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Challenges and opportunities during the COVID-19 pandemic: Treating patients for substance use disorders during the perinatal period

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ARTICLE INFO

Keywords:

Pregnancy
Pandemic
COVID-19
Postpartum
Opioid use disorder
Alcohol
Substance use disorder

ABSTRACT

The coronavirus disease 2019 (COVID-19) pandemic exacerbated the opioid use disorder epidemic and accelerated alcohol and other substance use disorders. Sudden health care service delivery changes during the COVID-19 pandemic created both challenges and opportunities for all patients with substance use disorders including the use of virtual or telemedicine visits, medication access issues and ensuring access to naloxone when supplies cannot be handed out. Unique challenges for pregnant and post-partum patients with substance use disorders includes some evidence of reduced access to medication to treat opioid use disorders and changes in delivery protocols that isolate birthing people from supports. Opportunities for all patients with substance use disorders include virtual platforms presenting positive opportunities for treatment. They are time efficient, eliminate transportation barriers, and potentially reduce childcare barriers. For pregnant and post-partum patients with substance use disorders, hybrid models of telemedicine and in-person visits reduced no-show visit rates and increased flexibility in medication dosing regimens. Thus, there is a unique opportunity to study the success of different virtual care models given the variety of implemented strategies. The COVID-19 pandemic provides an unprecedented opportunity to dramatically transform standard care approaches to help optimize care for all patients, including pregnant and post-partum people.

The United States of America (USA) faces a continuing opioid use disorder (OUD) epidemic and growing rates of alcohol and other substance use disorders (SUD) within a pandemic of coronavirus disease 2019 (COVID-19). It is now known that the conditions enhancing physical health and safety triggered initiation of substance use among some individuals, a return to substance use among others (even in those with years of SUD remission), or intensified substance consumption in individuals actively using substances (Serafini et al., 2016; Sinha et al., 2009). Within the intersection of COVID-19 and substance use disorders, there are sub-populations of patients that face unique issues. This commentary focuses the challenges and opportunities that emerged for pregnant and post-partum patients with substance use disorders and the health care providers treating them during the COVID-19 pandemic.

COVID-19 represents a major stressor for pregnant and post-partum (Mayopoulos et al., 2021). A scoping review reported that compared to non-pregnant people, pregnant people may experience more severe COVID-19 symptoms (Koltar et al., 2021). Further, rates of domestic

violence and clinically concerning anxiety and depression spiked (Koltar et al., 2021). Compared to pre-pandemic conditions, birthing people reported greater traumatic childbirth experiences and less successful postpartum adjustments during COVID-19 (Mayopoulos et al., 2021). Such reports are not surprising given the stress on the healthcare infrastructure and the rapid implementation of potentially harmful policies (e.g., birthing without supportive partners and separation of mother and baby at birth) implemented with little empirical evidence (Koltar et al., 2021). COVID-19 pandemic related stress is also seen in data from 83 pregnant women suggesting that they experienced increased psychological distress and increased opioid, cannabis, tobacco and alcohol use during the pandemic (Smith et al., 2021). Such data raise concern with possible increases of in-utero exposures resulting in potentially concerning child outcomes (e.g., prematurity, low birth weight, fetal alcohol spectrum disorders).

As treatment providers, we observed and experienced challenges in the transition from physical in-person to virtual SUD treatment, many of

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<https://doi.org/10.1016/j.ypmed.2021.106742>

Received 8 February 2021; Received in revised form 5 June 2021; Accepted 18 July 2021

Available online 22 July 2021

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which apply to patients of all types, including those who are pregnant or post-partum. These challenges include issues around the “digital divide,” for patients including those living in rural or other areas where internet or broadband is not available or not having funds to pay for such services. Additionally, patients did not always have a device with a camera to use for treatment or the funds to pay for the minutes or data service needed for virtual visits. Once gaining digital treatment access, modifications for obtaining informed consent from patients virtually was needed (Sadicario et al., 2021). Earning a patient’s trust, a task already complicated by past experiences of discriminatory/stigmatizing interactions with health care providers related to substance use, may be compromised in the virtual environment (Cockroft et al., 2019; Sadicario et al., 2021). Relatedly, we observed that the lack of privacy during a virtual visit may be an engagement barrier making it difficult to discuss sensitive issues related to mental health. The lack of privacy may also pose a risk of interpersonal violence if the abuser is present during discussion of sensitive topics. Thus, virtual visit treatment challenges included careful timing of sessions when patient privacy can be assured, developing “safe words” to reduce the likelihood of violent interactions and implementing crisis plans if patients are in danger. Last, ensuring patient access to naloxone in a virtual treatment environment is difficult at best.

In addition to these issues that likely apply to patients with SUD broadly, data suggest pregnant people face additional barriers in terms of both finding and remaining in SUD during the COVID-19 pandemic. One study of buprenorphine clinics found that only half accepted pregnant patients before the pandemic and once the pandemic began, only two-thirds of these clinics continued to offer pregnant women treatment (Lensch et al., 2021). Subsequently, only 33% of buprenorphine clinics noted in the study provided treatment to pregnant women. The time-sensitive nature of SUD treatment during pregnancy heightens the need to prioritize this population where two lives are at risk for adverse health outcomes. In addition, like other healthcare professionals, SUD treatment providers responded to the pandemic by shifting to reduced patient volumes and/or to a virtual format, including medication induction/management (Samuels et al., 2020). Sudden treatment transitions potentially exacerbated already substantial care barriers for pregnant patients treated for OUD (Dunlop et al., 2020). In a study of 13 patients receiving treatment in a co-located maternal fetal medicine and OUD outpatient treatment program, attendance at virtual group treatment sessions was 3-fold lower than for in-person sessions (67% vs 21%, respectively) and patients reported more intense cravings. While these changes did not result in more positive urine drug screens, a previously stable patient experienced an overdose. Patients also reported more emergency department and/or obstetrical triage visits and more assaults (McKiever et al., 2020). Such small sample results are interesting and need replication.

Although the COVID-19 pandemic challenges SUD treatment providers, it has also fostered treatment-advancing opportunities that have been well-received by both general obstetric patients (Peahl et al., 2020), and SUD-specific patients (Patton et al., 2021). Such innovations include telemedicine (eg, Fryer et al., 2020; Aziz et al., 2020) and innovative hybrid telemedicine/in-person prenatal care models. For example, Patton et al. (2021) noted increased patient attendance associated with hybrid treatment models among pregnant persons in medication assisted treatment for OUD, with no show rates falling from 34% to 10%, an improvement of 71%. Virtual platforms may not only promote patient engagement in treatment, but may also provide easier access to treatment by eliminating barriers associated with transportation and childcare, and serve as a means to ensure privacy for some patients.

The COVID-19 pandemic has also offered other exciting opportunities to adapt and innovate the ways MOUD is provided to patients. SAMHSA quickly increased flexibility for Opioid Treatment Programs, allowing patients to receive 14–28 days of Take-Home doses, depending on their level of stability, and providers to conduct buprenorphine

inductions over the phone without an in-person or virtual visit (SAMHSA, 2020). Such “bridge clinics” fill care gaps for people with OUD and yielded high rates of retention and linkage to treatment (Samuels et al., 2020). Protocols developed to address other aspects of the opioid crisis could also be adapted for COVID-19 pandemic conditions. For example, Sigmon et al. (2015, 2016) implemented an efficacious protocol that leverages technology (e.g., secure computerized medication dispenser with 28-day capacity, automated interactive voice response system to monitor patient well-being) allowing treatment facilities with long waiting lists to provide interim MOUD treatment without further straining limited clinic resources. The original protocol was developed using buprenorphine, and more recently adapted for use with patients receiving methadone (Dunn et al., 2021). The combination of relaxing both federal and state rules for medication prescribing and dispensing holds promise to benefit pregnant and post-partum patients with OUD. For example, in conversation with patients receiving MOUD, they reported satisfaction with reduced in-person visits for receiving medication.

Results from ongoing studies enrolling pregnant people with OUD may have unforeseen implications for treating this population during a pandemic. For example, the National Institute on Drug Abuse Clinical Trials Network (NIDA CTN) has developed a pragmatic randomized trial comparing daily versus extended-release (weekly during pregnancy and monthly post-partum) buprenorphine dosing on mother and infant outcomes (Winhusen et al., 2020). Demonstrating the safety and efficacy of extended-release formulations during and after pregnancy could make this treatment modality widely available to patients who would otherwise be relegated to more frequent in-person dosing. While this trial is unlikely to yield results during the current pandemic, the data will have implications for future disease epidemics and pandemics, which are becoming more common (Tollefson, 2020).

As the COVID-19 pandemic wanes, we must take advantage of treatment innovations that emerged through necessity and cement them in the care system. Ways to advance treatment include making telehealth law and regulation permanent and investing in telehealth infrastructure to enable health care providers and patients to use telehealth training. Other ways forward include equipping providers to provide SUD treatment through telehealth and providing patients with the financial and social support, hardware, and training necessary to use telehealth (Drake et al., 2020). The time is ripe for systematically comparing the success of different virtual care models for pregnant and post-partum patients with SUD given the variety of strategies that have been implemented. Now more than ever, it is imperative to drive meaningful change in the intersecting areas of SUD treatment and pregnancy status as our field has an unprecedented opportunity to dramatically transform standard care approaches during the pandemic.

Source of support

NIDA R01-047867.

Conflicts of interest

None.

Declaration of competing interest

Hendree Jones, PhD: Dr. Jones receives or has received grant support from NIH-NIDA.

Essence Hairston: None.

Ashley C. Lensch: None.

Lori Keyser Marcus, PhD: Dr. Marcus receives or has received grant support from NIH-NIDA.

Sarah Heil, PhD: Dr. Heil receives or has received grant support from NIH-NIDA.

Acknowledgments

We thank NIDA for support of R01-047867.

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