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Substance use disorder treatment services for pregnant and postpartum women in residential and outpatient settings

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Abstract

The increasing prevalence of opioid use disorders among pregnant and postpartum women (PPW) has generated a need for greater availability of specialized programs offering evidence-based and comprehensive substance use disorder treatment services tailored to this population. In this study, we used data from the 2007 to 2018 National Survey of Substance Abuse Treatment Services to describe recent time trends and the geographic distribution of treatment facilities with specialized programs for PPW. We also compared differences in the availability of opioid agonist medication treatments (MT), key ancillary services, and health insurance acceptance between PPW Programs and Other Programs, overall and by residential and outpatient settings. We found that the prevalence of PPW Programs increased from 17% in 2007 to 23% in 2018, for a total of 3,429 PPW Programs and 11,230 Other Programs in 2018. The prevalence of PPW Programs was lowest in some states in the South and Midwest. Compared to Other Programs, PPW Programs were more likely to accept Medicaid (75% vs. 64%) and offer opioid agonist MTs methadone (24% vs. 6%), buprenorphine (44% vs. 30%), or both (18% vs. 4%). PPW Programs were also more likely to offer other key ancillary services such as childcare (16% vs. 3%), transportation (50% vs. 42%), and domestic violence assistance (51% vs. 35%). Compared to PPW Programs in outpatient settings, PPW Programs in residential settings were more likely to offer these key ancillary services but less likely to offer methadone or accept Medicaid. Our findings reflect considerable variation in the availability of PPW Programs over time and across states, as well as substantial gaps in key services offered in PPW Programs, let alone in Other Programs.

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Keywords

pregnant women; opioid use disorder; substance use disorder treatment; residential; outpatient

1. Introduction

Opioid overdose deaths and rates of opioid misuse and opioid use disorder (OUD) have increased exponentially in the United States since the early 2000s (Centers for Disease Control and Prevention, 2011, 2017; McCance-Katz, 2018; Substance Abuse and Mental Health Services Administration, 2018). Rates of opioid misuse and OUD among pregnant women have also increased substantially during this time, leading to a marked growth in adverse maternal and neonatal outcomes (Maeda et al., 2014; Patrick et al., 2012; 2015; Admon et al., 2018). The rate of neonatal drug withdrawal syndrome per 1,000 hospital births increased from 1.2 in 2000 to 5.8 in 2012 (Patrick et al., 2012; 2015a). Likewise, the proportion of pregnant women with OUD or entering treatment for OUD also increased substantially (Patrick et al., 2012; Maeda et al., 2014; Short et al., 2018; Martin et al., 2015).

Opioid agonist medication treatment (MT) with methadone or buprenorphine is considered the standard of care for pregnant women with OUD (Jones et al., 2012a; 2012b; ACOG 2012; ASAM, 2017; SAMHSA 2018). MTs are associated with longer durations of maternal drug abstinence, obstetric care adherence, and improved neonatal outcomes (Jones et al., 2005; 2010; Krans et al., 2016; Jansson et al., 2017).

Treatment services for pregnant women with OUD should have a level of comprehensiveness that matches the complexity and multifaceted nature of OUD and its correlates in this population (WHO, 2014). Pregnant women with OUD often face challenging circumstances, including polysubstance use, a history of sexual abuse and domestic violence, inadequate social supports, poor nutrition, unstable housing, and co-occurring mental health disorders (SAMHSA, 2016; 2018). They also face unique challenges for initiating and remaining in treatment such as a lack of childcare and other accessibility issues, financial barriers, stigma, and even criminal prosecution (Jackson et al., 2012). Several states have criminal justice focused prenatal substance use laws that discourage pregnant women from disclosing their substance use and entering treatment (Kozhimannil et al. 2019). Additionally, while more than 50% of pregnant women who enter OUD treatment have Medicaid and 5% have private insurance, about one third are uninsured (Smith & Lipari 2017). Even among those with insurance, financial barriers might remain since key services may not be covered, substance use disorder (SUD) treatment providers may not accept insurance, and many pregnant women in states that did not expand Medicaid under the Affordable Care Act will lose Medicaid 60 days postpartum (Ranji et al., 2019; Meinhofer et al., 2018). Another important challenge is that either due to a lack of training, experience, or other factors, some providers are unwilling to treat pregnant women with OUD (Patrick et al., 2018).

For these reasons, treatment for pregnant women with OUD should be delivered in the context of specialized programs that include providers who are trained to care for this population and that offer comprehensive services along with opioid agonist MTs, including

mental health care, prenatal care, childcare, housing assistance, domestic violence assistance, and other key ancillary services (Jones et al., 2008; 2014; SAMHSA, 2016; 2018). Previous work shows that pregnant women receiving treatment in specialized programs exhibit higher rates of treatment retention, illicit drug abstinence, and report fewer barriers to care (Niccols et al., 2012; Grella, 1999; Hser et al, 2011; Ashely et al., 2003).

In spite of improved outcomes of opioid agonist MT delivered along with other specialized services, a large proportion of pregnant women with OUD do not receive these services, let alone any SUD treatment. According to the 2007 to 2017 National Survey on Drug Use and Health, an estimated 37% of pregnant women with OUD received any SUD treatment in the past year and 25% received OUD-specific treatment in the past year. About 50% of pregnant women in OUD-specific treatment did not receive opioid agonist MTs (Short et al., 2018; Martin et al., 2015). Limited availability of providers may be one possible explanation for the treatment gap. The proportion of SUD treatment facilities with a specialized program for pregnant and postpartum women (PPW) has been arguably low and declined from 19% in 2002 to 15% in 2009 (Terplan et al., 2015). The proportion of SUD treatment facilities offering methadone and buprenorphine has also been low and estimated at 10% and 25% in 2016, respectively (Mojtabai et al., 2019). MT provider availability is even more limited in many areas (Andrilla et. al. 2019).

In an effort to improve service availability and treatment outcomes for PPW with substance use disorders, the Federal government has historically funded treatment in residential settings through the Substance Abuse and Mental Health Services Administration's (SAMHSA) Services Grant Program for Residential Treatment for Pregnant and Postpartum Women. Only recently, did SAMHSA expand the grant program to fund treatment in outpatient settings. This shift may have important implications for treatment outcomes in the PPW population. Evidence suggests that residential settings result in better treatment outcomes than outpatient settings among individuals with OUD (Stahler, 2016; Grella, 1999). These findings might be partially due to differences in service availability across treatment settings.

Neither the prevalence of PPW Programs over the last decade nor the availability of treatment services in these programs are known. It is also unknown whether service availability in these programs varies by treatment setting. In this study, we used data from the 2007 to 2018 National Survey of Substance Abuse Treatment Services to describe recent time trends in the prevalence of SUD treatment facilities with PPW Programs and MTs in these programs, overall and by treatment setting. The geographic distribution of treatment facilities with PPW Programs was also described. Additionally, we compared the prevalence of MTs and other key treatment services between PPW Programs and Other Programs, overall and by treatment setting. By characterizing the availability of SUD treatment services for pregnant and postpartum women, we provide policymakers with timely information that can help identify and overcome barriers to treatment in this vulnerable population.

2. Methods

2.1. Data

We analyzed data from the 2007 to 2018 National Survey of Substance Abuse Treatment Services (N-SSATS), an annual survey of substance use disorder (SUD) treatment facilities administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) (N=165,350). N-SSATS is designed to survey all specialty SUD treatment facilities in the United States, both public and private. Each year, approximately 90% of eligible facilities respond and are included in the sample. N-SSATS collects information on the services offered at these treatment facilities and the utilization of those services. Services include medication management for substance use disorder and mental health disorders, testing, and ancillary services, among others. Information on facility characteristics such as type of ownership, geographic location (i.e. state), and payer acceptance are also collected. The unit of observation in N-SSATS is a facility, defined as the physical location where treatment services are provided.

2.2 Sample

Pregnancy is defined as the period between conception and childbirth and the postpartum period is commonly defined as the six weeks after childbirth. While the N-SSATS questionnaire does not explicitly define pregnant and postpartum women (PPW), it asks SUD treatment facilities to report whether they “offer a substance abuse treatment program or group specifically tailored” to PPW and clarifies that if the “facility treats [PPW] clients but does not have a specifically tailored program or group for them” to *not* report offering such program or group. We used this information to identify and stratify facilities into those with specific programs or groups for pregnant and postpartum women (PPW Programs) and those without these programs or groups (Other Programs). We further stratified treatment facilities based on treatment setting, including residential and outpatient settings. Treatment setting was not mutually exclusive. In our sample, 73% of facilities offered services in outpatient settings only, 16% in residential settings only, 9% in both, and 2% in neither. When stratifying the sample by treatment setting, we identified residential settings and outpatient settings without residential services (i.e. non-residential).

2.3 Analysis

2.3.1 Time Trends in PPW Programs—Using the 2007 to 2018 N-SSATS, we examined time trends in the percentage of treatment facilities with PPW Programs, overall and by treatment setting. Time trends in the number of treatment facilities with PPW Programs and the total number of treatment facilities, overall and by treatment setting, were included in Appendix Figure A1. We also examined time trends in the percentage of treatment facilities with PPW Programs offering opioid agonist MTs methadone -measured as the number of opioid treatment programs- and buprenorphine, overall and by treatment setting.

2.3.2 Geographic Distribution of PPW Programs—Using the 2018 N-SSATS and the 2016 to 2017 National Survey on Drug Use and Health through SAMHSA’s Restricted-use Data Analysis System, we examined the geographic distribution of treatment facilities

with PPW Programs across states. We did this by calculating and mapping quintiles based on the number of PPW Programs per 1,000 reproductive age women (ages 15 to 44) with a substance use disorder in the past year. This rate and the percentage of treatment facilities with PPW Programs in each state as well as underlying numerators, denominators, and other information were included in Appendix Table A1.

2.3.3 Treatment Services and Payer Acceptance at PPW Programs—Using the 2018 N-SSATS, we calculated the number and percentage of treatment facilities with PPW Programs offering key services, including medications, testing, and ancillary services, overall and by treatment setting. Since financial barriers are often reported as a reason for not seeking treatment, we also considered payer acceptance, including cash, free treatment, and different types of health insurance. Services offered and payer acceptance at Other Programs were reported for comparison.

We used Chi-square tests to compare services at PPW Programs to services at Other Programs and to compare services at residential settings to services at outpatient settings separately for PPW Programs and for Other Programs. Given the large sample size and number of hypotheses tested per comparison groups (33), we implemented a Bonferroni correction that considered a P-value lower than $.05/33 = 0.002$ evidence against the null.

3 Results

3.1 Time Trends in PPW Programs

The top panel of Figure 1 shows that the percentage of facilities with PPW Programs increased from 17% in 2007 to 23% in 2018. The bottom panel of Figure 1 shows that while initially the percentage of residential facilities with PPW Programs was slightly higher than the percentage of outpatient facilities with PPW Programs, these differences became nearly identical after 2013.

The top panel of Figure 2 shows that PPW Programs offered methadone and buprenorphine at higher rates than Other Programs and that buprenorphine availability in PPW Programs increased at a faster rate than in Other Programs over the sample period. However, the proportion of PPW Programs offering methadone declined from 29% in 2013 to 24% in 2018. The bottom panel stratifies the PPW Program sample by treatment setting and shows that residential PPW Programs offered methadone at a substantially lower rate than outpatient PPW Programs. However, buprenorphine prevalence and growth was similar regardless of setting.

3.2 Geographic Distribution of PPW Programs

There was considerable variation in the number of PPW Programs per 1,000 reproductive age women with SUD across states, ranging from 0.09 in the District of Columbia to 1.83 in Maine (see Figure 3 and Appendix Table A1). Figure 3 shows that the rate of PPW Programs was highest in Maine, Kentucky, Alaska, Idaho, Delaware, Vermont, Wyoming, West Virginia, New Mexico and New Hampshire, but lowest in many states in the South (District of Columbia, Texas, South Carolina, Arkansas, Tennessee, Louisiana, Alabama) and the Midwest (Illinois, Ohio, Missouri, Iowa, Wisconsin).

3.3 Treatment Services and Payer Acceptance at PPW Programs

In Table 1, we compared the availability of treatment services in PPW Programs and Other Programs. Across medications, PPW Programs were more likely to offer methadone (24% vs. 6%, 18 percentage point difference), buprenorphine (44% vs. 30%, 14 percentage point difference) or both methadone and buprenorphine (18% vs. 4%, 14 percentage point difference), but less likely to offer medications for psychiatric disorders (41% vs. 46%, -5 percentage point difference) even when PPW have a high burden of mental health conditions. PPW Programs were more likely to test for Hepatitis C (40% vs. 26%, 14 percentage point difference), HIV (39% vs. 26%, 13 percentage point difference) and STDs (31% vs. 20%, 11 percentage point difference). Likewise, PPW Programs offered several key ancillary services at substantially higher rates than Other Programs, child care (16% vs. 3%, 13 percentage point difference) and assistance with social services (72% vs. 57%, 15 percentage point difference), employment assistance (49% vs. 36%, 13 percentage point difference), housing assistance (69% vs. 50%, 19 percentage point difference), and domestic violence services (51% vs. 35%, 16 percentage point difference). Lastly, there were few meaningful differences in payer acceptance although notably, PPW Programs accepted Medicaid more often than Other Programs (75% vs. 64%, 11 percentage point difference).

In Table 2, we further stratified PPW and Other Programs by residential and outpatient settings. Across medications, residential PPW Programs were more likely than outpatient PPW Programs to offer naltrexone (39% vs. 28%, 11 percentage point difference), acamprosate (26% vs. 18%, 8 percentage point difference), nicotine replacement (52% vs. 20%, 32 percentage point difference) and medication management for psychiatric disorders (55% vs. 36%, 19 percentage point difference). There was no statistically significant difference in buprenorphine between residential and outpatient PPW Programs, and methadone was offered in 30% of outpatient settings but only in 5% of residential settings (-25 percentage point difference).

Residential PPW Programs dominated among most categories of testing and ancillary services relative to outpatient PPW Programs. Notably, residential PPW Programs offered the highest rates of assistance with child care (36% vs. 11%, 25 percentage point difference), social services (88% vs. 68%, 20 percentage point difference), employment (64% vs. 45%, 19 percentage point difference), domestic violence (62% vs. 49%, 13 percentage point difference), housing (88% vs. 63%, 25 percentage point difference), and transportation (76% vs. 42%, 34 percentage point difference). Across payers, residential facilities were less likely to accept health insurance than outpatient facilities, including Medicaid, both in PPW and Other Programs.

4 Discussion

The increasing prevalence of opioid use disorders among pregnant and postpartum women has generated a need for identifying and overcoming barriers to SUD treatment in this population. Our study estimated the availability of SUD treatment services for pregnant and postpartum women, focusing on specialized PPW Programs, MTs, key ancillary services, and payer acceptance. Service availability and payer acceptance across residential and outpatient settings was also considered.

Overall, we found a higher and growing prevalence of treatment facilities with PPW Programs since 2009 estimates in Terplan et al., (2015) and an increasing prevalence in buprenorphine availability, especially in PPW Programs. Despite the growing prevalence of PPW Programs, there was considerable variation in the availability of these Programs across states. In particular, the availability of PPW Programs was most limited in some Southern and Midwestern states. This is concerning because previous work has shown that the rates of neonatal drug withdrawal syndrome are high in many Southern and Midwestern states (Patrick et al., 2015), that the prevalence of foster care entries for parental drug use is highest in Southern states (Meinhofer et al., 2019), that the proportion of reproductive age women who fill opioid prescriptions is highest in Southern states (Ailes et al., 2015), and that pregnant women entering treatment for OUD in Southern states are less likely to have health insurance or receive opioid agonist MT (Hand et al., 2017).

PPW Programs offered most medications, key ancillary services, and Medicaid acceptance at a higher rate than Other Programs. Nonetheless, there was still a considerable gap in MT availability in PPW Programs. Less than 45% of PPW Programs offered buprenorphine, less than 25% offered methadone, and less than 50% offered any of these MTs, both of which are considered the gold standard of care for treating pregnant women with OUD. This service gap extended to key ancillary services for the PPW population. Most notably, childcare was offered in less than 20% of PPW Programs. The low availability of childcare services may be an important barrier to PPW with OUD seeking treatment. Less than half of PPW Programs offered testing for Hepatitis C, HIV, and STDs and 25% did not accept Medicaid, the main insurer of pregnant women with OUD. Gaps in MTs and other key services for the PPW population were even more critical in Other Programs, which is concerning since Other Programs represented 77% of all specialty SUD treatment facilities in 2018 while PPW Programs only represented 23%.

When stratifying PPW Programs by residential and outpatient settings, we found substantial heterogeneity in the availability of treatment services. Residential PPW Programs tended to offer ancillary services, such as child care, employment, housing, and domestic violence assistance at significantly higher rates than outpatient PPW Programs. Perhaps most notably, only 11% of outpatient PPW Programs offered childcare services versus 36% of residential PPW Programs. However, residential PPW Programs were less likely to accept Medicaid or offer methadone than outpatient PPW Programs. The low prevalence of methadone in residential PPW Programs plausibly stems from the fact that opioid treatment programs (OTPs), the only providers licensed to administer methadone for OUD treatment, are more likely to offer both outpatient services and PPW Programs. By law, OTPs must maintain current policies and procedures that reflect the special needs of patients who are pregnant. Prenatal care and other gender specific services for pregnant patients must be provided either by the OTP or by referral to appropriate healthcare providers (42 CFR § 8.12). Buprenorphine prevalence was not significantly different between outpatient and residential PPW Programs. There was substantial heterogeneity in the availability of treatment services by setting in Other Programs as well.

Taken together, our results suggested that while the prevalence of treatment facilities with specialized PPW Programs has increased and that these Programs offered more

comprehensive services relative to Other Programs, in absolute terms there were critical gaps in the availability of key services for PPW. Increasing capacity, funding, insurance coverage, and reimbursement of key services for PPW may be one way to ensure sufficient availability of such services at PPW and Other Programs. Since 2017, the State Targeted Response Grants and the State Opioid Response Grants by SAMHSA have offered opportunities to states for innovations in the area of OUD treatment among the PPW population and a number of states have used this funding to design programs for reproductive-aged women. With the passage of the FY 2019 appropriations law and the 2018 SUPPORT Act, Congress has shown commitment and support for the continuation of these grants, which would give more states opportunities to expand treatment availability for reproductive age women with OUD. Our results also suggested there were significant differences in service availability and payer acceptance between outpatient and residential PPW Programs. These differences may have important implications for treatment utilization, retention and downstream outcomes in the PPW population, especially in light of increasing federal funding for PPW treatment in outpatient settings through the State Pilot Grant Program for Treatment for Pregnant and Postpartum Women, which historically has been funded in residential settings through the Services Grant Program for Residential Treatment for Pregnant and Postpartum Women.

This study has several limitations. First, since N-SSATS does not specifically define postpartum women and assumes it to be whatever each facility considers postpartum women, there might be some inconsistencies in the definition PPW Programs across facilities. Second, our definition of PPW Programs measures whether services are offered but does not capture capacity. It is possible that facilities may have expanded the number of beds or treatment slots for PPW during 2007 to 2018. Finally, there is heterogeneity in how organizations respond to N-SSATS. Some organizations respond for individual programs within a facility, some report at the facility level, and some for multiple facilities. This may create some measurement error in our prevalence rates.

5 Conclusion

Pregnant and postpartum women with OUD face many social, structural and economic barriers to accessing treatment and recovery services. Specialized programs that offer comprehensive, integrated approaches to treatment combining clinical and social services with care coordination and trauma-informed care have been found to be most effective. Our study shows that the prevalence of such specialized programs and the availability of key services within these programs remains low. States that want to improve treatment outcomes among pregnant and postpartum women should consider designing programs especially for this population.

Acknowledgments

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Appendix

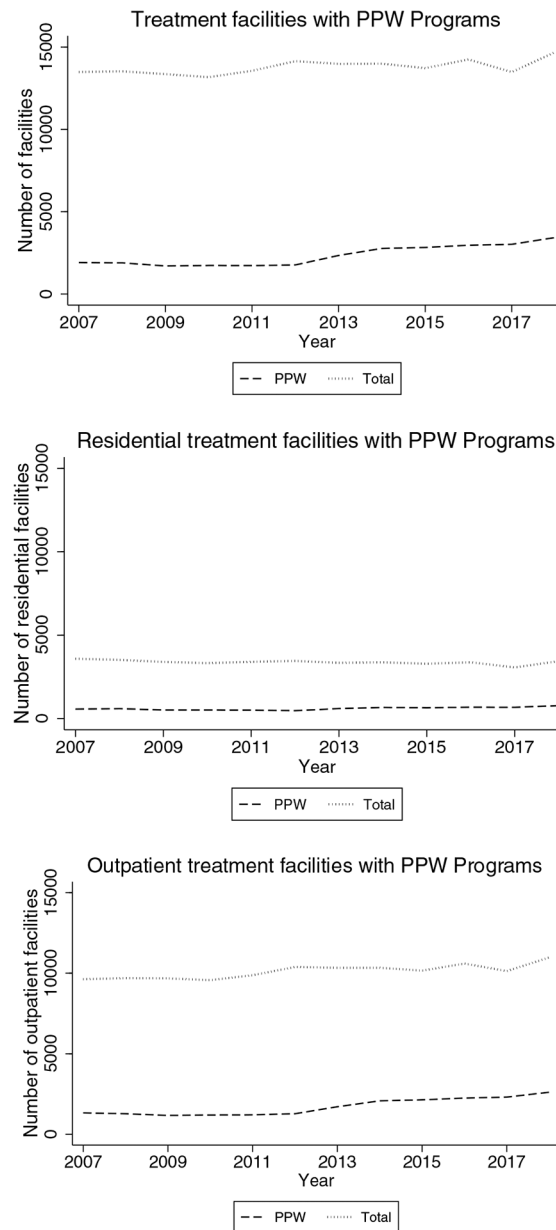


Figure A1. Treatment facilities with specialized programs for pregnant and postpartum women, overall and by treatment setting

Notes: National Survey of Substance Abuse Treatment Services, 2007–2018.

Table A1.

Specialized programs for pregnant and postpartum women by state, N-SSATS 2018

Code	State	PPW No.	Birth No.	SUD No.	PPW %	PPW/Births	PPW/S UD	Quintiles
DC	DISTRICT OF COLUMBIA	2	9209	23000	8	0.22	0.09	1
TX	TEXAS	121	376945	403000	24	0.32	0.30	1

Code	State	PPW No.	Birth No.	SUD No.	PPW %	PPW/ Births	PPW/S UD	Quintiles
SC	SOUTH CAROLINA	35	56662	101000	31	0.62	0.35	1
MT	MONTANA	10	11509	26000	14	0.87	0.38	1
LA	LOUISIANA	32	59517	83000	22	0.54	0.39	1
AR	ARKANSAS	22	36996	55000	15	0.59	0.40	1
MO	MISSOURI	42	73222	103000	15	0.57	0.41	1
TN	TENNESSEE	46	80678	112000	21	0.57	0.41	1
OH	OHIO	88	135112	210000	19	0.65	0.42	1
IL	ILLINOIS	95	144787	225000	14	0.66	0.42	1
IA	IOWA	27	37754	63000	16	0.72	0.43	1
NV	NEVADA	26	35659	58000	32	0.73	0.45	2
WI	WISCONSIN	48	64088	101000	18	0.75	0.48	2
AL	ALABAMA	32	57745	67000	24	0.55	0.48	2
NY	NEW YORK	168	226175	348000	19	0.74	0.48	2
MS	MISSISSIPPI	21	36999	37000	21	0.57	0.57	2
WA	WASHINGTON	86	86061	150000	19	1.00	0.57	2
FL	FLORIDA	190	221532	323000	26	0.86	0.59	2
VA	VIRGINIA	72	99787	117000	31	0.72	0.62	2
OR	OREGON	55	42152	88000	24	1.30	0.63	2
MI	MICHIGAN	106	109782	166000	23	0.97	0.64	2
AZ	ARIZONA	76	80702	118000	19	0.94	0.64	2
IN	INDIANA	69	81585	106000	19	0.85	0.65	3
GA	GEORGIA	88	126152	135000	27	0.70	0.65	3
CA	CALIFORNIA	409	454526	622000	27	0.90	0.66	3
PA	PENNSYLVANIA	138	135551	205000	24	1.02	0.67	3
KS	KANSAS	38	36257	55000	21	1.05	0.69	3
CT	CONNECTICUT	48	34723	69000	22	1.38	0.70	3
SD	SOUTH DAKOTA	12	11889	17000	20	1.01	0.71	3
NE	NEBRASKA	23	25416	32000	19	0.90	0.72	3
OK	OKLAHOMA	54	49792	70000	27	1.08	0.77	3
RI	RHODE ISLAND	19	10506	24000	34	1.81	0.79	4
MN	MINNESOTA	66	67327	82000	18	0.98	0.80	4
ND	NORTH DAKOTA	13	10636	16000	17	1.22	0.81	4
CO	COLORADO	107	62873	127000	26	1.70	0.84	4
NJ	NEW JERSEY	117	101313	131000	32	1.15	0.89	4
MA	MASSACHUSETTS	139	69133	150000	34	2.01	0.93	4
UT	UTAH	57	47210	60000	21	1.21	0.95	4
MD	MARYLAND	112	71080	113000	27	1.58	0.99	4
NC	NORTH CAROLINA	140	118930	141000	27	1.18	0.99	4
HI	HAWAII	23	16964	23000	14	1.36	1.00	4
NH	NEW HAMPSHIRE	26	11992	25000	36	2.17	1.04	5
NM	NEW MEXICO	43	23007	41000	31	1.87	1.05	5

Code	State	PPW No.	Birth No.	SUD No.	PPW %	PPW/ Births	PPW/S UD	Quintiles
WV	WEST VIRGINIA	24	18110	21000	22	1.33	1.14	5
WY	WYOMING	12	6557	10000	23	1.83	1.20	5
VT	VERMONT	19	5431	15000	41	3.50	1.27	5
DE	DELAWARE	18	10615	14000	45	1.70	1.29	5
ID	IDAHO	41	21398	31000	31	1.92	1.32	5
AK	ALASKA	19	10076	13000	21	1.89	1.46	5
KY	KENTUCKY	111	53806	64000	27	2.06	1.73	5
ME	MAINE	44	12308	24000	24	3.57	1.83	5

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Highlights

- 23% of treatment facilities had programs for pregnant/postpartum women (PPW)
- PPW Programs offered methadone 24% and buprenorphine 44%
- Childcare 16%, transportation 50%, and domestic violence 51% services were offered
- Service availability was even lower in outpatient PPW Programs & Other Programs
- There are significant gaps in the availability of treatment services benefiting PPW

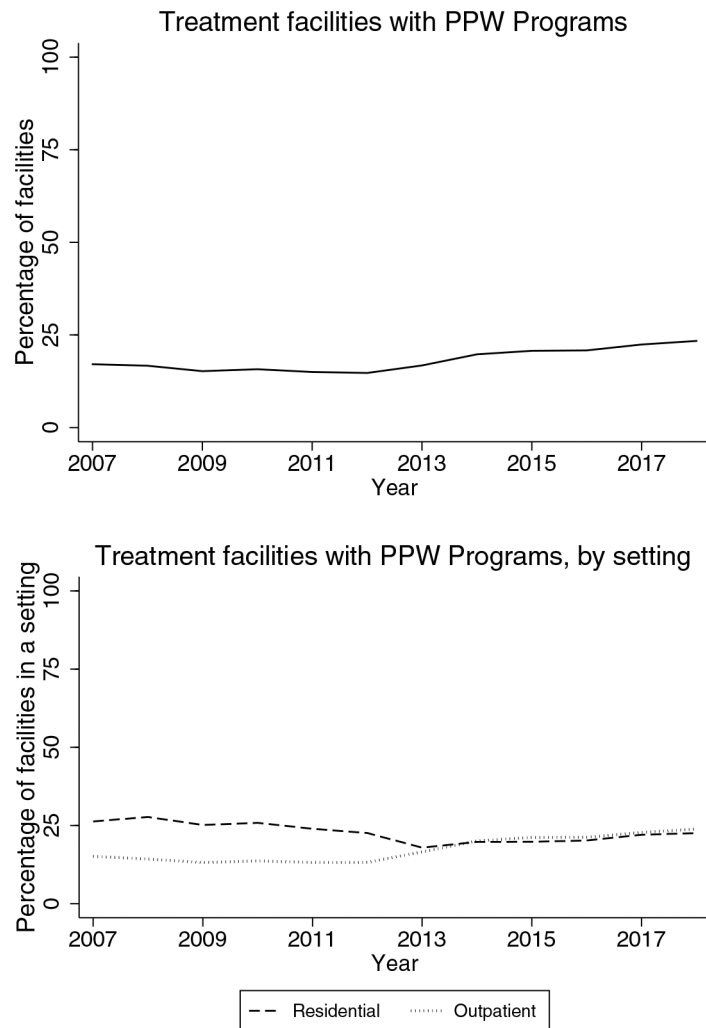
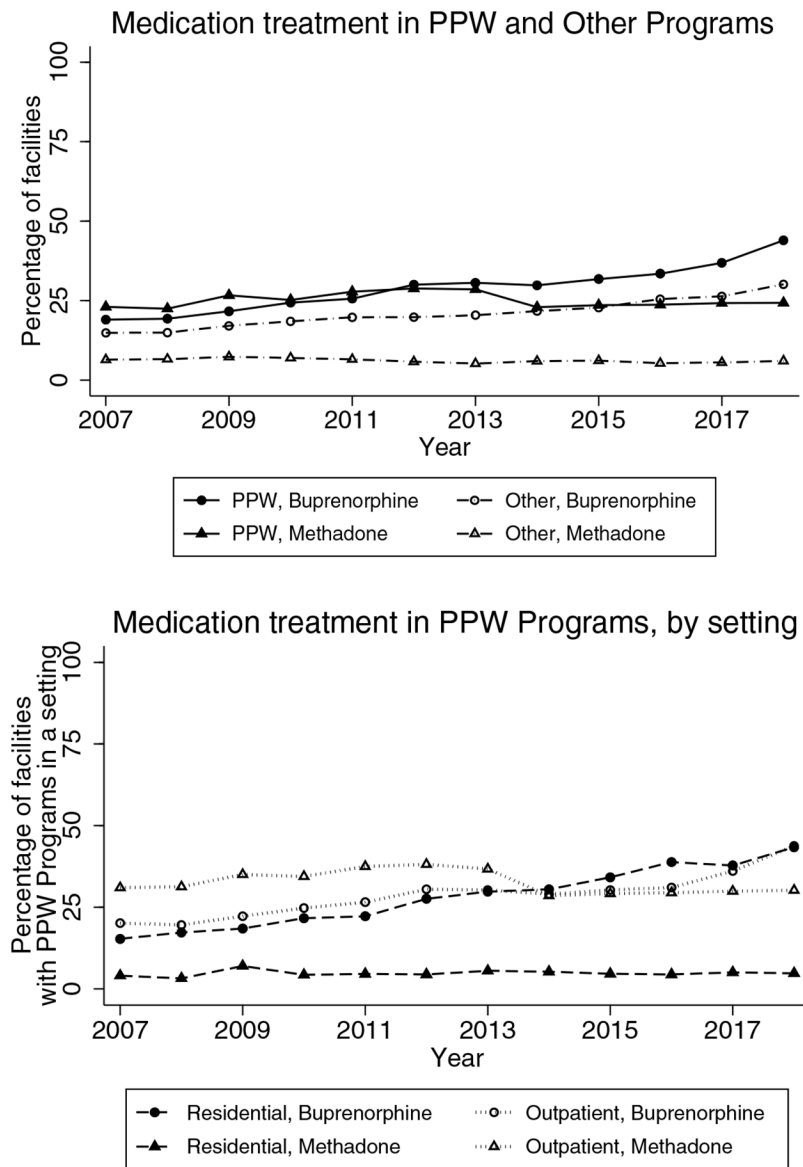


Figure 1. Substance use disorder treatment facilities with specialized programs for pregnant and postpartum women, overall and by treatment setting

Notes: National Survey of Substance Abuse Treatment Services, 2007–2018.



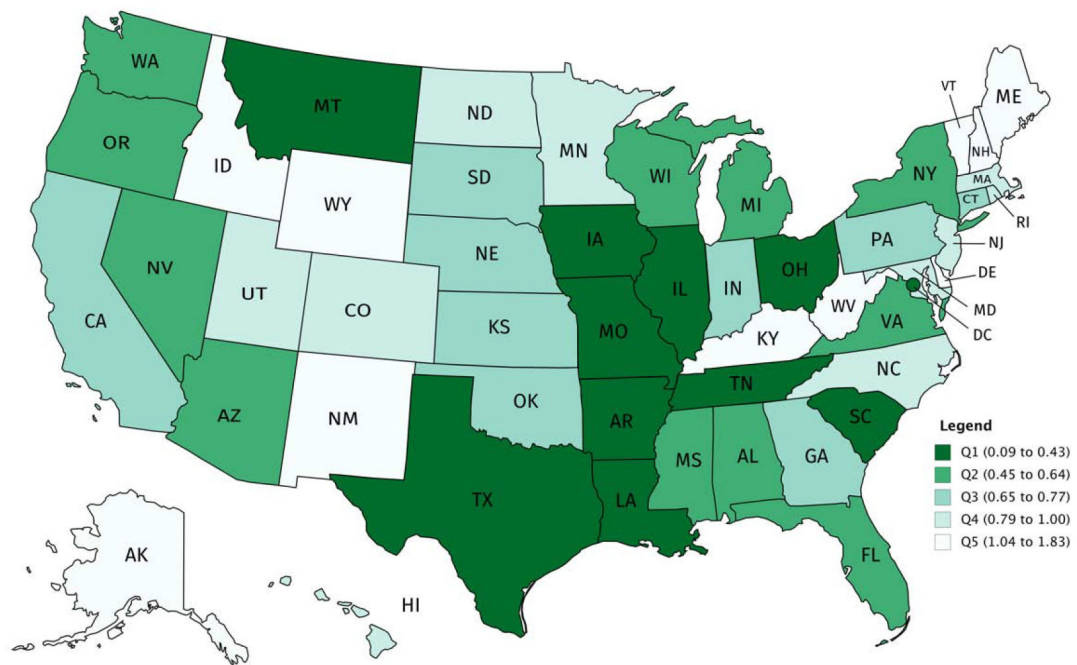


Figure 3. Geographic distribution of substance use disorder treatment facilities with specialized programs for pregnant and postpartum women per 1,000 reproductive age women with substance use disorders, by state

Notes: National Survey of Substance Abuse Treatment Services, 2018. PPW Programs per 1,000 reproductive age women with substance use disorders in a given state were classified into quintiles (Q1 to Q5).

Table 1.

Service availability at SUD treatment facilities with specialized programs for pregnant and postpartum women, N-SSATS 2018

	PPW Programs N=3,429		Other Programs N=11,230		Chi-2
	No.	%	No.	%	P-value
Medications					
Methadone	833	24	677	6	0.000
Buprenorphine	1508	44	3382	30	0.000
Meth. or Bup.	1713	50	3594	32	0.000
Meth. and Bup.	628	18	465	4	0.000
Naltrexone	1058	31	3210	29	0.010
Disulfiram	677	20	2180	19	0.668
Acamprosate	692	20	2324	21	0.515
Nicotine Replacement	968	28	3151	28	0.845
Psychiatric Disorders	1415	41	5150	46	0.000
Testing					
HCV	1383	40	2937	26	0.000
HIV	1351	39	2897	26	0.000
STD	1052	31	2276	20	0.000
Ancillary Services					
Case Management	3075	90	9109	81	0.000
Social Skills	2832	83	8316	74	0.000
Mentoring/Peer Support	2230	65	6263	56	0.000
Child Care	564	16	287	3	0.000
Beds for Clients' Children	300	9	73	1	0.000
Assist. Social Services	2485	72	6354	57	0.000
Employment	1673	49	4031	36	0.000
Housing Assist	2365	69	5646	50	0.000
Domestic Violence	1761	51	3881	35	0.000
Intervention HIV	1198	35	2067	18	0.000
HIV/AIDS Edu	2315	68	5456	49	0.000
Hepatitis Edu	2177	63	4755	42	0.000
Health Edu	2259	66	5332	47	0.000
Transportation Assistance	1714	50	4694	42	0.000
Mental Health Svcs	2339	68	7653	68	0.943
Self-Help Groups	1758	51	4953	44	0.000
Smoking Cessation	2007	59	5300	47	0.000
Payer Acceptance					
Cash/self-payment	3182	93	10048	90	0.000
Free Tx	66	2	320	3	0.003
Medicaid	2536	75	7127	64	0.000

	PPW Programs		Other Programs		Chi-2
	N=3,429		N=11,230		
	No.	%	No.	%	P-value
Other Public	2244	65	7053	63	0.005
Private Insurance	2432	72	8080	73	0.219

Notes: National Survey of Substance Abuse Treatment Services, 2018.

Table 2.

Services offered in treatment facilities with specialized programs for pregnant and postpartum women by treatment setting, N-SSATS 2018

	PPW Programs					Other Programs				
	Residential		Outpatient		Chi-2	Residential		Outpatient		Chi-2
	N=775		N=2,609			N=2,663		N=8,340		
	N	%	N	%	P-value	N	%	N	%	P-value
Medications										
Methadone	37	5	788	30	0.000	95	4	541	6	0.000
Buprenorphine	336	43	1142	44	0.837	1025	38	2219	27	0.000
Meth. or Bup.	341	44	1340	51	0.000	1037	39	2413	29	0.000
Meth. and Bup.	32	4	590	23	0.000	83	3	347	4	0.000
Naltrexone	303	39	727	28	0.000	1002	38	2091	25	0.000
Disulfiram	159	21	495	19	0.339	587	22	1495	18	0.000
Acamprosate	201	26	464	18	0.000	678	25	1544	19	0.000
Nicotine Replacement	403	52	523	20	0.000	1268	48	1672	20	0.000
Psychiatric Disorders	428	55	946	36	0.000	1437	54	3510	42	0.000
Testing										
HCV	332	43	1013	39	0.045	1018	38	1728	21	0.000
HIV	376	49	935	36	0.000	1106	42	1603	19	0.000
STD	268	35	746	29	0.001	886	33	1207	14	0.000
Ancillary Services										
Case Management	730	94	2311	89	0.000	2378	89	6551	79	0.000
Social Skills	730	94	2071	79	0.000	2306	87	5873	70	0.000
Mentoring/Peer Support	658	85	1555	60	0.000	2099	79	4069	49	0.000
Child Care	281	36	281	11	0.000	69	3	216	3	0.997
Beds for Clients' Children	300	39	0	0	0.000	73	3	0	0	0.000
Assist. Social Services	679	88	1770	68	0.000	1817	68	4381	53	0.000
Employment	496	64	1172	45	0.000	1386	52	2623	31	0.000
Housing Assist	684	88	1654	63	0.000	1908	72	3638	44	0.000
Domestic Violence	477	62	1266	49	0.000	859	32	2971	36	0.001
Intervention HIV	334	43	845	32	0.000	785	29	1221	15	0.000
HIV/AIDS Edu	616	79	1663	64	0.000	1764	66	3550	43	0.000
Hepatitis Edu	581	75	1560	60	0.000	1620	61	2989	36	0.000
Health Edu	620	80	1601	61	0.000	1795	67	3377	40	0.000
Transportation Assistance	591	76	1098	42	0.000	1698	64	2908	35	0.000
Mental Health Svcs	575	74	1725	66	0.000	1678	63	5803	70	0.000
Self-Help Groups	679	88	1047	40	0.000	2207	83	2580	31	0.000
Smoking Cessation	526	68	1445	55	0.000	1531	57	3602	43	0.000
Payer Acceptance										
Cash/self-payment	669	87	2472	95	0.000	2317	88	7521	91	0.000
Free Tx	32	4	34	1	0.000	106	4	211	3	0.000

	PPW Programs					Other Programs				
	Residential		Outpatient		Chi-2	Residential		Outpatient		Chi-2
	N=775		N=2,609			N=2,663		N=8,340		
	N	%	N	%	P-value	N	%	N	%	P-value
Medicaid	523	69	1971	76	0.000	1269	49	5657	69	0.000
Other Public	469	61	1733	66	0.002	1338	50	5505	66	0.000
Private Insurance	521	69	1867	72	0.067	1736	67	6131	74	0.000

Notes: National Survey of Substance Abuse Treatment Services, 2018.