Critical Conversations: Discussing Fertility Plans with Women with Substance Use Disorders

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Disclosure Information

- Sara Spinella, MD
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  - No disclosures
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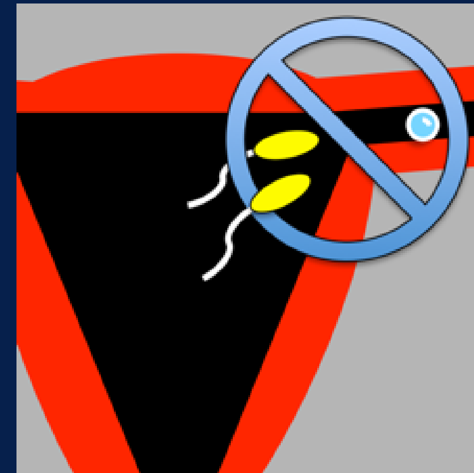
  - University of Pittsburgh School of Medicine, Department of Medicine
  - No disclosures

Learning Objectives

- Elicit patient-driven fertility goals among with women with SUDs
- Formulate plans with women about reproductive choice that minimize the risks of "unplanned' pregnancies
- Prescribe emergency contraception with confidence

Outside of the scope of this workshop

- Contraception prescribing



Contraception Point of Care App

- Management of SUD <u>during</u> pregnancy

A word on terminology

- We will use the term “women” to describe people with vaginas/uteruses
- This workshop highlights differences with experiences and attitudes about contraception based on sex
- This terminology does not capture the full spectrum of gender experiences and identifies

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Outline

- Background
- Pregnancy ambivalence
- How to discuss fertility plans
  - PATH Framework
- Breakout discussion
- Pregnancy harm reduction
- Conclusions

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Background

- Unplanned pregnancy = a woman not attempting pregnancy at the time of conception
- 50% of pregnancies in the US are unplanned[1]
- May be as high as 80% among women with SUD[1]

1. Heil SH, Jones HE, Arria A, et al. Unintended Pregnancy in Opioid-abusing Women. Journal of Substance Abuse Treatment. 2011;40(2):199-202.

Background

- 55% of heterosexually active women with SUDs use contraception[2]
- 25% of women with SUDs reported difficulty accessing reproductive health care[3]
  - 83% would want to receive reproductive healthcare through their substance use treatment program[3]
- Women with SUDs are:
  - Less likely to receive prescription contraception[4]
  - Less likely to be offered highly effective forms of contraception[4]

2. Terplan M, Hand DJ, Hutchinson M, Salisbury-Afshar E, Heil SH. Contraceptive use and method choice among women with opioid and other substance use disorders: A systematic review. Prev Med. 2015;80:23-31.

3. Terplan M, Lawental M, Connah MB, Martin CE. Reproductive Health Needs Among Substance Use Disorder Treatment Clients. J Addict Med. Jan-Feb 2016;10(1):20-5. 4. Callegari LS, Zhao X, Nelson KM, Lehavot K, Bradley KA, Borrero S. Associations of mental illness and substance use disorders with prescription contraception use among women veterans. Contraception. Jul 2014;90(1):97-103.

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SUD in Pregnancy

- Active substance use is associated with adverse pregnancy outcomes[5]
  - Alcohol – Still birth, SIDS, Fetal Alcohol Spectrum Disorders
  - Opioids – Neonatal abstinence syndrome
  - Stimulants – Premature birth, placental abruption, pre-eclampsia, low birth weight
  - Marijuana – Low birth weight, ? Premature birth, ? ADD in childhood
  - Tobacco – Premature birth, low birth weight, still birth, SIDS,
- Addiction is associated with behaviors that increase the risk of sexually transmitted infections[6]

5. NIDA. Substance Use While Pregnant and Breastfeeding. National Institute on Drug Abuse website. https://www.drugabuse.gov/publications/research-reports/substance-use-in-women/substance-use-while-pregnant-breastfeeding. June 6, 2020 Accessed February 28, 2021.

6. Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids. American Society of Addiction Medicine. Updated Jan 18, 2017. Accessed Feb 15, 2021, https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2017/01/19/substance-use-misuse-and-use-disorders-during-and-following-pregnancy-with-an-emphasis-on-opioids

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One key question

Do you want to be pregnant in the next year?

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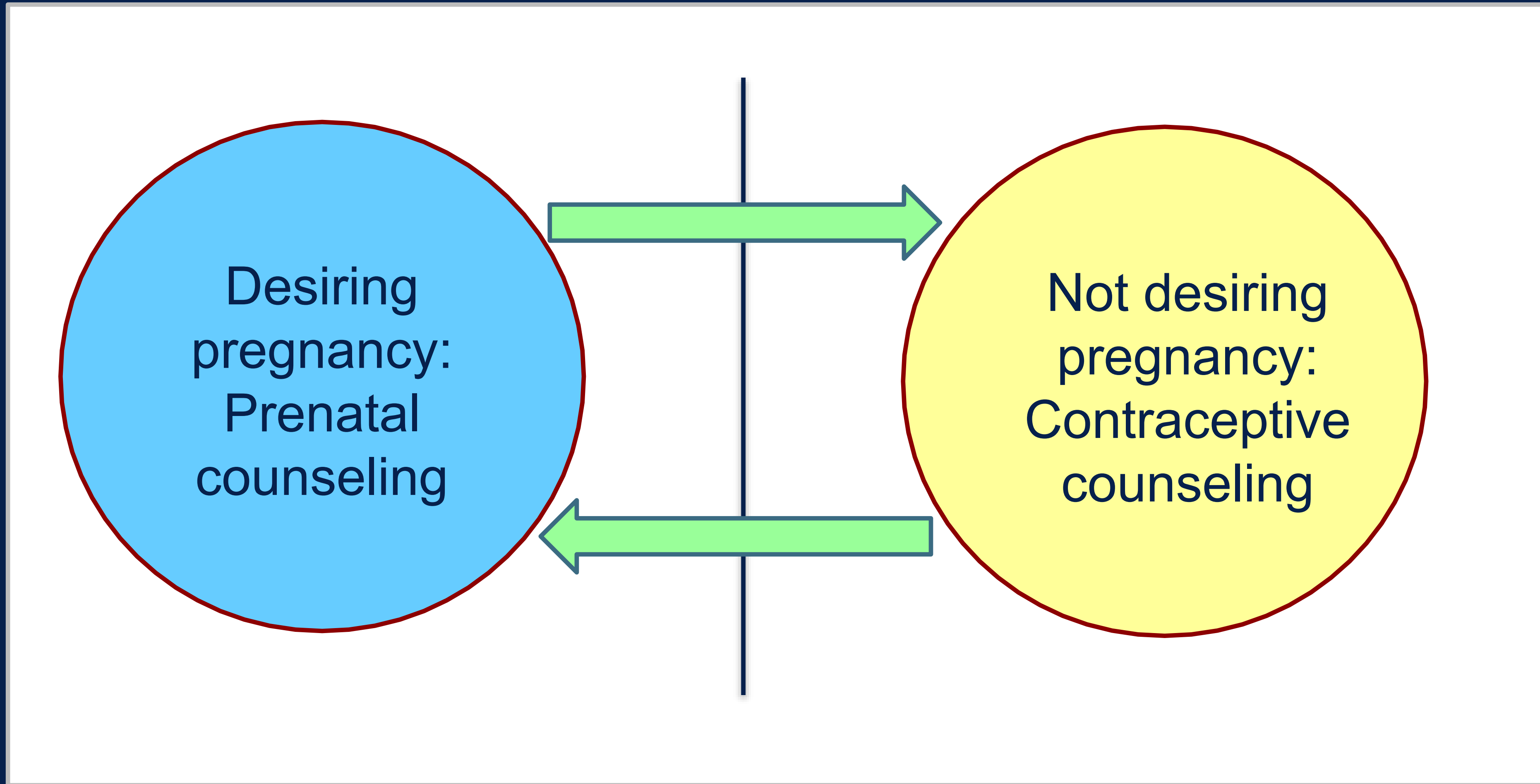
Pregnancy Intentions



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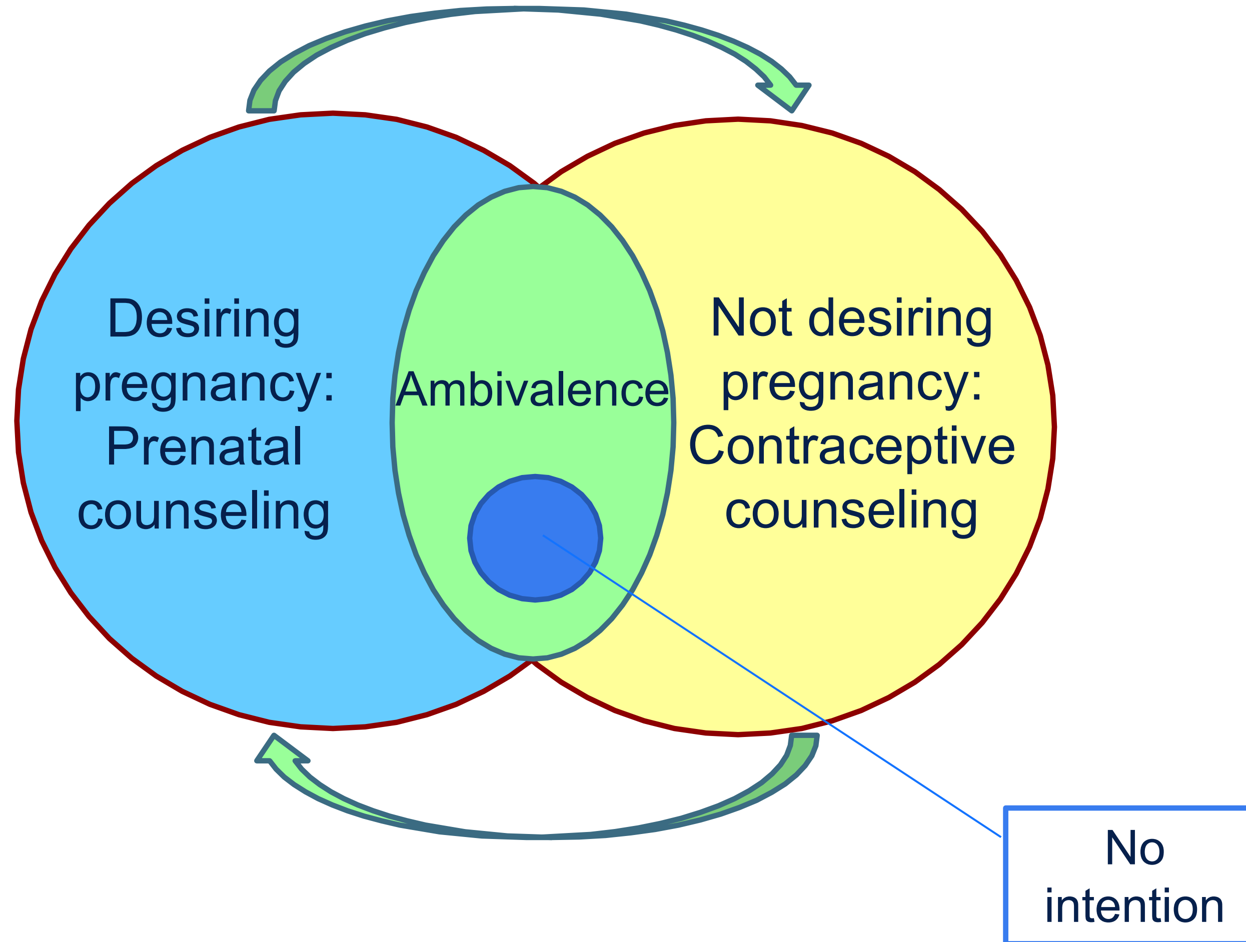
Pregnancy Intentions



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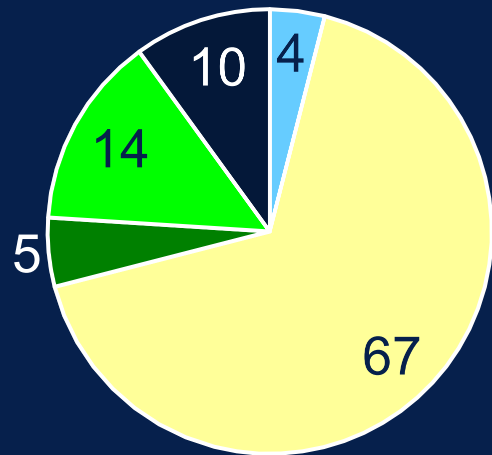
Ambivalence



- Trying to conceive
- Trying to avoid pregnancy
- Would not mind avoiding pregnancy
- Would not mind getting pregnant
- I don't know

- **29%** of women expressed ambivalence about pregnancy intentions in general population[7]
- **36%** in follow-up studies of women 18-29[8]
- Fewer studies look specifically at women with SUDs, but one study with 91 women in OAT clinics showed **30%** were ambivalent and **10%** were "unsure"[9]

7. Schwarz EB, Lohr PA, Gold MA, Gerbert B. Prevalence and correlates of ambivalence towards pregnancy among nonpregnant women. Contraception. Apr 2007;75(4):305-10.
8. Higgins JA, Popkin RA, Santelli JS. Pregnancy ambivalence and contraceptive use among young adults in the United States. *Perspect Sex Reprod Health*. Dec 2012;44(4):236-43.
9. Leinaar E, Brooks B, Johnson L, Alamian A. Perceived Barriers to Contraceptive Access and Acceptance among Reproductive-Age Women Receiving Opioid Agonist Therapy in Northeast Tennessee. *South Med J*. May 2020;113(5):213-218.

Impact of ambivalence

- Ambivalent women more likely to choose **withdrawal** and **natural family planning** for contraception [7]
- Meta-analysis[10]
  - OR 2.41 (CI 1.40-4.15) of not using any contraception among ambivalent women
- Conclusion:
  - "Providers are advised to guide [people with ambivalence] to formulate concrete opinions about family planning."

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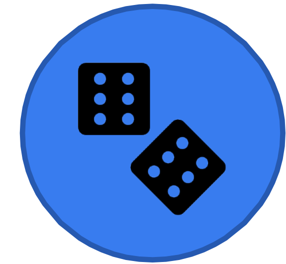
Why do people have no pregnancy plan?

Spontaneous encounters

God's plan



It just happens

Desire for surprise

11. Borrero S, Nikolajski C, Steinberg JR, et al. "It just happens": a qualitative study exploring low-income women's perspectives on pregnancy intention and planning. *Contraception*. Feb 2015;91(2):150-6. doi:10.1016/j.contraception.2014.09.014

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Why are some people ambivalent?

- Many women have opinions about “ideal” pregnancy timing
- Seems inappropriate to plan a pregnancy under non-ideal circumstances
- More acceptable for a pregnancy to happen unplanned!

Image: texasready.gov

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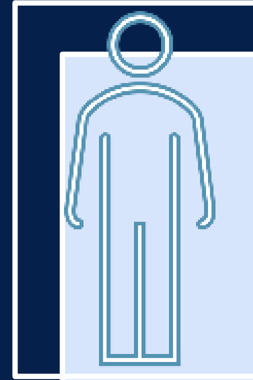
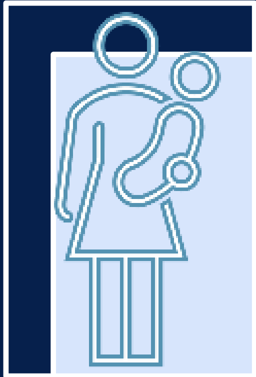
Why are people ambivalent?

Fear of disappointment if conception doesn't occur



Male partner coercion or contraceptive sabotage



Happiness with other unplanned pregnancies

Opportunity to “grow up” or have a purpose/direction in life

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Perception of low fertility

- Seen in general populations[11,12]

"I was on the methadone programme last year for ten months and I didn't get a period then. I thought that was a form of contraception but I was mistaken… I went to the hospital and they said I was pregnant, and I was in shock. It was the wrong timing."

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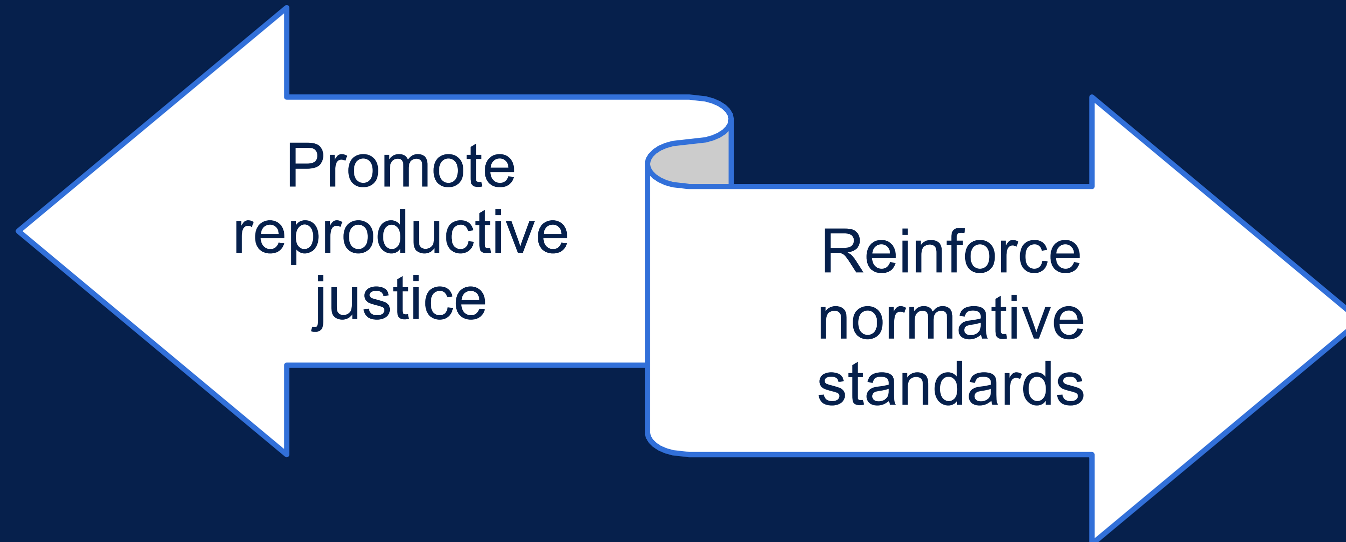
13. Olsen A, Banwell C, Madden A. Contraception, punishment and women who use drugs. BMC Women's Health. 2014/01/09 2014;14(1):5. doi:10.1186/1472-6874-14-5.

How do providers see this conversation?



- Empowering women
- Supporting healthy pregnancies
- Enabling sexual pleasure
- Parenting with dignity

- Awaiting recovery
- Awaiting relationship stability
- Awaiting financial stability
- Age

14. Heil SH, Melbostad HS, Rey CN. Innovative approaches to reduce unintended pregnancy and improve access to contraception among women who use opioids. *Prev Med*. 2019;128:105794-105794. doi:10.1016/j.ypmed.2019.105794
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Authoritative

Fear and disgust

Education

Connection and empathy

Empowerment

More patient-centered

Often more effective

16. Henderson JT, Raine T, Schalet A, Blum M, Harper CC. "I wouldn't be this firm if I didn't care": preventive clinical counseling for reproductive health. Patient Educ Couns. 2011/02// 2011;82(2):254-259. doi:10.1016/j.pec.2010.05.015

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What do patients want?

- Provider initiated conversations
- Information on options
- Non-judgmental provider responses
- Individualized value-based counseling

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17. Callegari LS, Borrero S, Reiber GE, et al. Reproductive Life Planning in Primary Care: A Qualitative Study of Women Veterans' Perceptions. Womens Health Issues. Sep-Oct 2015;25(5):548-54. doi:10.1016/j.whi.2015.05.002

Patient-centered tools: PATH

Pregnancy Attitudes

- Do you think you might like to have (more) children at some point?

Timing

- When do you think that might be?

How important

- How important is it to you to prevent pregnancy (until then)?

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PATH and Shared Decision Making

- Expert on own goals/values
- Past experiences

- Elicit goals/values
- Provide medical information

Decision

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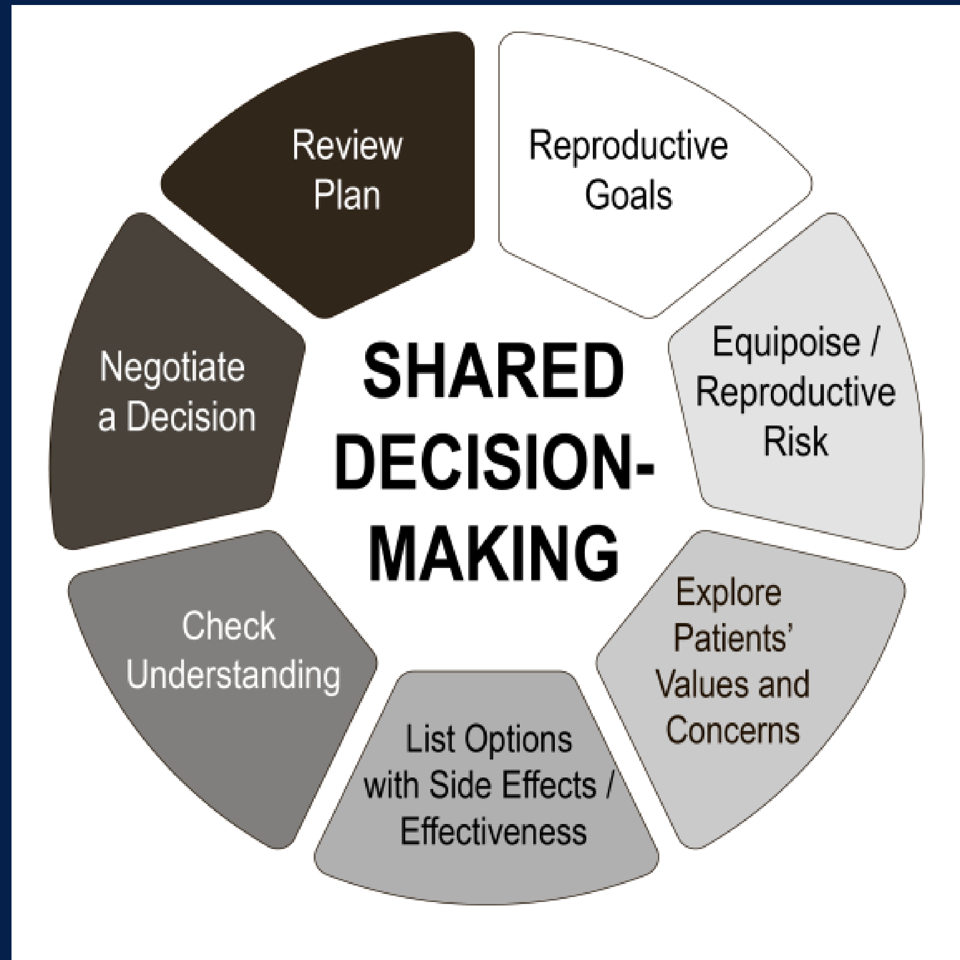
Shared Decision Making



18. Worthington RO, Oyler J, Pincavage A, Baker NA, Saathoff M, Rusiecki J. A Novel Contraception Counseling and Shared Decision-Making Curriculum for Internal Medicine Residents. MedEdPORTAL. 2020;16:11046-11046. doi:10.15766/mep_2374-8265.11046

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A Demonstration

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Let’s practice

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Promoting healthy pregnancies

- Prenatal vitamin

- Vaccination

- Routine STI testing

- Engagement in SUD care!

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Case

- Emily is a 37yo woman with SUD. She has been on buprenorphine for a year. She is certain that she does not want to become pregnant in the next year, so she has been using condoms consistently with her new partner.
- You discuss contraception with her. She has had prior bad experiences with COCPS, so she would like to have the Nexplanon inserted.
- Is there anything you can offer her while she’s waiting for a gyn appointment?

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"Morning after pill" myths

- Not just the morning after
  - Take ASAP!
  - But can be used even a few mornings after…
- Emergency contraception incudes devices and pills
- Can plan for the unexpected!

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Emergency contraception

Method	Efficacy[20]	Timing	To Know	Access
Copper IUD ("Paragard")	99.9%	Within 5 days	Heavier bleeding Long-lasting!	Trained provider
Levonorgestrel IUD ("Mirena, Skyla, Kyleena")	99.7% (non-inferior)	Within 5 days	Long lasting! Hormonal	Trained provider
Ulipristal ("Ella") 30 mg x1 "Anti-progesterone"	62-87%	ASAP Ideally 72 hours Efficacy through 5 days	Interacts with hormonal contraception	Prescription only **Plan ahead –** may not be stocked, may require prior authorization
Levonorgestrel ("Plan B") 1.5 mg	60-90% **Less effective than ulipristal**	ASAP!! 72 hours *some efficacy through day 5	Less effective in overweight women!	Over-the-counter

19. Turok DK, Gero A, Simmons RG, et al. Levonorgestrel vs. Copper Intrauterine Devices for Emergency Contraception. N Engl J Med. Jan 28 2021;384(4):335-344. doi:10.1056/NEJMoa2022141
20. ACOG practice bulletin Number 152 (Replaces Practice Bulletin Number 112, May 2010. Reaffirmed 2019)

Case, continued

- You ask if Emily would like to have a prescription for emergency contraception, as a backup method if the condoms fail before she is able to get the Nexplanon inserted
- You prescribe her ulipristal (Ella) and ask her to pick it up from the pharmacy and keep it in her home in case of contraceptive failure. You prescribe her refills as a back up as well.

Ulipristal (Ella) – Take one 30mg tablet as soon as possible but within 120 hours (five days) of unprotected sexual intercourse or contraceptive failure

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Final Takeaways/Summary

- Women with SUDs are at risk for unplanned pregnancy
- PATH questions help elicit information about intention and recognize ambivalence
- Contraception conversations depend on shared decision making
- Ambivalent women may benefit from risk mitigation strategies:
  - Planning for a healthy unplanned pregnancy
  - Planning for emergency contraception

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