1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

KING COUNTY

Signature Report

Ordinance 19783

Proposed No. 2024-0011.3 **Sponsors** von Reichbauer, Zahilay and Mosqueda

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

STATEMENT OF FACTS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:

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

Attachment A to this ordinance, is hereby adopted to govern the expenditure of crisis care 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:
David Upthegrove
E76CE01F07B14EF...
Dave Upthegrove, Chair

ATTEST:

DocuSigned by:
Melani Hay
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Melani Hay, Clerk of the Council

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

DocuSigned by:
Dow Constantine
4FBCAB8196AE4C6...
Dow Constantine, County Executive

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

Crisis Care Centers Levy
Implementation Plan 2024-2032

June 2024

King County

I. Contents

II. Executive Summary

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

Crisis Care Centers Levy Purposes

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

Figure 1. Summary of Crisis Care Centers Levy Purposes

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

Background

Unmet Behavioral Health Needs in King County

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

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

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

Need for Crisis Care Centers

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

Reduction in Residential Treatment Capacity

Residential treatment is a community-based behavioral health treatment option for people who need a higher level of care than outpatient behavioral health services can provide.[4] As of October 2023, King County had a total of 240 mental health residential treatment beds for the entire county, a decrease of 115 beds, down nearly one third from the capacity of 355 beds in 2018.[5] One of the supporting purposes to be funded by the CCC Levy is to restore the number of residential treatment beds to 355.

Behavioral Health Workforce Needs

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

Crisis Care Centers Levy Implementation Plan Methodology

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

Community Engagement Summary

DCHS staff engaged community partners to inform this Plan, including participation from behavioral health agencies, people with lived experiences of behavioral health crises, and frontline behavioral health workers. See Appendix F: Community Engagement Activities Appendix F: Community Engagement ActivitiesAppendix F: Community Engagement Activitiesfor a complete list of community engagement 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. McQuistion (Editor), Jules M. Ranz (Editor). Springer 2022, pp. 369-384.

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

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

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

Behavioral Health Equity Framework

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

Crisis Care Centers Levy Strategies

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

Figure 2. Summary of the CCC Levy Strategies

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

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

Crisis Care Centers Implementation Timeline

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

Restore, Expand, and Sustain Residential Treatment Capacity

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

Strengthen the Community Behavioral Health Workforce

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

Financial Plan

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

Evaluation and Performance Measurement

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

VII. Evaluation and Performance Measurement for more information about the CCC Levy's evaluation and performance measurement plan.

Crisis Care Centers Annual Reporting

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

Crisis Care Centers Levy Advisory Body

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

Conclusion

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

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

III. Background

A. Department of Community and Human Services

Department Overview

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

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

Behavioral Health and Recovery Division

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

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

Ordinance 19572 defines the CCC Levy's paramount and supporting purposes , which are summarized in 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]

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

- 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.

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.

C. Key Historical and Current Conditions

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

Behavioral Health Service Funding Limitations and Opportunities

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

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

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

- 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.

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[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]

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

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

Unprecedented Rates of Suicide and Overdose Deaths

The scale of suffering related to behavioral health conditions remain persistently elevated. A total of 1,229 people died by suicide in Washington in 2021, equivalent to 15.3 out of every 100,000 people, which is the 27th highest rate nationally.[33] King County accounted for 292 deaths by suicide in 2021.[34] Suicide deaths increased nationally by 2.6 percent from 2021 to 2022.[35] In the State of Washington, suicide is the seventh leading cause of years of potential life lost, surpassing liver disease, diabetes, and HIV.[36]

Youth are especially impacted. According to the 2021 Healthy Youth Survey, 18.6 percent of King County's 8th graders considered suicide in past year, and 8.8 percent made attempts.[37] Among 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]

identifying as LGBTQIA+ considered suicide, and 22.7 percent and 17.9 percent attempted suicide, respectively.[38,39]

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

Unmet Behavioral Health Service Needs

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

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

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

Among Medicaid-enrolled children in Washington, 87,000 of the 223,000 children with mental health 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]

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

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

Who Experiences Behavioral Health Inequities

Behavioral health inequities include disparities in how mental health and substance use impact specific populations and how well those populations can access behavioral health services.[49] It is also important to consider how those populations that experience such disparities are impacted by social determinants of behavioral health such as homelessness.[50]

Given the breadth and complexity of these challenges, this section describes "populations experiencing behavioral health inequities," which is the term this Plan uses in subsequent sections

Key Findings of Community Engagement Process

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

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.

Theme A: Implement Clinical Best Practices in Crisis Services

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

Welcoming and Safe

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

Person-Centered and Recovery-Oriented Care

Community partners described the importance of ensuring that crisis care centers provide person-centered and recovery-oriented care.[7] Peer specialists and people with lived experience of a behavioral health conditions emphasized the importance of keeping people in control of their care as much as possible. They also emphasized minimizing care transitions, maximizing continuity of care, and following up after discharge to start ongoing care.

Culturally and Linguistically Appropriate Services

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

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

Integrate Care for People Who Use Substances

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

Least Restrictive Care

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

Special Considerations for Serving Children, Youth, and Young Adults in Crisis

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

Additional Clinical and Support Considerations

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

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

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

Desirable Location Attributes

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

Community Outreach among Populations Experiencing Behavioral Health Inequities

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

Theme C: Challenges of Community Resource Limitations

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

Need to Build a "Bridge to Somewhere"

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

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

Care Coordination and Peer Engagement

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

Theme D: Interim Solutions While Awaiting Crisis Care Centers

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

Importance of Community-Based Response

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

Urgency of the Opioid Overdose Crisis

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

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

Theme E: Residential Treatment Facility Preservation and Expansion

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

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

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

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

Theme F: Behavioral Health Workforce Development

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

Low Wages

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

Barriers to Entering the Behavioral Health Workforce

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

Worker Retention and Professional Development

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

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

VII. Evaluation and Performance Measurement, which describes the evaluation and performance management plan for the CCC Levy.

Community Engagement During Future Planning Phases

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

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

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

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

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

[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]

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

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

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

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.[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]

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.[70] 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.[71]

Need for Places to Go in a Crisis

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

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

With no specialty behavioral health setting in King County to walk in and receive care if a person is experiencing a behavioral health crisis, the front door to crisis services at the time of this Plan's drafting is typically hospital emergency departments, where people seeking help for a behavioral health crisis 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] Esmy Jimenez, "King County mental health facilities still reject a quarter of patients, report shows." The Seattle Times, September 5, 2023. [LINK]

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

The creation of specialized crisis facilities is frequently identified as a key strategy in the crisis service continuum. These facilities enable diverting people from emergency department and carceral settings and serving people in a higher quality specialized settings that can provide care using trauma-informed, recovery oriented, and cultural humility best practices.[77, 78, 79] Multiple local behavioral health system needs assessments have arrived at a similar conclusion. The 2016 recommendations of the King County Community Alternatives to Boarding Task Force called for by Motion 14225 included a recommendation to expand crisis diversion capacity.[80] Similar conclusions were reached in needs assessments by the Washington State Office of Financial Management behavioral health capital funding prioritization and feasibility study in 2018, a Washington State Health Care Authority crisis triage and stabilization capacity and gaps report in 2019, and the Initial Assessment of the Behavioral Health Crisis Response and Suicide Prevention Services from the Crisis Response Improvement Strategy (CRIS) Committee in 2021.[81,82,83] Federal and state legislation have rapidly advanced the implementation of crisis services across the United States.[84] Expanding access to crisis response services has been a recent focus of the Washington Legislature. This includes its first-in-the-nation support of the implementation and expansion of 988 and other crisis services, with its passage of Engrossed Second Substitute House Bill 1477 in 2021.[85] Additional legislation, including Engrossed Second Substitute House Bill (E2SHB) 1134 in and Second Substitute Senate Bill (2SSB) 5120 in 2023, have further demonstrated the state's commitment to these services.[86,87] The 23-hour Crisis Relief Centers established under 2SSB 5120, which are undergoing Washington State Department of Health and Health Care Authority rulemaking into 2024, will establish important frameworks for licensure and Medicaid payment that will inform the future development of crisis care centers.

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

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

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

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

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

[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]

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

Need for Post-Crisis Stabilization Services

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

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

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

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[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

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

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

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

Reduction in Residential Treatment Capacity

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

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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].

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

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

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

Behavioral Health Workforce Needs

It takes people to care for people, and King County is experiencing a behavioral health workforce 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.

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

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

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

[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

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

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

D. Implementation Plan Methodology

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

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[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 Manderschield & MJ Henderson (Eds.), Mental health, United States, 2002 (pp. 327-368; DHHS Publication No. SMA 04-3938). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2004

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

[126] The Mental Health Needs and Statistics of the BIPOC Community [LINK]

[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]

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

Crisis Care Center Methodology

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

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

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

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

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

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

crisis care center program model development and strategies for crisis system coordination and quality improvement.[129]

Residential Treatment Methodology

Community partner engagement, subject matter expert consultation, and residential treatment operator engagement informed the residential treatment recommendations in this Plan. DCHS BHRD clinical staff with mental health residential subject matter expertise participated in an internal workgroup to provide guidance on preserving and expanding residential treatment capacity. DCHS planning staff met with leadership and frontline workers of agencies operating residential treatment facilities to solicit feedback about residential treatment gaps and how to sustain and increase residential treatment capacity. This included seven site visits to residential treatment facilities in King County, which are listed in Appendix E: Site and Field Visits. It also included an RFI soliciting information from operators about residential treatment facility capital improvement funding needs. The RFI is included in 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.
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.

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

Workforce Methodology

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

E. Community Engagement Summary

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

[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.

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

Key Findings of Community Engagement Process

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

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.

Theme A: Implement Clinical Best Practices in Crisis Services

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

Welcoming and Safe

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

Person-Centered and Recovery-Oriented Care

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

Culturally and Linguistically Appropriate Services

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

- Crisis Care Center Clinical Program OverviewA. Strategy 1: Create and Operate Five Crisis Care Centers, which defines the crisis care center clinical model and post-crisis stabilization resources;
- Capacity Building for Providers with Expertise in Culturally and Linguistically Appropriate Services, which will invest in capacity building for crisis care centers operators to further enhance their capacity to deliver culturally and linguistically appropriate services, and
- A. Evaluation and Performance Measurement Principles, which will measure how well crisis care centers are meeting these needs to hold DCHS accountable for implementing 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]

Integrate Care for People Who Use Substances

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

Least Restrictive Care

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

Special Considerations for Serving Children, Youth, and Young Adults in Crisis

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

recommendations were critical to informing the clinical model for the youth crisis care center described in Clinical Model for Youth Crisis Care Center.

Additional Clinical and Support Considerations

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

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

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

Desirable Location Attributes

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

Community Outreach among Populations Experiencing Behavioral Health Inequities

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

impacts of their proposed facility as described in Crisis Care Center Capital Facility Development describing the capital facility siting process.

Theme C: Challenges of Community Resource Limitations

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

Need to Build a "Bridge to Somewhere"

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

Care Coordination and Peer Engagement

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

Theme D: Interim Solutions While Awaiting Crisis Care Centers

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

Importance of Community-Based Response

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

Urgency of the Opioid Overdose Crisis

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

Theme E: Residential Treatment Facility Preservation and Expansion

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

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

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

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

Theme F: Behavioral Health Workforce Development

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

Low Wages

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

Barriers to Entering the Behavioral Health Workforce

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

Worker Retention and Professional Development

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

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

VII. Evaluation and Performance Measurement, which describes the evaluation and performance management plan for the CCC Levy.

Community Engagement During Future Planning Phases

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

F. Behavioral Health Equity Framework

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

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

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.

Figure 7. CCC Levy Implementation Plan Behavioral Health Equity Framework

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

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

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

Equitable Access to Behavioral Health Crisis Care

As described in Who Experiences Behavioral Health Inequities, behavioral health services remain inaccessible to far too many people who need help. Community 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]

locally, as described in Theme B: Increase Access to Care for Populations Experiencing Behavioral Health Inequities.

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

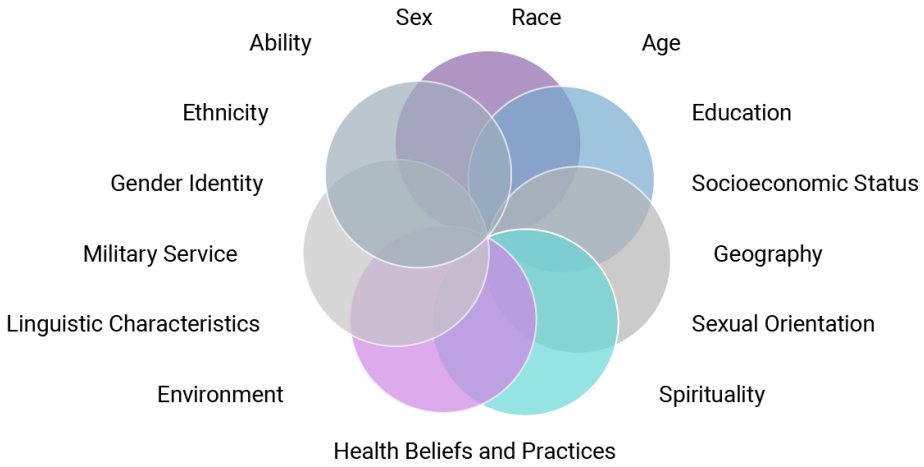
Culturally and Linguistically Appropriate Services

Access to, and engagement in, behavioral health care can also be impeded by a lack of cultural and linguistic appropriate services among providers,.[142] 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 best practices (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.[143] According to the U.S. Department of Health and Human Services, which developed the CLAS standards, all aspects of a provider's and a client's cultural identity, as depicted in Figure 9, influence the therapeutic process and are relevant to the expansion of CLAS as 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 Health[144]***



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1478 *Image Source: U.S. Department of Health and Human Services, Think Cultural Health.*
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[144] Image Source: U.S. Department of Health and Human Services, Think Cultural Health: Improving Cultural Competency for Behavioral Health Professionals [LINK]

The CCC Levy will increase availability of these clinical best practices by investing in crisis care centers and post-crisis follow-up services that include CLAS, as described in Crisis Care Center Clinical Model and Culturally and Linguistically Appropriate Post-Crisis Follow-Up Services. CCC Levy funds will also 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. Finally, behavioral health providers with expertise in CLAS will be eligible to receive funds to build their own capacity to better serve populations experiencing behavioral health inequities, as described in Capacity Building for Providers with Expertise in Culturally and Linguistically Appropriate Services.

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.

Representative Behavioral Health Workforce

In addition to offering CLAS as part of clinical best practices, 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.[147,148] Based on both the background in Behavioral Health Workforce and the community engagement described in Importance of Workforce Representation, there are investments to improve the representativeness of the community behavioral health workforce, as described in **Error! Reference source not found.**.

Quality Improvement and Accountability

The final behavioral health equity focus in this Plan relates to ensuring that equity objectives are realized to both improve quality of care and hold the County and behavioral health providers accountable. Community members provided this feedback prominently, as described in Theme G: Accountability Mechanisms and Ongoing Community Engagement. The CCC Levy's operations funding for crisis care 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]

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

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

In addition to collecting, analyzing, and reporting on data and metrics in a way that accounts for this Plan's behavioral health equity framework, DCHS will engage community partners in an ongoing manner, as described in Community Engagement. The Behavioral Health Advisory Board, the advisory body of the CCC Levy, will also 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 advise DCHS on the CCC Levy implementation, as described in

1524 IX. Crisis Care Centers Levy Advisory Body.

IV. Crisis Care Centers Levy Purposes

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

Paramount Purpose

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

Supporting Purpose 1

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

Supporting Purpose 2

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

V. Crisis Care Centers Levy Strategies and Allowable Activities

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

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

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

[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]

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

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

Overview

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

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

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

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

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

Crisis Care Center Clinical Program Overview

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

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

The crisis care center clinical program model has four parts:

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

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

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

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

- 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
"Crisis care center" means a single facility or a group of facilities that provide same-day access to multiple types of behavioral health crisis stabilization services, which may include, but are not limited to, those described in RCW 71.24.025(20), as amended.[155] A crisis care center shall endeavor to accept at least for initial screening and triage any person who seeks behavioral health crisis care. Among the types of behavioral health crisis stabilization services that a crisis care center shall provide are: • A behavioral health urgent care clinic that offers walk-in and drop-off client screening and triage 24 hours per day, seven days per week; • Access to onsite assessment by a designated crisis responder; • A 23-hour observation unit or similar facility and service that allows for short-term, onsite stabilization of a person experiencing a behavioral health crisis; and • A crisis stabilization unit that provides short-term, onsite behavioral health treatment for up to 14 days or a similar short-term behavioral health treatment facility and service.

[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.

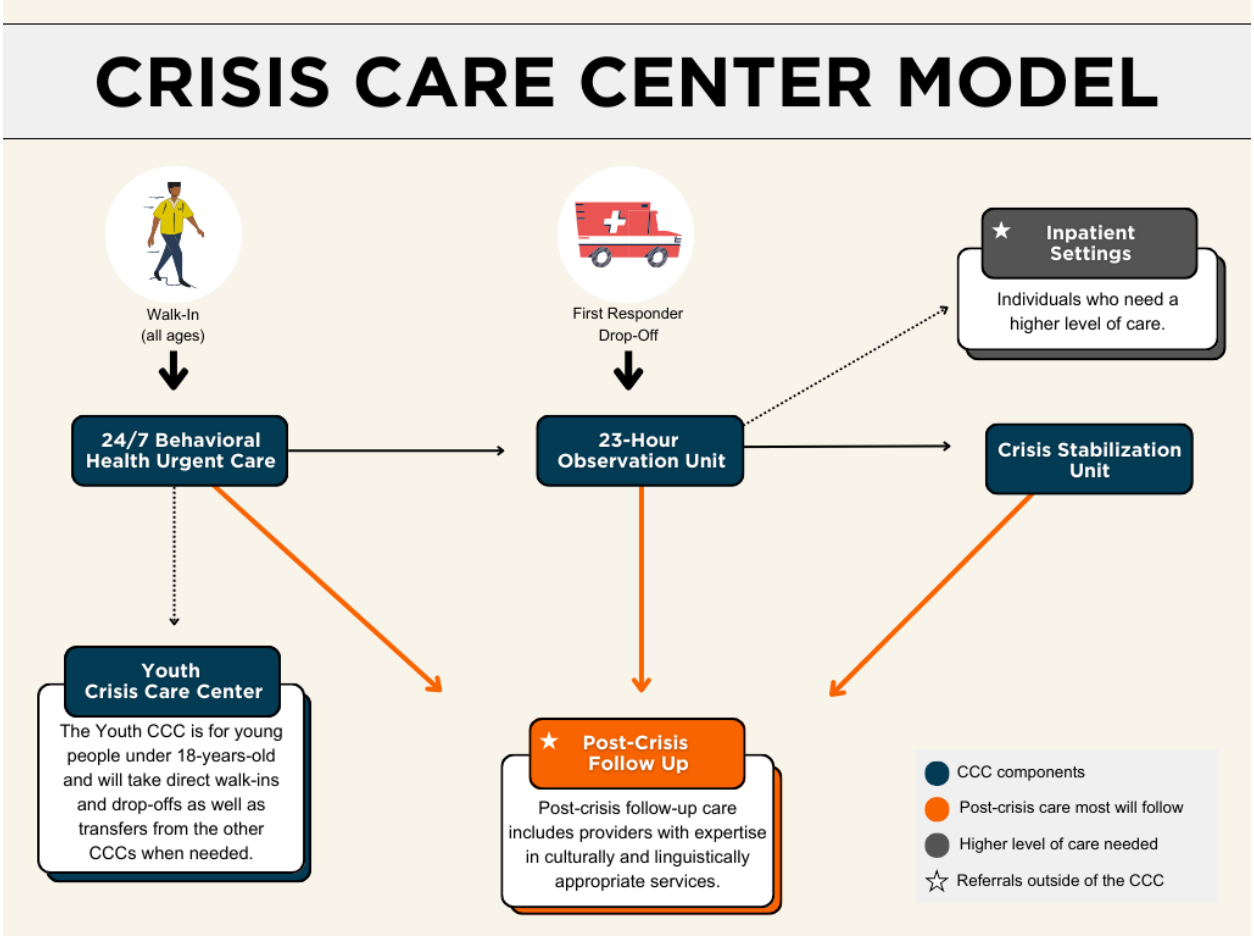
DCHS intends for crisis care centers to incorporate clinical best practices, as described throughout the clinical model below. These best practices are summarized in Appendix G: Clinical Best Practices in Behavioral Health Crisis Services and include care that is trauma-informed, recovery-oriented, person-centered,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

Figure 13. Crisis Care Center Clinical Model



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

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Access to Crisis Care Centers

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

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

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

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

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

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

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]

Initial Screening and Triage

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

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

Services Available at Crisis Care Centers

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

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

Crisis stabilization services will be offered only in the 23-hour observation units (up to 23 hours and 59 minutes, with possible exceptions depending on Washington State Department of Health regulations) and crisis stabilization units.[161] Services and methodologies in these components will include, but are not limited to, maintaining a safe and healing environment, using de-escalation techniques, creating safety 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]

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

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

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

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

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

Triage to the Next Level of Care

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

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[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.

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

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

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

DCHS expects that, when someone is ready for discharge from a crisis care center, crisis care center 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]

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

Clinical Model for Youth Crisis Care Center

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

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

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

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

Crisis Care Center Operational Activities

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

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

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.

[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.

Figure 15. Allowable Crisis Care Center Operations Activities

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

Post-Crisis Stabilization Activities

In addition to crisis care center operations, CCC Levy Strategy 1 funds will support people after they have received services at a crisis care center. Community partners state that many people will likely need additional community-based behavioral health services, health care, and social services after they leave a crisis care center, to support their ongoing recovery and wellbeing. Need for Post-Crisis Stabilization ServicesCommunity partners also shared during implementation planning process engagement that significant supports are needed by people exiting the crisis care centers in the period 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.

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

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

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

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]

DCHS anticipates that the post-crisis stabilization resources within this strategy will be inadequate to meet the behavioral health needs of all people who access King County's crisis care centers. Complementary investments from philanthropic partners and the state or federal governments will be needed to bring the services to scale. Washington State must continue to be a primary funder of post-crisis services, including through state funding for the Behavioral Health Administrative Services Organizations (BHASOs), and enhanced Medicaid reimbursement for eligible clinical services. D. Seeking and Incorporating Federal, State, and Philanthropic Resources describes how the Executive intends to 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.

Crisis Care Center Post-Crisis Follow-Up Program

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

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

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

Culturally and Linguistically Appropriate Post-Crisis Follow-Up Services

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

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

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

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

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

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.

Housing Stability Resources

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

[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]

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

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

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

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

Oversight of Crisis Care Center Quality and Operations

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

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

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

[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]

responders and other behavioral health crisis service providers to coordinate policies and procedures, improve quality of services, and collect and report high quality data, as directed by Ordinance 19572.[182]

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

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

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

Coordination Between Crisis Care Centers and Crisis System Partners

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

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

Outreach to Increase Awareness

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

Continuous Quality Improvement and Quality Assurance

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

Key Findings of Community Engagement Process

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

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.

Theme A: Implement Clinical Best Practices in Crisis Services

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

Welcoming and Safe

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

Person-Centered and Recovery-Oriented Care

Community partners described the importance of ensuring that crisis care centers provide person-centered and recovery-oriented care.[7] Peer specialists and people with lived experience of a behavioral health conditions emphasized the importance of keeping people in control of their care as much as possible. They also emphasized minimizing care transitions, maximizing continuity of care, and following up after discharge to start ongoing care.

Culturally and Linguistically Appropriate Services

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

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

Integrate Care for People Who Use Substances

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

Least Restrictive Care

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

Special Considerations for Serving Children, Youth, and Young Adults in Crisis

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

Additional Clinical and Support Considerations

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

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

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

Desirable Location Attributes

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

Community Outreach among Populations Experiencing Behavioral Health Inequities

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

Theme C: Challenges of Community Resource Limitations

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

Need to Build a "Bridge to Somewhere"

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

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

Care Coordination and Peer Engagement

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

Theme D: Interim Solutions While Awaiting Crisis Care Centers

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

Importance of Community-Based Response

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

Urgency of the Opioid Overdose Crisis

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

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

Theme E: Residential Treatment Facility Preservation and Expansion

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

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

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

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

Theme F: Behavioral Health Workforce Development

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

Low Wages

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

Barriers to Entering the Behavioral Health Workforce

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

Worker Retention and Professional Development

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

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

VII. Evaluation and Performance Measurement, which describes the evaluation and performance management plan for the CCC Levy.

Community Engagement During Future Planning Phases

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

F. Behavioral Health Equity Framework

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

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

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

Collect and Report High Quality Data

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

VIII. Crisis Care Centers Levy Annual Reporting.

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).

Crisis Care Center Capital Facility Development

Crisis Care Center Capital Activities

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

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.

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

Crisis Response Zone Requirements

At least one crisis care center must be located within each of the four crisis response zones defined in 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]

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

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

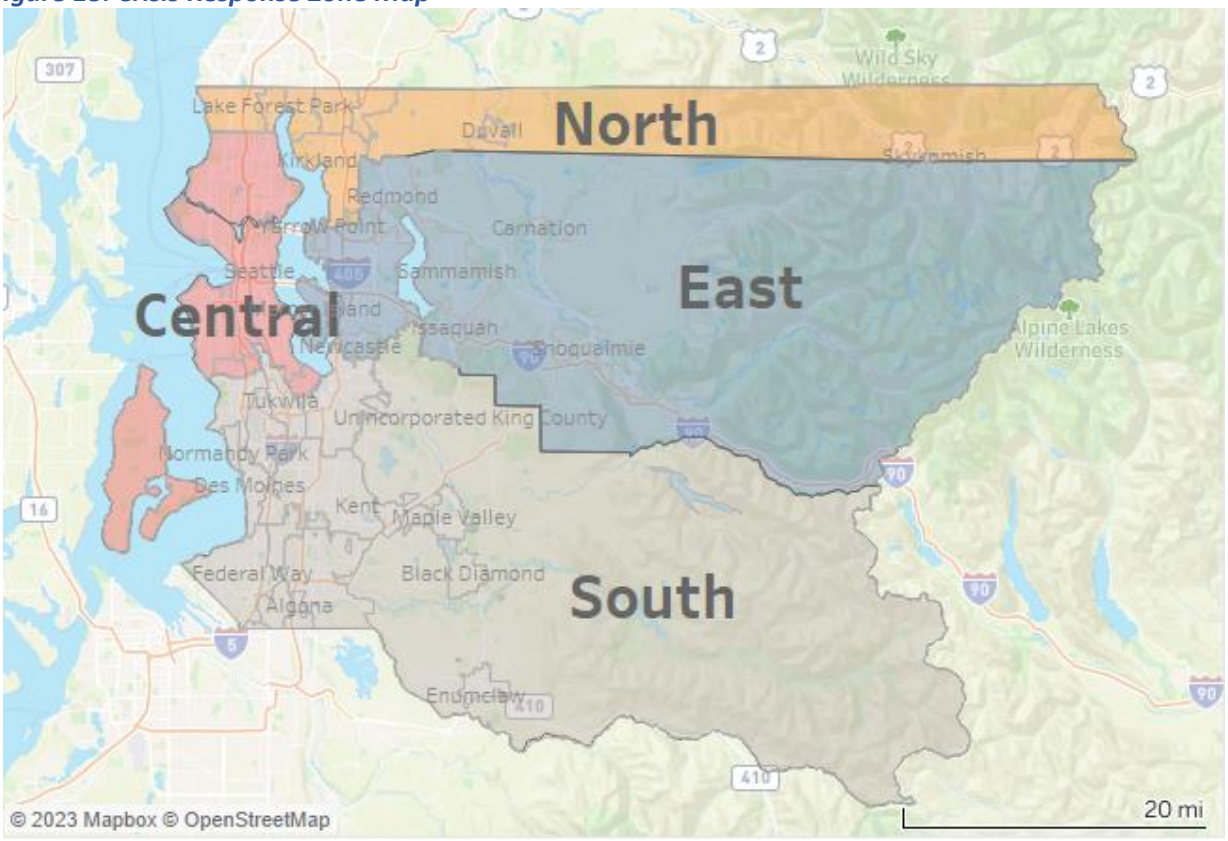

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Figure 19. Cities and Unincorporated Parts of King County Located Within Each Crisis Response Zone

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

Public Interest Requirements

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

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.

Site and Facility Requirements

Crisis care center sites must meet the minimum requirements described in Figure 21. Minimum 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]

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

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.

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

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.	

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

- Community health clinics;
- Outpatient behavioral health clinics;
- Sobering, metabolizing[195], and post-overdose recovery centers;
- Substance use treatment programs;
- Affordable housing and permanent supportive housing, and
- Other services that support the health and wellbeing of people accessing crisis care center services, their families, and their caregivers.

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

Crisis Care Center Procurement and Siting Process

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

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

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

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

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

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

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

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

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

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

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.	

The competitive procurement process shall include an evaluation of how operators will ensure a therapeutic milieu for individuals with disparate and often conflicting needs, especially age disparities between youth in the youth facility, age disparities between seniors and adults in the adult facilities, individuals with substance use needs, and people in active psychosis.

DCHS will prefer crisis care center procurement proposals that demonstrate support from a jurisdiction located within the crisis response zone where the facility is proposed. Jurisdictions can demonstrate support for a proposed site by providing a written statement as part of the procurement process that includes, but is not limited to, the following criteria:

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

Preference will be given to potential sites for crisis care centers with support from the host jurisdiction 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.

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

DCHS will support the crisis care center facility siting process through CCC Levy funding as described in E. Strategy 5: Capacity Building and Technical Assistance. DCHS will also support the siting process by providing technical advice to jurisdictions and facility operators, supporting interjurisdictional partnerships, supporting partnerships between facility operators and jurisdictions, supporting community engagement, and creating and deploying communication content.

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

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

This Plan recognizes the necessity of:

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

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

Crisis Care Center Procurement when a Facility or Site Is Purchased by King County

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

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

The Executive's notification letter shall include:

A copy of the purchase and sale agreement;

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

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

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

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

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

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

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

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

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

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

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

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

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

Alternative Siting Process

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

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

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

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

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

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

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

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

Sequence and Timing of Planned Expenditures and Activities

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

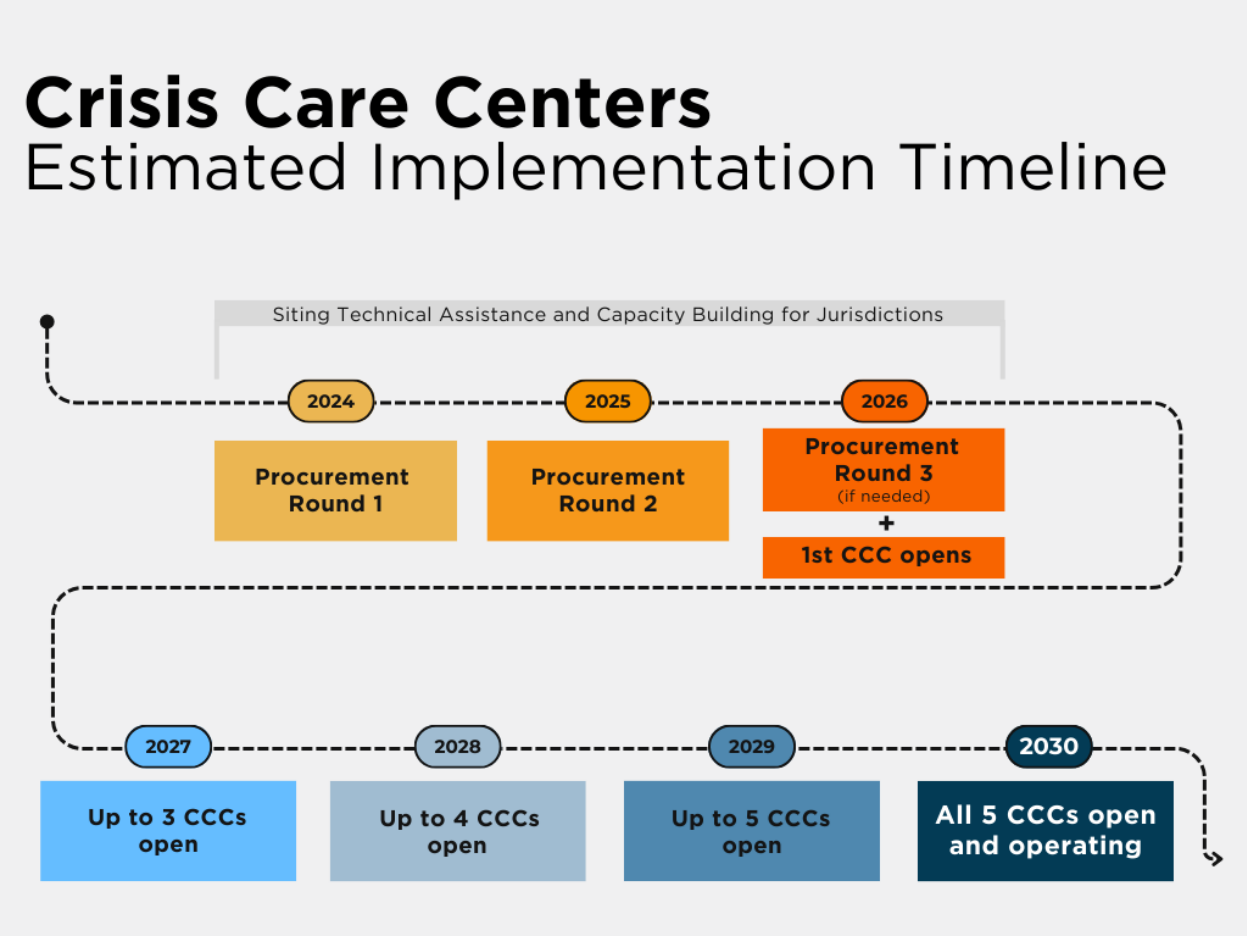
This subsection describes the sequence and timing of expenditures and activities related to developing crisis care centers. It also describes when timelines may vary and how DCHS intends to work to mitigate these variables.

Crisis Care Centers Implementation Timeline

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

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

Figure 24. Planned Crisis Care Center Development Timeline



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

Managing Development Timeline Variability

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

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

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

DCHS will work to mitigate potential timeline delays by:

- 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.

To ensure that five crisis care centers open by 2032, DCHS may choose to redistribute capital development funds, alter the siting location, and release additional procurements if DCHS determines that the development and opening timeline proposed by the selected crisis care center operator is no longer viable. Before exercising this option, DCHS will work closely with the selected operator and host jurisdiction to explore other paths to expedite the crisis care center development and opening.

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

Overview

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

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

Activities to Restore, Expand, and Sustain Residential Treatment Capacity

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

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.

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

Residential Treatment Capital Facility Procurement and Siting Process

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

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

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

2024 Levy Funding Approach for Rapid Initial Progress on Residential Treatment

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

[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.

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

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

Initial Prioritization of Residential Treatment Capacity

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

C. Strategy 3: Strengthen the Community Behavioral Health Workforce

Overview

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

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

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

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

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]

Community Behavioral Health Career Pathway Activities

Strategy 3 will fund career pathway activities to support the development of King County's community behavioral health workforce, as described in Figure 29 and Figure 30.[202] Career pathway resources will support the recruitment, training, retention, and wellbeing of community behavioral health workers through activities such as:

- Tuition assistance;
- Stipends for paid internships;
- Clinical supervision costs;
- Professional licensure fees;
- 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.

- Clinical training, including evidence-based practice training.

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

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

Initial Prioritization and Assessment of Career Pathway Activities

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

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

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

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

[204] See Who Experiences Behavioral Health Inequities

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

Figure 29. Community Behavioral Health Career Pathway Activities Timeline

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

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.

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

Labor Management Workforce Development Partnership Activities

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

Behavioral Health Apprenticeship Program Activities

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

[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]

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

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

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

Labor Management Partnership Training Activities

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

Crisis Workforce Development Activities

King County will need more people to join the region's community behavioral health workforce to staff CCC Levy-funded crisis care centers. Specific roles that crisis care centers need include, but are not limited to, peer specialists, substance use disorder professionals, mental health professionals, behavioral health technicians, nurses, nurse practitioners, and physicians. In addition to training and recruiting additional behavioral health workers, building a crisis workforce will require training existing 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.

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

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

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

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

Crisis Workforce Training Activities

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

2024 Funding Approach for Rapid Initial Progress on Behavioral Health Workforce

DCHS intends to make rapid initial progress towards fulfilling Supporting Purpose 2 by allocating CCC Levy proceeds through Strategy 3 in 2024. Early workforce investments planned for 2024 and depicted in Figure 30 will help strengthen King County's community behavioral health workforce, support the development of the behavioral health worker pipeline, and prepare to build the crisis specialty skills of 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].

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

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.

D. Strategy 4: Early Crisis Response Investments

Crisis care centers are major capital facility projects that will take time to develop and will not open immediately. The anticipated crisis care center opening timeline is described in Sequence and Timing of Planned Expenditures and Activities. Strategy 4's early crisis system activities will bring additional behavioral health crisis services and resources to King County beginning in 2024, particularly to increase community-based crisis response capacity, reduce fatal opioid overdoses, and invest in substance use 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.

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]

Increase Community-Based Crisis Response Capacity

Strategy 4 includes activities to increase the capacity of community-based crisis response programs. Community-based crisis response programs are services that can support a person experiencing a behavioral health crisis in a community-based setting. DCHS intends to expand the capacity of mobile crisis teams and a pilot program that redirects 911 calls to behavioral health specialists. These programs, which are described in more detail in the subsections below, will expand access to community-based crisis resources starting in 2024 before crisis care centers open. In addition, these investments will complement crisis care centers by increasing capacity to resolve a person's crisis in community-based settings whenever possible without a transfer to facility-based care at a crisis care center. These investments may help manage crisis care centers' capacity and client flow, which is further discussed in Ensuring that people efficiently move through the clinical components of a crisis care center will be an important focus of continuous quality improvement and quality assurance activities. .

Expand Mobile Crisis Services

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

contract expansions with existing mobile crisis service providers and through a competitive procurement process. This expansion will create additional crisis service capacity before crisis care centers open. It will also complement crisis care centers once they open by addressing crises in community settings whenever possible and serving as a key referral source when people need facility-based crisis care.

Mobile crisis service funding is an investment area that the state has an opportunity to increase and complement the CCC Levy. The state is responsible for funding mobile crisis services, including in King County, but the level of state investment is not yet adequate to provide the scale of mobile crisis services that is needed in King County. This means that people who could benefit from mobile crisis services are unable to access care. If the state increases mobile crisis funding during the CCC Levy period to a level that is better able to meet the needs of people living in King County, then DCHS may redirect Strategy 4 funds for this activity to another use, according to the funding prioritization described in F. Process to Make Substantial Adjustments to the Financial Plan.

Embed Behavioral Health Counselors in 911 Call Centers

When a person in King County is experiencing a behavioral health crisis and calls 911 seeking help, the main ways to access behavioral health care are through first responders transporting the person to emergency departments, or in limited cases, the Crisis Solution Center described in 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. An innovative national program model is being piloted in King County to co-locate trained behavioral health counselors in 911 call centers.[215,216] This model makes it possible to redirect behavioral health crisis calls to specialized behavioral health counselors in lieu of law enforcement dispatch.[217] Once the call is redirected to a behavioral health counselor, the counselor works to support the person over the phone or dispatches a mobile crisis team to respond to the 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]

this model to reduce strain on emergency services.[218] Strategy 4 invests funding to expand this King County pilot starting in 2024.

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.

Reduce Fatal Opioid Overdoses by Expanding Low Barrier Opioid Reversal Medication

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

Substance Use Facility Investments

Strategy 4 also includes capital facility funding for one or more site-based behavioral health facilities, especially those that are already permitted and can create faster in-person access to substance use crisis services, such as post-overdose recovery services, sobering services, and metabolizing services. Capital development activities may include, but are not limited to, facility renovation or expansion costs, new construction costs, and other capital development or capital improvement costs. One facility funded by Strategy 4 will include the 3rd Avenue post-overdose recovery center in Seattle. Strategy 4 may also include funding for the operations of a 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 if that client engagement team is operated by the same organization, or a subcontractor,

[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]

providing services within a capital facility funded by this strategy for the purpose of engaging persons in services or promoting a healthy environment in which to seek or receive services.

E. Strategy 5: Capacity Building and Technical Assistance

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

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.

Facility Operator Capital Development Assistance Activities

Strategy 5 will support technical assistance and capacity building activities to support organizations in developing behavioral health facilities funded by CCC Levy proceeds. Organizations that are applying for or receiving CCC Levy capital funding will be eligible to apply for capacity building and technical assistance funding during CCC Levy procurement processes related to developing residential treatment facilities or crisis care center facilities. Activities funded by Strategy 5 include, but are not limited to, capital facility predevelopment planning, capital financial planning, facility siting, facility design, facility construction, and post-construction facility activation. DCHS may use a portion of these resources to hire organizations or consultants with relevant subject matter expertise to provide capacity building and technical assistance directly to individual facility operators or through learning collaboratives for 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.

Crisis Care Center Operator Regulatory and Clinical Quality Activities

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

- Support crisis care center operators to deliver high quality clinical services;
- Provide inclusive care for populations experiencing behavioral health inequities (see Who Experiences Behavioral Health Inequities), and
- Comply with regulatory requirements.[225]

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

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

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

- Assisting crisis care center operators to institute CLAS best practices for providing culturally and linguistically appropriate services;
- Providing cultural humility and health equity training for crisis care center staff[227];
- Providing organizational leadership training on best practices to advance health equity at an organizational level, and
- Consulting with organizations with expertise in serving populations that experience behavioral health inequities (see Section III.C. Key Historical and Current Conditions: Who Experiences Behavioral Health Inequities) around adopting clinical best practices and supporting individual client case consultations when appropriate.[228]

Activities related to regulatory technical assistance and capacity building include, but are not limited to, assisting crisis care center operators to comply with applicable local, state, and federal regulatory rules, and licensing, auditing, and accreditation requirements.

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[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]

Crisis care center operators will be able to apply for technical and capacity building support related to regulatory and quality assurance during crisis care center procurement processes. DCHS may use a portion of these resources to hire organizations or consultants with relevant subject matter expertise to provide the capacity building and technical assistance described in this subsection. Consultation may be provided to individual crisis care centers or through learning collaboratives for multiple crisis care centers.

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

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

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

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.

Local Jurisdiction Capital Facility Siting Support Activities

DCHS also plans to award grants under Strategy 5 to local jurisdictions to help offset a portion of jurisdictions' costs that are directly related to siting behavioral health capital facilities funded by CCC Levy proceeds and that are not recoverable under the jurisdiction's permitting process, such as meeting facilitation, production of communication materials, and event costs and other expenses to complete outreach and engagement. Grants will be prioritized for uses that expedite the opening of crisis care center facilities funded in 2024, 2025, and 2026, which aligns with the preferred crisis care center siting timeline and process described in Crisis Care Center Procurement and Siting Process. Funding for jurisdiction siting support activities may not be used to offset siting costs incurred by other parties or other jurisdiction costs that cannot be directly attributed to siting capital facilities funded by CCC Levy proceeds.

DCHS Capital Facility Siting Technical Assistance

Strategy 5 also includes resources for DCHS to provide capital facility siting technical assistance to local jurisdictions and operators of capital behavioral health facilities funded by CCC Levy proceeds. DCHS 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.

deploying communication content and supporting siting community engagement, interjurisdictional collaboration, and facility operator and jurisdictional partnerships. The community engagement activities funded by Strategy 5 are intended to augment the community engagement activities funded in G. Strategy 7: Crisis Care Centers Levy Administration . They include, but are not limited to, costs related to engaging community members in capital facility siting processes and soliciting community input, communication costs, translation and interpretation costs, community engagement event costs, and costs to reduce barriers for community members to participate in related community engagement activities. DCHS may use a portion of these resources to fund organizations or consultants with relevant subject matter expertise to provide technical assistance directly to jurisdictions or capital facility operators to support the siting of capital facilities funded by this Plan.[230]

F. Strategy 6: Evaluation and Performance Measurement Activities

DCHS will assess the impact of the CCC Levy through evaluation and performance measurement 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 .

VII. Evaluation and Performance Measurement details how DCHS will conduct evaluation and performance activities.

VIII. Crisis Care Centers Levy Annual Reporting describes how the CCC Levy's results will be reported to the public and policymakers annually. This subsection describes what activities will be funded with CCC Levy proceeds, which are summarized in Figure 33. DCHS will measure and evaluate data to assess the CCC Levy's impact, report its results, and inform efforts to improve the quality of CCC Levy funded services. DCHS may also engage in more in-depth evaluation activities to complement regular performance measurement and deepen learnings about the effect of the CCC Levy and the services the CCC Levy funds.

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.

G. Strategy 7: Crisis Care Centers Levy Administration

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

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]

Community Engagement

DCHS intends to prioritize community engagement throughout the term of the CCC Levy to help inform the ongoing implementation, quality improvement, evaluation and performance measurement, and accountability of the Levy. In addition to its engagement related to ongoing implementation activities, DCHS plans to engage community members around the opening of crisis care centers to raise awareness about these new services, including sharing information that is accessible in multiple languages and formats. The importance of community engagement in an ongoing and meaningful way was a consistent theme during implementation planning activities (see Community Engagement During Future Planning Phases). DCHS will engage community partners and community members impacted by the CCC Levy, including populations experiencing behavioral health inequities (see Who Experiences Behavioral Health Inequities).[232] Community partners also include, but are not limited to, people who have received CCC Levy funded services, community-based organizations, contracted service providers, and elected officials and policy makers. DCHS intends to conduct listening sessions at least annually to solicit community feedback about the CCC Levy implementation. After the siting and provider selection process is completed, the selected crisis care center operator in each crisis response zone will create a "Good Neighbor Policy" that proactively manages relationships with the neighboring community of each crisis care center. The purpose of a Good Neighbor Policy is to identify ways that community stakeholders can work together to address potential impacts of the crisis care center and to formalize a positive working relationship between stakeholders for the benefits of all neighbors, including those being served by the crisis care center. At minimum, the Good Neighbor Policy should address the process for communicating with neighboring businesses and residents and policies and procedures for addressing neighborhood concerns, both during construction and ongoing operations of the crisis care centers. DCHS also intends to engage community partners in the CCC Levy's performance measurement and evaluation activities by publicly sharing and disseminating its annual reporting, and by soliciting provider feedback on performance measurement to foster accountability and collaboration in the measurement of the CCC Levy's progress.

Expertise to Support Oversight of Behavioral Health Equity

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

[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.

Develop Data Systems Infrastructure and Technology

To advance the purposes of the CCC Levy, DCHS needs to have access to timely and accurate information and secure and reliable data systems. The CCC Levy will invest in data systems infrastructure and technology to improve service providers' ability to coordinate care for people experiencing a behavioral health crisis and to support providers' and DCHS's operational and administrative activities associated with implementing this Plan. These enhancements would have the added benefit of strengthening the administration of the entire public behavioral health system in King County, in line with the activities described in Oversight of Crisis Care Center Quality and Operations. Furthermore, these enhancements would provide more robust data to support DCHS's performance measurement and evaluation activities, including internal and external-facing dashboards and annual reporting, as described in Section VIII. Crisis Care Centers Levy Annual Reporting. CCC Levy investments in data systems infrastructure and technology may include upgrading outdated technology, redesigning databases to make them more efficient, and automating more data processing tasks and reports.

Care coordination is essential during a crisis encounter. Crisis service providers need to be able to efficiently access clinical information, such as a client's prior use of clinical services, their responses to prior treatments, and their current active services. This kind of information is critical for informing the initial risk assessment and triage, discharge planning, and engagement in post-crisis follow-up services. It is equally as important for crisis service providers to communicate with other providers, including automated alerts when someone has entered an acute care setting and information sharing to inform warm handoffs as a client begins to transition to longer-term care.

At the time of this Plan's drafting, providers in King County currently have limited access to relevant clinical and social services data, which is a common problem across the United States.[234] The Washington State Health Care Authority and Department of Health are developing statewide crisis system data sharing platforms to support implementation of the 988 Suicide and Crisis Line and related crisis services, as required under E2SHB 1477.[235] DCHS intends to coordinate with the state in these efforts to maximize the local benefits of these state investments. While these state activities are promising, there may remain a need for local investments in data systems and technology infrastructure if there is not full alignment with King County's local needs or timelines. DCHS will assess its progress toward data system and technology infrastructure and technology goals periodically to determine if 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]

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

Designated Crisis Responder Accessibility

Ordinance 19572 requires crisis care centers to provide access to onsite assessment by a designated crisis responder (DCR) when needed.[236] A persistent feature of King County's pre-CCC Levy behavioral health system has been that wait times for a DCR evaluation in community settings have too often been measured in days and weeks instead of minutes and hours.[237,238] While immediately seeking an involuntary commitment hold may, in rare cases, be appropriate, DCRs' primary responsibility is to conduct a DCR evaluation and make an initial legal determination about whether a person meets legal criteria for detention under Washington's Involuntary Treatment Act.[239] DCRs are mental health clinicians, but they do not provide treatment. DCRs are an essential part of the region's behavioral health crisis response system, but they should rarely be the first or only call a community member makes in a crisis.

The CCC Levy will create a regional network of crisis care centers that will enable treatment to become the first response to a behavioral health crisis. The creation of 24/7 walk-in facilities that provide specialized treatment for crises as they happen is central to the CCC Levy proposal. In addition to increasing access to care, crisis care centers are a key part of DCHS's strategy to reduce DCR response times in community settings by reducing the number of calls that DCRs receive.

During the implementation planning process, DCHS received feedback from community members that timely access to a DCR evaluation is critical when needed, but that DCR access should be held in balance with trying treatment first, promoting least restrictive care, and prioritizing voluntary services. DCHS will address this feedback by investing in activities to expedite DCR assessments of a person who is experiencing a behavioral health crisis at a crisis care center when clinically appropriate. These activities are described in Figure 34 and include costs such as satellite DCR offices and transportation costs to reduce response times. DCHS will work with crisis care center operators to prioritize least restrictive

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

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

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

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

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

H. Strategy 8: Crisis Care Centers Levy Reserves

The CCC Levy will maintain fund reserves as directed by Ordinance 19572. The expenditure plan described in Annual Expenditure Plan includes a fund reserve equal to 60 days of budgeted expenditures, less capital expenses, consistent with King County Comprehensive Financial Management Policies.[240] The purpose of the reserve is to ensure continuity of levy-funded operating activities for 60 days if the CCC Levy is not renewed after 2032. The 60-day operating reserve will also help promote continuity of levy-funded activities in the event of fluctuations in CCC Levy revenue or strategy costs.

In addition, A. Strategy 1: Create and Operate Five Crisis Care Centers and Section V. A. B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity each reserve a portion of CCC Levy funding to help pay for ongoing capital maintenance costs of behavioral health capital facilities funded by Levy proceeds. These capital resources will promote the future sustainability of behavioral health capital facilities funded by this Plan.

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

VI. Financial Plan

A. Overview

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

B. Financial Plan

CCC Levy Annual Revenue Forecast

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

Annual Expenditure Plan

The CCC Levy's annual expenditure plan between 2024 and 2032 is described in Figure 35. The expenditure plan includes annual investment amounts for each of the CCC Levy's strategies, which are described in 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.

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

[245] King County Elections. Ballot Measures: April 25, 2023 Special Election. King County Proposition No. 1: Crisis Care Centers Levy. [LINK]

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

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

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

[246] The dollar amounts in this table are approximate and are rounded to the nearest thousand dollars.

[247] The revenue forecast incorporated into this Plan is from the King County Office of Economic and Financial Analysis' August 2023 revenue forecast. [LINK] The revenue forecast assumes a 99 percent revenue collection rate and an assumption that the CCC Levy's proceeds will generate annual interest revenue at a rate of 0.5 percent.

C. Sequencing and Timing of Planned Expenditures

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

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

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

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

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

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

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

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

Through King County's annual legislative agenda and policymaker engagement activities, such as but not limited to briefings, work sessions, and public meetings, the Executive intends to seek federal and state government funding to complement the CCC Levy . DCHS will strive to coordinate the CCC Levy with federal and state crisis service initiatives and investments to maximize resource coordination and crisis system integration. As the state makes ongoing, state-wide investments in crisis facilities and programs, the Executive will continue to seek funds to augment the CCC Levy.

The Executive and DCHS also plan to seek philanthropic funding by sharing opportunities for philanthropic partners to amplify the impact of the CCC Levy proceeds with targeted funding support. Similar to state and federal initiatives, DCHS will strive to coordinate with existing philanthropic initiatives related to crisis services whenever feasible to maximize resource coordination across 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.

E. Health Insurance Assumptions

Medicaid Health Insurance

The CCC Levy financial plan assumes that Medicaid health insurance ("Medicaid") will pay for approximately 40 percent of the crisis care centers' operating and service activities and approximately 40 percent of the post-crisis follow-up program's operating and service activities that are described in A. Strategy 1: Create and Operate Five Crisis Care Centers. CCC Levy proceeds will be used to pay for the remaining 60 percent of these activities' operating and service costs that are expected not to be covered by Medicaid.

DCHS developed the 40 percent Medicaid assumption by analyzing King County's historic crisis service health insurance billing codes and utilization data, estimating the likely health insurance coverage payer mix of people who may access crisis care centers, and reviewing Medicaid funding rates at comparable facilities in Washington State. A review of crisis service health care billing codes and utilization rates showed a range of 29 percent to 50 percent of the client population was covered by Medicaid, depending on the service type, with a 34 percent average rate of people accessing behavioral health crisis services. The crisis care centers' payer mix will likely be higher than this 34 percent average rate because crisis care centers are anticipated to disproportionally serve people who are eligible for Medicaid. King County reviewed the share of costs Medicaid covered at two comparable crisis facilities in Washington. Medicaid covered 24 percent of the operating and service costs at one facility and 86.5 percent of the operating and service costs at the second facility.[250] This analysis, along with King County's commitment to maximize Medicaid billing through supporting Medicaid enrollment and billing infrastructure, resulted in this Plan's funding assumption reflecting a modest increase from Medicaid utilization rates for crisis services that existed at the time of this Plan's drafting, up to 40 percent Medicaid funding.

The actual Medicaid reimbursement amount, which may vary annually, may be higher or lower than this 40 percent projection based on the implementation of state law directing the state to maximize the use of Medicaid for behavioral health services, including crisis services.[251] Section VI. F. Process to Make Substantial Adjustments to the Financial Plan describes how excess funding or reduced funding, including funding changes resulting from Medicaid assumptions, will be prioritized.

Commercial Health Insurance

Recent state legislation regarding emergency health insurance coverage requires commercial health insurance plans ("commercial plans") to cover behavioral health crisis services at the same level as physical health emergency services.[252] As a result of this legislation, beginning in 2024, commercial plans will pay for the types of behavioral health crisis services that will be delivered at crisis care centers as described in A. Strategy 1: Create and Operate Five Crisis Care Centers. At the time of this Plan's transmittal, commercial plan payment rates were being negotiated and were unknown. Due to the 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]

commercial plan funding. The actual commercial plan funding will likely be higher than zero dollars. The real amount will be determined by the insurance coverage payer mix of people who receive services at crisis care centers and the final negotiated commercial plan rates. Any future commercial insurance payments will offset CCC Levy expenses and will allow for CCC Levy proceeds to be prioritized for uses described in the next section, Section VI. F. Process to Make Substantial Adjustments to the Financial Plan.

F. Process to Make Substantial Adjustments to the Financial Plan

Overview

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

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

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

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

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

Process for Communicating and Making a Substantial Adjustment

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

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

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

This subsection describes the process for prioritizing substantial adjustments that reduce this Plan's annual allocations to one or more strategies. If the projected CCC Levy revenue or health insurance funding assumptions are less than this Plan's projections in any year, then it may be necessary to make a substantial adjustment to an allocation amount in one or more strategies. If this occurs, the Executive will identify necessary substantial adjustments according to the priorities described in Figure 37.

Figure 37. Funding Priorities if CCC Levy Proceed Allocations Must be Reduced Due to Funding that is 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]

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

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

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

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[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]

VII. Evaluation and Performance Measurement

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

VIII. Crisis Care Centers Levy Annual Reporting.

A. Evaluation and Performance Measurement Principles

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

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.

[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.

B. Evaluation and Performance Measurement Framework

The CCC Levy evaluation and performance measurement framework will focus on reporting measures relevant to monitoring performance of the CCC Levy, advancing continuous quality improvement, and generating clear and actionable evaluation products for the public. It is critical that the crisis services system can grow and evolve by building on what works well and improving what does not. This process should be continuously informed by performance metrics, outcome data, client experiences, and other relevant information, as described in **Error! Reference source not found.**.

Evaluation of the CCC Levy will aim to inform strategic learning and accountability. Strategic learning is using data to understand which strategies are effective and why they are effective to inform continuous quality improvement activities.[260] Data from evaluation also supports shared responsibility and accountability for CCC Levy activities between the County and community agencies. Providers are accountable for the activities they are funded to do, while the County is accountable for the overall results of the CCC Levy.

The scale and complexity of the CCC Levy requires an evaluation approach that encompasses a range of measurement techniques. The evaluation framework will therefore include three overall approaches:

1. **Population Indicators:** DCHS will use population level measures to identify needs, characterize baseline conditions, and track trends.
2. **Performance Measurement:** Performance measures are regularly generated and collected descriptors of program processes and outcomes that can be used to assess how well a strategy is working.
3. **In-Depth Evaluation:** Additional evaluation activities will complement performance measurement to deepen learnings and understand selected CCC Levy investments' effectiveness. Approaches may include piloting new programs, developing new evaluation tools, and identifying areas that may benefit from new or deeper community supports. DCHS may contract with one or more third party, independent organization(s), or engage in public private partnerships to conduct in depth evaluations.

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]

Population Indicators

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

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

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

Performance Measurement

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

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

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

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

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

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

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

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

In-Depth Evaluation

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

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

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

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

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

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

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

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

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

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

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

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

possible new data products, including online dashboards, that provide insight on participants in programs and activities and how they access services, as well as how investments and services are geographically distributed. This information supports monitoring and evaluating the collective impact in communities and informs continuous improvement of service delivery. Using these tools, DCHS collaborates with program participants, contracted service providers, and its own direct services staff to collect high-quality data, review program performance, and develop and monitor quality improvement initiatives.

In July 2022, DCHS released a consolidated dashboard to report data on BSK, MIDD, and VSHSL funded services.[263] In 2023, the dashboard added data for all programs and activities, including those that were federally funded, in the Behavioral Health and Recovery Division and the Developmental Disabilities and Early Childhood Supports Division. By 2025, expansion of this dashboard will include further information from all DCHS divisions to transparently share how the department works to help strengthen the communities of King County. By 2026, CCC Levy data will be included in this dashboard to transparently show how this initiative works to help strengthen the communities of King County.

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

VIII. Crisis Care Centers Levy Annual Reporting

A. Annual Reporting Process and Requirements

Beginning in 2025, and until 2033, DCHS staff will generate an annual report in alignment with reporting requirements of this Plan and Ordinance 19572. The report will then be reviewed and certified by the CCC Levy advisory body.[264] By no later than August 15 of each year, the certified annual report will be made available online so that the community and all interested parties, including the King County Council and Regional Policy Committee or its successor, will have unfettered access.

The first year's report will report on information from calendar year 2024. Subsequent certified, annual reports will report on the previous year, including updating the previous year's data. In consultation with Cities and the Sound Cities Association, as part of the annual report, DCHS will provide historical and current data in a manner that can be used to analyze services and to make year-over-year comparisons.

Recognizing that the annual report reflects a collaborative commitment from DCHS to provide useful data at the local level for local jurisdiction partners in support of levy purpose outcomes, , each CCC Levy online annual report will, consistent with Ordinance 19572, include:

1. Total expenditure of CCC Levy proceeds by crisis response zone, crisis care center, purpose, strategy, activities related to crisis care center post-crisis stabilization, and activities related to expanding mobile crisis services, reported by King County ZIP code where the services were received, and
2. The number of individuals receiving CCC Levy funded behavioral health care services by crisis response zone, crisis care center, purpose, strategy, , activities related to crisis care center post-crisis stabilization, and activities related to expanding mobile crisis services, reported by the ZIP code where the individuals resided at the time of services and by the King County ZIP code where the services were received, provided that individually protected information is not disclosed.

In addition, DCHS will, in consultation with Cities, develop strategies for ZIP code reporting for the CCC Levy's Supporting Purpose Two, workforce development, informed by evolving career pathways programming and data availability, and include in the Executive's 2026 career pathways notification letter a plan for annual reporting of this ZIP code data.

Additionally, each CCC Levy online annual report will include:

3. An overview of CCC facility utilization data as described in the Continuous Quality Improvement and Quality Assurance subsection of Strategy 1 in this Plan;
4. Crisis care center operator awards made and progress on each awarded operator contract during the reporting period as required in the Alternative Siting Process section of Strategy 1 in this Plan;
5. An overview of CCC Levy accomplishments during the previous calendar year, and changes DCHS intends to make or direct to improve performance in the following year, when applicable;

[264] Described in

IX. Crisis Care Centers Levy Advisory Body

6. Transportation data required by Section V.A. Strategy 1: Collect and Report High Quality Data subsection;
7. The assessment and reporting required by the Initial Prioritization of Residential Treatment Capacity of this Plan;
8. The CCC Levy's fiscal and performance measurement during the applicable calendar year, and
9. A map or summary describing the CCC Levy's geographic distribution.

No later than by August 15 of each year, the Executive will transmit directly to the Council, with a copy sent to the Regional Policy Committee, a summary of the online annual reporting in the form of a letter that:

- Confirms availability of the online annual report and includes a web link or links;
- Identifies how the online annual report meets the requirements of Ordinance 19572, and
- Summarizes key data and conclusions in the five areas above, including an overview of accomplishments; fiscal and performance management; expenditure of levy proceeds by crisis response zone, strategy, and levy purpose by King County ZIP code; the number of individuals receiving levy-supported services by crisis response zone, strategy, and levy purpose by King County ZIP code; and a map or summary describing CCC Levy's geographic distribution. This information will be described in greater detail within the online annual reporting.

The Executive will transmit with the summary letter a motion acknowledging receipt of the summary letter and completion of the online annual report requirement. The Executive will be prepared to present a briefing at the invitation of the King County Council or its committees, including the Regional Policy Committee, on the contents of the online annual report, to inform the Council's consideration of this motion.

B. Reporting Methodology to Show Geographic Distribution by ZIP Code

Consistent with Ordinance 19572, each annual report shall provide total expenditures of CCC Levy proceeds by crisis response zone, purpose, and strategy by ZIP code in King County, reflecting the methodology and limitations described in this subsection. DCHS will also report the number of individuals receiving CCC Levy funded services by crisis response zone, purpose, and strategy by the ZIP code in King County where the individuals resided at the time of service, also reflecting the methodology and limitations described in this subsection. ZIP code data will be reported using maps or other visualizations to aid interpretation of the data.

ZIP Code Reporting Methodology

DCHS intends to report expenditures by ZIP code data for all services that operate from a fixed brick and mortar location in each CCC Levy annual report, beginning with the inaugural 2025 report. DCHS intends to align methodology and dissemination practices for reporting program expenditures by ZIP code based on available data or modeling with approaches implemented in 2023 for Best Starts for Kids, and that are planned for the Veterans, Seniors, and Human Services Levy consistent with the adopted Veterans, Seniors, and Human Services Levy Implementation Plan for 2024-2029.[265]

DCHS evaluators may calculate expenditures by ZIP code through service provider location and program participant residence. Both approaches provide an understanding on the spread of expenditures across 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]

person programs and services. Reporting by service provider location may not fully capture the service reach. Alternatively, reporting by program participant residence may not capture difficulties participants may have accessing services, including transportation. Many program participants access programs in more than one way. Using more than one methodology to assess expenditures by ZIP code can help deepen understanding of how programs are accessible to people throughout the County.

ZIP Code Reporting Limitations

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

IX. Crisis Care Centers Levy Advisory Body

A. Overview

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

B. BHAB Background and Connection to CCC Levy Purposes

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

Ordinance 19572 defines the CCC Levy advisory body's membership requirements and duties, which complement BHAB's existing statutory and contractual requirements. BHAB membership requirements and duties are established in the Revised Code of Washington (RCW) 71.24.300, Washington State Administrative Code (WAC) 182-538C-252, King County's BHASO contract with the HCA, and King County Code 2A.300.050.[267,268,269,270] Thus, an expansion of the BHAB's board member composition requirements and advisory duties to include advising on the CCC Levy will not conflict with its state requirements.

To reduce the potential of conflicts, the reader is directed to Ordinance XXXXX (Proposed Ordinance 2024-0013), for the composition and duties to be fulfilled the BHAB serving as the CCC Levy 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.

BHAB Member Recruitment Process

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

BHAB Support

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

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

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

- 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

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

- VIII. Crisis Care Centers Levy Annual Reporting.

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

E. Process to Update CCC Levy Advisory Body if Necessary

Existing BHAB membership requirements and duties defined by state law and state contracts may be updated during this Plan's term. These potential changes could require adjustment of BHAB's membership composition or duties that are described in this Plan and the accompanying of Ordinance XXXXX (Proposed Ordinance 2024-0013). If BHAB's requirements are updated by the state in a way that is no longer compatible with the CCC Levy or if the Executive determines that a different CCC advisory body will better serve effective administration of the CCC Levy, then the Executive may propose an ordinance to the Council to update the CCC Levy's advisory body structure, that will not require an amendment to this Plan. If the Executive proposes an ordinance to Council to update the CCC Levy's advisory board structure, the Executive will notify the Regional Policy Committee.

X. Conclusion

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

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

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

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

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

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

XI. Appendices

Appendix A: Crisis Care Centers Levy Ordinance 19572 Text

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

STATEMENT OF FACTS:

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

988 Suicide and Crisis Lifeline, call for the development of safe places for persons in crisis to go for help as part of a robust behavioral health crisis system.

11. In 2021, the Washington state Legislature passed Engrossed Second Substitute House Bill 1477, which became Chapter 302, Laws of Washington 2021, to support implementation of 988 in Washington, to further SAMHSA's overall vision and build on the crisis phone line change by expanding and transforming crisis services.

12. RCW 71.24.025 defines crisis stabilization services to mean services such as 23-hour crisis stabilization units based on the living room model, crisis stabilization centers, short-term respite facilities, peer-operated respite services, and behavioral health urgent care walk-in centers, including within the overall crisis system components that operate like hospital emergency departments and accept all walk-ins, and ambulance, fire, and police drop-offs. Chapter 302, Laws of Washington 2021 further expressed the state legislature's intent to expand the behavioral health crisis delivery system to include these components.

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

14. King County is losing mental health residential treatment capacity that is essential for persons who need more intensive supports to live safely in the community due to rising operating costs and aging facilities that need repair or replacement. As of August 2022, King County had a total of 244 mental health residential beds for the entire county, down 111 beds, or nearly one third, from the capacity in 2018 of 355 beds.

15. As of July 2022, King County residents who need mental health residential services must wait an average of 44 days before they are able to be placed in a residential facility.

16. Data from the U.S. Centers for Disease Control and Prevention, the U.S. Census Bureau and the Kaiser Family Foundation show that about three in ten adults in the United States reported symptoms of anxiety or depressive disorder in June 2022, up from one in ten adults who reported these symptoms in 2019.

17. The National Council for Mental Wellbeing's 2022 access to care survey found that 43 percent of U.S. adults who say they need mental health or substance use care did not receive that care, and they face numerous barriers to accessing and receiving needed treatment.

18. According to the Washington state Department of Social and Health Services, the number of Medicaid enrollees in King County with an identified mental health need increased by approximately 34 percent for adults and nine percent for youth between 2019 and 2021.

19. The Washington state Department of Social and Health Services reports that in 2021, among those enrolled in Medicaid in King County, nearly half of adults and over a third of youth with an identified mental health need did not receive treatment.

20. The Washington state Department of Social Health Services reports that in 2021, among those enrolled in Medicaid in King County, approximately 62 percent of adults and 80 percent of youth with an identified substance use disorder need did not receive treatment.

21. SAMHSA's National Guidelines for Behavioral Health Crisis Care recommend including peers with lived experience of mental health conditions or substance use disorders on crisis response teams. Those guidelines also feature the living room model as an example of crisis service delivery innovation featuring peers.

22. The 2021 King County nonprofit wage and benefits survey showed that many nonprofit employees delivering critical services earn wages at levels that make it difficult to sustain a career doing community-based work in this region.
23. A 2021 King County survey of member organizations of the King County Integrated Care Network found that job vacancies at these community behavioral health agencies were at least double what they were in 2019. Providers cited professionals' ability to earn more in medical systems or private practice, and the high cost of living in the King County region, as the top reasons their workers were leaving community behavioral healthcare.
24. The behavioral health workforce advisory committee to the state of Washington's Workforce Training and Education Coordinating Board found in 2021 that Washington continues to face a shortage of behavioral health professionals, while demand for services, and qualified workers to deliver them, continues to grow. The advisory committee also found that workers need increased financial support and incentives to remain in community behavioral health care.

BE IT ORDAINED BY THE COUNCIL OF KING COUNTY:
SECTION 1. **Definitions.** The definitions in this section apply throughout this ordinance unless the context clearly requires otherwise.
A. "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. A crisis care center shall endeavor to accept at least for initial screening and triage any person who seeks behavioral health crisis care. Among the types of behavioral health crisis stabilization services that a crisis care center shall provide are a behavioral health urgent care clinic that offers walk-in and drop-off client screening and triage twenty-four hours per day, seven days per week; access to onsite assessment by a designated crisis responder; a twenty-three-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 fourteen days or a similar short-term behavioral health treatment facility and service. A crisis care center shall be staffed by a multidisciplinary team that includes peer counselors. A crisis care center may incorporate pre-existing facilities that provide crisis stabilization services so long as their services and operations are compatible with this definition. Where a crisis care center is composed of more than one facility, those facilities shall either be geographically adjacent or shall have transportation provided between them to allow persons using or seeking service to conveniently move between facilities.
B. "Designated crisis responder" has the same meaning as in RCW 71.05.020, as amended.
C. "King County crisis response zone" means each of four geographic subregions of King County:
1. North King County crisis response zone, which is the portion of King County within the boundaries of the cities of Bothell, Duvall, Kenmore, Kirkland, Lake Forest Park, Shoreline, Skykomish and Woodinville, plus the unincorporated areas within King County council district three as it is drawn on the effective date of this ordinance that are north or northeast of the city of Redmond;
2. Central King County crisis response zone, which is the portion of King County within the boundaries of the city of Seattle, plus all unincorporated areas within King County council districts two and eight as they are drawn on the effective date of this ordinance;
3. South King County crisis response zone, which is the portion of King County within the boundaries of the cities of Algona, Auburn, Black Diamond, Burien, Covington, Des Moines, Enumclaw, Federal Way, Kent, Maple Valley, Milton, Normandy Park, Pacific, Renton, SeaTac and Tukwila, plus all unincorporated areas within King County council districts five, seven and nine as they are drawn on the effective date of this ordinance; and

4. East King County crisis response zone, which is the portion of King County within the boundaries of the cities of Beaux Arts, Bellevue, Carnation, Clyde Hill, Hunts Point, Issaquah, Medina, Mercer Island, Newcastle, North Bend, Redmond, Sammamish, Snoqualmie and Yarrow Point, plus the unincorporated areas within King County council district three as it is drawn on the effective date of this ordinance that are east or southeast of the city of Redmond, plus all unincorporated areas within King County council district six as it is drawn on the effective date of this ordinance.

D. "Levy" means the levy of regular property taxes for the specific purposes and term provided in this ordinance and authorized by the electorate in accordance with state law.

E. "Levy proceeds" means the principal amount of moneys raised by the levy and any interest earnings on the moneys and the proceeds of any interim or other financing following authorization of the levy.

F. "Regional behavioral health services and capital facilities" means programs, services, activities, operations, staffing and capital facilities that: promote mental health and wellbeing and that treat substance use disorders and mental health conditions; promote integrated physical and behavioral health; promote and provide therapeutic responses to behavioral health crises; promote equitable and inclusive access to mental health and substance use disorder services and capital facilities for those racial, ethnic, experiential and geographic communities that experience disparities in mental health and substance use disorder conditions and outcomes; build the capacity of mental health and substance use disorder service providers to improve the effectiveness, efficiency, and equity, of their services and operations; provide transportation to care for persons receiving, seeking, or in need, of mental health or substance use disorder services; promote housing stability for persons receiving or leaving care from a facility providing mental health or substance use disorder services; promote service and response coordination, data sharing, and data integration amongst first responders, mental health and substance use disorder providers, and King County staff; promote community participation in levy activities, including payment of stipends to persons with relevant lived experience who participate in levy activities whose employment does not already compensate them for such participation; administer, coordinate and evaluate levy activities; apply for federal, state and philanthropic moneys and assistance to supplement levy proceeds; and promote stability and sustainability of the behavioral health workforce.

G. "Residential treatment" means 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.

H. "Strategy" means a program, service, activity, initiative or capital investment intended to achieve the purposes described in section 4 of this ordinance.

I. "Technical assistance and capacity building" means assisting organizations in applying for grants funded by the levy and in implementing and improving delivery of a strategy or strategies for which levy moneys are eligible, and includes assisting community-based organizations in delivery of strategies to persons and communities that are disproportionately impacted by behavioral health conditions.

SECTION 2. **Levy submittal.** To provide necessary moneys to fund, finance or refinance the purposes identified in section 4 of this ordinance, the King County council shall submit to the qualified electors of the county a proposition authorizing a regular property tax levy in excess of the levy limitation contained in chapter 84.55 RCW for nine consecutive years, with collection commencing in 2024, at a rate not to exceed $0.145 per one thousand dollars of assessed value in the first year of the levy period. The dollar amount of the levy in the first year shall be the base upon which the maximum allowable levy amounts in years two through nine (2025-2032) shall be calculated using the limit factor in chapter 84.55 RCW, as amended.

SECTION 3. **Deposit of levy proceeds.** The levy proceeds shall be deposited into the crisis care centers fund, or its successor.

SECTION 4. **Levy purposes.**

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

D. Unless made otherwise eligible in subsection C. of this section, levy proceeds shall not be used to provide, supplant, replace or expand funding for non-behavioral health purposes including, but not limited to, jails, prisons, courts of law, criminal prosecution, criminal defense or law enforcement, except for costs that provide or coordinate regional behavioral health services and capital facilities within or between crisis care centers and other health care settings or that remove or reduce a barrier to receiving behavioral health services such as quashing a warrant. Nothing in this subsection shall be interpreted or construed to limit, discourage, or impede law enforcement agencies' or other first responders' coordination with, use of and access to crisis care centers for persons they encounter in the conduct of their duties.

SECTION 6. **Call for special election.** In accordance with RCW 29A.04.321, the King County council hereby calls for a special election to be held on April 25, 2023, to consider a proposition authorizing a regular property tax levy for the purposes described in this ordinance. The King County director of elections shall cause notice to be given of this ordinance in accordance with the state constitution and general law and to submit to the qualified electors of the county, at the said special county election, the proposition hereinafter set forth. The clerk of the council shall certify that proposition to the director of elections in substantially the following form:

> PROPOSITION___: The King County Council passed Ordinance ____ concerning funding for mental health and substance use disorder services. If approved, this proposition would fund behavioral health services and capital facilities, including a countywide crisis care centers network, increased residential treatment; mobile crisis care; post-discharge stabilization; and workforce supports. It would authorize an additional nine-year property tax levy for collection beginning in 2024 at $0.145 per $1,000 of assessed valuation, with the 2024 levy amount being the base for calculating annual increases in 2025-2032 under chapter 84.55 RCW, and exempt eligible seniors, veterans, and disabled persons under RCW 84.36.381. Should this proposition be:
>
> Approved? _____
>
> Rejected? _____

SECTION 7. **Implementation plan.**

A. If voters approve the levy, the executive shall transmit by December 31, 2023, a proposed levy implementation plan for council review and adoption by ordinance. The proposed implementation plan shall direct levy expenditures from 2024 through 2032.

B. The executive shall electronically file the implementation plan required in subsection A. of this section with the clerk of the council, who shall retain the original and provide an electronic copy to all councilmembers, the council chief of staff, the policy staff director and the lead staff for the law, justice, health and human services committee and the regional policy committee, or their successors. The implementation plan shall be accompanied by proposed ordinances that adopt the implementation plan and that establish or empower the advisory body, the description of which is set forth in subsection C.9. of this section.

C. The implementation plan required in subsection A. shall include:

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;

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:

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;

b. capital and maintenance investments for mental health residential treatment capacity;
c. investments to increase attraction to, retention in, and sustainability of the behavioral health workforce;
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;
e. activities that promote post-crisis stabilization, including housing stability, for persons receiving or discharging from levy-funded services;
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 behavioral health services for persons experiencing or at risk of a behavioral health crisis;
g. technical assistance and capacity building for organizations applying for or receiving levy funding, including 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;
h. capital facility siting support, communication and city partnership activities;
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
j. performance measurement and evaluation activities;
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:
a. the forecast of annual revenue for each year of the levy;
b. an annual expenditure plan for each year of the levy that allocates forecasted levy proceeds among the levy's strategies;
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
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;
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;
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;
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;
7. A summary of the process and key findings of the community and stakeholder engagement process that informs the proposed implementation plan;
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;
9. A description of the composition, duties of, and process to establish the advisory body for the levy. The advisory body may be a preexisting King County board or commission that has relevant

expertise or a new advisory body. The composition of the advisory body shall be demographically representative of the population of King County and shall include at least one resident of each King County crisis response zone, persons who have previously received crisis stabilization services, and persons with professional training and experience in the provision of behavioral health crisis care. The duties of the advisory body shall include advising the executive and council on matters pertaining to implementation of the levy, annually visiting each existing crisis care center and reporting annually to the council and community, through online annual reports beginning in 2025, on the levy's progress over the previous year towards accomplishing the levy purposes described in section 4 of this ordinance and on the levy's actual financial expenditures in the previous year relative to the financial plan required in subsection C.3. of this section that shall include, but not be limited to, the following:

a. total expenditure of levy proceeds by crisis response zone, strategy, and levy purpose by ZIP Code in King County; and

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;

10. A description of how the executive shall provide each online annual report described in subsection C.9. of this section to the clerk of the council, to all councilmembers and all members and alternate members of the regional policy committee, or its successor, including confirmation that the executive shall electronically file a proposed motion that shall acknowledge receipt of the report; and

11. A description of how the purpose of the crisis response zones described in this levy will promote geographic distribution of crisis care centers so that they are accessible for walk-in and drop-off crisis care throughout King County, but that the crisis care zones shall not be used to limit the ability of any person in King County to use any particular crisis care center.

SECTION 8. **Updating the definition of crisis care center.** If new research, changing best practices, updated federal or state regulations or other evidence-based factors cause this ordinance's definition of "crisis care center" to become infeasible, impracticable or inconsistent with the levy's paramount purpose, King County may, upon recommendation of the advisory body described in section 7.C.9. of this ordinance and with mandatory referral to the regional policy committee, update the definition of "crisis care center" through adoption of an ordinance to a definition substantially similar to what is recommended by the advisory body.

SECTION 9. **Exemption.** The additional regular property taxes authorized by this ordinance shall be included in any real property tax exemption authorized by RCW 84.36.381.

SECTION 10. **Ratification and confirmation.** Certification of the proposition by the clerk of the county council to the director of elections in accordance with law before the special election on April 25, 2023, and any other act consistent with the authority and before the effective date of this ordinance are hereby ratified and confirmed.

SECTION 11. **Severability.** If any provision of this ordinance or its application to any person or circumstance is held invalid, the remainder of the ordinance or the application of the provision to other persons or circumstances is not affected.

Appendix B: Crosswalk of Implementation Plan Requirements from King County Ordinance 19572

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

[272] King County Ordinance 19572 [LINK].

Crosswalk of Implementation Plan Requirements from King County Ordinance 19572[272]	
King County Ordinance 19572 Requirements	**Implementation Plan Section(s)**
behavioral health services for persons experiencing or at risk of a behavioral health crisis;	
Technical Assistance and Capacity-Building	*See Section(s)*
g. technical assistance and capacity building for organizations applying for or receiving levy funding, including …	• Section V.E. Strategy 5: Capacity Building and Technical Assistance
… a strategy or strategies to promote inclusive care at levy-funded facilities for racial, ethnic and other demographic groups that experience disproportionate rates of behavioral health conditions in King County;	• Section V.E. Strategy 5: Capacity Building and Technical Assistance
Capital Facility Siting Support, Communication, City Partnership	*See Section(s)*
h. capital facility siting support, communication and city partnership activities;	• Section V.E. Strategy 5: Capacity Building and Technical Assistance
Administration, Coordination, and Quality	*See Section(s)*
i. levy administration activities and activities that monitor and promote coordination, more effective crisis response, and quality of care within and amongst crisis care centers, other behavioral health crisis response services in King County, and first responders, and	• Section V.G. Strategy 7: Crisis Care Centers Levy Administration
Performance Measurement and Evaluation	*See Section(s)*
j. performance measurement and evaluation activities;	• Section V.F. Strategy 6: Evaluation and Performance Measurement Activities
Financial Plan: Revenue Forecast and Expenditures by Strategy	See Section(s)
3. A financial plan to direct the use of the proceeds for regional behavioral health services and capital facilities that achieve the purposes and strategies described in subsection C.1. and 2. of this section, which must at a minimum include:	• Section VI. Financial Plan
a. the forecast of annual revenue for each year of the levy;	• Section VI. Financial Plan
b. an annual expenditure plan for each year of the levy that allocates forecasted levy proceeds among the levy's strategies;	• Section VI. Financial Plan
Sequence and Timing of Planned Expenditures/Activities to establish CCCs	*See Section(s)*
c. a description of the sequence and timing of planned expenditures and activities to establish and operate the regional network of five crisis care centers required to satisfy the levy's paramount purpose; and	• Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers
Description of Use of Portion of First-Year Revenue for Rapid Progress on MH Residential and Workforce	*See Section(s)*

Crosswalk of Implementation Plan Requirements from King County Ordinance 19572[272]	
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;	• Section V.B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity • Section V.C. Strategy 3: Strengthen the Community Behavioral Health Workforce
Plan to Seek Other Funds to Accelerate/Enhance Levy Purposes	*See Section(s)*
4. A description of how the executive will seek and incorporate when available federal, state, philanthropic and other moneys that are not proceeds of the levy to accelerate, enhance, compliment or sustain accomplishment the levy's paramount purpose and supporting purposes one and two;	• Section VI. Financial Plan
Description of Medicaid and Private Insurance Assumptions	See Section(s)
5. A description of the executive's assumptions about the role of Medicaid funding in the financial plan and the executive's planned approach to billing eligible crisis care services to Medicaid or other sources of potential payment such as private insurance;	• Section VI. Financial Plan
Description of Collaboration with Cities in Siting	See Section(s)
6. A description of the process by which King County and partner cities shall collaborate to support siting of new capital facilities that use proceeds from the levy for such facilities' construction or acquisition;	• Section V.A. Strategy 1: Create and Operate Five Crisis Care Centers • Section V.B. Strategy 2: Restore, Expand, and Sustain Residential Treatment Capacity
Community and Stakeholder Engagement Summary	See Section(s)
7. A summary of the process and key findings of the community and stakeholder engagement process that informs the proposed implementation plan;	• Section III. Background
Process for Substantial Adjustments to Financial Plan	See Section(s)
8. A process to make substantial adjustments to the financial plan required in subsection C.3. of this section, which process shall require notice to the council and provide for the council the ability to stop any substantial adjustment that the council does not support;	• Section VI. Financial Plan
Advisory Body (New or Preexisting)	See Section(s)
9. A description of the composition, duties of, and process to establish the advisory body for the levy. …	• Section IX. Crisis Care Centers Levy Advisory Body
…The advisory body may be a preexisting King County board or commission that has relevant expertise or a new advisory body. …	• Section IX. Crisis Care Centers Levy Advisory Body
Advisory Body Composition	*See Section(s)*

Crosswalk of Implementation Plan Requirements from King County Ordinance 19572[272]	
King County Ordinance 19572 Requirements	**Implementation Plan Section(s)**
… The composition of the advisory body shall be … …	• Section IX. Crisis Care Centers Levy Advisory Body
… demographically representative of the population of King County and shall include …	• Section IX. Crisis Care Centers Levy Advisory Body
… at least one resident of each King County crisis response zone, …	• Section IX. Crisis Care Centers Levy Advisory Body
… persons who have previously received crisis stabilization services, and …	• Section IX. Crisis Care Centers Levy Advisory Body
… persons with professional training and experience in the provision of behavioral health crisis care. …	• Section IX. Crisis Care Centers Levy Advisory Body
Advisory Body Duties	*See Section(s)*
… The duties of the advisory body shall include …	• Section IX. Crisis Care Centers Levy Advisory Body
… advising the executive and council on matters pertaining to implementation of the levy, …	• Section IX. Crisis Care Centers Levy Advisory Body
… annually visiting each existing crisis care center …	• Section IX. Crisis Care Centers Levy Advisory Body
Annual Reporting (framed as an advisory body role)	*See Section(s)*
… and reporting annually to the council and community, through online annual reports beginning in 2025, on …	• 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 …	• 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 …	• VIII. Crisis Care Centers Levy Annual Reporting
… that shall include, but not be limited to, the following:	• 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	• 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;	• 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	• VIII. Crisis Care Centers Levy Annual Reporting

Crosswalk of Implementation Plan Requirements from King County Ordinance 19572[272]	
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.	• A. Strategy 1: Create and Operate Five Crisis Care Centers

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

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

CRISIS CARE CENTERS INITIATIVE REQUEST FOR INFORMATION (RFI)
for
KING COUNTY LOCAL JURISDICTIONS

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

PLEASE NOTE:
This RFI is informational only and will help inform the Crisis Care Centers Initiative planning, including future Crisis Care Center siting processes and Procurement processes to select organizations to develop and operate Crisis Care Centers. 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.

RFI Overview

A. **PURPOSE**

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

B. **BACKGROUND**

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

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

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

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

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

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

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

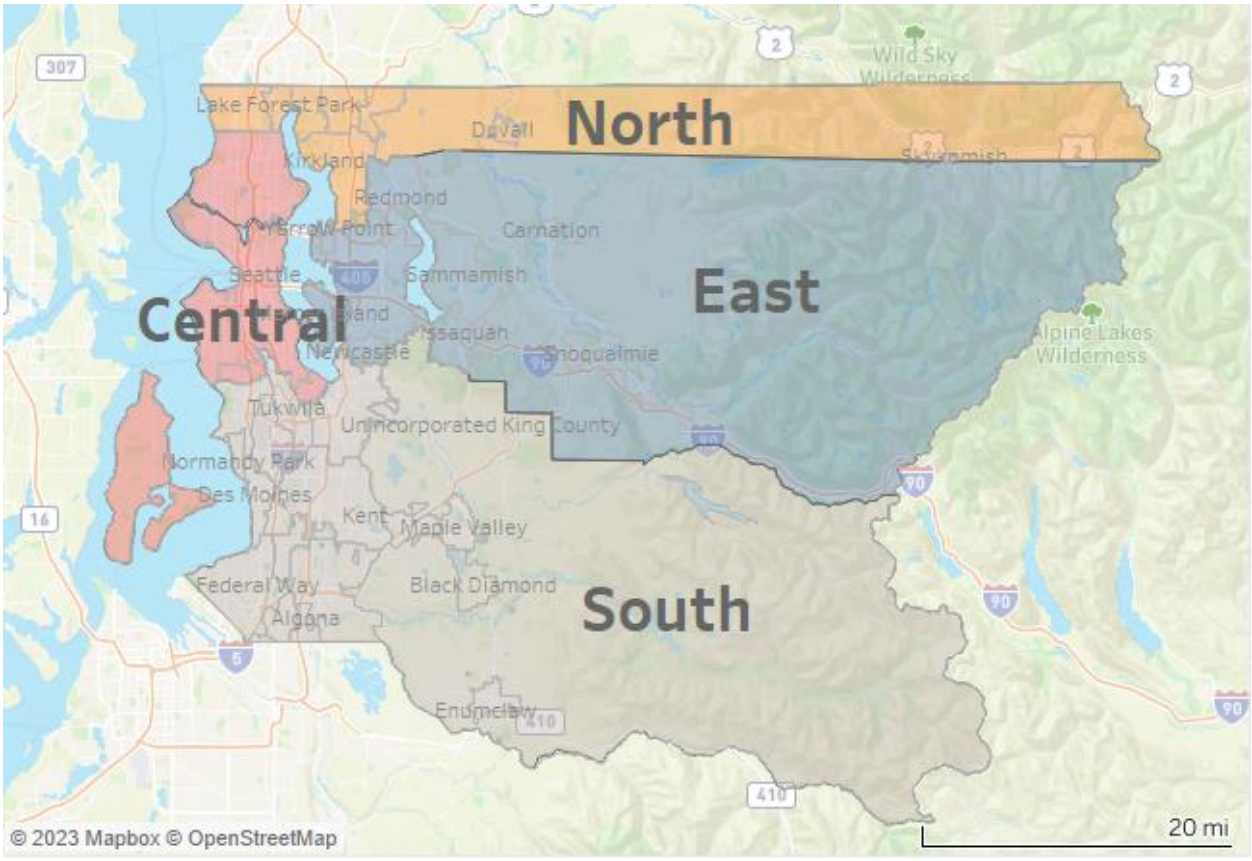

Figure 1: Map of Crisis Response Zones

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

C. **WHO SHOULD RESPOND**

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

D. **HOW TO RESPOND**

Jurisdictions can respond to this RFI by submitting responses to the questions listed below through an online survey located at the following link: https://forms.office.com/g/vmeUMAhMZd.

Responses will be accepted between Friday, September 29 and Friday, October 27 at 11:59pm Pacific Time. King County's Department of Community and Human Services will hold an RFI information session for local government officials and staff on Thursday,

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

Glossary

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

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

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

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

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

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

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

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

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

County council district three as it is drawn on the effective date of this ordinance that are north or northeast of the city of Redmond;

2. **Central King County Crisis Response Zone**, which is the portion of King County within the boundaries of the city of Seattle, plus all unincorporated areas within King County council districts two and eight as they are drawn on the effective date of this ordinance;

3. **South King County Crisis Response Zone**, which is the portion of King County within the boundaries of the cities of Algona, Auburn, Black Diamond, Burien, Covington, Des Moines, Enumclaw, Federal Way, Kent, Maple Valley, Milton, Normandy Park, Pacific, Renton, SeaTac and Tukwila, plus all unincorporated areas within King County council districts five, seven and nine as they are drawn on the effective date of this ordinance; and

4. **East King County Crisis Response Zone**, which is the portion of King County within the boundaries of the cities of Beaux Arts, Bellevue, Carnation, Clyde Hill, Hunts Point, Issaquah, Medina, Mercer Island, Newcastle, North Bend, Redmond, Sammamish, Snoqualmie and Yarrow Point, plus the unincorporated areas within King County council district three as it is drawn on the effective date of this ordinance that are east or southeast of the city of Redmond, plus all unincorporated areas within King County council district six as it is drawn on the effective date of this ordinance."

"**Crisis Stabilization Unit**" means a behavioral health facility where people recovering from an acute mental health and/or substance use crisis can receive continued behavioral health stabilization services for up to 14 days.

"**Implementation Plan**" means a plan required by King County Ordinance 19572 that will direct Crisis Care Centers Levy expenditures from 2024 through 2032.

"**Jurisdictions**" means cities, tribes and other jurisdictional entities with siting authority that are physically located within King County.

"**King County Ordinance 19572**" means the ballot measure ordinance that was enacted by King County Council on February 9, 2023 and passed by King County voters on April 25, 2023 to create the Crisis Care Centers Levy.

"**Post-Crisis Follow-Up Program**" means short-term case management and peer engagement services to connect people to care after they leave a Crisis Care Center.

"**Procurement"** means a future solicitation to determine who will be contracted to develop, own, and operate Crisis Care Centers.

"RFI" means this Request for Information plus all written amendments, addenda, or attachments hereto, and all terms and conditions incorporated herein.

Upcoming Procurement Description

A. **UPCOMING PROCUREMENT FUNDING AMOUNT AND OBJECTIVES**

King County intends to release one or more Procurements beginning in 2024. Funding will include resources to construct and operate Crisis Care Centers, and the funding amount that will be available is not yet determined. The siting of Crisis Care Centers will be coordinated in partnership with local Jurisdictions and King County.

B. **ANTICIPATED TIMELINE**

One or more rounds of Procurement processes will be released in 2024. The timeline will be determined in 2024 after the King County Council passes the Crisis Care Centers Initiative Implementation Plan.

C. **PROGRAM DESCRIPTION**

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

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

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

RFI Questions

A. **QUESTIONS**

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

Contact Information

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

Crisis Care Center Information

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

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

B. **DOCUMENT REQUESTS**

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

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

Appendix D: Coordination with State and County Partners

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

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

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

* Facilities under construction or not yet operational

Appendix F: Community Engagement Activities

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

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

Focus Groups and Listening Sessions

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

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

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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/arcr.v41.1.09. [LINK]

[275] Substance Abuse and Mental Health Services Administration (SAMHSA) Person- and Family-centered Care and Peer Support [LINK]

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

[277] National Council for Mental Wellbeing, The Comprehensive Healthcare Integration (CHI) Framework, April 22, 2022. [LINK]

[278] Expectations for integrated medical care in a behavioral health crisis care setting are described here similar to state requirements for 23-hour Crisis Relief Centers as defined in RCW 71.24.916 – 23-hour crisis relief centers—Licensing and certification—Rules—Standards. [LINK]

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

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[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]

Appendix H: BHRD Capital Improvement Funding for Behavioral Health Facilities Request for Information (RFI)

The purpose of this RFI was to solicit information from contracted behavioral health provider organizations about necessary capital improvements, repairs, and innovations in behavioral health facilities located in County. Information provided through this RFI may be fused to inform a potential Request for Proposal and be used to improve access to and availability of behavioral health services by assisting with costs associated with building repairs, renovations, or expansion of existing behavioral health provider facilities. This RFI was open from June 23, 2023, to July 17, 2023.

Department of Community and Human Services
Behavioral Health and Recovery Division
401 Fifth Avenue, Suite 400
Seattle, WA 98104

REQUEST FOR INFORMATION (RFI)
BHRD Capital Improvement Funding for Behavioral Health Facilities
RFI Release Date: June 23, 2023
Questions Due: July 07, 2023
Due Date: July 17, 2023
RFI Lead: Brandon Paz, branpaz@kingcounty.gov

Purpose of RFI

This Request for Information (RFI) is seeking input from contracted behavioral health provider organizations to inform a potential Request for Proposal (RFP) that may be released in late 2023. The King County Department of Community and Human Services (DCHS) Behavioral Health and Recovery Division (BHRD) seeks information related to necessary capital improvements, repairs and renovations in behavioral health treatment facilities located in King County. Information provided through this RFI may be used to improve access to and availability of behavioral health services by assisting with costs associated with building repairs, renovations or expansion of existing behavioral health provider facilities.

DCHS is releasing this RFI to understand the level of need agencies have for capital projects and expected costs. Please note that **no funding will be released as a result of this RFI**. Submitting a response to this RFI does **not** constitute a commitment to a project in any subsequent RFPs. This RFI is for informational purposes only, to inform potential investments by the County in late 2023.

Who should respond?

The following entities are encouraged to respond:

- Behavioral health provider organizations that are contracted with the King County Behavioral Health and Recovery Division, including but not limited to King County Integrated Care Network providers, King County Behavioral Health Administrative Service Organization (KCICN-BH-ASO) providers, and providers contracted through the MIDD program.

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

Background

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

Request for Information

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

How to Respond

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

Questions

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

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

- Renovation and repairs of an existing property to address critical health and safety issues, or improve treatment environment
- Facility improvements, including new paint and furniture to improve the treatment environment to promote healing
- Expansion of an existing facility to increase availability of treatment services, or allow more clients to be served

7. If you currently own or lease the project site, please provide the address. If not, please provide the zip code or general location of the proposed site and whether you plan to own or lease it.
8. Please share the following information regarding the project's funding needs:

a. What is the estimated total cost of your project?
b. Do you have funding secured from other sources?
c. Are you anticipating applying for other funding sources?
d. How much funding do you anticipate requesting from a potential 2023 capital program RFP?
e. What is the anticipated timeline for completion of the project?

RFI Terms and Conditions

A. Revisions to the RFI

If DCHS determines in its sole discretion that it is necessary to revise any part of this RFI, an addendum to this RFI will issued via email. For this purpose, the published questions and answers and any other pertinent information will also be provided as an addendum to the RFI and will be issued via email. DCHS also reserves the right to cancel or to reissue the RFI in whole or in part, prior to execution of a contract.

B. Cost to Propose

DCHS will not be liable for any costs incurred by the Responder in preparation of a Response submitted in response to this RFI, in conduct of a presentation, or any other activities related in any way to this RFI.

C. No Obligation to Contract

DCHS will not contract with any vendor as a result of this RFI. While DCHS may use responses to this RFI to develop a competitive solicitation for the subject of this RFI, issuing this RFI does not compel DCHS to do so.

D. Public Records Act

1. Washington State Public Records Act (RCW 42.56) requires public organizations in Washington to promptly make public records available for inspection and copying unless they fall within the specified exemptions contained in the Act or are otherwise privileged.

2. All submitted Responses and RFI materials become public information and may be reviewed by anyone requesting to do so at the conclusion of the RFI, negotiation, and award process. This process is concluded when a signed contract is completed between the County and the selected Responder. Note that if an interested party requests copies of submitted documents or RFI materials, a standard County copying charge per page must be received prior

to processing the copies. King County will not make available photocopies of pre-printed brochures, catalogs, tear sheets or audiovisual materials that are submitted as support documents with a Response. Those materials will be available for review at King County Department of Community and Human Services.

3. No other distribution of Responses will be made by the Responder prior to any public disclosure regarding the RFI, the Response or any subsequent awards without written approval by King County. For this RFI all Responses received by King County shall remain valid for ninety (90) days from the date of Response. All Responses received in response to this RFI will be retained.

4. Responses submitted under this RFI shall be considered public documents and with limited exceptions, Responses that are recommended for contract award will be available for inspection and copying by the public. If a Responder considers any portion of his/her Response to be protected under the law, the Responder shall clearly identify on the page(s) affected such words as "CONFIDENTIAL," PROPRIETARY" or "BUSINESS SECRET." The Responder shall also use the descriptions above in the following table to identify the effected page number(s) and location(s) of any material to be considered as confidential. If a request is made for disclosure of such portion, the County will review the material in an attempt to determine whether it may be eligible for exemption from disclosure under the law. If the material is not exempt from public disclosure law, or if the County is unable to make a determination of such an exemption, the County will notify the Responder of the request and allow the Responder ten (10) days to take whatever action it deems necessary to protect its interests. If the Responder fails or neglects to take such action within said period, the County will release the portion of the Response deemed subject to disclosure. By submitting a Response, the Responder assents to the procedure outlined in this paragraph and shall have no claim against the County on account of action taken under such procedure. Please notify the County of your needs and reference the table information below

Type of Exemption	Beginning Page/Location	Ending Page/Location

E. American with Disabilities Act

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

DocuSign

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
Envelope Originator:
Supplemental Document Pages: 187
Initials: 0
Cherie Camp
Certificate Pages: 5
AutoNav: Enabled
401 5TH AVE
EnvelopeId Stamping: Enabled
SEATTLE, WA 98104
Time Zone: (UTC-08:00) Pacific Time (US & Canada)
Cherie.Camp@kingcounty.gov
IP Address: 198.49.222.20

Record Tracking

Status: Original
6/20/2024 12:08:06 PM
Holder: Cherie Camp
Cherie.Camp@kingcounty.gov
Location: DocuSign
Security Appliance Status: Connected
Pool: FedRamp
Storage Appliance Status: Connected
Pool: King County-Council
Location: DocuSign

Signer Events	Signature	Timestamp
Dave Upthegrove dave.upthegrove@kingcounty.gov Chair Security Level: Email, Account Authentication (None)	DocuSigned by: E76CE01F07B14EF... Signature Adoption: Uploaded Signature Image Using IP Address: 67.185.138.82	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

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp
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	COPIED	Sent: 6/20/2024 1:30:19 PM Viewed: 6/24/2024 10:35:20 AM

Witness Events	Signature	Timestamp

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
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

Electronic Record and Signature Disclosure

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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 paper copies from King County-Department of 02

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.

To withdraw your consent with King County-Department of 02

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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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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- 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.