Recovery Support & Stability Program

Enhancing Outcomes in Felony Mental Health Diversion (MHD)

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Recovery-Oriented ● Engagement-Focused ● Evidence-Based

Center Point

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Purpose

- Present a proposed enhancement to the Felony Mental Health Diversion (MHD) program
- Strengthen outcomes for individuals with co-occurring disorders
- Improve engagement, stabilization, and public safety
- Support committee consideration for pilot implementation
- Align with Sacramento County's lower barrier, engagement-focused care model

Program Framing & Terminology

- This proposal includes the use of urine drug testing (UDT) as a clinical tool
- Terminology matters in engagement and treatment outcomes
- Sacramento County is advancing lower barrier, engagement-focused care
- The term UDT may be perceived as punitive or stigmatizing
- For this proposal, UDT will be referred to as: **Recovery Support & Stability Program**

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Lower Barrier Care Alignment

- The Recovery Support & Stability Program is designed to align with Sacramento County's lower barrier approach
- Lower Barrier Care:
  - Reduces barriers to accessing and staying in treatment
  - Prioritizes trust, engagement, and harm reduction
  - Avoids punitive approaches
- Program framing and implementation are intended to support engagement rather than surveillance

Sacramento County BHS (2023); SAMHSA (2020)

Background

- Sacramento County Felony Mental Health Diversion (MHD) serves individuals with diagnosed co-occurring mental health and substance use disorders as a condition of program eligibility
- Substance use within this population can:
  - Exacerbate psychiatric symptomatology
  - Interfere with psychotropic medication adherence
  - Undermine treatment effectiveness and stabilization
- These clinical factors increase the risk of:
  - Diversion non-compliance
  - Program attrition or failure
  - Recidivism
  - Psychiatric decompensation related to medication non-adherence
- **Sustained success in diversion is closely tied to the early identification of substance use and timely clinical intervention prior to escalation**

Current Gap in MHD

- Limited objective visibility into substance use and medication non-adherence during participation
- Reliance on self-report and observation
- Gap between clinical intent and real-time behavioral insight
- Participants may underreport use due to fear, stigma, or perceived consequences
- Opportunity:

Enhance early detection, improve clinical insight, and support real-time intervention

SAMHSA (2021)

Proposed Enhancement

- Integrate objective recovery support monitoring into MHD
- Designed as a therapeutic support—not a compliance tool

Core Components:

- Random and periodic monitoring
- Integration with treatment plans
- Non-punitive clinical responses
- Cross-system coordination
- Recovery reinforcement strategies
- Structured accountability to support behavior change

What is the Program?

- Structured clinical monitoring approach
- Incorporates drug testing as one component
- Used to inform care and clinical decision-making
- Can be random, scheduled, or clinically driven
- Grounded in national evidence-based clinical guidelines

ASAM (2017); ASAM (2020)

Evidence-Based Clinical Foundation

- Improves the accuracy of self-reported substance use
- Provides objective data to supplement clinical judgment
- Supports medication adherence monitoring
- Detects relapse early
- Recommended as part of ongoing clinical monitoring
- Critical in outpatient and community-based settings

ASAM (2017); SAMHSA (2021)

Why This Works

- Provides objective clinical data
- Enables early intervention
- Strengthens treatment engagement
- Reinforces accountability
- Supports more honest and productive clinical dialogue
- Enables real-time treatment adjustments

Phased Monitoring Model

Initial Phase:
• 3x per week for a minimum of 30 days

Stabilization Phase:
• 2x per week for the next 30 days

Maintenance Phase:
• 1-2x per week ongoing

Frequency adjusted based on:

- Clinical need
- Risk level
- Observed behaviors

Model remains flexible and responsive rather than rigid

Guiding Principles

- Therapeutic First—not punitive
- Proportional Response—relapse triggers clinical intervention
- Individualized care based on risk and need
- Transparency with participants
- Cross-system collaboration
- Reinforces that monitoring is part of treatment—not surveillance

ASAM (2017); NAATP et al. (2015)

Therapeutic Value

- Identifies relapse early
- Improves clinical dialogue
- Enables real-time treatment adjustments
- Reinforces recovery behaviors
- Prevents escalation into psychiatric or behavioral crises

ASAM (2017); SAMHSA (2021)

Public Safety Impact

- Identifies relapse before escalation
- Reduces the likelihood of reoffending
- Stabilizes mental health conditions
- Strengthens diversion effectiveness
- Supports diversion as a safe alternative to incarceration

ASAM (2017); SAMHSA (2021)

Implementation Strategy

- Start with pilot cohort
- Establish clear protocols
- Train staff and partners
- Ensure consistent application across systems
- Track outcomes:
  - Engagement
  - Completion rates
  - Recidivism
- Evaluate scalability based on pilot results

Ethical Alignment

- Must remain non-punitive
- Use non-stigmatizing language
- Maintain trust and dignity
- Ensure consistent staff approach
- Protect confidentiality and privacy

ASAM (2017)

Cost Assumptions & Pilot Structure

- Approx. 500 participants enrolled in the program
- Average monitoring frequency: 2x weekly
- Approx. 1,000 tests conducted weekly (52,000 annually)
- Staffing model includes:
  - 11 FTE Case Managers / UDT Techs (1 FTE = 90 Tests/Week)
  - 1 Program Director
  - Administrative support
  - Medical oversight depending on implementation structure
- Operational assumptions include:
  - 25% instant-read test cups (13,000 annually)
  - 50% laboratory confirmation analysis (26,000 annually)
  - Monitoring frequency adjusted based on clinical need and stabilization
- Cost projections are preliminary planning estimates intended to support pilot evaluation and implementation discussion

Projected Annual Cost Comparison

Option 1: Traditional Monitoring Model *(Includes Laboratory Analysis Costs)*	
Cost Category	**Estimated Annual Cost**
Personnel	$748,800
Benefits (30%)	$224,640
Total Personnel & Benefits	**$973,440**
Operations *(Excludes Laboratory Analysis)*	$188,100
Laboratory Analysis	$1,300,000
Subtotal (Direct Costs)	**$2,461,540**
Indirect or OHP (15%)	$369,231
Total Annual Projection	**$2,830,771**

Option 2: Therapeutic Partnership Model *(Lab Analysis Potentially Covered by Eligible Payors)*	
Cost Category	**Estimated Annual Cost**
Personnel	$754,800
Benefits (30%)	$226,440
Total Personnel & Benefits	**$981,240**
Operations *(Excludes Laboratory Analysis)*	$188,100
Laboratory Analysis	**$0** *(Potentially $0 Direct County Cost*)*
Subtotal (Direct Costs)	**$1,169,340**
Indirect or OHP (15%)	$175,401
Total Annual Projection	**$1,344,741**

Potential Cost Offset Opportunity

Under appropriately structured therapeutic treatment models with medical oversight, laboratory providers may be able to bill eligible payors directly for medically necessary clinical testing services, potentially reducing or eliminating direct county laboratory analysis costs.

**Dependent on program design, payer requirements, and medical necessity documentation.*

Recommendation

Consider implementing a pilot of the Recovery Support & Stability Program within Felony Mental Health Diversion (MHD) for individuals with co-occurring disorders.

Expected Outcomes:

- Increased treatment engagement
- Early relapse identification
- Improved program completion
- Reduced recidivism
- Strengthened confidence in diversion

Approach aligns with clinical best practices and Sacramento County priorities

Key Takeaways

- This is not a punitive UDT model—it is a **Recovery Support model**
- Evidence-based and widely used in treatment systems
- Strengthens both clinical outcomes and public safety
- Fully aligned with lower barrier care when implemented correctly
- Structured monitoring + treatment improves outcomes

References

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