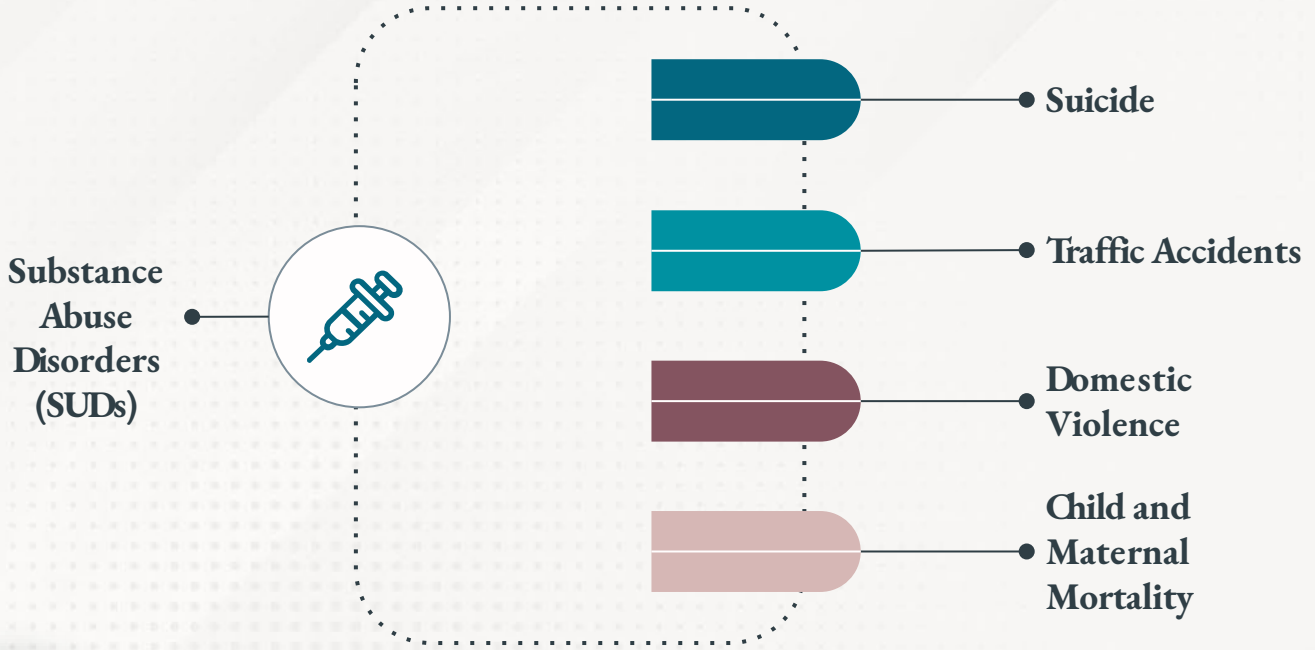
Rehabilitation Over Retribution

Team 49

TRIGGER WARNING

This presentation contains discussions of sensitive topics, including suicide, domestic violence, and substance abuse. Please take care of yourself and feel free to step away if you need to.

A COMMON THREAD: SUBSTANCE ABUSE



11.2 times more likely with SUDs[1]

4-12 times more likely with alcohol use[2]

1.3-11.5 times more likely with SUDs[3,4]

44% of pregnancy associated deaths in LA attributed to SUDs[5]

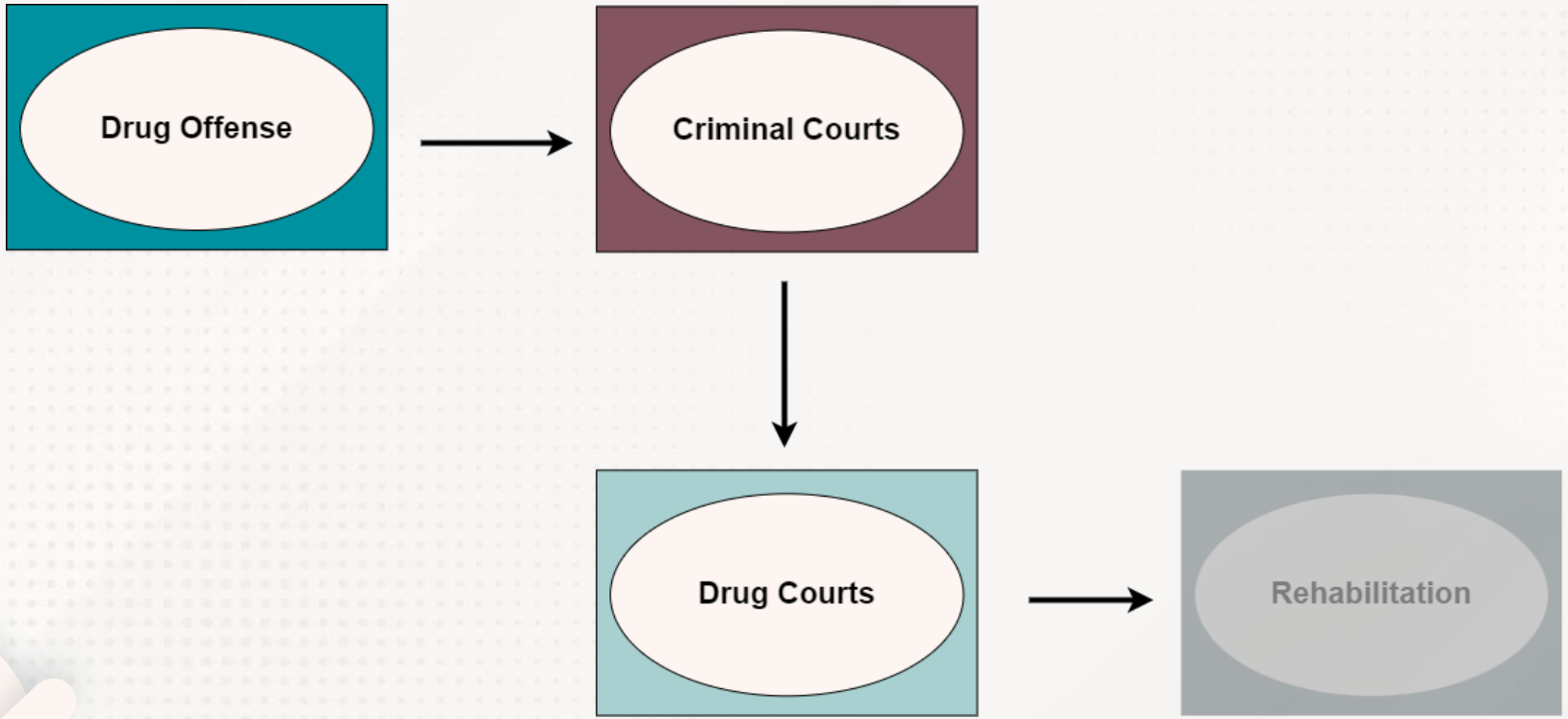
IMPRISONMENT PERPETUATES SUD CRISIS

65% percent of the United States prison population has an **active SUD**.[6]

Louisiana ranks **second** in **per capita incarceration** in the US[7]

Probationers for drug-related offenses were **70% more** likely to recidivate than non drug-using probationers.[8]

EXISTING INFRASTRUCTURE: DRUG COURTS



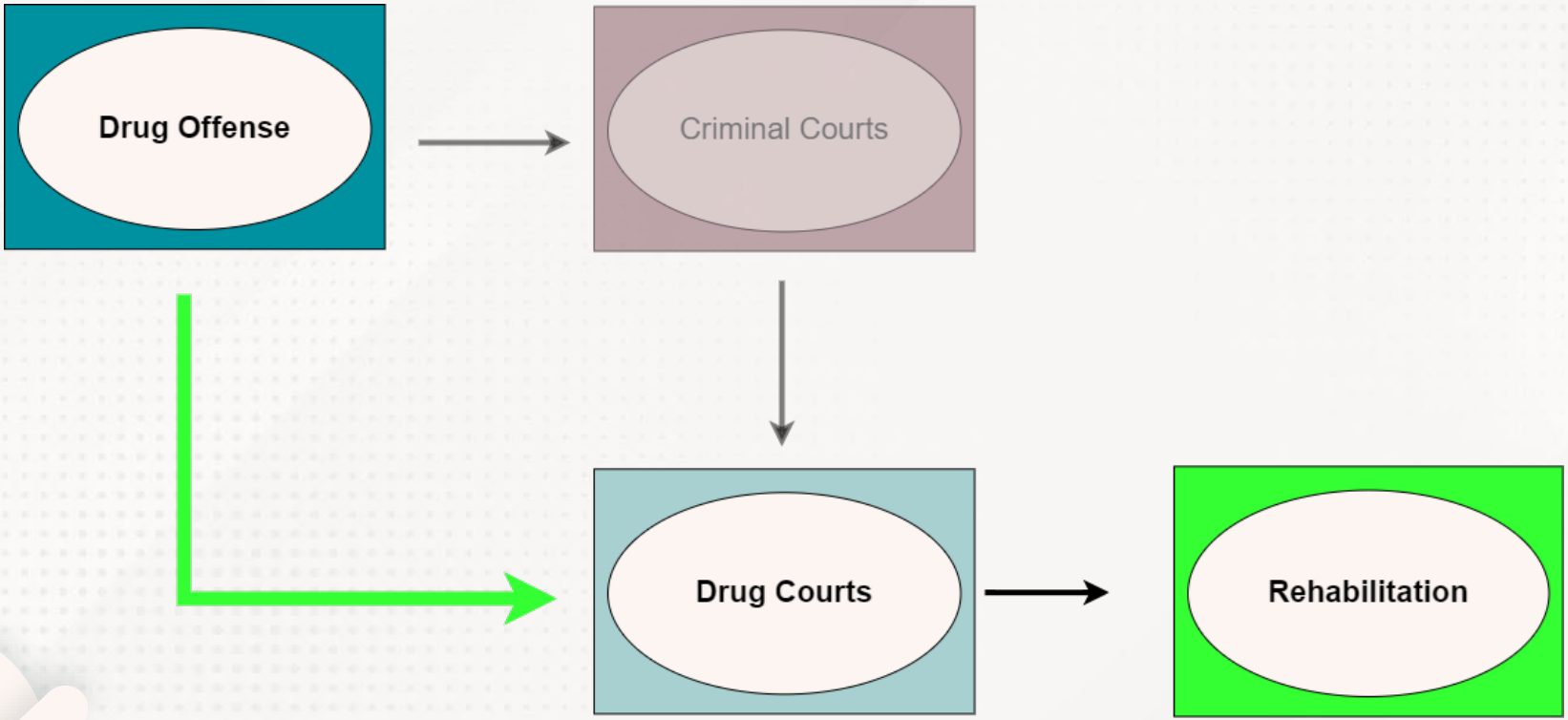
THE PROBLEM: A LOCAL PERSPECTIVE

We conducted a key informant interview (KII) with **Jennifer Couret**, the Clinical Director for Lake Wellness Center - the clinical provider for St. Charles Parish Drug Court, who helped us identify the two-pronged challenges burdening the criminal rehabilitation system in New Orleans[9]

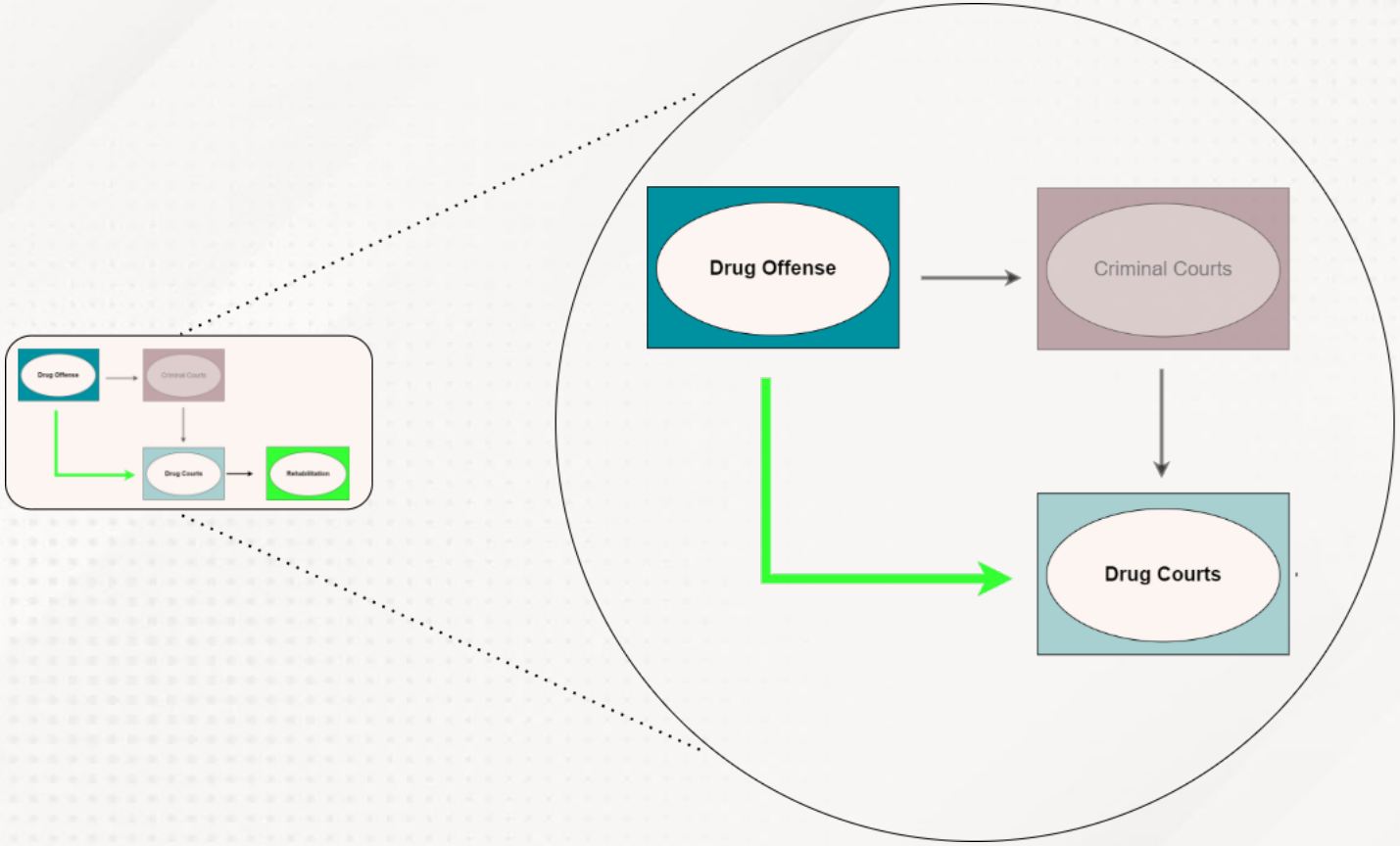
Not enough offenders suffering from SUDs get sent to drug court

Not all parishes in New Orleans effectively rehabilitate their patients

A TWO-PRONGED SOLUTION



SOLUTION 1: STREAMLINING

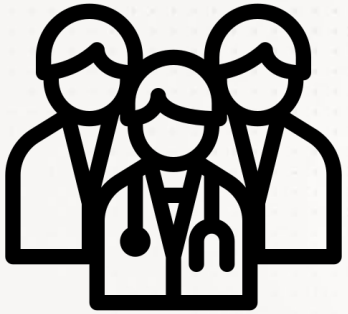


NEED FOR STREAMLINING

Criminal courts are ill-oriented to drug offenses, sinking the current system.

Louisiana's criminal justice system is overwhelmed, leading to backlog and incomplete decision making.[7, 8]

Drug-related education and training is not a part of Louisiana's annual Continuing Legal Education Requirements for criminal court justices.[10]



In criminal courts, clinicians are not involved with determining whether individuals need rehabilitation.

PLAN FOR STREAMLINING

We are shifting the responsibility from criminal court justices to clerical and clinical court workers.

The screening process will be trifold to ensure only and all necessary, relevant cases go to drug courts:

- **Primary Screen**
  - Court clerks will screen for legal eligibility immediately following arrest.
    - Defendant must meet all 6 of New Orlean's legal requirements for drug court eligibility.[11]
- **Secondary Screen**
  - The District Attorney reviews the primary screening and consents for the tertiary screen.
- **Tertiary Screen**
  - Court clinical staff will conduct a detailed clinical screen including a urine toxicology screen to determine presence and severity of SUD.

ALL those who pass the 3 screens will present before a drug court.

EMPIRICS ON STREAMLINING

A similar screening plan was implemented first in Brooklyn in 2003.[12]

By 2008, the Brooklyn borough alone "accounted **64%** of all defendants referred to a drug court for assessment" and "for **30%** of all new participants" in NYC's 5 boroughs.[12]

The screening plan has **empirically proven** to decrease the amount of SUD patients that slip through the cracks and serve time rather than receive treatment.

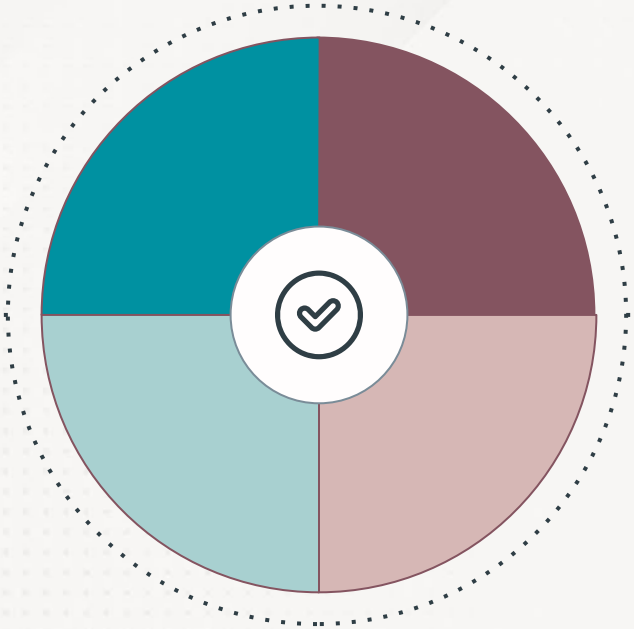
BENEFITS OF STREAMLINING

Equity

The universal screening process brings impartiality to drug courts, equitably divorcing the qualification process from the opinions of the presiding judge and prosecuting attorney

Accuracy

The current criminal justice system misjudges which SUD patients should be incarcerated vs rehabilitated.[6,9] Routing eligible cases to drug courts for assessment through the screening plan will improve these decisions.



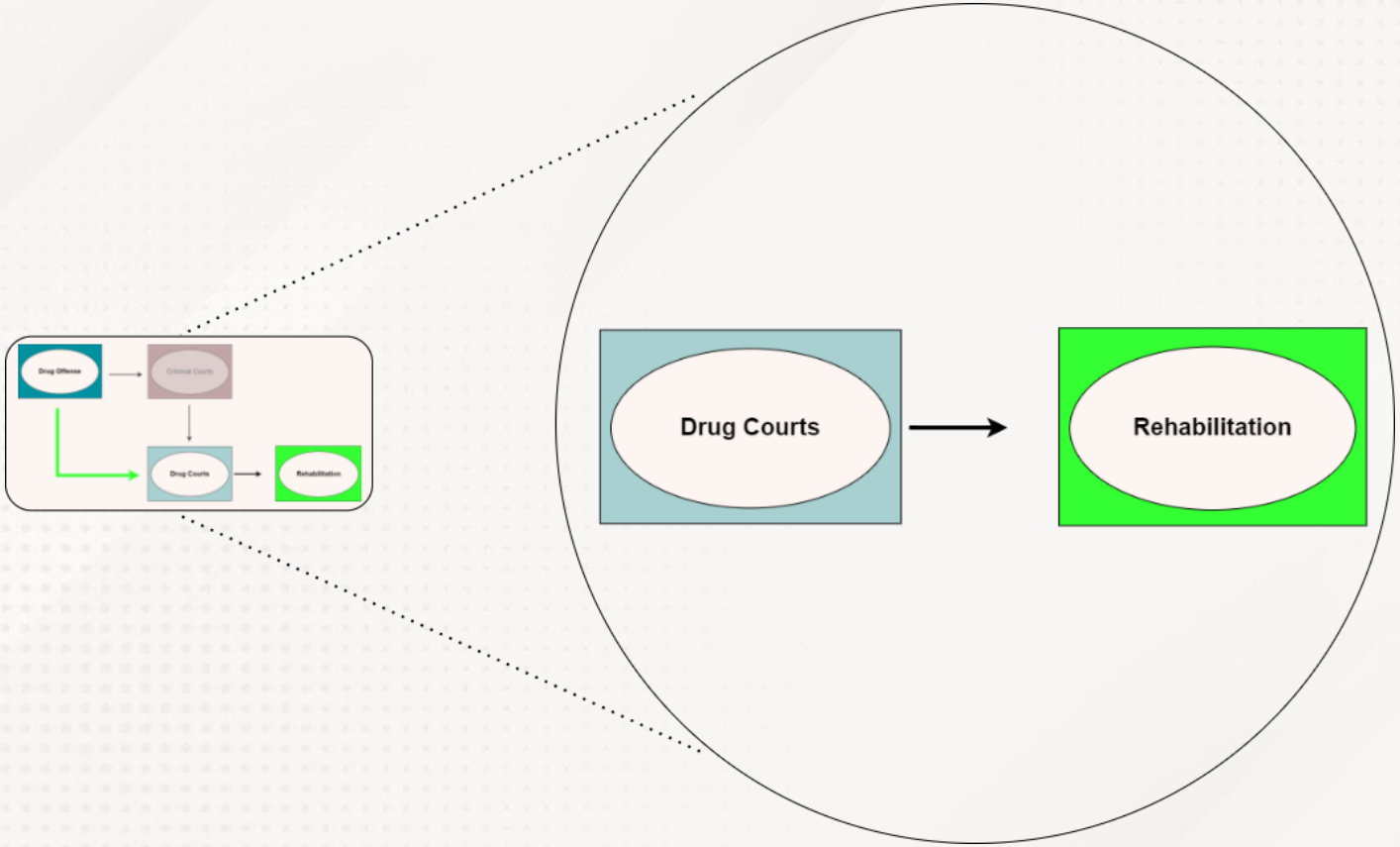
Speed

By removing the need to present before a criminal court, the process to present before a drug-court is greatly sped up.

Task Shifting

By redistributing all eligible drug-related cases from criminal to drug courts, this solution allows both drug courts and criminal courts to focus on what they do best.

SOLUTION 2: OPTIMIZING CARE



NEED FOR OPTIMIZATION

Decentralization

Most New Orleans parishes have **too many providers** involved in rehabilitation.[9]

The KII with **Jennifer Couret** revealed that decentralization in select parishes causes a difficulty in standardizing medication assisted treatment (MAT) and coordinating group therapy

Insufficient Inpatient Care

Patients are immediately thrust into intensive **outpatient** care, Phase 1, regardless of situation

An interview with **Dr. Satish Kedia**, Associate Dean and Professor at the University of Memphis, revealed that outpatient care as the first step is inadequate for some patients. [13]

PLAN FOR OPTIMIZATION

Centralization

All drug courts within the 8 of the Parishes that have jurisdiction in New Orleans (Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. James, St. John the Baptist, and St. Tammany) must be mandated to work with a sole provider for all rehabilitation services.

The single provider will offer all necessary:

- Individual counseling sessions
- Group therapy sessions
- Random drug tests
- Nurse practitioner visits
- AA or NA meetings

Phase 0

Phase 0 is an option for 28 days of inpatient care before transitioning to Phase 1.

Eligibility considerations:

- How long they have been using
- What drug they are using
- Environmental and personal factors

The judgement on whether a 28 day inpatient phase is necessary will be made by the drug court team - the same team that currently devises the treatment plan.

As with all phases currently, patients will need to apply and be assessed to move from phase 0 to phase 1.

EMPIRICS ON OPTIMIZATION

Centralization

Centralization is working **in New Orleans**.

Jennifer Couret works with St. Charles Parish Drug Court, one of the only parishes operating under a single provider.[9]

Lake Wellness Center is the parish's sole provider, drives the parish's especially effective medication assisted treatment and group therapy.

Phase 0

Massachusetts can serve as a proof of concept for Phase 0.

Inpatient detoxification resulted in improved outcomes even compared to outpatient treatments, as measured by overdose risk and serious opioid - related acute care use.[14]

BENEFITS OF OPTIMIZATION

Centralization

Both Jennifer Couret and Dr. Kedia emphasize that **both medication assisted treatment and group therapy** are necessary for successful rehabilitation. Centralization bolsters both and offers other benefits.

Many providers use suboxone to decrease drug dependence during MAT. Suboxone is susceptible to abuse and illegal distribution by patients.[9,13,15] Centralizing to a provider that uses the less addictive and non-distributable alternative, sublocade, makes MAT safer and more effective.

Groups stick together through each phase under 1 provider.[9] Unity improves group therapy outcomes.[16]

Continuity of care is proven to be higher under 1 provider than multiple.[17]

Centralization allows for standardized quality control and higher quality care.[18]

Centralizing healthcare facilities offers more than 20% cost-savings.[19]

Phase 0

A personalized approach to care effectively uses the resources available to provide the best outcome for all patients. Attempting to use a “one-size-fits-all” approach perpetuates the cycle of rehab failure, putting people further at risk.

Metrics and Logistics

METRICS OF EVALUATION

SOLUTION 1	SOLUTION 2
• Number of screens at each level • Referral rate to drug courts • Screening delay times, between and within levels	• Number of patients in centralized rehab (inpatient and outpatient) • MAT adherence rate • Group therapy attendance • Treatment completion
OVERALL	
• Recidivism • Substance use relapse rate • Patient satisfaction • Judicial feedback	

TIMELINE

Month 1

- Assemble key stakeholders, including court officials, rehab centers, legal experts, and MAT providers
- Finalize screening tools and confirm eligibility criteria with stakeholders

Month 2

- Train court clinical staff on the newly updated systems and test out data collection system.
- Finalize contracts with MAT providers

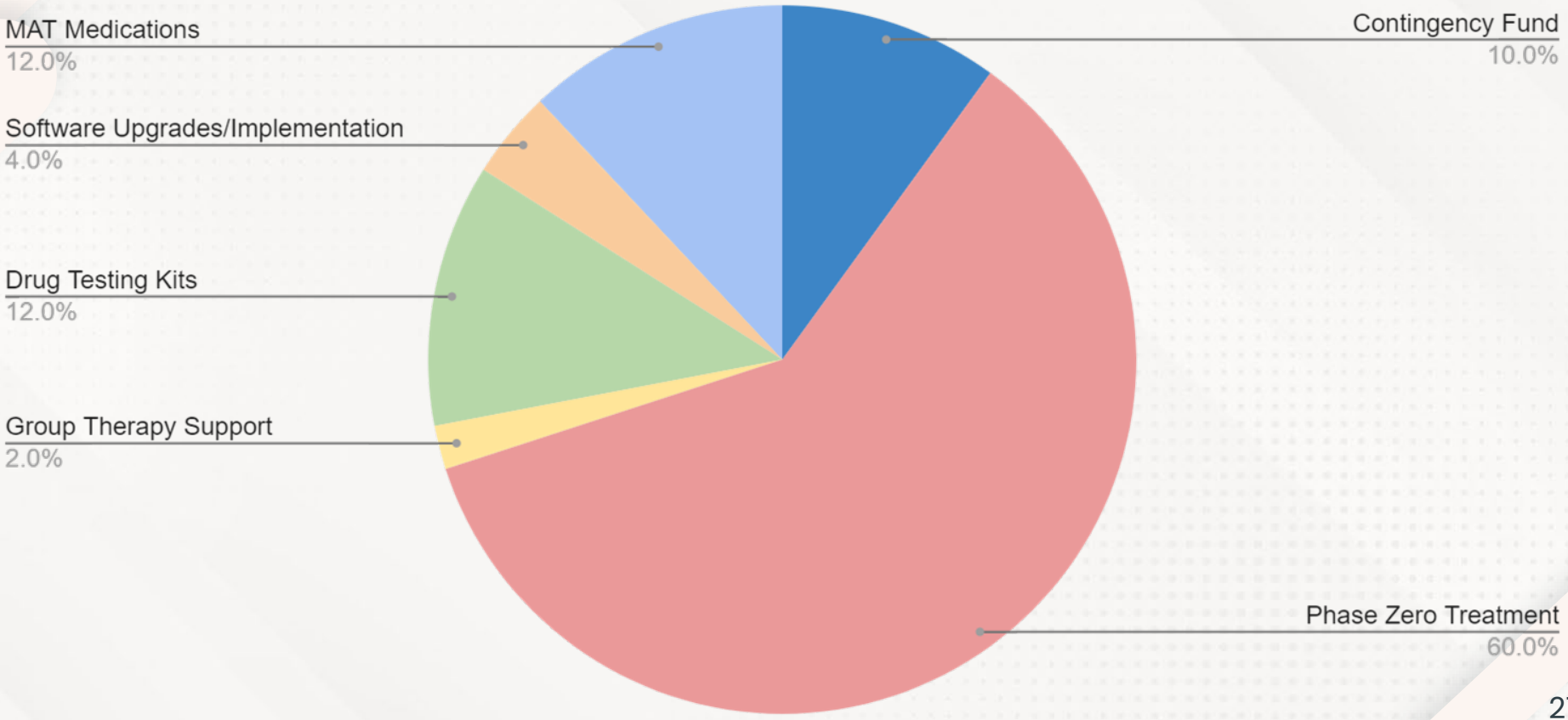
Month 3

- Pilot the screening process and system of referrals
- Begin group therapy and improved rehabilitation clinics

Month 4

- Use pilot data to improve and begin widespread rollout throughout New Orleans

BUDGET


MAT Medications
12.0%
Software Upgrades/Implementation
4.0%
Drug Testing Kits
12.0%
Group Therapy Support
2.0%
Contingency Fund
10.0%
Phase Zero Treatment
60.0%

SUSTAINABILITY BY COST REDUCTION

- Recidivism, that we can prevent, costed Louisiana $232M in 2021[20]

- "Every $1.00 invested in drug courts, communities receive an average of $3.36 in benefits" - Louisiana Supreme Court[21]

- Louisiana Drug Court participants give birth to drug-free babies, each of which saves $250,000 in the first year of life as per the Office of Justice Systems[21]

TRADE OFFS

- Trade-Off 1: Sending all eligible cases to drug courts has the potential to overload the drug courts themselves.
- Solution 1: Improve training of criminal court justices in drug court workings so that the workload can be shifted and both courts can complete sentencing. This could be accomplished through revised CLE rules.
- Trade-Off 2: Having a single provider makes changing any part of the process more difficult, as everything would have to be changed instead of modularized portions.
- Solution 2: Ensure that rehabilitation clinics include flexible scheduling and frequent feedback opportunities so that patients still have control over their treatment.

THE FINAL MESSAGE

The **story of injuries and deaths** in New Orleans cannot be told without a **foreword from the drug crisis**. Entrusted with knowledge from those on the ground, we advocate for a solution that addresses **a common denominator** that has long been mishandled—**substance use disorders.**

THE FINAL MESSAGE

SUDs critically underlie the problems in New Orleans identified by the case document: suicide, traffic accidents, domestic violence, child and maternal mortality, all on top of the **499 graves dug by accidental drug-related incidents** in New Orleans every year.[22]

THE FINAL MESSAGE

Our vision for a safer New Orleans **stops the incarceration of a disorder**. By sending more people to rehabilitative services and streamlining the delivery of those services, we **leverage the city's existing infrastructure** to ensure that these vital programs are fully utilized and expanded — turning a system that is already a blessing into a lifeline for even more in need.

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Appendix A: Budget

- Solution 1: Streamlining, responsibility from criminal court justices to drug courts based on tertiary screening
  - For drug testing kits:
    - 7502 arrests/year in NOLA 2023 (https://council.nola.gov/dashboards/)
    - 65% of people in criminal justice system have SUDs (https://nida.nih.gov/publications/drugfacts/criminal-justice)
    - 5000 people * $12/kit = 60K (https://meditests.com/product/18-panel-urine-cup-inclds-etg-fen-k2-tra-kratom/?utm_source=Google%20Shopping&utm_campaign=Shopping&utm_medium=cpc&utm_term=3033&gad_source=1&gclid=CjwKCAjw1NK4BhAwEiwAVUHPUB2EEoQcZwQ-HQoCIJus2S4eBtz17As2oWII6uBJdxXAXKlXf23MCxoCTOUQAvD_BwE)
  - Clinical software for case management, mostly for upgrading and maintenance of a system that will be handling a larger number of tests: $20,000

Appendix A: Budget (cont.)

- Solution 2: Centralization, improve the rehabilitation process and centers
  - MAT Medication costs $60K:
    - Sublocade costs $1-4/month through Medicaid (https://bocarecoverycenter.com/medication-assisted-mat/sublocade/cost/)
    - Vivitrol is covered through Medicaid (https://www.brightviewhealth.com/latest-updates/does-medicaid-cover-vivitrol-injections/)
    - Most treatment plans last 6 months or longer
  - Phase Zero people: 28 day inpatient process for people that need it
    - 7502 arrests/year in NOLA 2023 (https://council.nola.gov/dashboards/)
    - 65% of people in criminal justice system have SUDs (https://nida.nih.gov/publications/drugfacts/criminal-justice)
    - Of those, 1-2% are those that need inpatient care (https://www.samhsa.gov/data/sites/default/files/reports/rpt35313/2020_NSSATS_FINAL.pdf)
    - Mostly 10-25K, some sub 10K (link), use 7K estimate
    - Comes out to about 45 people/year, 300K
  - Group therapy support: $10K to cover various expenditures that may become necessary
- Contingency fund: 10%, $50K/year