

Transforming South Carolina Emergency Mental Health Care with Telehealth

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In the United States, there are an estimated 44.7 million adults who report having a mental illness in the past year (National Institute of Mental Health, 2016). Of these adults, 10.4 million identified having a serious mental illness which interrupted their ability to function normally in one or more major domains of their lives. In addition to adults with mental illness, there are an estimated 49.5% of adolescents between the ages of 13-18 who also report being diagnosed with a mental illness (Merikangas et al., 2010). This growing number of people experiencing symptoms of mental illness, has brought this public health concern to the forefront for many communities, as they work to create effective and efficient avenues for treatment.

In an effort to find treatment and relief from the symptoms of mental illness, many individuals present to their local hospital Emergency Departments (ED). According to the U.S. Agency for Healthcare Research and Quality (AHRQ), an average of 1 out of every 8 ED visits involves a mental illness and/or substance abuse issue (Owens, Mutter, & Stocks, 2010). This rate has continued to increase over the last decade. The AHRQ report shows an increase of 55.5% in people presenting to the ED with depression, anxiety, or other stress disorders, and an increase in 52% for those with psychosis and Bipolar Disorder, between the years of 2006-2013. As a result, EDs nationwide are experiencing overwhelming numbers of behavioral health patients in their hospitals. Unfortunately, not all of the hospitals are equipped with mental health counselors and psychiatrists to appropriately assess the needs of each patient and provide the treatment needed, so many of these patients have longer wait times in the ED and are hospitalized more frequently than individuals presenting with other medical needs (American College of Emergency Physicians, 2016). As the number of behavioral health patients in the ED has been increasing, so has the cost to the healthcare community.

In Charleston, South Carolina the need to increase emergency services for those experiencing mental health symptoms has been apparent for over 30 years. The Charleston Dorchester Mental Health Center (CDMHC) attempted to address this growing problem in the local EDs by creating the Assessment Mobile Crisis (AMC) team in 1987. The new AMC team was a collaborative effort, comprised initially of psychiatrists and master's prepared mental health counselors, which responded to individuals in psychiatric crisis anywhere in Charleston and Dorchester counties. This team is available 24/7, 365 days a year, and presents to the community with law enforcement, provides a mental health assessment, and determines the appropriate disposition to meet the individual's needs. By developing relationships with the local inpatient treatment providers and the probate court, AMC is also able to facilitate inpatient admissions, both voluntary and involuntary, without the need for an individual to go to the ED if there is not a medical concern. The development of this team has had a profound impact on Charleston and Dorchester counties, and has helped to divert numerous people from unnecessary ED visits when they were in need of treatment. Those in need of emergency mental health treatment are given more efficient and effective routes to the appropriate level of care.

Despite the existence of the AMC team, Charleston area EDs have continued to report overwhelming numbers of behavioral health patients in recent years. In an effort to address this issue, the leadership for CDMHC and the Charleston County Emergency Medical Services (CCEMS) discussed options for improving CCEMS' ability to utilize the services AMC offers. They discovered that individuals experiencing a psychiatric crisis were frequently calling 911, in order to have police and EMS dispatched to take them to the local ED. Due to time constraints and lack of training to complete mental health assessments, CCEMS staff were transporting the majority of these patients, contributing to the growing problem of overcrowding in the local EDs.

CCEMS staff were not utilizing AMC for most of these situations because they couldn't afford to stay on scene for extended time periods, waiting for AMC clinicians to arrive and assess the patient. Every minute an ambulance stays on scene, they are not available to respond to medical emergencies in the community, so they frequently transported behavioral health patients so that they could return to service. In brainstorming ways to improve this system, the idea of using telehealth technology (See Appendix A for operational definitions) to link CCEMS with AMC offered the most promise to address this growing concern.

In May 2017, CDMHC and CCEMS began a pilot project, using telehealth technology to link crisis counselors on the AMC team to CCEMS supervisors, to provide emergency mental health assessments for the community. The project start was funded by both agencies and a Telehealth Grant through the South Carolina Telehealth Alliance (SCTA) in collaboration with the Medical University of South Carolina (MUSC). For this project, CCEMS continue to send an ambulance to all 911 calls for psychiatric emergencies. After assessing the patient for medical needs, if emergency transport is not needed, a CCEMS supervisor is able to come to the scene and the ambulance can return to service for other medical emergency calls in the community. The supervisor then uses a Health Insurance Portability and Accountability Act (HIPAA) compliant Vidyo technologies to link to AMC clinicians, to assess the patient's mental health needs using telehealth technology. After the assessment, possible outcomes include de-escalation of the current crisis and linking the patient to outpatient treatment options, direct admissions to a local inpatient psychiatric treatment facility, and/or helping the patient to utilize their natural support systems to meet their needs.

The telehealth pilot project has been operational for approximately 8 months, and has received 513 calls from CCEMS in that time. Of these calls, 56% resulted in diverting patients

from the local ED (See Appendix B for data). Prior to this project, the majority of these 513 patients would have been transported by CCEMS to the local ED for an assessment. During the first 8 months, only 55 of the 513 patients were transported by CCEMS after the telehealth assessment. This pilot project has only been implemented in Charleston County, South Carolina at this point, and is estimated to have saved the local healthcare community approximately \$803,500 in the first 8 months (based on an estimated \$250 per ambulance transport and \$2000 per ED visit). The cost savings is likely more significant, after considering the number of possible hospitalizations which have been avoided by early intervention and connecting patients to the appropriate level of care. The purpose of this paper is to explore the scalability of the Charleston Telehealth Project to all 46 counties of South Carolina. While every county will not have a comparable volume of EMS calls for behavioral health patients, the potential cost savings to the community could be immense if the program were to be successfully expanded statewide.

Data Collection

In order to determine the scalability of the Charleston Telehealth Project to the entire state of South Carolina, the first step is to determine what similar projects are already in existence in the country, and to use these projects to determine potential obstacles and considerations an expansion would need to explore. A review of the literature for Emergency Medical Services and Mental Health Services, reveals that there are not currently any published projects utilizing telehealth in the same way as the Charleston Telehealth Project. Due to the uniqueness of this project, several similar programs were explored to collect the list of potential concerns.

The state of Texas has two similar initiatives within the last few years. The first project involves using telehealth to link EMS to trauma surgeons in a 108 county area of Texas, served by the Texas Tech University Health Sciences Center (Landi, 2017). In this large area of Texas, trauma patients may be transported by ambulance or airlifted, and the ground transport can take between 30-90 minutes. By linking EMS in the ambulance to trauma surgeons and physicians, they are able to immediately start care while in transit, and determine the best location and mode of transport for further care at a hospital. The second project in Texas is in the beginning stages, and involves utilizing telehealth technology to link law enforcement officers to mental health professionals for consultation purposes when they encounter someone in psychiatric crisis (Wicklund, 2017). The biggest barrier identified by these projects was difficulty maintaining connectivity in areas with low bandwidth. While many telehealth software providers, indicate the ability to adjust for changes in bandwidth, maintaining this connectivity is vitally important in providing an accurate assessment and communication of next steps for patient care. Also, upon speaking with staff with these programs, they indicated the importance of community stakeholder involvement from the beginning of the project (S. Rose, personal communication, November 30, 2017). They indicated that these stakeholders should be identified early, determining what points of value they have in the project, and ensuring that these points of value are measured and tracked throughout the project implementation. Creating a feedback loop with stakeholders becomes vitally important to program development and monitoring of efficiencies.

In western North Carolina, a new initiative started in 2017 to equip EMS providers with a telemedicine backpack to take to rural/mountain residents, in an effort to link them to care within the six-hospital health system covered by Mission Health (Wicklund, 2017). This program utilizes the DOT Telemedicine Backpacks created by swyMed, based in Lexington,

Massachusetts. The 20lb backpacks overcome the internet connectivity issues with 2 modems and 4 high-gain antennas. The use of these backpacks helps to improve response to 911 calls as well as to provide home visits as a way to prevent future hospitalizations for those with chronic health conditions or recent hospital discharges. While the value to the community of NC is clear with this project, one of the key concerns identified by the Mission Health leadership was financial sustainability. The project was initially started with a grant and investment capital, but one key has been their identification as an Accountable Care Organization (ACO). This classification allows for Medicaid and Medicare reimbursement for services, and will make it possible for the program to expand and sustain this much needed service. Without the avenue for reimbursement, sustaining the services would be very difficult, as grant funding would eventually end.

In Georgia, the Hancock Healthcare Access Initiative, a telemedicine project linking EMTs to local hospital doctors, began in 2015 to address the severe lack of adequate emergency care in rural areas of their state (Lee, 2015). This project utilizes a “black box” of telemedicine medical tools to allow for advanced assessments in the community, in order to determine if a medical transport is needed. Individuals familiar with this project shared lessons learned in the first 3 years of the project, as well as aspects which help make this project sustainable (L. Sirmons, personal communication, November 15, 2017). A primary consideration is the costs of internet carrier services. With the data charges associated with the bandwidth required to provide telehealth services, this cost can quickly escalate and off-set any program savings. Also, in the State of Georgia, parity laws mandate reimbursement for telehealth services, and this has been vitally important to the sustainability of the program. This legislation is not in place in SC, and would inhibit reimbursement for the services provided.

Within South Carolina, there are a few telehealth projects that are also in the pilot stages, and anecdotally reporting some of the same considerations/obstacles as those previously mentioned. Also, the Beckman Mental Health Center, with the South Carolina Department of Mental Health, previously explored the possibility of using telehealth to provide emergency mental health assessments (M. Gambrell, personal communication, October 11, 2017). For this center, the prospect was mainly considered because they cover a large rural area consisting of 7 counties. The ability to provide an adequate response time for an in-person evaluation, would be difficult after business hours and on weekends. While the Center's leadership reports that the law enforcement agencies in their catchment area are great to work with, the logistics of coordinating personnel and training across 7 counties with 26 law enforcement agencies was very burdensome. The staff needed to implement this type of emergency response service went beyond the capabilities of the mental health center, if they were to act independently from the agency to implement the project.

A review of these projects provides the following list of potential obstacles and considerations for determining the scalability of a state-wide telehealth emergency mental health project:

1. Technical considerations, including but not limited to connectivity;
2. Personnel and logistical considerations for a variety of agencies and counties;
3. Reimbursement and legislative requirements; and
4. Need for improved services and value to stakeholders in each community.

Data Analysis

Technical Considerations

The Charleston Telehealth Project utilizes Vidyo technologies, to link the crisis counselors with CCEMS. Vidyo was selected for the ease of use with minimal training, and the software's ability to maintain the quality of the audio and video despite variations in bandwidth. This product provides encrypted communications which enable security on networks through which a portal can link the two parties to provide the assessment. The software is licensed in two ways, through the number of concurrent calls taking place and the number of people who can be logged in at one time. In Charleston, the pilot project utilizes MUSC's network instance of Vidyo for the 20 local users, free of cost. For the project to expand to cover the entire state, the addition of Vidyo software licenses along with additional Vidyo hardware, utilized to route and secure video traffic would be required (M. Haschker, personal communication, November 30, 2017). Currently, Palmetto Care Connections manages the Palmetto State Providers Network (PSPN), a private healthcare network in South Carolina. They are working on developments PSPN which would support expansion of this kind, including already established Vidyo hardware and licensing for 50 concurrent calls and 250 users logged on at a time. This would need to be expanded to accommodate for the number of users and concurrent calls anticipated for all 46 counties, which would likely exceed 250 users.

Another technical consideration mentioned was cellular connectivity. While the Vidyo software platform advertises an ability to adjust for changes in bandwidth without losing the quality of audio and video, adequate connectivity is still required for it to function. Most of the state of South Carolina has adequate coverage with the Verizon cellular provider, which is the

provider used by the SC Department of Mental Health (SCDMH). The Charleston Telehealth Project initially utilized Verizon Jetpacks for 4G connection for the crisis counselors and EMS supervisors in the community. Recently, the Vidyo application has also been securely added to iPhones for increased flexibility and use of cellphone data to provide assessments when needed. In rural areas of the state, there are pockets where this type of device would not be sufficient for staff to have adequate reception. Since the mental health counselors would mostly be located in more populated areas, this concern is specifically for EMS personnel. EMS in some areas may need to explore adding network extenders and/or high-gain antennas to allow for clear transmission and reception of the telehealth assessment. CCEMS ambulances are equipped with cradle point routers. Many of the EMS agencies in rural communities of SC already have these antenna and/or would welcome the opportunity to install them in vehicles (J. Decker, personal communication, November 18, 2017).

One of the benefits of the Vidyo software, is that it is easy to use without expensive equipment purchases. In Charleston, both the mental health professionals and EMS personnel already had laptops with video cameras installed. Installation of the software application onto the existing computers was easy and did not disrupt the normal daily workflow of the machines. If this project were to be expanded, each participating EMS agency would need to be contacted to determine their equipment availability and needs.

With each of these technical needs, there is a cost associated. The initial expansion costs for the PSPN and the Vidyo licenses would be substantial. One way to possibly off-set this cost would be to explore a Network Development Grant and/or a partnership with the Vidyo software company to provide free or low cost licenses in exchange for access to intellectual property related to the expansion. Also, as mentioned before, contacting the cellular service provider to

negotiate a lower controlled cost would be a valuable step in minimizing the overall cost of data charges. When network extenders are needed, this cost could be up to \$5,000 per extender, depending on the type of extender needed. Equipment costs for laptops with counselors and EMS should be minimal, depending on the pre-existing equipment with each agency. Grants and partnerships with other agencies may help to off-set these equipment costs as well.

Personnel and Logistical Considerations

A key component to the success of a statewide expansion would be to accommodate for the need for consistency, while still adjusting for the unique needs in each county. Implementing this program in 46 different ways would prove problematic for all of the entities involved. In South Carolina there are 106 EMS agencies providing emergency transportation (R. Wronski, personal communication, November 13, 2017). While these agencies are all regulated by the DHEC EMS Bureau, the day-to-day functioning, size of catchment area, and resources for equipment are different in each area. If expansion is pursued, each of the area agencies would need to be approached and assessed with regards to each of these characteristics. Also, each agency will need to establish a policy and workflow for EMS personnel to follow to ensure safety and consistency.

Since 1987, AMC has been the only 24/7 emergency response team in South Carolina. Expansion of the emergency mental health services with telehealth would require an expansion of staff to provide the emergency mental health assessments. In 2017, SCDMH received funds from the Department of Health and Human Services to establish a statewide emergency mental health response team, which they call Community Crisis Response and Intervention (CCRI) (A. Gilchrist, personal communication, September 12, 2017). CCRI will utilize approximately 40

master's prepared counselors, similar to AMC, and will provide in-person emergency assessments in communities statewide. Once staff have been hired and trained, CCRI will operate in all 46 counties of the state, and would be the ideal agency to provide the emergency assessments for a telehealth expansion. Utilizing the SCDMH counselors would allow for consistency in process/protocol, supervision, and staffing for each county. CCRI is anticipated to begin providing services in portions of the state in late spring/early summer of 2018. One lesson learned from the Charleston Telehealth Project is the need for a consistent 24/7 contact number for EMS to use for requesting the telehealth assessments. In order for CCRI to successfully provide telehealth assessments for EMS across the state, they would also need to establish a centralized phone number for EMS to call 24 hours a day 7 days a week.

Reimbursement and Legislation

While several of the projects discussed were started with grant funding, financial sustainability was a major concern. The ability to establish Medicaid, Medicare, and private insurance reimbursement for the services provided was a vital part of each project's ability to function after the grant funds ended. Some states in the United States have legislation mandating equal reimbursement for services provided via telehealth technology, such as those present in Georgia (Thomas and Capistrant, 2016). While this is a growing area of coverage, most states limit that coverage to physicians, with 21 states reimbursing for licensed social workers and 16 states reimbursing for licensed professional counselors. In South Carolina, the laws governing telehealth are limited to "telemedicine". SC Medicaid coverage for telehealth services, to include behavioral health services, are limited in scope and practitioner type, which would exclude reimbursement for the emergency mental health services provided in this project expansion. In order for the Charleston Telehealth Project to be expanded successfully to all 46 counties and

financially sustainable, a revenue stream would need to be established. Introducing legislation to support reimbursement for emergency mental health assessments to be provided by master's prepared clinicians via telehealth technology would be mutually beneficial to the program, the healthcare community of South Carolina, and the residents of the state. Such legislation would allow for legal and ethical oversight of these services, while supporting a program with significant potential to save money for the healthcare community of South Carolina. First steps to introducing such legislation would involve soliciting the support of the SC Hospital Association and the Medicaid division of the South Carolina Department of Health and Human Services. Gaining this support would require determining what outcomes are important to each entity and measuring/tracking how the current pilot project impacts each of those outcomes.

Need for services and Value to Stakeholders

South Carolina contains 46 counties, each consisting of numerous communities. Some counties, such as Charleston, have very rural portions as well as more heavily populated cities, each with their own specific needs. SCDMH operates 17 mental health centers, with clinics in almost every county of the state. These clinics have been involved in their communities for years, and most of the staff live in those same communities. These pre-existing relationships would assist in identifying the needs of each community, as well as determining the stakeholders who would need to be involved in the planning and development process. As mentioned previously, determining these stakeholders early will be vitally important to the successful expansion of the program.

Another aspect to consider in determining the value of project expansion to each community is the availability of emergency medical care and psychiatric inpatient treatment in

each area of the state. As mentioned in several of the projects discussed, the telehealth projects were initiated for communities for which the closest hospital was 30-60 minutes away. In SC, this is likely true for residents in several of the more rural counties. Reducing the number of lengthy transports for EMS personnel would be even more valuable in these communities. Also, according to a 2015 SC Department of Health and Environmental Control Health Plan, there are six counties in the state with no psychiatric hospital beds in their region of the state. For those communities a telehealth would add value for patients who could be diverted to outpatient services, a determination EMS cannot currently make on their own. In contrast, it could decrease the value for those requiring psychiatric hospitalization, as no direct admissions to a psychiatric bed would be available, and likely, all patients would still need to access inpatient treatment through an ED.

Lastly, a major area of consideration is the call volume of EMS calls in each county, which varies significantly (R. Wronski, personal communication, December 14, 2017). In the last two years, DHEC data reports indicate that EMS responded emergently to behavioral health calls an average of over 5000 times per year in Greenville and Spartanburg counties (See Appendix C for full listing of calls to each county). In contrast, during the same time period, Calhoun, Allendale, and Hampton counties have averaged fewer than 50 behavioral health calls per year. Obviously, the fewer EMS calls for behavioral health needs may decrease the perceived value of this type of service in those communities and to EMS agencies. Thorough evaluation of the call volume for each county and the related resource availability (i.e. hospital proximity, length of transport) should be explored to determine value and need for expansion in each community.

Summary and Implementation Recommendations

After reviewing all of the possible obstacles and considerations for expansion of the emergency mental health telehealth project, it is clear that expansion would have to be a collaborative effort in order to be successful. Thankfully, many of the relationships already exist between SCDMH, inpatient facilities across the state, Palmetto Care Connections, and the South Carolina Telehealth Alliance. In collaboration, this group of agencies would be able to support the successful expansion of emergency mental health telehealth services statewide in SC. The major barrier which would inhibit the long-term sustainability of such an expansion is the lack of reimbursement for the services provided in this program. Leadership from each of the involved agencies will need to work continually towards communicating the statewide value of the program to the entities who can influence and introduce legislation and change in insurance reimbursement practices.

Recommended Implementation Steps

While an expansion of the telehealth project will need to be a collaborative effort to be successful, SCDMH will likely need to be the lead party in coordinating the expansion, as they will supply the personnel to provide the assessments. SCDMH will not be able to support the full financial responsibility of the expansion, and will need to work closely with community partners to implement the program statewide, specifically regarding costs of the technology needed. The following steps are the suggested implementation steps for this expansion:

1. CCRI is a vital aspect of establishing the personnel necessary for the success of an expansion to the telehealth program. Hiring and training CCRI staff will be a necessary first step to program expansion.

2. Determine communities with the highest need and adequate resources. Using the data on EMS calls for behavioral health emergencies as well as the map of hospitals across the state, areas most similar to Charleston, SC would be recommended areas to start the expansion. This strategy would help to build the program in order to support the neighboring rural counties with fewer resources.
3. Build support in the communities selected. Building this support should start with the local mental health center and EMS agencies, and grow outward to the local hospitals with EDs and psychiatric hospitals. Utilizing clinical champions from the Charleston Telehealth Project, both with CCEMS and CDMHC, will help communicate the value of the program to these entities.
4. Develop technology to support the selected areas. Development in this area should happen concurrently with other steps, and will include approaching the cellular service provider, software provider, and potential grant funding sources to reduce cost where possible.
5. Training and policy development. Training for EMS personnel and mental health clinicians will be vitally important. This process should involve policy development and a flowchart for all parties to follow.
6. Diligently keep accurate data to track efficacy of the program and support further development. This data should be provided regularly to the entities who can effect change in legislation and reimbursement.

Conclusion

The United States is facing a growing number of people experiencing symptoms of a mental illness and seeking treatment for these symptoms. Our local hospital EDs are not all

equipped to assess and treat these symptoms, leading to longer wait times and an overwhelming number of behavioral health patients in EDs. Telehealth technology is becoming an increasing part of healthcare reform to address these growing concerns and needs. The Charleston Telehealth Project has shown a significant impact on these concerns in the first 8 months of implementation, including a large potential cost savings to the healthcare community in Charleston County. Expansion of this program to all 46 counties of South Carolina would allow for increased access to care for patients and an expansion of the potential cost savings to the entire state. Through collaboration, building community relationships, and establishing a plan for financial sustainability, this expansion would be feasible and beneficial to each of the agencies involved, the healthcare community of South Carolina and, most importantly, the residents of the state who are seeking relief from symptoms of a mental illness.

References

1. American College of Emergency Physicians. (2016). *Waits for care and hospital beds growing dramatically for psychiatric emergency patients*. Retrieved from <https://newsroom.acep.org>
2. Lee, M. (2015). Telemedicine may improve healthcare in rural Georgia. *The Macon Telegraph*. Retrieved from <https://www.ems1.com>
3. Landi, H. (2017). Telemedicine pilot aims to connect EMS with trauma centers in west rural Texas. *Healthcare Informatics*. Retrieved from <https://www.healthcare-informatics.com>
4. Merikangas, K.R., He, J.P., Burstein, M., Swanson, S.A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication-Adolescent Supplement. *Journal of the American Academy of Child Adolescent Psychiatry*, 49(10), 980-9.
5. National Institute of Mental Health (2016). *Mental Health Information*. Retrieved from <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>
6. Owens, P.L., Mutter, R., and Stocks, C. (2010). *Mental health and substance abuse-related emergency department visits among adults, 2007*. Agency for Healthcare Research and Quality. HCUP Statistical Brief #92
7. South Carolina Department of Health and Environmental Control. (2015). *South Carolina health plan*. August 13, 2015.
8. Thomas, L. and Capistrant, G. (2016). State telemedicine gaps analysis. *American Telemedicine Association*.

9. Wicklund, E. (Feb. 2017). Telemedicine backpack gives providers a new mobile health tool. *mHealth Intelligence*. Retrieved from <https://mhealthintelligence.com>.
10. Wicklund, E. (Dec. 2017). Texas deputies turn to telemedicine to treat mental health crises. *mHealth Intelligence*. Retrieved from <https://mhealthintelligence.com>.

Appendix A

Operational Definitions

Telehealth- Use of telecommunications technology and electronic records to provide remote clinical healthcare.

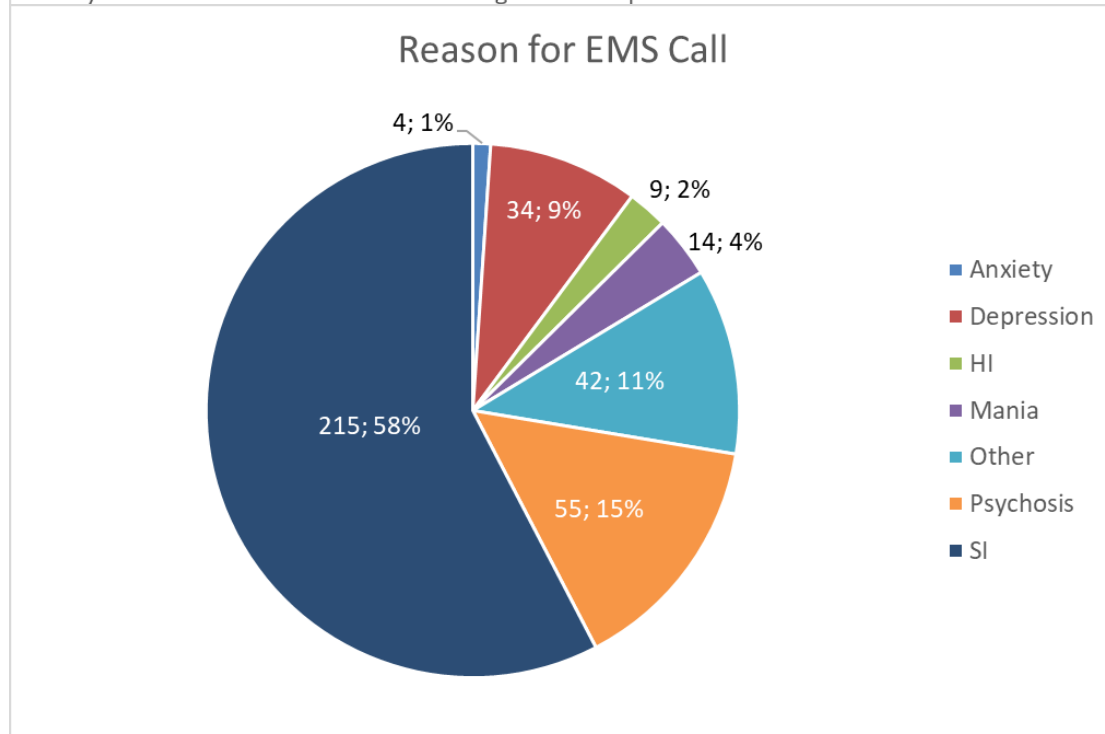
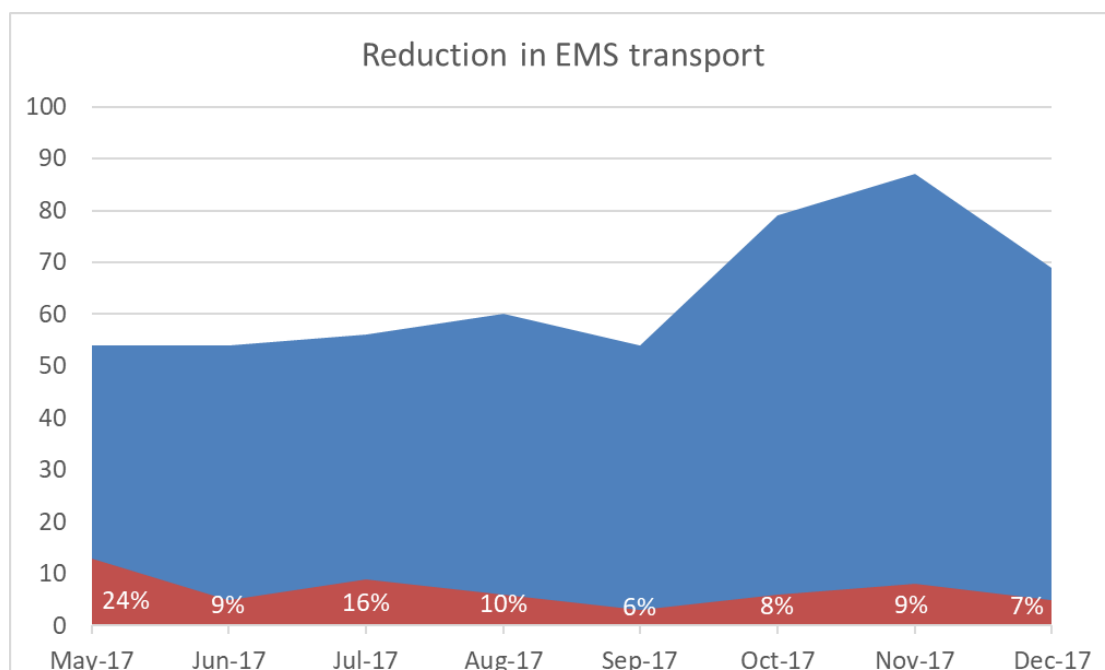
Telemedicine- Use of telecommunications technology to provide remote diagnosis and treatment. Typically limited to physicians, nurse practitioners, and physician's assistants.

Emergency Mental Health Assessment- An interview style of assessment focused mainly on the current symptom presentation and mental status, including a brief history of the illness, recent changes in symptoms, current risk factors, mental status exam, determination of contributing factors, and willingness for the appropriate level of treatment.

Appendix B

Charleston Telehealth Project Results

Call total in 2017 (May-Dec)	513
ED diversions in 2017 (May-Dec)	283



Appendix C

SC DHEC Transport Data

August 2015 - July 2016	
Incident County	312.90-BEHAVIORAL/PSYCHIATRIC DISORDER
Abbeville	182
Aiken	1411
Allendale	45
Anderson	2423
Bamberg	154
Barnwell	160
Beaufort	557
Berkeley	934
Calhoun	7
Charleston	4015
Cherokee	184
Chester	301
Chesterfield	255
Clarendon	275
Colleton	435
Darlington	142
Dillon	171
Dorchester	857
Edgefield	127
Fairfield	213
Florence	1123
Georgetown	457
Greenville	5170
Greenwood	603
Hampton	56
Horry	2483
Jasper	124
Kershaw	330
Lancaster	544
Laurens	608
Lee	139
Lexington	3191
Marion	214
Marlboro	62

McCormick	92
Newberry	139
Not Recorded	905
Oconee	610
Orangeburg	98
Pickens	1037
Richland	3549
Saluda	251
Spartanburg	4689
Sumter	618
Union	172
Williamsburg	74
York	1143
Grand Total	41329
August 2016 - July 2017	
Incident County	312.90-BEHAVIORAL/PSYCHIATRIC DISORDER
Abbeville	197
Aiken	982
Allendale	23
Anderson	2811
Bamberg	112
Barnwell	166
Beaufort	586
Berkeley	1032
Calhoun	7
Charleston	4003
Cherokee	64
Chester	60
Chesterfield	185
Clarendon	315
Colleton	319
Darlington	173
Dillon	155
Dorchester	476
Edgefield	139
Fairfield	226
Florence	1137
Georgetown	419
Greenville	5514
Greenwood	568
Hampton	28

Horry	2597
Jasper	143
Kershaw	278
Lancaster	564
Laurens	598
Lee	127
Lexington	3218
Marion	231
Marlboro	62
McCormick	110
Newberry	153
Not Recorded	1075
Oconee	646
Orangeburg	56
Pickens	1015
Richland	3713
Saluda	300
Spartanburg	5281
Sumter	847
Union	245
Williamsburg	47
York	962
Grand Total	41965