Pills, periods, and prenatals: providing reproductive health services in low-barrier SUD care

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Disclosures

- The presenters have no conflicts of interest to disclose.

Learning Objectives

- Practice family planning counseling approaches that are sensitive to the needs of people with SUD
- Apply knowledge of opioid-related effects on the HPA axis to assess, diagnose, treat, and counsel patients with OUD who have irregular periods
- Identify tangible steps to implement reproductive health care in low-barrier SUD treatment settings

Why is this important?

Why address reproductive health in SUD treatment?

Patients with SUD have:

- High rates of unintended pregnancy* (>75% in pregnancy-capable people w/ OUD)
    - *Caveats: convenience sample, treatment-seeking population; what is "unintended"*
- Low rates of contraception use, particularly of highly effective methods
- Significant barriers to accessing reproductive health care

Heil 2011; Fischbein 2018; Stone 2020.

Patients with SUD face barriers to accessing reproductive care

- Untreated SUD
- Homelessness
- Incarceration
- Intimate partner violence
- **Reproductive coercion**
- Misconceptions about fertility
- Fears about pelvic exam and pain control
- **Uncertainty about capacity to consent**
- **Health care stigma and trauma**

Do people want to talk about family planning in SUD treatment?

YES!

From focus groups with women in SUD treatment (n=59):

- Access to birth control is very important
- People with SUD have unique reproductive needs (e.g., history of IPV, sex work, sexual trauma)
- Importance of supportive, noncoercive counseling
- **Siloed SUD treatment makes it difficult to access family planning**

Johnston et al. 2022

Bridge clinics offer a prime opportunity for reproductive care

- Walk-in, low-threshold model
- Often see patients not engaged w/ PCP or OB/GYN care
- Addiction specialists who understand SUD-related medical and social effects that influence reproductive health needs

Reproductive Justice

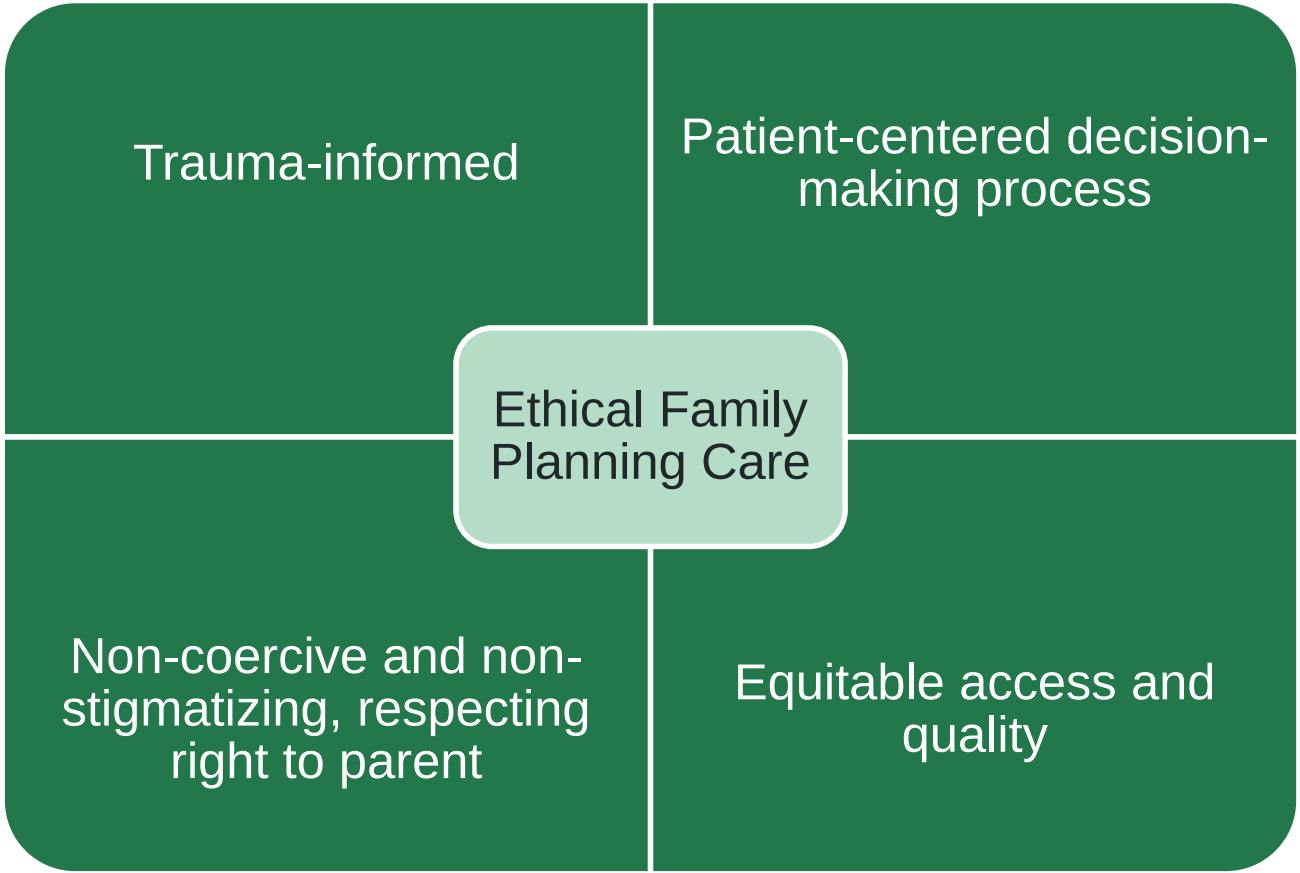
- “The **human right to maintain personal bodily autonomy**, have children, not have children, and parent the children we have in safe and sustainable communities.” – SisterSong Women of Color Reproductive Justice Collective

Core Reproductive Justice Principles

Every person has the right to:

1. Decide if and when they will have a baby and the conditions under which they will give birth, adopt or parent
2. Decide if they will not have a baby and their options for preventing or ending a pregnancy
3. Parent the children they already have with the necessary social supports in safe environments and healthy communities, and without fear of violence from individuals or the government
4. Bodily autonomy free from all forms of reproductive oppression
5. The right to express sexuality and spirituality without violence or shame
6. A quality of life before and beyond the ability to give birth or parent

SisterSong, Reproductive Justice 101


Trauma-informed
Patient-centered decision-making process
Ethical Family Planning Care
Non-coercive and non-stigmatizing, respecting right to parent
Equitable access and quality

How to start the conversation?

Open-ended questions

- Some patients I see are interested in talking about birth control. Is that something that you would like to talk about today?
- Do you get regular periods? Tell me about your periods.
- Do you have any concerns about your periods or pregnancy?

How to Be Reasonably Certain That a Woman is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- is ≤7 days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses
- has been correctly and consistently using a reliable method of contraception
- is ≤7 days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum

If there is still a potential the patient is pregnant, and they want to start contraception today:

<u>Recommend starting anytime with follow-up pregnancy test in 2-4 weeks:</u>

- Implant
- Combined hormonal contraceptive
- Progesterone-only contraceptive
- Depo (DMPA)

SHARED DECISION-MAKING APPROACH TO CONTRACEPTIVE COUNSELING

Use this mnemonic
- PICK ONE -
to remember the elements of shared decision-making for person-centered contraceptive counseling, leading to a more satisfying encounter for you and your patients

P ASK PAST HISTORY WITH CONTRACEPTION

I ASK IMPORTANT FACTORS IN A METHOD

C EXPLORE CONTRAINDICATIONS TO METHODS

K SHARE KNOWLEDGE ABOUT METHODS WITH DECISION AID

O EXPLORE OBSTACLES TO DECISION-MAKING

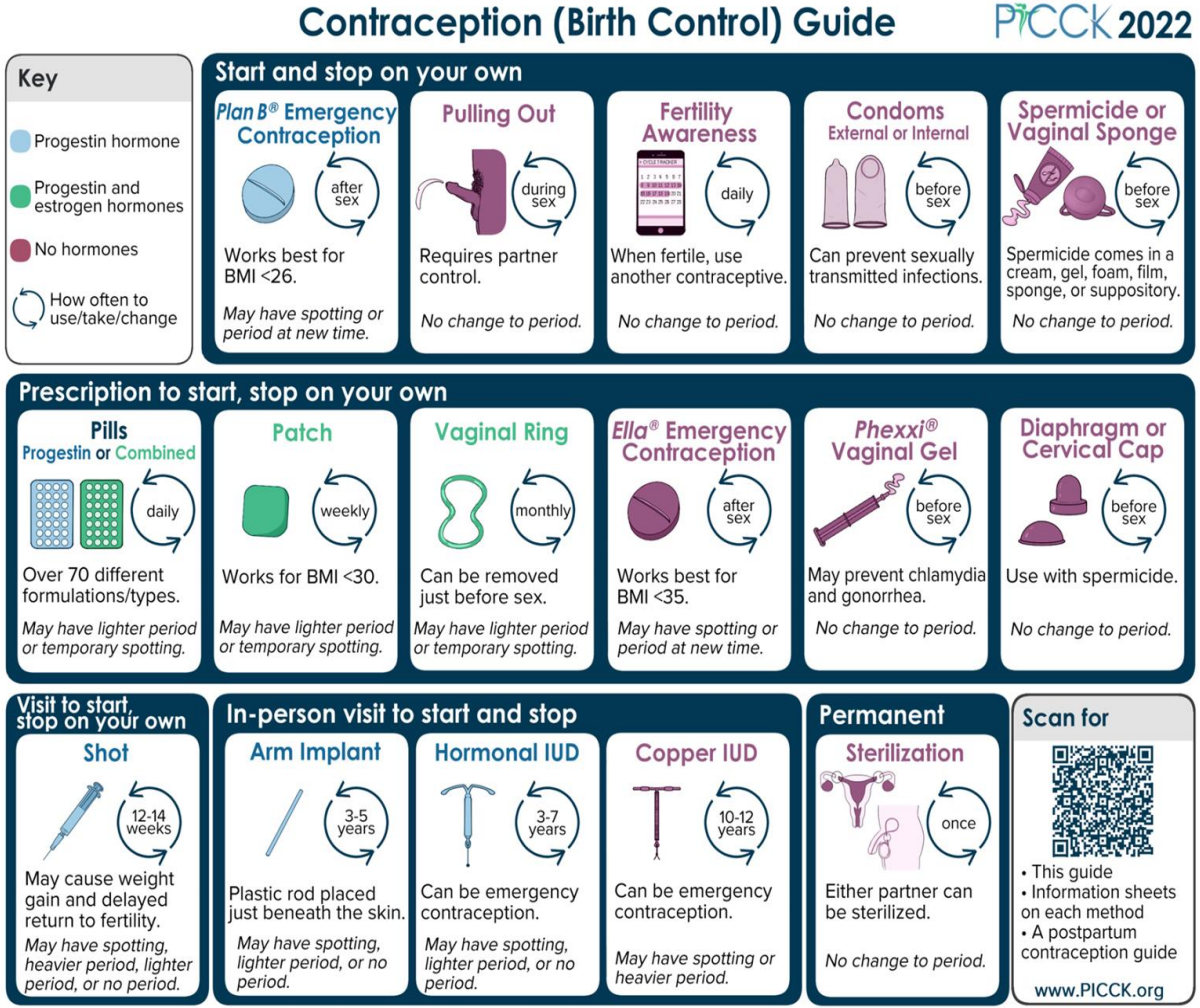
N ASK IF THE PATIENT IS READY TO MAKE A DECISION NOW

E RESPECT PATIENT EXPERIENCE WITH THE METHOD

www.PICCK.org

PICCK
PARTNERS IN CONTRACEPTIVE CHOICE AND KNOWLEDGE

☆Prioritizes patient autonomy☆



Qualitative research demonstrates special family planning considerations for people with OUD

Barrier Methods

- Benefit of STI protection

Housing stability affects choice

- Limited access to storing medication (e.g., refrigerator for ring)

Side effects or risks may trigger relapse

- Weight gain, amenorrhea

Methods as reminders of opioid use

- Contraceptive patch mistaken for fentanyl patch

Remembering methods during recovery and active use

- Difficulty remembering a daily pill

Sobel 2021

Small Group Case Practice 1

- Practice two cases addressing family planning during a bridge clinic visit
- Please discuss in your small groups and designate a spokesperson to summarize your answers when we return

Case Study #1

You are seeing a patient with OUD presenting to a bridge clinic to start buprenorphine. They do not get periods, do not want to be pregnant, and have condomless sex with multiple partners.

- How would you open the conversation about pregnancy planning?

- How would you ask about their interest in a contraception method? If they are interested, how would you counsel them on the different contraception options using a decision aid?

Case Study #2

You are seeing a patient with alcohol use disorder seeking alcohol withdrawal treatment. They want to get pregnant within the next year but are not actively trying. They are not interested in using a regular contraception method but would consider emergency contraception or therapeutic abortion if needed.

- How would you counsel them on how to reduce harms from alcohol use in the case of pregnancy?

- How would you counsel them about emergency contraception options?

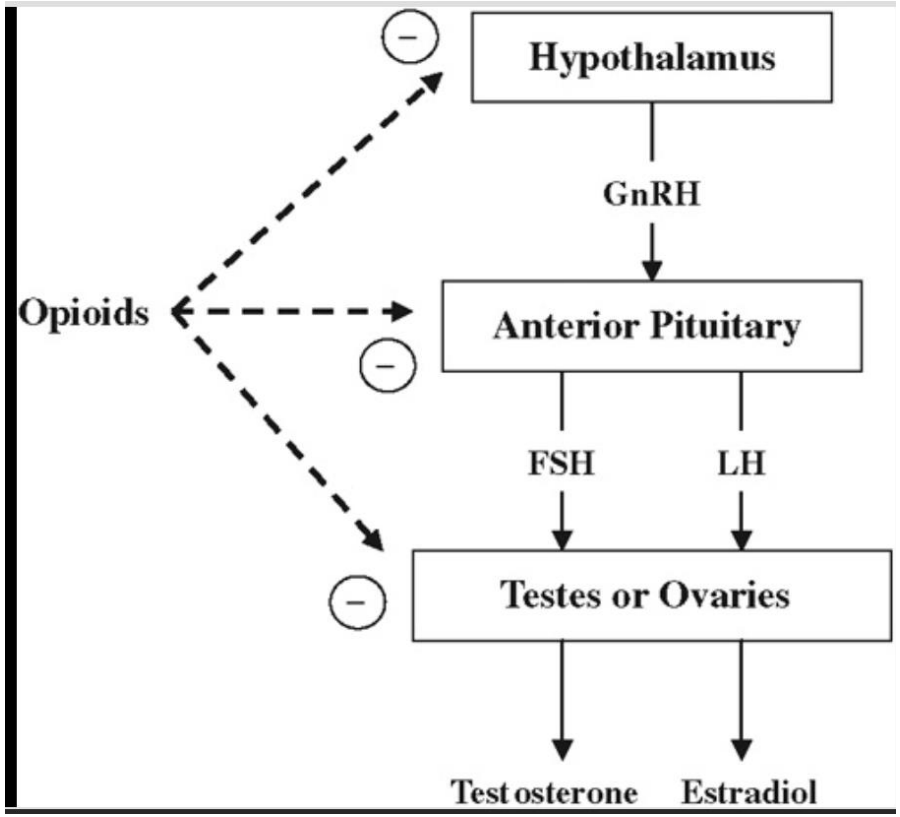
Opioid effects on HPA axis and menstruation

Opioid use affects menstruation and fertility

- Opioid use, stress, and other substances can cause dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis leading to amenorrhea or irregular periods
- Medications for OUD (methadone, buprenorphine, naltrexone) also affect period patterns
- Long-term effects on the HPA axis and fertility are very limited

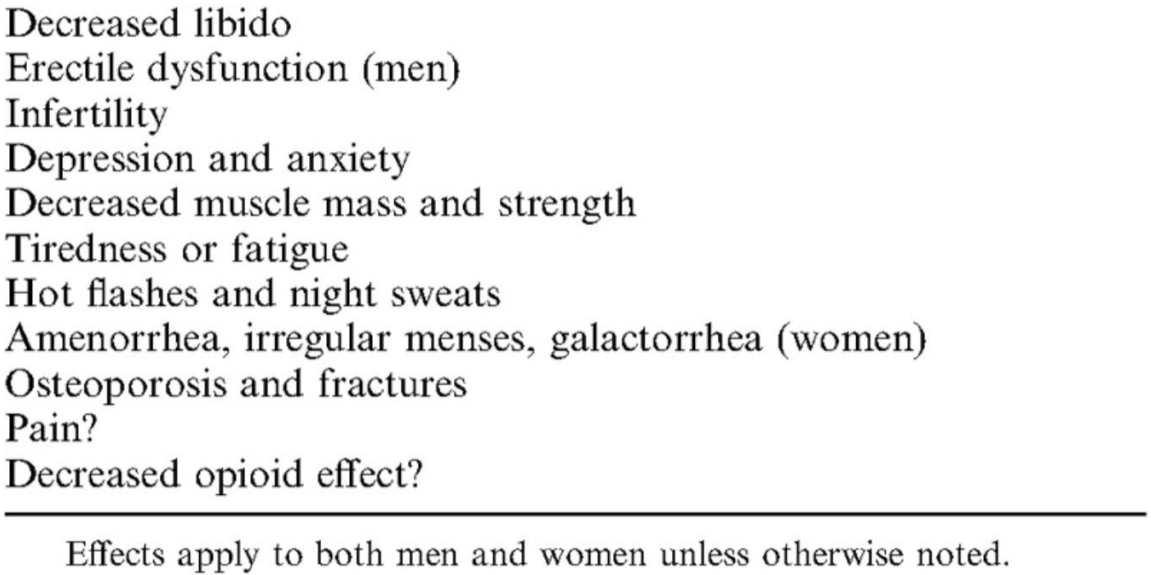
Patients with OUD often have concerns about irregular periods and their fertility

"Pseudomenopausal state"



What does low estrogen state present like?

- **Large research gap**



Decreased libido
Erectile dysfunction (men)
Infertility
Depression and anxiety
Decreased muscle mass and strength
Tiredness or fatigue
Hot flashes and night sweats
Amenorrhea, irregular menses, galactorrhea (women)
Osteoporosis and fractures
Pain?
Decreased opioid effect?

Effects apply to both men and women unless otherwise noted.

TABLE 2

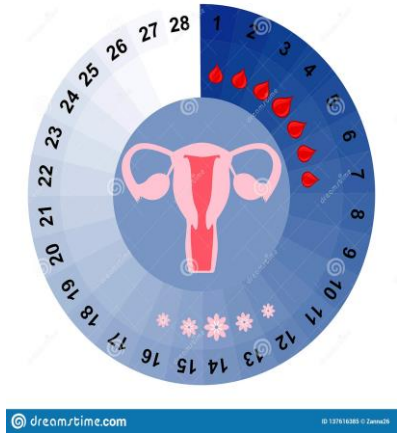
Symptoms of Hypogonadism

Source

The Impact of Opioids on the Endocrine System

The Clinical Journal of Pain25(2):170-175, February 2009.

Important Counseling Points



1. **Amenorrhea does not equal infertility**
   a. stress + substances ➔ increased cortisol and decreased GnRH/LH ➔ feeds back to ovaries ➔ anovulation/oligomenorrhea

2. Regular periods *may* return as you start MOUD
   a. this may affect your ability to get pregnant
   b. can be triggering as a symbol of current state of addiction, is NOT linear

Workup/Evaluation

- **Low estrogen state vs. PCOS**
  - Progesterone withdrawal bleed (10d) and if the patient does NOT bleed --> diagnostic of **hypo**estrogenic amenorrhea
  - PCOS is a **hyper**estrogen state
- Anovulation labs to assess for etiology
  - FSH, LH, hCG, estradiol, TSH, prolactin
    - If LH is high and FSH is low, suspect PCOS --> then add androgen labs (T, DHEA)
- Rule out premature ovarian insufficiency (POI)
  - Can reassure on fertility potential with normal range FSH

Contraception in the "pseudomenopausal state"

Considerations

- Not well studied!
- What is important to patient?
- How do we balance bone impacts, VTE risk, bleeding profiles, liver damage?

Research gaps

- Need for estrogen for bone protection in low estrogen state
- Liver disease and smoking: should estrogen patch be first line for everyone?
  - Increase risk of changes in liver metabolism in setting of HCV, AUD etc and also increase in VTE risk in setting of liver disease and smoking
  - Estrogen (low dose HRT) patches as way to avoid first pass liver metabolism in concurrent smokers

Considerations with respect to "pseudomenopause"

	Bone
Depo	
IUD	
Implant	
COCs, ring (EE)	
E2 patch	

 Negative impact

 Unpredictable

 Good/doesn't negatively impact

EE = ethinyl estradiol (synthetic)
E2 = estradiol

Small Group Case Practice 2

- Practice two cases addressing irregular periods in people with OUD during a bridge clinic visit
- Please discuss in your small groups and designate a spokesperson to summarize your answers when we return

Case Study #1

Person with OUD with active IV fentanyl use who has irregular periods 3-4 times/year and does not think they can get pregnant.

- How would you counsel the patient about their fertility potential with irregular periods?
- Would you consider any diagnostic testing? If so, what would you order?

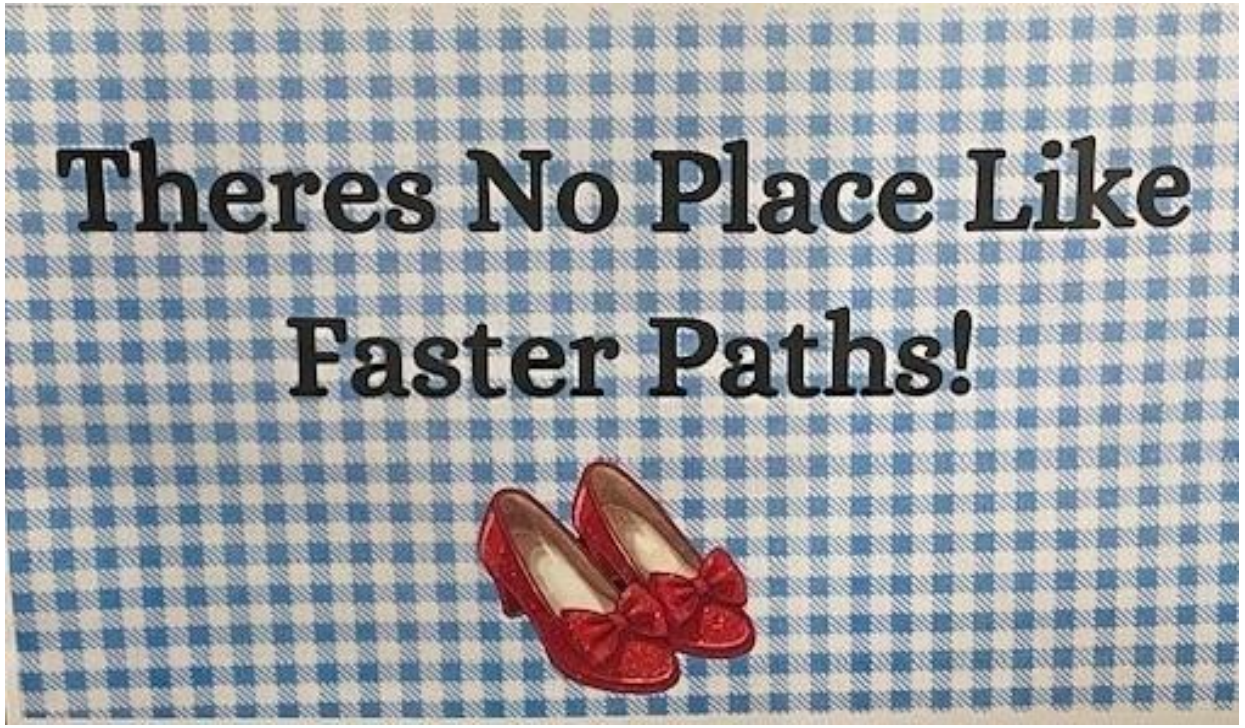
Case Study #2

Person with OUD on methadone 140 mg who has amenorrhea and low libido since starting methadone.

- What symptoms would you ask them about?
- How would you counsel the patient on methadone’s effects on ovulation and libido?

Implementation Strategies

Create a Welcoming Space




Local Addiction Resources
SUPPORT GROUP
FAUSTER PATHS SEXUAL HEALTH CLINIC
START
START
ASK US ABOUT
RAPID
HIV
TESTING TODAY!
NO BLOOD DRAW NEEDED.
RESULTS IN 20 MINUTES.

FASTER PATHS

FASTER PATHS SEXUAL HEALTH CLINIC

Thursdays 12:30-4:30 PM

- STI TESTING AND TREATMENT
- PREGNANCY PLANNING
- BIRTH CONTROL (INCLUDING NEXPLANON)
- PAP SMEARS
- SEXUAL HEALTH NEEDS
- OTHER GYNECOLOGICAL ISSUES

Call 617-414-4580 to make an appointment!

DID YOU KNOW?

FASTER PATHS OFFERS:

- STI TESTING AND TREATMENT
- PREGNANCY TESTING & PLANNING
- BIRTH CONTROL
- PAP SMEARS
- SEXUAL HEALTH ASSESSMENTS

FASTER PATHS

Boston Medical Center
HEALTH SYSTEM

Address pressing needs first!

Deciding whether to ask about family planning

- Physical comfort (e.g., pain, withdrawal)
- Time and competing priorities
- Openness with other relevant topics (HIV/STI risk assessment)
- Likelihood of follow-up visit, other opportunities to address this
- Regular follow-up with PCP or other provider

Each patient and each scenario is different – no universal rule!

Please come back!!

Nurse triage note template

- Goal of visit: ***
- History of treatment: ***
- Response to treatment: *** (duration, pt experience, why ended, etc)
- Current use: what substances***, amount***, route***
- Last use:***
- Vital Signs:
- COWS/CIWA:***
- Other concerns: (wounds, STI testing, vaccines)***
- (things to consider, labs, rapid HIV tests, swabs at sites)
- LMP: (for women of reproductive age- offer Urine HCG if applicable)
- Current Contraception, if any:
- Pregnancy Desired in next year: yes/no
- Mention offerings available in clinic, if pt interested

Implementing long-active reversible contraceptives (LARCs)

Appropriate Supplies

Access to needed LARC

How to start tomorrow!

Break into 3 groups and brainstorm what steps you can take next:

1. LARC implementation
2. Patient recruitment and engagement
3. Clinic workflow

Conclusion

- Low barrier SUD treatment can provide trauma-informed reproductive care
- Reproductive justice is a guiding framework that prioritizes a person's right to decide when they become pregnant and parent.
- Patients want to understand opioid effects on menstruation and fertility – this is a major research gap!
- Implementation requires an intentional plan and team-based approach

Thank you!

Special thank you to Dr. Elisabeth Woodhams and Dr. Rachel Cannon, who provided some of the content for these slides.

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- Sister Song, Reproductive Justice 101. https://www.sistersong.net/reproductive-justice/

Resources:

- PICCK: Contraception Guide. https://picck.org/resource/contraception-guide-contraception-information-sheets-and-postpartum-contraception-guide/
- Bedisder. https://www.bedsider.org/birth-control
- CDC: How to be Reasonably Certain that a Patient is Not Pregnant. https://www.cdc.gov/contraception/hcp/usspr/not-pregnant.html