

South Dakota's Virtual Crisis Care Pilot Program: A model for rural states



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Cover photo credit: South Dakota Sheriffs’ Association

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PURPOSE

Between January 2020 and June 2021, the Helmsley Charitable Trust provided funding to the Unified Judicial System (UJS) and Avera eCare (now known as Avel eCare) to develop and implement a pilot program to test a virtual mobile crisis response model in South Dakota’s rural communities. Together, UJS, with the Crime and Justice Institute (CJI) as its contractor, Avera eCare, and the South Dakota Sheriffs’ Association partnered to pilot Virtual Crisis Care. Within the 18-month pilot period, the program proved to be a viable statewide crisis response solution, particularly for areas where traditional mobile crisis teams and other crisis care options are unavailable.

This report describes the impetus for the pilot program, documents the effort and its outcomes, and includes lessons learned and recommendations for consideration when expanding or replicating the program.

PROBLEM

Responding to mental health crises is a challenge in every state across the nation, and the challenges are more pronounced in rural communities.

Access to Mental Healthcare

Healthcare access is often discussed using the ‘five As’ – access, availability, accommodation, affordability, and acceptability. People living in rural communities face unique challenges in accessing timely mental health care. Compared to urban communities, rural communities have fewer behavioral health providers. In fact, it has been shown “that more than 60% of rural Americans live in Mental Health Professional Shortage Areas, [and] that more than 90% of all psychologists and psychiatrists and 80% of Masters of Social Work, work exclusively in metropolitan areas. More than 65% of rural Americans get their mental health care from primary healthcare provider, and the mental health crisis responder for most rural Americans is a law enforcement officer” (access).¹ In addition, rural Americans often have further distances to travel to access care (availability), and where there is local access, it can be limited to a day a week in a satellite office, for example (accommodation).

Affordability is another factor in accessing mental healthcare. According to the US Census Bureau, there is a higher percentage of uninsured people in rural and mostly rural communities than in urban areas.² This has been the case for decades according to Center for Disease Control data on uninsured people living in metropolitan statistical areas (MSAs) and those outside MSAs.³

¹ Mohatt, Dennis. “Mental Health and Rural America: Challenges and Opportunities.” 30 May 2018. Available from: <https://www.nimh.nih.gov/news/media/2018/mental-health-and-rural-america-challenges-and-opportunities>

² US Census Bureau. Health Insurance in Rural America: Rates of Uninsured Fall in Rural Counties, Remain Higher Than Urban Counties, 2019. Available from: <https://www.census.gov/library/stories/2019/04/health-insurance-rural-america.html>

³ National Center for Health Statistics. Health, United States, 2019: Table 49. Hyattsville, MD. 2021. Available from: <https://www.cdc.gov/nchs/hus/contents2019.htm>.

Accessing care is compounded by the stigma associated with treatment (acceptability). A 2015 study funded by The Leona M. and Harry B. Helmsley Charitable Trust, for example, found that ten percent of people in rural South Dakota indicated stigma is a main reason for going without mental health treatment; this number was about 16 percent for people living on reservations.⁴

“More than half of people with mental illness don’t receive help for their disorders. Often people avoid or delay seeking treatment due to concerns about being treated differently or fears of losing their jobs and livelihood. That’s because stigma, prejudice and discrimination against people with mental illness is still very much a problem.”

American Psychiatric Association:
<https://www.psychiatry.org/patients-families/stigma-and-discrimination>

These factors are common across the country, as described by the Rural Health Information Hub; stigma impacts people’s decision to seek treatment because it can “lead to shame or embarrassment for the individual experiencing mental health conditions,” and “anonymity and privacy are particularly challenging in rural communities” because they may know the staff working in a mental health provider’s office or they “may fear being seen walking into a mental health clinic.”⁵

The stigma around mental health treatment can be compounded in rural areas by a lack of mental health professionals who are Native American or people of color. Language differences and lack of understanding can serve as additional obstacles to comfort in accessing care.⁶

Access to Crisis Response Services

Given the overall mental healthcare access issues, it is not surprising that many communities lack access to mobile crisis response or other such services that involve clinically trained personnel, and that the absence of these services is more pronounced in rural areas. In many places across the country, law enforcement officers are the only crisis response option.

Past studies have found that seven to ten percent of law enforcement contacts involve someone with a mental health issue.⁷ The challenges facing law enforcement as primary mental health crisis responders were well articulated by the Treatment Advocacy Center (TAC) in its 2019 study, *Roadrunners: The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness, A National Survey*. TAC received survey responses from 355 police and sheriffs’ departments in all but three states and the key findings include the following:

- “10% of law enforcement agencies’ total budgets was spent responding to and transporting persons with mental illness in 2017.”
- “21% of total law enforcement staff time was used to respond to and transport individuals with mental illness in 2017.”

⁴ Spurlock M, Davis MM, Dulacki K, Meath T, Li HF, McCarty D, Knight-Richardson N, Write B, Warne D, McConnell KJ. Focus on South Dakota: A Picture of Health. Report Findings from the South Dakota Health Survey. May 2015.

⁵ NORC Walsh Center for Rural Health Analysis and University of Minnesota Rural Health Research Center, 2017. Rural Community Health Toolkit [online] Rural Health Information Hub. Available at: <https://www.ruralhealthinfo.org/toolkits/rural-toolkit>. [Accessed 19 December 2021].

⁶ Ibid.

⁷ Stephanie Franz & Randy Borum (2011) Crisis Intervention Teams may prevent arrests of people with mental illnesses, *Police Practice and Research*, 12:3, 265-272, DOI: [10.1080/15614263.2010.497664](https://doi.org/10.1080/15614263.2010.497664). Accessed: 12 September 2021.

- On average, the distance officers drive to transport a person to a medical facility is 5 times farther than if driving the individual to a jail.
- Officers waited “2.5 hours longer when dropping a person off at a medical facility than if transporting to a jail.”
- “...of those persons with a severe mental illness who were transported to a medical facility, on average, 55% of persons transported were admitted for evaluation, 37% were evaluated and then released, and 8% were immediately released.”⁸

Without options to address these crises when and where they occur and to divert some of these individuals from inpatient hospitalization, there is no reason to believe these trends will not continue.

South Dakota’s Challenges with Crisis Response

A brief survey conducted by CJI in early 2020 with stakeholders involved in the early development of the Virtual Crisis Care model in South Dakota characterized the state’s challenges in the following ways that touch on many of the same findings as the TAC report.

- **Mental health crises can be complicated, yet law enforcement is generally expected to respond rather than behavioral health professionals.** Law enforcement is most frequently called upon to be the frontline intervention in mental health crisis situations in the state. These situations are often complex as they can involve legal, medical, behavioral health, social and even financial dynamics.

Law enforcement is tasked with efforts to calm or deescalate the situation, assure the safety of the person in crisis and those around them, assess the person’s mental status, determine whether the person is a danger to self or others due to a severe mental illness,⁹ and potentially place the person on an emergency mental health hold.¹⁰ If the person in crisis is placed on an emergency hold, law enforcement must be familiar with the state laws concerning this intervention, the proper legal and local processes, and necessary paperwork.

- **Many communities lack crisis response options, which can lead to overutilization of the highest level of mental healthcare and unnecessary costs.** The fundamental duty of law enforcement is to keep people safe. When faced with a crisis situation, the officer or deputy often has a binary choice, 1) deescalate the situation and leave the person home if safe to do so, or 2) initiate an emergency hold and take the individual to a behavioral health hospital if the County Board of Mental Illness so determines. The natural inclination for some in law enforcement may be to choose the option they think is guaranteed to keep the person safe (an emergency hold). This can lead to overutilization of inpatient beds when a less intensive service would be appropriate if it were available.

⁸ Treatment Advocacy Center. (2019). Road Runners: The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness, A National Survey. Retrieved from <https://www.treatmentadvocacycenter.org/storage/documents/Road-Runners.pdf>. Accessed: 11 May 2021.

⁹ SDCL 27A-10-3 and SDCL 27A-10-1

¹⁰ SDCL 27A-10-3

Involuntary hospital admissions represent costs to the state and referring county, but can also result in a financial burden for individuals. Counties can seek reimbursement for their portion of the post-commitment treatment and medication costs and attorney costs, if there is an appeal.¹¹ Involuntary commitment also takes people away from their families and jobs, which can lead to financial hardship. Additionally, when they are released from hospitalization, there currently is no systematic means for people to be connected to local services, particularly if they are not a current client of a local provider.

- **When law enforcement initiates an emergency mental illness hold, public safety can be impacted.** Sheriffs' deputies and police officers indicate that their involvement with crisis situations and emergency holds can take many hours. During much of this time they are unavailable for other law enforcement activities because they may be delivering paper work to the County Board of Mental Illness and waiting for the person in crisis to be evaluated and medically cleared. In addition, they may be outside of their jurisdiction for a considerable amount of time transporting the person to (and often from) a mental health hospital.¹²
- **A lack of local crisis response resources can lead to the criminalization of people with mental health issues.** When an individual is in crisis and local crisis response options are unavailable, an emergency mental illness hold may be initiated and the individual brought to a local hospital to be medically cleared. This means the person is handcuffed and placed in the back of a police car and driven to the hospital. Following this clearance, the individual can again be handcuffed and driven to one of four behavioral health hospitals in the state by one or two law enforcement officers, depending on the situation. Additionally, there are times when law enforcement cannot find an available inpatient bed, so an individual with no criminal charges may be held in jail for up to 24 hours to keep them safe.¹³

¹¹ SDCL 27A-10-5

¹² SDCL 27A-10-2, SDCL 27A-10-3 and SDCL 27A-10-14

¹³ SDCL 27A-10-2

MOBILE CRISIS TEAMS: A PROVEN MODEL

The availability of crisis response options can support law enforcement and keep them in their communities for public safety functions, reduce overuse of high-end and costly resources, connect people to local services, and reduce the criminalization of mental health crises.

Mobile crisis teams are one option that can be utilized to achieve these goals. The purpose of these teams is to provide intervention services to individuals wherever they may be when a mental health emergency arises. The teams provide screening and assessment, de-escalation, coordination with other mental health services, peer supports, and follow-up care and planning.¹⁴

As shown in the text box below, a 2014 report by the Substance Abuse and Mental Health Services Administration (SAMHSA)¹⁵ found mobile crisis services to be effective at averting hospitalization and connecting people to services.

Four studies were identified with empirical evidence on the effectiveness of mobile crisis services: one randomized controlled trial (Currier et al., 2010) and three that used quasi-experimental designs (Guo, Biegel, Johnsen, and Dyches, 2001; Hugo, Smout, and Bannister, 2002; Scott, 2000; Dyches, Biegel, Johnsen, Guo, and Min, 2002). The studies suggest that mobile crisis services are effective at diverting people in crisis from psychiatric hospitalization, effective at linking suicidal individuals discharged from the emergency department to services; and better than hospitalization at linking people in crisis to outpatient services.

In the same report referenced above, SAMHSA summarized the findings of a small number of early cost studies of mobile crisis programs. One study compared the cost of a mobile crisis program to regular police intervention in mental health crisis situations and found that mobile crisis program costs (including program and hospitalization costs) were 23% lower than regular police intervention (including police costs and hospitalization costs). Another study on mobile crisis intervention costs found that this type of intervention can reduce inpatient hospitalization costs by 79% post-crisis episode.¹⁶

South Dakota Codified Law 27A-10-20 defines a mobile crisis team as “an interdisciplinary team of one or more mental health professionals able to respond to any person in the community, either in person or through real-time interactive audio and video, for mental health and chemical dependency or abuse intervention.”

The state has two in-person mobile crisis teams, one in Minnehaha County and another in Hughes County. The program in Hughes County started in 2016. Data from Capitol Area Counseling in Pierre show that between July 1, 2018 and November 9, 2020 in the Hughes County coverage area, 74 percent

¹⁴ Substance Abuse and Mental Health Services Administration. National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2020.

¹⁵ Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

¹⁶ Ibid.

of people assessed were able to remain home with a safe at home plan rather than be hospitalized.¹⁷ The mobile crisis team in Minnehaha County has been operating since 2011 and the program reports that more than 90 percent of the individuals served were diverted from inpatient hospitalization in 2018 and 2019.¹⁸

¹⁷ Iversen-Pollreisz, Amy. Email to Sadie Stevens. 19 November 2020.

¹⁸ Lindquist, Steve. Email to Barbara Pierce. 19 November 2020.

A RURAL SOLUTION: VIRTUAL CRISIS CARE

While the mobile crisis team model has proven effective in South Dakota, a key question was: How can this service be brought to other parts of the state and be offered 24 hours a day seven days a week, given a shortage of mental health staff and the distances from provider locations? This remainder of this document identifies one answer to this question to these and the other challenges noted above – Virtual Crisis Care.

Virtual Crisis Care provides law enforcement and probation officers with access to mobile crisis services via tablets and telehealth technology in communities where these services did not exist before. The program allows law enforcement to seek assistance from behavioral health professionals, who can assist with deescalation, stabilization and safety assessment during a crisis situation wherever the crisis is occurring. Also, following the crisis, Virtual Crisis Care connects individuals to local mental health resources for follow-up care. The program was piloted with sheriffs’ departments in 18 counties across South Dakota, as well as with probation officers covering eight counties in one Judicial Circuit.

Goals

The goals for the pilot fell into three categories – goals for individuals, law enforcement, and state and local governments:

For Individuals

- Provide care from mental health professionals at the time of a crisis so people can remain at home when safe to do so, and avoid hospitalization and related individual financial burdens
- Allow people to continue with daily routines (e.g., work, school, caregiving responsibilities)
- Avoid the stigma and criminalization of behavioral health issues by providing care without requiring transport in a law enforcement vehicle

For Law Enforcement

- Provide around-the-clock access to trained behavioral health professionals
- Decrease petitions filed for mental health holds
- Reduce transports to mental health hospitals
- Keep law enforcement in their communities for public safety functions
- Decrease probation violations

For Governments

- Avoid unnecessary admissions to the state hospital
- Avoid county costs associated with unnecessary mental health holds

According to the Center for Disease Control, 46 million people, or 15%, of people in the US live in a rural area. *

Virtual Crisis Care is a program intended for statewide implementation to support law enforcement and reduce disparities in access to care.

*<https://www.cdc.gov/ruralhealth/about.html>

Pilot Participants

The pilot program operated from January 2020 to June 2021 and included 19 jurisdictions—18 sheriff departments and 4th Circuit Probation that operates in eight counties (Butte, Corson, Dewey, Harding, Lawrence, Meade, Perkins and Ziebach). The program was implemented with pilot sites over a 9-month period as shown below.

Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020
1. Brookings	<i>No sites added</i>	<i>No sites added</i>	<i>No sites added</i>	2. Butte 3. Clay 4. Jerauld 5. McPherson 6. Meade	<i>No sites added</i>	7. Beadle 8. 4th Circuit Probation	9. Roberts 10. Faulk 11. Lyman 12. Day	13. Campbell 14. Custer 15. Davison 16. Pennington 17. Lawrence 18. Walworth 19. Codington

The participating jurisdictions were recruited and selected for various reasons, including location, size, and perceived need, as well as willingness and desire to participate.

How Virtual Crisis Care Works

The process for using the Virtual Crisis Care service is straightforward. Once a deputy or probation officer determines the service would be helpful in a particular crisis situation, they call a dedicated phone line at Avera eCare (now Avel eCare) and provide the behavioral health professional with basic information such as who is calling and from which agency, their location, which iPad they will be using and the name, address and age of the person in crisis, as well as the reason they are contacting eCare.

As the diagram on the following page depicts, law enforcement and eCare next determine if the video session with the behavioral health professional will be initiated. The deputy or officer will not activate it if:

- The person in crisis needs immediate medical attention, is too intoxicated to develop a safety plan, or is too violent, aggressive or disorderly;
- There is a concern about a possible overdose;
- The person is located in an emergency department; or
- There is a connectivity or other technical issue.

During the video session via iPad, the behavioral health provider assesses the individual, may help deescalate and stabilize them, and, when possible, develops a safety plan. After the conclusion of the session, eCare documents the interaction and calls the deputy or officer to discuss the recommended action. At that point, law enforcement determines the course of action. eCare then sends documentation of the encounter to the law enforcement agency as well as the Community Mental Health Center that covers the area where the person who experienced the crisis lives. The Community Mental Health Center reaches out to the individual to determine if they need and are willing to engage with local mental health service providers.

Program Rollout

The rollout of Virtual Crisis Care happened over a 9-month period as noted above and included introductory meetings with the pilot sites; equipment deployment and cell service testing; end-user training; and monthly calls with each site throughout the pilot period to troubleshoot any issues that arose.

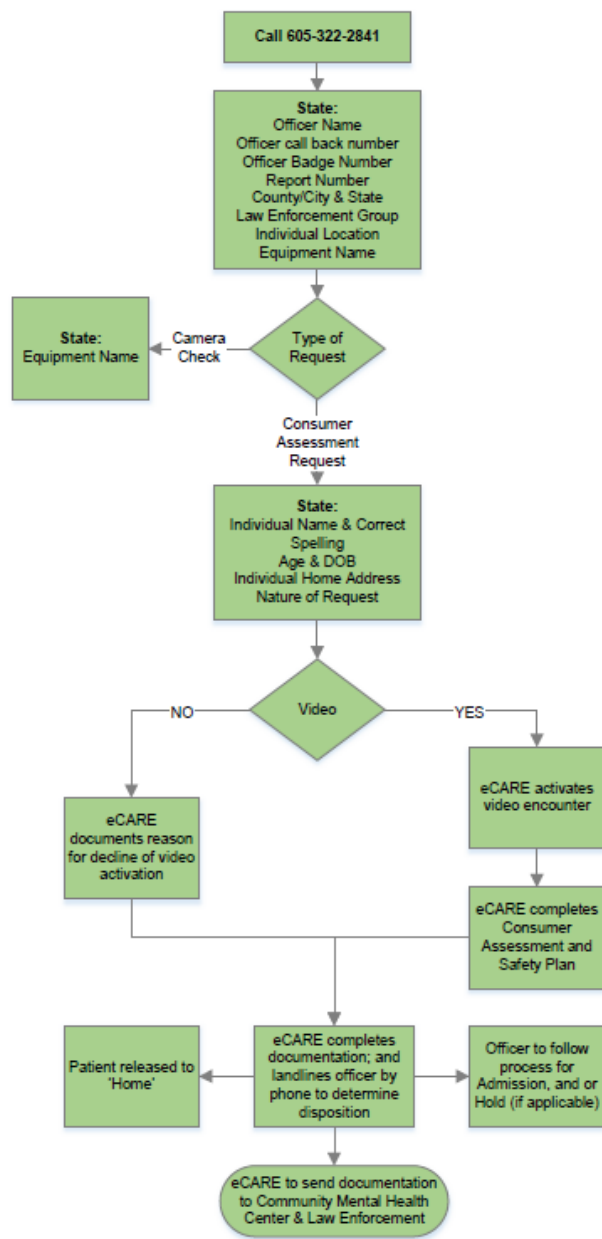
As jurisdictions were selected for the pilot, introductory meetings were held with each site to explain the program in detail and determine what equipment was needed. Depending on site-specific staffing, staff location and work shifts, the number of iPads needed was determined. For example, in some jurisdictions, an iPad was provided for every deputy and, in others, iPads were provided to cover the maximum number of deputies per shift or provided for each car. Tablets were mailed to the pilot sites and the agency points of contact were asked to arrange for testing the connectivity in different parts of each jurisdiction. The testing was to determine if there were areas where there are issues connecting via video and with network quality.

User training was provided by Avera eCare to deputies and probation officers in each pilot site. The training generally took an hour¹⁹ and included:

- An overview of the process for accessing the service, when to use it and when it is not appropriate to use it;
- How to log into the iPad and access the software to communicate with eCare behavioral health professionals; and,
- A review of common issues people have with telehealth technology and instructions for what to do if issues arise (e.g., if the video will not connect for any reason, deputies and officers were instructed to connect the person to the behavioral health professional via phone instead).

Avera eCARE[®] Behavioral Health

Mobile Crisis Activation & Workflow



¹⁹ Trainings were conducted virtually because of the COVID-19 pandemic. Subsequent expansion sites participated in in-person training.

Monthly calls were scheduled with each pilot site. The calls included the sheriff’s department or probation representative(s), UJS and CJI, Avera eCare, and Community Mental Health Center staff. Regular agenda items included utilization in the prior month, any successes or obstacles, and any questions the pilot sites had. The utilization agenda item was an opportunity to determine if there were crisis situations for which Virtual Crisis Care may have been used but was not and why. The successes and obstacles discussions were often about how the different parts of the process worked for different types of cases, including whether the provider had any issues receiving the crisis incident report or with outreach to the person who was able to remain at home.

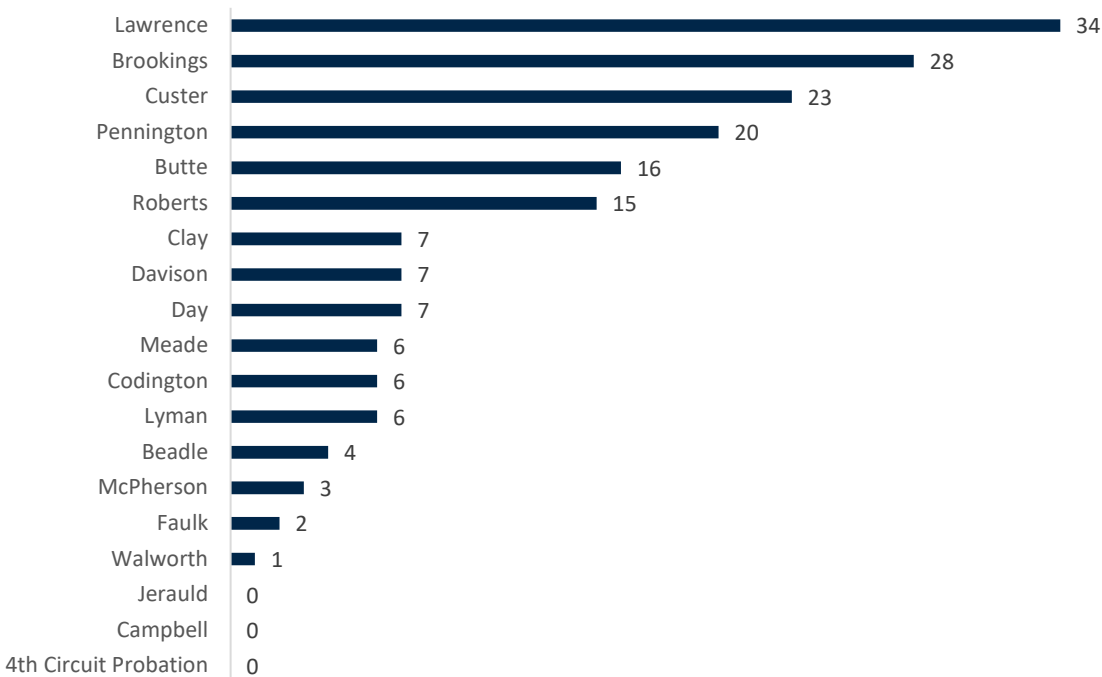
Program Utilization

Between January 2020 and June 2021, Virtual Crisis Care was used 185 times across 16 pilot sites. Three jurisdictions did not utilize the program in the 18-month pilot (Jerauld and Campbell Counties and 4th Circuit Probation).

Despite being the among the last group to begin using the program, Lawrence, Custer, and Pennington Counties were among the top five utilizers of Virtual Crisis Care. The other top users were Brookings and Butte Counties.

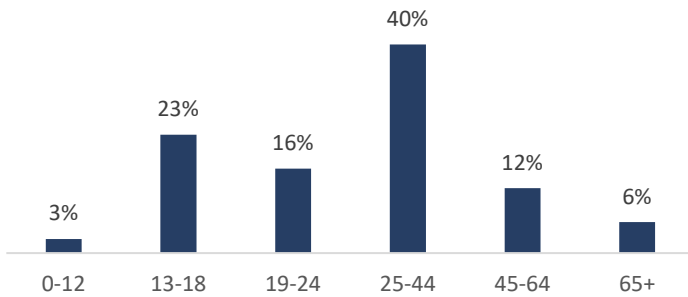
Utilization by Site

January 2020-June 2021



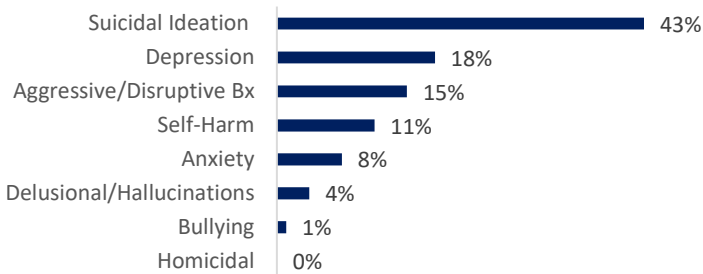
During the pilot, six of every ten people with whom Virtual Crisis Care was used were male. Forty percent were between the ages of 25 and 44, a quarter of these individuals were age 18 or younger, and just under 20 percent were over 44 years of age.

Age of People with Whom Virtual Crisis Care Was Used
January 2021-June 2020



Suicidal ideation (43%) was the most common reason Virtual Crisis Care was used in the pilot phase. Depression (18%), aggressive or disruptive behavior (15%), and self-harm (11%) were the next most common reasons.

Nature of Request for Service
January 2020-June 2021



Virtual Crisis Care Outcomes

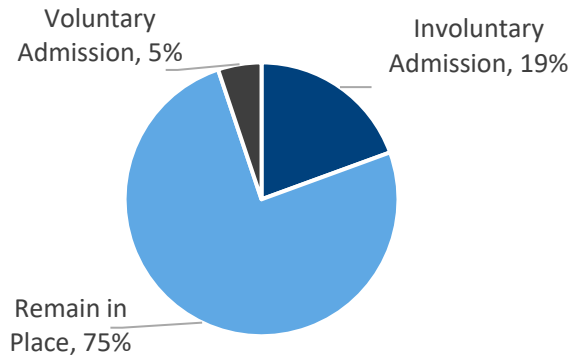
In the 18 months of the pilot period, eight of every ten people with whom Virtual Crisis Care was used were diverted from involuntary hospitalization. This includes people who were able to remain at home and a small percentage of people who voluntarily admitted themselves.

When the pilot began, there were concerns that people would not be willing to engage with a mental health professional via video. Only five percent, or ten of 185 people, refused to engage, or the mental health professional was unable to complete the assessment.

Ideally, part of the evaluation of pilot program outcomes would include an examination of cost effectiveness. This type of study was difficult to do in South Dakota because of the lack of data (e.g., the number of law enforcement responses to mental health crises and the outcomes of those encounters) and a lack of centralized data to track relevant information pre- and post-Virtual Crisis Care. There is no central repository for data or costs related to emergency mental illness holds and involuntary commitments. The information needed to determine associated costs is collected and housed by different county agencies (e.g., law enforcement, county auditors’ offices, County Boards of Mental Illness), private mental health evaluators and service providers, Community Mental Health Centers, private hospitals, and the state’s Human Services Center. While not impossible to do, compiling the data for a statewide cost analysis to compare the cost of Virtual Crisis Care versus business as usual could be a significant and time-consuming effort.

Virtual Crisis Care Outcomes

January 2020-June 2021



SUSTAINABILITY

As shown in the prior section, Virtual Crisis Care is an effective intervention. Involuntary hospitalization was averted in 80 percent of the cases. Baseline data were not available on how many or what percentage of mental health-related law enforcement calls for service resulted in involuntary commitments, but participating agencies reported significant reductions in involuntary commitments during monthly calls and as part of a formal evaluation by the Rural Telehealth Research Center.²⁰ One county in western South Dakota that was one of the earlier implementers in 2020 started tracking mental health calls for service, costs, and outcomes of those calls. The sheriff reported the following:

- An approximate 15% cost savings on mental illness costs compared to 2019, and
- An approximate 31% cost savings on Mental Health Board costs compared to 2019.²¹

In addition to avoiding hospital admissions and avoiding county and state costs associated with involuntary commitments, the pilot program also demonstrated that Virtual Crisis Care meets individual-level goals. Most often, people were able to remain at home and continue with their daily activities, avoiding the costs associated with hospitalization and the stigma of being transported by law enforcement in handcuffs.

Another measure of effectiveness that can impact outcomes and viability is a program's alignment with best practices. SAMHSA, in its National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit, identified minimum expectations for operating mobile crisis services. These include:

1. Including a licensed and/or credentialed clinician capable to assessing the needs of individuals within the region of operation;
2. Responding where the person is (home, work, park, etc.) and not restricting services to select locations within the region or particular days/times; and
3. Connecting individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations.²²

Virtual Crisis Care meets these minimum expectations. The telehealth provider involved in safety assessment, deescalation and safety planning utilizes staff with psychiatric nurse and medical social worker credentials. They have specialized crisis assessment and safety planning training. The program is designed to be used in any location in which a person is experiencing a mental health crisis. And, follow up care for the person experiencing the crisis is initiated by the telehealth provider with a Community Mental Health Center if the person is able to remain at home. In the small number of cases where involuntary commitment is necessary, law enforcement transports the person to the hospital per state law.

In addition to the minimum expectations above, SAMHSA guidelines indicate that for programs to fully align with best practice guidelines, mobile crisis teams should also:

1. "Incorporate peers within the mobile crisis team;
2. Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion;

²⁰ Rural Telehealth Research Center, Implementation and Utilization of the Avera eCARE Virtual Crisis Care Service, Undated.

²¹ Email correspondence to Barbara Pierce and Sadie Stevens. January 26, 2021.

²² Substance Abuse and Mental Health Services Administration. National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2020.

3. Implement real-time GPS technology in partnership with the region’s crisis call center hub to support efficient connection to needed resources and tracking of engagement; and
4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff in order to support connection to ongoing care.”²³

Currently, Virtual Crisis Care in South Dakota does not involve or contemplate any of these four specific practices. As the state implements the Crisis Now model as part of its 988 planning, these factors could be considered. Peer supports would provide another support option for the person who experienced a crisis. How those peers are requested and deployed would need to be discussed and documented.

Virtual Crisis Care, while initially developed as a tool for rural law enforcement, could be used by non-law enforcement responders, such as EMTs, if they are available and willing to take on this role in rural communities. The staffing and technology would be no different for this type of intervention; however, planning for the deployment of tablets or allowing personal devices to be used would require careful planning to ensure the service is secure and accessible.

Implementation of real-time GPS technology along with the call center is something that would most likely need to be part of the 988 planning process. And, scheduling outpatient appointments to support ongoing care would require a level of coordination that does not currently exist but could be a longer term goal.

Looking at best practices in a different way, there is a set of principles of effective crisis response that was published in 2012. These principles are listed in the left hand column below.²⁴ The column on the right shows how Virtual Crisis Care aligns with these principles.

Principles of Effective Crisis Response	Virtual Crisis Care Alignment with the Principles
Proximity	Proximity in this situation refers to a person in crisis being in a familiar and reassuring environment. Virtual Crisis Care can be used in any location with connectivity so access to the behavioral health professional can be in the person’s home or wherever they are located at the time. The program does not require law enforcement to transfer the individual to participate in the video session.
Immediacy	Immediacy refers to the intervention being immediate. The behavioral health professionals staffing Virtual Crisis Care are available 24/7. Once law enforcement is on scene, it takes only a few minutes to call eCare to request the service. It then typically takes five minutes at the most to connect the person in crisis to a behavioral health professional. In addition, following the video consultation, a report is sent to law enforcement immediately after the encounter and to the Community Mental Health Center on the same day as the encounter (if the encounter occurs at night, the report is sent in the morning). ²⁵
Expectancy	In this context, expectancy refers to a provider who is familiar, optimistic, and hopeful for the client. As part of the introduction to a Virtual Crisis Care session,

²³ Ibid.

²⁴ Obembe, Samuel B. “Management of Addiction.” Practical Skills and Clinical Management of Alcoholism & Drug Addiction, 2012. <https://www.sciencedirect.com/topics/medicine-and-dentistry/crisis-intervention>

²⁵ Olson, Becky. Email to Barbara Pierce. 17 December 2021.

	<p>the eCare professional is trained to build rapport, express empathy and understanding, and discuss areas of life the person is hopeful about.</p> <p>If the person experiencing the crisis is able to remain at home, they are connected with their local Community Mental Health Center. In some instances, the person is already a client of that center or former client.</p>
Brevity	<p>Brevity indicates that the intervention is swift. Law enforcement reports that the Virtual Crisis Care video sessions last 20 minutes to an hour. Avera eCare estimates the same.</p>
Simplicity	<p>Simple processes are important to crisis response and intervention. Law enforcement is trained and provided documentation that lays out the process of accessing Virtual Crisis Care. It involves a call to eCare, connecting the person in crisis to eCare via iPad, and a short follow-up call with eCare to discuss the behavioral health professional’s recommended disposition. The process for the person in crisis is simple—they talk to the behavioral health professional via iPad and then hand the tablet back to the deputy or officer who is on-scene.</p>
Creativity	<p>Creativity is about innovation and the ability to improvise to address each unique situation. Virtual Crisis Care itself is a creative way to bring the mobile crisis team model to rural communities and provide law enforcement with the ability to use it when needed and not use it if they are confident in their ability to make a decision about how to deal with the crisis.</p> <p>eCare staff are trained to assist with deescalation and stabilization that matches the specific needs of the person in crisis and provide individualized safety assessments.</p>
Practical	<p>Practicality is about actions and interventions that are doable given that a person is in crisis and timeliness is crucial. Connecting a person with a behavioral health professional via iPad wherever the crisis is occurring is practical and allows for timely action.</p>

Virtual Crisis Care is very much aligned with accepted principles of effective crisis response and SAMHSA’s minimum expectations for mobile crisis teams. It has also proven to be an effective intervention that meets the program’s stated goals and is a feasible crisis response option in rural communities.

As further evidence of Virtual Crisis Care’s viability, the Governor recommended in her FY2022 budget and the legislature agreed to fund the following:

- \$285,000 in general funds to extend the Unified Judicial System's Virtual Crisis Care Pilot through FY2022, and
- \$75,000 in general funds to allow additional counties to participate in the Virtual Crisis Care Grant Pilot.

The \$75,000 in expansion funding resulted in an additional six Sheriff’s Departments and ten Police Departments adopting Virtual Crisis Care.

LESSONS LEARNED AND RECOMMENDATIONS

The South Dakota Virtual Crisis Care pilot program was a success by the most important measures. The program achieved good outcomes for people with whom the service is used, such as diverting 80 percent of individuals from involuntary hospitalization; the program was continued and grew and is on a path toward statewide access, where needed; and expansion funding was included in the state budget. Throughout the pilot, many lessons were learned that could benefit future initiatives and new pilots. Below are those lessons learned as well as related recommendations.

Project Startup and Oversight

Implementation of a cross-system crisis response pilot program necessitates partnerships among entities that have not traditionally worked together. While the pilot generally rolled out smoothly, interviews with representatives of the partner entities indicated there were a few parts of project startup and oversight that were challenging at times.

A main challenge was that partners' roles were assumed rather than explicitly defined and discussed as a group. There were times when 'it felt like no one is in charge,' as one interviewee described. Another challenge noted was the lack of early buy-in by some local mental health providers.

Engagement of law enforcement early and often in the rollout and communications efforts was seen as a key to the success of the pilot. The South Dakota Sheriffs' Association was a partner from the start and was instrumental in providing feedback on the pilot and promoting it.

Recommendations:

- When all partners are identified for project startup, develop a formal, written leadership and oversight structure with clearly defined roles for all people and organizations involved. Articulate who the decision makers are, who the lead is for each partner entity, and what and how information will be shared across partners.
- Consider enlisting a project manager to develop an implementation plan for the pilot, facilitate the activities of the partners and monitor implementation progress.
- Carefully assess prior to rollout of a pilot which entities need to be engaged before and during the pilot and ensure there is a plan for communication. Periodically discuss support and buy-in issues and act to mitigate the hesitancy or lack of support.

Bridging the Mental Health and Law Enforcement Differences

Mental health and law enforcement often do not fully understand each other's roles and procedures, terminology, and legal responsibilities.

Recommendation: Cross-train the project partners. At a minimum, the telehealth provider should understand law enforcement agency organizational structures, roles and titles; terminology; and law enforcement's role in the emergency hold process. Participating law enforcement personnel should understand the role of the telehealth provider and what the provider does during a Virtual Crisis Care session, and key terminology (e.g., what a safety assessment is and the difference between conducting a safety assessment and a Qualified Mental Health Professional evaluation).

Program Utilization

Because Virtual Crisis Care is specifically designed to address crisis response access issues in rural communities, utilization was fairly low. It is important for clear messaging to external stakeholders that the numbers were not expected to be and will not be large.

Recommendations:

- Recognizing that there may be relatively small numbers of people with whom Virtual Crisis Care is used in rural communities, be cautious about how the numbers are communicated. For example, instead of focusing on and encouraging more utilization (meaning more people in crisis), focus on encouraging appropriate utilization. This can include reminding officers and deputies about the circumstances when the program can be used and regularly checking in to see if there were missed opportunities to use it and why (the monthly calls served this purpose during the pilot).
- As a way to better meet the crisis response access goal, consider engaging all law enforcement agencies in a geographic area. For example, Virtual Crisis Care started with sheriff's departments, but to truly address access it makes sense to engage the county sheriff as well as local police departments within the county.

Information Sharing

The reports eCare completes about the crisis assessment and recommendations are completed quickly and transmitted to both law enforcement and the appropriate Community Mental Health Center. Law enforcement appreciated the reports, but expressed frustration in not knowing if the follow up post-crisis situation when the person was able to remain at home was occurring and the person was receiving mental health services.

Recommendation: Explore ways in which communication can be strengthened and some information be shared about the follow up (e.g., contact with the person was made) between law enforcement and Community Mental Health Centers. This would help build and maintain confidence in the program.

Performance and Outcome Measurement

As part of an early communications planning effort, a set of goals were established for South Dakota's Virtual Crisis Care program by the program partners. Measuring progress toward those goals became challenging because there were separate evaluative interests and processes established. Avera eCare's contracted evaluators were focused largely on telehealth-related measures, whereas other partners were interested in prioritizing programmatic measures. This resulted in disjointed program evaluation.

In the South Dakota pilot, there were some important data that were not collected. For example, an essential component of Virtual Crisis Care is the handoff from the telehealth provider to a local provider to follow up with the person who experienced the crisis and was able to remain at home. Data on this process were not collected during the pilot.

Recommendations:

- Before beginning to pilot Virtual Crisis Care, convene all partners, determine key metrics of interest that should and can be tracked, define the metrics (i.e., how they will be calculated) and the data elements needed for those metrics, decide who will collect the data and how, and establish any necessary data sharing agreements.

- Decide on a reporting strategy upfront, including what will be reported, who will be responsible for compiling reports and which stakeholders should be kept apprised of program progress and outcomes.
- Regularly report on the diversion rate (percent of people with whom Virtual Crisis Care was used who were not involuntarily committed), as this is a core metric that should be used regularly in communications about the project.
- Ensure performance and outcomes are reported in such a way that the information can be disseminated to many different audiences and easily understood. This includes simple, clear visualizations with understandable titles and labels.

Sustainability

With the completion of the pilot, the legislature continuing and expanding the program, and the 988/Crisis Now planning, it is important to plan for sustaining Virtual Crisis Care.

Recommendation: Create a written sustainability plan for Virtual Crisis Care. The plan should articulate the following:

- Program goals;
- Accomplishments to date;
- The leadership/governance structure;
- Program staffing;
- Policies and procedures, including information sharing and ongoing training, for entities involved in program delivery;
- Funding mechanism(s);
- Procedures for monitoring and disseminating progress and results;
- A communications strategy and champion development;
- Planned program additions or other changes;
- Articulation of where the program fits in the state's planned crisis response system, considering SAMHSA's best practices for mobile crisis teams; and
- Anticipated obstacles and plans to address them.