

Pregnancy and the Opioid Crisis: Heightened Effects of COVID-19

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The opioid epidemic continues to affect pregnant women with opioid use disorder adversely in unique and enduring ways. The onset of the coronavirus disease 2019 (COVID-19) pandemic and the necessary public health measures implemented to slow the transmission have increased barriers to care for these same women. This commentary explores the implications of these measures and discusses strategies we have developed to manage these challenges based on our work in a clinical trial providing patient navigation to pregnant mothers with OUD. We believe these solutions can be applied in medical, behavioral health, and research settings through the pandemic and beyond to increase the quality of care and resources to this vulnerable population.

Key Words: clinical trial, COVID-19, opioid use disorder, pregnancy

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The current opioid epidemic has led to a drastic rise in pregnant women with opioid use disorder (OUD).¹ Pregnant women with OUD are less likely to engage in prenatal care² and are at increased risk of adverse maternal and perinatal outcomes.³ Compared to men and nonpregnant women with OUD, pregnant women are more likely to

struggle with other substance use disorders³ and co-occurring mental illness.⁴

This commentary highlights our experiences working with pregnant women with OUD in our ongoing clinical trial: Optimizing Pregnancy Interventions for Moms 2.0. (NCT03833245). This trial is testing a patient navigation model to increase linkage and retention in OUD and other substance use treatment and physical and mental health care for pregnant women in Utah and Pennsylvania. Trained patient navigators within large health systems provide individualized support to pregnant patients with OUD through strength-based case management and motivational interviewing.

The onset of the coronavirus disease 2019 (COVID-19) pandemic at the study midpoint has posed unique challenges and increased risks for the pregnant women with OUD enrolled in this trial. Although research has yet to fully illuminate the direct results of the COVID-19 pandemic during the opioid crisis, working directly with our participants has illustrated challenges in recruiting and retaining women. Our research has also elucidated additional challenges this population faces in working to achieve physical and mental health stability. We discuss 4 unintended consequences faced by this population stemming from the pandemic from which we offer key insights that may be useful to researchers and clinicians across the US serving this population.

PATIENT SAFETY

Social distancing is one public health strategy designed to contain COVID-19, with multiple campaigns strongly encouraging individuals to “stay home.” This valuable strategy may, unfortunately, increase risks of harm given that some 47% to 90% of reproductive age women with a SUD report intimate partner violence (IPV).⁵ Early indications suggest domestic violence rates have escalated internationally during the pandemic.⁶ Further exacerbated IPV risks during the pandemic have been related to decreased access to places of refuge, such as churches and shelters.⁷ Moreover, limitations on in-person safety screening in obstetric and other healthcare settings likewise increase IPV risk for pregnant women with OUD. Indeed, given that isolation is known to work against women at risk of IPV,⁸ policies that undermine in-person connection may result in unintended consequences.

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Given that pregnant women with OUD are more often utilizing virtual visits and less often seeing their medical team in person, in-person appointments for essential medical services, such as ultrasounds and bloodwork, are critical opportunities to offer support. It is vital to prepare, train, and organize for these important in-person appointments to capitalize on opportunities to discuss sensitive subjects with greater privacy. Confidentiality cannot be assured during a virtual appointment, when family members may be present and listening in. Attempting to discuss IPV, sexual history, substance use, or other sensitive topics with an abusive partner in the background could put participants in dangerous situations. Though we can suggest participants find a private space or ask them directly if they are alone, we cannot be sure of their privacy. Utilizing in-person visit time for patient coaching regarding upcoming virtual appointments is one effective approach our research team has taken. Research and medical staff can prepare for domestic violence situations, for example, by formulating a “code word” with women that can be used to indicate when they may not be able to speak about topics, or when they are in imminent danger. The participant and patient navigator can formulate a plan together, such as speaking only about innocuous subjects, when the “code word” is given. Plans can also include having a safe family member or friend contacted or having the local authorities perform a wellness check when the word is given.

When special preparation for virtual visits is not possible, the unique circumstances introduced by COVID-19 require increased vigilance and situational awareness among research and medical staff. For example, we have found clients have subtly communicated that there are topics they do not feel comfortable assessing virtually. One participant, for instance, who indicated at intake that she lived with an individual she did not feel safe around, made a vague, hesitating statement when the patient navigator brought up a sensitive subject. The navigator noticed this hesitancy and suggested they speak about the subject at the participant’s next in-person obstetrics appointment, as opposed to pushing the topic in the moment. Offering a chat option where a patient can type in concerns rather than saying them aloud may also provide a more confidential means for patients experiencing IPV to communicate with providers during virtual visits.

ROADBLOCKS TO PATIENT/PROVIDER ALLIANCE

Masking is a critical safety measure recommended by health officials to slow transmission and is required in most medical facilities. Nevertheless, our patients have shared feeling “awkward” while trying to converse wearing a mask. Masks also increase the possibility of missing crucial information from our patients because hearing is more difficult and providers miss facial expressions. Communication via telemedicine visits also produces challenges to conducting thorough assessments. Visual representations provide many cues about patients’ wellbeing and functioning, such as signs of intoxication or withdrawal, difficulty maintaining eye contact, body posture, and facial expressions.⁹ Safety measures limit or confuse such cues making it critical to assess for risks routinely and explicitly such as perinatal and postpartum

depression and anxiety, substance use patterns, and the safety of the patient and her family. In response to these challenges, our teams again have worked to increase preparation and readiness for addressing multiple service domains and increasing patient navigator administered verbal/self-report assessments when meeting with participants in person or virtually. To this important point, given social connectedness has been shown to increase overall mental health and decrease addictive behaviors,¹⁰ our team has increased its availability to all study participants via phone or web meeting during evening time and weekend hours.

ACCESS TO RESOURCES

Increasing access to existing resources for pregnant women with OUD is an important goal at all times; however, the COVID-19 pandemic has made this need even more urgent. Diapers, formula, clothing, and food are resources that have been more difficult to obtain due to the serious financial repercussions of the pandemic.¹¹ Due to Americans utilizing services of food banks and social services at higher rates than before the pandemic,¹² we have observed that pregnant women with OUD have experienced increased difficulty accessing such resources as there is greater competition for these scarce items. It has thus been paramount for staff to stay up to date—by the day—on the offerings of human service agencies, with such information being provided in person or virtually while participants wait for medical providers. Social work staff has also expanded their search for resources to individual members of the community, posting on various forums and groups in search of needed items. Many community members have offered assistance in the form of donations.

INCREASED OVERDOSE RISK

The multifaceted stressors participants in our study experience have made us acutely aware of the increased risk for overdose during the pandemic. More than 40 states have reported increases in opioid-related deaths.¹³ In an effort to counter this risk, participants are provided naloxone during in-person visits; however, given that in-person visits have become rare, pregnant women with OUD have limited opportunities to receive naloxone. Consistent with harm-reduction principles, we have increased our commitment to directly inquiring about participants’ current substance use, asking if they have naloxone, and providing naloxone referrals. Likewise, in light of social isolation, we speak to our participants about the importance of educating those around them about naloxone administration and the dangers of using it without someone there to revive them.

CONCLUSIONS

Pregnant women with OUD face complex challenges and barriers, which have been heightened during the COVID-19 pandemic. Although some challenges may appear intractable, solutions discussed herein have the potential to attenuate many of the negative repercussions. By being prepared, encouraging women to connect to support networks, staying flexible, increasing communication, and remaining vigilant; clinicians and researchers on our team are working conjointly

to aid pregnant women with OUD in overcoming challenges faced within clinical care and research, subsequently improving the health of mothers and infants. Clinicians and researchers working with such vulnerable populations have an obligation to address and attend to the well-being of participants. Research staff, particularly those without a clinical background, need to be trained on the concerns addressed above, counseled on how and when to provide referrals and long-term support, and given adequate clinical support themselves.

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