

COMMUNITY MENTAL HEALTH CRISIS RESPONSE AND STABILIZATION IN SOUTH CAROLINA

THE PAST, THE PRESENT, AND THE FUTURE

Debbie Blalock, Charleston Dorchester Mental Health Center,
Executive Director, October 26, 2017

WHAT'S THE POINT....

DESIRED OUTCOMES ARE:

Appropriate level of care at the appropriate time by the appropriate staff; therefore:

- Clinically appropriate emergency department (ED) diversion.
- Clinically appropriate inpatient hospital diversion.
- Legally appropriate jail diversion.
- Clinically and legally appropriate shortened length of stay (LOS) in ED, inpatient bed, jail.

DEFINITIONS SPECIFIC TO THIS PRESENTATION

- MHP - mental health professional, a master's prepared clinician.
- Crisis response - face:face, telephonic, and/or video assessment and intervention between a mental health clinician (MHP, RN, MD) and a patient in psychiatric distress; may be 24/7.
- Psychiatric distress - suicidal, homicidal, delusional, psychotic, depressed, manic, etc.may be comorbid with substance use disorder.
- Crisis stabilization - intensive treatment modality specifically related to the mental health crisis and avoidance of future crises; may be 24/7; may have bed capacity.
- CSU/CSC - crisis stabilization unit/center.
- Diverted patient - in absence of crisis response or stabilization intervention, patient would have gone to an ED and/or inpatient bed or to a jail/detention center.
- Direct admission - patient bypasses an ED and goes straight into an inpatient bed.
- Step down patient- patient no longer needs full inpatient care, but not quite ready to go home or inmate legally released from jail, but would benefit from further intensive mental health treatment.

THE PAST

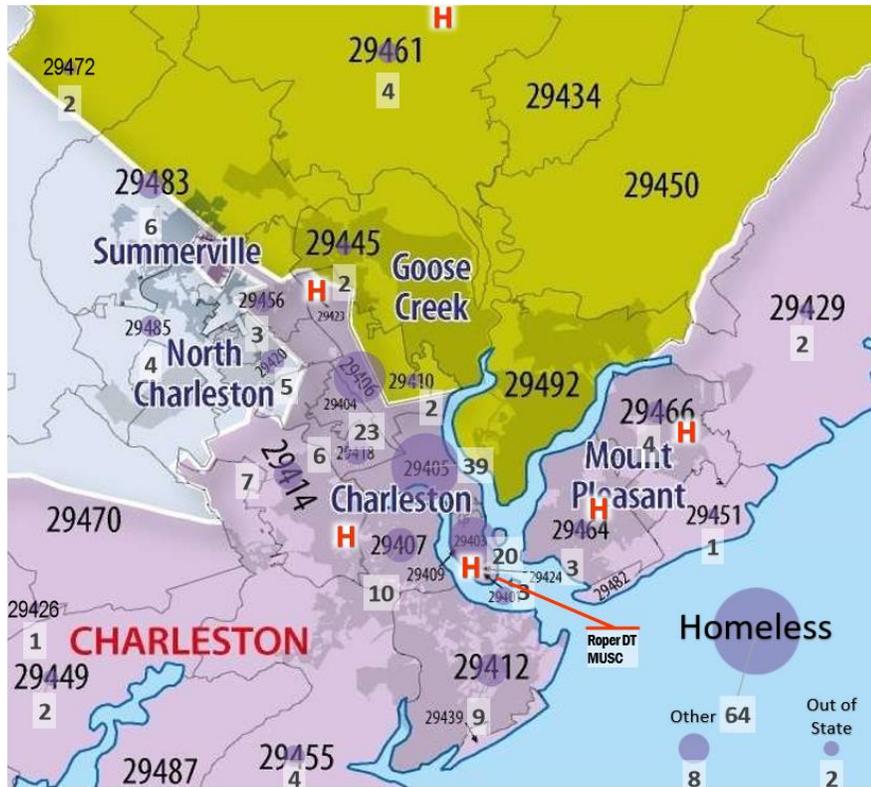
- 1987 - Charleston Dorchester Mental Health Center (CDMHC), in partnership with MUSC, created the first Mobile Crisis team in SC, a 24/7 psychiatric “EMS.”
- Late 1980s - CDMHC embeds MHP into the Charleston county detention center - other centers also embed staff in detention centers; currently 6 CDMHC staff embedded in AL Cannon Detention Center.
- Early 2000s - various SCDMH mental health centers place clinicians in EDs around state.
- 1990s - Anderson Oconee Pickens (AOP) MHC and Columbia Area (CA) MHC develop versions of CSUs.
- 1999 - CDMHC creates its medical model crisis stabilization unit, the Tricounty Crisis Stabilization Center (TCSC). 24/7, 10 bed unit. Average LOS 3.5 days. Closed in 2009 due to SCDHEC regulations related to licensure as a community residential care facility. In final year, diverted over 780 patients from inpatient hospital stays. Financial support from MUSC, Trident Medical Center, Roper St. Francis Hospital system (RSFH), Charleston Center (CC), Charleston County Sheriff’s Office (CCSO), Berkeley Mental Health Center (BMHC), South Carolina Department of Mental Health (SCDMH), and Trident United Way.
- 2003 - Charleston County Probate Court and CDMHC create the first mental health court in SC. 4 more created in the state - Richland County, Greenville County, Marlboro County (since closed) and Horry County.
- 2009 - SCDMH starts telepsych ED program - currently in 25 EDs across state; SCDMH also using center to clinic and center to center telepsych.
- 2015 - Berkeley MHC created a workweek Mobile Crisis team.

THE PRESENT

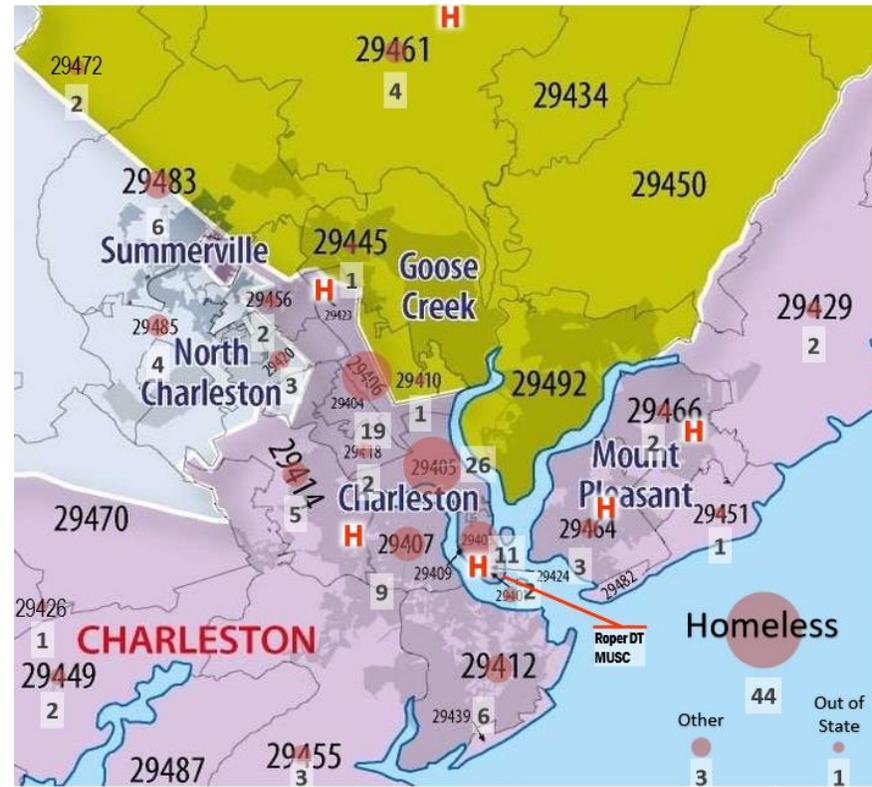
- CDMHC reopened TCSC on June 5, 2017. Financial stakeholders - CDMHC (300k), SCDMH (250k), MUSC (250k), RSFH (250k), CCSO (218k), Charleston County Criminal Justice Coordinating Council (CCCJCC) (90k), CC (30k), and BMHC (18k). Stakeholders are advisory board members - NAMI to be included. Startup budget - approximately \$1,406,000.00. Recurring budget - approx. 1.1 mil.
- 24/7, 10 bed unit housed in CC.... critical location.
- Licensed as CRCF by SCDHEC - not a locked unit.
- Criteria - 18+, voluntary, medically stable, in psychiatric distress, not violent, not intoxicated, able to participate in rigorous treatment regime.
- The function - ED diversion, hospital diversion, jail diversion, triage service for law enforcement (17 calls to date).
- Staffing - minimum of 5 on day shift, 2 on evening and 2 on night shift. RN on every shift. No less than BS/BA staff. Psychiatrist on site 3 hours 7 days a week and on call 24/7. 16 staff total. Crisis intervention, de-escalation, and assessment training critical.
- At full capacity, 10, 2x. At capacity related to gender bed availability, 3x.

WHERE DO PATIENTS LIVE?

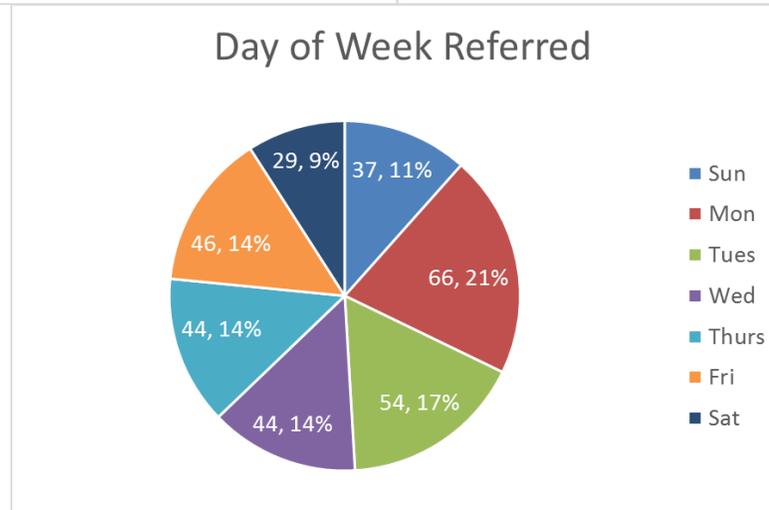
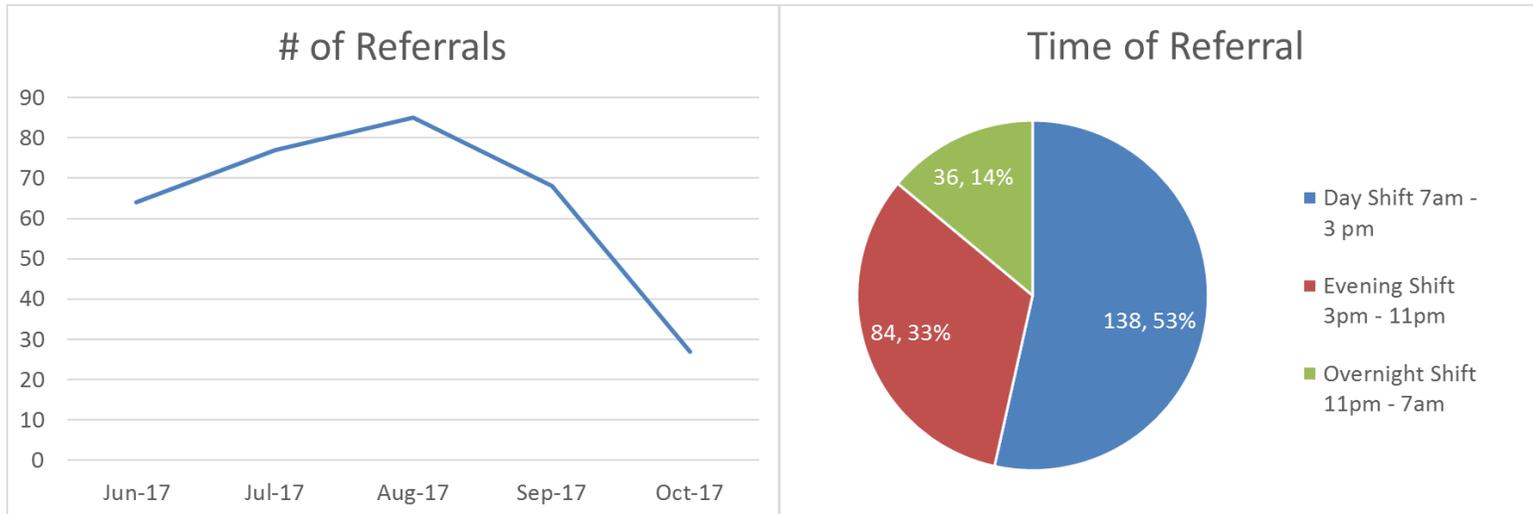
Referrals



Admissions

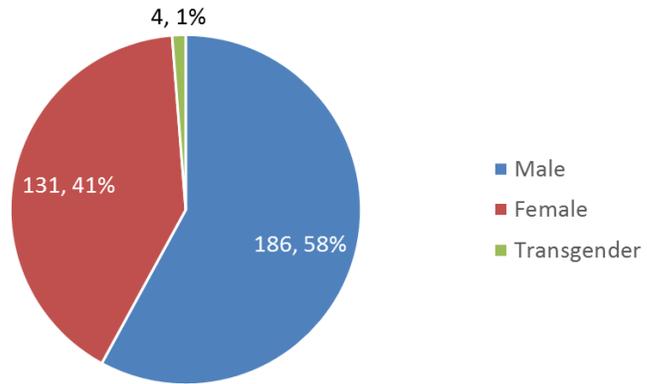


HOW MANY, WHO, and WHEN?

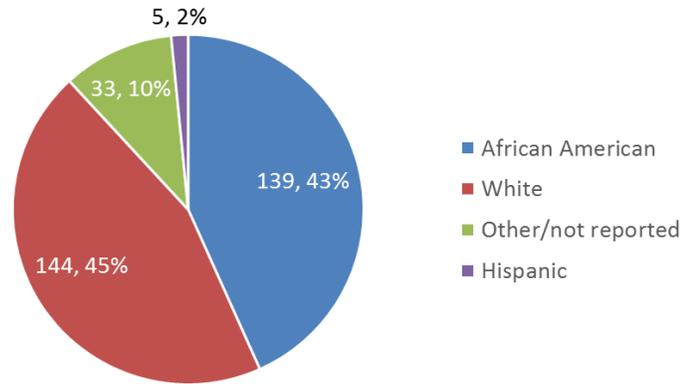


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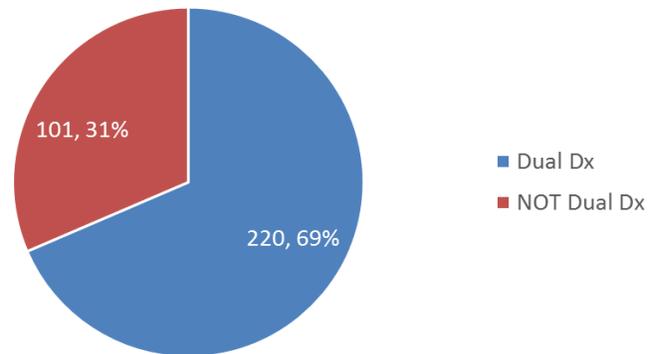
Gender of Referrals



Race of Referrals

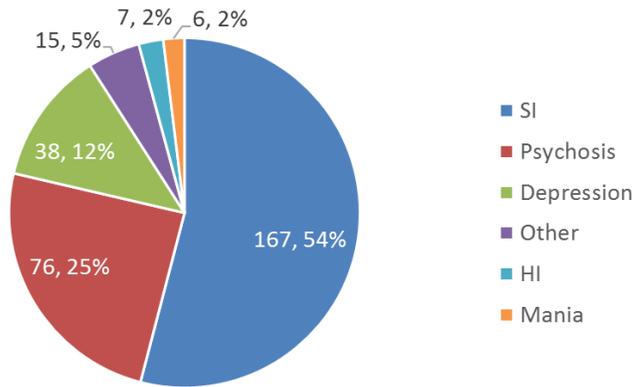


MH Dx vs. both A & D + MH Dx

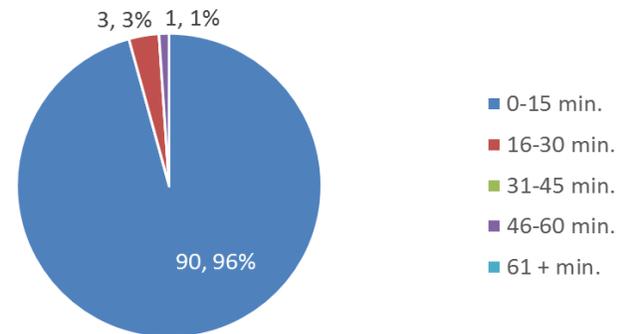


WHO AND WHY.....OR WHY NOT?

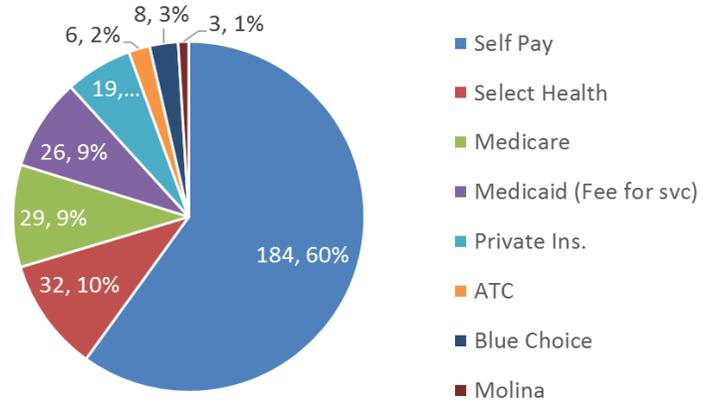
Reason for Referral



Time between referral and admission decision

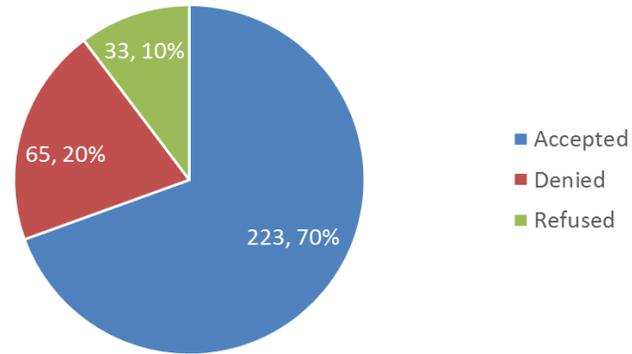


Insurance Type

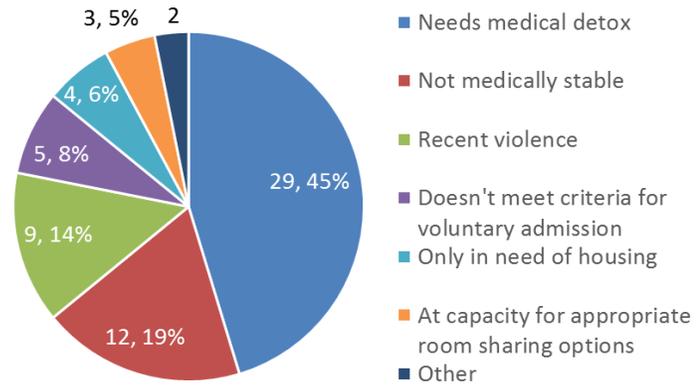


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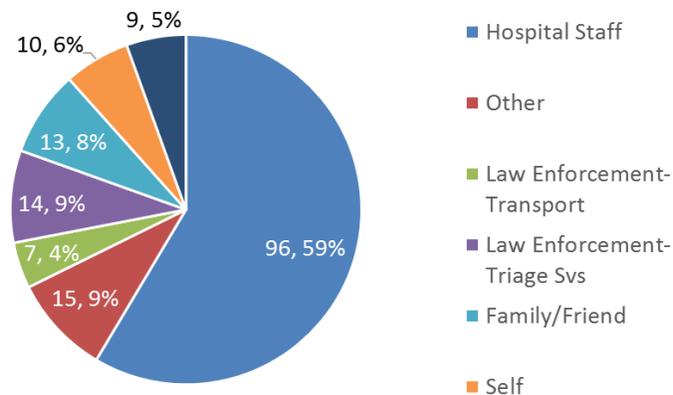
Pts Accepted, Denied, Refused



Reasons for Denial to Unit

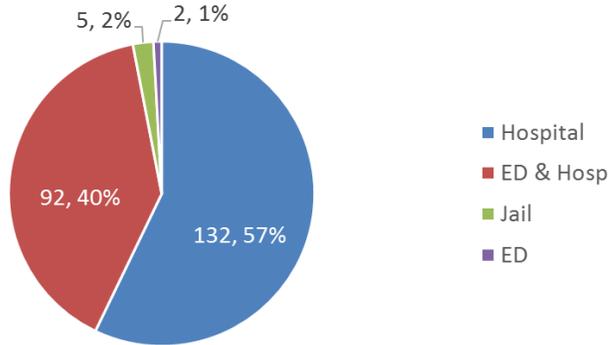


Transport to Unit, if accepted



RESULTS....SO FAR.....

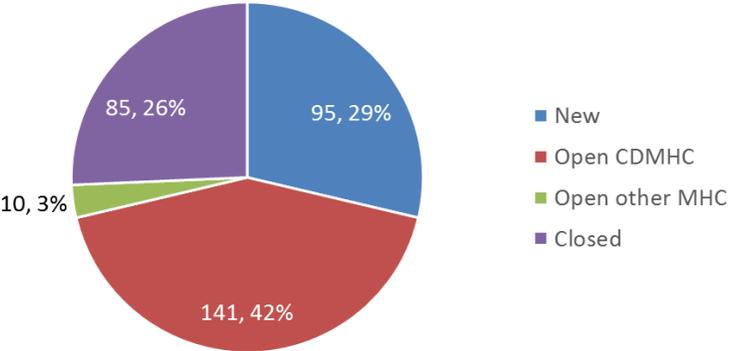
Pt Diversions due to TCSC admission



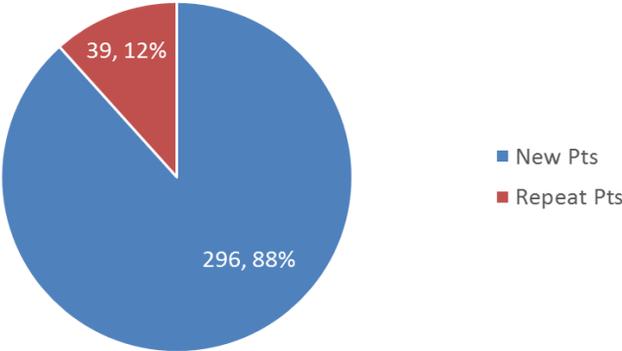
Average Length of Stay



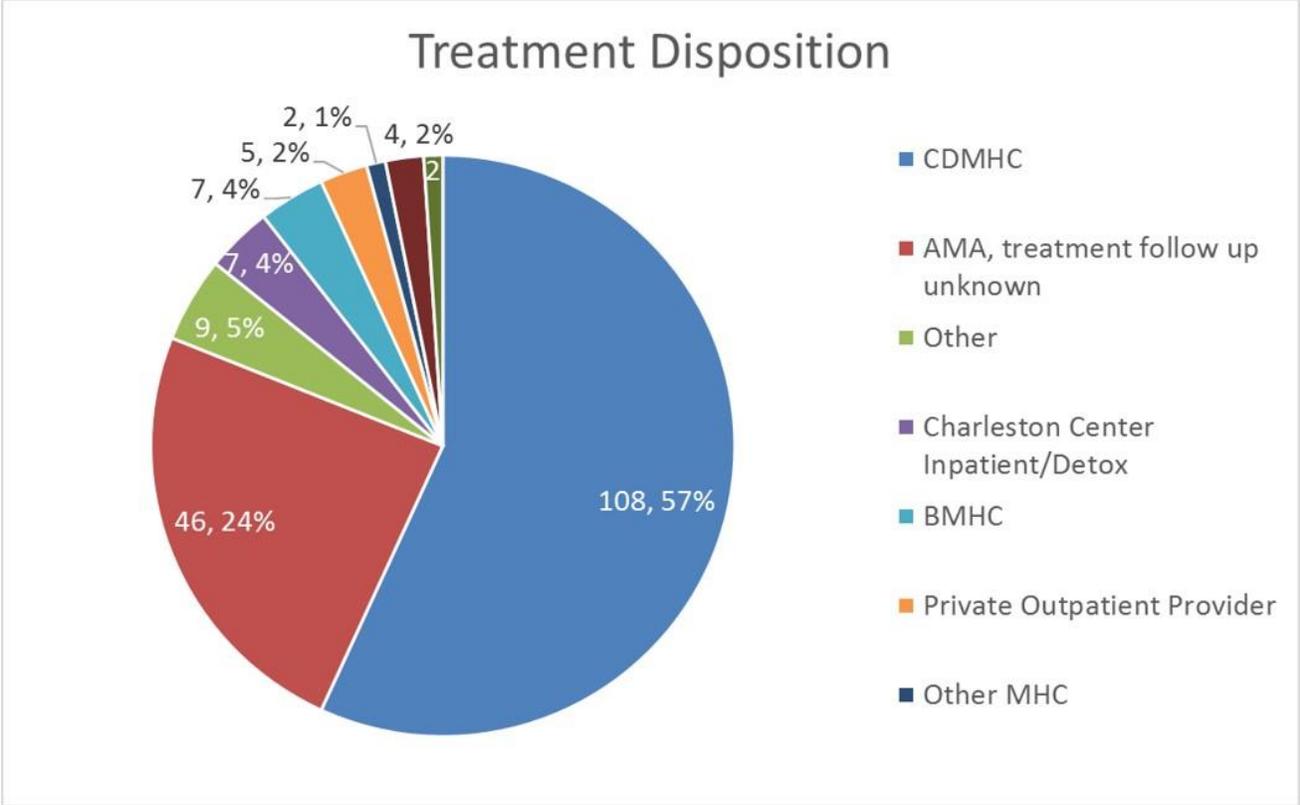
MHC Status



Repeat Patients vs. New to Unit



RESULTS....SO FAR.....



ANOTHER PROMISING EFFORT - EMS/MOBILE CRISIS/MUSC 24/7 TELEHEALTH

- Started May 3, 2017.
- Charleston County EMS responds to a call.
- Determines no primary care emergent/urgent needs.
- Calls out supervisor with telehealth equipment.
- Supervisor contacts Mobile Crisis staff via 'VIDYO.'
- Mobile Crisis evaluates patient and makes treatment recommendation.
- MUSC role is to evaluate outcomes.
- Very broad application for future projects.

EMS/MOBILE CRISIS TELEHEALTH OUTCOMES - 5 MONTHS

Total calls	ED Diversions	Hospital Diversions	Commitments
329	157	155	46

THE FUTURE

- New SCDHEC licensure being created for crisis stabilization units - no more fitting a square peg into a round hole.
- Greenville community working on its plan.
- Spartanburg community working on its plan.
- Anderson, Oconee, Pickens (AOP) community working on its plan.
- Community crisis response and intervention (CCRI) - a collaboration between SCDMH and SCDHHS to create 24/7 community crisis response across the state.
- Sobering Center to potentially open next month at Charleston Center to divert intoxicated folks, not at risk for withdrawal, from EDs, jail, inpatient beds.

GREENVILLE MODEL

“The South Carolina Department of Mental Health, Greenville Mental Health Center, Greenville Health System, Bon Secours St. Francis Health System, Greenville City Police, FAVOR, Phoenix Center (DAODAS), Greenville Probate Court, and The Greenville Miracle Hill Rescue Mission are joining together for Greenville Mental Health’s Shared Solutions-supporting a psychiatric/substance use crisis evaluation triage and stabilization services for individuals referred by collaborative entities this project is intended to serve the purpose of providing more appropriate evaluation and intervention services for those in the city of Greenville with the goal of decreasing unnecessary emergency department visits and jail utilization.”

SPARTANBURG MODEL

- “Peer Support Crisis Center.
- Modeled after a nationally recognized program in Asheville (C3356).
- Provides a safe “drop-in” environment for individuals to prevent unnecessary emergency room visits.
- 24/7 reassurance line providing repeated contact to provide support and assistance in following treatment regimen to avoid crises.
- Collaboration with NAMI and SAMHC staff to implement recovery plans and coordination with other local resources.
- Anticipated location between MHC and SRMC (Spartanburg Regional Medical Center).
- Providing services between 10:00 and 8:00, the times identified by the ER as the highest volume.”

AOP MODEL

- “The idea of a Crisis Stabilization Program based on the Charleston model (licensed facility staffed by clinicians and registered nursing staff with Psychiatrist services available) has been presented to the group and there is a great deal of interest in this concept. On August 24, Charleston Dorchester Mental Health Center, and some of its community partners will discuss their model with AOP Mental Health staff and community hospital CEOs by videoconference. This will help educate the AOP group as to what is required to implement the Charleston model and whether it, or a hybrid of it and the previous crisis shelter concept, would be best to serve the crisis stabilization needs of this area.
- Following the videoconference on August 24, the AOP group will decide the best model for this area, other partners to include in this effort, and joint funding responsibilities for this effort.”

LESSONS LEARNED THUS FAR

- One size does not fit all!
- The entire community has to own and fund the project!
- CSUs are not a silver bullet, but one piece of the solution to a complex problem!
- Questions?