Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Journal of Substance Abuse Treatment 122 (2021) 108200

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

journal homepage: www.elsevier.com/locate/jsat

Caring for women with substance use disorders through pregnancy and postpartum during the COVID-19 pandemic: Lessons learned from psychology trainees in an integrated OBGYN/substance use disorder outpatient treatment program

Jaclyn S. Sadicario [a,*], Anna Beth Parlier-Ahmad [a], Julia K. Brechbiel [a], Leila Z. Islam [b], Caitlin E. Martin [c]

[a] Virginia Commonwealth University, Department of Psychology, United States of America
[b] Virginia Commonwealth University Health System, Department of Psychiatry, United States of America
[c] Virginia Commonwealth University Health System, Department of Obstetrics and Gynecology, VCU Institute for Drug and Alcohol Studies, United States of America

ARTICLE INFO

Keywords:
Substance use disorder treatment
Perinatal
Telehealth
COVID-19
Primary care psychology
Training

ABSTRACT

Objective: This article presents a brief overview of the challenges and facilitators to the provision of substance use disorder (SUD) treatment for pregnant and parenting women during the COVID-19 pandemic. Specifically, we highlight the deployment of telepsychology services during the pandemic by an integrated, trainee-based women & addictions program that provides care via a multidisciplinary team, including an obstetrician, addiction medicine fellow, nurse, behavioral health trainees, violence prevention advocates, and pediatric provider.
Methods: We outline unique adaptations that the program made to shift from in-person psychology trainee services to telepsychology. Additionally, we describe supporting factors and barriers to success for continued treatment planning, service provision, and educational training.
Results: The program identified and addressed numerous opportunities for improvement to implement and continue telepsychology within an integrated women & addictions program during the COVID-19 pandemic. The program maintained the unique components of care integration with the proliferation of digital resources for patients and providers, as well as the flexibility of attending physicians and supervising psychologists.
Conclusions: Provision of telepsychology services within an integrated women & addictions program employing trainees is crucial during the COVID-19 pandemic. The program addressed barriers to care in creative ways, through the use of various technologies, to meet patients where they are. Continuing to have this option available requires adaptation to the maturing needs of the clinic.

1. Introduction

The COVID-19 pandemic has altered the delivery of substance use disorder (SUD) treatment. Guidelines encouraged providers to use telehealth to meet with patients when possible (CDC, 2020a; Nitkin, 2020; Stiepan, 2020; VHA, 2020) and new guidelines eliminated previous barriers to telehealth treatment provision: HIPAA Security and Privacy Rule requirements were waived, reimbursement changed to support telehealth, and the DEA and DMAS relaxed prescribing regulations for buprenorphine for treatment of opioid use disorder (DHHS, 2020a; DHHS, 2020b; DeAngelis, 2020; DEA, 2020). Though published data on the impacts of COVID-19 are in their early stages, individuals with SUD may be at an increased risk for more severe disease due to health status, and psychosocial and environmental factors (NIDA, 2020). It is important for patients to continue to remain engaged in treatment, including psychosocial support, especially individuals with SUD and complex circumstances, such as those who are pregnant and parenting.

* Corresponding author at: Clinical Psychology Doctoral Trainee, Virginia Commonwealth University, Richmond, VA 23284-2018, United States of America.
E-mail address: sadicariojs@mymail.vcu.edu (J.S. Sadicario).

https://doi.org/10.1016/j.jsat.2020.108200
Received 15 June 2020; Received in revised form 1 October 2020; Accepted 9 November 2020
Available online 17 November 2020
0740-5472/

Table 1. Clinic components and format, and subsequent adjustment to COVID-19 circumstance

Program component	Workflow/setting pre-COVID-19	Workflow/setting during COVID-19
Interdisciplinary plan of care (IPOC) meeting	In person, in hospital, Thursday afternoon	Weekly Zoom call for disciplines to participate in while at separate locations
Shared drive	No centralized location for resources, schedules, and patient tracking information. Pertinent information was shared in person at clinic	OneDrive, HIPAA compliant shared folder created to house resources for patients and providers as well as schedules Pertinent information to be shared between disciplines can be written in agenda for IPOC meeting (see below) or on clinic schedule, which edits can be viewed in real time, viewable by all providers housed in OneDrive
Agenda for IPOC meeting	Presented in person during meeting by nurse coordinator	Outline saved in OneDrive in advance of meeting, individuals can update before meeting with patient case notes and clinic concerns
Patient scheduling	Completed in clinic by nurse coordinator and staff; for behavioral health, follow ups discussed with BH trainees and scheduled by nurse	OB appointments: Completed by nurse and staff in clinic or telemedicine. BH appointments: Completed by BH trainees by phone, text, or via patient portal. Documented scheduling and relevant information in shared scheduling document on OneDrive, should a patient see both MD and BH trainees in same clinic day (see below for more information).
Behavioral health schedule	Paper schedule for trainees in Behavioral Health	Schedule posted in OneDrive, actively updated as patients are contacted via Zoom/phone. These live updates are viewable by the MD and other providers. BH Trainees also gained the ability to have their confirmed appointment schedule in the EMR September 2020.
Interdisciplinary care coordination and referrals (pediatric, nutrition, domestic violence advocates)	In clinic, during IPOC meeting In clinic, during clinic day	During IPOC meeting on ZOOM. Via impromptu phone calls or messages in the EMR/skype during clinic time while staff work across settings.
Clinic visits	In clinic, each team member seeing patient as needed in same room	Medical visits take place both in person and via Doximity and phone. Behavioral Health visits take place via phone or Zoom.
Trainee training and education within women & addictions program	Before clinic, during journal club, and in clinic	Points of education discussed via Zoom in clinical and educational meetings. E.g. several organizations began offering didactics and workshops which were disseminated by OB attending and BH supervisors to BH trainees BH trainees provided peer support to younger trainees via phone during and after clinic
Psychology trainee supervision from licensed clinical supervisor	In person, bi-weekly group supervision, phone supervision for high risk cases	BH trainees met via Zoom weekly to discuss cases and clinic logistic concerns. BH trainees could message their supervisor and other team members via secure software to alert them of high-risk cases, and follow-up with a phone call for supervision or coordinating care (e.g. OB or psychiatry appointment if necessary).
Psychology trainee peer supervision from advanced students	In clinic, as needed to help support clinical decision making	BH trainees meet with advanced peer supervisor via Zoom or phone before and after clinic shifts to discuss cases and concerns

1.1. Challenges specific to pregnant and parenting individuals with SUD

Although there is no current data that states that COVID-19 poses a greater risk to pregnant women, there is a documented higher risk for respiratory illnesses in general (CDC, 2020a). Stress and anxiety related to COVID-19 are also concerning, as worsened mood during pregnancy can have negative impacts on child and maternal outcomes (Field, 2011; Stewart & Vigod, 2016; Lindgren, 2001). CDC guidelines encourage pregnant women to continue regular care and deliver under the supervision of health care professionals (CDC, 2020b). COVID-19 may cause women to be both apprehensive about attending regular hospital appointments and avoid care when indicated (i.e., delivering outside of hospital). Thus, care teams should encourage treatment engagement, which can be facilitated via ongoing psychosocial support.

2. Methods: Women & addictions program at VCU

The women & addictions program at Virginia Commonwealth University Health System provides integrated women's health services and SUD treatment. In 2019, the program expanded its team to include additional providers across specialties, specifically embedding psychology trainees who take part in the primary care psychology collaborative at VCU (see Perrin et al., 2020). Psychology trainees provide behavioral health (BH) services alongside medical care and onsite care coordination (inpatient and outpatient obstetrics care, pediatrics, anesthesia, psychiatry, addiction treatments, social work, domestic violence advocates). The integrated nature of the clinic supports multidimensional service provision for patients and vital educational

opportunities for trainees across disciplines.

2.1. Training model before and during COVID-19

COVID-19 created some unique barriers for our clinic due to the program's embedded training. Before COVID-19, our clinic director had no training or experience in clinical teaching using telehealth. Thus training was initially compromised, as trainees across the health system were removed from providing in person services in clinic in March 2020. BH trainees immediately began providing services via telepsychology, with no gap in treatment for patients. We identified several potential issues with remote work: it limits trainee ability to consult with other providers across disciplines, to receive warm handoffs, and to provide patient education alongside medical providers (ensuring consistent messaging). Additionally, BH trainees employ a peer supervision model wherein advanced trainees support new clinicians in clinical decisions in real time, which was difficult to replicate with remote work. We had to make creative adjustments to maintain the benefits of our model and training standards.

3. Results: COVID-19 clinic changes, integrated care at a distance

The switch to telehealth allowed for the utilization of digital resources to support training and services (Table 1). New tools including a shared drive that allows trainees to communicate patient status in a HIPAA protected manner. The ability to check patient status in real-time via shared documents has helped our team to discuss patients' issues that have potentially catastrophic health outcomes (i.e., interpersonal violence, suicidal ideation, substance use recurrence) in a timely manner to ensure proper support. We established protocols for BH trainees to operate remotely, including remote peer consultations, supervisions, and integrated clinic meetings to discuss points of education and patient status outside of clinic.

3.1. 3.2 Challenges and advantages to telepsychology services within an integrated care model for pregnant/parenting individuals

There have been challenges to the telepsychology transition. Some patients do not have consistent access to resources (i.e., a phone) that support telepsychology services. For others, clinic visits may be the only time to privately discuss sensitive issues related to mental health and safety in a supportive environment. A patient disclosure of suicidal or homicidal ideation in clinic is easier to address than via telehealth because trainees have in-person peer support to assist with safety planning. Discussions of domestic violence require appropriate timing and consent from patients while they are at home. Remote protocols to address these issues have required increased flexibility across team members, which can be challenging in a busy clinical environment. During high-risk situations, trainees can message another team member to alert their clinical supervisor or violence prevention advocates while safety planning to facilitate additional support.

Another issue with telehealth is attendance to therapy. McKiever et al. (2020) recently found the transition to telehealth for patients in a similar clinic was associated with decreased attendance to therapy and uptitration of medication secondary to cravings. In our clinic, many patients are unable to access childcare and either have to parent during or no-show to telehealth appointments due to COVID constraints and lack of resources. This issue has pushed providers to be more flexible with appointment times; however, dense scheduling can interfere with our ability to provide flexibility. Another driver of the decreased telepsychology attendance is likely related to compromised ability to engender patient-provider trust and relationships. Many women with SUD note high level of mistrust of the health care system related to repeated prior stigmatizing interactions with health care providers related to substance use (Cockroft et al., 2019). Not being able to perform "warm handoffs" between medical and BH providers in the clinic limits the ability for clinical team members to gradually gain patients' trust, which then likely compromises their uptake of telepsychology services with a new team member who they have not been able to meet yet in person.

Although COVID-19 has presented challenges, there have been some relative advantages to using telehealth. Telehealth allows us to reach our patients where they are. Transportation is no longer a barrier for patients who do not have a vehicle. Though not ideal, parenting patients are not required to find childcare during appointments, which was even more critical during COVID visitor restrictions in the clinic. Overall, telehealth services are more acceptable to some, but not all, patients. For example, telehealth allows us to reach those who may have missed appointments due to extenuating factors or those who may feel more comfortable starting with BH services via virtual rather than in-person care.

4. Conclusion: Is this the new normal? Considerations for integrated SUD care

As a multidisciplinary, trainee-based program, we hope to continue to use these cross-discipline communication tools and to offer telehealth when appropriate. In the context of ongoing uncertainty, our role will focus on supporting patients in their progress toward and maintaining recovery while also continuing our training. These changes may help the clinic to grow; evidence-based psychology treatment for pregnant and parenting individuals with SUD includes addiction treatment (e.g., medication for OUD) and medical services (e.g., prenatal care), preferably in one location. An unanticipated benefit of using telehealth is increased flexibility to connect patients with other disciplines, such as psychiatry, and to integrate wrap-around services. These positive changes can help other programs to reach the quality of care that evidence base supports (SAMHSA, 2018). Current circumstances, though unfortunate, may provide an opportunity to continue to improve and better serve our patients.

Acknowledgments

This project [publication] is supported in part by awards D40HP33378 (Rybarczyk) and M01HP31388 (Jones) from the Health Resources and Services Administration, NIH award T32DA007027 (Dewey), and CTSA award KL2TR002648 from the National Center for Advancing Translational Sciences. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the National Institutes of Health.

Declarations of competing interest

None

References

Centers for Disease Control and Prevention. (2020a). Resources for clinics and healthcare facilities. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html on 2020, June 14.

Centers for Disease Control and Prevention. (2020b). Coronavirus 2019: If you are pregnant, breastfeeding, or caring for young children. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/pregnancy-breastfeeding.html on 2020, June 14.

Cockroft, J. D., Adams, S. M., Bonnet, K., Matlock, D., McMillan, J., & Schlundt, D. (2019). "A scarlet letter": Stigma and other factors affecting trust in the health care system for women seeking substance abuse treatment in a community setting. *Substance Abuse, 40*(2), 170–177.

DeAngelis, T. (2020). What the COVID-19 telehealth waiver means for psychology practitioners. American Psychological Association https://www.apaservices.org/practice/legal/technology/covid-19-telehealth-waiver.

Drug Enforcement Agency (2020). COVID-19 information page. Retrieved from https://www.deadiversion.usdoj.gov/coronavirus.html on 2020, June 14.

Field, T. (2011). Prenatal depression effects on early development: A review. *Infant Behavior and Development, 34*(1), 1–14.

Lindgren, K. (2001). Relationships among maternal-fetal attachment, prenatal depression, and health practices in pregnancy. *Research in Nursing and Health, 24*(3), 203–217.

McKiever, M. E., Cleary, E. M., Schmauder, T., Talley, A., Hinely, K. A., Costantine, M. M., & Rood, K. M. (2020). Unintended consequences of the transition to telehealth for pregnancies complicated by opioid use disorder during COVID-19 pandemic. *American Journal of Obstetrics and Gynecology*. https://doi.org/10.1016/j.ajog.2020.08.003.

NIDA. (2020). COVID-19: Potential implications for individuals with substance use disorders. Retrieved from https://www.drugabuse.gov/about-nida/noras-blog/2020/04/covid-19-potential-implic.ations-individuals-substance-use-disorders on 2020, June 14.

Nitkin, K. (2020). In fight against coronavirus, telemedicine ramps up at Johns Hopkins. Johns Hopkins Health System. https://www.hopkinsmedicine.org/coronavirus/telemedicine.html.

Perrin, P. B., Rybarczyk, B. D., Pierce, B. S., Jones, H. A., Shaffer, C., & Islam, L. (2020). Rapid telepsychology deployment during the COVID-19 pandemic: A special issue commentary and lessons from primary care psychology training. *Journal of Clinical Psychology, 76*(6), 1173–1185.

SAMHSA. (2018). Clinical guidance for treating pregnant and parenting women with opioid use disorder and their infants. HHS publication no. (SMA) 18-5054. Rockville, MD, Substance Abuse and Mental Health Services Administration.

Stewart, D. E., & Vigod, S. (2016). Postpartum depression. *New England Journal of Medicine, 375*(22), 2177–2186.

Stiepan, D. (2020). How video appointments are changing the way Mayo Clinic patients receive care. Mayo Clinic https://newsnetwork.mayoclinic.org/discussion/how-video-appointments-are-changing-the-way-mayo-clinic-patients-receive-care/.

U.S. Department of Health and Human Services' Office for Civil Rights. (2020a). BULLETIN: HIPAA Privacy and Novel Coronavirus. https://www.hhs.gov/sites/default/files/february-2020-hipaa-and-novel-coronavirus.pdf.

U.S. Department of Health and Human Services' Office for Civil Rights. (2020b). OCR eases HIPAA telehealth enforcement for COVID-19 emergency. https://www.aha.org/news/headline/2020-03-18-ocr-eases-hipaa-telehealth-enforcement-covid-19-emergency.

Veterans Health Administration - Office of Emergency Management. (2020). COVID-19 response plan.