PENNINGTON COUNTY, SOUTH DAKOTA
BEHAVIORAL HEALTH CONTINUUM OF CARE

SUBMITTED BY

THE NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

EXECUTIVE SUMMARY

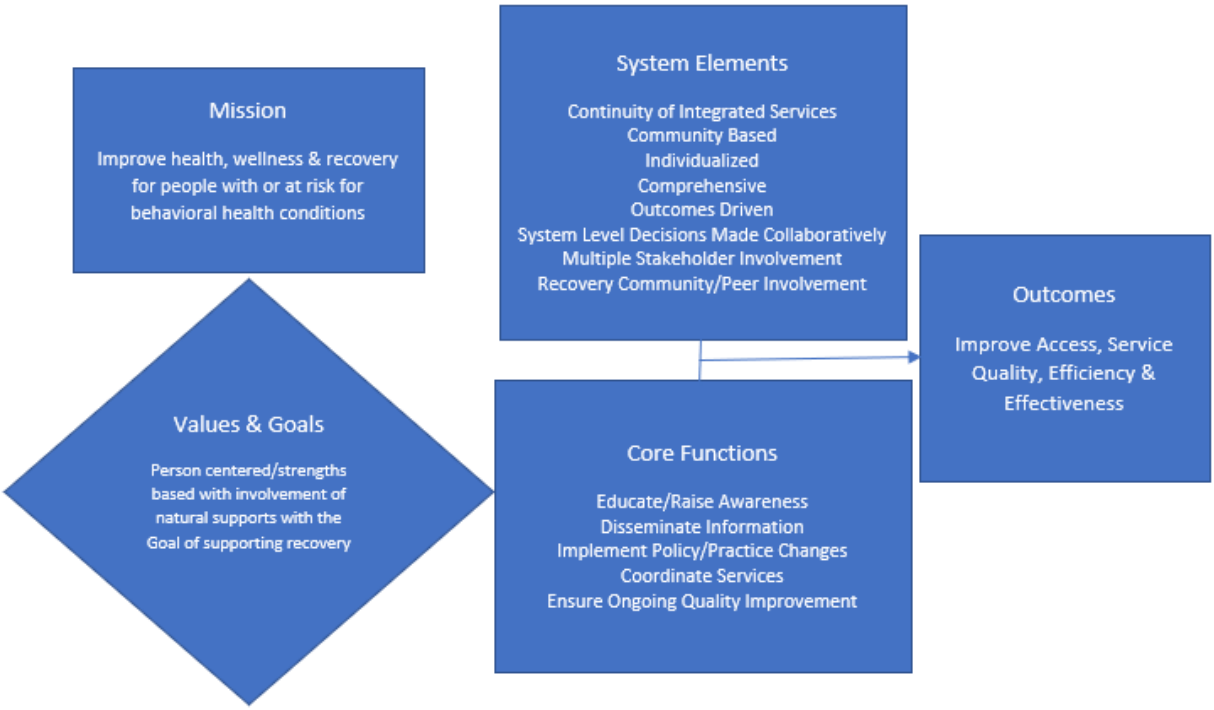
Between November 2018 and September 2019, the National Council for Behavioral Health (National Council) worked closely with Pennington County Health and Human Services (PCHHS), the Western South Dakota Behavioral Health Alliance (the Alliance), Helmsley Charitable Trust, and other key stakeholders to develop a conceptual framework and key recommendations for the implementation of a comprehensive behavioral health care continuum to best serve adults with mental health (MH) and substance use disorder (SUD) challenges in Pennington County. The project's main goals include:

- Identifying the strengths and opportunities that currently exist in the County and understanding the effectiveness of the existing structures, providers, and programs in addressing community need;
- Identifying gaps in the current system;
- Engaging key community members in the planning effort; and
- Providing recommendations about an ideal service array.

To guide our assessment and recommendations, the principles of a recovery-oriented system of care (ROSC) were used, and we are recommending this as the guiding framework for Pennington County. A ROSC shifts care from a professionally driven, acute care, reactive approach to a proactive approach that provides long-term services and supports and many pathways to recovery. A ROSC recognizes that professional treatment is one component among many that support people in managing their own challenges. Additionally, a ROSC focuses on the role of friends and families in responding to, managing, and helping to overcome challenges. This focus is used as an organizing principle for the entire system.[1] When applying ROSC principles, services must be directed toward initiating and supporting the recovery process for people living with behavioral health challenges. Data collected through an environmental scan, including key informant interviews, site visits, and survey informed the development of the following conceptual framework and recommendations for key service components. Figure 1, below, illustrates the core mission, values, goals, system elements, functions, and outcomes of a ROSC.

[1] Philadelphia Department of Behavioral Health and Intellectual disAbility Services, Recovery Advisory Committee. (2006). Recovery. Retrieved from https://dbhids.org/recovery/

FIGURE 1. RECOVERY-ORIENTED SYSTEM OF CARE



Using ROSC as a guiding framework, our major recommendations for a comprehensive behavioral health continuum in Pennington County include:

1. Developing a Crisis Stabilization Unit at the Care Campus operated by Behavior Management Systems (BMS)
2. Develop telehealth crisis services for remote counties to support law enforcement
3. Expand the network of recovery houses and supported employment
4. Increase the number of psychiatric beds at Regional West Hospital (Regional West)
5. Conduct a Care Campus environmental scan
6. Conduct a study on funding challenges for services for American Indians
7. Expand case management services in all specialty courts
8. Conduct an environmental scan on the continuum of services for children with behavioral health needs
9. Develop a comprehensive plan for incorporating the voice of people in recovery
10. Establish a clear focus on and collaboration with integrated primary care
11. Create stronger community coalitions with clear focus on creating ROSC
12. Strengthen coordination across and within the system of care
13. Educate the community about behavioral health and wellness

INTRODUCTION AND BACKGROUND

Pennington County Health and Human Services (PCHHS) engaged the National Council for Behavioral Health (National Council) to conduct an environmental assessment of the current service system for individuals living with mental health (MH) and substance use disorder (SUD) challenges and to develop recommendations for concrete and actionable next steps to improve care and associated outcomes.

Pennington County has many noteworthy services in place for individuals living with behavioral health challenges. The County's correctional Rebound Program is the first of its kind in South Dakota resulting in reduced recidivism and $3.3 million in savings since 2006. The County developed and operates the Care Campus which provides an array of services, including crisis services, detoxification, Safe Solutions, outpatient services, and beginning in October, residential treatment beds for individuals with SUDs. Safe Solutions provides support to individuals who are intoxicated and at risk of incarceration. Two Quality of Life Officers support people who receive Care Campus services by providing case management support. The Economic Assistance and Veterans Services Office is also operated by PCHHS. Within the County, there is robust community involvement and partnerships with foundations and the business sector, which has advanced creative solutions to challenges in the past.

While the County and the South Dakota Behavioral Health Alliance (the Alliance) have provided critical leadership, the community is currently facing several significant challenges, including:

- Several years ago, the hospital requested that people experiencing behavioral health crises be taken to jail rather than to the emergency department which violates parity laws, creates difficulty for law enforcement, and provokes conflict within the community. While the hospital leadership has changed and there is a genuine commitment to provide care for people with behavioral health issues, there are remaining challenges;
- The uninsured rate for Pennington County is 10 percent for adults and three percent for children, but the uninsured rate for people seeking services for behavioral health challenges approaches 70 percent;
- There is a current shortage of psychiatric providers with anticipated retirements of several of the current group within a few years;
- The community mental health provider is at capacity and facing funding challenges because of the high rate of uninsured people in need of behavioral health services;
- Community members of the neighboring reservations face high prevalence of behavioral health challenges and have limited resources to address them;
- A need exists for improved coordination related to the delivery of crisis services and inpatient care, including clarifying the roles of Regional Health Rapid City Hospital (Regional) and the State Hospital at Yankton (HSC);
- There is a greater need for services coordination both at the individual and systems levels of care;

- Pennington County is the center of the region, therefore, law enforcement from the surrounding smaller communities becomes the de facto community behavioral health providers, and their only option for crisis care is to transport people to Rapid City;
- A need exists for the development of a comprehensive continuum of care which increases positive outcomes and makes the best use of the resources in the community, including service use data; and
- There is a pressing need for a stronger partnership with the state in terms of financial support for the regional needs; Pennington County cannot absorb all the costs that are associated with being a provider for a large region.

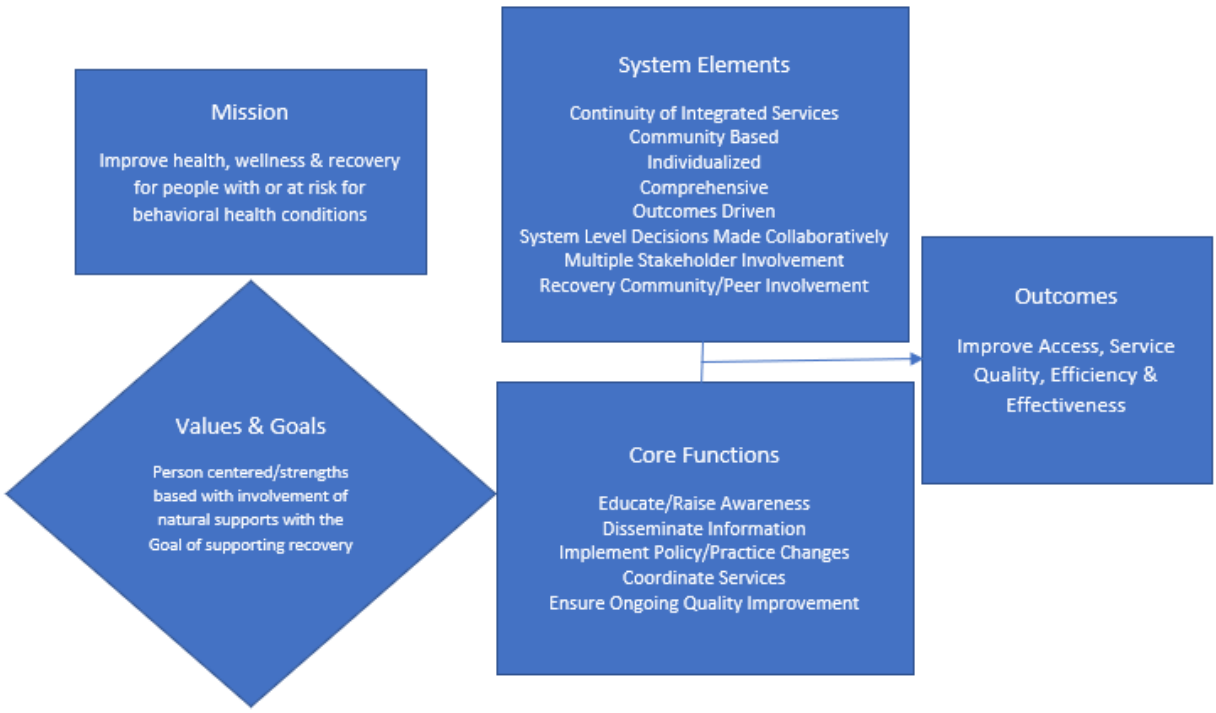
In response to these issues, the Alliance sought consultants to assess the community's current capacity and provide information on successful models being employed to address challenges in similar communities across the country. The project's main goals include:

- Identifying the strengths and opportunities that currently exist in the County and understanding the effectiveness of the existing structures, providers, and programs in addressing community need;
- Identifying gaps in the current system;
- Engaging key community members in the planning effort; and
- Providing recommendations about an ideal service array.

CONCEPTUAL FRAMEWORK: RECOVERY-ORIENTED SYSTEM OF CARE (ROSC)

We recommend the adoption of a Recovery-Oriented System of Care (ROSC) which implements service delivery components and supports that are built upon and in response to a set of core values shared across the continuum of care, including individuals who receive services and the professionals who provide them. Figure 1, below, illustrates the mission, values, goals, system elements, and core functions of a ROSC.

FIGURE 1. RECOVERY-ORIENTED SYSTEM OF CARE



Communities that have a ROSC continuum of services and supports ensure all citizens have the support they need to be productive members of society. This report sets out to provide an assessment of Pennington County's current capacity as a ROSC and the steps it can take in the immediate term to improve opportunity areas. This framework was chosen because it:

- Requires a community-based approach to building out the continuum of care needed to support people with behavioral health conditions;
- Recognizes that treatment is seen as one part, an important part, of the overall continuum of care;

- Recognizes the science of behavioral health treatment, that the emphasis on integration (both at the system and practice level) is critical to prevention and early intervention as well as for acute care and recovery support over the lifespan;
- Considers social determinant needs that present barriers to recovery;
- Acknowledges and addresses the impact of trauma, both historical and contemporary, racism, and poverty to increase the chances of positive outcomes;
- Supports the development of strong models of care coordination, data sharing between providers, and a focus on outcomes demonstrating the efficiency and effectiveness of the system of care;
- Provides an overall framework within which an individual's whole health (e.g., mental, physical, and substance use/misuse) and wellness (e.g., social determinants of whole health) intersect with the community's network of social and healthcare services;
- Creates an opportunity to build services and supports that are based in the understanding that providing those services in a way that is trauma-informed, recovery-oriented, and based in hope increases the chances of positive outcomes;
- Engages the community of people in recovery in all aspects of service planning and delivery and recognizes the critical role that informal support networks (mutual aid groups, recovery groups, recovery housing, etc.) play in initiating and sustaining recovery; and
- Recognizes that each person is responsible for their health and wellness, however many conditions (e.g., mental illness, SUD, socio-economic, family of origin, historical trauma, racism, heredity, etc.) leave some individuals at a disadvantage through no fault of their own.

The ROSC framework also provides an organizing conceptual and practice guide to develop coherent systems of care. Care Campus, One Heart, The Mission, Regional West, the community health center, and BMS are all participants in this system and to the degree that they align their mission, values, elements, and core functions with this model and with each other will determine their success in both tracking and improving outcomes. This is not an all-inclusive list as there are many other components in the Pennington County community that are part of the "big tent" of ROSC. The State also has a key role to play in financing and in supporting this developing system of care.

To operationalize these values, core components are identified. The core components of a ROSC include:[2,3]

1. Providing integrated services;
2. Creating an atmosphere that promotes strength, recovery, and resilience;
3. Developing inclusive, collaborative service teams and processes;

[2] Substance Abuse and Mental Health Services Administration (SAMHSA). (2010, September). Recovery-Oriented Systems of Care (ROSC) Resource Guide. Retrieved from https://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf
[3] American Association of Community Psychiatrists. (n.d.). AACP Guidelines for Recovery Oriented Services. Retrieved from https://www.nasmhpd.org/sites/default/files/III_A_ART_AACPRecoveryOSGuidelines.pdf

4. Providing services, training, and supervision that reflect recovery and resilience;
5. Providing individualized services to identify and address barriers to wellness;
6. Implementing evidence-informed approaches; and
7. Promoting recovery and resilience through evaluation and quality improvement.

ENVIRONMENTAL SCAN

Between February and September 2019, National Council consultants conducted a comprehensive environmental scan which gathered information and data from an array of diverse stakeholders, including community behavioral health providers, hospitals, County staff, the Alliance, the Pennington County Sheriff's Office, among others. Findings from the environmental scan identified current opportunities, challenges, and gaps in the Pennington County behavioral health system discussed in the sections below.

ENVIRONMENTAL SCAN METHODOLOGY

The environmental scan methodology included site visits, a survey, key informant interviews, and a literature review of published and unpublished reports. Key data and information that were assessed include:

- Pennington County health demographics;
- State and regional hospital utilization;
- Crisis Care Center utilization; and
- The number and type of social service and health care provider agencies in the community.

Over the past seven months, National Council consultants conducted three site visits during which key informant interviews were conducted in-person and telephonically with a total of 83 stakeholders. A complete list of key informants interviewed can be found in **Appendix C**.

In addition to key informant interviews, the National Council project team, in collaboration with PCHHS and the Alliance, created a survey to assess the existing resources in Pennington County for people with behavioral health challenges. The purpose of the survey was to identify services that support recovery and improve the overall health of the community. The survey was disseminated electronically through several community and provider listservs and completed by 120 respondents. Findings from the environmental scan are described below.

ENVIRONMENTAL SCAN FINDINGS

Findings from the environmental scan provide a comprehensive view of the current state and breadth of services, including services that are exemplary, opportunities for improvement, existing challenges, and gaps.

EXISTING RESOURCES

As described above, there are many existing resources in the Pennington County community that meet the criteria for being part of a ROSC as they address the holistic needs of individuals with behavioral health challenges.

Geography plays a key role in any community's strengths and challenges. Rapid City is surrounded by beautiful landscape, historical sites, and has a busy tourist industry in the spring, summer, and fall. Winter in Rapid City is harsh and presents challenges to those living without stable housing or reliable transportation.

Behavior Management Systems (BMS) is the community mental health center serving approximately 6,500 people a year in Butte, Bennett, Custer, Fall River, Harding, Jackson, Lawrence, Meade, Oglala Lakota, and Pennington counties. BMS has developed a full array of MH and SUD services for youth and adults despite having significant financial limitations due to significantly lower Medicaid reimbursement rates compared to other states[4] (e.g., in 2018 only Wyoming had lower Medicaid spending).[5] BMS is a committed community member and is open to developing new services with appropriate financial support. The 2019 state of South Dakota accreditation review shows services are being provided at or above state standards and clients report being satisfied with services.[6] Compared to providers across the state, adults receiving high intensity substance use treatment services were twice as likely to have been arrested for substance misuse within 30 days of engaging in services and four times more likely to report thoughts of suicide. Upon treatment completion, engagement with law enforcement was significantly curtailed. Substances that are the focus of treatment for BMS clients are predominantly alcohol and methamphetamine. Treatment completion rates are high; however penetration rates are low, likely due to lack of funding. The size of BMS's workforce is small, with six full-time masters prepared substance abuse treatment counselors. For people receiving MH treatment, there was a much higher incident of emergency department admissions within thirty days of intake than in other parts of the State. BMS staff report wait times are approximately 10 days for intakes and five days to see a prescriber, which is the industry average. No show rates average 25 percent which is also the industry average.

As mentioned above, in September 2018, Pennington County opened the Care Campus to provide substance use detoxification, crisis services, and a sobering center called Safe Solutions. In addition, outpatient services are provided. The facility is modern, clean, safe, and staffed predominantly by the

[4] Advisory Board. (2018, August 24). The states that spend the most-and least-on health care mapped. Retrieved from https://www.advisory.com/daily-briefing/2018/08/24/health-care-spending
[5] Every state Medicaid Spending in One Map. (2018, January 30). Retrieved from https://howmuch.net/articles/medicaid-spending-by-state
[6] Behavioral Management Systems. (2019). State of South Dakota Community Behavioral Health Treatment Services: Behavior Management Systems (BMS) Annual Report.

Sheriff's Office with BMS mental health professionals operating the crisis unit. To date, the Care Campus has had 24,137 admissions. The planned expansion into substance use treatment this fall will add to this needed service array. Through the generous support of the philanthropic community, 64 residential treatment beds will be opening October of this year. The Cornerstone Rescue Mission (the Mission) has played an important role in the community since 1982. Its residential services for women and children provide transitional housing. Today, dozens of men spend their nights at the Mission instead of on the street. In recent months the organization has made changes in its vision and mission, tightening requirements and timelines for men receiving housing at the Mission. This will be addressed in the recommendations section below.

The One Heart Campus will play an important role in the future of Rapid City. The vision of establishing a "health care neighborhood" on the campus with space for all the major service providers presents a tremendous opportunity for partnership and coordination of services, including an onsite federally qualified health center (FQHC) which also has a healthcare for the homeless program.

In Pennington County and the surrounding counties, the sense of urgency around change is, in large part, driven by law enforcement who are confronted daily with the challenges of people living with behavioral health needs. Law enforcement has led, in partnership with other community stakeholders, many of the innovative approaches to care that currently exist in Rapid City. This includes the Care Campus, One Heart, the Quality of Life Officers, and the specialty courts. They have demonstrated vision and the capacity to achieve important outcomes related to public safety. Under the leadership of Sheriff Thom, Chief Jegeris, the Rapid City Police Department, and the sheriffs of surrounding counties, there is a strong commitment to Crisis Intervention Team (CIT) training for all law enforcement officers. In Rapid City, funding of Quality of Life Officers and the Care Campus detoxification and treatment units by Sheriff 's Department staff conveys the importance of behavioral health services.

The presence of four specialty courts (Drug Court, DUI Court, Veterans Court and Mental Health Court) with active and engaged judges has provided many residents of Pennington County a pathway out of jail and toward recovery. These specialty courts are at capacity but with additional case management, staff could serve more people and link more strongly with the developing health care neighborhood at One Heart located across the street from the courthouse.

The work of Collective Impact in the areas of housing, food insecurity, and leadership development, and the emerging partnership with Common Bond to develop affordable housing in Rapid City are important initiatives that can support the full continuum of services for people living with behavioral health challenges and/or at risk for homelessness. The Homeless Coalition has worked tirelessly to support the development of housing options and now is on the cusp of hiring a staff person to continue to facilitate this work. These will be important partnerships in the continued development of ROSC.

Rapid City has an engaged and active business community, generous philanthropy, and a growing regional hospital. There is a history of collaboration among different community members which has

resulted in the formation of the Alliance. The Alliance has led significant change initiatives, provided leadership in the ongoing development of the current system of care, and provided key consultation for this report.

KEY HEALTH INDICATORS

Behavioral health demographic indicators were used to understand the current state of behavioral health needs of South Dakota and Pennington County citizens. Compared to national data, South Dakota and Pennington County have several areas of opportunity when it comes to improving the behavioral health of its citizens.

TRAUMA

Physical and psychological trauma, particularly during childhood, can have lasting negative impacts on a person's health and associated health behaviors. The Adverse Childhood Experiences Scale (ACES) is a validated instrument designed to measure a person's experience of trauma. High scores on this measure are highly correlated with poor health outcomes.[7] In South Dakota and Pennington County, citizens' ACES scores are twice the national rate. Statewide, ACES scores among American Indians are significantly higher than non-American Indians. One study found that approximately 83 percent of American Indians experienced at least one ACE (compared to 50% of non-American Indians) and American Indians were more than five times more likely to have experienced six or more ACEs.[8] Across the entire statewide study population, prevalence of ACEs was found to be positively correlated with MH conditions, severe alcohol misuse, and cigarette smoking.[9] This high level indicates the need for access to behavioral health services that can engage the person in a way that acknowledges the long-lasting impacts of trauma (both present day and historical trauma), while providing the skills and support needed to assist individuals with trauma histories in achieving their goals.

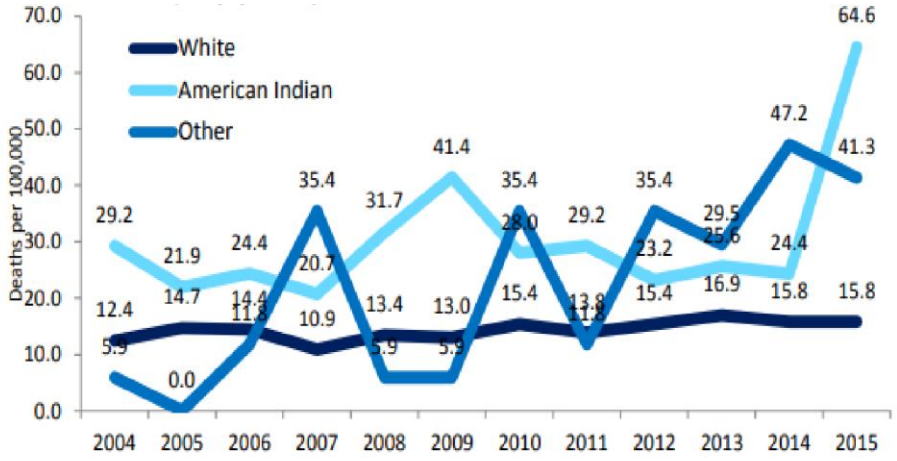
SUICIDE

Suicide is a major challenge in South Dakota and is increasing in incidence across the country. In the U.S., death due to overdose and suicide has doubled since 2013.[10] The suicide rate in South Dakota is nearly twice the national rate.[11] Among American Indians living in South Dakota, the suicide rate is significantly higher at 65 per 100,000 people, resulting in one out of every 1500 American Indians in South Dakota dying by suicide annually. Alarmingly, the death by suicide rate among American Indians

[7] The Centers for Disease Control and Prevention (CDC). (2019). Adverse Childhood Experiences. Retrieved from https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html
[8] Warne, D., Dulacki, K., Spurlock, M. Meath, T., Davis, M. M., Wright, B., & McConnell, K. J. (2017). Adverse Childhood Experiences (ACE) among American Indians in South Dakota and Associations with Mental Health Conditions, Alcohol Use, and Smoking. *Journal of Health Care for the Poor and Underserved, 28*(4), 1559-1577.
[9] Ibid.
[10] Trust for America's Health. (2019, July 13). Alcohol and Drug Misuse and Suicide and the Millennial Generation- A Devastating Impact. Retrieved from https://www.tfah.org/report-details/adsandmillennials/
[11] Data USA. (2017). Pennington County, South Dakota. Retrieved from https://datausa.io/profile/geo/pennington-county-sd#health

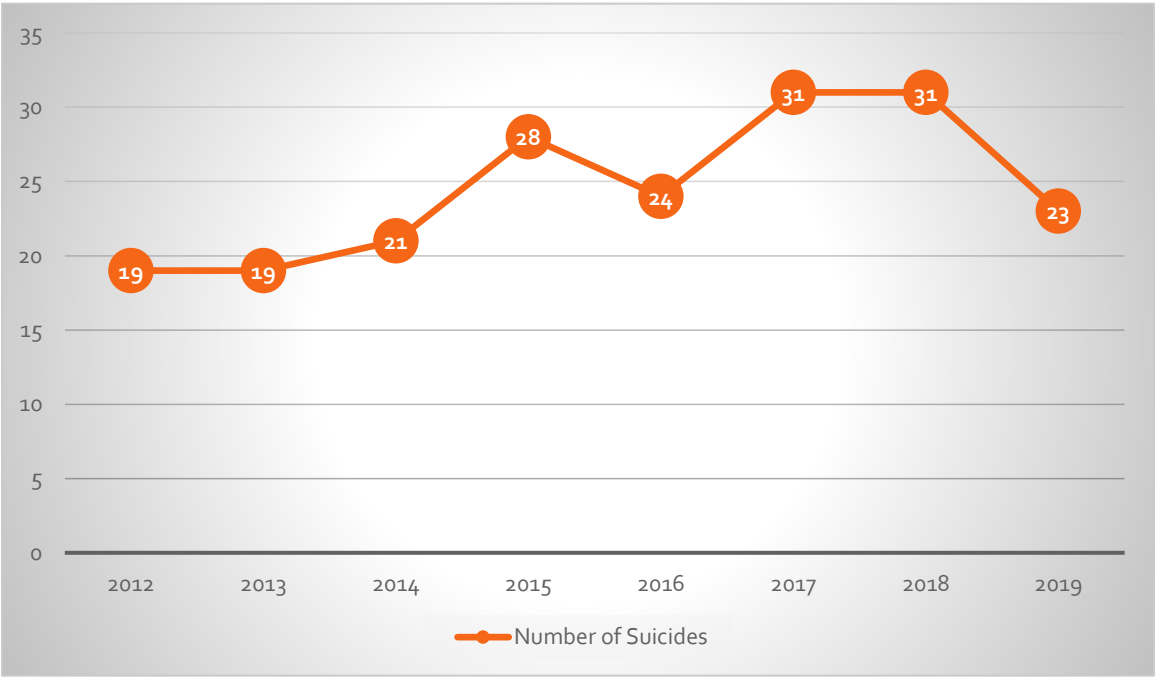
in South Dakota is three times the rate for South Dakota and four times higher than the national rate (see Figure 2 below).[12] Suicide rates are also rising in Pennington County. Between 2012 and 2018, the number of suicides in Pennington County rose from 19 to 31, a 61 percent increase (see Figure 3 below). In 2019, between January and September, there have been 23 suicides in Pennington County.

FIGURE 2. SUICIDE DEATH RATES BY RACE, SOUTH DAKOTA, 2004-2015 (DEATHS PER 100,000 POPULATION)



[12] South Dakota Department of Health. (2017). Suicide Surveillance. Retrieved from https://doh.sd.gov/documents/statistics/SuicideSurveillanceJan2017.pdf

FIGURE 3. NUMBER OF SUICIDES IN PENNINGTON COUNTY 2012-2019[13]



DEPRESSION AND SUBSTANCE USE DISORDERS (SUD)

The rate of depression and SUD is an important indicator of the overall behavioral health of a community. In South Dakota, the rate of depression is 24 percent above the national rate. American Indians/Alaskan Natives in South Dakota report frequent mental distress at rates nearly twice as high as Whites (16.2% compared to 8.8%).[14] In 2016, on average, individuals in Pennington County reported having 3.2 mentally unhealthy days per month, which is higher than the state average of 2.9.[15] Depression, coupled with untreated substance use conditions, results in higher rates of suicide. Most people who died by suicide in Pennington County have a history of depression and/or SUD.[16] There is one mental health provider for every 380 people in Pennington County and only approximately 2 percent of individuals who need SUD treatment in South Dakota are accessing it.[17] This is 90 percent below the already problematic national average of approximately 20 percent.[18] A 2011 assessment

[13] Information provided to National Council staff by the Pennington County Coroner. Data from 2019 reflects number of suicides between January and September.
[14] United Health Foundation. (2019). America's Health Rankings analysis of CDC, Behavioral Risk Factor Surveillance System, South Dakota. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/mental_distress/state/SD
[15] County Health Rankings and Roadmaps. (2019). Pennington County. Retrieved from https://www.countyhealthrankings.org/app/south-dakota/2019/rankings/pennington/county/outcomes/overall/snapshot
[16] Front Porch Coalition. (2019).
[17] County Health Rankings and Roadmaps. (2019). Pennington County. Retrieved from https://www.countyhealthrankings.org/app/south-dakota/2019/rankings/pennington/county/outcomes/overall/snapshot
[18] U.S. Department of Health and Human Services. (2016). Facing Addiction in America: The Surgeon General's Report on Alcohol. Retrieved from https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf

found that mental health concerns comprised three of the top four community concerns, including suicide prevention services (57.6%), depression care and treatment (57%), and stress and anxiety care and treatment (54.9%).[19]

INVOLUNTARY COMMITMENT

The high rates of depression, substance misuse, suicide, and trauma in Pennington County illustrate a picture of significant need which is further colored by the high rate of petitions for involuntary commitment as a means to providing behavioral health treatment.[20] In 2018, there were 1353 petitions for involuntary commitment, and of those, 110 people were committed to HSC. In 2018, Lawrence County referred 43 people for petition, the most of any outlying county. Lawrence County includes Spearfish and Lead-Deadwood Hospitals and borders Sturgis Hospital in Meade County which referred the second highest number of people for petition, 35. South of Pennington County, Custer Hospital, in Custer County north of Fall River County, 27 people were referred for petition in 2018. The Regional Hospital system includes hospitals in Spearfish, Custer, Lead-Deadwood and Sturgis. If a treatment provider, family member, friend, or law enforcement officer decides a person needs to be petitioned because they are a risk of danger to themselves or others, the only way to do this is to go to the emergency department at Regional in Rapid City where an emergency doctor completes the petition. In South Dakota, Qualified Mental Health Professionals (QMHP) are designated to determine if a person should be brought before the mental health board for a commitment determination. The majority of petitions (approximately 63%) are dropped at Regional West after the person is seen in the emergency department.

Only eight percent of people who are petitioned got committed to HSC in 2018. The reasons for this include people becoming sober and agreeing to voluntary treatment and dismissed or disqualified petitions. Approximately 66 percent of petitioned patients "convert" meaning they come off petition and agree to voluntary treatment at Regional West.

Adults committed to HSC remain in the hospital for an average of four days which is slightly below the national average of five days. This number does not consider the time a person spends waiting, typically at Regional West, to be transported to HSC. Shorter lengths of stay are correlated with higher likelihood of readmission. For people with significant behavioral health conditions, 28 days or more of inpatient treatment has been shown to be most effective.[21] In most cases, the HSC population is composed of people with significant diagnoses (e.g. schizophrenia, other psychotic disorders, etc.). Additionally, patients that do not have a robust plan to receive services post discharge are two times

[19] Rapid City Collective Impact. (2017). Rapid City Service Programs Report. Retrieved from http://www.rccimpact.org/wp-content/uploads/2017/09/RCCI-Service-Program-Report-June-2016-1.pdf
[20] For information on the South Dakota law regarding involuntary commitment see: 2011 A Roadmap of South Dakota's Revised Mental Health Code: The Involuntary Commitment and Voluntary Hospitalization of Adults. Available at http://sdlegislature.gov/docs/interim/2018/documents/DAMH10172018-C.pdf
[21] Donisi, V., Tedeschi, F., Salazzari, D., & Amaddeo, F. (2016). Pre- and post-discharge factors influencing early readmission to acute psychiatric wards: implications for quality-of-care indicators in psychiatry. *General Hospital Psychiatry, 39,* 53-58.

more likely to be hospitalized again in the same year.[22] However, the majority of people petitioned and committed to HSC from Pennington County did not carry a diagnosis of a severe and persistent mental illness, such as schizophrenia or bipolar illness. Most people committed had a diagnosis of depression without psychosis, emotion dysregulation disorder, or adjustment disorders with no people carrying a major thought disorder or anxiety disorder barring one person with post-traumatic stress disorder (between November 2017 and March 2019).

The fact that people with more serious diagnoses are not being committed indicates that local behavioral health providers are doing a good job of helping people with severe and persistent mental illness remain out of the state hospital. This is also a result of the flow of state funding. People with serious mental illness typically qualify for Medicaid insurance.

Seven percent of those petitioned during 2018 had SUD as a primary diagnosis. Twenty-seven percent of those petitioned had street drugs or alcohol in their blood with 12 percent having a blood alcohol content (BAC) of .05 or higher. Most of the people who were petitioned were employed, in school, or retired with 33 percent unemployed and 16 percent disabled.

The fact that fewer people with a serious mental illness are not being committed, that most who are committed are employed or in school and have mental health and/or addiction condition(s) that do not meet the level of severity to receive Medicaid or other funded services, indicates a need for alternative ways of responding to people in crisis and the buildout of upstream and downstream services for this population.

Regional West is authorized as a state hospital treatment facility meaning patients can be committed and receive treatment at Regional; however, this option is not commonly used. Patients generally remain at Regional for an average of three weeks and as long as eleven weeks waiting for a bed to open at HSC. During this time the person is provided maintenance treatment until they can get to HSC. People are transported to HSC by the law enforcement. Getting to HSC is an uncomfortable process for anyone, let alone someone who is experiencing unmanaged and debilitating symptoms of a mental illness. Typically, people who need transport to hospitals for life threating illnesses receive transportation by an ambulance staffed with medical professionals; however, in South Dakota, like most places in the U.S., people are transported by law enforcement. A law enforcement officer is taken out of service to provide transport via a police vehicle or prison bus. During transport, patients are chained to the floor of the bus in a separate section with prisoners who are going to facilities on the east side of the state. The ride is six to seven hours long. As in many communities, law enforcement becomes the de facto behavioral health transport service and the county must pay the cost for transportation. This is traumatizing to people who are already suffering from symptoms of mental illness. It also takes a toll on law enforcement staff and the communities they serve. A survey

[22] Ortiz, G. (2019). Predictors of 30-day Post discharge Readmission to a Multistate National Sample of State Psychiatric Hospitals. *Journal for Healthcare Quality, 41*(4), 228–236.

conducted in association with the National Sheriffs' Association and the New York State Association of Chiefs of Police found[23]:

- An average of 10 percent of law enforcement agencies' total budgets was spent responding to and transporting persons with mental illness in 2017.
- Nationwide, an estimated $918 million was spent by law enforcement on transporting people with severe mental illness in 2017.
- The amount of time spent transporting people with mental illness by law enforcement agency survey respondents in 2017 sums to 165,295 hours, or more than 18 years.
- Twenty-one percent of total law enforcement staff time was used to respond to and transport individuals with mental illness in 2017.
- Survey respondents drove a total of 5,424,212 miles transporting individuals with serious mental illness in 2017, the equivalent of driving around the Earth's equator more than 217 times.

In 2018, Care Campus programs opened serving 24,137 admissions as of September of 2019. Eighty-four percent of the people being admitted are Native American. Sixty-four percent of the admissions are self-referral with 30 percent referred by police. Most people use the Safe Solutions sobering center (68%). Crisis services account for eight percent of the services used and detoxification accounts for 18 percent. Four percent are held in one of six isolation rooms. The Care Campus has reduced jail involvement by the population it serves by 19 percent resulting in a cost offset of $677,563 to date by utilizing Safe Solutions, Detox and the Crisis Care Center programs.

SOCIAL DETERMINANTS OF HEALTH

The business community, law enforcement, and the provider communities are concerned about the perceived lack of services for people living with behavioral health challenges. Social, economic, and environmental factors such as income and housing stability, health insurance, education, and employment are critical to improving behavioral health. Rates of frequent mental distress in South Dakota are correlated with social factors, for example, 10.9 percent of individuals with less than high school education report frequent mental distress compared to 6.1 percent of individuals with college degrees, and 14.3 percent of individuals who have annual incomes less than $25,000 report frequent mental distress compared to 3.8 percent of individuals earning $75,000 or more.[24]

Because South Dakota did not expand Medicaid eligibility, the number of individuals who are uninsured is high; approximately 10 percent of individuals in Pennington County lack insurance.[25] A lack of

[23] Treatment Advocacy Center. (2019, May). Road Runners: The Role and Impact of Law Enforcement in Transporting Individuals with Severe Mental Illness. Retrieved from https://www.treatmentadvocacycenter.org/road-runners
[24] United Health Foundation. (2019). America's Health Rankings analysis of CDC, Behavioral Risk Factor Surveillance System, South Dakota. Retrieved from https://www.americashealthrankings.org/explore/annual/measure/mental_distress/state/SD
[25] County Health Rankings and Roadmaps. (2019). Pennington County. Retrieved from https://www.countyhealthrankings.org/app/south-dakota/2019/rankings/pennington/county/outcomes/overall/snapshot

insurance not only causes hardship to individuals but adds a financial burden to the behavioral health provider community that is already underfunded. This provides a challenge for BMS and limits the number of people they can serve and also the types of diagnoses as the state general fund dollars only cover people who meet the criteria for severe and persistent mental illness (SPMI). For example people being served at the Care Campus are not eligible for BMS services and/or do not have insurance. This tight funding makes it difficult to expand services. Regional West loses approximately $2 million per year on unreimbursed behavioral health services.

Rapid City is the urban hub for American Indians living on nearby reservations. As is evident from the Care Center data, some of this flow brings with it people with high behavioral health needs and few resources. The County has attempted to respond to this need through development of the Care Campus and outreach to tribal partners but much need remains.

Housing stability is also a challenge in Pennington County where harsh winters have led to the deaths of people living without proper housing. Fourteen percent of Pennington County residents report severe housing problems, which is higher than the state average of 12 percent.[26] In 2019, 995 individuals were identified as homeless through a statewide point-in-time count. Of those, 322 were in Rapid City.[27] This number is most likely higher because of limitations on the point-in-time count.

Employment and education in Pennington County also affect health outcomes. Approximately 78 percent of individuals in Pennington County have high school degrees, which is lower than the state average (84%). Additionally, the unemployment rate is 3.4 percent, slightly higher than the state average (3.3%).[28] Transportation is also a major challenge for some residents in Pennington County reducing their ability to consistently access behavioral health care and services.

SURVEY FINDINGS

National Council staff, in partnership with PCHHS, developed and administered an electronic survey tool to assess the current continuum of behavioral health services and supports in Pennington County and to identify challenges and opportunities. The National Council team partnered with leadership within Pennington County government to distribute the survey through active listservs reaching a wide-range of key stakeholders in the County.

The survey was completed by 120 respondents; however, all respondents did not answer each question. Sample sizes are included with results in **Appendix B**. The majority of participants reported being employed by non-profit organizations (56%); two respondents reported that they were currently

[26] Ibid.
[27] Mearhoff, Sarah. (2019, April 5). Nearly 1,000 homeless identified in one-day snapshot study. *Rapid City Journal.* Retrieved from https://rapidcityjournal.com/news/local/nearly-homeless-identified-in-one-day-snapshot-study/article_88054f78-ee78-5aae-901c-4b2afc02d22a.html
[28] County Health Rankings and Roadmaps. (2019). Pennington County. Retrieved from https://www.countyhealthrankings.org/app/south-dakota/2019/rankings/pennington/county/outcomes/overall/snapshot

receiving behavioral health services; and 11 respondents were family members of a person who is currently receiving or who has received behavioral health services.

Survey respondents were asked to identify the highest priority for improvement in Rapid City, for example, a change that could help Rapid City support the long-term recovery and/or whole health and wellness of each community member including, but not limited to, those with behavioral health challenges. Respondents indicated that 1. mental health services, 2. housing, 3. substance use/SUD, 4. poverty, and 5. education were the top five priority areas. Detailed findings from the survey can be found in **Appendix B**.

RECOMMENDATIONS

As a next step in meeting the needs of the residents and visitors to Pennington County we are recommending the adoption and implementation of a ROSC which implements service delivery components and supports that are built upon and in response to a set of core values shared across the continuum of care, including individuals who receive services and their families. These values form an organizing accountability framework for the ongoing development of all services and supports.

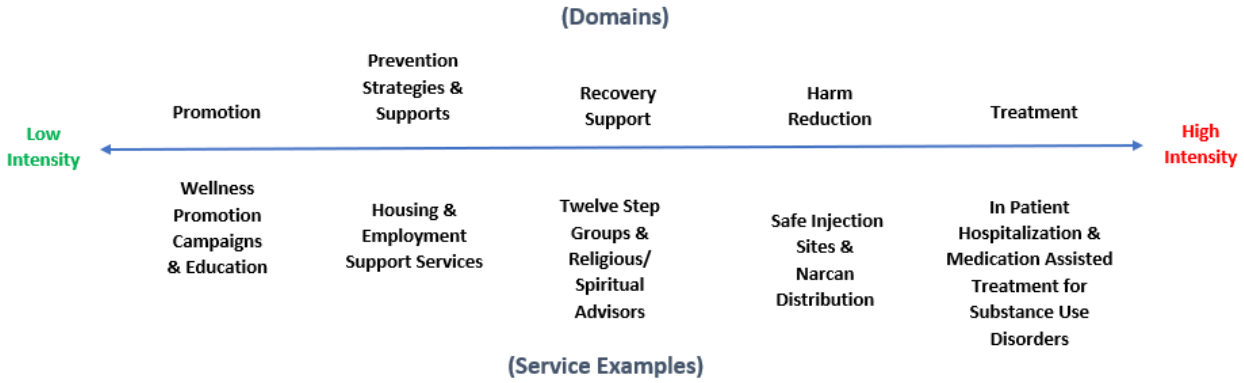
The following recommendations were informed by numerous sources of data, key informant interviews, survey findings, evidence-based practices, and national trends. The findings discussed below align with the values and goals of a ROSC and should be implemented in a collaborative manner engaging stakeholders across the system.

These recommendations come with a cost which should not be borne by Pennington County alone. The surrounding counties which rely on Pennington County, especially the Care Campus and crisis services, will need to provide support. In addition, the state will need to be an active partner in financing services and supports, which if used in connection with a strong care coordination approach, should decrease costs of emergency department use and hospitalization over time.

Underlying all of these recommendations is an acknowledgement that there is a current and developing shortage of psychiatric providers. This shortage reflects national trends. The partnership with Avera for telehealth services that Regional has negotiated is one way of addressing this but long-term providers in this area will need to consider innovation in recruiting and retention. Signing bonuses, loan repayment, work schedules that consider quality of life and partnering with residency programs are all strategies that are being used in other places to address this need with mixed success. Considering this national shortage it is critical that psychiatric providers are being used as specialists, seeing the most complex patients and supporting primary care providers in managing patients who are less complex.

Across the continuum of care needs, there are specific key considerations that Pennington County should take to determine the best existing resources and needed supports to implement a comprehensive behavioral health system that aligns with ROSC principles. Figure 4, below, illustrates the full continuum of care. **Appendix A** provides more detail on the ROSC service delivery continuum that could be used in Pennington County to continue to build out a ROSC services array.

FIGURE 4. RECOVERY-ORIENTED SYSTEM OF CARE (ROSC) SERVICES CONTINUUM



1. DEVELOP A CRISIS STABILIZATION UNIT AT THE CARE CAMPUS OPERATED BY BMS

To address the needs of individuals facing an acute mental health crisis, a Crisis Stabilization Unit should be developed at the Care Campus that is operated by BMS. Most people who are petitioned to go to HSC convert to voluntary treatment and do not have serious mental illness and so could be served by this alternative level of care. This Crisis Stabilization Unit would serve the larger region (including the surrounding counties) and would also provide a "home base" for the regional crisis telehealth services described in recommendation #2 below. Research indicates crisis residential services are up to 40 percent less costly than use of inpatient hospital facilities[29].

This Crisis Stabilization Unit would ideally have 10 to 12 beds; however, there are space limitations that will keep the number of beds at eight at the present time. We recommend moving ahead with the Crisis Stabilization Unit at the eight-bed size and if demand exceeds capacity that over the next six to 12 months, another location could be considered or the space built-out. The current 23-hour crisis bed service would be incorporated into the Crisis Stabilization Unit. Placing the crisis stabilization unit at the Care Campus will allow for easy access to other services that are geographically nearby and increase the likelihood of coordinated discharge planning.

This new level of care will be the entry point for all people in crisis, except in the case of medical instability. The physical entrance to the Crisis Stabilization Unit should be private to ensure proper monitoring of the facility and to keep a low stimulation environment in place. BMS would remain the managing provider drawing from their expertise in working with people with serious behavioral health challenges. Qualified mental health professionals (QMHP) should be onsite to provide petition assessments, initiate therapeutic interventions, including MH and SUD individual therapy, treatment groups, and other services. The 24-hour staffing can include two to three high school or college degreed staff, ideally who have lived experience. Psychiatric care at the Crisis Stabilization Unit could

[29] Fenton, W. S., Hoch, J. S., Mosher, L., & Dixon, L. (2002). Cost and cost-effectiveness of hospital vs residential crisis care for patients who have serious mental illness. *Archives of General Psychiatry, 59*(4), 357-364.

be provided by the Avera telepsychiatry program in partnership with Regional. This psychiatric coverage could be an "in-kind" donation from Regional.

The Crisis Stabilization Unit's physical environment should be warm, welcoming, and to the extent possible, not institutional. The importance of providing a low stimulation environment (e.g., low lighting and sound) is due to research showing visual, tactile and auditory senses are heightened when experiencing the symptoms of a mental illness. This over stimulation can overwhelm the person resulting in the further exacerbation of symptoms [30,31] Funding for the unit would include reimbursement for clinical services and a per diem rate obtained by other funding sources (i.e. state dollars, potentially county dollars not only from Pennington County, but from the surrounding counties as well).

The goal of the Crisis Stabilization Unit is to support individuals through an immediate crisis, help develop a safety plan, and develop a comprehensive plan for follow up in the community. Some people may be able to leave the unit within the first day while others may need three to five days to stabilize, work with community based providers to develop a support plan, and start appropriate medications. For people who are not able to stabilize in three to five days and return to the community with appropriate support, a transfer to the inpatient psychiatric until at Regional West would allow for additional treatment. The Crisis Stabilization Unit could also be used as a hospital step-down facility for patients who are medically stable but still in need of supervised support until they can develop a plan for transition back into the community.

CASE EXAMPLE: HOPE HOUSE, GALLATIN COUNTY, MONTANA[32]

Gallatin County, Montana is of similar size to Pennington County. Part of the continuum of care includes Hope House which provides "around-the-clock" crisis stabilization services for adults with a diagnosis relating to a mental health crisis. Services include medication therapy management (assisted by an on-site psychiatric nurse practitioner), individual, group, and family practices, peer support, nursing, and case management services. Hope House has eight voluntary crisis stabilization rooms and two emergency detention rooms. A patient is placed into this medical center under the prescription of the Crisis Response Therapists in connection with an individual's treatment customer support group. The emergency detention patients are directed to the health center by the Gallatin County Attorney's Office in connection with the Crisis Response Therapist. Hope House receives funding as a crisis stabilization unit, with a $300 per day flat rate, but providers can also bill for clinical services on top of that. Psychiatry and therapists see people (and bill for services provided) daily.

[30] Javitt, D. C. & Freedman, R. (2015). Sensory Processing Dysfunction in the Personal Experience and Neuronal Machinery of Schizophrenia. *American Journal of Psychiatry, 172,*(2), 17-31.
[31] Huisman, E. R. C. M., Morales, E., van Hoof, J., & Kort, H. S. M. (2012). Healing environment: A review of the impact of physical environment factors on users. *Building and Environment,58,* 70-80.
[32] Gallatin Mental Health. (2019). Crisis Stabilization (Hope House). Retrieved from http://www.gallatinmentalhealth.org/services/crisis-stabilization-hope-house

2. DEVELOP TELEHEALTH CRISIS SERVICES FOR REMOTE COUNTIES TO SUPPORT LAW ENFORCEMENT

To increase capacity for crisis services in remote counties, thus alleviating the burden that out-of-county transports for involuntary commitment have on Pennington County, a telehealth system of care for crisis services should be developed and implemented. This service would operate out of the Crisis Stabilization Unit at the Care Campus and would be staffed by a combination of the QMHPs already employed there and the telemedicine psychiatric program from Avera. Local healthcare staff in rural emergency departments should be trained in basic assessment and intervention to adequately assess patients in crisis. All levels of staff should receive training, including nurses and nurses' aides. The fact that most of the county level commitments are coming from hospitals associated with Regional will make training easier as it can be part of a system wide approach to increase capacity for behavioral health and is a natural extension of the hospital's current Zero Suicide initiative.

To establish this system, investments in technology infrastructure, including iPads or other tablet devices and mobile phones, for example, should be made. Law enforcement should be given these devices to facilitate access to care by a QMHP through telehealth. Law enforcement in rural jurisdictions could then bring patients to an appropriate location within their own county to receive services via telehealth from a remote practitioner. Since there are already 24-hour QMHPs available at the Crisis Center, responding to telehealth calls could be included in their routine work. Patients who need additional support could then be brought to the Crisis Stabilization Unit at the Care Campus. This would eliminate, except in specific cases, the use of the Regional Hospital emergency department and would provide 24-hour support both through telehealth and if needed, through the Crisis Stabilization Unit. Psychiatric coverage could come from Regional West through their partnership with Avera. This service would be available to hospital staff and law enforcement staff in these outlying counties and should be partially paid for by local county commitments to financial support.

CASE EXAMPLE: HARRIS COUNTY SHERIFF'S OFFICE[33]

In 2017, the Harris County Sheriff's Office implemented a program that connects individuals experiencing a mental health emergency with telepsychiatry by equipping deputies with iPads. Using the iPad and the Cloud 911 application, deputies can offer individuals in crisis the opportunity to speak directly with a clinician. Telepsychiatry appointments general last 20 minutes. The telepsychiatry providers assist with deescalating situations, make recommendations for follow up care, and can immediately prescribe medications that the deputies help facilitate getting to the patient. Program administrators noted that the program helped save money within the county by diverting individuals away from jail.

[33] Ramsey, J. (2018, March 6). How iPads Changed a Police Force's Response to Mental Illness. Retrieved from https://thecrimereport.org/2018/03/06/how-ipads-are-changing-one-police-forces-response-to-the-mentally-ill/

3. EXPAND THE NETWORK OF RECOVERY HOUSES AND SUPPORTED EMPLOYMENT

Housing and employment are key determinants of behavioral and physical health outcomes that challenge Pennington County residents. The network of housing units and apartments operated by BMS should be expanded to increase housing stability among residents. Considerations for individuals with behavioral health challenges should be a priority in the planning and implementation of a housing expansion. Financial support for BMS for supported housing approaches and supported employment should be explored, including reimbursement for services by the state for insured and uninsured populations.

To successfully expand these services, partnerships should be strengthened and developed. The current housing coalition is a dedicated group of stakeholders, but at the present time, they are not connected to the behavioral health provider community. While there is conversation around hiring a housing coordinator going forward, we recommend a much stronger coalition that encompasses not only the new Common Bond project, but also One Heart, Cornerstone Rescue Mission, the Care Campus and develops methodologies for tracking people who are homeless/experiencing housing insecurity and wraps services around them. This community level coalition development has proven successful in many other cities and with the current passion and commitment of stakeholders to this issue, the work coming out of Collective Impact with Common Bond, the opening of One Heart, the changing approach of Cornerstone Rescue mission, and the ongoing presence and work of the Care Campus, Rapid City is primed for this next step in innovation. In the interviews conducted for this report, we heard a repeated concern that so many efforts are happening in a parallel process, rather than in a coordinated fashion, around housing development and services to help people experiencing homelessness move toward permanent and safe housing.

CASE EXAMPLE: BEACON INTERFAITH HOUSING COLLABORATIVE, ST. PAUL, MINNESOTA[34]

The Beacon Interfaith Housing Collaborative in St. Paul, Minnesota is a collaborative of congregations that has come together to create homes and advance equitable housing for individuals in the Twin Cities. Beacon embeds services for individuals with behavioral health needs within housing through their supportive housing program to ensure individuals remain stably homed and healthy. Services offered include employment, education, community connection, and health care services. Advocates are located on-site to work with individuals on goal planning. In addition to establishing new homes and helping individuals remain housed, Beacon engages in education and advocacy efforts to ensure systems and policies are in alignment with community needs and evidence-based practices.

In addition, support should be given to the development of additional recovery houses in Rapid City. Recovery Houses provide needed recovery supports to individuals who are in the early days of their recovery from SUDs. These Recovery Houses are mostly self-supporting; however, financial support to

[34] Beacon Interfaith Housing Collaborative. (2019). Retrieved from https://www.beaconinterfaith.org/

assist the leadership of this program in establishing additional houses and supporting their ongoing capacity would be of great assistance.

The establishment of evidence-based supported employment approaches at Cornerstone Rescue Mission should be encouraged. The increased emphasis on employment already in place at Cornerstone would be enhanced by using the evidence-based practice of supported employment. This practice not only teaches necessary skills for employment but also supports application in real life settings. To ask people who have a long history of unemployment, poverty, and behavioral health challenges to engage in the world of work on their own is to ask for failure. This would require additional staff at Cornerstone including a master's prepared therapist.

4. INCREASE THE NUMBER OF PSYCHIATRIC BEDS AT REGIONAL WEST HOSPITAL

Expert consensus guidelines recommend a minimum of 50 inpatient psychiatric beds per 100,000 with a suggested ratio of 64 to 100,000. Currently, South Dakota has approximately 15 beds per 100,000.[35] Regional West has 18 pediatric and 30 adult inpatient psychiatric beds. This number reflects the recent addition of eight beds but at points not all beds can be open due to staffing issues. Given this ratio, Regional West should add 34 additional inpatient beds. If the recommendation to develop a Crisis Stabilization Unit is accepted, this number may be decreased as more people will be diverted from inpatient care.

Part of the potential expansion of beds will require addressing the current shortfall of $2 million annually due to unreimbursed services. These expenses are a result of underfunding for patients on petition waiting for admission to HSC (the state of SD only pays up to $600 for the initial evaluation), uninsured patients, and difficulty processing insurance claims from Indian Health Services. Regional West should become the major treatment facility for Western South Dakota with transfers to HSC being rare and only for the most severely ill patients with serious mental illness who cannot be stabilized and treated at Regional. This will require a coordinated effort on the part of the Mental Health Board, QMHPs, the Regional Hospital system, BMS, and other providers to ensure only those who cannot be treated in the County are transported to HSC. This will require the development and implementation of new protocols, including training of providers so they are prepared to assist people in crisis. This change will nearly eliminate the need for law enforcement to transfer people to HSC thereby saving time, money, and stress on both staff and patients.

This shift, while including a potential increase in the number of inpatient beds, will also require a shift in the approach to care at Regional West inpatient. If people are no longer waiting for transfer to HSC, then it is imperative that all patients begin treatment at the moment of their admission with an eye to developing a plan for community support. This will require increased coordination between the inpatient unit and community-based providers. Increasing the number of psychiatric beds and

[35] Treatment Advocacy Center. (2018). South Dakota. Retrieved from https://www.treatmentadvocacycenter.org/browse-by-state/south-dakota)

stabilizing funding will contribute to the development of a comprehensive psychiatric system for people who are not able to be stabilized at the Crisis Stabilization Unit and do not need to be petitioned as well as those rare patients who do need HSC level of care.

Additionally, to reduce the burden on Regional Hospital emergency department staff and to curb the high rate of petitions, most of which convert to voluntary treatment or are dropped by the QMHP, the policy requiring all people with a behavioral health crisis to go through the Regional emergency department must be dropped and replaced with a policy that states people, unless medically unstable, should be brought to the Care Campus Crisis Stabilization Unit, or if willing to receive inpatient treatment and appropriate for admission should be brought directly to Regional West. Across the country, emergency department staff are struggling to efficiently and effectively respond to the increasing rate of patients presenting in the emergency department in a psychiatric crisis.

CASE EXAMPLE: SIERRA SACRAMENTO VALLEY MEDICAL SOCIETY AND WASHINGTON STATE MEDICAID EMERGENCY DEPARTMENT INFORMATION EXCHANGE[36,37]

In response to high emergency department admission rates for people in a psychiatric crisis, the Sierra Sacramento Valley Medical Society (SSVMS) developed a committee to identify solutions. The use of emergency medical service staff in the field, under the authority of the emergency department, to provide medical clearance and transport of people to a crisis center instead of the emergency room was among the solutions identified. For those who need to be assessed in the emergency room, protocols that reduce the time needed to medically clear the person were developed, including a SMART clearance form. A training series was recently developed for emergency department providers that draws from the lessons learned by the SSVMS initiative. Additionally, an Emergency Department Information Exchange (EDIE) system was developed replicating work done by the Washington State Medicaid office to increase data sharing for care coordination between the emergency department and community providers. The EDIE system allows community providers, the crisis center, and the emergency department to access real-time information about people in crisis.

5. CONDUCT A CARE CAMPUS ENVIRONMENTAL SCAN

An environmental scan should be conducted with the Care Campus to identify recommendations to strengthen the Campus' recovery orientation and focus and to identify trauma-informed approaches that could be integrated into service delivery. The environmental scan should be developed and completed in collaboration with individuals who receive services from the Care Campus. Additionally, Care Campus staff would benefit from receiving training on trauma-informed, recovery-oriented services provision to transition from a culture at the Care Campus of institutionalized care to one of recovery-oriented care. A trauma-informed approach has been found to not only improve the

[36] Sierra Sacramento Valley Medical Society. (2019). Smart Medical Clearance. Retrieved from http://smartmedicalclearance.org/forms/
[37] Brookings Center for Health Policy. (2015, May 4). Washington State Medicaid: Implementation and Impact of "ER is for Emergencies" Program. Retrieved from https://www.brookings.edu/wp-content/uploads/2016/07/050415EmerMedCaseStudyWash.pdf

experience of care received but also the experience of care provided by staff.[38] Importantly a trauma-informed approach is also correlated with reduced incidents of disruptive behaviors, improved outcomes, and cost savings.[39]

The Care Campus and One Heart are impressive examples of the commitment the county and the law enforcement have to engaging and helping citizens who are experiencing chronic behavioral health conditions. Currently the Care Campus is staffed by Sheriff Department personnel. We recommend a stronger partnership between BMS staff and the current staff to increase the treatment services available at the Care Campus. This stronger partnership could include frequent training of all Care Campus staff in principles and practices that suppo9rt recovery oriented approaches. The partnership could support expansion into medication assisted detox services. The residential treatment beds that are opening in the fall will be served in part by Lutheran Social Services which will increase capacity or treatment in this unit.

We recommend using these clinical partners and other community resources to address the number of members who use the care center repeatedly. This "high needs" coordination group could provide more wrap around services for this group of approximately 125 members. Working to engage this group in recovery would also provide an opportunity to discover additional barriers and resources that impact other Care Campus members. The state should be consulted about providing partial (or full) support for these staff members.

6. CONDUCT A STUDY ON FUNDING CHALLENGES FOR SERVICES FOR AMERICAN INDIANS

A study should be conducted to better understand the challenges and opportunities related to financing care and services for American Indians. Information gathered through the environmental scan identified several potential funding challenges related to the Indian Health Services reimbursement model and other issues. Investing in a study specifically focused on supporting services and care for American Indians will provide insight on how to best address challenges and maximize opportunities. As a result of the study, training should be conducted with all finance staff in organizations that are affected by these finance streams. This recommendation would require foundation or other grant funding to support this work.

This study would also provide a foundation for the development of a stronger partnership with tribal leadership on the Sioux San and Pine Ridge reservations. These partnerships take time and consistent leadership to develop because of the historical mistrust that has developed over years. With new leadership at Sioux San and the developing 638 program, this is an ideal time to develop these

[38] Amaro, H., Chernoff, M., Brown, V., Arevalo, S., & Gatz, M. (2007). Does integrated trauma-informed substance abuse treatment increase treatment retention? *Journal of Community Psychology,* 35(7), 845-862.
[39] Domino, M. E., Morrissey, J. P., Chung, S., Huntington, N., Larson, M. J., & Russell, L. A. (2005). Service use and costs for women with co-occurring mental and substance use disorders and a history of violence. *Psychiatric Services, 56*, 1223–1232. https://doi.org/10.1176/appi.ps.56.10.1223

relationships. The Pine Ridge reservation behavioral health staff are open and ready to develop this kind of long term relationship. We recommend consistent leadership and attendance and involvement of staff from the Vucurevich Foundation as the neutral convener from this group.

7. EXPAND CASE MANAGEMENT INTO ALL SPECIALTY COURTS

Specialty courts have been shown to be effective in reducing recidivism and methamphetamine use among participants.[40,41] The current specialty courts are providing a valuable service to Pennington County by diverting people from jail into a process the creates the possibility of long-term recovery. The courts are limited at this time by the number of case managers available to them. Increasing the case management staff by one additional case manager per court would allow those case managers to both engage more effectively with their clients and build additional relationships in the community. These expanded case managers could facilitate connections with the newly developed One Heart campus and the many organizations that will be located on that campus.

8. CONDUCT AN ENVIRONMENTAL SCAN ON THE CONTINUUM OF SERVICES FOR CHILDREN WITH BEHAVIORAL HEALTH NEEDS

The scope of the current environmental scan and recommendations are limited to the adult service system. A similar effort should be conducted analyzing the scope of services and supports for children in Pennington County. This effort should include the staff working at Rapid City schools in the critical areas of suicide prevention and MH awareness. This environmental scan would require additional funding from foundations or other grants and should be conducted keeping in mind the direction set by whatever recommendations are adopted from this project.

9. DEVELOP A COMPREHENSIVE PLAN FOR INCORPORATING THE VOICE OF PEOPLE IN RECOVERY

One of the core components of a ROSC is the inclusion of people with lived experience in all aspects of service planning, delivery, and evaluation. South Dakota has not moved forward with statewide, formalized training or reimbursement for peer support specialists/recovery coaches. With the ultimate goal of hiring paid staff with lived experience, a starting point can be to ensure that each coalition and planning group related to behavioral health has peer representation. Initially, this could be challenging because people living with behavioral health challenges often have been disenfranchised and are often not experienced in participating in leadership roles. Developing peer leadership training would fit within the mission of the Vucurevich Foundation and would provide an initial opportunity to develop skill and leadership for the future. This training could be developed in partnership with existing peer

[40] Mitchell, O., Wilson, D. B., Eggers, A., MacKenzie, D. L. (2012). *Journal of Criminal Justice, 40*(1), 60-71.
[41] Marinelli-Casey, P., Gonzales, R., Hillhouse, M., Ang, A., Zweben, J., Cohen, J., . . .Rawson, R. A. (2008). Drug court treatment for methamphetamine dependence: Treatment response and posttreatment outcomes. *Journal of Substance Abuse Treatment, 34*(2), 242-248.

organizations in Rapid City. The Dimensions: Peer Support Program Toolkit, developed at the University of Colorado is a helpful guide to support planning and implementation of peer models.

In addition to developing leadership skills and gaining membership on all key planning committees, creating informal opportunities for peer led groups in the existing services in Rapid City should be a focus of the next stage of program development.

10. ESTABLISH A CLEAR FOCUS ON AND COLLABORATION WITH INTEGRATED PRIMARY CARE

Both Community Health Center of the Black Hills (CHC of the Black Hills) and the primary care practices owned by Regional are establishing integrated behavioral and primary health care approaches. Supporting the full integration of these and other primary care practices in Rapid City with robust screening programs for depression, suicide, anxiety, and substance use provides a key "front door" approach to identifying behavioral health challenges before a person goes into crisis. Depression, anxiety, and at-risk substance use can be effectively treated in integrated primary care settings where there is an embedded behavioral health clinician working within the primary care team. A high percentage (83%) of people who die by suicide have seen their primary care provider in the past year, 50 percent within the past month.[42] Providers who are working in integrated care settings have behavioral health resources at hand and can efficiently and effectively provide brief treatment, care coordination, and referral for long-term treatment when indicated, therefore reducing the incidence of behavioral health related crises and suicide.

At a minimum, representatives from these practices and from the CHC of the Black Hills should be included in planning work related to behavioral health issues. BMS and the Mission currently work with the CHC of the Black Hills to coordinate care for people with behavioral health conditions. As the clinic is established at the One Heart campus, this collaboration becomes easier. People being served at the Care Campus and at One Heart will also have access on site to this service. Including support for physical health issues is key to improving outcomes of care.

11. CREATE STRONGER COMMUNITY COALITIONS WITH CLEAR FOCUS ON CREATING A ROSC

It is not uncommon for health care, law enforcement, and social service providers to struggle with sharing information about shared clients. This is due in part to health information protections, poor data capture and exchange systems, and service missions and organizational cultures that do not align. These realities create gaps into which consumers of services fall when transitioning from one service provider to another. In order for the consumer of services to fully take advantage of a comprehensive services array, those providers must have relationships at the executive and frontline staffing levels to

[42] Durkin, M. (2018, October). Preventing suicide in primary care. *ACP Internist.* Retrieved from https://acpinternist.org/archives/2018/10/preventing-suicide-in-primary-care.htm

ensure information about people being served is exchanged and that the system can provide a "no wrong door" approach where a person regardless of where they turn will be connected to the right provider. Without this network of well established relationships between providers and the business agreements to support these relationships, the system becomes siloed and the consumer of services must navigate the system blindly. Having a community wide agreement to the principles and practices inherent in a ROSC can help to create a shared framework. Three additional critical features of a well-established continuum of care that must be in place include: 1. Executive leaders that work well together with a shared vision of the community continuum of care through which their services are provided; 2. Formal agreements that clearly articulate how the providers will work together to jointly serve and/or refer people to services when indicated; and 3. Data sharing and review of agreed upon community key performance indicators (KPIs) that tell the story of how well the providers are able to serve community member needs.

It is common for organizations to disagree on a course of action (e.g., use of community resources) that negatively impacts the ability of these organizations to effectively collaborate in the provision of services to community members. Pennington County is not immune to this; therefore it is important that the community has a way to declare when a disagreement between two or more provider agencies has reached the level of needing a structured process for conflict resolution. The Rapid City Collective Impact (RCCI) has called for "Continuous Communication" as a means to building trust. Similarly the Black Hills Regional Homeless Coalition has called for increased collaboration between provider agencies. Processes like "Walk in the Woods" allows for a third party convener (e.g., a local foundation) to help resolve conflict between one or more providers.

12. STRENGTHEN COORDINATION ACROSS THE SYSTEM OF CARE

People with behavioral health conditions require consistent and comprehensive assistance which includes care coordination. Care coordination occurs when two or more people come together, either within an organization or between organizations, to help a person with their social determinants, physical health, or behavioral health needs. There are three key requirements for effective care coordination: 1. Agreed upon protocols for how care will be coordinated that are understood by the staff doing the care coordination work; 2. Data in the form of KPIs to provide evidence the care coordination occurred and had the desired effect; and 3. A system for continuous quality improvement to respond to the date findings. Business Associate Agreements (BAA) and Qualified Service Organization Agreements (QSOA) are formal agreements that allow for data sharing by clarifying how two or more agencies will work together to coordinate care and share data within the requirements of the Health Information Portability and Accountability Act (HIPAA) or 42 CFR Part2, the federal regulations that govern sharing SUD records and information.[43]

[43] SAMHSA. (2019, April 18). Substance Abuse Confidentiality Regulations. Retrieved from https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs

For example, if a primary care provider refers a person to substance use treatment, both providers need a shared protocol as part of an agreement describing how that referral is made and what is measured to show it worked (e.g., a KPI that data will be captured and shared showing the person made it to their first two substance use treatment sessions). Protocols allow for providers to structure their interactions so both staff and the people receiving services know how the continuum of services work. KPIs allow providers to see that care is being provided effectively. Key performance indicators help inform if the protocols are working and or not. If not, the collaborating staff have an opportunity to use quality improvement tools like a root cause analysis exercise to determine next steps for improving and testing a new protocol.

The use of KPIs and shared data enhances the capacity of the system to monitor the movement of people across the continuum of care and test new ways of providing service. "Shared Measurement" is also one of the five RCCI key ingredients.

Data should also be leveraged to monitor the health of populations and risk stratify people accessing services to ensure the appropriate level of care, regardless of where they entered the continuum of care. For example, the Care Campus currently collects an impressive amount of data that describes how services are being accessed and used. These data tell only part of the story. If the Care Campus had agreements with surrounding providers to share data, data tracers could be conducted to see how individual consumers of services and populations of consumers are being impacted by the services.

For example, are people being referred to certain providers in the community and engaging in treatment? People who are high utilizers of Care Campus services are a risk group that need aggressive engagement and care coordination. The Quality of Life Officer program is a good example of how a high risk population is identified and aggressively engaged through wrap-around services to reduce risk and engage them in services that align with their readiness for change. Based on the Care Campus data there are several risk populations (e.g., high utilizers of Safe Solutions) that could benefit from wrap-around care coordination and data tracking to see if the interventions are working. Benchmarks that the Care Campus or other providers have established as KPIs could tell the story of clinical improvement (e.g., attendance in treatment for SUD, connection with primary care for physical health conditions) or social determinants being met (e.g., people becoming housed, or employed). These KPIs provide process and outcome evidence that the community of providers is effective in helping people recover. Beyond the availability of data and the sharing of data through use of agreements there must be key groups of providers meeting regularly to review KPIs to assess how well individual consumers and populations are doing as a result of receiving services.

Stakeholder interviews revealed there is a history of key providers meeting regularly to review data, share information, develop protocols, and establish KPI targets for the system. We recommend this practice be restarted using law enforcement, Lutheran and Catholic Social Services, Care Campus, BMS, the Mission, the emergency department, hospital staff, and associated data to start building protocols that lead to KPI targets being achieved. The Los Angeles County Department of Mental Health's Health Neighborhoods: A Toolkit for Service Delivery Providers is a helpful guide offering a

care coordination checklist, examples of agreements, and a data tracking log. Additionally, the Agency for Health Research and Quality (AHRQ) developed a Care Coordination Atlas which provides a variety of measurement tools and resources.

13. EDUCATE THE COMMUNITY ABOUT BEHAVIORAL HEALTH AND WELLNESS

While this recommendation may be listed last, in many ways community education is a foundation for a ROSC. In interviews and the survey, the issue of stigma and discrimination against people with behavioral health issues was raised frequently. Education and raising community awareness will reduce stigma and discrimination and increase overall community knowledge and commitment to be a healthy community. Mental Health First Aid (MHFA) should be expanded across the County as one education strategy. Currently, there are MHFA trainers in Rapid City, but it has not been disseminated across the City or County. We recommend a concerted campaign to increase the number of citizens of Pennington county who are trained in MHFA.

DISCUSSION

Pennington County has significant resources in its existing services, including its wide variety of stakeholders who are committed to improving the overall health of the County and its demonstrated track record for innovation. As we have conducted this assessment the willingness of people to give their time and energy to provide information and vision for the future has been impressive.

The recommendations in this report are based on the information gathered over the past year and represents the themes that emerged through quantitative data, survey findings, and conversations. By wrapping these recommendations in the framework of ROSC we have attempted to provide you with not only specific changes, but a unifying framework to guide the thinking, planning and development of services and supports.

APPENDIX A: KEY COMPONENTS OF A RECOVERY ORIENTED SYSTEM OF CARE FOR PENNINGTON COUNTY

ROSC Strategies and Services
Promotion
Social marketing campaigns
Community coalitions

Advocacy groups
Behavioral health training to service providers and community members
Prevention
School-based prevention programs
Faith-based prevention programs
Workplace prevention programs
Community-based prevention programs
Prescription drug disposal locations
Parenting education
Early childhood home visitation
Recovery Support Services
Peer support groups
Twelve step groups
Spiritual and religious advisors
Harm Reduction Strategies
Community naloxone (Narcan) distribution
Strategies and Supports to Address Harmful Social Determinants of Health
Transportation services
Employment support
Education support
Housing assistance
Health insurance assistance
Food assistance
Linkages to community legal services providers
Jail and prison reentry services and linkages to community care
Treatment
Outpatient employer-based services /Employee Assistance Programs (EAP)
Outpatient detoxification
Outpatient counseling, psychiatry, and psychotherapy
Moderate intensity habilitation/rehabilitation
Specialized residential MH services (includes group homes)

Specialized residential SUD services (includes group homes)
Medication-assisted treatment for SUD, including alcohol, nicotine, and opioid use disorder
High intensity rehabilitation
Homeless shelter
Inpatient detoxification
Inpatient psychiatric youth Regional*
Inpatient psychiatric adult Regional*
Twenty-four hour/Intensive day treatment program
Adult Treatment Courts ("Drug courts")
Adult MH Court(s)
Inpatient Psychiatric Youth Regional Hold
Inpatient Psychiatric Adult Regional Hold
Inpatient Psychiatric Adult Yankton**
Crisis Services
Hospital Emergency Department
Correctional-based MH and SUD services

APPENDIX B: SURVEY RESULTS

PENNINGTON COUNTY BEHAVIORAL HEALTH CONTINUUM OF CARE STAKEHOLDER SURVEY

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INTRODUCTION

To better assess the current continuum of behavioral health services in Pennington County, South Dakota, the National Council for Behavioral Health (National Council) in partnership with Pennington County Health and Human Services (PCHHS), collected information from a wide-range of stakeholders across the county to identify current resources, challenges, gaps, and opportunities to improve the provision of services for individuals with mental health and substance use challenges. Survey findings are discussed below.

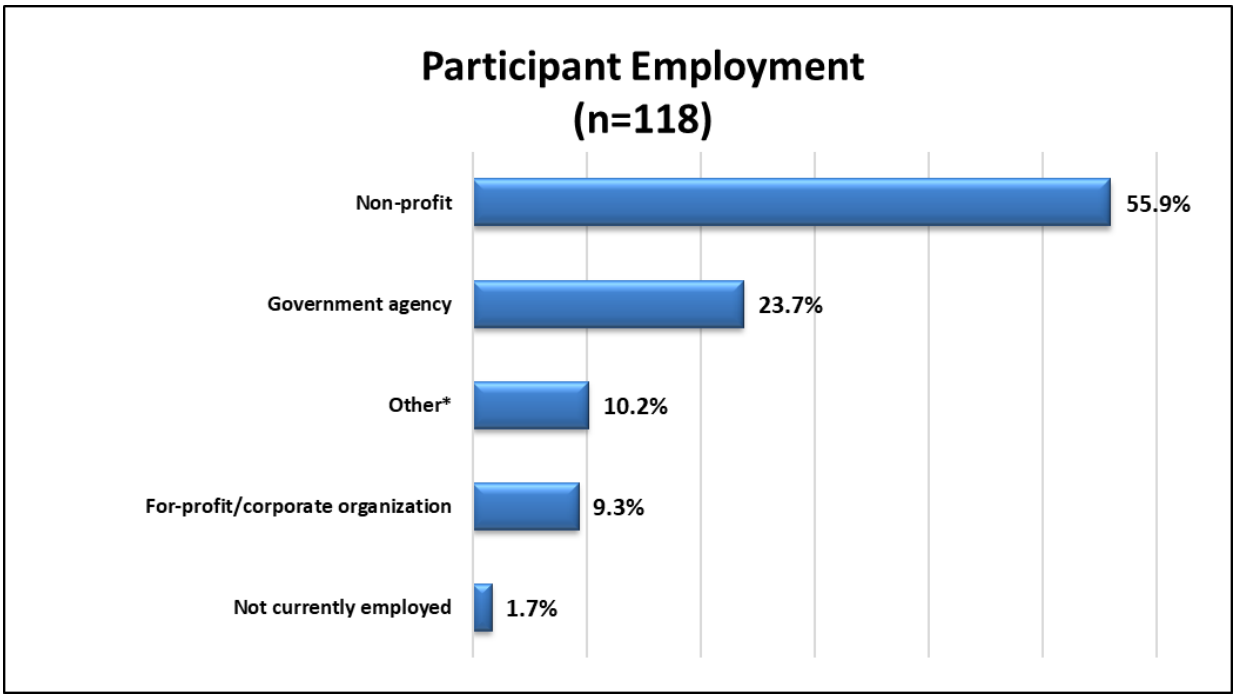
SURVEY METHODOLOGY

National Council staff developed an electronic survey tool to assess the current continuum of behavioral health services and supports in Pennington County and to identify challenges and opportunities. The survey was developed in partnership with Iteration Evaluation, a public health evaluation organization based in Oregon. The survey was pilot tested with National Council staff prior to being administered to respondents. The National Council partnered with leadership within Pennington County government to distribute the survey through active listservs reaching a wide-range of key stakeholders in the county. The survey was completed by 120 respondents.

SURVEY FINDINGS

SURVEY PARTICIPANT DEMOGRAPHICS

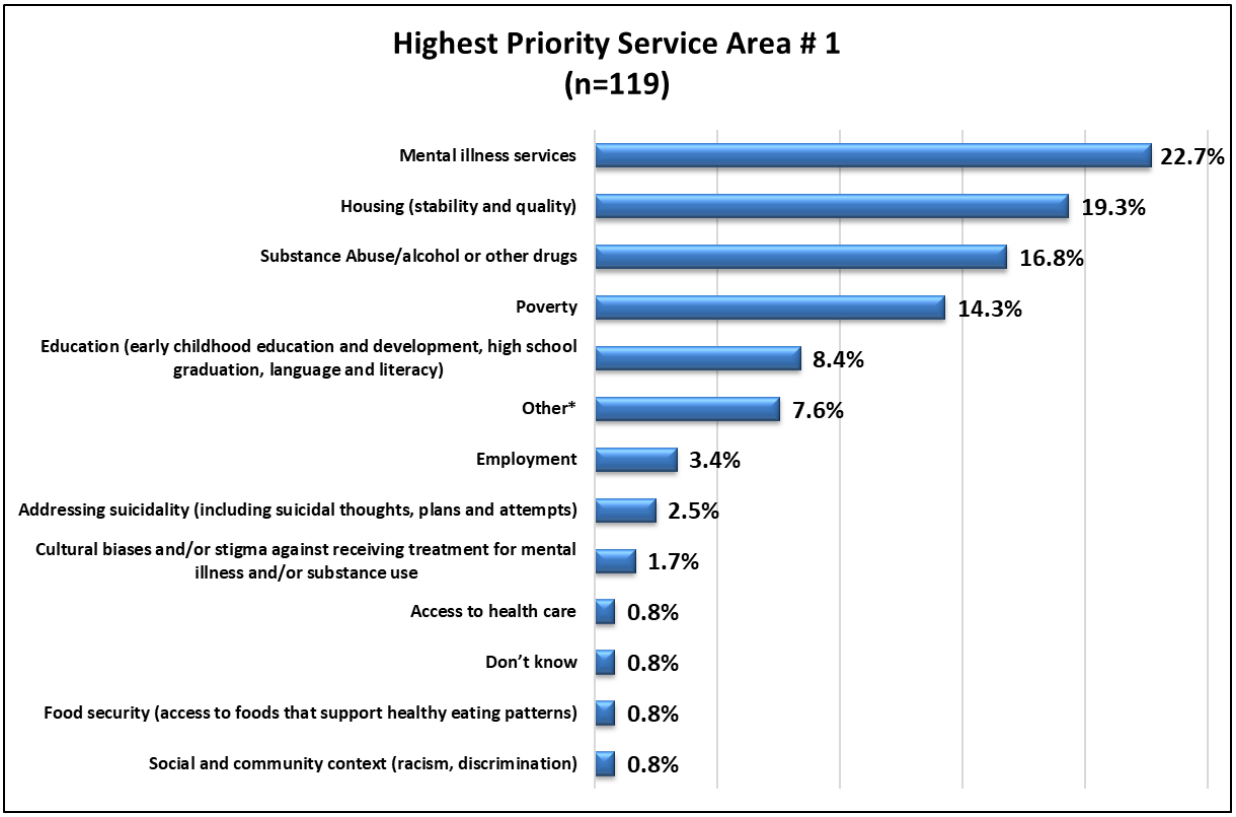
The survey was completed by 120 respondents; however, all respondents did not answer each question. Sample sizes are included with results. The majority of participants reported being employed by non-profit organizations (56%); two respondents reported that they were currently receiving behavioral health services; and 11 respondents were family members of a person who is currently receiving or who has received behavioral health services.



**Other* response options included self-employment, consultant, practitioner, private practice, and brain and body health group.

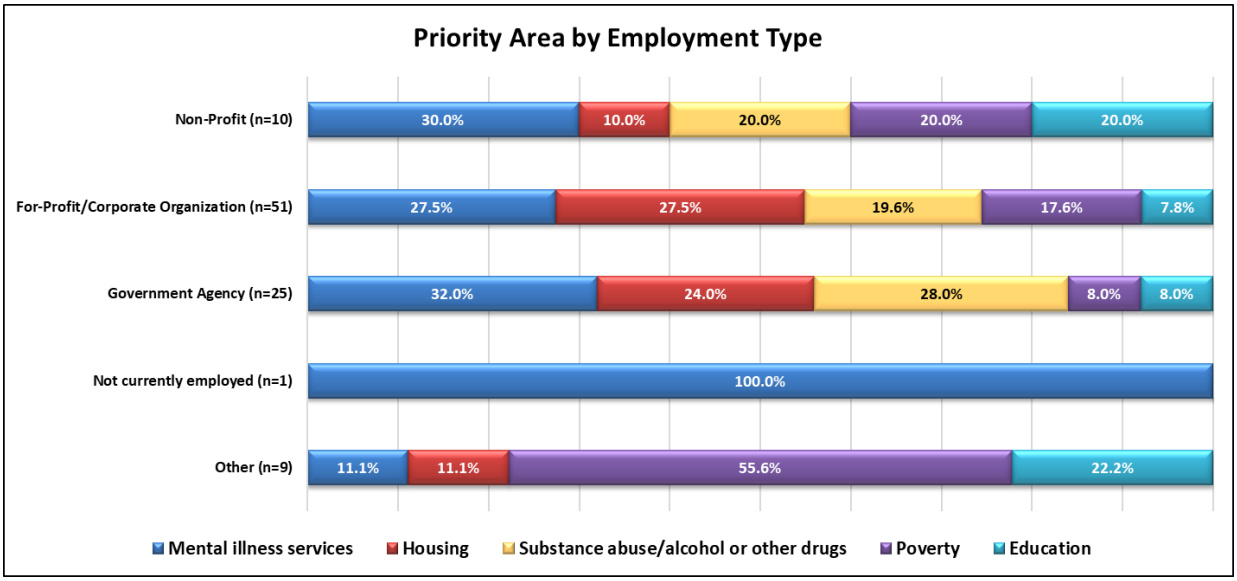
HIGH-PRIORITY IMPROVEMENT SERVICE AREAS

Survey respondents were asked to identify the highest priority for improvement in Rapid City, for example, a change that could help Rapid City support the long-term recovery and/or whole health and wellness of each community member including, but not limited to, those with behavioral health challenges. Respondents indicated that (1) mental illness services, (2) housing, (3) substance abuse/alcohol or other drugs, (4) poverty, and (5) education were the top five priority areas.



**Other* response options included timely access to services (e.g., overall health, mental health, wellness care), family involvement in children's emotional/behavioral needs, and transportation.

The next graphic presents the top five priority areas (listed above) by respondent employment type. Respondents working for non-profit organizations reported mental illness as the highest priority. Those working for for-profit/corporate companies rated mental illness and housing as the top priorities. Those working for government agencies also reported that mental illness was the top priority, as did an unemployed respondent. Respondents employed in the "other" group identified poverty as the highest priority issue.



IDEAS FOR CHANGE

The following five tables present respondents' ideas for a change (something new, something to do more of, less of, stop doing, etc.) that would help address one of the top five priority areas listed above. Respondents submitted up to three ideas for change.

PRIORITY AREA 1: MENTAL ILLNESS SERVICES

Idea for Change	Novelty of the Idea
We must fix the mental health system in western South Dakota. Presently, we have no physical plant dedicated to the care and treatment of the mentally ill.	New
Our judicial system needs to look at non-punitive approaches to non-violent crimes.	New
A west river mental health center	New
I believe Out-patient Commitment would help our community tremendously.	New
The Mental Health UC could be added to the RCRH Urgent Cares.	New
There should be a substance abuse treatment center in Rapid City for meth, opioid, alcohol and heroin addictions. There is no adult substance abuse treatment here and alcoholism and other addictions run rampant. There is no substance abuse treatment center that is respected in the state of SD.	New
We need to move past the idea of what a family should look like and how a family should function to what is reality for most family situations. It seems like we always want families to fall into a norm that is just not realistic.	New
Our community needs a more comprehensive and thorough model for the access to emergency mental health care for adolescents. It would be ideal to move this out of the Emergency Department and have more thorough triage for mental health needs.	New
We need a Long-Term Mental Health Hospital for dual diagnosis that can accommodate patients that need more in-depth care than Regional West or Care center can provide. We need to address the growing difficulty with suicide in our community and provide assistance that will give us options for community members who have family that have mental illness. Rather than sending them 350 miles from here. In this facility all psychiatrists, physicians, psychologists, social workers and counselors should work together as well as set up this facility to meet the needs of both mental ill and substance abuse needed care. Students from both medical, psychological, social work and counseling services should be involved in provided more of an integrated care system. There should be a step-down system in place for helping patients get back on their feet. There needs to be education for others to help them get a job, get back into the community, volunteer or feel as if they make a difference. Both case management and also a halfway house for mental ill and substance abuse folks should be available.	New
Separate mental health-focused ER.	New
Longer term in-patient care for individuals with mental health needs to include addiction recovery.	New
Create a program that focuses on adolescent mental health such as a crisis care center for teens, one that goes into schools, and a place for them to go before they try suicide.	New
Having some type of a crisis counselor to help families that are struggling with mental illness or substance abuse.	New
Get to root causes of issues - we do a lot of Band-Aid services, but rarely do we address the underlying issue.	New
Certainly, local efforts are needed to develop and sustain a more comprehensive approach to treating mental health and substance abuse issues in our community but, State government (Pierre) needs to step up and recognize it is an indispensable party to this as well - Yankton can't be the only solution from the State's perspective!	New
The idea would work as a Mental Health Urgent Care Clinic. Patients could come in, be seen by a Nurse, then Counselor, the psychiatrist and go home. Serious cases would then be transported to Care Campus or RCRH	New

Idea for Change	Novelty of the Idea
There should be several mobile mental health units for those that are homeless in Rapid City to bring to the care center, on the reservations, in rural areas where problems with mental illness, suicide and substance abuse are problematic. This mobile unit should provide counseling, medication by a CNP and other educational services. This unit also should provide assistance to get in patients to the mental health clinics, hospitals and also longer-term hospitals and halfway houses.	New
Stop the isolation of services and all get on the same page. If you get your funding through the state then the state needs to set certain criteria	New
Mental health-focused ER. Many cities are beginning to implement this and it is also cost-effective.	New
We must support all the private treatment centers, after care facilities, create new half- way houses- sober living houses and the like. We must also support new methods of treatment which include moral re-conation therapy, MAT- medication assisted treatment and CBISA-cognitive behavioral intervention of substance abuse.	Exists, but should do MORE or GET BETTER at
Have less discrimination against AI/AN males that are 18 to 30, that could be felons, that need assistance with employment and homes.	Exists, but should do MORE or GET BETTER at
Find ways to fund more mental health groups for teens and positive places for them to go	Exists, but should do MORE or GET BETTER at
We must urgently develop a comprehensive plan that addresses recovery over incarceration.	Exists, but should do MORE or GET BETTER at
More interventions in the K-12 schools.	Exists, but should do MORE or GET BETTER at
increase services for children and parents of young children. Fully staff and fund DSS	Exists, but should do MORE or GET BETTER at
We need another Mainstream Behavior Management System (BMS).	Exists, but should do MORE or GET BETTER at
Our community needs more mental health services. It is difficult when it can take months for families in crisis to speak to professional, creating more problematic situations.	Exists, but should do MORE or GET BETTER at
I would change the lack of extensive follow up treatment available in the area. It takes weeks and sometimes months to get an appointment.	Exists, but should do MORE or GET BETTER at
Additional Mental Health recovery support services	Exists, but should do MORE or GET BETTER at
More of law enforcements help, more of hospital's help, more trainings and educations on dealing with mental health crisis, and better partnerships for referring clients for mental health needs.	Exists, but should do MORE or GET BETTER at
Establish significantly more opportunity for inpatient/out-patient mental health/substance abuse services in our local community - Rapid City area.	Exists, but should do MORE or GET BETTER at
Counselors in K-8	Exists, but should do MORE or GET BETTER at
Find a way to either subsidize or encourage more mental health services in community.	Exists, but should do MORE or GET BETTER at
I think that Adverse Childhood Experiences (ACEs) really need to be a factor going forward. Not only will it show us which children are currently at risk, but will also continue to show us those adults with ACEs and how to treat that population. As an adult with ACEs in my past, I know how it can show you why we are the way we are. From addiction to violence, this science is the future of mental health.	Exists, but should do MORE or GET BETTER at
Mental Health Awareness and better information on how individuals can get help from service providers.	Exists, but should do MORE or GET BETTER at
Closer work between the Rapid City Police Department (RCPD) and mental health professionals.	Exists, but should do MORE or GET BETTER at
More resources available for adolescents.	Exists, but should do MORE or GET BETTER at

Idea for Change	Novelty of the Idea
improved access to mental health services: affordable, available, reduce red tape etc.	Exists, but should do MORE or GET BETTER at
Market the availability of mental health care services better. Most people don't know what is available and where to get started	Exists, but should do MORE or GET BETTER at
Better comprehensive services to address not only psychological needs but better access to basic needs; affordable housing, basic medical needs, jobs.	Exists, but should do MORE or GET BETTER at
To help American Indian/Alaskan Native males (ages 18 to 30) to receive services for suicidal tendencies or provide a program that can help them get counseling.	Exists, but should do MORE or GET BETTER at
Provide mandatory mental health classes in middle school/high school to start awareness and promote compassion.	Exists, but should do MORE or GET BETTER at

PRIORITY AREA 2: HOUSING

Idea for Change	Novelty of the Idea
Get the federal government to change the definition of "homeless" for the point-in-time count so that Rapid City receives more funding to assist its citizens with stable and adequate housing.	New
I feel that there is inadequate housing for felons and when they can find something it is so out of their price range they can't afford it anyway.	New
Housing First services	New
Get rid of slumlords charging too much for rent	New
Address the concern at the judicial level	New
Too many homeless adults and children affect all of us. RC as a community needs to be more responsive to the most vulnerable individuals in our community.	New
Put a housing cap on the amount of rent private property owners can collect so it can be affordable for people with hardships, such as being single mothers, collecting low wages, etc.	New
Look into building small homes/villages that accommodate 1 or 2 people as has been done in other cities.	New
Help prevent slumlords from taking advantage of our disadvantaged.	Exists, but should do MORE or GET BETTER at
As a community we need to put our money where our mouth is. It costs all of us more in time and money to be a community that honors the needs of all of our citizens. Families need access to good healthcare, jobs, education and support to get there.	Exists, but should do MORE or GET BETTER at
Community needs to better informed	Exists, but should do MORE or GET BETTER at
More intense after care availability for those coming out of inpatient treatment.	Exists, but should do MORE or GET BETTER at
More affordable housing	Exists, but should do MORE or GET BETTER at
Working to make current services more productive and less like money pits. Making low-income housing transitional and not permanent. Have more low-income housing available for families.	Exists, but should do MORE or GET BETTER at

Idea for Change	Novelty of the Idea
Build affordable housing units (single room occupancy units) that rent for about $350- 400/month including utilities	Exists, but should do MORE or GET BETTER at
Get behind RC Collective Impact	Exists, but should do MORE or GET BETTER at
Subsidized work experiences for youth aged 16-23 will provide young people with more opportunity to get going in life.	Exists, but should do MORE or GET BETTER at
Tiny homes- allowing people to take ownership of their property	Exists, but should do MORE or GET BETTER at
Creating a safe transitional housing for felons in recovery	Exists, but should do MORE or GET BETTER at
Affordable safe low-income housing	Exists, but should do MORE or GET BETTER at
More income-based housing and programs/apartments that are willing to work with folks with backgrounds with offenses like sex offenses.	Exists, but should do MORE or GET BETTER at
I think there is a shortage of middle levels of rentals. It seems to be that if you don't quite qualify for housing assistance you end up paying a large amount if not the majority of your income towards rent.	Exists, but should do MORE or GET BETTER at
Rapid City needs long term transitional housing for those just out of treatment and/or Prison/Jail	Exists, but should do MORE or GET BETTER at
There is a need for safe affordable housing to include housing for homeless youth.	Exists, but should do MORE or GET BETTER at
A public private partnership that creates a continuum of care to make affordable, sustainable, life enhancing housing available for all members of our community regardless of what stage of change they are in. Many efforts in the community are focused solely on those who have already overcome their ambivalence about change.	Exists, but should do MORE or GET BETTER at
Develop a housing structure for single adults, that is affordable because when a path to stability is achievable for one person, you can directly impact an entire family.	Exists, but should do MORE or GET BETTER at
Lower rent. Section 8 wait list is too long	Exists, but should do MORE or GET BETTER at
There is no recovery or transition housing in Hot Springs & not much information available for Rapid City	Exists, but should do MORE or GET BETTER at
Lower Taxes and Housing Cost	Exists, but should STOP or DO LESS of

PRIORITY AREA 3: SUBSTANCE ABUSE/ALCOHOL OR OTHER DRUGS

Idea for Change	Novelty of the Idea
In-patient treatment.	New

Idea for Change	Novelty of the Idea
Most of the power and decision making is in the hands of the White people, but the programs they run disproportionately include and impact American Indians. There really needs to be a change in power structure	New
Community-wide awareness campaign bringing education to all neighborhoods, groups, individuals regarding what is addiction, how there are agencies working to prevent addiction and they are using evidence-based models and how they can become involved, and how to build knowledge themselves and increase compassion. Also reaching parents about how it is not "normal" for youth to use alcohol/other drugs - most youth do not use substances. We must not "normalize" unhealthy behavior, especially in this day and age where our young adults after using "just" alcohol and pot during their school years, "graduate" into meth, heroin and other opioids and we are losing them if not by death, then their potential. Young people who are addicted are ending up without jobs or have dead end jobs with no skills nor enough sobriety to obtain those skills. We must do a broad and researched plan to help our youth. Lifeways is working in the schools yet with 50% cut in their funding they can only do so much. We need to work together to address how our community can reach our youth before they become addicted - at first they are a child.	New
The city county treatment center is run by the Sheriff's office and there is no fire wall. They violate 42 CFR Part 2 (confidentiality of SUD records regulation) and go into the center and investigate patients without special court orders. They violate HIPAA they take photos of patients' positive urine and use it to prosecute. Law enforcement runs the treatment center.	New
Recognize that addiction is a disease.	New
Livable wage/ affordable housing. If one's basic needs are meet less stress, less need for escape and less substance abuse.	New
Besides increased drug treatment we are also in a mental health crisis. Not sure if it is related to drug use and the changing of the brain but we have a shortage. Juvenile Mental health is in serious need of a 24-hour crisis center similar to adults. After hours or weekends the hospital is the only resource which can be expensive for families and they will not go because of the price. Juveniles with social media and bullying are always facing mental health issues. I believe some of this has led to an increase use of marijuana and fights/assaults.	New
Housing for the chronically homeless and address their substance use/behavioral health issues while housing them instead of refusing shelter.	New
Treatment facility for meth and other substance abuse and addiction that will treat for the longer periods needed for success.	New
Sobriety coach for families that show a will to be sober. Many families have a multi- use issue and need daily support to experience 6 months to 18 months of sober living.	New
Our meth problem is endangering family work housing and the family. This is a complex addiction and very hard to deal with, a continuum of care step-up and step-down process over the course of a year. This involves both mental health and substance treatment we need more co-occurring treatment. We can't just deal with the symptoms, but we need to deal with the reasons behind (trauma, self-image, abuse) it we do this right we will by default help other issues.	New
Comprehensive Chemical Dependency Treatment for parents and teens the that has a general systems approach to treatment and includes family therapy.	New
Integrate BH / MH and Substance Use education and prevention into schools.	New
Additional quality treatment centers and treatment options.	Exists, but should do MORE or GET BETTER at
The one heart center, and care center concepts created to deal with complex issues. Getting out of poverty is hard but it creates hope with hope there is less depression, suicide, substance abuse. it takes form an efficiency standpoint groups working together and the agencies in RC are at a point they can work together.	Exists, but should do MORE or GET BETTER at
More outpatient/inpatient treatment help.	Exists, but should do MORE or GET BETTER at
More free resources for treatment	Exists, but should do MORE or GET BETTER at

Idea for Change	Novelty of the Idea
More prevention programming in the elementary schools, especially with alcohol and drug prevention	Exists, but should do MORE or GET BETTER at
Early adolescent prevention services funding	Exists, but should do MORE or GET BETTER at
The alcohol and drug problem in Rapid City as well as the surrounding communities has skyrocketed in the last 10 years especially when it comes to Meth. The State of South Dakota introduced senate bill 70 so drug abusers would not be criminalized or sent to prison for usage. I believe the idea was noble but they did not provide resources and treatment for these individuals as it would cost a significant amount of money. The same Meth users / dealers are getting out and need to support their habit which leads to the breakdown of family structures and increased crime. If we want to help people we need to have a large scale drug treatment program and if that doesn't work then the individuals may need to clean up by being in jail.	Exists, but should do MORE or GET BETTER at
Prevention education to youth	Exists, but should do MORE or GET BETTER at
Additional service providers for inpatient, outpatient, and recovery support services.	Exists, but should do MORE or GET BETTER at
Address shame; address not too young to drink. Not too young to be sober/ clean	Exists, but should do MORE or GET BETTER at
More funding for immediate treatment.	Exists, but should do MORE or GET BETTER at
Really address the characteristics of an adult child	Exists, but should do MORE or GET BETTER at
I believe that there could be increased cooperation between state, federal and local authorities to assist in finding mechanisms to help people who are interested in treatment.	Exists, but should do MORE or GET BETTER at
need 24/7 treatment facilities for both youth and adults. people should be able to have access to this at no cost and at all hours.	Exists, but should do MORE or GET BETTER at
Prevention education for alcohol and drug use in the middle and elementary schools. Teaching our youth skills to help them be more successful	Exists, but should do MORE or GET BETTER at
Better Medicaid reimbursement for providers	Exists, but should do MORE or GET BETTER at
Long term sobriety houses.	Exists, but should do MORE or GET BETTER at
Treatment services that are LONG TERM for alcohol/drug addicted individuals. Not 30-day. We need GREAT follow-up aftercare services.	Exists, but should do MORE or GET BETTER at
I believe the only overnight detox facility Rapid City had is now closed. I'm not sure why?	--
Expand Lifeways into elementary schools	--

PRIORITY AREA 4: POVERTY

Idea for Change	Novelty of the Idea
Training & opportunity enhancement for those under- or unemployed	New
Instituting a state income tax and taking some of that money to invest in a universal basic income program for qualifying persons.	New
A mentorships program that is long term for kids who come from/life with families that are constantly in crisis.	New
Job sharing. We have numerous part-time, low-income and SEASONAL jobs. If for-profit businesses would work together to ensure their employees get 40 hours of work in a week and in every season of the year, that would be fantastic.	New
Helping people with a $1000 a month fund to add on to their cost of living for 2 years. No attachments necessary. Pilot 100 families in Rapid City who have proofed they can't beat getting out of poverty. DSS should have information on clients. Examples to look for: stable (drug free, working), and can't get out of poverty.	New
Placing rent caps for rental properties.	New
Guaranteed income for people who are not able to work whether due to record, addiction, mental health, lack of vocational training or other condition. Choice is a concept that is a privilege to enjoy in life, and one not afforded to the impoverished in Rapid City.	New
One Heart - funded	Exists, but should do MORE or GET BETTER at
Renting should not be as high as it is here! We don't live on a beach in Florida! There should be a policy in place that protects renters of owners increasing rent on people.	Exists, but should do MORE or GET BETTER at
Constant wrap around services and mentoring for people in the crisis of poverty.	Exists, but should do MORE or GET BETTER at
I think the city should be more active in fighting poverty, whether through providing greater funding for nonprofit organizations or creating their own programming.	Exists, but should do MORE or GET BETTER at
Improve access to high-quality early childhood centers (the quality of early childhood care is largely well below that of other places or costs are too high for those in poverty to attend)	Exists, but should do MORE or GET BETTER at
Community education of issues so anyone understands issues and can provide support or help.	Exists, but should do MORE or GET BETTER at
We need to do more to break down barriers that keep people in poverty. Reliable transportation and childcare expenses, for example, often keep low-income workers from the education or job training necessary to get into better jobs.	Exists, but should do MORE or GET BETTER at
Create more jobs that provide a living wage	Exists, but should do MORE or GET BETTER at
There are so many changes that need to be made. One big change is all organization to work together instead of against each other.	Exists, but should do MORE or GET BETTER at

Idea for Change	Novelty of the Idea
Improve access to transportation that is affordable for even those with the lowest of incomes, easy to navigate, and safe.	Exists, but should do MORE or GET BETTER at
Expanding current resources to provide support to professionals providing assistance/case management services to those in poverty in a way that relieves caseload burden, so professionals can be more competent and present with current clients.	Exists, but should do MORE or GET BETTER at
Raise the minimum wage	Exists, but should do MORE or GET BETTER at
When living in poverty, it would be beneficial to raise the level of their capabilities to solve their situation and issues in order to continue their efforts to make behavioral change that will be sustainable.	Exists, but should do MORE or GET BETTER at
"Band-Aids" are necessary but until long term sustainable solutions are put into place to address affordable housing, wages, availability of long-term treatment options, and care for mental illness, most programs are just dealing with the symptoms without treating the cause	Exists, but should do MORE or GET BETTER at
Stop putting limitations on the poor, such as credit scores being a factor in housing. Allowing more affordable services to people in poverty.	Exists, but should do MORE or GET BETTER at

PRIORITY AREA 5: EDUCATION

Idea for Change	Novelty of the Idea
Early child education that includes nutritional support/education to the family. This should include cooking classes to teach low-income people how to buy, cook and enjoy unprocessed, whole foods.	New
Expanding school bus service to high school level.	New
Have a community website where people with produce, such as that from apple trees or extra garden bounty, can list their offerings. The golf courses have fruit trees that simply drop their fruit annually without being used by anyone except deer and squirrels. As a community, we have the ability to grow apples, pears, plums, nectarines, raspberries, tomatoes and zucchini like crazy. These unused resources would augment a healthy food supply for developing brains! An added benefit of growing and using food locally would be in reducing the carbon footprint of imported foods.	New
Put more focus on early education in South Dakota. In previous volunteer experience in the school district, I noticed the math skills and reading skills were lacking.	New
Increase presence of childhood education/mentoring services, such as Big Brothers Big Sisters.	Exists, but should do MORE or GET BETTER at
Mentoring and career counseling programs for youth and adults	Exists, but should do MORE or GET BETTER at
A community garden network work be a huge asset and great tool for accomplishing idea for change	Exists, but should do MORE or GET BETTER at
I think our school system needs to put more emphasis on financial literacy.	Exists, but should do MORE or GET BETTER at

Idea for Change	Novelty of the Idea
Cultural understanding and healing. We must address the tragic past and have real, inclusive conversations to help us progress as a community.	Exists, but should do MORE or GET BETTER at
Getting our school system the necessary funding to not only provide services for students in early childhood programs, but also helping to intervene for students at all grade levels is essential in order to make change happen.	Exists, but should do MORE or GET BETTER at
Well-functioning, stable families are also essential to the development of educated societies that have grit, can problem-solve, have resources to take care of themselves, and recognize that all life has equal value.	Exists, but should do MORE or GET BETTER at
Provide more pay/benefits/resources to K-12 teachers.	Exists, but should do MORE or GET BETTER at
Expansion of community transportation	Exists, but should do MORE or GET BETTER at
Ensuring all students have access to early childhood education in order to prepare them for the educational, social and emotional needs of the school system is the best form of prevention to address so many of the needs from the previous question.	Exists, but should do MORE or GET BETTER at
Comprehensive sexual education courses need to be taught in schools.	Exists, but should do MORE or GET BETTER at
Paid Parental leave, improved daycare, and early childhood education	Exists, but should do MORE or GET BETTER at
Ensuring that all children have access to stable, respectful, well-informed educational opportunities during the critical developmental years of birth - 3 and 11 - 14 (middle-school years).	Exists, but should do MORE or GET BETTER at
Improve our education system by investing funding.	Exists, but should do MORE or GET BETTER at
Career paths other than 4-year college degree	Exists, but should do MORE or GET BETTER at

IMPLEMENTATION OBSTACLES

Respondents ranked several obstacles to implementing ideas for a change (listed above) in order of importance from 1 to 7, where 1 is the greatest obstacle and 7 is the most minor obstacle to implementing the idea. Money/Funding was reported as the greatest obstacle by nearly half of respondents (47%).

Potential Obstacle	1 Greatest obstacle	2	3	4	5	6	7 Most minor obstacle
Money/Funding	47.3%	24.3%	7.7%	10.1%	5.3%	4.1%	1.2%
Attitudes/Norms	28.8%	21.8%	24.1%	13.5%	7.6%	4.1%	0.0%
Labor/Staffing	4.2%	15.7%	24.1%	18.1%	21.7%	15.7%	0.6%
Communication/Coordination	6.0%	16.3%	26.5%	30.7%	14.5%	4.8%	1.2%
Community leaders are not engaging in recovery-oriented activities in the areas of prevention, intervention, treatment, and post-treatment.	9.6%	19.2%	13.5%	16.0%	24.4%	12.8%	4.5%
Existing Policy	8.5%	6.2%	7.8%	16.3%	7.8%	48.1%	5.4%
Other*	2.8%	5.6%	4.2%	1.4%	4.2%	4.2%	77.5%

**Other* response options included: institutionalized racism; competition between agencies; lack of cooperation between service providers; lack of cultural sensitivity to Native American population to enhance their recovery process; lack of understanding about alcoholism, addiction, historical trauma, trauma and oppression; and resistance to change.

ADDITIONAL COMMENTS

When asked about any other comments, survey respondents mentioned the following:

- We must fix the mental health system and build a physical plant dedicated to the care and treatment of the mentally ill. Tragically, the current system is broken.
- I don't think our little corner of the planet is recognizing the role that a heathy food supply plays in a child's early brain development.
- I hope that we can build a better community to support difficulties with mental illness. I am for a longer-term hospital facility with step down halfway houses for both mental illness and substance abuse. We need to get better at using our own resources such as students in various programs (medical, social work, psychology and counseling) to provide services. We need to adequately pay supervisors to help the students learn and assist our community members. We need to get the government involved and help to provide a better support for mental ill people. We need to demand that we have more financial support to build this community. We need not give up and keep moving forward.
- Mental health needs to be marketed better in this area. The services are available, but people don't know about them or where to get started.
- The relative lack of mental health services in the Rapid City area is the second high-need priority and is directly related to the first priority: Poverty.
- The Rapid City and greater Black Hills community focuses heavily on folks who are homeless and we have a total lack of services if you are not drunk, high or homeless or a vet - we need services for folks who want to clean up and understand using alcohol or drugs is but a symptom of a much larger issue most often one of exceptional trauma - oppression and historical trauma when we treat we are treating the poor solution folks created to deal with their greater challenge - we are not treating the underlying issues.

- There are 31 mental health providers of some kind, yet the lack of services is cited by court and legal personnel involved in the local justice system as the problem. That's not the problem. Rapid City Collective Impact initially issued a report that really called out the biases and assumptions of the governmental actors involved, and thus, they had a cop's wife takeover, kick out or alienate the undesirable Native community leaders, and then erase all the initial work completed by the professionals who came from Minnesota. Rapid City and Pennington County are not only a subject of study for the taking of the Black Hills from the Great Sioux Nation, aka the Oceti Sakowin or Lakota and Dakota people, but also for their contemporary racism and the mass incarceration and mass impoverishment of Lakota people here today. This needs to be dealt with. It is appalling. The RCPD has beaten, killed and raped many Lakota people and they will continue to act in this manner until the powerful people of Rapid City stop them.
- Poverty has a direct and reciprocal relationship to many of the other categories, i.e. housing, employment, access to food, behavioral health. All need to be addressed in order to support the whole of the individual. It is difficult to determine which to focus on first but focusing on any of these areas will create a system wide change and improve well-being as a whole.
- There are a number of wonderful organizations in Rapid City. The Mayor has been a leader in change, the Vucurevich foundation brings everyone to the table and there is a lot of synergy. There is a lot of good things happening and this effort should complement a community on the move.
- This has been going on forever and nothing with change without more services, more diverse services, a more diverse workforce. Without that, none of the issues discussed will improve. They will only get worse. Plain and simple. You can put up a building, but without money for services and well-trained people to serve people and need, people will keep dying by suicide. Learn from other communities across the country.
- We have very good services in Rapid City, they are just not far reaching enough.
- We shouldn't have to ship our family members out to different communities to get their needs met. Katy Urban's story of her options to get help for her daughter is the perfect example of how shipping people out disrupts families and takes away a person's network of support.

APPENDIX C: LIST OF KEY INFORMANTS

	First Name	Last Name	Organization	Title	Visit(s)
1	Al	Scovel	Scovel Law Office	Lawyer	February, May
2	Alan	Solano	Behavior Management Systems	CEO	February, May, August
3	Amanda	Lacroix	Bennett County Mental Illness Chair	Chair	May
4	Amy	Iversen-Pollreisz	Human Services Center	Deputy Secretary of Social Services	May
5	Anne	Kidd	Pine Ridge HIS Behavioral Health	Supervisory Social Worker	May
6	Annie	Lloyd	Recovery Coalition		May
7	Annie	Bachand	RCOSD		May
8	Anpetu	Luta Otipi	Pine Ridge HIS Behavioral Health	Director	May
9	Arlana	Bettelyoun	Oglala Lakota Children's Justice Center	Executive Director	May
10	Audra	Hill	Pennington County Qualified Mental Health Professional		February
11	Barbara	Mechtenberg-Ruffinott	Human Services Center	Director of Social Services	May
12	Barry	Tice	Pennington County Health and Human Services		February, May, August
13	Bette	Goings	Oglala Sioux Tribal Court		May
14	Bob	Evans	Fall River County		May
15	Brad	Hansen	Fall River County		May
16	Brian	Mueller	Pennington County Sheriff's Office		May
17	Charity	Doyle	OneHeart	Executive Director	May
18	Cherie	Clifford	Indian Health Service		May
19	Christina	Janis	Kyle Behavioral Health		May
20	Clay	Pavlis	Department of Corrections	Psychiatrist	May
21	Craig	Pfeifle		Specialty Court Judge	May
22	Dan	Mertz	Rapid City Police Department Quality of Life Unit	Officer	February
23	Dana	Livermont	Rapid City Area Schools	Lead Counselor	May
24	Evalina	Murphy	Sioux San Behavioral Health		February

25	Fred	Lamphere	Butte County Sheriff's Office		May
26	Greg	Bartron	Alliance		February, May
27	Greg	Barnier	Mental Health Board Chairman		May
28	Greg	DeSautel	Governor's Office	Social Services Secretary	May
29	Heidi	Edison	Rapid City Regional Hospital Emergency Department	Needs Assessment Coordinator	February
30	Jackie	Big Crow	Pine Ridge Hospital		May
31	Jamie	Toennis	United Way		August
32	Jamie	Kirsch	Black Hills Area Community Foundation		August
33	Jay	Alderman	State's Attorney Office	Chief Deputy	February, May
34	Jeff	Connolly		Specialty Court Judge	May
35	Jeff	McGraw	Custer County	Lieutenant	May
36	Jennifer	Murray	Rapid City Regional Hospital Emergency Department	ED Director	February
37	Jeremy	Johnson	Human Services Center	Clinical Director	May
38	Jessica	Gromer	John T. Vucurevich Foundation	Program Officer	May
39	Jessica	Olson	John T. Vucurevich Foundation	Program Associate	May
40	Jim	Castleberry	Pennington County		February, August
41	Jim	Hansen	Rapid City Police Department Quality of Life Unit	Officer	February
42	Jodi	Bourne	Indian Health Service		May
43	John	Pierce	Rapid City Regional Hospital	President	February
44	John	Ligtenberg	Love INC	Executive Director	May
45	John	Pierce	Rapid City Regional Hospital	President	May, August
46	Josephine	Chase	Sioux San Behavioral Health		February
47	Kari	Scovel	Scovel Psychological		February, May
48	Karl	Jegeris	Rapid City Police Department	Chief	February, May
49	Katy	Sullivan	Regional Health Behavioral Health Center	Director	February

50	Kelly	Serr	Perkins County Sheriff		May
51	Ken	Cole	Human Services Center	CEO	May
52	Kevin	Thom	Pennington County Sheriff's Office	Sheriff	February, May
53	Kip	Littau	Rapid City Regional Hospital Emergency Department	Nurse Manager	February
54	Larry	Swallow	Oglala Lakota Children's Justice Center	Investigator/Case Manager	May
55	Linda	Reidt Kilber	Behavior Management Systems	CEO	May
56	Lysa	Allison	Cornerstone Rescue Mission	Executive Director	February
57	Marla Jean	Big Boy	Oglala Lakota Children's Justice Center		May
58	Marty	Mechaley	Custer County	Sheriff	May
59	Matt	Brown		Specialty Court Judge	May
60	Matt	Haugen	Jackson County Sheriff's Office		May
61	Matthew	Stanley	Avera Behavioral Health Center	VP of Behavioral Health	May
62	Melissa	Klemann	Governor's Office	Policy Advisor	May
63	Melody	Eide	Rapid City Regional Hospital Emergency Department	ER Physician	February
64	Michael	Williams	Sioux San Behavioral Health		May
65	Mike	Diedrich	Rapid City Regional Hospital	VP of Governmental Affairs	August
66	Paula	Williams	Bennett County Sheriff		May
67	Paula	Wilkinson Smith	Lifeways	Executive Director	February, May
68	Paulette	Davidson	Regional Health	President and CEO	February, August
69	Randy	Allen	Crisis Care Center	Director Mental Health Services Administration	February
70	Robin	Gillespie	Rapid City Area Schools	Director Federal Programs	May
71	Ron	Merwin	Meade County Sheriff's Office	Sheriff	May
72	Sarah	Zimmerman	Rapid City Area Schools		May
73	Sarah	Pierce	Rapid City Area Schools	Indian Education Manager	May
74	Staci	Ackerman	SD Sheriffs Association		May

75	Stephanie	Schweitzer Dixon	Front Porch Coalition	Executive Director	February, May
76	Stephen	Kidd	Pine Ridge HIS Behavioral Health		May
77	Steve	Linquist	Avera Behavioral Health Center	Special Projects Manager	May
78	Steve	Manlove	Manlove Psychiatric Group	Psychiatrist	February, May
79	Teri	Corrigan	Behavior Management Systems	Director	February, May
80	Terra	Garnier	Oglala Sioux Tribal Court		May
81	Tim	Trithart	Community Health Center	CEO	February
82	Tina	Wildberger	Scovel Law Office	Paralegal	February
83	Willie	Whelchel	Pennington County Sheriff's Office		May