Remote Access: Using Video Technology to Treat Substance Users on Probation and Parole in South Dakota

October 2016
Brief

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From the Center Director

When states pass comprehensive criminal justice reform legislation as part of the Justice Reinvestment Initiative, politicians often herald the new law as a way to address prison overcrowding and stabilize the increasing costs of corrections. What sometimes gets overlooked are the ways that comprehensive reform at the top can trickle down to spur innovation on the ground. The pilot program featured in this brief is one such example.

Charged with expanding access to treatment services for people on parole and probation, South Dakota's Department of Social Services (DSS), working collaboratively with key stakeholders, decided to introduce a transformative practice: the use of videoconferencing to completely replace in-person group substance use counseling programs. Of course, in-person counseling remains available to people who can easily access such programs. But now, people who live in rural areas, where programs are often not available, and people who experience other types of barriers, such as lack of transportation or personal inhibitions towards in-person counseling, can participate in treatment remotely.

Increasing accessibility, not saving money, is what motivates the DSS and their contracted service providers. Through their efforts, more people are accessing and completing treatment and, ultimately, living healthier lives. By highlighting this innovation, we hope policymakers at the top appreciate both the big and small affects that comprehensive reform can have on a system.We also hope that administrators on the ground are inspired to explore this and other novel solutions.

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The Justice Reinvestment Initiative

In 2010, the U.S. Department of Justice's Bureau of Justice Assistance (BJA) launched the **Justice Reinvestment Initiative** (JRI), in partnership with the Pew Charitable Trusts. JRI is a data-driven approach to improve public safety, examine corrections and related criminal justice spending, manage criminal justice populations in a more cost-effective manner, and reinvest savings in strategies that can hold system-involved people accountable, decrease crime, and strengthen neighborhoods. At least 30 states have engaged in this process. From 2011 to 2016, BJA funded the Vera Institute of Justice (Vera) to provide technical assistance to eight of these states, helping them collect and analyze data on the drivers of criminal justice populations and costs, identify and implement policy and programmatic changes, and measure the fiscal and public safety impacts of those changes.[1]

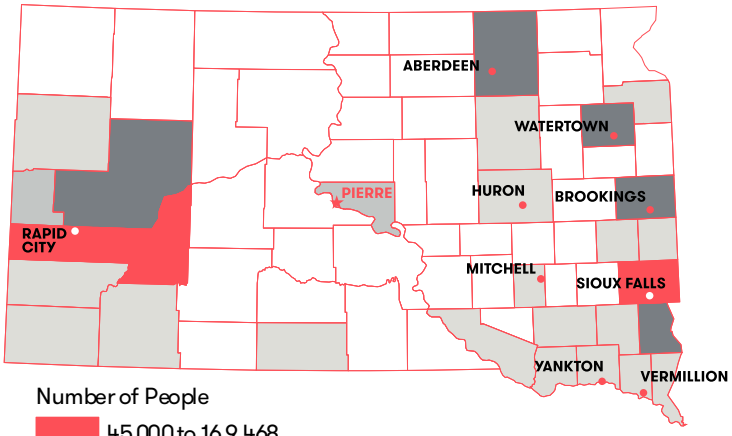
One JRI milestone is for states to pass comprehensive criminal justice reform legislation to usher in new policies, practices, and programs. This brief focuses on a promising program in South Dakota that addresses a problem common to many jurisdictions: providing appropriate and accessible treatment services to people on probation and parole, especially in rural areas. After describing the problem and identifying South Dakota's solution, this brief describes the implementation process and ends with lessons learned that could benefit other jurisdictions seeking to launch a similar program. This brief is the first in a series of three that focuses on JRI activities in states where Vera has worked.

The problem

In 2012, under the direction of Governor Dennis Daugaard, South Dakota embarked on a comprehensive effort to improve public safety and reduce the state prison population and its costs under the Justice Reinvestment Initiative. The task force responsible for studying the state's criminal justice system—the Criminal Justice Initiative (CJI) Work Group—identified a need to improve access and remove barriers to community-based services for probationers and parolees, especially those residing in the state's vast rural areas.[2] The challenges of accessing services, especially treatment for alcohol and other drug use, may have contributed to the high percentage of people convicted of low-level nonviolent offenses incarcerated in state prisons.

According to the analysis conducted for the CJI Work Group, people convicted of nonviolent offenses made up 61 percent of the state prison population in 2012. Of the 1,186 individuals admitted to prison in fiscal year 2012 for a new conviction, 22 percent were convicted of driving under the influence and 31 percent for a drug offense.[3] The analysis showed that drug possession is the most common reason for incarceration in state prison in South Dakota.[4] With substance use a known risk factor for reoffending, justice system–involved individuals with substance use disorders are more likely to be arrested or to violate the terms of their supervision in the community if they have limited or no access to treatment services.[5] Judges in South Dakota recognized that many people with treatment needs would not have access to services close to their home, and therefore sentenced them to prison instead of probation to ensure that they received adequate care.[6]

South Dakota population by county



South Dakota's behavioral health partners were well aware of this issue. The South Dakota Department of Social Services (DSS) is a direct care provider of behavioral health treatment services for the state's correctional institutions. The department contracts with community-based agencies to provide publicly funded behavioral health treatment services for people on probation and parole. DSS and its network of accredited treatment providers understand that people in rural areas who need substance use treatment may face one or more challenges:

- They have trouble accessing treatment services because none exist in most of their communities.
- Many lack reliable transportation to the nearest treatment program, which for some could mean a two- to four-hour return trip.
- Child- or elder-care responsibilities often prevent them from leaving home for long periods.

The solution

Under the Justice Reinvestment Initiative, Governor Daugaard signed South Dakota's Public Safety Improvement Act (PSIA) in February 2013. The new law restructured the state sentencing framework to prioritize prison space for people who commit crimes or repeatedly engage in criminal activities and expanded the use of evidence-based programs, practices, and policies shown to improve rehabilitation and reduce recidivism. The reforms included improvements to the state's community supervision infrastructure, including the expansion of drug and DUI courts.

Critically, the PSIA prompted a significant investment in behavioral health services for people on parole and probation. Although the PSIA did not explicitly require the expansion of substance use treatment services in rural locations, the Public Safety Improvement Act Oversight Council—the body responsible for monitoring the law's implementation—appropriated funding to DSS for the purpose of providing such services for as many as 100 individuals on probation or parole who reside in rural areas, with certain judicial circuits prioritized.

Planning the pilot

To implement the CJI Work Group's recommendation to "expand capacity for access to community-based interventions aimed at recidivism reduction," DSS set out to design a pilot program that would deliver treatment services to rural locations. During the planning phase, DSS considered the following objectives, which ultimately contributed to the program's overall success.

- ***Focus on available services.*** Prior to enactment of the PSIA, DSS had introduced an evidence-based curriculum for substance use services—the University of Cincinnati's Cognitive Behavioral Interventions for Substance Abuse (CBI-SA)—and was using it in the state's correctional facilities.[7] The PSIA mandated the expansion of these evidence-based services and, in the first year of the law's implementation, 13 treatment providers in each judicial circuit were trained and available to deliver CBI-SA to eligible probationers and parolees.[8] After receiving assurances from the developers of CBI-SA that providers could deliver the curriculum with fidelity through group videoconferencing sessions rather than in person, DSS decided that the rural pilot would use CBI-SA and not create a new curriculum or identify a different one.
- ***Consider a service-delivery solution with a proven track record.*** For the past several decades, the medical field has used new technological tools in the delivery of health and medical services, sometimes called "telehealth" technology. This includes the use of real-time video, mobile health applications, and the electronic transmission and exchange of records, data, and assessments.[9] Research suggests that trained clinicians using technology-based therapeutic tools can deliver the same results as traditional therapeutic approaches—or sometimes better results.[10] Some of these approaches were already familiar to DSS because the department had been successfully using videoconferencing technology to provide psychiatric services to people housed in state correctional institutions. Given the department's history of using telehealth services and the evidence of the technology's success, DSS leaders were ultimately comfortable adopting a telehealth solution for the pilot.
- ***Get service providers involved early.*** DSS issued a request for proposals (RFP) for a rural pilot project and asked service providers to consider the problem of accessibility and propose solutions, which the department suggested might involve addressing transportation needs or using videoconferencing or other measures. After receiving no responses to its initial RFP, DSS invited a technical-assistance provider to conduct a training session on telehealth technologies for all interested treatment providers. (The importance of educating and training service providers is discussed below.) DSS issued a second RFP after the training and selected Lutheran Social Services and Volunteers of America—both of which have staff trained in CBI-SA—to deliver the curriculum for the rural pilot project.

Implementation

DSS convened a Rural Pilot Implementation Team (RPIT), whose members included representatives from DSS and the two selected treatment providers. The agencies that would refer clients to the pilot program's services, including Court Services (probation) and Parole Services, collaborated with DSS and the selected treatment providers at the local level. The RPIT benefited from technical assistance from the National Frontier and Rural Addiction Technology Transfer Center and the Upper Midwest Telehealth Resource, which both provided valuable information regarding telehealth practices.

As the RPIT began its work, the team made the key decision to use videoconferencing to replace in-person counseling completely. This decision was contrary to some research, which recommends that telehealth technologies be used as a "clinical extender"—a supplement to in-person human services and support. But the RPIT members understood that using technology to "extend" in-person services would not solve their original problem: the absence of these services for people living in rural areas.[11]

The implementation process for the RPIT members included educating themselves about selecting a specific technology solution; adopting policies on relevant topics such as privacy and security; and getting buy-in from the key stakeholders, including the agencies that would refer clients to the program.

- ***Technology.*** One key decision was selecting a videoconferencing platform. To enhance efficiency and streamline implementation, the two service providers chose the same platform. Both providers involved their IT staff and methodically reviewed and narrowed the options, keeping in mind the need to select a platform that would allow the faithful delivery of the CBI-SA curriculum. Two key components of the CBI-SA are role-playing and skill-building. Not only would each individual need to be able to interact with other participants, but the counselor would need to share resources and emphasize certain points during a session. Therefore, the videoconferencing platform had to allow all participants to see one another on the screen at the same time, enable facilitators to send files during a session, and include a whiteboard function, which acts as an electronic blackboard and allows counselors to write on and share their screen with participants. The implementation team also had to make sure that the solution was accessible from as many devices and in as many places as possible (such as from mobile or handheld devices and desktops, and using Wi-Fi or other networking technologies). Ultimately, South Dakota selected Zoom as its videoconferencing platform.[12]

- ***Privacy, security, and related policies.*** Although DSS had already issued guidelines about how the contracted service providers would implement CBI-SA, the RPIT reviewed and adjusted them to give the two service providers the flexibility to customize the guidelines for the delivery of services through videoconferencing. DSS also needed to ensure that the new technology would be administered in a manner compliant with the Health Insurance Portability and Accountability Act (HIPAA). (See page 5 for a discussion about the training and technical assistance DSS delivered to service providers.)

- ***Buy-in.*** The key stakeholders in South Dakota included DSS, the two service providers, and the referral sources. Although these stakeholders participated on the RPIT or collaborated on a local level, introducing new technology and asking staff to deliver services in a nontraditional manner can be challenging due to the significant cultural change required. While the collaborative and inclusive nature of the implementation team was critical, accessible training, targeted technical assistance, and ongoing collaboration were needed to ensure the program's success. (Several of these strategies are discussed in more detail below.)

How the pilot works

Jane lives in Dewey County, which has a population of approximately 5,500 and is 131 miles away from a town that offers state-funded social services, including substance use treatment. Twelve weeks ago, Jane pleaded guilty to drug possession and was convicted and sentenced to probation. She was assessed as having a high risk for substance use and the court ordered her to participate in treatment.

On Wednesdays at 2 p.m., while her youngest child naps, Jane opens her laptop computer and connects to Zoom.com. She enters the meeting code, which her treatment counselor provided to her by e-mail, activates her computer's camera, and subsequently joins the transmission of her substance use group counseling session. On her screen she sees her counselor and each of the other participants pictured in a series of square images. She greets the facilitator/counselor, who is seated in Sioux Falls, and the six other members of the group, who live in other parts of South Dakota. The facilitator begins the session and the group continues the four-month cognitive behavioral therapy curriculum they started a few weeks ago.

If Jane had been arrested and convicted in 2012 and did not have transportation to the nearest substance use group, she might be sitting in prison rather than in her own home. With no treatment centers within two hours of her home, the judge may have sentenced her to prison simply so that she could receive treatment. Or, if she had been placed on probation and ordered to participate in treatment, it is likely that Jane would have violated the order, as it would have been all but impossible to maintain steady employment or care for her young children while traveling the long distance to comply with the court order. The chances were high that Jane would have returned to a life of substance use and cycled back into the criminal justice system. Instead, Jane and the other group participants are learning day by day, to change their behaviors and live healthier, crime-free lives.*

* This is a hypothetical situation meant to represent a typical meeting for a person who has violated his or her parole.

Implementation lessons

The path to successful implementation of South Dakota's rural pilot program involved many operational challenges—and people seeking to implement a technology-based tool for delivery of substance use treatment services will face many of the same barriers. A recent study identified 11 main types of barriers experienced when implementing a technology-based approach to behavioral health care, including funding, privacy, skill building, client access, and provider buy-in.[13] How South Dakota overcame some of these barriers may serve as a guide for interested jurisdictions facing the challenge of delivering treatment services across vast distances and hoping to start a similar program.

"Don't reinvent the wheel if you don't have to."

In planning the pilot, DSS considered whether serving people in rural locations demanded an entirely new curriculum. At the time, DSS had just introduced an evidence-based curriculum that emphasizes cognitive behavioral therapy and was embarking on an ambitious training program that would result in preparing all CJI-contracted service providers to deliver that curriculum. Delivery guidelines were already written, eligibility criteria for clients were in place, and outcome measures had been identified. After consulting with the developers of the curriculum, DSS leaders decided that they could adopt it with fidelity for remote service delivery. Creating a delivery system for an existing program—rather than devising an entirely new curriculum—eliminated a significant challenge for South Dakota.

"Provide training and technical assistance on the proposed technology."

Research consistently identifies two key barriers to implementing new technologies:

- lack of knowledge about, or skills in using, technology-based tools; and
- user buy-in.[14]

In South Dakota, these barriers first became apparent when DSS's initial RFP was met with no response. That experience taught DSS that treatment providers needed training on how to use technology to deliver behavioral health services. Therefore, prior to issuing the second RFP, DSS invited service providers to attend an informational session conducted by National Frontier and Rural Addiction Technology Transfer Center, which provided an overview of telehealth technologies and covered telehealth trends; treatment outcomes; privacy, security, and ethics concerns; and how to use technology to build a therapeutic alliance between the patient and counselor.[15] The session prepared the service providers to respond to the RFP in an informed and confident manner.

After DSS selected Lutheran Social Services and Volunteers of America, DSS provided more education to the service providers—not only to ensure that counselors would be skilled at using the technology, but also as a strategy to ease the cultural change that each provider organization was undergoing in adopting the new technology. DSS contracted with Upper Midwest Telehealth Resource Center to provide a daylong training session that covered everything from the very basics (such as how to turn on a computer and set up a meeting) to policies and procedures that ensure HIPAA compliance and strategies to run a group counseling session effectively.

The training gave counselors an opportunity to practice the necessary hands-on technical skills to use the conferencing tool, such as using a shared screen and the whiteboard function. It also provided a critical forum to ask questions, discuss how videoconferencing differs from in-person sessions, and brainstorm solutions to anticipated challenges. The training was an important event and instilled confidence in the counselors that they could handle and master the new program; it also contributed to the ongoing goal of achieving buy-in from the service providers.

"Facilitate ongoing conversations and collaboration."

South Dakota implemented this technology-based solution on a statewide level and benefited from having a single agency—DSS—responsible for providing behavioral health treatment services to eligible justice system–involved people through contracted service providers. As such, DSS was empowered to propose a solution, provide funding, organize training, and offer a full support structure. For those implementing on a local or county level, a single agency may not have similar authority, but a countywide working group could play a similar role. Taking intentional steps to promote buy-in among key stakeholders is critical. In South Dakota, DSS provided the leadership needed to foster collaboration.

Telehealth technical-assistance providers

A growing number of government-funded resources are available to jurisdictions planning to implement a telehealth solution for the delivery of mental health and substance use services. South Dakota accessed the resources available from the National Frontier and Rural Addiction Technology Transfer Center (NFR ATTC) and the Upper Midwest Telehealth Resource Center (UMTRC).

Established and funded by the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services (HHS), NFR ATTC is part of the national Addiction Technology Transfer Center Network, a multidisciplinary resource center that provides training, holds conferences, and develops resources to promote and advance the use of telehealth technologies for the delivery of addiction and recovery services.[a] NFR ATTC has specific expertise in delivering such services in frontier and rural areas.

UMTRC is a regional center affiliated with a national consortium of Telehealth Resource Centers (TRCs), each of which provides technical assistance and education on telehealth technologies.[b] TRCs are funded by the HHS's Health Resources and Services Administration. As federally funded programs, the ATTC Network and TRCs typically provide their services free of charge.

[a] Learn more about the National Frontier and Rural Addiction Technology Transfer Center (NFR ATTC) at http://www.attcnetwork.org/national-focusareas/?rc=frontierrural.

[b] Learn more about the Upper Midwest Telehealth Resource Center (UMTRC) at www.umtrc.org.

For instance:

- DSS convened the RPIT, which enhanced buy-in by getting all stakeholders to work together in making critical implementation decisions.
- Once the pilot launched, DSS had monthly meetings or phone calls with the core stakeholders to provide a forum to raise any unexpected challenges and brainstorm potential solutions. Agencies that refer clients participate in the monthly calls as needed. All stakeholders described these meetings as critical to the pilot program's success and many said the forum helped ensure that providers delivered services in a cohesive, integrated way. The meetings also increased familiarity and buy-in among supervising officers from Court Services and Parole Services, who not only make referrals to the program, but also make sure that clients have access to and are comfortable with the necessary technology. These monthly meetings continue today.
- DSS used the videoconferencing platform to hold the monthly meetings. By using the system, stakeholders became more familiar with how the services would be provided. Experiencing what the counselors and their clients experience helped all stakeholders respond more effectively to implementation challenges.

"The goal of increasing accessibility should guide all service-delivery decisions."

DSS's main goal for the pilot was to make treatment services accessible to anyone who needs them. When faced with service-delivery challenges, DSS and the RPIT returned to this central goal to help guide their decisions. For example, when supervising officers recognized that many clients did not own suitable technology—such as a laptop—and that many public locations such as a local library or law enforcement agency did not provide sufficient privacy, the RPIT decided to create technology "hubs" in a few areas, allowing one or more clients to come to a central location and access the technology and services with a modicum of privacy.

Although clients had to travel to the hub, the hubs enhanced accessibility in other ways. The hub setup allowed the supervising officer to help clients with any initial questions or unfamiliarity with the videoconferencing technology, ultimately fostering their comfort using it and possibly leading to more consistent attendance. The facilitators also found the hubs useful at the start, because it was easier to have three or four clients together in one place as the counselors became accustomed to the technology and delivering the curriculum in a remote format.

Although the hubs helped to legitimize the program, DSS is phasing them out as the pilot program transitions to a permanent one. The original purpose was to bring the services to the client. It is clear to DSS that if clients must continue to go to one central hub, this would inadvertently reinforce the original barrier the program was created to overcome. Moving forward, if a client does not have the equipment needed to access the telehealth services, the stakeholders will work together to figure out a solution—through providers loaning them the technology or accessing other resources in the community.

Initial successes

South Dakota's rural substance use pilot served 51 clients from January 26, 2015—when the first CBI-SA telehealth session was conducted—through May 31, 2016. The overall completion rate for pilot participants was 78 percent.[16] Of the 31 clients who were discharged from June 1, 2015 through May 31, 2016, 27 completed treatment successfully (87 percent), and only two were discharged because they had been incarcerated (6 percent).[17] All clients who completed the program successfully during this period reported that they were satisfied with their substance use treatment. Given these results, as of June 1, 2016, DSS officially transitioned the pilot into a permanent service and extended it in two significant ways. First, all eligible probationers and parolees can now participate, regardless of their location. By expanding the services to those living anywhere in the state, DSS is attempting to address the numerous barriers that urban dwellers face in accessing treatment, including the cost of and access to transportation, as well as personal inhibitions (such as anxiety or perceived stigma) of attending in-person counseling. Second, DSS expanded its telehealth offerings to include Moral Reconation Therapy (MRT), an evidence-based form of cognitive behavioral therapy that focuses on improving decision making and is approved by DSS and funded through the PSIA.[18] Since the expansion—and a brief pilot period—12 clients from judicial circuits beyond the pilot circuits have enrolled in telehealth-based CBI-SA; seven clients statewide have enrolled in telehealth-based MRT.

With this innovation, a greater number of justice system–involved individuals in South Dakota have access to substance use treatment. That alone is a significant accomplishment. Those responsible for delivering the services are reportedly energized and inspired by DSS's leadership and willingness to try something new. The stakeholders are creatively and collaboratively finding solutions for their clients and, ultimately, achieving better, healthier outcomes for entire communities.

Endnotes

1 Vera worked with Arkansas, Delaware, Georgia, Kentucky, Louisiana, Oregon, South Carolina, and South Dakota.

2 Almost one-third of South Dakota's nearly 858,000 residents live in the state's two largest cities, Sioux Falls and Rapid City. The remaining people live in much smaller cities, towns, and rural areas, nearly all of them with fewer than 6,000 residents and a majority with fewer than 1,500. Most South Dakotans live in rural or frontier areas. See U.S. Census Bureau, https://perma.cc/58ML-3J3S; U.S. Census Bureau, "Annual Estimates of the Resident Population for Minor Civil Divisions, by County: April 1, 2010 to July 1, 2015," https://perma.cc/U8LC-5W82; U.S. Census Bureau, "Annual Estimates of the Resident Population for Incorporated Places: April 1, 2010 to July 1, 2015," https://perma.cc/73LG-8WGT.

3 South Dakota Criminal Justice Initiative Work Group, *Final Report*, November 2012, 4-5, https://perma.cc/MAR5-E4E2.

4 Ibid., 5.

5 For research that discusses specific risk factors for reoffending—including lack of treatment—see for example, Matthew Makarios, Benjamin Steiner, and Lawrence F. Travis III, "Examining the Predictors of Recidivism Among Men and Women Released From Prison In Ohio," *Criminal Justice and Behavior* 37, no.12 (2010): 1377-1391. Also see Jeremy Travis, Amy Solomon, and Michelle Waul, *From Prison to Home: The Dimensions and Consequences of Prisoner Reentry* (Washington, DC: the Urban Institute, 2001) 25-28.

6 " 'Judges have often told state officials that treatment centers are too far from some rural parts of the state, leaving drug and alcohol abusers without help,' [Governor Daugaard's general counsel, Jim] Seward said. 'And if treatment isn't an option, judges said they're often forced to send people to prison instead of keeping them on probation.' " Kevin Burbach, *Associated Press*, "State to Test Telehealth Drug Treatment Program," *The Washington Times*, August 2, 2014, https://perma.cc/ZB3Q-XBPL.

7 CBI-SA is an evidence-based cognitive behavioral curriculum for substance use treatment for a criminal justice population. It focuses heavily on role-playing and skill-building. During the four-month program, clients attend hour-long group sessions two to three times a week. This program is group-based; individual sessions are arranged only as needed to focus on building specific skills. See University of Cincinnati Corrections Institute School of Criminal Justice, "University of Cincinnati Cognitive Behavioral Treatment for Substance Abuse Curriculum," https://perma.cc/33WQ-XY6W.

8 Public Safety Improvement Act Oversight Council, *2014 Annual Report*, 12, https://perma.cc/BM3G-6CUS.

9 The Center for Connected Health Policy defines telehealth as "a collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunications technologies." See Center for Connected Health Policy, "What is Telehealth?," https://perma.cc/D5T7-X3RU.

A comprehensive monograph exploring the use of technology and drug courts defines telehealth as "the use of communications technology—such as telephones, computers, interactive video, and specially designed medical devices—to deliver health-related services and information." See Annie Schachar, Aaron Arnold, and Precious Benally, *The Future Is Now: Enhancing Drug Court Operations Through Technology* (New York: Center for Court Innovation, 2015) 5, https://perma.cc/76CL-2MAZ.

10 See Schachar et al., 6; and Alex Ramsey, Sara Lord, John Torrey, Lisa Marsch, and Michael Lardiere, "Paving the Way to Successful Implementation: Identifying Key Barriers to Use of Technology-Based Therapeutic Tools for Behavioral Health Care," *Journal of Behavioral Health Services & Research*, 43, no. 1, 55 (2016). Other research suggests that videoconferencing, particularly in the delivery of psychotherapy treatment and services, results in positive outcomes. For example, in a systematic review of using videoconferencing for psychotherapy, "patients and providers perceived a strong therapeutic alliance" and patients have demonstrated "high levels of satisfaction and acceptance." See Terra Hamblin and James Von Busch, National Frontier and Rural Addiction Technology Transfer Center, "Telehealth Technologies, Curriculum – Part 1, Telehealth Technologies Foundation Presentation" 41, https://perma.cc/D468-Q6SV.

11 Schachar et al., 7.

12 Although South Dakota decided that Zoom would best meet their needs, many vendors provide videoconferencing services that can be used for telehealth purposes, including Adobe Connect, Vidyo, Lync, Lifesize, and OmniJoin. Neither the Vera Institute of Justice nor the Bureau of Justice Assistance endorses or recommends a particular vendor.

13 Ramsey et al., 59.

14 Ibid., 66.

15 See, for example, Part 1 of the National Frontier and Rural Addiction Technology Transfer Center's curriculum at https://perma.cc/D468-Q6SV

16 Data provided to Vera by the South Dakota Department of Social Services (DSS). DSS does not collect relapse data and the available recidivism data does not separately examine clients who participated in the rural pilot project.

17 Ibid. Of the remaining two clients, one left treatment against the advice of counselors. The provider terminated the other client's treatment due to non-compliance.

18 Developed in 1985 by Correctional Counseling, Inc., MRT has been used in prisons, jails, drug courts, residential facilities, and schools, and has been shown to be effective in a variety of settings. A recent meta-analysis of MRT that focused on adult and juvenile offenders—either in facilities or supervised in the community—reported that the intervention had a small but significant effect on recidivism. See Leon M. Ferguson and J. Stephen Wormith, "A Meta-Analysis of Moral Reconation Therapy," *International Journal of Offender Therapy and Comparative Criminology* 57, no. 9 (2013): 1076-1106.

For more information

The Vera Institute of Justice is a justice reform change agent. Vera produces ideas, analysis, and research that inspire change in the systems people rely upon for safety and justice, and works in close partnership with government and civic leaders to implement it. Vera is currently pursuing core priorities of ending the misuse of jails, transforming conditions of confinement, and ensuring that justice systems more effectively serve America's increasingly diverse communities. For more information, visit www.vera.org.

To learn more about the telehealth services offered by the South Dakota Department of Social Services, contact Tiffany Wolfgang, director of the Division of Behavioral Health, at 605-367-5236 or Tiffany.Wolfgang.state.sd.us; or Stacy Trove, program manager of the Criminal Justice Initiative, at 605-367-4589 or Stacy.Trove@state.sd.us.

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The authors would like to thank the many people in South Dakota who shared their experiences and insights about the rural pilot program and delivering telehealth services. We thank Tiffany Wolfgang and Stacy Trove from the South Dakota Department of Social Services (DSS); Amy Hartman and Teresa Peratt from Volunteers of America, Dakotas; Duane Kavanaugh from Lutheran Social Services of South Dakota; and LeAnn Birkeland from the Sixth Circuit Court in South Dakota. A special thank you to Stacy Trove from DSS for her time and attention to this report.

We would also like to thank Nancy Roget and Terra Hamblin from the National Frontier and Rural Addiction Technology Transfer Center who generously lent their expertise about the evolving field of telehealth services. We also thank Annie Schachar from the Center for Court Innovation who shared her knowledge about the use of telehealth technology in the criminal justice field.

An electronic version of this report is posted on Vera's website at www.vera.org/remote-access.

The authors would also like to thank Nancy Fishman and Mary Crowley from Vera for their review and comments. Thank you to Jules Verdone for her excellent editing, and Carl Ferrero for designing the report. We also thank Juliene James from the Bureau of Justice Assistance for her assistance in the report's development as well as her review and comments.