Improving access to effective contraception for women in drug and alcohol rehabilitation

Carolyn Day[1,2]

Latha Nithyanandam[2]

[1]University of Sydney

[2]NSW Alcohol and Drug Foundation

THE UNIVERSITY OF SYDNEY

Background

- Women in the drug and alcohol treatment setting have lower rates of contraceptive use and higher rates of unplanned pregnancies than the general population (e.g. Black et al. 2012 ANZJOG)

- Access to contraception is a human right (UN)

- Long acting reversible contraception (LARC) most effective

- Adequate family planning is about ensuring women are able to make informed decisions about their bodies and reproduction
  - For some women will this be about avoiding pregnancy
  - For others this will about appropriate timing of pregnancies

Project Prevention

- Controversial program which pays drug using women to be sterilised or use long acting reversible contraception

- Critique
  - Paternalistic, eugenic
  - Ethics and autonomy (see Luke & Hall 2012 Addiction)
  - Inadequate support and care (see Olsen et al 2014 BMC Public Health)
  - Less coercive options not trialled (see Black et al 2012 Addiction)

- Careful not to confuse coercion with assisted planning and support

Unintended pregnancies among drug using women

- More adverse outcomes for mothers and infants
  - Termination (2x)
  - Miscarriage (2x)
  - Still birth (3x)

    (Reid et al DAR 2015)

  - Preterm birth (3x)
  - Low birth weight (2x)

    (Mayet et al DAR 2008)

  - High level of child protection involvement (39%) and children in out-of-home-care (32%)

    (Taplin & Mattick, Child Abuse Neg 2013)

- Profound distress for the mother
- Uncertain outcomes for the child
- Large financial costs to society

Long acting reversible contraception (LARC)

Inter uterine devices (IUD) and Inter uterine systems (IUS)

- 5 years + protection

Hormonal Implant - Implanon™ (“the rod”)

- ~3 years of protection

Effectiveness of contraception

Risk of pregnancy within first year of use for different contraceptive methods – typical use vs 'perfect use'

Method	Typical use	Prefect use
Hormonal implant	**0.05**	**0.05**
Copper IUD	**0.8**	**0.6**
Hormonal IUS	**0.2**	**0.2**
Depot hormonal injections	6	0.2
Oral contraceptive pill	9	0.3
Diaphragm	12	6
Condoms	18	2

Adapted from Black & Day 2016 Substance Abuse: Research Treatment

Long acting reversible contraception (LARC)

- Non-user dependent - “set and forget”
- High level of protection - <1% of women pregnant within first year of *typical* use
- Most cost effective in the long term
- Easily removed and immediately reversible upon removal
- Suitable for nulliparous women

- Contraindications, but minimal

Barriers to contraception

1. Systems level barriers

- Contraception delivered primarily through general practice
  - Preference for oral contraception prescribing - 69% vs LARC 15% (Mazza et al., MJA 2012)
  - Reluctance to prescribe LARC, especially IUD/IUS in nulliparous women and in the presence of hepatitis

- Access to LARC will often requires a referral
  - Cost associated with specialist referral
  - Wait times for other agencies (e.g. FPA)
  - IUD/IUS may require more than one visit to be fitted

Barriers to contraception

2. Individual level barriers

- Misconceptions about fertility and/or need for barrier protection
- Intimate partner violence and coercion
- Histories of trauma and sexual violence
- Disclosure of drug use – avoidance of some services

(Edelman et al 2013 J Adv Nurs; J Fam Plan Reprod Health Care; Eyo & Chenoy 2014 Obstet Gynaecol; Howell& Chasnoff 1999 J Subst Abuse Treat; Reid et al DAR 2015)

Programs to improve access

- Post-natal pre-discharge contraception discussion
- Delivery of post natal LARC pre-discharge
- Project CHOICE in the USA reported a 70% increase in LARC uptake among low-income women when provided with education and counselling about different methods (Secura et al., 2010 Am J Obstet Gynecol)
- Provision of on-site contraception care and/or counselling at drug treatment services
  - Low threshold service access
  - Pilot study of women in opioid substitution treatment agreed it was ok for their prescriber/counsellor/case manager to discuss contraception with them (Reid et al., DAR 2016)

Aim

To improve access to effective contraception for women attending a residential drug and alcohol treatment program

- Women only service
- 6-month residential service
- Range of therapeutic approaches
- Case management
- Close to quality tertiary and primary care services
- Established general practice partnerships
- Transport available

Need

- 2009-2014
- 105 clients
- 82% ≥ 1 child
  - Data unavailable on other obstetric outcomes such as still birth and miscarriages
- Parity: median 2 children (range 2-9)
- 70% of women reported current or prior child protection involvement

Case study 1

"M"

- 24 year old woman
- 5 children
- Last baby born at KYH
- FaCs involvement
  - At admission 4 children in care (with family)
  - Obtained 2 children while in Aftercare programme
  - Recently obtained restoration of the other 2 children. All are back into her custody
- Was using "withdrawal" method as contraception
- Obtained Implanon whilst at KYH
- Completed residential and aftercare treatment

Case study 2

"T"

- 38 year old
- 10 children, 1 stillbirth
- FaCs involvement
  - All the children other than the oldest and new-born living with their fathers or in care
- No previous contraceptive history
- LARC canvased, but client decided upon sterilisation during residential treatment
- Completed residential treatment

Process

- Partner with local GPs (or other services) willing and able to provide LARC
- Educate staff on effective contraception, including LARC
- Develop policy and procedures around contraception discussion
- Include LARC uptake as service outcome

Policy development

CONTRACEPTIVE POLICY

1. PURPOSE

The women's contraceptive policy (WCP) has been designed to aid KYH caseworkers in effective and informative contraceptive delivery to clients, advocating personal health and wellbeing to maximize the uptake of long-acting reversible contraception (LARC).

2. BACKGROUND

There is a consensus, Australia wide, that increased access and uptake of LARC is needed (Black, Bateson & Harvey, 2013). Australia has a high rate of unintended pregnancy and abortion (19.7 per 1000 aged 15-44 years) (Black et al., 2013) with the rate often higher for women with substance abuse problems. Women account for approximately 30–40% of clients attending alcohol and drug treatment services, yet their sexual and reproductive health is characteristically overlooked by health services (Sherman, Kamarulzaman, Spittal, 2008). Women are often subjected to added challenges concerning sexual relations with men, contraception, pregnancy and childbearing responsibilities (Cornford, Close, Bray, Beere & Mason, 2015). Pregnant women with substance abuse issues brings a multitude of both legal and ethical issues, often resulting in prejudicial and judgmental treatment from medical services and acts as a deterrent for women seeking help (Jones & Kaltenbach, 2013). It is reported that 1.3% to 2% of Australian women use illicit drugs during pregnancy (Abdel-Latif, Bajuk, Lui, & Oei, 2007), with data showing detrimental affects for those who do (Turnbull & Osborn, 2011). Children of women who use drugs are considered to be at risk of neglect and abuse (Abdel-Latif et al. 2007) and parental drug use are increasingly seen as a factor in child protective service provision (Abdel-Latif et al. 2007; Dawe et al. 2007). Amid the health needs of these women and the barriers associated with availability, accessibility and approachability of contraceptive health services, a clear gap is evident. The benefits for the women, children, families and governments are significant with effective uptake of LARC, as the implications of unintended pregnancies impact the economic, social, psychological and physical elements of both a woman and child's life.

3. PRINCIPLES

While women at KYH are participating in their six-month rehabilitation program, though before they commence transition, caseworkers have the opportunity to discuss, educate, inform and encourage women to select a suitable long-acting reversible contraception (LARC). This policy applies to all staff that delivers contraceptive education to clients.

4. OUTCOMES

Contraception is currently taught in Stage 5 of the NSW PDHPE curriculum. However, adolescents is often a turbulent time, and may involve risk taking behavior such as truanting. If women at KYH missed the opportunity during school and/or have forgotten, it is likely their understanding of effective LARC is limited. Through effective contraceptive education, clients are provided with the tools to strengthen their independence, feel empowered and have control over their bodies and their reproductive choices. At the completion of this meeting clients will understand the risks associated with not using contraception; will have an understanding of the available methods of contraception, in particular LARC; and will know the health services they can access, both while at KYH, during transition and into the future.

1. Economic Empowerment Objectives

- To enable women to engage in LARC and improve long-term livelihood opportunities.

2. Social Empowerment Objectives

- To change current mindset that limits their active participation in reproductive decision-making by raising awareness of sexual health and contraceptive methods, educating women on their options and available choices.

3. Health and Wellness Objectives

- To strengthen their independence and self-confidence, improving their physical, mental and social health through effective uptake of LARC.

5. FUNCTIONS AND DELEGATIONS

A range of LARC contraceptive devices are currently available in Australia, with several providing highly effective contraception for up to 5 and 10 years, (Black et al 2013, p. 317), however we are still seeing high rates of terminations and unplanned pregnancies among drug users. The response needed from caseworkers, is to work on improving clients understanding of contraceptive options through non-discriminatory discussions; raise awareness of the current health services available; and improve the overall contraceptive up-take of LARC and reproductive advice for women. As a caseworker it may be beneficial to assess:

1. How, if at all, does substance abuse affect their thoughts on LARC?
2. What restrictions and obstacles currently exist for the client when accessing LARC?
3. Does the client prioritize contraception?

It is the responsibility of the caseworker to deliver the contraceptive information clearly and ensure clients have the opportunity to ask for clarification if need be.

6. RISK MANAGEMENT

There are several factors that should be considered before discussing contraception options with clients and taken into consideration during the meeting. Women have identified several reasons for not utilizing the existing health care services (Howell & Chasnoff, 1999; Curet & His, 2002):

- Mistrust of healthcare services
- Fear of forced treatment or fear of losing custody of children
- Guilt, denial or embarrassment regarding their substance use
- Stigma
- Costs and difficulty of accessing services

Developed by Rachel Blackburn, MPH capstone student University of Sydney 2015

1. Trauma management
2. Mistrust of healthcare services
3. Guilt, denial, and embarrassment
4. **Inadvertent coercion**
5. Costs

1. Careful prior assessment and therapeutic work; timing; method
2. Support and attendance
3. Support and counselling; timing
4. **Medical officer (or service) responsible for prescription, consent and procedure**
5. Partnership with services that bulk bill or provide subsidised care

Draft practice checklist

CHECK LIST [APPENIX 1]

Caseworker: _____ Date commenced: _____

Client: _____ Date completed: _____

TO-DO	NOTES	COMPLETED
Read policy document		
If unfamiliar with contraceptive content, conduct further readings [appendix 2]		
Organise a one-on-one meeting with client [schedule 30 minutes]		
Discuss clients personal history with contraception		
Discuss methods of contraception and what might work best		
Provide information sheets regarding contraception and dispel any myths surrounding LARC		
Highlight the benefits of LARC		
Discuss suitable options for the client to adopt, try to come to a concrete conclusion whilst the meeting is in process		
Discuss health services available and book appointments for the client		
Client chooses method		
Client is fitted with a LARC device: please provide date and location		

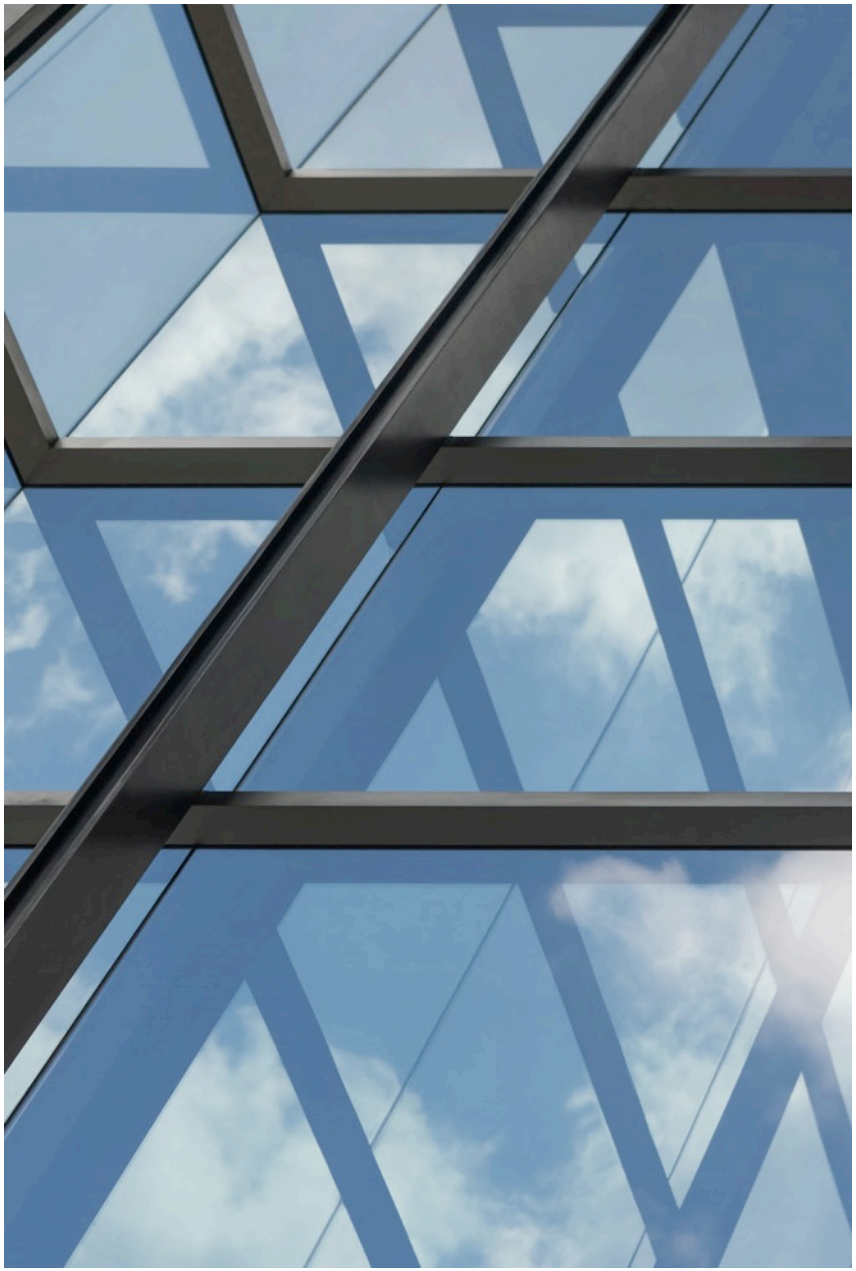
Additional comments:

Developed by Rachel Blackburn, MPH capstone student University of Sydney 2015

Outcomes

Since July 2015

- **6** women to have received hormonal implants
- All have completed residential treatment



THE UNIVERSITY OF SYDNEY

Summary

- Despite access to contraception being a deemed human right a variety of structural and individual barriers impede access for women with drug and alcohol problems

- The therapeutic environment of residential programs (and other drug treatment services) may provide a unique opportunity for women to effectively address these needs

- More work is needed to determine the most effective (and empowering) way of delivering or facilitating this type of care

Further work

- Formal evaluation
  - Consumer input
- Knowledge and attitudes of drug and alcohol workers to providing contraception support
- Contraception-related brief intervention training for drug and alcohol workers clinicians
- Expansion of program