



Characteristics of Substance Use Disorder and Mental Health Disorder Treatment Facilities with Perinatal Programs

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Background

Substance use disorders (SUD) and mental health disorders (MHD) are prevalent health concerns during the perinatal period. Approximately 15% of individuals in the perinatal period meet the criteria for a SUD, and 20% have been diagnosed with a MHD (Moore et al., 2021; Smid & Terplan, 2022). Both conditions, whether occurring separately or together, have severe and lasting health and social effects for both parents and children (Chang, 2020; Van den Bergh et al., 2020). Evidence suggests that SUD and MHD treatment for individuals in the perinatal period is associated with positive outcomes for parents and children, including increased engagement in prenatal care, reduced rates of preterm birth and low birth weight, and decreased risk of postpartum overdose (Howard & Khalifeh, 2020; Meinhofer et al., 2022; Schiff et al., 2018). Yet, significant barriers within the health, behavioral health and social care systems limit access to perinatal SUD and MHD treatment. These barriers include the need for integrated behavioral health and perinatal care, childcare, prioritizing the parent/child dyad staying together, transportation assistance, insufficient insurance coverage, stigma, and punitive state policies related to substance use, which can subject pregnant individuals to legal risks if they seek help for a SUD (Frazer et al., 2019; Kozhimannil et al., 2019; Moore et al., 2021, 2021; Webb et al., 2021).

To effectively address substance use and mental health issues during the perinatal period, treatment approaches must be responsive to the unique challenges faced by this population. Treatment facilities that offer perinatal programs catering specifically to the needs of individuals in the perinatal period have the potential to enhance access to care and mitigate the long-term consequences of SUDs and MHDs. However, there is limited knowledge about the proportion of SUD and MHD treatment facilities in the United States (US) that offer specialized programs for this population and the types of services these facilities provide.

Research Questions

1. What proportion of SUD or combined SUD/MHD facilities in the US offer specialized programs for individuals in the perinatal period?
2. What are the characteristics of the facilities that offer perinatal programs, including essential services for this population (e.g., childcare, beds for clients' children), types of treatment settings, geographic distribution by state, accepted payment types, and type of ownership?

Methods

The data for this study was drawn from the 2022 National Substance Use and Mental Health Services Survey (N-SUMHSS), an annual survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) (SAMHSA, 2021). The sample included SUD facilities (N=6,995) and facilities offering both SUD and MHD services (N=9,134). Our dependent variable was whether facilities offered a perinatal program and our independent variables were facility-level characteristics: if Medicaid was accepted; if private insurance was accepted; if low cost or free treatment was offered; for-profit ownership; non-profit ownership; receipt of federal or state grant funding; and whether facilities provided specific services, including detoxification services, integrated primary care, childcare, beds for clients' children, transportation assistance, social service assistance, trauma-related therapy, and telehealth. Descriptive statistics were calculated to summarize the characteristics and services available at both SUD facilities and combined SUD/MHD facilities that reported offering pregnancy or postpartum services. Two-tailed chi-square tests were employed to examine the bivariate relationships between variables.

Key Findings

SUD Facilities with Perinatal Programs

Among SUD-only facilities, 32.7% (n=2,288) reported offering a perinatal program. The characteristics of these facilities are detailed in Table 1. Of the facilities with perinatal programs, 81.7% (N=1,870) were outpatient, 23.9% (N=546) were residential, and 4.4% (N=100) were inpatient. States with the highest number of SUD facilities per 100,000 females aged 14-45 were New Hampshire (5.9 per 100,000), Kentucky (3.3 per 100,000), and Montana (3.1 per 100,000), while Texas (1.0 per 100,000), Wyoming (0.9 per 100,000), and Wisconsin (0.9 per 100,000) had the fewest (Figure 1). More than half of SUD-only facilities offering perinatal programs were owned by a for-profit organization (N=1,238 [54.1%]) as compared to non-profit organizations (N=912 [39.9%]). Additionally, just over a quarter received federal and/or state grant funding (N=610 [26.7%]). In relation to the types of payment accepted by the facilities, 80% (N=1,831) accepted Medicaid, 77.8% (N=1,781) accepted private insurance, and 40.4% (N=924) offered low-cost or free treatment services. Results varied widely for facilities that included services essential to the perinatal population—a limited number of facilities offered detox (N=729 [31.9%]), integrated primary care (N=480 [20.9%]), childcare (N=260 [11.4%]), or beds for clients' children (N=201[8.8%]), whereas a higher proportion of facilities offered transportation assistance (N=1,178 [52.2%]) assistance with accessing social services (N=1,850 [80.9%]), trauma related therapy (N=1,600[69.9%]), and telehealth (N=1,725 [75.4%]).

SUD/MHD Facilities with Perinatal Programs

Among combined SUD and MHD facilities, 31.1% (N=2,844) reported offering a perinatal program. The characteristics of these facilities are detailed in Table 1. Of the facilities with perinatal programs, 90% (N=2,558) were outpatient, 15.7% (N=446) were residential, and 6.9% (N=197) were inpatient. States with the highest number of SUD/MHD facilities per 100,000 females aged 14-45 were Alaska (6.5 per 100,000), Wyoming (6.0 per 100,000), and Kentucky (5.9 per 100,000), while North Dakota (0.6 per 100,000), Texas (0.6 per 100,000), and South

Carolina (0.2 per 100,000) had the fewest (Figure 2). In contrast to the SUD-facilities, most of the combined SUD/MHD facilities offering perinatal programs were owned by a non-profit organization (N=1,316 [46.3%]) as compared to for-profit organizations (N=1,191 [41.8%]). Additionally, just over one-third received federal and/or state grant funding (N=1,055 [37.1%]). In relation to the types of payment accepted by the facilities, 82.8% (N=2,355) accepted Medicaid, 88.9% (N=2,530) accepted private insurance, and 55.8% (N=1,583) offered low cost or free treatment services. Results varied widely for facilities that included services essential to the perinatal population—a limited number of facilities offered detox (N=693 [24.3%]), integrated primary care (N=1,092 [38.4%]), childcare (N=256 [7.9%]), or beds for clients' children (N=115 [4.0%]), whereas a higher proportion of facilities offered transportation assistance (N=1,590 [56.3%]), assistance with accessing social services (N=2,282 [80.2%]), trauma-related therapy (N=2,574 [90.5%]), and telehealth (N=2,574 [87.0%]).

Policy Implications

Only one-third of SUD and SUD/MHD facilities in the US offer perinatal-focused programs, suggesting there are significant gaps in availability of behavioral health services for perinatal individuals. The lack of facilities that offer perinatal focused programs in the US is likely associated with the lack of treatment utilization by perinatal populations. In addition to a limited number of facilities, facilities that do offer perinatal services are unequally distributed in the US, with significant state variation from 0.8 to 5.9 facilities per 100,000 perinatal-aged women in the population. In order to increase behavioral health treatment for perinatal populations, targeting policy interventions that increase perinatal facilities offering specialized programs is imperative.

Understanding factors that promote facilities offering perinatal focused services is needed. Facilities that offered perinatal programs were significantly different than facilities that did not. Facilities that offered perinatal programming were more likely to accept Medicaid, be owned by for-profit entities, and receive grant funding. Yet the directionality of these characteristics with perinatal services is unclear, and more research is needed to assess whether grant funding increases the ability of facilities to expand services—like perinatal-focused services—and if settings that offer perinatal facilities may be more competitive for grants. Future work should also examine if state policies, payment, and workforce characteristics promote facilities offering perinatal services. This study did not find an association between states having expanded postpartum Medicaid or states' substance use and/or suicide rates with facilities offering perinatal programs. Given this study did not assess changes over time, future studies could examine if policies impact changes over time.

Facilities that offer perinatal programs appear to offer more services that would be helpful for those who are pregnant and/or postpartum. Specifically, facilities that offered perinatal services were more likely to offer childcare, transportation assistance, and coordination of other social services. Although they were more likely to offer these services, most facilities did not have childcare or beds for clients' children. Future work could examine policies that include perinatal programs within treatment facilities to ensure patients have access to the services parents require to recover and sustain recovery.

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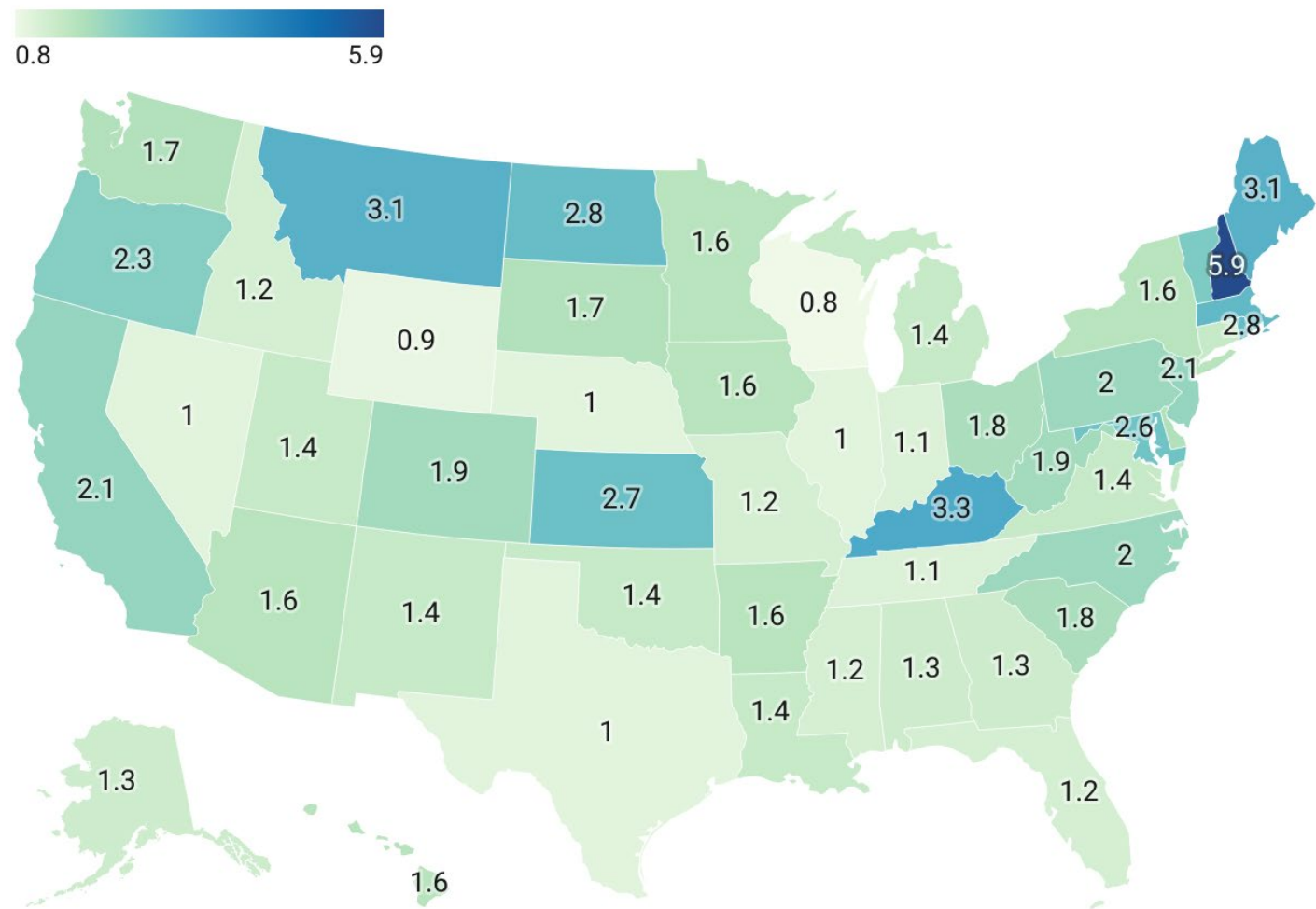
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Table 1. Characteristics of substance use and mental health facilities with and without perinatal programs

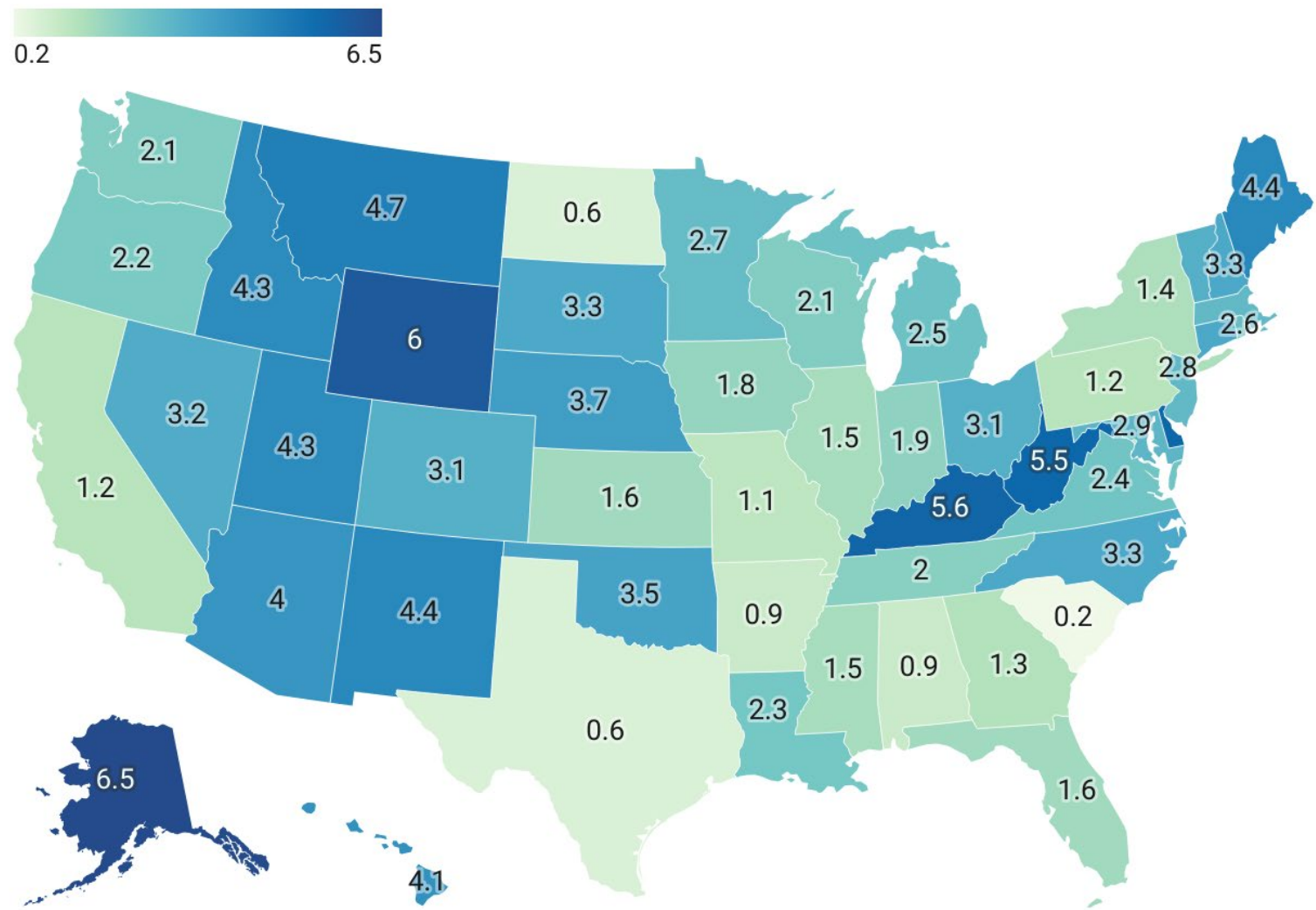
Variable	SUD Facilities			SUD/MHD Facilities		
	With Perinatal Programs (N=2,288)	All SUD Facilities (N =6,995)	Chi-square P value	With Perinatal Programs (N =2,844)	All MH/SUD (N =9,134)	Chi-square P value
	N (%)	N (%)		N (%)	N (%)	
Medicaid accepted	1,831 (80.0)	2,906 (63.2)	*	2,355 (82.8)	4,878 (79.8)	*
Private insurance accepted	1,636 (71.5)	2,940 (64.)	*	2,530 (88.9)	4,945 (80.9)	*
Low cost or free treatment services	924 (40.4)	1, 895 (41.2)		1,583 (55.8)	3,122 (51.3)	*
For-profit ownership	1,238 (54.1)	2,012 (43.7)	*	1,191 (41.8)	3,122 (51.3)	*
Non-profit ownership	912 (39.9)	2,295 (49.9)	*	1,316 (46.3)	3,223 (54.7)	*
Grant funding received	610 (26.7)	855 (18.6)	*	1,055 (37.1)	3,230 (68.6)	*
Outpatient Facility	1,870 (81.7)	3,320 (72.2)	*	2,558 (90.0)	5,373 (87.6)	*
Residential Facility	546 (23.9)	1,598 (34.7)	*	446 (15.7)	1,001 (16.3)	
Inpatient Facility	100 (4.4)	290 (6.3)	*	197 (6.9)	412 (6.73)	
Detoxification provided	729 (31.9)	919 (19.9)	*	693 (24.3)	1,057 (17.3)	*
Integrated-primary care provided	480 (20.9)	1,000 (22.1)		1,092 (38.4)	2,003 (32.9)	*
Childcare offered	260 (11.4)	115 (2.6)	*	256 (7.9)	135 (2.2)	*
Beds for clients' children available	201 (8.8)	48 (1.1)	*	115 (4.0)	53 (0.9)	*
Transportation assistance	1,178 (52.2)	2,166 (47.8)	*	1,590 (56.3)	2,895 (47.6)	*
Social service assistance	1,850 (80.9)	3,145 (70.0)	*	2,282 (80.2)	2,282 (81.9)	*
Trauma-related therapy offered	1,600 (69.9)	3,008 (43.0)		2,574 (90.5)	5,170 (56.6)	
Telehealth offered	1,725 (75.4)	3,045 (43.5)		2,475 (87.0)	4,997 (54.7)	
Facility located in state with postpartum Medicaid expanded	1,552 (67.9)	3,153 (69.2)		1,847 (65.1)	4,048 (66.4)	

Figure 1. Substance Use Facilities with Perinatal Programs in 2022 in the United States per 100,000 Women Aged 14-45



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Figure 2. Substance Use and Mental Health Facilities with Perinatal Programs in 2022 in the United States per 100,000 Women Aged 14-45



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