County, and first responders, and	<ul style="list-style-type: none"> • Section V.G. Strategy 7: Crisis Care Centers Levy Administration
<i>Performance Measurement and Evaluation</i>	<i>See Section(s)</i>
j. performance measurement and evaluation activities;	<ul style="list-style-type: none"> • Section V.F. Strategy 6: Evaluation and Performance Measurement Activities
Financial Plan: Revenue Forecast and Expenditures by Strategy	See Section(s)
3. A financial plan to direct the use of the proceeds for regional behavioral health services and capital facilities that achieve the purposes and strategies described in subsection C.1. and 2. of this section, which must at a minimum include:	<ul style="list-style-type: none"> • Section VI. Financial Plan
a. the forecast of annual revenue for each year of the levy;	<ul style="list-style-type: none"> • Section VI. Financial Plan
b. an annual expenditure plan for each year of the levy that allocates forecasted levy proceeds among the levy's strategies;	<ul style="list-style-type: none"> • Section VI. Financial Plan
<i>Sequence and Timing of Planned Expenditures/Activities to establish CCCs</i>	<i>See Section(s)</i>
c. a description of the sequence and timing of planned expenditures and activities to establish and operate the regional network of five crisis care centers required to satisfy the levy's paramount purpose; and	<ul style="list-style-type: none"> • Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers
<i>Description of Use of Portion of First-Year Revenue for Rapid Progress on MH Residential and Workforce</i>	<i>See Section(s)</i>

Crosswalk of Implementation Plan Requirements from King County Ordinance 19572²⁷²	
King County Ordinance 19572 Requirements	Implementation Plan Section(s)
d. a description of how a portion of first-year levy proceeds will be allocated to make rapid initial progress towards fulfilling supporting purposes one and two;	<ul style="list-style-type: none"> • Section V.B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity • Section V.C. Strategy 3: Strengthen the Community Behavioral Health Workforce
Plan to Seek Other Funds to Accelerate/Enhance Levy Purposes	<i>See Section(s)</i>
4. A description of how the executive will seek and incorporate when available federal, state, philanthropic and other moneys that are not proceeds of the levy to accelerate, enhance, compliment or sustain accomplishment the levy's paramount purpose and supporting purposes one and two;	<ul style="list-style-type: none"> • Section VI. Financial Plan
Description of Medicaid and Private Insurance Assumptions	<i>See Section(s)</i>
5. A description of the executive's assumptions about the role of Medicaid funding in the financial plan and the executive's planned approach to billing eligible crisis care services to Medicaid or other sources of potential payment such as private insurance;	<ul style="list-style-type: none"> • Section VI. Financial Plan
Description of Collaboration with Cities in Siting	<i>See Section(s)</i>
6. A description of the process by which King County and partner cities shall collaborate to support siting of new capital facilities that use proceeds from the levy for such facilities' construction or acquisition;	<ul style="list-style-type: none"> • Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers • Section V.B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity
Community and Stakeholder Engagement Summary	<i>See Section(s)</i>
7. A summary of the process and key findings of the community and stakeholder engagement process that informs the proposed implementation plan;	<ul style="list-style-type: none"> • Section III. Background
Process for Substantial Adjustments to Financial Plan	<i>See Section(s)</i>
8. A process to make substantial adjustments to the financial plan required in subsection C.3. of this section, which process shall require notice to the council and provide for the council the ability to stop any substantial adjustment that the council does not support;	<ul style="list-style-type: none"> • Section VI. Financial Plan
Advisory Body (New or Preexisting)	<i>See Section(s)</i>
9. A description of the composition, duties of, and process to establish the advisory body for the levy. ...	<ul style="list-style-type: none"> • Section IX. Crisis Care Centers Levy Advisory Body
...The advisory body may be a preexisting King County board or commission that has relevant expertise or a new advisory body. ...	<ul style="list-style-type: none"> • Section IX. Crisis Care Centers Levy Advisory Body
Advisory Body Composition	<i>See Section(s)</i>

Crosswalk of Implementation Plan Requirements from King County Ordinance 19572²⁷²	
King County Ordinance 19572 Requirements	Implementation Plan Section(s)
... The composition of the advisory body shall be	<ul style="list-style-type: none"> • Section IX. Crisis Care Centers Levy Advisory Body
... demographically representative of the population of King County and shall include ...	<ul style="list-style-type: none"> • Section IX. Crisis Care Centers Levy Advisory Body
... at least one resident of each King County crisis response zone, ...	<ul style="list-style-type: none"> • Section IX. Crisis Care Centers Levy Advisory Body
... persons who have previously received crisis stabilization services, and ...	<ul style="list-style-type: none"> • Section IX. Crisis Care Centers Levy Advisory Body
... persons with professional training and experience in the provision of behavioral health crisis care. ...	<ul style="list-style-type: none"> • Section IX. Crisis Care Centers Levy Advisory Body
<i>Advisory Body Duties</i>	<i>See Section(s)</i>
... The duties of the advisory body shall include ...	<ul style="list-style-type: none"> • Section IX. Crisis Care Centers Levy Advisory Body
... advising the executive and council on matters pertaining to implementation of the levy, ...	<ul style="list-style-type: none"> • Section IX. Crisis Care Centers Levy Advisory Body
... annually visiting each existing crisis care center ...	<ul style="list-style-type: none"> • Section IX. Crisis Care Centers Levy Advisory Body
<i>Annual Reporting (framed as an advisory body role)</i>	<i>See Section(s)</i>
... and reporting annually to the council and community, through online annual reports beginning in 2025, on ...	<ul style="list-style-type: none"> • VIII. Crisis Care Centers Levy Annual Reporting
... the levy's progress over the previous year towards accomplishing the levy purposes described in section 4 of this ordinance and ...	<ul style="list-style-type: none"> • VIII. Crisis Care Centers Levy Annual Reporting
... on the levy's actual financial expenditures in the previous year relative to the financial plan required in subsection C.3. of this section ...	<ul style="list-style-type: none"> • VIII. Crisis Care Centers Levy Annual Reporting
... that shall include, but not be limited to, the following:	<ul style="list-style-type: none"> • VIII. Crisis Care Centers Levy Annual Reporting
a. total expenditure of levy proceeds by crisis response zone, strategy, and levy purpose by ZIP Code in King County; and	<ul style="list-style-type: none"> • VIII. Crisis Care Centers Levy Annual Reporting
b. the number of individuals receiving levy-funded services by crisis response zone, strategy, and levy purpose by ZIP Code in King County of where the individuals reside at the time of service;	<ul style="list-style-type: none"> • VIII. Crisis Care Centers Levy Annual Reporting
10. A description of how the executive shall provide each online annual report described in subsection C.9. of this section to the clerk of the council, to all councilmembers and all members and alternate members of the regional policy committee, or its successor, including confirmation that the executive shall	<ul style="list-style-type: none"> • VIII. Crisis Care Centers Levy Annual Reporting

Crosswalk of Implementation Plan Requirements from King County Ordinance 19572²⁷²	
King County Ordinance 19572 Requirements	Implementation Plan Section(s)
electronically file a proposed motion that shall acknowledge receipt of the report; and	
Geographic Distribution/Crisis Response Zone Description	See Section(s)
11. A description of how the purpose of the crisis response zones described in this levy will promote geographic distribution of crisis care centers so that they are accessible for walk-in and drop-off crisis care throughout King County, but that the crisis care zones shall not be used to limit the ability of any person in King County to use any particular crisis care center.	<ul style="list-style-type: none"> • A. Strategy 1: Create and Operate Five Crisis Care Centers

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4406

4407 **Appendix C: King County Local Jurisdiction Request for Information (RFI)**

4408

4409 The purpose of this RFI was to solicit information from jurisdictions located within King County to help
 4410 inform this Plan and future CCC siting and procurement processes. The RFI was open from September
 4411 29, 2023, to October 27, 2023 and was extended to November 15, 2023.

4412

4413 **CRISIS CARE CENTERS INITIATIVE REQUEST FOR INFORMATION (RFI)**
 4414 **for**
 4415 **KING COUNTY LOCAL JURISDICTIONS**

4416

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

4417

4418 **PLEASE NOTE:**

4419 This RFI is informational only and will help inform the Crisis Care Centers Initiative planning,
 4420 including future Crisis Care Center siting processes and Procurement processes to select
 4421 organizations to develop and operate Crisis Care Centers. Responses will not be a commitment
 4422 to action. The decision to respond or not respond to this RFI will not give Jurisdictions
 4423 preferential nor disadvantageous treatment during any future Crisis Care Center site selection
 4424 or siting processes.

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4426 **RFI Overview**

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A. **PURPOSE**

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

B. **BACKGROUND**

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

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

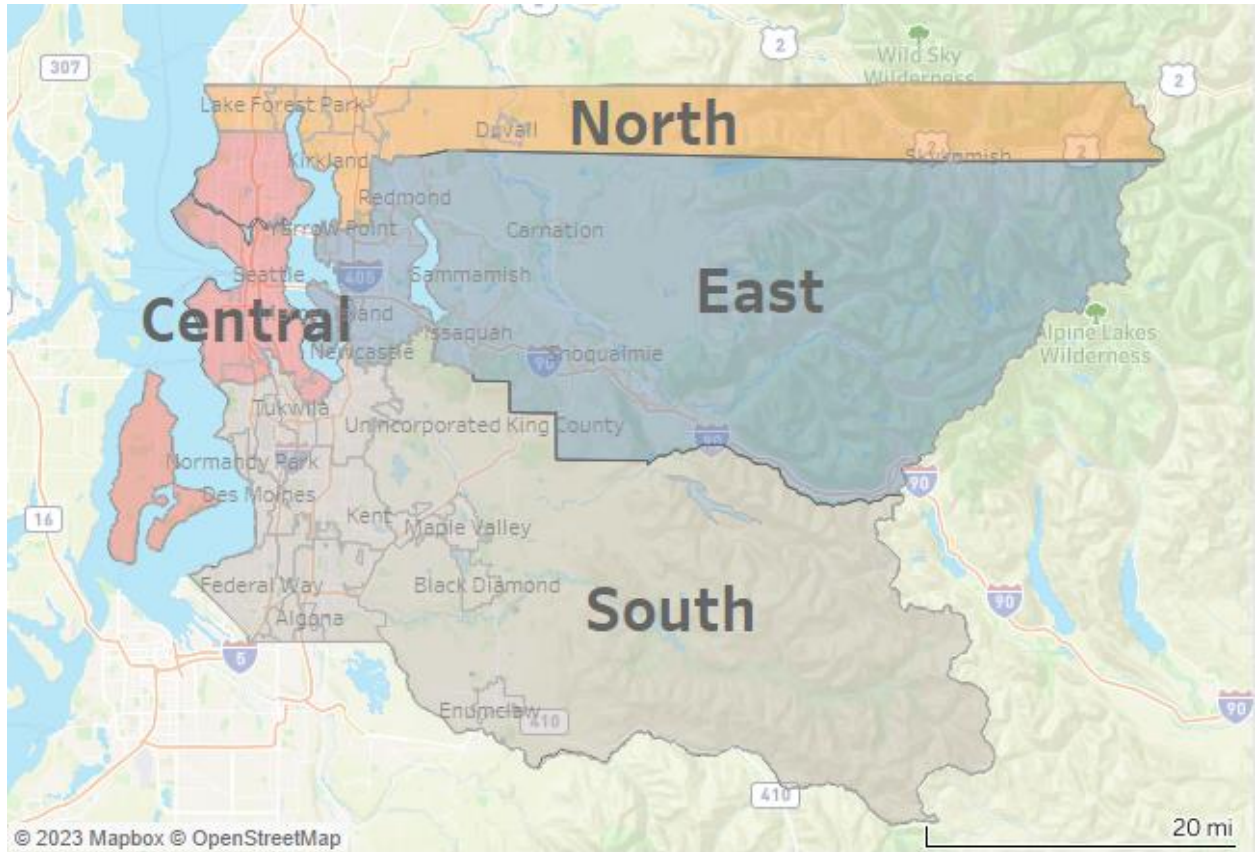
The site requirements for Crisis Care Centers are still being developed and are subject to change. Requirements will likely include:

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

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

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

4474 [King County Ordinance 19572](#) created four geographic Crisis Response Zones in King
 4475 County (see Figure 1). Each of the four Crisis Response Zones will contain at least one
 4476 Crisis Care Center and at least one of the five Crisis Care Centers will specialize in serving
 4477 youth.
 4478



4479 *Figure 1: Map of Crisis Response Zones*

4480
 4481
 4482 King County intends to release one or more Procurements in 2024 to begin to select
 4483 organizations to develop and operate Crisis Care Centers. Local Jurisdictions will be key
 4484 partners in siting Crisis Care Centers within the designated Crisis Response Zones. King
 4485 County is seeking information from Jurisdictions through this RFI to help inform the Crisis
 4486 Care Centers Initiative's Implementation Plan and the future planning of Crisis Care Center
 4487 siting processes and Procurement processes.

4488 **C. WHO SHOULD RESPOND**

4489 All Jurisdictions located within King County are invited to respond to this RFI. Elected
 4490 mayors or similar elected leadership, city managers, or their designee may submit a
 4491 response on behalf of the Jurisdiction that they represent.

4492 **D. HOW TO RESPOND**

4493 Jurisdictions can respond to this RFI by submitting responses to the questions listed below
 4494 through an online survey located at the following link:

4495 <https://forms.office.com/g/vmeUMAhMZd>.

4496 Responses will be accepted between Friday, September 29 and Friday, October 27 at
 4497 11:59pm Pacific Time. King County's Department of Community and Human Services will
 4498 hold an RFI information session for local government officials and staff on Thursday,

4499 October 12, 3:00 – 4:30pm via Zoom; please [register at this link](#). This is an optional meeting,
 4500 and its purpose is to provide background about the Crisis Care Centers Initiative and answer
 4501 questions about the RFI.
 4502

Glossary

4503
 4504 **“23-Hour Crisis Observation Unit”** means a behavioral health facility where people
 4505 experiencing an acute mental health and/or substance use crisis can receive psychiatric
 4506 services for up to twenty-three hours and fifty-nine minutes. 23-Hour Crisis Observation Units
 4507 serve people triaged as having higher clinical acuity as well as people dropped off by first
 4508 responders such as mobile crisis, emergency medical services, and law enforcement.
 4509 **“24/7”** means open twenty-four hours per day, seven days per week.
 4510 **“Behavioral Health Agency”** means an organization licensed by the Washington State
 4511 Department of Health to provide behavioral health services under [Chapter 246-341 Washington](#)
 4512 [Administrative Code](#).
 4513 **“Behavioral Health Urgent Care Clinic”** means a behavioral health clinic that is open twenty-
 4514 four hours per day, seven days per week (24/7) and can triage and assess people who walk-in
 4515 seeking mental health and/or substance use services.
 4516 **“Crisis Care Center”** means a behavioral health facility defined in [King County Ordinance](#)
 4517 [19572](#) as “a single facility or a group of facilities that provide same-day access to multiple types
 4518 of behavioral health crisis stabilization services, which may include, but are not limited to, those
 4519 described in RCW 71.24.025(20), as amended. A Crisis Care Center shall endeavor to accept
 4520 at least for initial screening and triage any person who seeks behavioral health crisis care.
 4521 Among the types of behavioral health crisis stabilization services that a Crisis Care Center shall
 4522 provide are a Behavioral Health Urgent Care clinic that offers walk-in and drop-off client
 4523 screening and triage 24/7; access to onsite assessment by a designated crisis responder; a 23-
 4524 Hour Crisis Observation Unit or similar facility and service that allows for short-term, onsite
 4525 stabilization of a person experiencing a behavioral health crisis; and a Crisis Stabilization Unit
 4526 that provides short-term, onsite behavioral health treatment for up to fourteen days or a similar
 4527 short-term behavioral health treatment facility and service. A Crisis Care Center shall be staffed
 4528 by a multidisciplinary team that includes peer counselors. A Crisis Care Center may incorporate
 4529 pre-existing facilities that provide crisis stabilization services so long as their services and
 4530 operations are compatible with this definition. Where a Crisis Care Center is composed of more
 4531 than one facility, those facilities shall either be geographically adjacent or shall have
 4532 transportation provided between them to allow persons using or seeking service to conveniently
 4533 move between facilities.”
 4534 **“Crisis Care Centers Initiative”** means the purposes defined in [King County Ordinance 19572](#),
 4535 which include creating a countywide network of five Crisis Care Centers, restoring and
 4536 expanding mental health residential treatment beds in the region, and growing the community
 4537 behavioral health workforce.
 4538 **“Crisis Care Centers Levy”** means the nine-year property tax levy described in [King County](#)
 4539 [Ordinance 19572](#) that was approved by King County voters in April 2023 and will raise revenue
 4540 between 2024 and 2032 to fund the Crisis Care Centers Initiative.
 4541 **“Crisis Response Zone”** means a geographic subregion of King County defined in [King County](#)
 4542 [Ordinance 19572](#) where at least one Crisis Care Center will be located. The four Crisis
 4543 Response Zones are depicted in Figure 1 and defined in [King County Ordinance 19572](#) as
 4544 follows:
 4545 1. **“North King County Crisis Response Zone**, which is the portion of King County
 4546 within the boundaries of the cities of Bothell, Duvall, Kenmore, Kirkland, Lake Forest
 4547 Park, Shoreline, Skykomish and Woodinville, plus the unincorporated areas within King

4548 County council district three as it is drawn on the effective date of this ordinance that are
4549 north or northeast of the city of Redmond;

4550 2. **Central King County Crisis Response Zone**, which is the portion of King County
4551 within the boundaries of the city of Seattle, plus all unincorporated areas within King
4552 County council districts two and eight as they are drawn on the effective date of this
4553 ordinance;

4554 3. **South King County Crisis Response Zone**, which is the portion of King County
4555 within the boundaries of the cities of Algona, Auburn, Black Diamond, Burien, Covington,
4556 Des Moines, Enumclaw, Federal Way, Kent, Maple Valley, Milton, Normandy Park,
4557 Pacific, Renton, SeaTac and Tukwila, plus all unincorporated areas within King County
4558 council districts five, seven and nine as they are drawn on the effective date of this
4559 ordinance; and

4560 4. **East King County Crisis Response Zone**, which is the portion of King County
4561 within the boundaries of the cities of Beaux Arts, Bellevue, Carnation, Clyde Hill, Hunts
4562 Point, Issaquah, Medina, Mercer Island, Newcastle, North Bend, Redmond,
4563 Sammamish, Snoqualmie and Yarrow Point, plus the unincorporated areas within King
4564 County council district three as it is drawn on the effective date of this ordinance that are
4565 east or southeast of the city of Redmond, plus all unincorporated areas within King
4566 County council district six as it is drawn on the effective date of this ordinance.”

4567 **“Crisis Stabilization Unit”** means a behavioral health facility where people recovering from an
4568 acute mental health and/or substance use crisis can receive continued behavioral health
4569 stabilization services for up to 14 days.

4570 **“Implementation Plan”** means a plan required by [King County Ordinance 19572](#) that will direct
4571 Crisis Care Centers Levy expenditures from 2024 through 2032.

4572 **“Jurisdictions”** means cities, tribes and other jurisdictional entities with siting authority that are
4573 physically located within King County.

4574 **“King County Ordinance 19572”** means the [ballot measure ordinance](#) that was enacted by
4575 King County Council on February 9, 2023 and passed by King County voters on April 25, 2023
4576 to create the Crisis Care Centers Levy.

4577 **“Post-Crisis Follow-Up Program”** means short-term case management and peer engagement
4578 services to connect people to care after they leave a Crisis Care Center.

4579 **“Procurement”** means a future solicitation to determine who will be contracted to develop, own,
4580 and operate Crisis Care Centers.

4581 **“RFI”** means this Request for Information plus all written amendments, addenda, or
4582 attachments hereto, and all terms and conditions incorporated herein.

4583

Upcoming Procurement Description

4584

A. UPCOMING PROCUREMENT FUNDING AMOUNT AND OBJECTIVES

4585

King County intends to release one or more Procurements beginning in 2024. Funding will
4586 include resources to construct and operate Crisis Care Centers, and the funding amount
4587 that will be available is not yet determined. The siting of Crisis Care Centers will be
4588 coordinated in partnership with local Jurisdictions and King County.

B. ANTICIPATED TIMELINE

4589

One or more rounds of Procurement processes will be released in 2024. The timeline will
4591 be determined in 2024 after the King County Council passes the Crisis Care Centers
4592 Initiative Implementation Plan.

C. PROGRAM DESCRIPTION

4593

4594

4595 Crisis Care Centers are behavioral health facilities defined by [King County Ordinance](#)
 4596 [19572](#) that will provide same-day access to mental health and substance use crisis
 4597 services. Crisis Care Centers will have three programmatic components:
 4598 1. 24/7 Behavioral Health Urgent Care Clinic;
 4599 2. 23-Hour Crisis Observation Unit; and
 4600 3. Crisis Stabilization Unit.

4601 Crisis Care Centers will also be expected to provide a Post-Crisis Follow-Up Program to
 4602 promote post-crisis stabilization for people who receive services at Crisis Care Centers.
 4603 Crisis Care Centers will strive for a “no-wrong door” approach and will endeavor to
 4604 accept, at least for initial screen and triage, any person who seeks behavioral health
 4605 crisis care. Crisis Care Centers will strive to create and foster a safe and welcoming
 4606 environment that provides care that is trauma-informed, recovery-oriented, person-
 4607 centered, integrated, and supports people in the least restrictive environment possible.
 4608

RFI Questions

4609
4610
4611

A. **QUESTIONS**

4612 Please submit responses to each of the following questions (* indicates response is
 4613 required; respondents are not required to answer all questions to submit a response).
 4614

Contact Information

- 4615
- 4616 1. *Name of Jurisdiction responding to RFI.
 - 4617 2. *Name of person submitting response.
 - 4618 3. *Title of person submitting response.
 - 4619 4. *Email address of person submitting response.
 - 4620 5. *Phone number of person submitting response.
 - 4621 6. What other points of contact from your Jurisdiction should receive
 4622 communication about this RFI and the Crisis Care Centers Initiative? Please
 4623 share their name, title, and contact information.

4624
4625

Crisis Care Center Information

- 4626 7. What communities or populations in your Jurisdiction have historically been,
 4627 or are at greatest risk of being, underserved in their behavioral health
 4628 needs?
- 4629 8. Is your Jurisdiction interested in siting an adult or youth Crisis Care Center, or
 4630 both? Why or why not?
- 4631 9. How would siting a Crisis Care Center in or adjacent to your Jurisdiction
 4632 benefit your Jurisdiction and region of King County?
- 4633 10. What additional information would you need from the County to help
 4634 determine if your Jurisdiction is interested in siting a Crisis Care Center?
- 4635 11. What are important attributes of a Crisis Care Center and its location from
 4636 your Jurisdiction's perspective?
- 4637 12. What are potential geographic features, transportation infrastructure, or other
 4638 factors in your Jurisdiction that may impact access to a Crisis Care Center?
- 4639 13. What obstacles would deter your Jurisdiction from siting a Crisis Care
 4640 Center?

- 4641 14. Does your Jurisdiction have any facilities that are like a Crisis Care Center? If
4642 yes, do you have recommendations of siting best practices based on your
4643 experience with existing facilities?
4644 15. What ideas do you have for how Jurisdictions and the County can work
4645 together to site Crisis Care Centers?
4646 16. If your Jurisdiction decided to site a Crisis Care Center, what type of capital
4647 facility siting support, communication, and Jurisdiction partnership activities
4648 would be helpful?
4649 17. Do you have one or more potential site(s) that may be suitable for a Crisis
4650 Care Center site(s) identified in your Jurisdiction? If yes, please share the
4651 location and a brief description. Alternatively, would you be interested in
4652 scheduling a meeting with the County to discuss possible locations?
4653 18. Does your Jurisdiction own one or more parcels of land or properties that
4654 could be rehabilitated to become a Crisis Care Center that your Jurisdiction
4655 would be willing to donate? If yes, please briefly describe the property.
4656 Alternatively, would you be interested in scheduling a meeting with the
4657 County to discuss possible properties?
4658 19. Does your Jurisdiction have any capital or operating resources it would be
4659 willing to contribute to a Crisis Care Center property or facility? If yes, please
4660 briefly describe the resource. Alternatively, would you be interested in
4661 scheduling a meeting with the County to discuss possible resources?
4662 20. Does your Jurisdiction have feedback regarding the types of entities that
4663 should be eligible to apply to the eventual Crisis Care Center
4664 Procurement(s)? Examples of entities could include Behavioral Health
4665 Agencies (Agencies), Agencies with letters of support from host Jurisdictions,
4666 formal partnerships between Jurisdictions and Agencies, or a Jurisdiction by
4667 itself?
4668 21. How would your Jurisdiction like to be engaged in the Crisis Care Center
4669 Initiative planning and future siting process?
4670 22. Do you have recommendations for how community members should be
4671 engaged during Crisis Care Center siting processes?
4672 23. Do you have any additional feedback about Crisis Care Center siting?

4673
4674 B. **DOCUMENT REQUESTS**

4675 Please respond to the following request for documentation, if applicable.
4676

- 4677 24. Please attach additional documentation describing potential Crisis Care
4678 Center sites or properties that your Jurisdiction has identified (i.e., photos,
4679 maps, real estate documentation, etc.).

4680

4681 **Appendix D: Coordination with State and County Partners**
 4682

State and County Partner Meetings June 2023 – November 2023	
Partners Internal to King County	
<ul style="list-style-type: none"> • Department of Adult and Juvenile Detention • Department of Natural Resources and Parks • Facilities Management Division • Metro • Prosecuting Attorney’s Office • Public Health – Seattle & King County • Sheriff’s Office 	
Washington State Partners and Meeting Topics	
<ul style="list-style-type: none"> • Health Care Authority <ul style="list-style-type: none"> ○ Billing and sustainability of crisis services ○ Reimbursement for ambulance transport to alternate destinations ○ Pharmacy regulations and reimbursement ○ Peer specialist programs ○ Data sharing related to implementation of 988 and 2SHB 1477 ○ Regulations regarding Institutes for Mental Disease • Department of Health <ul style="list-style-type: none"> ○ 23-hour Crisis Relief Centers (direct meetings and participation in 2SSB 5120 public rulemaking process) ○ 988 implementation ○ Regulations on ambulance transport to alternate destinations ○ Pilots to embed behavioral health counselors in public safety answering points to divert 911 calls from law enforcement response • Department of Social and Human Services <ul style="list-style-type: none"> ○ Department of Children, Youth, and Families ○ Developmental Disabilities Administration (DDA) 	

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Appendix E: Site and Field Visits

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

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

4691 * Facilities under construction or not yet operational
 4692

4693
4694**Appendix F: Community Engagement Activities**

Community Engagement Activities June 2023 – November 2023
Monthly CCC Levy Community Engagement Meetings
<ul style="list-style-type: none"> • Community Partner Evening Recap Meeting (1 meeting) • Community Partners Update Meeting (5 meetings) • Crisis System Integration Partners Meeting (3 meetings) • Substance Use Disorder Partners Meeting (3 meetings) • Youth Partners Meeting (5 meetings)
Presentations at Community Meetings
<ul style="list-style-type: none"> • CCORS Operations Meeting (2 meetings) • CCORS Young Adult Monthly Providers Meeting • CIT King County Coordinators Committee Meeting (2 meetings) • CRIS Committee • Cross Division Overdose Prevention Workgroup • External Partners Group • Just Access to Health Meeting • King County Behavioral Health Administrative Services Organization Inpatient Providers Quarterly Meeting • King County Behavioral Health Advisory Board (2 meetings) • King County Diversion and Reentry Services Managers Meeting • King County Hospital and Inpatient Psychiatric Leadership Meeting • King County Integrated Care Network, Network Provider Group (4 meetings) • King County Integrated Care Network, Clinical Operations Committee • King County Integrated Care Network, Joint Operations Committee • King County Outpatient Medical Leadership Team Meeting • King County Peer Network Meeting (4 meetings) • King County Youth Behavioral Health Learning Collaborative Meeting (2 meetings) • King County Behavioral Health and Recovery Division Clinical Provider Meeting • King County Behavioral Health and Recovery Division, Washington State Department of Youth and Family Services, and Coordinated Care Monthly Field Operations Meeting • King County Medications for Opioid Use Disorder (MOUD) Provider Meeting • King County Youth Service Providers Coalition (2 meetings) • Hospital and Mental Health Residential Provider Quarterly Meeting • MIDD Advisory Committee Meeting • Overdose Recovery and Care Access (ORCA) Center Planning Meetings (3 meetings) • Patient Placement Task Force (2 meetings) • Pediatrics Crisis Care Provider Meeting • Seattle/King County Coalition on Homelessness Member Meeting
Key Informant Interviews and Individual Engagement Meetings
<ul style="list-style-type: none"> • American Medical Response • Asian Counseling and Referral Services • Behavioral Health Institute, Harborview Medical Center • Challenge Seattle

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

Focus Groups and Listening Sessions

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

- Housing and Homelessness Focus Group
- MIDD Community Partnership Focus Group
- Mockingbird Society YAEH Chapter and New Members Chapter Listening Session
- Peer Counselors Focus Group
- Sound Alliance, United Tribes of All Indians, and FEEST Youth Partner Listening Session
- Sound Alliance and United Indians of All Tribes Youth Services Listening Session
- Veterans and Active Military Personnel Focus Group

King County Council and Local Jurisdiction Meetings

- City Mayor, Councilmember, and Staff Meetings (16 meetings)
- Countywide Sub-Regional Human Service Convening
- Councilmember Perry District Three First Responder Roundtable
- Councilmember Perry District Three Mayors Roundtable
- Councilmember Zahilay Community Mental Health Meeting (4 meetings)
- King County Councilmember and Council Staff Meetings (10 meetings)
- Snoqualmie Valley Government Association Quarterly Meeting
- Sound Cities Association (2 meetings)

CCC Levy Request for Information (RFI) Public Information Sessions

- King County Local Jurisdictions RFI Information Session
- Behavioral Health Organizations and Other Potential Partners RFI Information Session

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4696

4697
4698**Appendix G: Clinical Best Practices in Behavioral Health Crisis Services**

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

²⁷³ Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. [\[LINK\]](#)

²⁷⁴ Davidson L, Rowe M, DiLeo P, Bellamy C, Delphin-Rittmon M. Recovery-Oriented Systems of Care: A Perspective on the Past, Present, and Future. *Alcohol Res.* 2021 Jul 22;41(1):09. doi: 10.35946/arc.v41.1.09. [\[LINK\]](#)

²⁷⁵ Substance Abuse and Mental Health Services Administration (SAMHSA) Person- and Family-centered Care and Peer Support [\[LINK\]](#)

²⁷⁶ National Culturally and Linguistically Appropriate Services (CLAS) Standards. Think Cultural Health, U.S. Department of Health & Human Services [\[LINK\]](#).

²⁷⁷ National Council for Mental Wellbeing, The Comprehensive Healthcare Integration (CHI) Framework, April 22, 2022. [\[LINK\]](#)

²⁷⁸ Expectations for integrated medical care in a behavioral health crisis care setting are described here similar to state requirements for 23-hour Crisis Relief Centers as defined in RCW 71.24.916 – 23-hour crisis relief centers—Licensing and certification—Rules—Standards. [\[LINK\]](#)

Least Restrictive Setting	Least restrictive care refers to care provided in settings that least interfere with a person’s civil rights and freedom to participate in society. The practice of care in least restrictive settings supports the key values of self-determination in behavioral health care: that people should be able to disagree with clinician recommendations for care; that people should be informed participants in defining their care plan, and that state laws and agency policies are applied only as a last resort for people who are unable to act in their own self-interests. ²⁷⁹
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4700

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

4701 **Appendix H: BHRD Capital Improvement Funding for Behavioral Health Facilities Request for**
4702 **Information (RFI)**

4703
4704 The purpose of this RFI was to solicit information from contracted behavioral health provider
4705 organizations about necessary capital improvements, repairs, and innovations in behavioral health
4706 facilities located in County. Information provided through this RFI may be used to inform a potential
4707 Request for Proposal and be used to improve access to and availability of behavioral health services by
4708 assisting with costs associated with building repairs, renovations, or expansion of existing behavioral
4709 health provider facilities. This RFI was open from June 23, 2023, to July 17, 2023.

4710
4711 Department of Community and Human Services
4712 Behavioral Health and Recovery Division
4713 401 Fifth Avenue, Suite 400
4714 Seattle, WA 98104

4715
4716 REQUEST FOR INFORMATION (RFI)
4717 BHRD Capital Improvement Funding for Behavioral Health Facilities
4718 RFI Release Date: June 23, 2023
4719 Questions Due: July 07, 2023
4720 Due Date: July 17, 2023
4721 RFI Lead: Brandon Paz, branpaz@kingcounty.gov

4722
4723 Purpose of RFI

4724 This Request for Information (RFI) is seeking input from contracted behavioral health provider
4725 organizations to inform a potential Request for Proposal (RFP) that may be released in late 2023. The
4726 King County Department of Community and Human Services (DCHS) Behavioral Health and Recovery
4727 Division (BHRD) seeks information related to necessary capital improvements, repairs and renovations in
4728 behavioral health treatment facilities located in King County. Information provided through this RFI may
4729 be used to improve access to and availability of behavioral health services by assisting with costs
4730 associated with building repairs, renovations or expansion of existing behavioral health provider
4731 facilities.

4732
4733 DCHS is releasing this RFI to understand the level of need agencies have for capital projects and
4734 expected costs. Please note that **no funding will be released as a result of this RFI**. Submitting a
4735 response to this RFI does **not** constitute a commitment to a project in any subsequent RFPs. This RFI is
4736 for informational purposes only, to inform potential investments by the County in late 2023.

4737
4738 Who should respond?

4739 The following entities are encouraged to respond:

- 4740
4741 • Behavioral health provider organizations that are contracted with the King County Behavioral
4742 Health and Recovery Division, including but not limited to King County Integrated Care Network
4743 providers, King County Behavioral Health Administrative Service Organization (KCICN-BH-ASO)
4744 providers, and providers contracted through the MIDD program.

- 4745 • Nonprofit organizations, community-based organizations, tribe/tribal organizations interested in
4746 capital improvements, including renovations and repairs to an existing facility used for
4747 behavioral health programming/treatment.

4748 Background

4749 There is a need for capital improvements for many behavioral health provider facilities in King County.
4750 Capital improvements are necessary to increase or maintain access to effective behavioral health
4751 treatment. BHRD is considering an investment through a future procurement, to provide funding for
4752 small-medium scale capital improvement projects that can increase the health and safety and/or
4753 functional space of a facility, so providers can increase or maintain capacity to effectively provide quality
4754 behavioral health services. Capital improvement projects may include: building repairs, renovations, or
4755 expansions of existing locations to improve access to high quality programs and services.

4756
4757 Request for Information

4758 BHRD is requesting information related to behavioral health capital improvement projects. Information
4759 collected from RFI responses may inform the development of a RFP, including allowable costs and
4760 funding thresholds. Funded projects will be limited to existing facilities. New construction will not be
4761 eligible.

4762
4763 How to Respond

4764 Please submit a response that clearly addresses the questions below by 2:00 PM Pacific Time on
4765 Monday, July 17, 2023, to Brandon Paz at branpaz@kingcounty.gov. If you have any questions regarding
4766 your submission, please contact Brandon Paz at branpaz@kingcounty.gov.

4767
4768 Questions

4769 The following questions are for information only and will not be scored. Completing this RFI
4770 does not constitute a commitment to funding your project in any subsequent RFP.

- 4771
- 4772 1. Please provide the below information about your organization:
 - 4773 a. Organization Name
 - 4774 b. Address
 - 4775 c. Point of Contact Name
 - 4776 d. Title
 - 4777 e. Phone
 - 4778 f. Email
 - 4779 2. If your organization has a mission statement, please state it here.
 - 4780 3. Approximately how many clients annually does your organization provide services to?
 - 4781 4. Please briefly list the behavioral health services and/or programs that your organization offers to
4782 King County residents.
 - 4783 5. Why are you interested in applying for the anticipated Capital Improvement Funding for Behavioral
4784 Health Facilities RFP? Please explain in a short narrative, including describing the project and the
4785 need the project will address.
 - 4786 6. Please indicate the type of project you would be most likely to request funding for
 - 4787 o Renovation of an existing property to maintain or increase access to behavioral health
4788 treatment services

- 4789 ○ Renovation and repairs of an existing property to address critical health and safety issues, or
- 4790 improve treatment environment
- 4791 ○ Facility improvements, including new paint and furniture to improve the treatment
- 4792 environment to promote healing
- 4793 ○ Expansion of an existing facility to increase availability of treatment services, or allow more
- 4794 clients to be served
- 4795 7. If you currently own or lease the project site, please provide the address. If not, please provide the
- 4796 zip code or general location of the proposed site and whether you plan to own or lease it.
- 4797 8. Please share the following information regarding the project’s funding needs:
- 4798 a. What is the estimated total cost of your project?
- 4799 b. Do you have funding secured from other sources?
- 4800 c. Are you anticipating applying for other funding sources?
- 4801 d. How much funding do you anticipate requesting from a potential 2023 capital program
- 4802 RFP?
- 4803 e. What is the anticipated timeline for completion of the project?
- 4804

4805 RFI Terms and Conditions

4807 **A. Revisions to the RFI**

4808 If DCHS determines in its sole discretion that it is necessary to revise any part of this RFI, an
4809 addendum to this RFI will issued via email. For this purpose, the published questions and
4810 answers and any other pertinent information will also be provided as an addendum to the RFI
4811 and will be issued via email. DCHS also reserves the right to cancel or to reissue the RFI in whole
4812 or in part, prior to execution of a contract.

4814 **B. Cost to Propose**

4815 DCHS will not be liable for any costs incurred by the Responder in preparation of a Response
4816 submitted in response to this RFI, in conduct of a presentation, or any other activities related in
4817 any way to this RFI.

4819 **C. No Obligation to Contract**

4820 DCHS will not contract with any vendor as a result of this RFI. While DCHS may use responses to
4821 this RFI to develop a competitive solicitation for the subject of this RFI, issuing this RFI does not
4822 compel DCHS to do so.

4824 **D. Public Records Act**

4825 1. Washington State Public Records Act (RCW 42.56) requires public organizations in
4826 Washington to promptly make public records available for inspection and copying
4827 unless they fall within the specified exemptions contained in the Act or are otherwise
4828 privileged.

4829
4830 2. All submitted Responses and RFI materials become public information and may be
4831 reviewed by anyone requesting to do so at the conclusion of the RFI, negotiation, and award
4832 process. This process is concluded when a signed contract is completed between the County and
4833 the selected Responder. Note that if an interested party requests copies of submitted
4834 documents or RFI materials, a standard County copying charge per page must be received prior

4835 to processing the copies. King County will not make available photocopies of pre-printed
 4836 brochures, catalogs, tear sheets or audiovisual materials that are submitted as support
 4837 documents with a Response. Those materials will be available for review at King County
 4838 Department of Community and Human Services.

4839
 4840 3. No other distribution of Responses will be made by the Responder prior to any public
 4841 disclosure regarding the RFI, the Response or any subsequent awards without written approval
 4842 by King County. For this RFI all Responses received by King County shall remain valid for ninety
 4843 (90) days from the date of Response. All Responses received in response to this RFI will be
 4844 retained.

4845
 4846 4. Responses submitted under this RFI shall be considered public documents and with limited
 4847 exceptions, Responses that are recommended for contract award will be available for inspection
 4848 and copying by the public. If a Responder considers any portion of his/her Response to be
 4849 protected under the law, the Responder shall clearly identify on the page(s) affected such words
 4850 as "CONFIDENTIAL," "PROPRIETARY" or "BUSINESS SECRET." The Responder shall also use the
 4851 descriptions above in the following table to identify the effected page number(s) and location(s)
 4852 of any material to be considered as confidential. If a request is made for disclosure of such
 4853 portion, the County will review the material in an attempt to determine whether it may be
 4854 eligible for exemption from disclosure under the law. If the material is not exempt from public
 4855 disclosure law, or if the County is unable to make a determination of such an exemption, the
 4856 County will notify the Responder of the request and allow the Responder ten (10) days to take
 4857 whatever action it deems necessary to protect its interests. If the Responder fails or neglects to
 4858 take such action within said period, the County will release the portion of the Response deemed
 4859 subject to disclosure. By submitting a Response, the Responder assents to the procedure
 4860 outlined in this paragraph and shall have no claim against the County on account of action taken
 4861 under such procedure. Please notify the County of your needs and reference the table
 4862 information below

4863

Type of Exemption	Beginning Page/Location	Ending Page/Location

4864
 4865 **E. American with Disabilities Act**
 4866 DCHS complies with the Americans with Disabilities Act (ADA). Responder may contact the RFI
 4867 Coordinator to receive materials for this RFI in alternative formats, such as Braille, large print, audio
 4868 tape, or computer disc.

Certificate Of Completion

Envelope Id: F0608841B8AE45728E9165020D885D09	Status: Completed
Subject: Complete with DocuSign: Ordinance 19783.docx, Ordinance 19783 Attachment A.docx	
Source Envelope:	
Document Pages: 8	Signatures: 3
Supplemental Document Pages: 187	Initials: 0
Certificate Pages: 5	Envelope Originator:
AutoNav: Enabled	Cherie Camp
Envelopeld Stamping: Enabled	401 5TH AVE
Time Zone: (UTC-08:00) Pacific Time (US & Canada)	SEATTLE, WA 98104
	Cherie.Camp@kingcounty.gov
	IP Address: 198.49.222.20

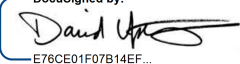
Record Tracking

Status: Original	Holder: Cherie Camp	Location: DocuSign
6/20/2024 12:08:06 PM	Cherie.Camp@kingcounty.gov	
Security Appliance Status: Connected	Pool: FedRamp	
Storage Appliance Status: Connected	Pool: King County-Council	Location: DocuSign

Signer Events

Dave Upthegrove
dave.upthegrove@kingcounty.gov
Chair
Security Level: Email, Account Authentication (None)

Signature

DocuSigned by:

E76CE01F07B14EF...
Signature Adoption: Uploaded Signature Image
Using IP Address: 67.185.138.82


Timestamp

Sent: 6/20/2024 12:14:13 PM
Viewed: 6/20/2024 1:26:30 PM
Signed: 6/20/2024 1:26:40 PM

Electronic Record and Signature Disclosure:

Accepted: 6/20/2024 1:26:30 PM
ID: 7c7bb1f0-69ff-4a04-ae74-af47cd56f1e3

Melani Hay
melani.hay@kingcounty.gov
Clerk of the Council
King County Council
Security Level: Email, Account Authentication (None)

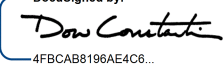
DocuSigned by:

8DE1BB375AD3422...
Signature Adoption: Pre-selected Style
Using IP Address: 198.49.222.20

Sent: 6/20/2024 1:26:43 PM
Viewed: 6/20/2024 1:30:11 PM
Signed: 6/20/2024 1:30:16 PM

Electronic Record and Signature Disclosure:

Accepted: 9/30/2022 11:27:12 AM
ID: 639a6b47-a4ff-458a-8ae8-c9251b7d1a1f

Dow Constantine
Dow.Constantine@kingcounty.gov
King County Executive
Security Level: Email, Account Authentication (None)

DocuSigned by:

4FBCAB8196AE4C6...
Signature Adoption: Uploaded Signature Image
Using IP Address: 97.113.208.5

Sent: 6/20/2024 1:30:19 PM
Viewed: 7/1/2024 9:47:54 AM
Signed: 7/1/2024 9:48:17 AM

Electronic Record and Signature Disclosure:

Accepted: 7/1/2024 9:47:54 AM
ID: b538fde6-6efc-4fa5-9535-14354c8cde1d

In Person Signer Events	Signature	Timestamp
Editor Delivery Events	Status	Timestamp
Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp
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Certified Delivery Events	Status	Timestamp
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Carbon Copy Events	Status	Timestamp
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Ames Kessler akessler@kingcounty.gov Executive Legislative Coordinator & Public Records Officer King County Security Level: Email, Account Authentication (None) Electronic Record and Signature Disclosure: Not Offered via DocuSign	<div style="border: 2px solid blue; padding: 5px; display: inline-block;">COPIED</div>	Sent: 6/20/2024 1:30:19 PM Viewed: 6/24/2024 10:35:20 AM
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Witness Events	Signature	Timestamp
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Notary Events	Signature	Timestamp
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Envelope Summary Events	Status	Timestamps
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Envelope Sent	Hashed/Encrypted	6/20/2024 12:14:13 PM
Certified Delivered	Security Checked	7/1/2024 9:47:54 AM
Signing Complete	Security Checked	7/1/2024 9:48:17 AM
Completed	Security Checked	7/1/2024 9:48:17 AM

Payment Events	Status	Timestamps
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Electronic Record and Signature Disclosure
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Withdrawing your consent

If you decide to receive notices and disclosures from us electronically, you may at any time change your mind and tell us that thereafter you want to receive required notices and disclosures only in paper format. How you must inform us of your decision to receive future notices and disclosure in paper format and withdraw your consent to receive notices and disclosures electronically is described below.

Consequences of changing your mind

If you elect to receive required notices and disclosures only in paper format, it will slow the speed at which we can complete certain steps in transactions with you and delivering services to you because we will need first to send the required notices or disclosures to you in paper format, and then wait until we receive back from you your acknowledgment of your receipt of such paper notices or disclosures. Further, you will no longer be able to use the DocuSign system to receive required notices and consents electronically from us or to sign electronically documents from us.

All notices and disclosures will be sent to you electronically

Unless you tell us otherwise in accordance with the procedures described herein, we will provide electronically to you through the DocuSign system all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you. To reduce the chance of you inadvertently not receiving any notice or disclosure, we prefer to provide all of the required notices and disclosures to you by the same method and to the same address that you have given us. Thus, you can receive all the disclosures and notices electronically or in paper format through the paper mail delivery system. If you do not agree with this process, please let us know as described below. Please also see the paragraph immediately above that describes the consequences of your electing not to receive delivery of the notices and disclosures electronically from us.

How to contact King County-Department of 02:

You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:

To contact us by email send messages to: cipriano.dacanay@kingcounty.gov

To advise King County-Department of 02 of your new email address

To let us know of a change in your email address where we should send notices and disclosures electronically to you, you must send an email message to us at cipriano.dacanay@kingcounty.gov and in the body of such request you must state: your previous email address, your new email address. We do not require any other information from you to change your email address.

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To request delivery from us of paper copies of the notices and disclosures previously provided by us to you electronically, you must send us an email to cipriano.dacanay@kingcounty.gov and in the body of such request you must state your email address, full name, mailing address, and telephone number. We will bill you for any fees at that time, if any.

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To inform us that you no longer wish to receive future notices and disclosures in electronic format you may:

- i. decline to sign a document from within your signing session, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;
- ii. send us an email to cipriano.dacanay@kingcounty.gov and in the body of such request you must state your email, full name, mailing address, and telephone number. We do not need any other information from you to withdraw consent.. The consequences of your withdrawing consent for online documents will be that transactions may take a longer time to process..

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The minimum system requirements for using the DocuSign system may change over time. The current system requirements are found here: <https://support.docusign.com/guides/signer-guide-signing-system-requirements>.

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To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please confirm that you have read this ERSD, and (i) that you are able to print on paper or electronically save this ERSD for your future reference and access; or (ii) that you are able to email this ERSD to an email address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format as described herein, then select the check-box next to ‘I agree to use electronic records and signatures’ before clicking ‘CONTINUE’ within the DocuSign system.

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- You can access and read this Electronic Record and Signature Disclosure; and
- You can print on paper this Electronic Record and Signature Disclosure, or save or send this Electronic Record and Disclosure to a location where you can print it, for future reference and access; and
- Until or unless you notify King County-Department of 02 as described above, you consent to receive exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you by King County-Department of 02 during the course of your relationship with King County-Department of 02.