Executive Summary

Purpose and Objectives

Aiken Barnwell Mental Health Center has provided essential behavioral services to the residents of Aiken & Barnwell counties since 1965. In response to decreased funding, increasing treatment needs, healthcare changes and opportunities as a result of the Affordable Care Act, ABMHC conducted a needs assessment to determine the specific needs of both counties for mental health and alcohol and substance abuse services as well as to identify the gaps and barriers in service delivery. The process of the needs assessment attempted to identify, quantify, and describe the strengths and weaknesses of the mental health and alcohol/substance service needs of Aiken & Barnwell County residents. It was anticipated that findings would be useful to the ABMHC, policymakers, planners, providers, consumer and the general public. Our objectives included:

1) To assess the extent of mental health and alcohol/substance abuse problems experienced by Aiken and Barnwell counties and to disseminate information gained from the needs assessment back to the ABMHC Board of Directors, the public and SCDMH.

2) To identify treatment capacity for services in Aiken and Barnwell counties for primary care, mental health and alcohol/substance abuse problems.

3) To identify barriers to access and treatment for Aiken and Barnwell counties residents of all ages.

4) To assess the knowledge and attitudes towards persons with mental illness and substance abuse/addiction problems in Aiken and Barnwell counties.

5) To assess the impact of fiscal issues on the delivery and accessibility of primary care, mental health and substance abuse/addiction treatment services.

6) To obtain an update of resources for information and referral, assessment and treatment of medical, mental health and substance abuse/addiction treatment for Aiken and Barnwell County Residents.

The ABMHC Community Needs Assessment employed multiple methods and data sources to achieve the objectives listed above. The data and findings are described in the following report.
Description of Agency (Mission, Values, Six Pillars of Excellence & Guiding Principles)

Aiken Barnwell Mental Health Center (ABMHC) is a community mental health center providing behavioral health services to families, adults and children who are diagnosed with a mental illness. Intervention, prevention and recovery services may include: Assessment, Therapy, Care-Coordination, Psychosocial Rehabilitation, Peer Support & Community Collaboration. ABMHC serves the residents of Aiken and Barnwell counties, South Carolina, rural communities. Aiken Barnwell Mental Health Center has provided essential behavioral services to the residents of Aiken & Barnwell counties since 1965.

Our Mission
Aiken Barnwell Mental Health Center (ABMHC) aspires to be the premier provider of behavioral services to support the recovery of families, adults and children living in Aiken and Barnwell counties.

Our Core Values
In order to best serve our clients and remain true to our employees, ABMHC embraces the following core values:

Celebrating Diversity- “Respecting the rights, differences, and dignity of others.”

Recovery-“Achieving a high quality, self-directed, satisfying life integrated in the community.”

Quality- “Commitment to Excellence.”

Public Awareness- “Dedicated to increasing the understanding of mental illness and eliminating stigma.”

Collaboration- “Partnering with clients and stakeholders to create healthy communities.”

Technology-“Embracing Technology” to improve efficiency and quality of care.”

The Six Pillars of Excellence
ABMHC adopted the Six Pillars of Excellence- Service, Quality, People, Finance, Growth, and Community- to demonstrate our commitment in making ABMHC the leader in behavioral care in Aiken and Barnwell Counties. The Six Pillars of Excellence are the foundation for our mission and provides the framework to help us align and prioritize operational goals, develop a strategic plan, and communicate our progress and outcomes to our stakeholders.

Quality- ABMHC provides safe, effective and evidenced based behavioral health care that can be defined, measured and published. ABMHC is committed to leading the community in improving health status and access to care. We take pride in what we do.
**Service**- Our job is to exceed customer (clients, families, stakeholders, employees) expectations at every turn thus establishing ABMHC as the preferred provider of choice in Aiken and Barnwell counties.

**People**- We recognize that being the behavioral health care provider and employer of choice means recruiting, developing and retaining a competent, culturally diverse, motivated and productive workforce. Every team member is selected for their leadership, professionalism, expertise, compassion and commitment to the values that set ABMHC apart.

**Finance**- It is our responsibility to provide cost-effective, compassionate care and excellent services to our payers and clients. We will demonstrate fiscal responsibility and accountability to advance our mission and values.

**Growth**- ABMHC is committed to the continual pursuit of new and better ways of serving our customers. We stay abreast of clinical practices and technological advances. We offer continuing education and training for all our team members. We are also a training resource for individuals pursuing mental health careers.

**Community**- ABMHC actively partners with local and regional organizations and service agencies to effectively meet the needs of the community and to increase the public’s awareness of mental health issues, mental health treatment and access to treatment.

**The Nine Guiding Principles**

The Nine Guiding Principles serve as a roadmap for leadership to develop an excellence-based culture and promote the organization’s successes. It’s a step by step process that takes ABMHC where we are to where we want to be.

**Commit to Excellence**
Excellence is when employees feel valued, staff feels their clients are getting great care and the clients feel the service and quality they receive are extraordinary. A commitment to excellence impacts the bottom line while living out the mission and values of the organization. It aligns staff and leaders and put the “why” back in health care. Commitment to excellence means setting measurable goals under each of the Six Pillars.

**Measure the Important Things**
In order to achieve excellence, ABMHC needs to be able to objectively assess its current status as well as progress. Principle 2 helps an organization define specific targets and measurable tools and align the necessary resources to hit those targets. What gets measured gets done.

**Build a Culture around Service**
All successful change requires well thought-out processes that must become the norm or be hardwired in the organization. This principle teaches how to connect services to organizational values- script behaviors, create employee-based service teams, teach service recovery, and develop standards of performance. There is no higher responsibility than to ensure high quality and a caring environment for our clients.

**Create and Develop Leaders**
In order for an organization to be great, it has to have great leaders. Leadership is crucial to sustaining a culture of excellence. This principle teaches how to identify current and future leaders and then how to develop, train, and equip those leaders in a cost-effective manner.
Focus on Employee Satisfaction
The saying, “A chain is only as strong as its weakest link,” holds true within every organization. Every employee is critical to the success of the organization. Satisfied employees do a better job. It's that simple. This principle shows how an organization, by focusing on employee satisfaction, can improve client satisfaction while decreasing costs.

Building Individual Accountability
Principle 6 teaches ABMHC how to create a self-motivated work-force by creating a sense of ownership in the organization.

Align Behaviors with Goals and Values
Through Principle 7, we are shown how to create and implement objective, measurable evaluation systems that are tied to the Six Pillars. The leader’s evaluation must be aligned with the desired outcomes and behaviors via implementation of an objective, measurable leader evaluation tool.

Communicate at ALL Levels
Change occurs when all leaders are aligned and everyone understands what is important, and what they need to do to help accomplish organizational goals. This method speeds up the decision process, creates proactive behavior and improves working relationships. Organizations who apply this principle will find that “Administration” is often viewed in a more positive manner.

Recognize and Reward Success
Everyone makes a difference. Create win-wins for staff and never let great work go un-noticed! Establish real life examples for others to follow.

Approach and Methods
The process of gathering data/information incorporated both qualitative and quantitative methods. Data was gathered many sources including but not limited to: the South Carolina Department of Health and Environmental Control (SCDHEC), Behavior Risk Factor Surveillance System (BRFSS) 2010 Report, Disability and Health in SC- A 2010 Behavioral Risk Factor Surveillance System Report, National Survey on Drug Use and Health (NSDUH-2012), CMHS Uniform Reporting System Output Tables (SAMHSA), South Carolina States in Brief (Substance Abuse and Mental Health Issues At-A-Glance), South Carolina Adolescent Behavioral Health in Brief (SAMHSA), Drug Abuse Warning Network (DAWN-SAMHSA), National Institute of Mental Health (NIMH), South Carolina Department of Mental Health (SCDMH), United States Census Bureau, South Carolina Department of Health and Human Services (DHHS), Department of Alcohol and Other Drug Services (DAODAS), American Hospital Association, America’s Health Rankings and Substance Abuse and Mental Health Services Administration. Additional sources can be found at the end of this report.
A community needs assessment was mailed to two hundred twenty four stakeholders from multiple human service sectors as well as consumers, policy makers, clergy and public safety in Aiken and Barnwell counties. Twenty seven percent completed the survey. Stakeholders were also invited to participate in a community mental health forum at Aiken Barnwell Mental Health Center in November 2012. An additional thirty-three specialized agency needs assessments were mailed specifically to providers of Mental Health services, Alcohol and Drug services and Medical Services to obtain additional information about the current treatment capacities in Aiken and Barnwell Counties. Only 3% completed the survey.

Some of the strengths of the assessment include:

- Behavior Risk Factor Surveillance System (BRFSS) is the world's largest random telephone survey of non-institutionalized population aged 18 or older that is used to track health risks in the United States. In 1981, the Centers for Disease Control and Prevention (CDC), in collaboration with selected states, initiated a telephone based behavioral risk factor surveillance system to monitor health risk behaviors. As of 1993, participation in the BRFSS expanded to include all 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. South Carolina began administering BRFSS in 1984. The basic philosophy is to collect data on actual behaviors, rather than on attitudes or knowledge, that would be especially useful for planning, initiating, supporting, and evaluating health promotion and disease prevention programs. Data is representative of gender, race, age, education, and household income.
- Behavioral Health, United States 2012 is the most recent edition of a publication issued biannually by the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. It provides behavioral health statistics using the most recent data available.
- Health and human service providers from multiple service sectors (e.g. mental health, family services, governmental, healthcare, policy, primary care, clergy, administration, education, treatment providers, legal/law enforcement, judicial) participated in this needs assessment; thus providing information from a diverse group.

Some limitations of the assessment include:

- National and state epidemiological data was utilized; henceforth, we assume that data is representative of Aiken and Barnwell county residents. It should also be noted that the BRFSS data is divided into regional data. Region 5 is inclusive of 6 counties in SC including Aiken and Barnwell counties. Additional information regarding specific limitations with various studies and statistics can be found in individual data reports.
- Although health and human service providers from multiple service sectors participated in the community needs assessment, only 27% of those surveyed actually completed the survey. Only 3% of agencies surveyed provided feedback regarding treatment capacities in Aiken and Barnwell counties thus greatly impacting our ability to determine treatment capacity in both counties.
**County Data**

Aiken County is the fourth largest South Carolina County by land area with a total of 1,073 square miles. It is located near the mid-point of SC’s 250 mile border with Georgia. Barnwell County has a total area of 557 square miles and is located along US route 278. Population data for Aiken and Barnwell counties is outlined in Table 1.

**Table 1: Population Data for Aiken and Barnwell Counties**

<table>
<thead>
<tr>
<th></th>
<th>Aiken County</th>
<th>Barnwell County</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td>162,812</td>
<td>22,360 (1.8% decrease since 2010)</td>
</tr>
<tr>
<td><strong>Persons under 18 years</strong></td>
<td>22.1%</td>
<td>24.8%</td>
</tr>
<tr>
<td><strong>Persons 65 years and over</strong></td>
<td>16.5%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Female persons</strong></td>
<td>51.6%</td>
<td>52.3%</td>
</tr>
<tr>
<td><strong>Minority persons</strong></td>
<td>27%</td>
<td>46%</td>
</tr>
<tr>
<td><strong>Median household income 2007-2011</strong></td>
<td>$43,999</td>
<td>$34,546</td>
</tr>
<tr>
<td><strong>Persons below poverty level</strong></td>
<td>18.5%</td>
<td>26.4%</td>
</tr>
</tbody>
</table>

**Treatment Needs**

**National Data**

According to SAMHSA (December 19, 2013), nearly one in five American Adults or 43.7 million people experienced a diagnosable mental illness in 2012. SAMHSA also reported that less than half (41 percent) of these adults received mental health services in the last year. Among adults with mental illness who reported an unmet need for treatment, the top three reasons given for not receiving help were that they could not afford the cost, thought they could handle the problem without treatment, or did not know where to go for services. SAMHSA further reported that 2.2 million youth aged 12-17 (9.1% of the population) experienced a major depressive episode in 2012. The new findings from SAMHSA also found that 9 million American Adults 18 and older had serious thoughts of suicide in the past year with 2.7 million making suicide plans and 1.3 million attempting suicide. Furthermore, nearly 9 million people are estimated to have both a mental health and substance abuse disorder in their lifetime. Highlights from SAMHSA’s “Behavioral Health United States 2012,” are listed below:

- Among adolescents between 13 and 18 lifetime anxiety disorders are most prevalent (31%) and have the earliest median age of first onset, usually around age 6.
- Behavior disorders (ADHD, Conduct Disorder, and Oppositional Defiant Disorder) are present in approximately 19% of adolescents.
Mood disorders (Bipolar disorder, Major Depressive Disorder) are experienced by approximately 14% of adolescents.

People whose disorder begins earlier rather than later in life are more likely to experience the disorder in adulthood and have more severe symptoms.

Research shows that early initiation of substance use increases the risk for subsequent substance use disorder.

Twenty-five percent of all years of life lost to disability and premature mortality are a result of mental illness.

The top reason for not getting treatment for substance use disorders is that people do not think they need it. Other reasons include: not ready to stop using, fear of having negative effect on job, and fear of negative judgments from neighbors/community.

The 2012 National Survey on Drug Use and Health (NSDUH) revealed the following:

- An estimated 23.9 million Americans (9.2% of population) aged 12 or older were current (past month) illicit drug users. Illicit drugs include marijuana/hashish, cocaine/crack, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics (pain relievers, tranquilizers, stimulants and sedatives) used non-medically.
- Marijuana is the most commonly used illicit drug. In 2012, there were 18.9 million past month users.
- More than half of Americans aged 12 or older reported being current drinkers of alcohol. This translates to 135.5 million current drinkers in 2012.
- 23.1 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem. Only 2.5 million received treatment at a specialty facility; therefore, 20.6 million persons needing treatment did not receive treatment at a specialty facility in the past year.

National Vital Statistics indicated there were 38,285 suicide deaths in 2011 and that suicide was the 2nd leading cause of death for adults aged 15-24 (DAWN).

Pharmaceuticals were involved in 94.9% of emergency room visits for drug-related suicide attempts (DAWN).

By applying prevalence rates from national data to the 2010 US Census, it is estimated that 25,366 adults in Aiken County and 3362 adults in Barnwell county would be diagnosed with a mental illness.

**State Data**

The BRFSS Survey Results 2010 for South Carolina (Region 5) data revealed the following from those surveyed:

- 7.2% indicated their health was poor.
- 16.7% indicated there was a time in the past 12 months when they needed to see a doctor but could not because of cost.
17.9% indicated they did not have any kind of health care coverage, including health insurance, prepaid plans such as HMO’s, or government plans such as Medicare.

48.3% indicated that poor physical or mental health kept them from doing their usual activities such as self-care, work, or recreation between 1-30 days during the past 30 days.

31.4% indicated that their mental health was not good between 1-30 days during the past 30 days.

14% indicated they were told by an MD or healthcare provider that they have a depressive disorder and 10.6% indicated they were told by an MD or healthcare provider that they have an anxiety disorder.

4.1% surveyed are at risk for heavy alcohol consumption (having greater than 2 drinks per day for men and 1 drink per day for women).

In September 2013, The South Carolina Department of Alcohol and Other Drug Services (DAODAS) estimated that 315,000 individuals in South Carolina are suffering from substance abuse problems that require immediate intervention and treatment. DAODAS met this need for 47,077 or 15% of South Carolinians in FY13.

The South Carolina Department of Mental Health (FY13) served 90,000 children, adolescents, adults, and families providing a total of 1,157,751 clinical contacts to persons served. This is approximately 10% of the estimated South Carolinians who are diagnosed with mental illness.

According to the South Carolina Violent Death Reporting System (SCVDRS/SCDHEC), suicide was the eleventh leading cause of death among SC residents for years 2003-2005. Suicides accounted for 1.3% of all deaths in SC. Suicide was the seventh leading cause of death for SC males and the sixteenth leading cause of death for SC females. The age group with the highest rate of suicide death is 45-54 and 75-84 years. Among SC suicides with toxicology tests (905) being conducted, 34% tested positive for alcohol; 16.6% for antidepressants; 12.3% for cocaine; 11.5% for opiates; 8.3% for marijuana; and 5.5% for amphetamines.

South Carolina is ranked forty-second according to America’s Health Rankings 2013. SC ranks 42nd for obesity rates, 49th for diabetes, and 39th for smoking. In the past five years children who are living in poverty has increased from 15.6% to 26.3% for persons under age 18.

Based on data, it is evident that South Carolina State Agencies (SCDMH and SCDOADAS) are only providing services to a small percentage of those in need of treatment for mental health and/or substance abuse issues.

**Local Mental Health & Substance Abuse Data**

From July 1, 2012-June 30, 2013 (FY 13), Aiken Barnwell MHC served a total of 4520 people with an average caseload of 2247 clients. Sixty-three percent were diagnosed with a major mental illness. Of those open cases approximately 55% were female; 57% were white; 33% were ages 0-17; 67% were ages 18 and older. From July 1, 2012-June 30, 2013, a total of 59,
602 clinical client contacts were provided in regards to the following clinical services: Crisis intervention services, Mental Health assessment, Psychiatric Medical Services, Case-Management, Individual Therapy, Peer Support Services, Psychosocial Rehabilitation Services, Group Therapy, Nursing Services, and Family Support.

ABMHC (FY 13) had a total of 23 inpatient admissions (2947 bed days) to the following inpatient facilities: Bryan Psychiatric Hospital (BPH), William S Hall Psychiatric Institute Children and Adolescent Hospital (WSHPI-C&A), William S Hall Psychiatric Institute- Residential Treatment Facility (WSHPI-RTF), William S Hall Psychiatric Institute- Substance Abuse (WSHIP-SA) and Earl E Morris Jr Alcohol and Drug Addiction Treatment Center.

Based on ABMHC’s statistics in comparison with national trends, ABMHC would have only provided services to approximately 10% of such adults leaving 90% to be untreated and/or seeking treatment from another provider.

According to DAODAS there were a total of 1285 persons admitted to services in Aiken County during calendar year 2012 due to Alcohol, Cocaine, Marijuana, Methamphetamine and Opiate Use/Abuse. Barnwell County had 255 admissions. It should be noted that there was a 36.4% increase in opiate admissions from 2011. Based on state data, only 15% of persons needing substance abuse treatment in Aiken County received it and less than 7% in Barnwell county received treatment.

In 2010, the suicide rate in Aiken County was 14.4% (per 100K). Aiken County is on pace for 20 suicides this year, which would put it at 14.2 suicides per 100,000 above the national average. Because of the high rate of suicides in Aiken County, Mental Health America-Aiken County and the Aiken Center for Alcohol and Drug Services initiated a Suicide Coalition which is designed to eliminate suicide through education and collaboration in Aiken County. Representatives from various human service agencies participate in this collaboration.

**Access & Utilization**

SAMHSA (Behavioral Health United States 2012) available data suggest that most mental health and substance abuse treatment does not meet guidelines to be minimally adequate. Rates of minimally adequate treatment are highest in the specialty mental health sector and lowest in the general medical care sector. Less than one-third of adults get minimally adequate care. Recent research suggests that a majority of children and adolescents with mental health or substance use disorders do not receive treatment.

Southern Palmetto Hospital (BHC) reported serving more than 12,000 persons annually via the emergency department. In September 2013, Kay Atkins, Southern Palmetto Hospital (BHC) reported approximately fifteen to twenty emergency room visits per month for persons diagnosed with mental illness. She further noted that the majority have a co-occurring disorder. Hospitalizations are due to: non-compliance with medications for persons diagnosed with Schizophrenia; substance abuse; major depression, and anxiety and adjustment issues with life stressors. A high prevalence of behavioral health conditions exists for Barnwell County.
Aiken Regional Medical Center (ARMC) reported serving approximately 48,000 annually via the emergency department. As part of the healthy outcomes plan application for SCDHHS, Aiken Regional Medical Center indicated the following, “the population with the highest disease prevalence in Aiken County as identified by the environmental scan, are patients with behavioral health conditions.” Upon further review of information specific to uninsured patients with behavioral health conditions, ARMC found that these ED behavioral patients often required inpatient treatment at Aurora Pavilion (ARMC’s inpatient facility) or acute hospitalization. From April 1, 2012-March 31, 2013, behavioral health patients averaged two emergency department encounters and one in-patient psychiatric facility stay. The average cost per patient typically exceeded $15,000. In addition, data showed recurrent contacts via emergency department or readmissions to a psychiatric facility. Geographical portions of Aiken County (Graniteville, Jackson, Langley, North Augusta, Warrenville, Windsor, and Wagener) are identified areas for a high prevalence of behavioral health conditions.

Stakeholders surveyed felt the following groups have more difficulty than others accessing services: persons living in rural areas, persons who are homeless, persons diagnosed with co-occurring disorders (mental illness and substance abuse) and offenders. Stakeholder felt that the following groups were not served well at all in regards to mental health treatment and substance abuse treatment: persons who are homeless, persons of Hispanic and Latino ethnicity and persons who are physically disabled or chronically ill.

Stakeholders felt the following services are needed for mental health treatment and support: Supportive services, Case-Management, Crisis treatment, Housing/Residential, Community outreach, Long-Term Hospitalizations, Counseling for non-chronically Ill, Medication, Education, Marriage and family counseling and pastoral counseling. Other programs recommended for development and/or expansion included: Case-management, Crisis-management, Housing, Integration, Counseling/Treatment, Inpatient Services, Education, School Based Services, Cognitive Behavioral Therapy and Drop-In Centers.

It should be noted that the majority of stakeholders felt that the following five services were particularly helpful and should be expanded:

- Inpatient Services
- Housing
- Counseling/Therapy
- Case-Management
- Integration of Services

Stakeholders felt the following services are needed for alcohol and drug treatment and support: detoxification, medication management, education for youth, detoxification facility for the uninsured, housing, more counseling resources, increase in consumer buy-in, prevention, maintenance, retention, and more inpatient facilities.
Stakeholders felt the following services are needed for medical care: case-management services, medical monitoring in collaboration with other mental health providers within the community, and referrals to specialists and dental care.

**Treatment Capacity**

According to SAMSHA’s 2012 Behavioral Health United States report, in 2011 there were 2.1 child and adolescent psychiatrists (across the United States) per 100,000 people and 62 clinical social workers per 100,000 people. In 2010, there were 10,374 specialty mental health treatment facilities and 13,339 specialty substance abuse treatment facilities in the United States. In 2009, South Carolina had the following mental health and substance treatment providers: 111 child and adolescent psychiatrists (2.4% per 100K) and 381 psychiatrists (8.4% per 100k). In 2011, SC had 1241 clinical social workers, 726 Substance Abuse Counselors and 2100 Counselors. Aiken and Barnwell Counties both have very limited behavioral resources especially for persons who are un-insured or receiving Medicaid.

Figure 1 illustrates the percentage of and type of services provided by stakeholders responding to the agency survey. Respondents noted they also provided the following services: Domestic Abuse, Dating Violence, Stalking, Sexual Abuse, Elder Abuse, Housing, Prevention Awareness and Marriage and Family Issues.

**Figure 1: What types of mental health services do you provide?**

Aiken and Barnwell Counties have limited medical resources for persons who are un-insured. SCDHHS reported that prior to the Affordable Care Act, 17% of South Carolinians are uninsured. With Medicaid expansion, South Carolina could see an additional 513,000 persons enrolled in
Medicaid by 2015. Based on national data and trends and population data for SC, an estimated 130,000 persons will need behavioral health services. By 2015, over half a million people will gain access to affordable health insurance coverage as defined under the new health care law, even without Medicaid expansion. The system will have a difficult time absorbing this growth—it may require between 250-300 full-time physician equivalents.

**Barriers to Treatment in Aiken and Barnwell Counties**

Stakeholders reported six significant barriers to getting help or treatment in Aiken and Barnwell Counties. It should be noted that the barriers reported are representative of national data.

- Cost
- No insurance
- Client does not know where to get help.
- Client does not recognize need for help.
- No transportation.
- Basic needs are unmet and prohibits client from focusing on treatment or healthcare needs.

ARMC noted additional barriers to healthcare in their healthcare proviso application (2013). A major barrier to gaining access to follow-up care is the wait times for obtaining a follow-up appointment following their post-acute episode. Many agencies reported limited staffing to meet the demand for services. Furthermore office times are limited to business hours only. Aurora Pavilion shows a higher correlation of ED visits during the evenings and weekends when patients have no other access to care.

Another significant barrier is a patient’s inability to navigate the referral process for care including knowing how to complete applications and required paperwork. An additional common barrier is obtaining affordable care. Although some agencies offer payment plans or reduced fees based on incomes, patients cannot afford medications, diagnostic work-up, or referrals to specialists when needed.

**Financial Issues**

Mental health and substance abuse disorders are among the leading causes of disability in the United States. The symptoms of behavioral health disorders may affect a person’s ability to function each day thus impacting interpersonal relationships, ability to find and sustain employment, ability to complete work or school assignments and/or care for themselves or their families.

In FY2010, South Carolina state mental health agency revenues totaled 286 million dollars. State general funds accounted for 44.9%; Medicaid for 47% and Medicare/Block Grant/other federal/local/other for 8.2%. In FY2010, South Carolina State Mental Health Agency expenditures totaled 286 million dollars. State Psychiatric hospitalizations (inpatient) accounted
for 34.9%, Community mental Health Centers accounted for 59.3% and the state mental health agency central office for 5.9%.

Local agency personnel rated their current ability to meet demand for services compared to 5 years ago (Figure 2) and their ability to meet the demand for services in the next five years (Figure 3). At least forty percent surveyed felt that state reductions have impacted service availability to the residents of Aiken and Barnwell counties.

Figure 2: Agency’s ability to meet demand for services (compared to 5 yrs. ago)

![Figure 2: Agency’s ability to meet demand for services (compared to 5 yrs. ago)](image)

Figure 3: Agency’s ability to meet demand (next 5 years)

![Figure 3: Agency’s ability to meet demand (next 5 years)](image)

As noted earlier, the BRFSS Survey Results 2010 SC (Region 5) 17.9% of those surveyed indicated they did not have any kind of health care coverage, including health insurance,
prepaid plans such as HMO’s, or government plans such as Medicare. This increases to 38.7% for those with income less than $15,000.

Forty-eight percent of clients served at ABMHC have Medicaid. Thirty-four percent have no type of health insurance and self-pay for mental health services. Figure 4 below illustrates the payor sources for ABMHC.

![Figure 4: Payor Sources at ABMHC](image)

In its report “State Mental Health Cuts: A National Crisis (2011), the National Alliance for the Mentally Ill (NAMI) reported that the South Carolina Department of Mental Health’s budget was dramatically cut $73.6 million dollars from fiscal years 2009-2012. This resulted in a 39.3% budget cut which put SCDMH’s funding at 1987 levels. SCDMH faced more cuts than any other state run mental health department in the United States. SCDMH challenged NAMI’s report citing additional funding sources such as grants which actually decreased spending by $30 million. Due to budget cuts, SCDMH lost 460 workers (10% of employees). Employees were also furloughed. SCDMH closed or consolidated Community Mental Health Centers forcing patients to travel further distances to get services. SCDMH closed five residential care facilities and lost forty beds. For FY 2009, per capita mental health state spending was $60.24.

As a result of budget cuts, mental health shifted resources to primarily treat clients with serious mental illness receiving Medicaid. July 2008- January 2013, Aiken Barnwell Mental Health Center primarily treated adults and children with serious mental illness. Unfortunately this left clients not diagnosed with serious mental illness and/or without Medicaid with little options for behavioral healthcare. Emergency departments, homeless shelters and jails struggled with the effects of people not receiving treatment and support. Emergency departments had to “board” some clients, thus keeping them in the Emergency Room until an inpatient bed could be found.
Although SCDMH did receive $18.7 million increased funding for FY2014, SCDMH is not funded at the level it needs to be funded in order to effectively treat the behavioral needs of persons diagnosed with mental illness. Aiken Barnwell Mental Health Center received $1000 in county funding from Aiken and Barnwell County Councils for FY 2014.

**Knowledge, Attitudes and Beliefs of Aiken and Barnwell Counties**

**Stakeholders**

Stakeholders felt like the most important thing that the community needs to understand about people with mental health or alcohol/substance abuse problems is “how and where to access treatment.”

Stakeholders recognized the impact that mental health and substance abuse issues have on with public safety being significantly ranked first, impairment on the quality of life of individuals and families being ranked second and meeting basic needs and interpersonal problems being ranked third. The ability to obtain or manage finances, health problems, legal problems and stigma were frequently cited as well.

**Conclusions and Recommendations**

The process of this needs assessment attempted to identify, quantify and describe the strengths and weaknesses of the mental health and alcohol/substance service needs of Aiken and Barnwell County residents. The findings will be useful to Aiken Barnwell Mental Health Center, policymakers, planners, providers, potential funding agencies, consumers and the general public. The following conclusions and recommendations are directed to Aiken-Barnwell Mental Health Center Executive Management Team.

1) Based on national data and trends, approximately 25,366 adults (Aiken County) and 3362 adults (Barnwell County) would suffer from a diagnosable mental disorder in any given year with less than 41% receiving treatment for it. Based on state data and trends, approximately 8410 adults in Aiken County and 225 adults in Barnwell county would need treatment for substance abuse with only a very small percentage receiving treatment for it. Based on ABMHC’s statistics in comparison with national trends, ABMHC would have only provided services to approximately 10% of such adults leaving 90% to be untreated and/or seeking treatment from another provider. Based on the fact that Aiken Barnwell Mental Health Center is the largest provider of mental health services to clients that are un-insured or receiving Medicaid in Aiken and Barnwell counties, the assumption can be made that there is a large percentage of adults with mental illness not receiving treatment. Most likely due to cost, lack of insurance, lack of transportation, lack of knowledge of where to get help and inability to recognize the need for help.

It is recommended that ABMHC use their expertise to educate the public about mental health issues in general, how, where and why to access mental health services, the
benefits of treatment and to emphasize that recovery is possible. It is also recommended that due to the high prevalence of co-occurring disorders (Mental illness and substance abuse) that ABMHC expand services offered to persons with co-occurring disorders.

2) Major barriers to mental health treatment included: Cost, lack of transportation, and basic needs being unmet which prevented clients from focusing on behavioral healthcare treatment. It is recommended that ABMHC educate the public about the affordability of behavioral health services and access to care-coordination services at ABMHC. Furthermore, ABMHC should advocate with local transportation providers to increase availability of transportation in rural areas and explore additional options for transportation.

3) It is important for ABMHC to have on-going discussions with community stakeholders to prioritize the development and expansion of needed services as well as to educate stakeholders about current services offered as it is apparent there is some misperception about current operations. This may include the development and expansion of integrated services and school-based services thus resulting in a “no wrong door” approach for persons seeking behavioral services. This includes the expansion of integrated services with primary care physicians. This may be an option to serve a number of people who have lost services when programming was eliminated and/or serve people who will not come to the mental health center. It is recommend that ABMHC set up collaborative educational meetings with stakeholders to educate about current services and operations to include policies regarding eligibility, referral, screening, costs and treatment services as well as to build partnerships with stakeholders to enhance continuity of care and quality of life in Aiken and Barnwell Counties.

4) In the process of generating county-level and state level funding for the support, development and expansion of services, there are a number of components that should be considered:
   - Improve data collection and outcome measurements for mental health services
   - Educate policy makers about mental health services and the needs of persons with mental health needs
   - Require mandatory quality improvement reporting and outcome evaluation of services to incorporate consumer satisfaction
   - Report data outcomes for mental health services to stakeholders
5) Based on the findings of the needs assessment, some priority areas for direct service delivery expansion and development include:

- Outreach and increased accessibility for persons living in rural areas, persons who are homeless, persons of Hispanic/Latino ethnicity, offenders and persons diagnosed with co-occurring disorders (mental illness and substance abuse)
- Expansion of Care-Coordination Services to assistance with basic needs especially housing and transportation
- Expansion of counseling and therapy services
- Availability of inpatient treatment
Data Resources


“Public Mental Health In South Carolina.” South Carolina Department of Mental Health. 1 November 2013. WEB. December 18, 2013. http://www.state.sc.us/dmh/dmh_presentation.pdf


https://www.scdhec.gov/administration/phsis/biostatistics/brfss/brfss2010.htm

