Characteristics of For-Profit Owned Versus Non-Profit Owned Behavioral Health Facilities with Perinatal Programs

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INTRODUCTION

Perinatal Mental Health And Substance Use Disorders

- Between 10-20% of women experience a perinatal (i.e., conception to one-year postpartum) mental health disorder[1]
- Up to 30% of women reported consuming alcohol at any point during pregnancy and 5% of pregnant women reported nonmedical opioid use[2]
- Overdose and suicide are the leading causes of death during the perinatal period[3]

Support Services and Ownership Trends

- To effectively address substance use disorders (SUDs) and mental health disorders (MHDs) during the perinatal period, treatment facilities should provide:[4]
  - Prenatal care tailored to individuals with SUDs and MHDs
  - Affordable or low-cost treatment options
  - On-site childcare to reduce barriers to access
  - Housing that accommodates the parent/child dyad
- These supports are more commonly found in non-profit (NP) owned facilities[5]
- However, there has been a significant rise in for-profit (FP) ownership of behavioral health facilities over the past decade, raising concerns about the availability of these essential services

The impact of this shift on the provision and quality of perinatal SUD and MHD care is not fully understood.

RESEARCH QUESTIONS

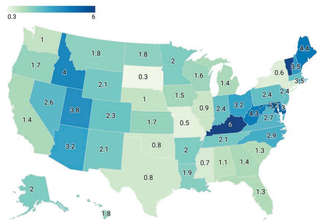
To characterize trends in combined substance use treatment and mental health treatment facilities, this study:

1) Examined the proportion of FP- and NP-owned facilities offering perinatal programs and their prevalence by state
2) Compared the perinatal supports provided by these facilities

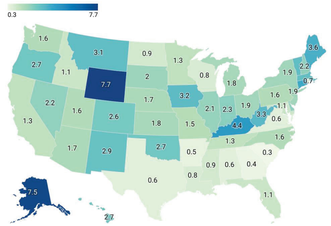
METHODS

- This study utilized data from the 2023 National Substance Use and Mental Health Services Survey (N-SUMHSS), a cross-sectional survey of SUD and MHD treatment facilities in the United States (U.S.)
- FP- and NP-owned SUD and MHD facilities offering perinatal programs (PPs) were identified and their state prevalence per 100,000 females aged 14 to 45 was estimated using U.S. Census Bureau data
- Descriptive analyses were conducted to compare the differences between FP- and NP-owned facilities in terms of their provision of essential perinatal supports
- Multilevel logistic regression models with random intercepts were used to assess how the provision of perinatal supports influenced the likelihood of facilities offering perinatal programs
- Facilities were nested within states to account for clustering, and analyses were conducted using Stata version 17

Substance Use and Mental Health FP Facility Ownership per 100,000 Females Aged 14-45



Substance Use and Mental Health NP Facility Ownership per 100,000 Females Aged 14-45



RESULTS

- From 2021 to 2023, the number of FP facilities offering PPs increased by 18.6% (from *n* = 2,129 to *n* = 2,526)
- In 2023, a similar number of NP-owned (*n* = 2,193; 46.5%) and FP-owned (*n* = 2,526; 53.5%) facilities offered PPs
- States with the highest prevalence of facilities offering PPs per 100,000 females aged 14 to 45:
  - NP-owned: Alaska (7.5), Wyoming (7.7)
  - FP-owned: Kentucky (6.0), Vermont (5.9)

Association of FP and NP Substance Use And Mental Health Facility Characteristics with Having a Perinatal Program

	FP facilities with perinatal programs (N=2,526)			NP facilities with perinatal programs (N=2,193)		
Facility-level characteristics	n of facility responses	n (%)	OR (95% CI)	n of facility responses	n (%)	OR (95% CI)
Low cost or free treatment	2,520	618 (24.5)	.19 (.16, .24)***	2,189	1,432 (65.4)	5.1 (4.2, 6.1)***
Detoxification	2,526	823 (32.6)	3.1 (2.5, 3.9)***	2,192	364 (16.6)	.32 (.26, .40)***
Integrated-primary care	2,503	660 (26.4)	.74 (.61, .90)**	2,186	817 (37.4)	1.3 (1.1, 1.6)***
Beds for clients' children	2,501	20 (.80)	.13 (.06, .28)***	2,184	270 (12.4)	7.8 (3.6, 16.6)***
Transportation assistance	2,503	987 (39.4)	.43 (.35, .52)***	2,185	1,504 (68.8)	2.3 (1.9, 2.8)***

*<.05, **<.01, ***<.001

CONCLUSIONS

- Ownership type appears to influence the availability of perinatal SUD and MHD treatment services
- NP ownership may support more comprehensive care models that are responsive to the needs of vulnerable perinatal populations
- In contrast, FP facilities may prioritize financial outcomes, potentially limiting the scope of perinatal care offered
- A key limitation of this study is the use of the N-SUMHSS dataset, which does not capture all for-profit facilities nationwide
- As FP ownership continues to expand across the U.S., future research should incorporate more comprehensive data to examine how financial priorities affect the availability and quality of perinatal services

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FUNDING STATEMENT & REFERENCES

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1. Van Niel MS, Payne JL. Perinatal depression: A review. Cleve Clin J Med. 2020;87(5):273-277. doi:10.3949/ccjm.87a.190542
2. Kozhimannil KB, Graves AJ, Levy R, Patrick SW. Nonmedical Use of Prescription Opioids among Pregnant U.S. Women. Womens Health Issues. 2017;27(3):308-315. doi:10.1016/j.whi.2017.03.001
3. Davis NL, Smoots AN, Goodman DA. Pregnancy-Related Deaths: Data from 14 U.S. Maternal Mortality Review Committees, 2008-2017. Published online 2017. Accessed August 22, 2024. https://archive.cdc.gov/www_cdc_gov/reproductivehealth/maternal-mortality/erase-mm/MMR-Data-Brief_2019-h.pdf
4. Webb R, Uddin N, Ford E, et al. Barriers and facilitators to implementing perinatal mental health care in health and social care settings: a systematic review. Lancet Psychiatry. 2021;8(6):521-534. doi:10.1016/S2215-0366(20)30467-3
5. Moon J, Shugan SM. Nonprofit Versus For-Profit Health Care Competition: How Service Mix Makes Nonprofit Hospitals More Profitable. J Mark Res. 2020;57(2):193-210. doi:10.1177/0022243719901694.
6. Brown B, O'Donnell E, Casalino LP. Private Equity Investment in Behavioral Health Treatment Centers. JAMA Psychiatry. 2020;77(3):229. doi:10.1001/jamapsychiatry.2019.3880