ASAM COVID-19 TASK FORCE RECOMMENDATIONS

CARING FOR PATIENTS DURING THE COVID-19 PANDEMIC

Treating Pregnant People with Opioid Use Disorder

AMERICAN SOCIETY OF ADDICTION MEDICINE
FOUNDED 1954
ASAM

ASAM COVID-19 TASK FORCE RECOMMENDATIONS

TREATING PREGNANT PEOPLE WITH OPIOID USE DISORDER

A guide for addiction treatment clinicians and programs working to treat patients with substance use disorders safely and effectively during the COVID-19 pandemic[1].

For additional recommendations for the Ongoing Management of the Continuum of Addiction Care during COVID-19, please click here.

CONTENT DISCLAIMER

This Clinical Guidance ("Guidance" is provided for informational and educational purposes only. It is intended to provide practical clinical guidance to addiction medicine physicians and others caring for individuals with substance use disorders during the COVID-19 pandemic as it unfolds. Adherence to any recommendations included in this Guidance will not ensure successful treatment in every situation. Furthermore, the recommendations contained in this Guidance should not be interpreted as setting a standard of care or be deemed inclusive of all proper methods of care nor exclusive of other methods of care reasonably directed to obtaining the same results.

The ultimate judgment regarding the propriety of any specific therapy must be made by the physician and the patient in light of all the circumstances presented by the individual patient, and the known variability and biological behavior of the medical condition.

This Guidance and its conclusions and recommendations reflect the best available information at the time the Guidance was prepared. The results of future studies may require revisions to the recommendations in this Guidance to reflect new data.

ASAM does not warrant the accuracy or completeness of the Guidance and assumes no responsibility for any injury or damage to persons or property arising out of or related to any use of this Guidance or for any errors or omissions.

TREATING PREGNANT PEOPLE WITH OPIOID USE DISORDER

Purpose of the document

To provide guidance to addiction treatment clinicians and programs on the treatment of pregnant people with addiction during the COVID-19 pandemic. In March 2020, ASAM released a focused update to the National Practice Guideline for the Treatment of Opioid Use Disorder. The COVID-19 crisis is likely to require adjustments in care for this population to balance the risks from both addiction and COVID-19. The purpose of this document is to provide guidance on adjusting that care in the current crisis, with a particular focus on Opioid Use Disorder (OUD).

[1]This resource was developed by a Task Force appointed by ASAM's Executive Council. To enable more rapid development and dissemination it was not developed through ASAM's normal process for clinical guidance development that is overseen by the ASAM Quality Improvement Council.

TOPICS

1. Are Pregnant People at Greater Risk from COVID-19 than Non-pregnant People?

The CDC says "Pregnant people have changes in their bodies that may increase their risk of some infections. Pregnant people have had a higher risk of severe illness when infected with viruses from the same family as COVID-19 and other viral respiratory infections, such as influenza." [2]

There does not seem to be an increased risk of miscarriage in women with symptomatic COVID-19, although data are limited. Outcome data are limited by reports from symptomatic women at the time of delivery: women that are clinically ill with COVID-19 at delivery have increased rates of preterm birth (20%) and cesarean delivery (80%).[3]

Over 8000 pregnancies affected by COVID-19 have been reported. Symptoms of COVID-19 occur at the same rate in pregnant people and non-pregnant women. Pregnant people with COVID-19 report more underlying disease such as diabetes, chronic lung disease, and cardiovascular disease. If COVID-19 symptoms occur, **pregnant people might be at an increased risk** for severe illness from COVID-19 compared to non-pregnant people. Additionally, there may be an increased risk of adverse pregnancy outcomes, such as preterm birth, among pregnant people with COVID-19. The increased risk is especially true for pregnant people of Hispanic and Black background. Hospitalization is more common in pregnant people with COVID-19 symptoms, but it is not known if this is due to infection symptoms, pregnancy complications, or a lower threshold for admission. Severe disease due to COVID-19 is more common in pregnant people, with increased rate of ICU admission (5 fold) and mechanical ventilation (4-fold). Pregnant people do not have an increased risk of death from COVID-19. [4]

2. Does having COVID-19 Harm the Fetus?

Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives says, "There are currently no data suggesting an increased risk of miscarriage or early pregnancy loss in relation to COVID-19. Case reports from early pregnancy studies with SARS and MERS do not demonstrate a convincing relationship between infection and increased risk of miscarriage or second trimester loss. There is no evidence currently that the virus is teratogenic. Very recent evidence has, however, suggested that it is probable that the virus can be vertically transmitted, although the proportion of pregnancies affected and the significance to the neonate has yet to be determined. There are case reports of preterm birth in women with COVID-19, but it is unclear whether this was iatrogenic in every case, or whether some were spontaneous. Iatrogenic birth was predominantly for maternal indications related to the viral infection, although there was evidence of fetal compromise and prelabour preterm rupture of the membranes in at least one report."[5]

3. Transmission of Coronavirus Between Mothers and Babies

Is there in utero mother-to-child transmission of COVID-19?

The largest series of symptomatic COVID infections during pregnancy suggested negligible vertical viral transmission.[6] Nonetheless, there have been multiple case reports of congenital transmission of SARS-CoV-2 but overall congenital transmission rate is low and of uncertain clinical significance. Clinical disease in a neonate related to vertical transmission has not been definitively demonstrated.[7]

Should mothers and babies be separated?

There is very little research available on risks to newborns associated with COVID-19. However, the limited research that is available suggests that infants and children are at low risk of infection and, according to the WHO, "The few confirmed cases of COVID-19 in young children to date have experienced only mild or asymptomatic illness." Further, there are clear harms associated with maternal infant separation. Separation can interfere with maternal infant bonding as well as with the establishment of breastfeeding. Breastfeeding supports the development of immunity in infants as mothers pass on antibodies through their milk. In addition, skin to skin contact has been shown to reduce infant mortality and improve long term health outcomes. **Given the specific benefits of skin-to-skin and rooming in of mother and baby who may have opioid withdrawal, the risk of maternal infant separation must be carefully considered.**

---

[2] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/pregnancy-breastfeeding.html (accessed 4/24/2020)

[3] Rates of Maternal and Perinatal Mortality and Vertical Transmission in Pregnancies Complicated by Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-Co-V-2) Infection: A Systematic Review. Huntley BJF, Huntley ES, Di Mascio D, Chen T, Berghella V, Chauhan SP Obstet Gynecol. 2020.

[4] https://www.cdc.gov/mmwr/volumes/69/wr/mm6925a1.html (accessed 7-19-20)

Royal College of Obstetricians and Gynecologists and the Royal College of Midwives says, "Literature from China has advised separate isolation of the infected woman and her baby for 14 days. However, routine precautionary separation of a woman and a healthy baby should not be undertaken lightly, given the potential detrimental effects on feeding and bonding. Given the current limited evidence, we advise that women and healthy babies, not otherwise requiring neonatal care, are kept together in the immediate postpartum period. A risk and benefits discussion with neonatologists and families to individualize care in babies that may be more susceptible is recommended." [8]

The CDC guidance recommends that:

- Although it is well recognized that the ideal setting for care of a healthy term newborn while in the hospital is within the mother's room, temporary separation of the newborn from a mother with confirmed or suspected COVID-19 should be strongly considered to reduce the risk of transmission to the neonate.[9]
- "The determination of whether or not to separate a mother with known or suspected COVID-19 and her infant should be made on a case-by-case basis using shared decision-making between the mother and the clinical team."
    - If mother and infant are not separated, steps should be taken to reduce the risk for transmission from mother to infant, including use of respiratory and hand hygiene practices.
    - Infants born to mothers with known COVID-19 at the time of delivery should be considered to have suspected COVID-19 and should be tested and isolated from other healthy infants[8].

A study of 68 neonates of mothers that tested positive for SARS-CoV-2 roomed in with mothers and were breastfed. Those infants were followed for 14 days and none were positive . Best practices for infection control highlighted by this study include:

- Mothers with confirmed or suspected COVID-19 should maintain a reasonable distance from their infants when possible. While performing hands-on care, the mothers should wear a mask and use hand hygiene. An isolette may facilitate distancing and provide added protection; take care to properly latch isolette doors to prevent infant falls.
- Mothers who are acutely ill may not feel up to providing all care for their babies. They might need to be temporarily separated or have the infant cared for by another, healthy caregiver in the room.
- Noninfected partners or other family members present during the birth hospitalization should use masks and hand hygiene when delivering hands-on care to the baby.

---

[5] https://www.rcog.org.uk/globalassets/documents/guidelines/2020-04-17-coronavirus-covid-19-infection-in-pregnancy.pdf (accessed 4/23/2020). [6]

[6]Rates of Maternal and Perinatal Mortality and Vertical Transmission in Pregnancies Complicated by Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-Co-V-2 Infection: A Systematic Review. Huntley BJF, Huntley ES, Di Mascio D, Chen T, Berghella V, Chauhan SP Obstet Gynecol. 2020

[7] Transplacental transmission of SARS-CoV-2 infection. Alexandre J. Vivanti, Christelle Vauloup-Fellous, Sophie Prevot, Veronique Zupan, Cecile Suffee, Jeremy Do Cao, Alexandra Benachi & Daniele De Luca Nature Communications volume 11, Article number: 3572 (2020).

https://www.nature.com/articles/s41467-020-17436-6

[8]https://www.cdc.gov/coronavirus/2019-ncov/hcp/inpatient-obstetric-healthcare-guidance.html

4. Considerations for Breastfeeding

Can mothers breastfeed if infected with COVID-19 virus?

Both the World Health Organization and the CDC support breastfeeding by mothers with COVID-19.

> "WHO recommends that all mothers with confirmed or suspected COVID-19 continue to have skin-to-skin contact and to breastfeed. In all socio-economic settings, breastfeeding improves survival and provides lifelong health and development advantages to newborns and infants. Breastfeeding also reduces the risk of breast and ovarian cancer for the mother. Skin-to-skin contact, including kangaroo mother care, reduces neonatal mortality, especially for low birth weight newborns.
>
> While infants and children can contract COVID-19, they are at low risk of infection. The few confirmed cases of COVID-19 in young children to date have experienced only mild or asymptomatic illness."[9]

The CDC says, **"**If you are sick and choose to directly breastfeed: Wear a facemask and wash your hands before each feeding. If you are sick and choose to express breast milk:

- Express breast milk to establish and maintain milk supply.
- A dedicated breast pump should be provided.
- Wash hands before touching any pump or bottle parts and before expressing breast milk.
- Follow recommendations for proper pump cleaning **after each use, cleaning all parts that come into contact with breast milk.**
- If possible, consider having someone who is well feed the expressed breast milk to the infant." [10]

The American Academy of Pediatrics recommends breast milk feeding with suspected or confirmed COVID-19.[11] Breastfeeding may occur with careful hand hygiene and maternal masking. Alternatively, breastmilk may be expressed and fed by a healthy caregiver. Breastfeeding has been demonstrated to reduce NAS symptoms and should be encouraged if can be performed safely.

---

[9] https://www.who.int/news-room/q-a-detail/q-a-on-covid-19-and-breastfeeding

[10] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/pregnancy-breastfeeding.html (accessed 4/24/2020).

[11] https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/breastfeeding-guidance-post-hospital-discharge/

5. Policies and Practices to Consider in Caring for Pregnant People with Addiction During COVID

- **Provide education and resources to pregnant patients regarding COVID-19.**
    - Educate pregnant and post-pregnant people and their family members about COVID-19 and steps to stay healthy. Education needs to be repeated frequently.
    - Have resources available to help pregnant and post-pregnant people obtain personal protective equipment
    - Provide resources to pregnant and post-pregnant people for dealing with anxiety and practicing self-care.
- **Use telehealth, including telephonic visits, whenever possible and appropriate (See** Supporting Access to Telehealth for Addiction Services Guidance**).**
    - If moving to "tele-treatment," discuss the risks and benefits of such a modality of care and document this discussion in the patient's chart. If possible, consider having patients sign a specific care consent that discuss risks and benefits of the new treatment modality. Such a process could be done via patient portals for electronic medical records or secure email (if available).
    - Discuss with each patient their ability to use tele-treatment platforms and continue to troubleshoot (data plans, connectivity, minutes are all issues). If an in-person visit is needed, remember to use PPE and practice physical distancing.
    - Complete staff training on" ethics and technology"
    - Develop new "ground rules for tele-treatment" to share with patients
    - Offer tele-counseling visits
    - Ensure clinical crisis plan response is updated to reflect new treatment modality
    - Explicit conversations with patients around confidentiality and guidelines for engagement – meaning they should not drive and be on the tele-treatment platform, they need to wear clothes, avoid eating, performing hygiene routines while on the tele-treatment platform
    - Encourage the patient to find a quiet, private space for telehealth visits, or to put on headphones if a child or other person is in the same room listening to the discussion.

- **Help patients to manage their stress and anxiety.**
    - Remember that all patients are under more stress during this time. COVID-19 and the isolation associated with sheltering in place may be triggering for many patients.
    - Make sure that pregnant patients and post-pregnant patients are having psychosocial assessments and there are responses in place for any issues that arise.
    - Social support is even more important during this crisis. Encourage virtual support group attendance.
        - But note that some patients are reporting fatigue with the online platform.
        - Help patients to develop a plan for obtaining social support that will work for them.
    - Be more understanding, flexible, and compassionate during this time.
    - Be flexible in re-scheduling sessions if the patient is having a rough day or transportation, childcare or other issues are preventing them from an in-person clinic visit.
- **Increase your efforts to maintain patient engagement in treatment.**
    - There is a risk that even fewer women will attend post-pregnancy visits. Thus, be more vigilant about ensuring they are completed.
- **Help women develop a COVID-19 birth plan.**
    - Can they virtually tour the hospital?
    - Can they refuse COVID-19 testing if they do not want it?
    - What if they cannot have visitors?
    - Can they FaceTime with a support person?
    - What can and can't they bring to the hospital, including medications?
    - What other changes to delivery and post-partum care has the hospital put in place?
    - What is the NAS care plan at the hospital?
    - Any special COVID-19 procedures in place?
    - Once the birth plan is developed, then share with all care providers.
    - What will happen if they have COVID at the time of delivery?
- **Increase communication with patients during this time.**
    - Avoid relying on written memos with patients for communication; now is the time to talk with patients and over-communicate to ensure they have the information they need.
- **Implement infection control and mitigation procedures**
    - See ASAM's COVID-19 Guidance on Infection Mitigation in Outpatient Settings and Infection Mitigation in Residential Settings

- **Continue to support comprehensive care.**
    - Counseling on contraception options
    - Postpartum depression screening
    - Nutrition
    - Smoking cessation
    - Pre-eclampsia education
    - Harm reduction (e.g. naloxone)
    - Be vigilant in providing support and resources to patients regarding domestic violence/ interpersonal violence and child abuse and neglect prevention or intervention.

6. Initiation of Medication for Opioid Use Disorder

ASAM's National Practice Guideline for the Treatment of Opioid Use Disorder recommends that hospitalization during initiation of treatment with buprenorphine or methadone may be advisable due to the potential for adverse events, especially in the third trimester. The decision of whether to hospitalize a patient for initiation of medication should consider the experience of as well as comorbidities and other risk factors for the individual patient.

However, during the COVID-19 crisis, clinicians will need to weigh the individual patient's risks associated with hospitalization versus the risks for outpatient-based initiation of medication. Outpatient initiation of methadone and buprenorphine is generally safe and effective. Clinicians should consider:

- Is the patient at high risk for severe COVID-19 illness?
- Which setting is associated with higher risk of COVID-19 transmission?
    - Are there high levels of community transmission?
    - What is the situation at the hospital where initiation would occur?
    - What is the situation at the outpatient clinic?
        - Are they providing services through telehealth?
        - Do they have adequate PPE?
        - Are sufficient infection control procedures in place?
    - How many in-person visits are anticipated?
        - Would the patient need to take mass transit or ride with another person to the visit?

- After discussing the risks, what does the patient prefer?
- Is the patient experiencing any symptoms consistent with COVID-19 or have they had any potential exposures?

- Is the patient living in a high-risk environment for COVID-19 transmission?
  - Is the patient at high risk of adverse events related to their OUD (e.g. overdose, suicide) or co-occurring conditions?
- Can and will the patient engage in telehealth visits?
- Is the patient more likely to disengage from treatment?
- Can the patient appropriately and safely manage take home medications?
  - Is the patient likely to divert or misuse their medication?

7. Drug Testing

ASAM's National Practice Guideline for the Treatment of Opioid Use Disorder notes that, for pregnant people:

> Drug testing may be used to detect or confirm suspected opioid and other drug use but should be performed only with the patient's consent and in compliance with state laws (See ASAM's Appropriate Use of Drug Testing in Clinical Addiction Medicine document). State laws differ in terms of clinicians' reporting requirements of identified drug use (through either drug testing or self-report) to child welfare services and/or health authorities. Laws that penalize pregnant women for substance use disorders serve to prevent women from obtaining prenatal care and treatment for opioid use disorder, which may worsen outcomes for mother and child. [...] Even with patient consent, urine testing should not be relied upon as the sole or valid indication of drug use. [...] Positive urine screens should be followed with a definitive drug assay.

The same considerations discussed in Adjusting Drug Testing Protocols Guidance apply to pregnant and postpartum women.

8. Take Home Doses of Opioid Agonist Medication

The same considerations discussed in Ensuring Access to Care in Opioid Treatment Programs Guidance and Access to Buprenorphine in Office Based Settings Guidance apply to pregnant and postpartum women. However, dose adjustments may be needed more often during pregnancy and postpartum, which should be considered in the determination of the appropriate number of take-home doses.

9. Supporting Parents in the Child Welfare System

During the COVID-19 crisis, there has been increased stress on the child welfare system. Treatment clinicians need to know about both the challenges that face the system and families as well as the information as to how the system has been instructed to respond.

Challenges that parents have encountered include:

- Delays in family court hearings
- Denial of visitation for parents
- Over-reliance on tele-visits for all children including newborns (which is developmentally inappropriate)
- Increase in reporting of parents for certain substances used and removals of children due to parental substance use.

The Children's Bureau issued important guidance that[12]:

- Urged avoiding making wide orders to stop, suspend or delay hearings
- Stressed a case by case approach
- Recommended attorneys file written motions raising issues of immediate concern
- Advised use of technology to facilitate remote proceedings where possible and appropriate
- Recommended ensuring parents and children have access to the necessary technology and internet connection to be able to participate in connection with the family and in hearings or other meetings/ proceedings
- Advised engaging attorneys to resolve issues that have already been agreed upon using virtual meetings to prevent unnecessary delays to reunification.

[12] https://www.acf.hhs.gov/cb/resource/covid-19-resources

10. General Resources

- CDC's Considerations for Inpatient Obstetric Healthcare Settings: https://www.cdc.gov/coronavirus/2019-ncov/hcp/inpatient-obstetric-healthcare-guidance.html
- Society for Maternal Fetal Medicine COVID-19 Resources: https://www.smfm.org/covidclinical
- SMFM Coronavirus (COVID-19) and Pregnancy: What Maternal-Fetal Medicine Subspecialists Need to Know: https://s3.amazonaws.com/cdn.smfm.org/media/2322/COVID19-What_MFMs_need_to_know_revision_4-11-20_ (final)_highlighted_changes._PDF.pdf
- World Health Organization Guidance on Breastfeeding and COVID-19: https://www.who.int/news-room/q-a- detail/q-a-on-covid-19-and-breastfeeding
- Administration for Children and Families, Children's Bureau COVID-19 Guidance: https://www.acf.hhs.gov/cb/resource/covid-19-resources
- A Joint Statement on Child Welfare Courts During a Public Health Crisis: Access to Justice and Advocacy are Critical Anchors During Uncertain Times: https://www.acf.hhs.gov/sites/default/files/cb/statement_child_welfare_crisis.pdf