

NAVIGATING THE MAZE:

Sexual Health and Literacy for Pregnant and Postpartum Women with Substance Use Disorders June 23 – 24, 2020

TTC Technology Transfer Centers
Funded by Substance Abuse and Mental Health Services Administration



Disclaimer

This *Navigating the Maze: Sexual Health and Literacy for Pregnant and Postpartum Women with Substance Use Disorders* was prepared for the Mid-America Addiction Technology Transfer Center under a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA). All material appearing in this presentation, except that taken directly from copyrighted sources, is in the public domain and may be reproduced or copied without permission from SAMHSA or the authors. Citation of the source is appreciated. Do not reproduce or distribute this presentation for a fee without specific, written authorization from the Mid-America ATTC. For more information on obtaining copies of this presentation please email sherry@umkc.edu.

At the time of this presentation, Elinore F. McCance-Katz, MD, PhD serves as SAMHSA Assistant Secretary. The opinions expressed herein are the views of Hendrée E. Jones, PhD, Elisabeth Johnson, FNP, PhD and Essence Hairston, MSW and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.



Mid-America (HHS Region 7)

ATTC

Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration



Mountain Plains (HHS Region 8)

MHTTC

Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration



Disclosures

Conflict of Interest

In accordance with continuing education guidelines, the speaker and planning committee members have disclosed commercial interests/financial relationships with companies whose products or services may be discussed during this program.

Speakers

Hendrée E. Jones, PhD, Elisabeth Johnson, FNP, PhD and Essence Hairston, MSW have nothing to disclose.

Planning Committee

Sharon Colbert, Angela Bolen, and Shelby Webb have nothing to disclose.

Kristin Metcalf-Wilson serves on the Afaxys Pharmaceuticals advisory board.

Jacki Witt serves on the Afaxys Pharmaceuticals advisory board (Resolved).



Special Guest

Elinore McCance-Katz, M.D., Ph.D.
Assistant Secretary for Mental Health and
Substance Use



Today's Q&A Panelists



Kristin Metcalf-Wilson, DNP, WHNP-BC, University of Missouri Kansas City, School of Nursing and Health Sciences
metcalf-wilsonk@umkc.edu



Maridee Shogren, DNP, CNM, University of North Dakota, College of Nursing & Professional Disciplines
maridee.shogren@und.edu



Jacki Witt, JD, MSN, WHNP-BC, SANE-A, University of Missouri Kansas City, School of Nursing and Health Sciences
wittj@umkc.edu



Presenters



Hendrée Jones, Ph.D., Executive Director, UNC Horizons, and Professor, Dept. of Obstetrics and Gynecology, School of Medicine, University of North Carolina at Chapel Hill, NC



Elisabeth Johnson, Ph.D., FNP-BC, Director of Health Services, UNC Horizons, and Professor, Dept. of Obstetrics and Gynecology, School of Medicine, University of North Carolina at Chapel Hill, NC



Essence Hairston MSW, Outpatient Program Manager at Wake County, UNC Horizons Program at Wake County, and Clinical Instructor, Dept. of Obstetrics and Gynecology, School of Medicine, University of North Carolina at Chapel Hill, NC



Learning Objectives

- 1** **Identify** the unique and common issues women who are pregnant or post-partum with SUD face in accessing and implementing reproductive life planning.
- 2** **Identify** ways stigma, discrimination and prejudice play a role in access and implementing reproductive life planning for women who are pregnant or post-partum with SUD.
- 3** **Examine** the roles that trauma experiences and intimate partners play in access and implementing reproductive life planning for women who are pregnant or post-partum with SUD.
- 4** **Discuss** how to have productive and engaging conversation with pregnant or post-partum women with SUD about sexual health and reproductive planning.



Outline

Day 1

- **Entering the Maze:** Overview of Sexual Health Research with Pregnant and Postpartum Women who have Substance Use Disorders.
- 10-minute break.
- **Guiding Compass for Navigating the Maze:** Assessing Values, Erasing Discrimination and Building Empathy.

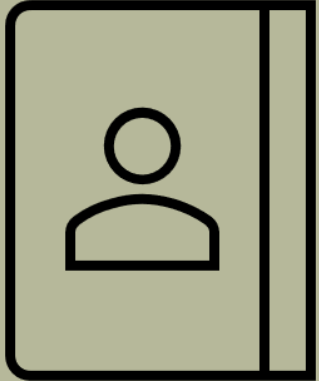
Day 2

- **Decision Points in the Maze:** Ways Trauma Influences Sexual Health and Literacy among women with Substance Use Disorders.
- 10-minute break.
- **Completing the Maze:** How to have an effective sexual health conversation with pregnant or postpartum women with substance use disorders.



Entering the Maze: Overview of Sexual Health Research with Pregnant and Postpartum Women who have Substance Use Disorders

Case Study



Patient is a 29-year-old woman who is currently 8 weeks post-partum. During her pregnancy, she thought about having a tubal ligation but changed her mind. She has five other children. Currently two of her children live with her. She has previously expressed an interest in starting Depo injection but during this visit, she is feeling too overwhelmed to talk about contraception. She states that she and her partner are “mostly” using condoms.



Background: History of Contraception

The methods of ancient scholars fall into three general categories:

Reasonable but now known to be ineffective
(e.g., wiping out the vagina after intercourse [Greek writings of 100 AD Soranus])

Reasonable and perhaps effective
(e.g., using honey, pomegranate treated with vinegar as pessaries and barriers like balls made of linen strips [Ebers Papyrus 1550 BC; Dioscorides 58-64 AD; Soranus])

Unreasonable and fully ineffective
(e.g., woman holding her breath at the time of ejaculation or jumping backward seven times after coitus)



Background: Drugs and Contraception

In the case of family planning in the English-speaking countries, moral condemnation has often been underscored with threats of physical harm:

“The majority of gynecologists ... have reached the conclusion... that contraception is a cause of sterility, neuresthenia and of fibroid tumors in women.”

1929 physician's conference maintained, “Inflammation of the neck of the womb results not infrequently from the use of preventives. That such inflammation may in turn lead to cancer is mentioned in nearly all scientific publications dealing with the subject.”

“Birth control often leads to lunacy in women. If you are to have birth control on a large scale, you will have to add to your lunatic asylums for women...This is a fact.”



Background: Contraception to Women's Rights

In October 1916

Sanger opened America's **first birth control clinic** in Brownsville, New York, and 140 women came on the first day.

Until 1959

National Institutes of Health was explicitly **forbidden to support** research connected with contraception.

In 2000

United Nations set a number of **Millennium Development Goals** (MDGs), the mention of family planning and population was still considered too controversial.

On 1/1/2016

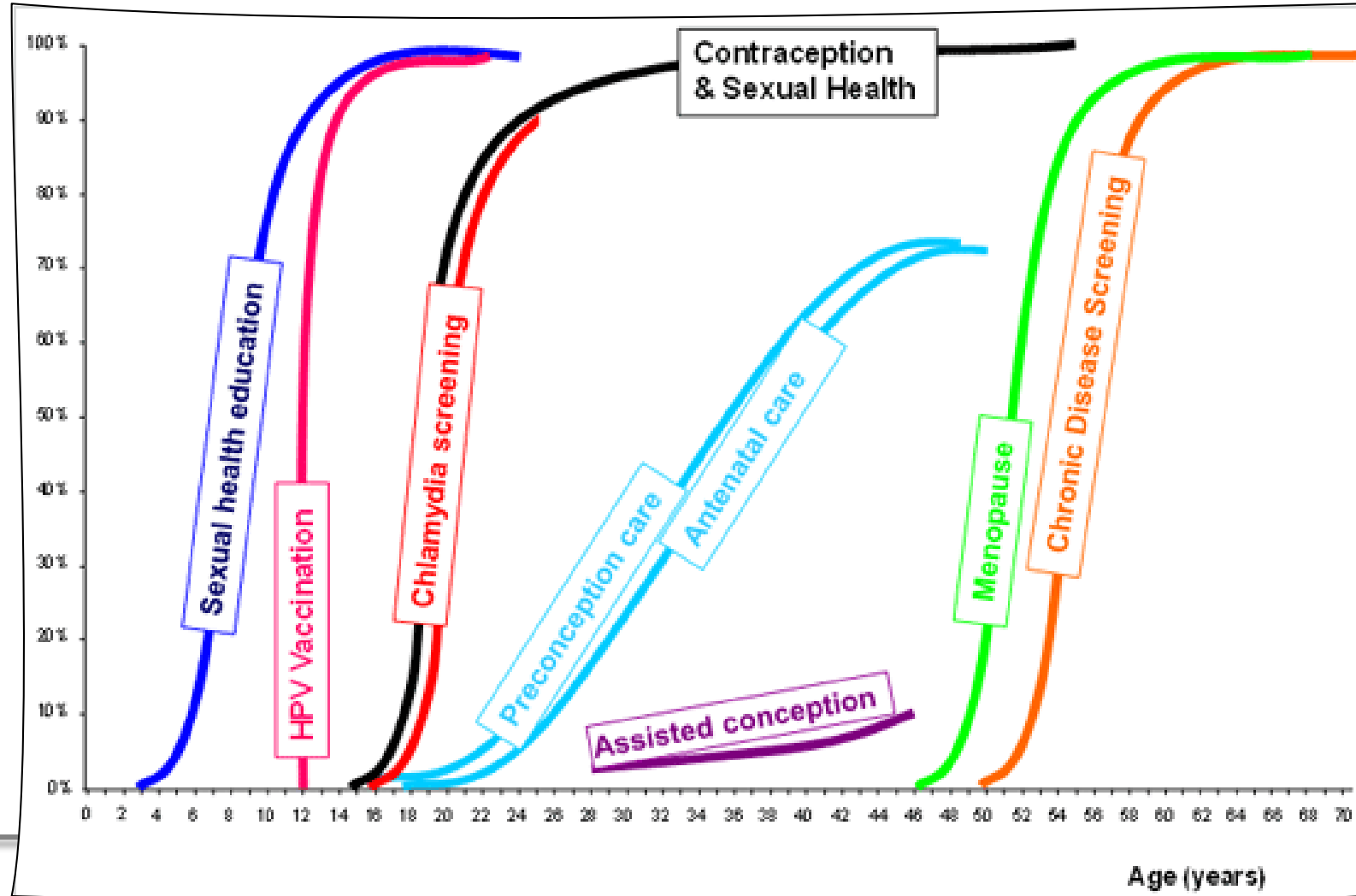
MDGs, **17 Sustainable Development Goals** with 169 associated Targets.

Goal 3.7 By 2030

Ensure universal access to sexual and reproductive health care services, including family planning, information and education, and integration of reproductive health into national strategies and programs.”

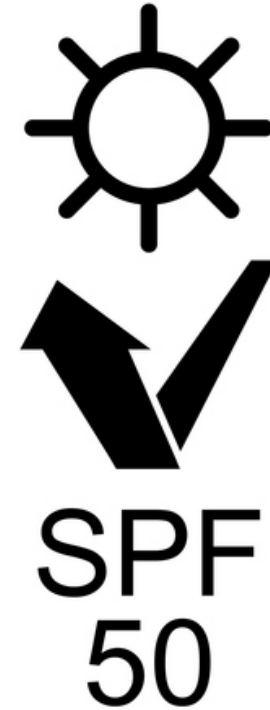


Background: Life Course Perspective



Background: A Lifelong Approach

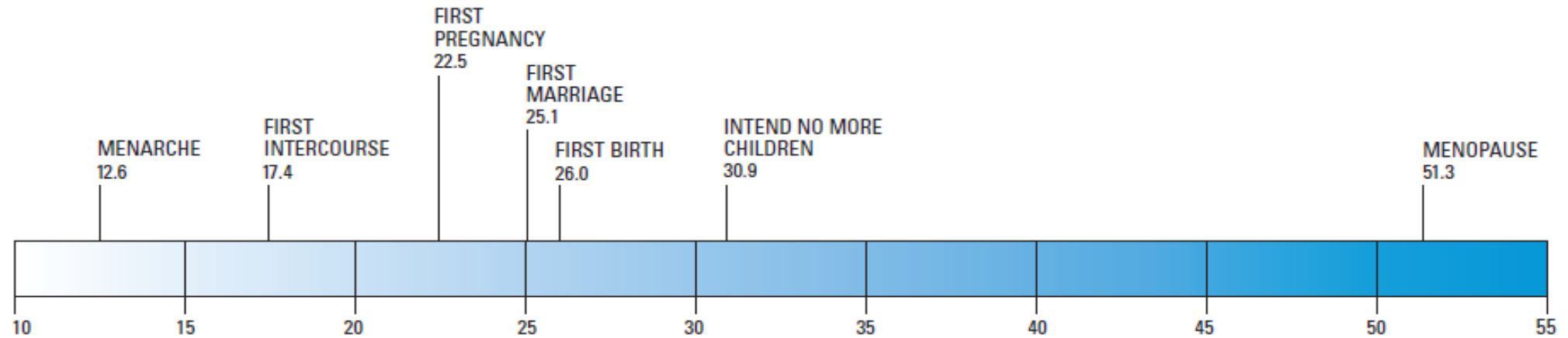
The approach to sexual health education and contraceptive methods and practices needs to be thought of as a lifespan approach for all humans.



Background: Women Spend Decades Avoiding Pregnancy

FIGURE 1.1

The typical woman spends five years pregnant, postpartum or trying to get pregnant and 30 years trying to avoid pregnancy.



Median age at which event occurs*

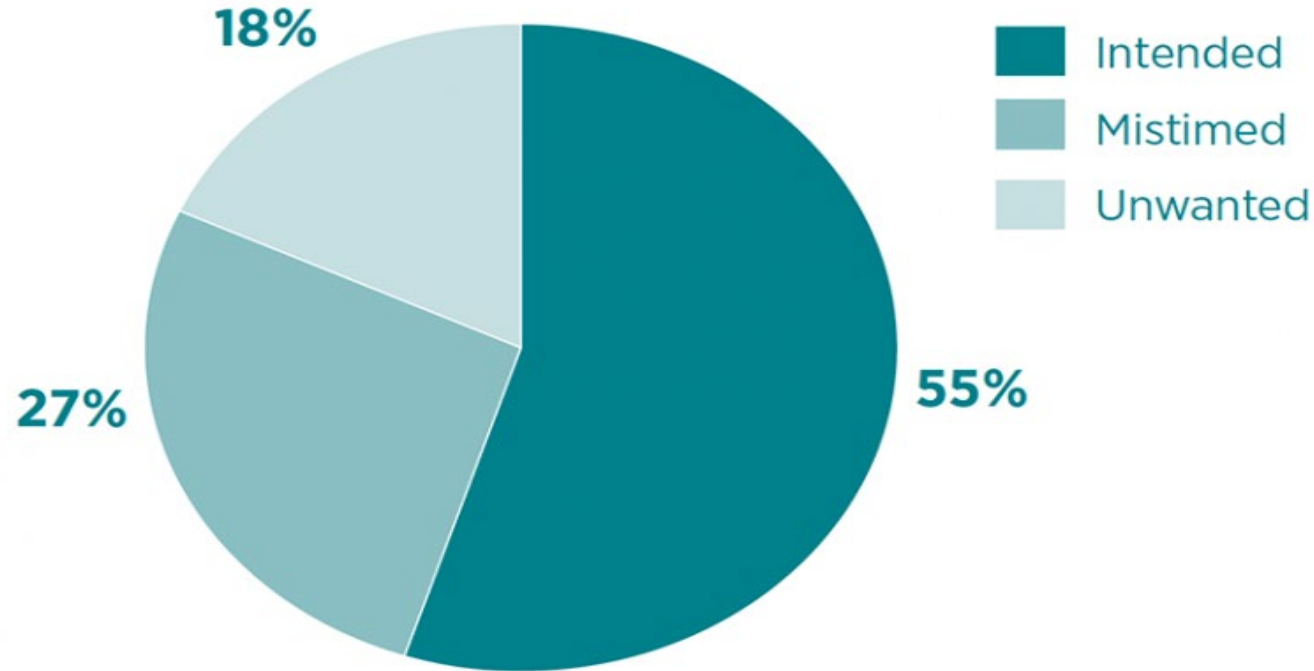
Note *Age by which half of women have experienced event.

Source Reference 6.



Background: Pregnancies by Intention Status

Nearly half of U.S. pregnancies were unintended in 2011.



www.guttmacher.org

Intended: pregnancy desired at the time it occurred or sooner.

Mistimed: woman did not want to be pregnant at the time the pregnancy occurred but did want to be pregnant at some point in the future.

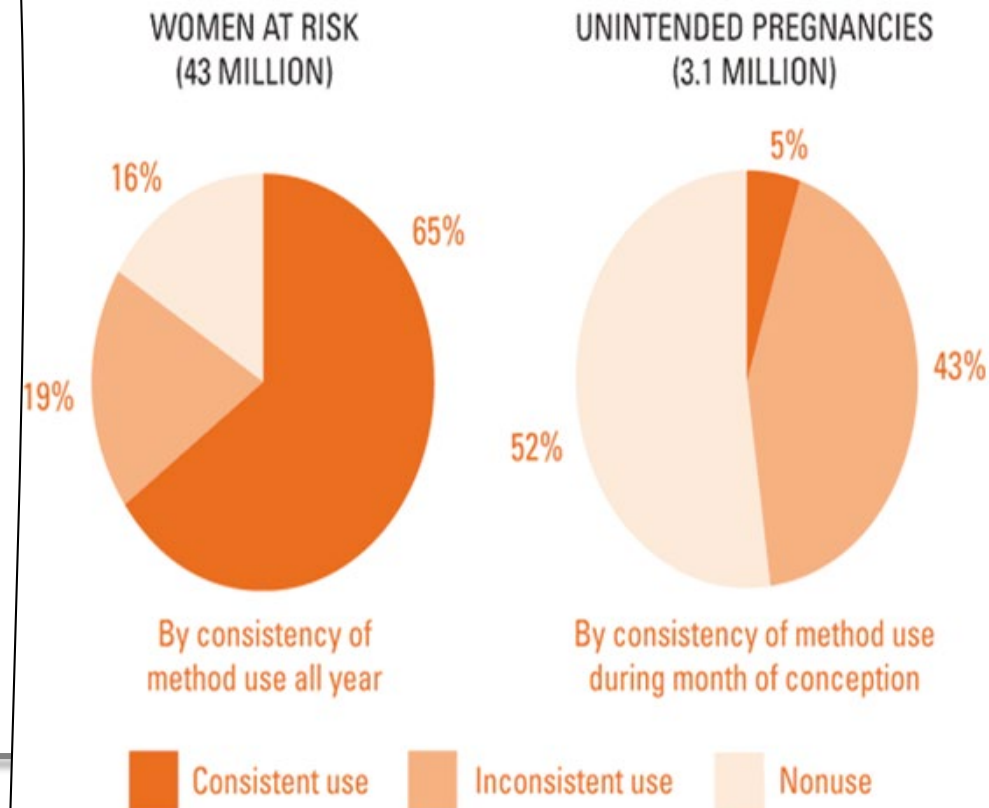
Unwanted: did not want to be pregnant then or at any time in the future.



Background: Preventing Unintended Pregnancies

Contraception Works

The two-thirds of U.S. women at risk of unintended pregnancy who practice contraception consistently and correctly account for only 5% of unintended pregnancies.



Background: Why are Contraceptive Methods Needed?

Although contraceptive methods have made dramatic advances in the last fifty years, approximately 222 million women worldwide **cannot get the birth control** they want and need.

Access to safe, appropriate, and affordable family planning and abortion care helps women have children when they desire and saves lives.

It can **prevent dangers** from pregnancies that are:

- Too Soon
- Too Late
- Too Close
- Too Many
- Not Wanted

Male and female condoms also prevent the spread of some STIs including HIV.



Background: Access to Family Planning is a Human Right

The 2012 U.N. Population Fund's annual report first describes family planning as a human right.

“Women who use contraception are generally healthier, better educated, more empowered in their households and communities and more economically productive. Women's increased labor-force participation boosts nations' economies”.

— *Dr. Babatunde Osotimehin, executive director of the fund.*

The United Nations Every Woman, Every Child campaign, Family Planning 2020 a global partnership designed to expand access to voluntary family planning information, contraceptives, and services by 2020.



Background: Preventing Unintended Pregnancies

Improves Educational Attainment



Workplace Participation



Economic Stability



Background: Investing in the Health of Women and Children Makes Good Sense

It reduces poverty.

Healthy women work more productively and stand to earn more throughout their lives.

It stimulates economic productivity and growth. (Maternal and newborn deaths slow growth and lead to global productivity losses of US \$15 billion each year.)

It is cost-effective.

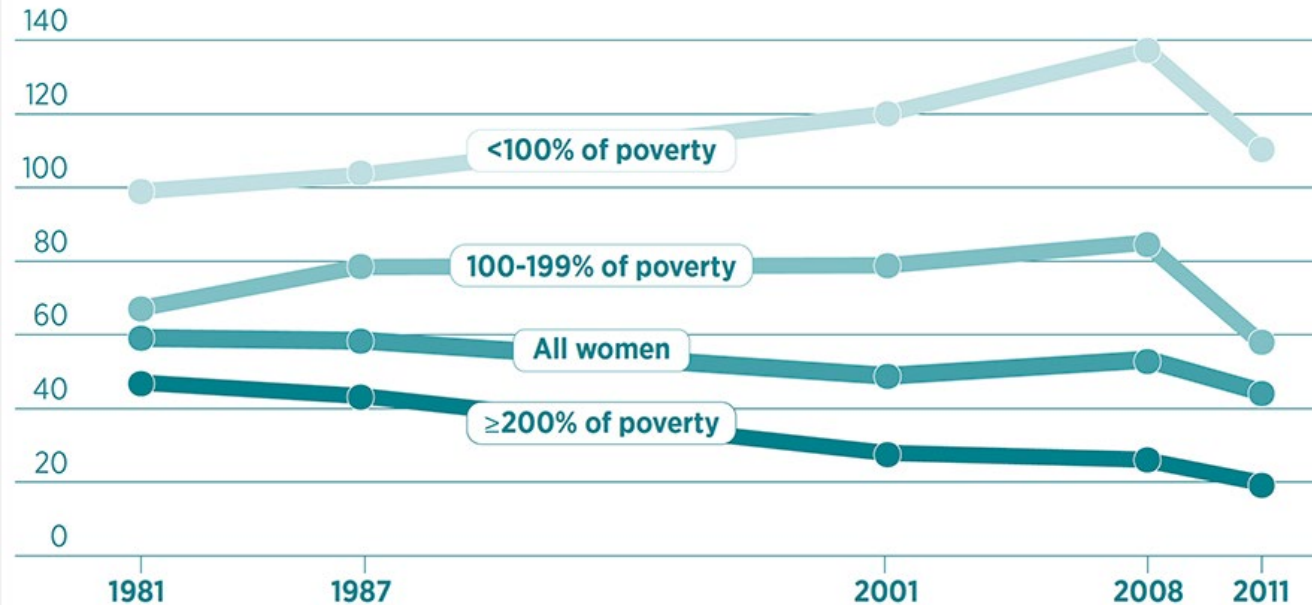


Background: Pregnancies and Poverty

UNINTENDED PREGNANCY RATES

Between 1981 and 2011, unintended pregnancy has become increasingly concentrated among poor and low-income women.

Rate (per 1,000 women aged 15-44)



www.guttmacher.org



Background: Rich Women Get Contraception/Poor Women Get Pregnant

	<100% Poverty	Mid-income	400%+ of poverty
Sexually active	69.9	68.0	71.0
Unprotected sex	15.9	13.0	7.9
Became pregnant	9.0	6.3	2.9
Abortion	8.6	10.9	31.9
% pregnant women who carried to term	77.6	71.7	52.2
Unintended birth rate	72.4	46.5	15.4



Background: Fewer Poor Women Receive LARC

Fewer Women

with Medicaid than private insurance **received LARC.**

(66% vs. 79%, $p < 0.01$)

More Women

with Medicaid than private insurance **became pregnant.**

(18% vs. 6%, $p < .001$)



Background: Indicators of Inconsistent Contraception Use Among Women Attending Family Planning Clinics

- 37% at risk for unintended pregnancy due to incorrect use.
- Compared to women with correct use, incorrect users:
 - Had less education.
 - More partners.
 - Dissatisfied with current method.
 - Not confident in reproductive knowledge.
 - Less likely to stop and use contraception before sex.



Background: The Proportion Of Women Who Will Become Pregnant Over One Year

Most Effective



Least Effective

Method	Perfect Use	Typical Use
Implant	0.05	0.05
Vasectomy	0.10	0.15
IUD		
Levonorgestrel-releasing	0.2	0.2
Copper-T	0.6	0.8
Tubal sterilization	0.5	0.5
Injectable	0.2	6
Pill/vaginal ring/patch	0.3	9
Male condom	2	18
Female condom	5	21
Withdrawal	4	22
No Method	85	85



Background: Unintended Pregnancies and Substance Use Disorders

- Rates of unintended pregnancy among women receiving agonist medication (methadone or buprenorphine) range from 67% to 86%.
- Among women with opioid use disorder in the United States, 54% report having four or more pregnancies in their lifetime compared with 14% of the general female population.
- 56% of women with substance use disorders use contraception vs. 81% of women who do not use drugs.



Background: Ethical Compass

- Debates discuss ways to increase access to effective sexual and reproductive health services for women who have substance use disorders.
- All individuals deserve access to effective contraceptives.
- Everyone has a right to high quality sexual and reproductive health services.



Background: Ethical Compass No Stigma!

Recognizing and addressing prejudice, discrimination and stigma toward women who have opioid and/or other substance use disorders.



Reproductive Health Needs: Women In Treatment for Substance Use Disorders

- Women who use substances report less use of contraceptives regardless of age, STI status or substance used.
- When asked about timing 89% of women said not now for pregnancy.
- Most women accessed health care in the past 3 years.
- 70% women received HIV testing.
- 53% STI testing.
- 49% annual medical exam.
- 77% Gyn appointment.
- 68% pap smear.
- 25% had difficulty accessing a health care provider.



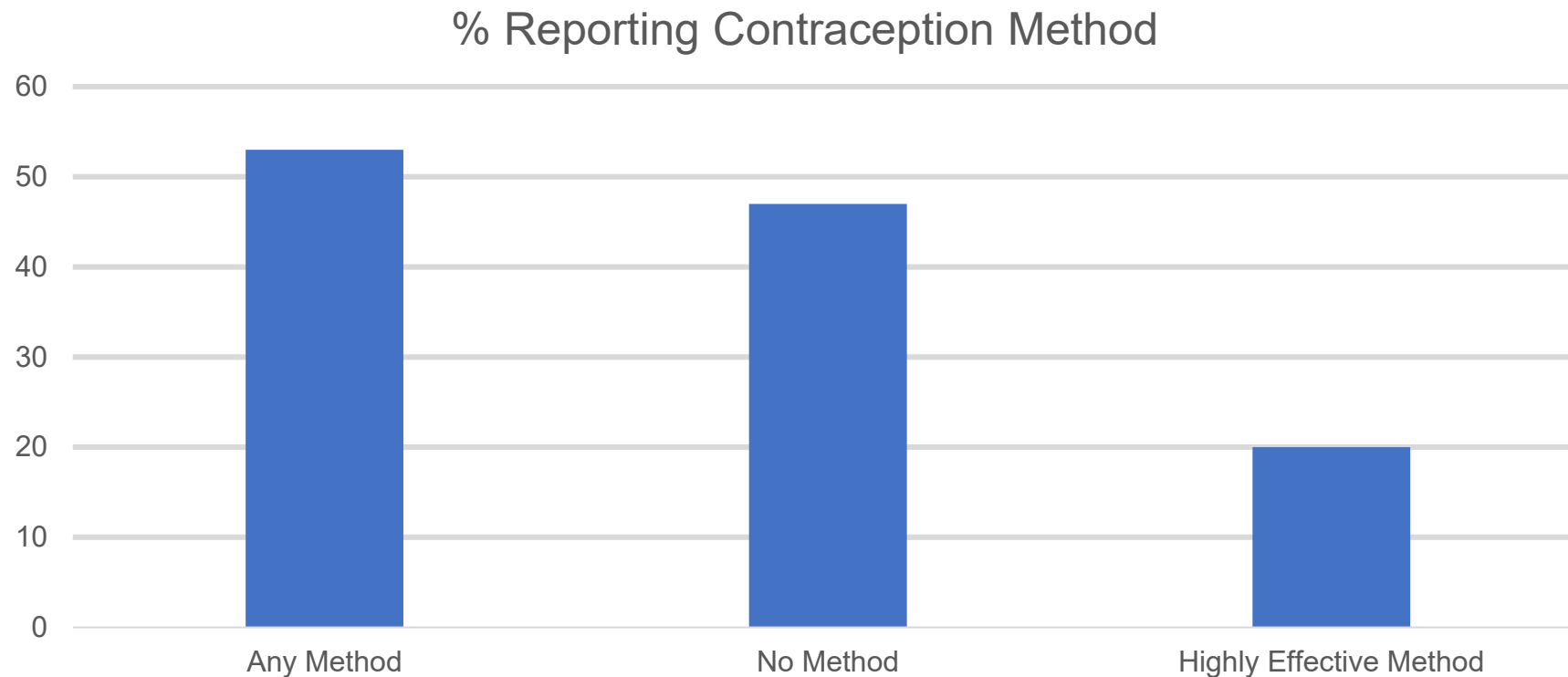
Background: Contraceptive Use and Method Choice

- 55% report contraceptive use.
- Of those who report using any contraceptive method:
 - 65% report using condoms
 - 17% pills
 - 15% implant
 - 7% IUD
- The majority of women with opioid use disorder who do not want to become pregnant are at risk of unintended pregnancy.



Background: Few Women in Treatment for Substance Use Disorders Use Highly Effective Contraceptive Methods

83% of women said they would use family planning services if they were available in treatment programs for substance use disorders.



Background: Women With Opioid Use Disorders May Benefit from Contraceptive Access and Education

Retrospective cohort study

N=376 women aged 20-61 years; active treatment for opioid use disorders compared to age-matched population data:

- had less use of planned (non-condom) contraception-24% vs 50%, $p < 0.001$
 - low use of oral contraceptives 4% vs. 25%, $p < 0.001$
 - IUD 1% vs. 6%, $p < 0.001$
 - sterilization 7% vs. 6%, $p = 0.053$
 - higher rates of injectable contraceptives 6% vs. 3%, $p = 0.003$
- more frequent pregnancy terminations 0.46 vs. 0.025, $p = 0.004$
- higher annual incidence of chlamydia 1.1% vs. 0.33%, $p < 0.001$



Background: Women's Knowledge and Concerns

Opportunity for Education

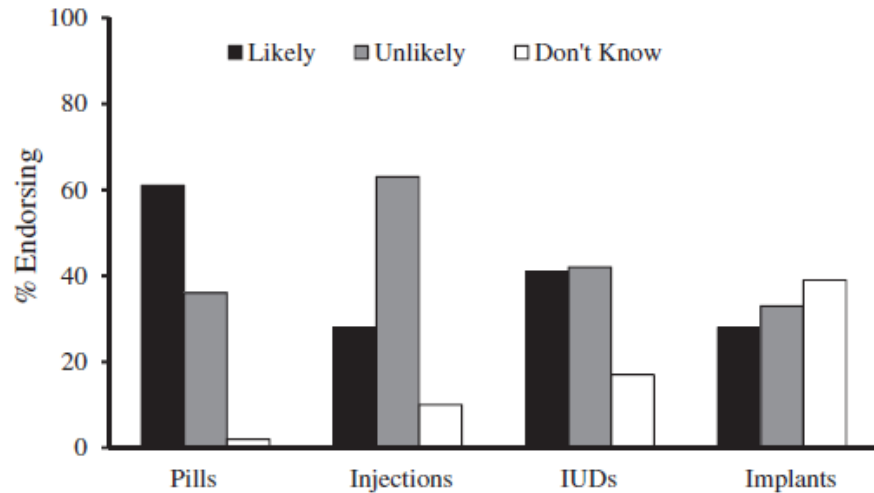


Fig. 1. Self-rated likelihood of birth control pill, injection, intrauterine device (IUD) and implant use in the future among women in medication assisted treatment for opioid use disorder and at risk for unintended pregnancy. Note that the original survey did not ask about the likelihood of future condom use. $N=83$ for pills, injections and IUDs and $n=51$ for implants.

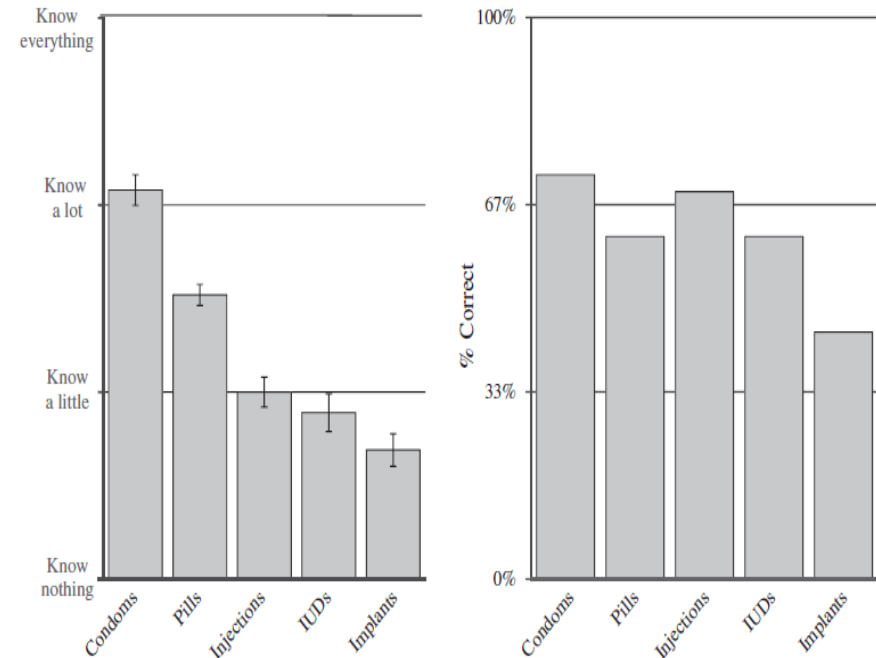


Fig. 2. Mean \pm standard error of the mean of self-rated contraceptive knowledge (left panel) and percentage of correct responses to contraceptive knowledge questions (right panel) as a function of method type (IUDs = intrauterine devices) among women in medication assisted treatment for opioid use disorder and at risk for unintended pregnancy. $N=83$ for pills, injections and IUDs and $n=51$ for implants.

Matusiewicz AK et al., Contraception. 2017; 96:365-369.



Background: Women's Perceptions of Long-acting Reversible Contraception

Common Themes

Fear of complications-side effects, bleeding and pain.

Heard others talk about bad experiences with the method.

Discomfort with the idea of a foreign object inserted into the body.



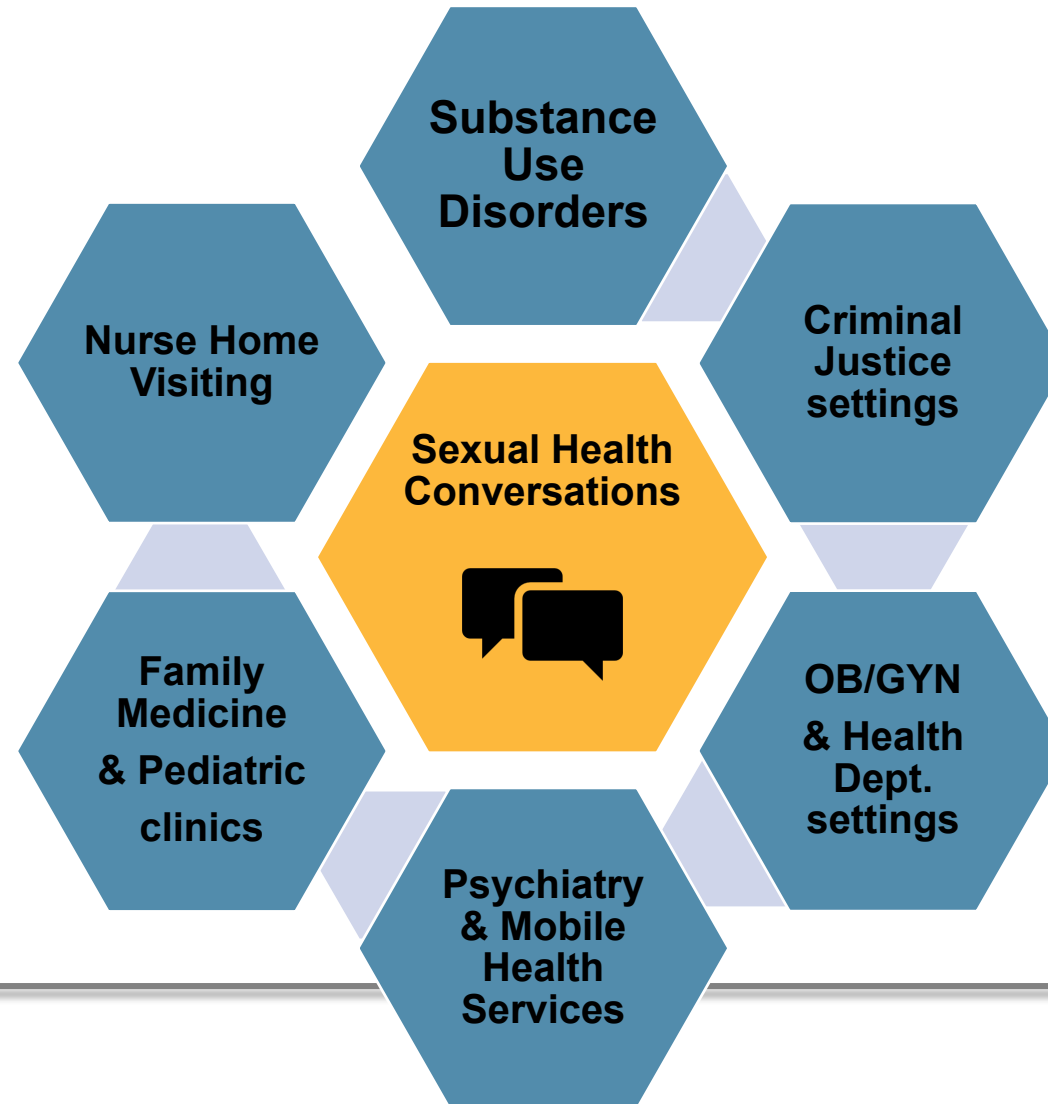
Background: Differing Approaches

Approaches

- Co-locating family planning services with settings that serve women with substance use disorders.
- Integrating family planning services into SUD treatment services.
- Integrating family planning services into the criminal justice system.
- Integrating family planning service into syringes exchange programs.
- Integrating SUD treatment into OB settings.



Settings: Many Settings Offer Opportunity for Sexual Health Conversations



Common Themes: Women and Men Who Use Substances and Providers All See Value in Access to Contraceptives

100% of providers, men and women:

Saw a need for accurate sexual health and contraceptive practice information.

Believed that treatment settings were the ideal place to receive messages and access to practices.

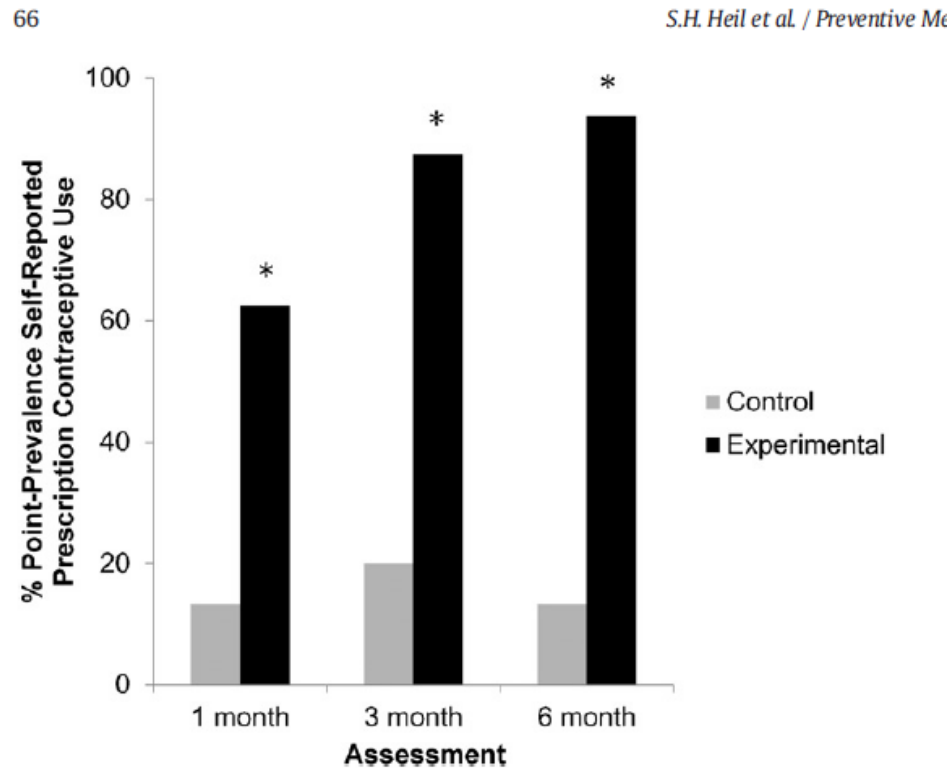
All women of childbearing age deserve easy and affordable access to contraception.

Barriers include cost, fear of judgment, long waiting times to get to see a health care professional.



Common Themes: Interventions With Women Who Receive OUD Treatment Works

First published experimental intervention



↪ **Pregnancy:**
↪ **20% Control**
↪ **vs.**
↪ **0% Experimental**



Common Themes: Barriers to Sexual Health Education and Method Access

- Too few trained healthcare providers.
- Lack of knowledge about contraceptive methods.
- Limited choices.
- High costs.
- Limited supplies.
- Long distances to services.
- Cultural objections.
- The right of a woman to choose when and how many children she has is seen as someone else's decision or right.
- Disparity

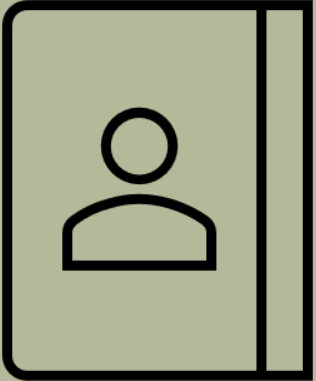


Common Issues That are Tricky

- Helping the provider feel comfortable talking about sex.
- Coercion by partner or others.
- Negative Word of mouth experiences with a method.
- Fear of changing bleeding (too little, too much etc.).
- Transportation
- Lack of resources (financial).
- Access to Medicaid – women are removed from it; difficult system to navigate- have to re-apply.
- Stability in treatment- less stable treatment = focus is substance use and sexual health goes unaddressed or under-addressed.



Let's Visit our Case Study a Second Time



Patient is a 29-year-old woman who is currently 8 weeks post-partum. During her pregnancy, she thought about having a tubal ligation but changed her mind. She has five other children. Currently two of her children live with her. She has previously expressed an interest in starting Depo injection but during this visit, she is feeling too overwhelmed to talk about contraception. She states that she and her partner are “mostly” using condoms.

- **What education might be helpful in this situation?**
- **What barriers do you think that she is facing?**



Entering the Maze

Learning Objective Met: Identify the unique and common issues women who are pregnant or post-partum with SUD face in accessing and implementing reproductive life planning.

- Education about sexual health and contraceptive methods should occur across the lifespan.
- Access to all safe, appropriate, and affordable family planning care helps women have children when they desire and saves lives.
- The majority of women with opioid use disorder who do not want to become pregnant are at risk of unintended pregnancy.
- Women with opioid use disorder face multiple barriers to sexual health and contraceptive methods.

Summary



Guiding Compass for Navigating the Maze: Assessing Values, Erasing Discrimination and Building Empathy

Stigma

- Dynamic and complex process.
- Linked to power.
- Elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a lower situation that allows them.

To overcome stigma we must identify the...

structures

behaviors

practices

processes

...that operate to sustain stigma.



What is Substance Use Disorder-Related Stigma?

It assumes many forms and appears in many contexts:

Prejudice

Discrimination

Fear

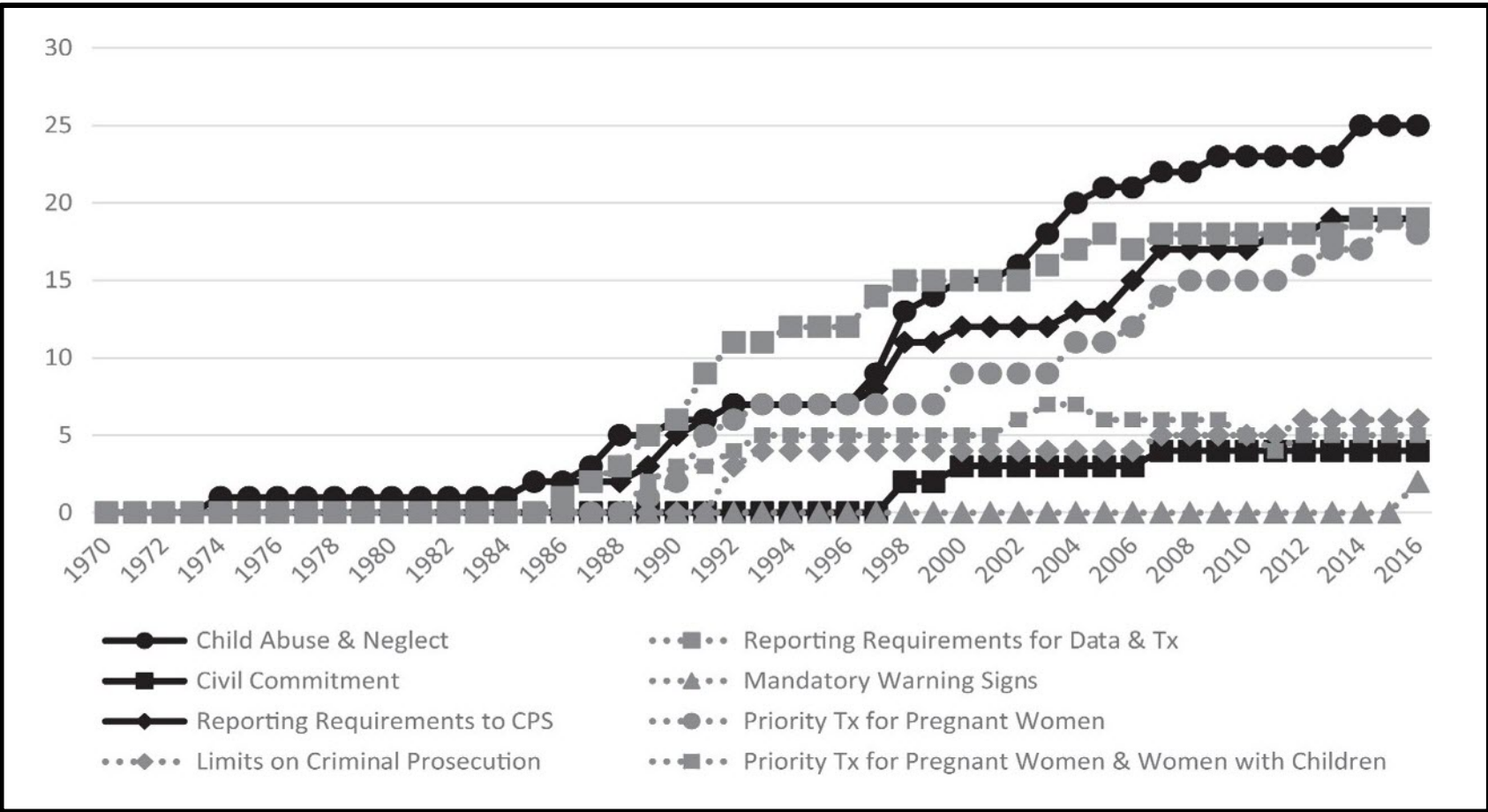
Shame

Stereotyping

Stigma against substance use disorders is a pervasive and damaging influence on the number of services, geography of services, quality of services, treatment outcomes and therapeutic, professional and personal relationships.



Where Does Stigma Show Up? In Policies (1 of 2)

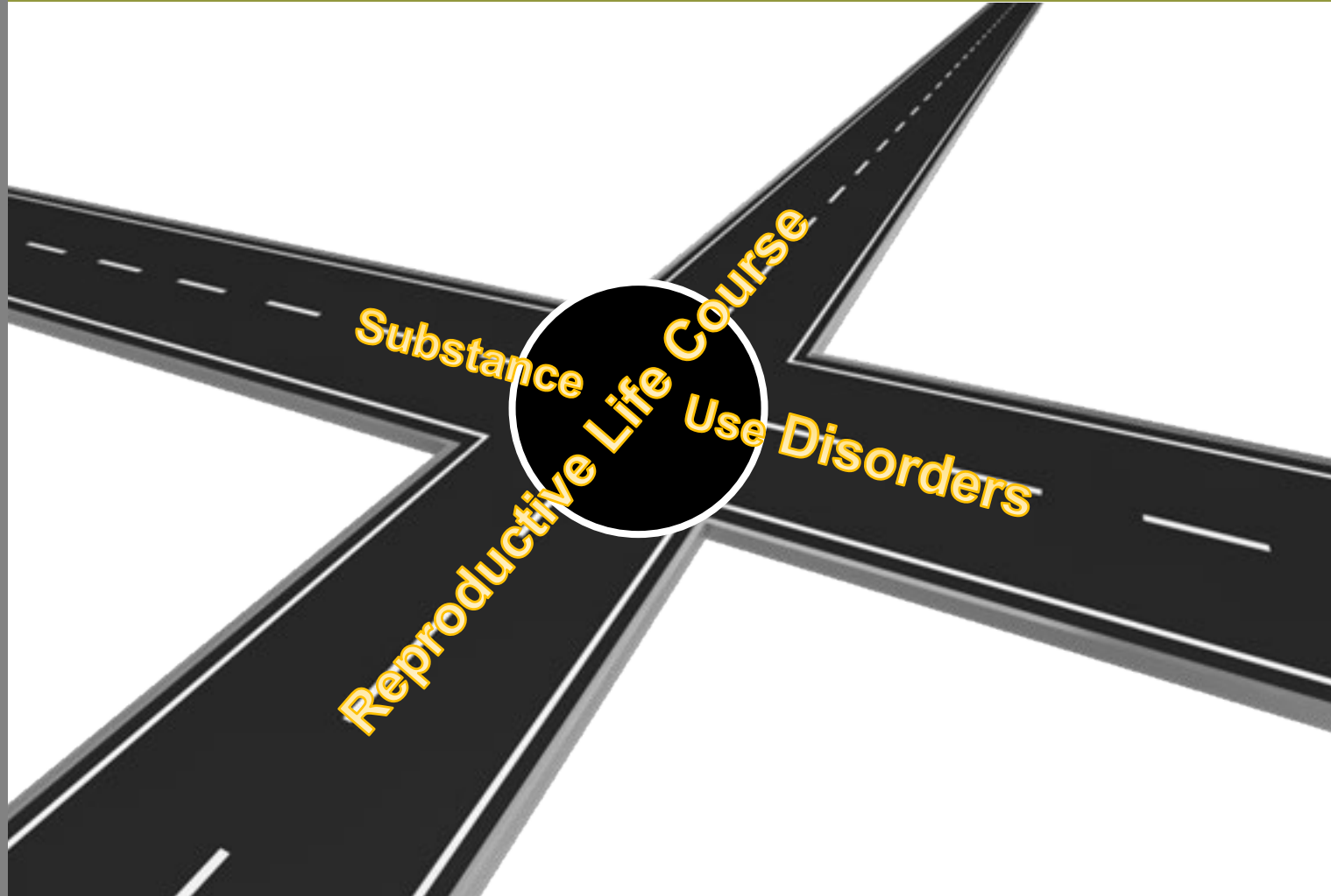


Where Does Stigma Show Up? In Policies (2 of 2)

- The ways women are treated in jail and prison.
- The loss of Medicaid when incarcerated.
- Difficulty of obtaining employment at a living wage and safe housing after incarceration.
- Lack of access to physical and mental health services.
- Lack of access to quality affordable childcare.
- Birth control not covered by insurance when Viagra is.
- Laws or policies that limit access to all forms of family planning.
- Changes to definition of domestic violence and loss of protection for those being trafficked.



Where Does Stigma Show Up? Intersecting Issues



Where Does Stigma Show Up? In Public Actions and Attitudes

Project Prevention

Formerly **C**hildren **R**equiring **A** **C**aring **K**ommunity or **CRACK**...

An American non-profit organization that pays "drug addicts" cash for volunteering for long-term birth control, including sterilization.

Attention Drug Addicts and Alcoholics!



Get Birth Control. Get \$300



Where Does Stigma Show Up? In The Media

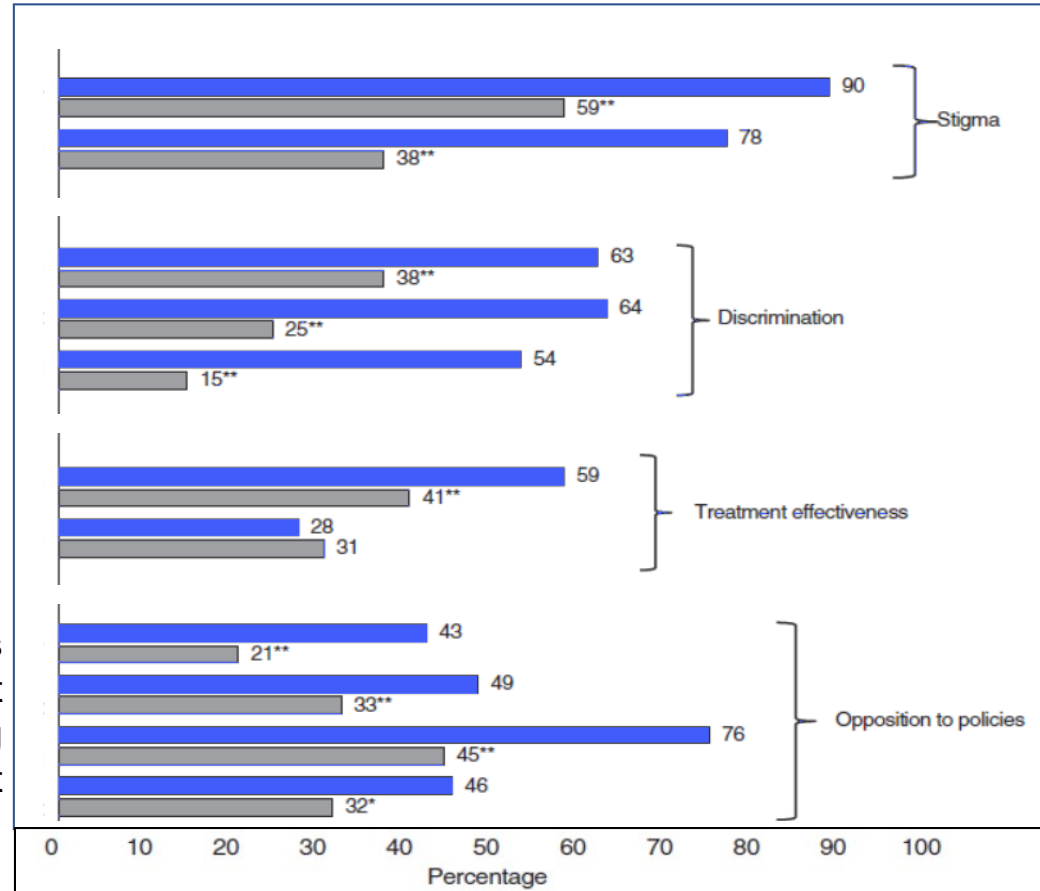
- The frequency with which stigmatizing terms and less-stigmatizing alternatives are used in U.S. news media coverage of the opioid epidemic.
- N=6399 news stories about the opioid epidemic published/aired July 2008 through June 2018.
- 49% of news stories about the opioid epidemic mentioned any stigmatizing term and 2% mentioned any less-stigmatizing alternative.
- The proportion of news stories mentioning stigmatizing terms over the 10-year study period increased from 37% in July 2008–June 2009 to 45% in July 2017–June 2018.
- “The language included in U.S. news media coverage of the opioid epidemic may contribute to and reinforce widespread public stigma toward people with opioid use disorders. This stigma may be a barrier to implementation of evidence-based interventions to prevent opioid overdose deaths. Establishing journalistic standards to de-stigmatize the language of addiction is a public health priority.”



Where Does Stigma Show Up? In Public Attitude

Figure 1 Public attitudes about persons with drug addiction (N=347) and mental illness (N=362), 2013 ^[a]

- 1 Drug addiction
 - Unwilling to marry into family
 - Unwilling to work closely on job
- 2 Mental illness
 - Discrimination not a serious problem
 - Employers should be allowed to deny employment
 - Landlords should be allowed to deny housing
 - Treatment options not effective
 - Recovery not possible
 - Opposed to equivalent insurance benefits
 - Opposed to increased government spending on treatment
 - Opposed to increased government spending on housing
 - Opposed to increased government spending on job support



Legend:

[a] Responses on 7-point Likert scales were collapsed to dichotomous measures. Pearson chi square tests assessed whether attitudes differed by the drug addiction or mental illness version of each survey item.

*p<.01
**<.001



Where Does Stigma Show Up? In Treatment Deserts

Facilities Providing Some Medication Assisted Treatment (2020)

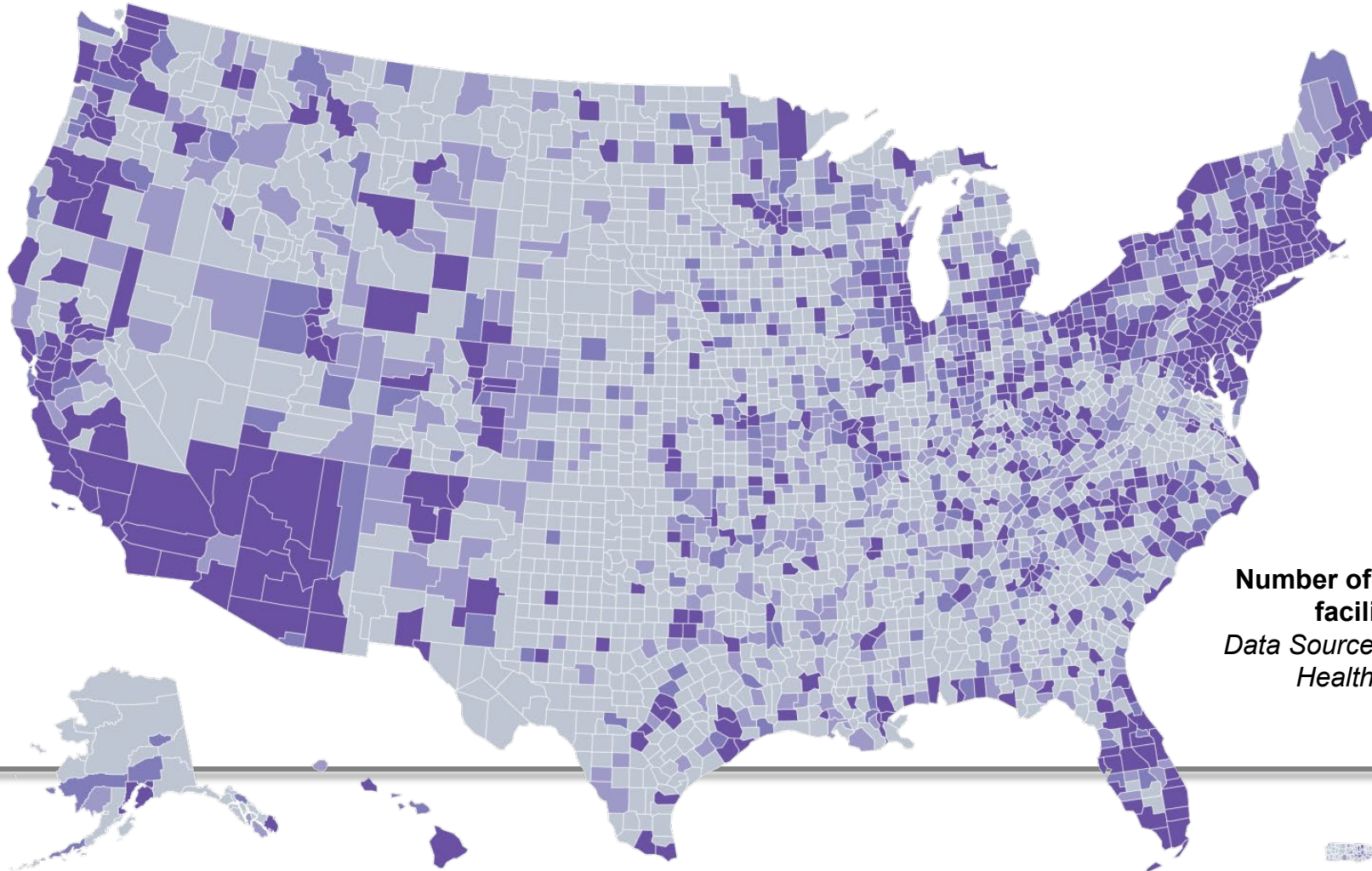
National: 6,610

Key:

1

2

3



Number of substance abuse treatment facilities offering any MAT
Data Source: Substance Abuse and Mental Health Services Administration.



Where Does Stigma Show Up? In Treatment Deserts (cont.)

Facilities Providing All Medication Assisted Treatments (2020)

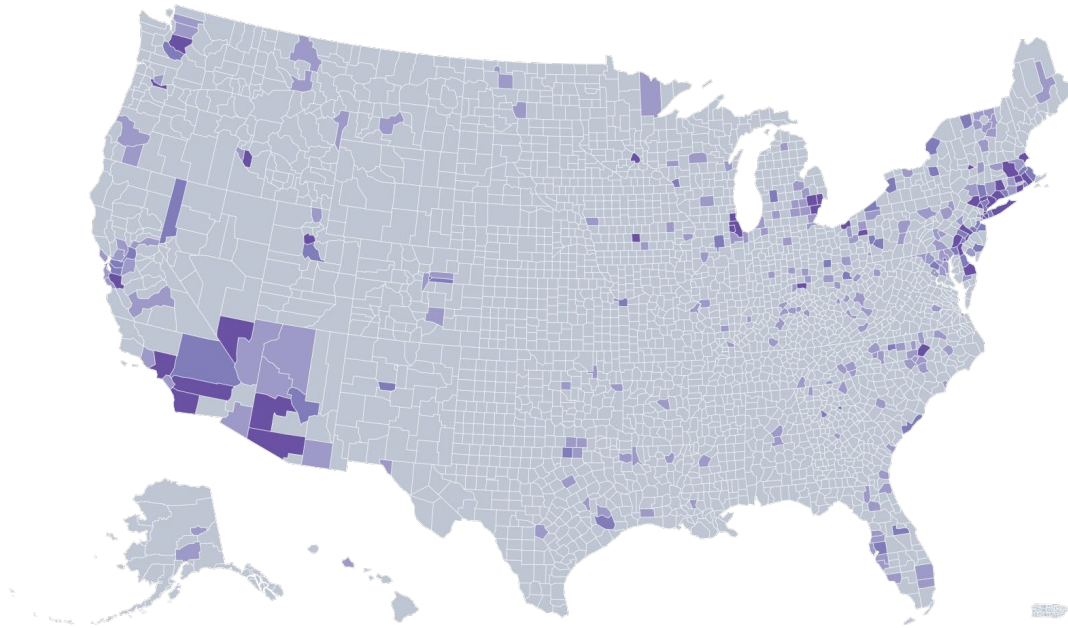
National: 546

Key:

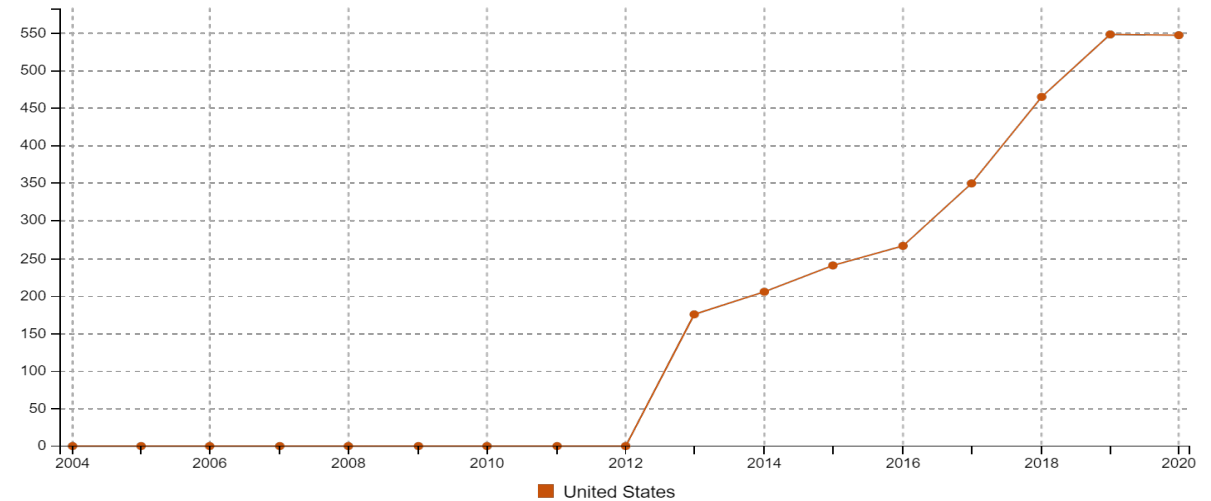
1

2

3



Historical Trends (2013 - 2020)



Number of substance abuse treatment facilities offering all three MAT services (Buprenorphine, Methadone, Naltrexone)

Data Source: Substance Abuse and Mental Health Services Administration.



Where Does Stigma Show Up? In Stigmatized individuals' Behavior

- Participants repeatedly cited the impact of stigma on syringe access, particularly in the context of pharmacist interactions.
- They described being denied syringe purchase as stigmatizing and embarrassing, and these experiences discouraged them from attempting to purchase syringes under the new pharmacy access law.
- Participants described feeling similarly stigmatized in their interactions with first responders and hospital staff and associated this stigmatization with delayed and substandard medical care for overdoses and injection-related infections.
- Participants described macro-level public stigma towards methadone (e.g., equating methadone treatment with illicit drug use) as discouraging participation and justifying exclusion of methadone patients from recovery support services like sober living and Narcotics Anonymous.



Where Does Stigma Show Up? In Women's Treatment Barriers

Interviews revealed major themes in motivators to seek treatment:

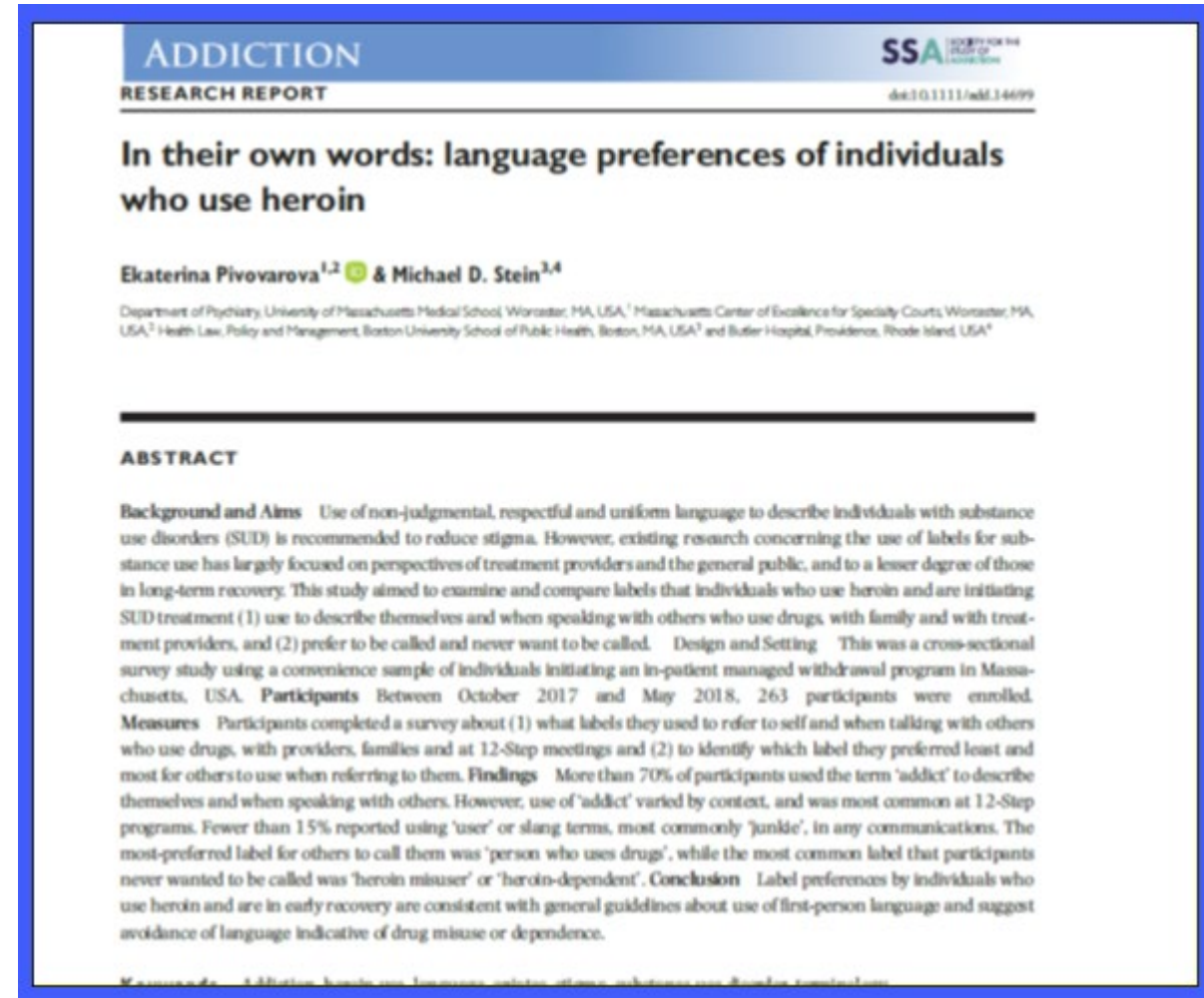
Readiness to stop using, concern for the baby's health, concern about custody of the baby or other children, wanting to escape violent environments or homelessness, and seeking structure.

Barriers to treatment included fear of loss of custody, not wanting to be away from children/partner, concern about stigma or privacy, and lack of childcare and transportation.



Where Does Stigma Show Up? In Context

- More than 70% of participants used the term “addict” to describe themselves when speaking to others. However, use of the term “addict” varied by context and was most common in 12 steps meetings.
- Fewer than 15% reported using “user” or slang terms, most commonly “junkie”, in any communications.
- The most preferred label for others to call them was “person who uses drugs”. The most chosen label that they never wanted to be called was “heroin misuser” or “heroin-dependent.”



What Sustains Stigma?

- Keeping a distance
- Expressing disapproval
- Feel superior
- Promote agendas
- Control others
- Express fear
- Hurt others



How to Eliminate Stigma?

Learn more



Speak out

Keep hope
alive



Treat people
with dignity

Think about
the whole
person



The Power of Words to Hurt or Heal

Stigmatizing Language	Preferred Language
abuser	a person with or suffering from, a substance use disorder
addict	person with a substance use disorder
addicted infant	infant with neonatal abstinence syndrome (NAS)
addicted to [alcohol/drug]	has a [alcohol/drug] use disorder
alcoholic	person with an alcohol use disorder
clean	abstinent
clean screen	substance-free
co-dependency	term has not shown scientific merit
crack babies	substance-exposed infant
dirty	actively using
dirty screen	testing positive for substance use
drug abuser	person who uses drugs
drug habit	regular substance use
experimental user	person who is new to drug use
lapse / relapse / slip	resumed/experienced a recurrence
medication-assisted treatment (MAT)	medications for addiction treatment (MAT)
opioid replacement	medications for addiction treatment (MAT)
opioid replacement therapy (ORT)	medications for addiction treatment (MAT)
pregnant opiate addict	pregnant woman with an opioid use disorder
prescription drug abuse	non-medical use of a psychoactive substance
recreational or casual user	person who uses drugs for nonmedical reasons
reformed addict or alcoholic	person in recovery
relapse	reoccurrence of substance use or symptoms
slip	resumed or experienced a reoccurrence
substance abuse	substance use disorder

Adapted from: The Rhetoric of Recovery Advocacy: An Essay On the Power of Language W.L. White; E.A Salsitz, MD., Addiction Medicine vocabulary; Substance Use Disorders: A Guide to the Use of Language Prepared by TASC, Inc. Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services (DHHS), rev. 4.12.04



Take A Trauma-Informed Approach



Cultural and Linguistic Environment

- That is responsive to the people and communities being served.

Programmatic Environment

- Predictable and consistent, while also maximizing flexibility and responsiveness to individual and family needs (e.g., have resources, create a LGBT alliance).



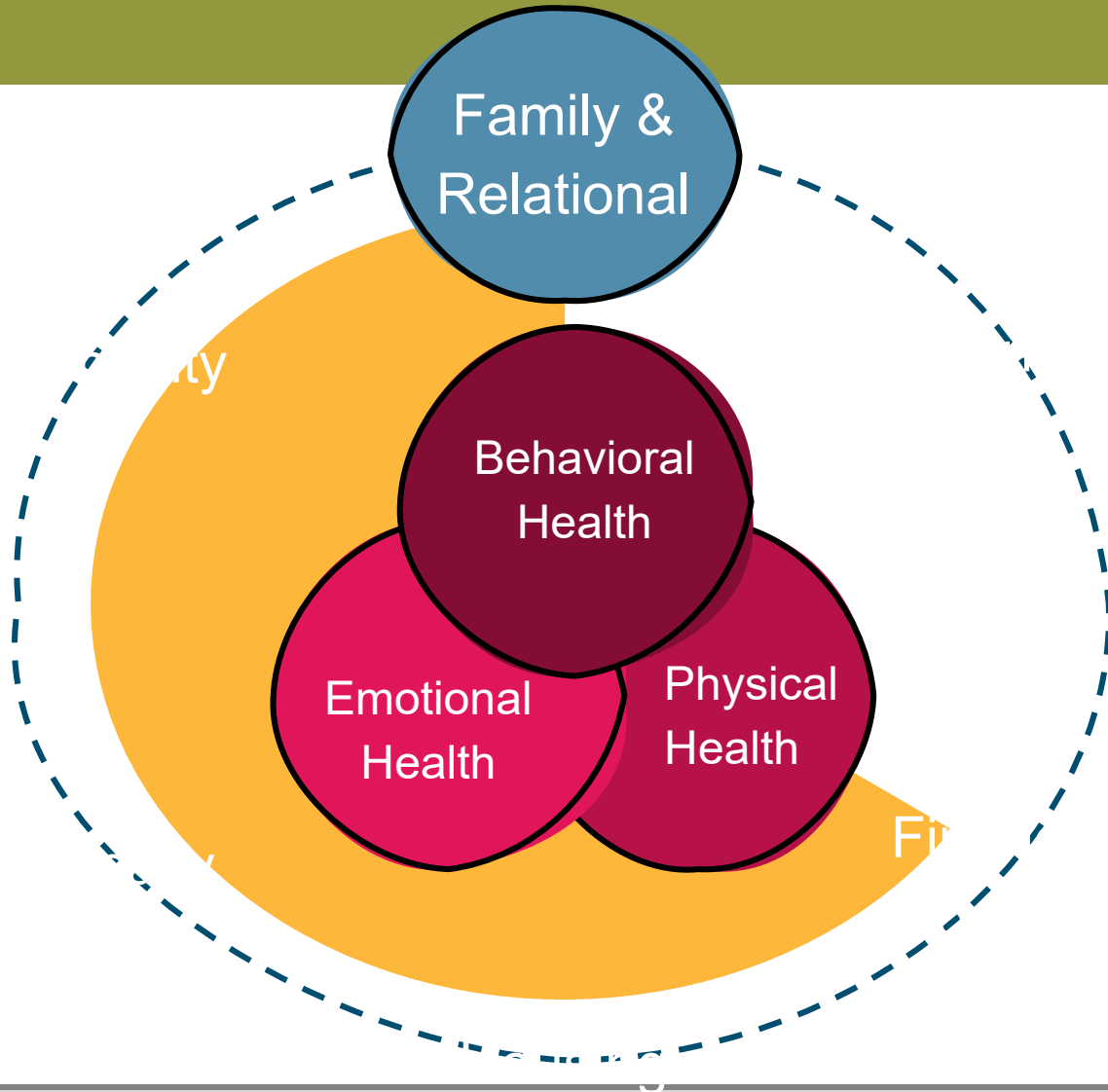
Relationally-Oriented Recovery Support

Include:

- Flexible treatment schedule.
- Family/dependent care resources.
- Couple, family and child therapy/services.
- Coordinating children's services with mother's.
- Parenting development and support.
- Feminine-identified supports and role models.
- Women-only recovery-oriented spaces.



Holistic Services



Women deserve to have health and substance use disorder treatment services in a holistic manner that encompasses behavioral, physical and emotional health care. These services are ideally provided in an integrated way. Within such care, there needs to be links to help and services for financial and employment, housing, helping women find their voice to advocate for themselves and others and be part of the community as well as promoting the health and wellbeing of their families.



Understand Your Own Implicit Biases

- Patient-centered contraceptive counseling encourages patients to make the best choice for themselves among all birth control options.
- Implicit bias can lead clinicians to encourage certain contraceptive methods over others for particular groups of patients.
- How do we know that implicit bias affects contraceptive counseling? Third- and fourth- year medical students were asked to complete an online survey. They reviewed the same scenarios, with the exception of the patient's name— which was randomly assigned to indicate one of five racial/ethnic groups (White, Chinese, Filipina, Native Hawaiian, and Micronesian).
- Students suggestions varied with patients' age and race. For example, students recommended sterilization for 60% of older Micronesian women and 27% of older White women.
- Research has shown that implicit bias affects seasoned clinicians, too.
- A review of 42 studies indicated that clinicians exhibit the same levels of implicit bias as the general population.
- In the absence of medical contraindications, the best birth control method for each patient is the one the patient wants.



Minimize Implicit Biases

Here are 4 things you can do to help minimize implicit biases:

1

Challenge your current negative biases about specific groups with contrary or positive information that goes against negative stereotypes.

2

Be empathetic. Many people may not have friends who are black, Latinx, LGBTQ, or differently-abled. It's harder to be empathetic towards them. Find ways to learn more about racial or ethnic groups you do not interact with, if that's reading a book, or watching a movie/documentary.

3

See differences. The idea of being colorblind negates or minimizes a person's lived experience.

4

Engage in dialogue with others about their biases. When we see people being discriminated against based on stereotypes, we're afraid to step up. But being an ally or an advocate for people experiencing bias helps us create positive experiences for ourselves and them.



Strategies to Reduce Implicit Biases

- Individuation — Seeing the person as an individual rather than a stereotype (e.g., learning about their personal history and the context that brought them to the doctor’s office or health center).
- Perspective taking — “Putting yourself in the other person’s shoes”
- Partnership building — Reframing the interaction with the patient as one between collaborating equals, rather than between a high-status person and a low-status person
- Have a basic understanding of the cultures your patients come from.
- Understand and respect the tremendous power of unconscious bias.
- Recognize situations that magnify stereotyping and bias.
- Do a “Teach Back.” [Teach Back](#) is a method to confirm patient understanding of health care instructions that is associated with improved adherence, quality, and patient safety.



Next Steps

- **Take the pledge:**

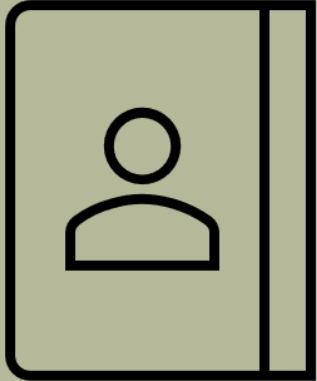


From this day forward I will use person-first language in all of my interactions with patients, colleagues and the public.

- **Name one thing** you can implement quickly within your organization, practice, provider community to better support women in recovery in their sexual health literacy and actively eliminate stigma.



Let's Visit our Case Study a Third Time



Patient is a 29-year-old woman who is currently 8 weeks post-partum. During her pregnancy, she thought about having a tubal ligation but changed her mind. She has five other children. Currently two of her children live with her. She has previously expressed an interest in starting Depo injection but during this visit, she is feeling too overwhelmed to talk about contraception. She states that she and her partner are “mostly” using condoms.

- **How might stigma impact this patient's care?**
- **Can you think of any personal biases that may impact your care of this patient?**



Guiding Compass for Navigating the Maze

Summary

Learning Objective Met: Identify ways stigma, discrimination and prejudice play a role in access and implementing reproductive life planning for women who are pregnant or post-partum with SUD.

- Stigma, discrimination and prejudice can be present in the media and in policies that impact women with opioid use disorders.
- Stigma discrimination and prejudice impacts access to services
- When caring for women with substance use disorders, it is helpful for providers to understand their own implicit biases.



NAVIGATING THE MAZE:

Sexual Health and Literacy for Pregnant and Postpartum Women with Substance Use Disorders June 23 – 24, 2020

TTC Technology Transfer Centers
Funded by Substance Abuse and Mental Health Services Administration



Disclaimer

This *Navigating the Maze: Sexual Health and Literacy for Pregnant and Postpartum Women with Substance Use Disorders* was prepared for the Mid-America Addiction Technology Transfer Center under a cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA). All material appearing in this presentation, except that taken directly from copyrighted sources, is in the public domain and may be reproduced or copied without permission from SAMHSA or the authors. Citation of the source is appreciated. Do not reproduce or distribute this presentation for a fee without specific, written authorization from the Mid-America ATTC. For more information on obtaining copies of this presentation please email sherry@umkc.edu.

At the time of this presentation, Elinore F. McCance-Katz, MD, PhD serves as SAMHSA Assistant Secretary. The opinions expressed herein are the views of Hendrée E. Jones, PhD, Elisabeth Johnson, FNP, PhD and Essence Hairston, MSW and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.



Mid-America (HHS Region 7)

ATTC

Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration



Mountain Plains (HHS Region 8)

MHTTC

Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration



Disclosures

Conflict of Interest

In accordance with continuing education guidelines, the speaker and planning committee members have disclosed commercial interests/financial relationships with companies whose products or services may be discussed during this program.

Speakers

Hendrée E. Jones, PhD, Elisabeth Johnson, FNP, PhD and Essence Hairston, MSW have nothing to disclose.

Planning Committee

Sharon Colbert, Angela Bolen, and Shelby Webb have nothing to disclose.

Kristin Metcalf-Wilson serves on the Afaxys Pharmaceuticals advisory board.

Jacki Witt serves on the Afaxys Pharmaceuticals advisory board (Resolved).



Today's Q&A Panelists



Kristin Metcalf-Wilson, DNP, WHNP-BC, University of Missouri Kansas City, School of Nursing and Health Sciences
metcalf-wilsonk@umkc.edu



Maridee Shogren, DNP, CNM, University of North Dakota, College of Nursing & Professional Disciplines
maridee.shogren@und.edu



Jacki Witt, JD, MSN, WHNP-BC, SANE-A, University of Missouri Kansas City, School of Nursing and Health Sciences
wittj@umkc.edu



Presenters



Hendrée Jones, Ph.D., Executive Director, UNC Horizons, and Professor, Dept. of Obstetrics and Gynecology, School of Medicine, University of North Carolina at Chapel Hill, NC



Elisabeth Johnson, Ph.D., FNP-BC, Director of Health Services, UNC Horizons, and Professor, Dept. of Obstetrics and Gynecology, School of Medicine, University of North Carolina at Chapel Hill, NC



Essence Hairston MSW, Outpatient Program Manager at Wake County, UNC Horizons Program at Wake County, and Clinical Instructor, Dept. of Obstetrics and Gynecology, School of Medicine, University of North Carolina at Chapel Hill, NC



Learning Objectives

- 1** **Identify** the unique and common issues women who are pregnant or post-partum with SUD face in accessing and implementing reproductive life planning.
- 2** **Identify** ways stigma, discrimination and prejudice play a role in access and implementing reproductive life planning for women who are pregnant or post-partum with SUD.
- 3** **Examine** the roles that trauma experiences and intimate partners play in access and implementing reproductive life planning for women who are pregnant or post-partum with SUD.
- 4** **Discuss** how to have productive and engaging conversation with pregnant or post-partum women with SUD about sexual health and reproductive planning.



Outline

Day 1

- **Entering the Maze:** Overview of Sexual Health Research with Pregnant and Postpartum Women who have Substance Use Disorders.
- 10-minute break.
- **Guiding Compass for Navigating the Maze:** Assessing Values, Erasing Discrimination and Building Empathy.

Day 2

- **Decision Points in the Maze:** Ways Trauma Influences Sexual Health and Literacy among women with Substance Use Disorders.
- 10-minute break.
- **Completing the Maze:** How to have an effective sexual health conversation with pregnant or postpartum women with substance use disorders.



**Decision Points in the Maze: Ways
Trauma influences Sexual Health and
Literacy Among Women with Substance
Use Disorders**

What the Nurse Sees....

- Emily is a 26-year-old woman she is attending her post-partum visit.
- Her boyfriend/father of the baby is waiting in the lobby.
- She has become increasingly agitated each time a provider enters the exam room.
- She says she is ambivalent about birth control- her partner wants things to be “natural”.
- She only wants her buprenorphine she says and does not have time for talking about “family planning” – there are too many other things going on in life right now.



What the Patient Feels...

- Emily is a 26-year-old woman she is attending her post-partum visit.
- She is nervous because her boyfriend told her he does not believe in birth control and wants to have sex as soon as they leave, and she is “cleared.”
- She overheard the nurses talking about her in a negative way and she feels hurt.
- She also knows her boyfriend needs her buprenorphine to help stop his withdrawal.



Trauma

The event

+ *the way the event is experienced*

+ *the effect on the person*

= Trauma



Types of Trauma

Interpersonal (Relationship) Violence Includes:

Interpersonal Violence includes

physical, sexual, emotional, economic, or psychological actions or threats of actions



that a **reasonable person** in **similar circumstances** and with **similar identities**



would find **intimidating, frightening, terrorizing, or threatening.**

Such behaviors may include threats of violence to one's self, one's family member, or one's pet.

*Interpersonal Violence can encompass a broad range of **abusive behavior** committed by a person who is or has been:*

- In a **romantic or intimate relationship** with the Reporting Party (of the same or different sex);
- The Reporting Party's **spouse or partner** (of the same or different sex);
- The Reporting Party's **family member**; or
- The Reporting Party's **cohabitant or household member**, including a **roommate**.

Whether there was such a relationship will be gauged by its length, type, and frequency of interaction.

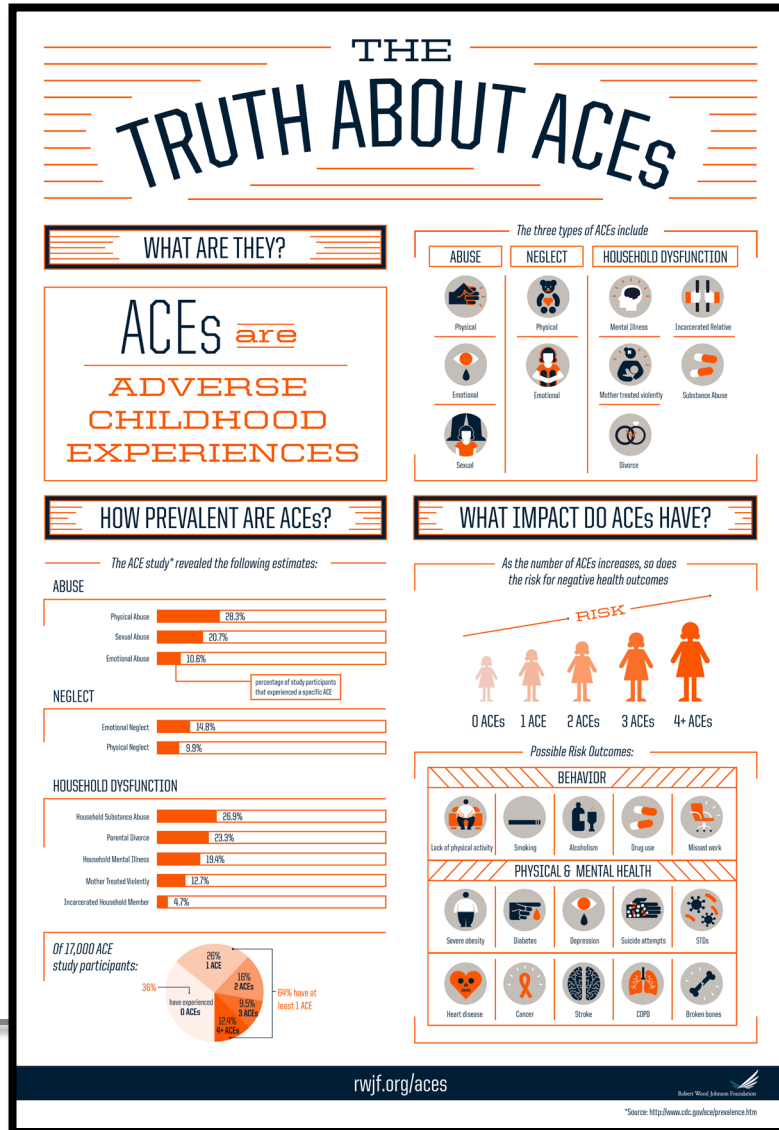


Facts About Trauma

- What trauma is.
- How common it is.
- How trauma effects the brain and body.
- Relationship between trauma, substance use, and other mental health issues.



Adverse Childhood Experiences Study



Authors: Drs. Robert Anda and Vincent Felitti

N =17,421 adults who were having medical difficulties received a survey about their childhood experiences.

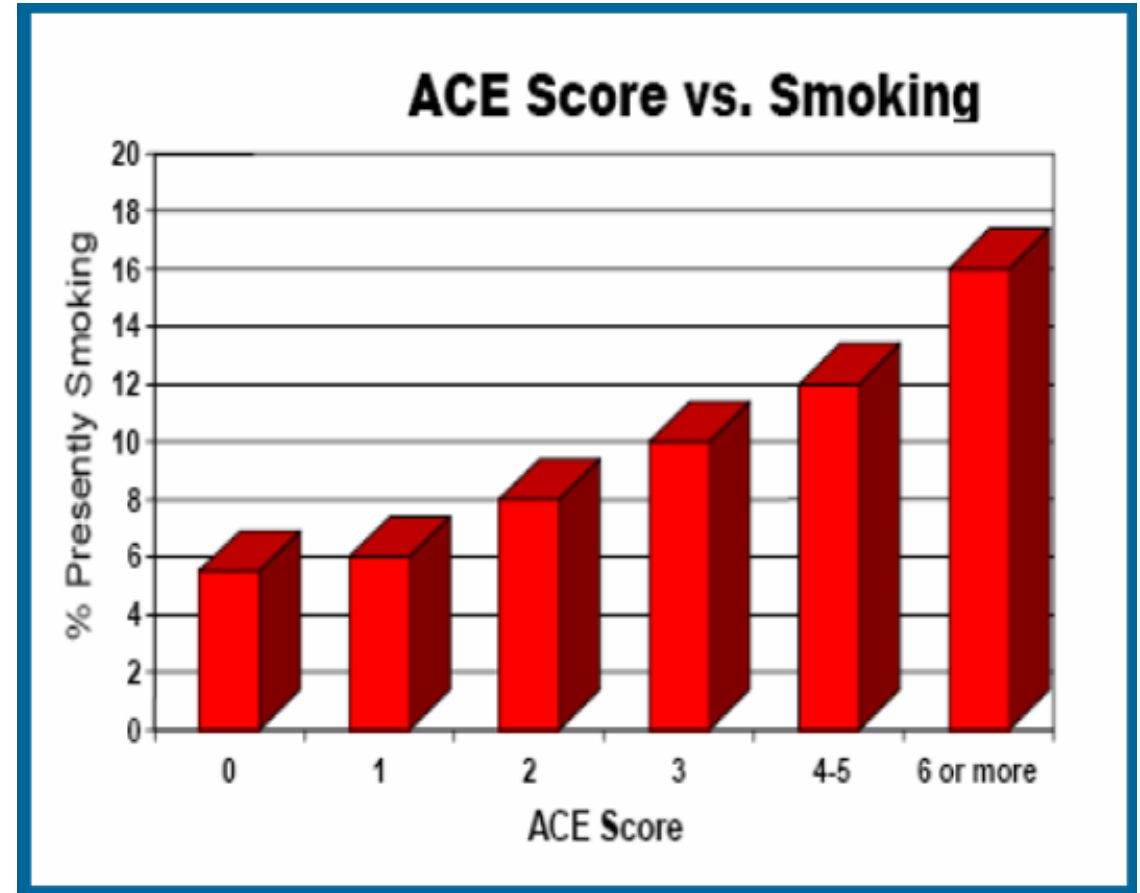
9 categories of adverse childhood experiences were examined.

A person's ACE score is sum of the number of categories a person experienced.



ACE Scores Are Related To Health

- Adolescent Health
- Teen pregnancy
- Sexual abuse
- Risk of re-victimization
- Smoking
- Alcohol use disorders
- Illicit drug use disorders
- Mental health
- Relationship stability
- Workforce performance



Pregnancy Does Not Protect Against Trauma

- Data indicate violence can get worse during pregnancy
- Review of the literature reported 1-20% prevalence of IPV during pregnancy
- Among 104 Appalachian women during pregnancy:
 - 81% reported some type of IPV during the current pregnancy
 - 28% reporting physical IPV
 - 20% reporting sexual violence
- Among 715 urban drug-dependent pregnant women attending a drug addiction treatment program:
 - Lifetime: 73% physical 71% emotional 45% sexual
 - During pregnancy: 41% emotional, 20% physical 7% sexual



Facts About Interpersonal Violence/Trauma (IPV)

- **Approximately 960,000** incidents of violence against a current or former spouse, boyfriend, or girlfriend per year.
- **More than 1 in 3** women in the USA have experienced rape, physical violence, and/or stalking by an intimate partner.
- **More than 1 in 4** men in the United States have experienced rape, physical violence, and/or stalking by an intimate partner.
- **Nearly 80%** of female offenders with a mental illness report having been physically and/or sexually abused.
- **More than 3 in 4** women and men in treatment for substance use disorders report trauma histories.



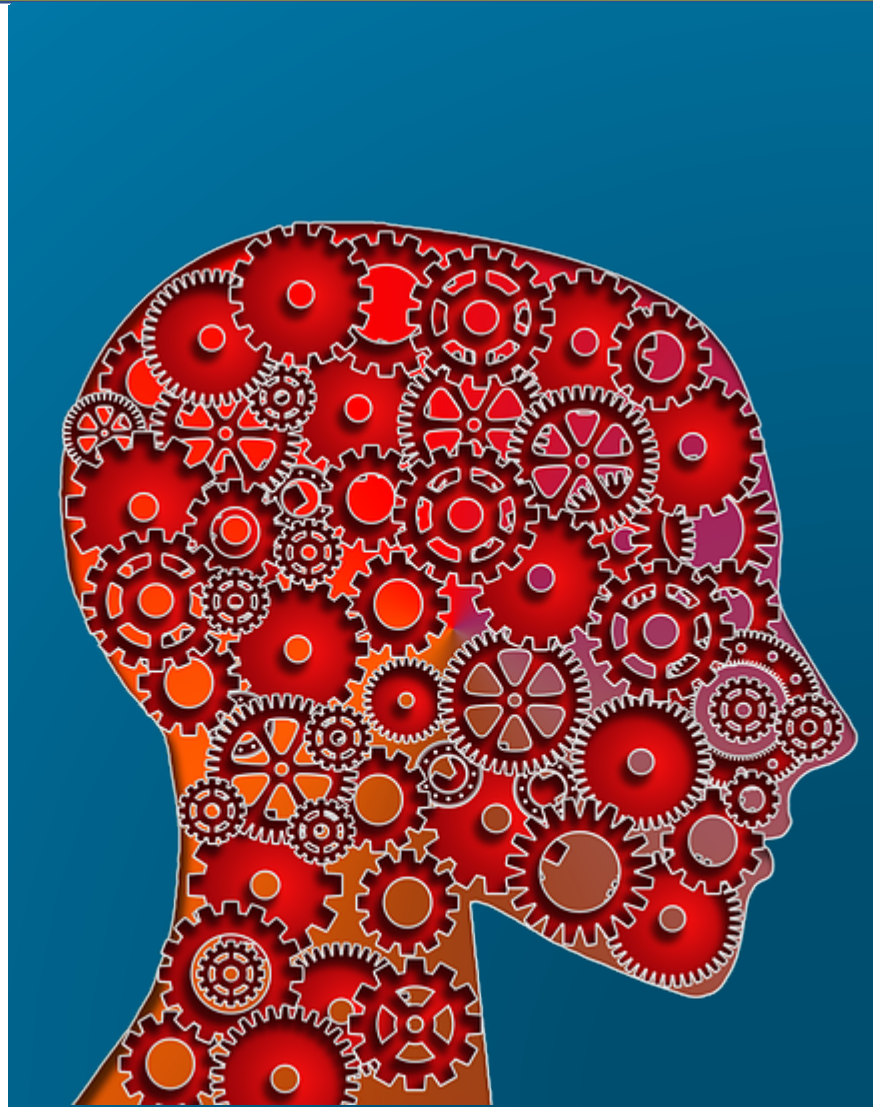
Radiating Effects of Trauma

Psychological

- Anxiety
- Depression/Suicide
- PTSD
- Poor self-esteem
- Blame and guilt
- Uncontrollable emotions

Social

- Isolation/Withdrawn
- Few social interactions
- Rigid sex-role expectations



Physical/Stress Related

- Injury
- Sleep problems
- Nutritional/ Low weight gain
- Substance use/ Smoking
- Chronic pain
- Hypertension
- Inadequate prenatal care
- Miscarriage
- Pre-term labor
- Fetal fracture/ Fetal death
- Placental abruption
- Uterine rupture



Trauma Exposure: A Risk Factor for Women

History of Interpersonal Violence, Childhood Sexual Abuse, and Other Traumas

- History of traumatic events, including:
 - sexual and physical assaults
 - childhood sexual and physical abuse
 - domestic violence
 - Have been found to predict both initiation of drug use and development of drug use disorders in women
- ↳ ***Najavits et al. (1997) reported a lifetime history of trauma in 55-99% percent of women who used drugs, compared with population-based rates of 36-51%***



Challenges in Treating Traumatic Stress and Substance Use Disorders

Drug abstinence may not resolve comorbid trauma-related disorders – for some PTSD may worsen.

12-Step Models often do not acknowledge the need for pharmacologic interventions.

Confrontational approaches typical in addictions settings frequently exacerbate mood and anxiety disorders.

Treatments for PTSD only —such as Exposure-Based Approaches often may not be advisable to treat women with addictions or may be marked by complications.



Treatment Models for Trauma and Substance Use Disorders

Sequential

Initial phase may focus on substance use disorder related symptoms in preparation for working on trauma **related symptoms later.**

Concurrent

Additional components may be delivered **at the same time** but sometimes in parallel.

Integrated

Components are **all working together**; one informing the other.



Trauma-Responsive Care

A trauma-informed approach incorporates three key elements:

Realizing the prevalence of trauma.

Recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce.

Responding by putting this knowledge into practice.



Integrating Trauma Treatment

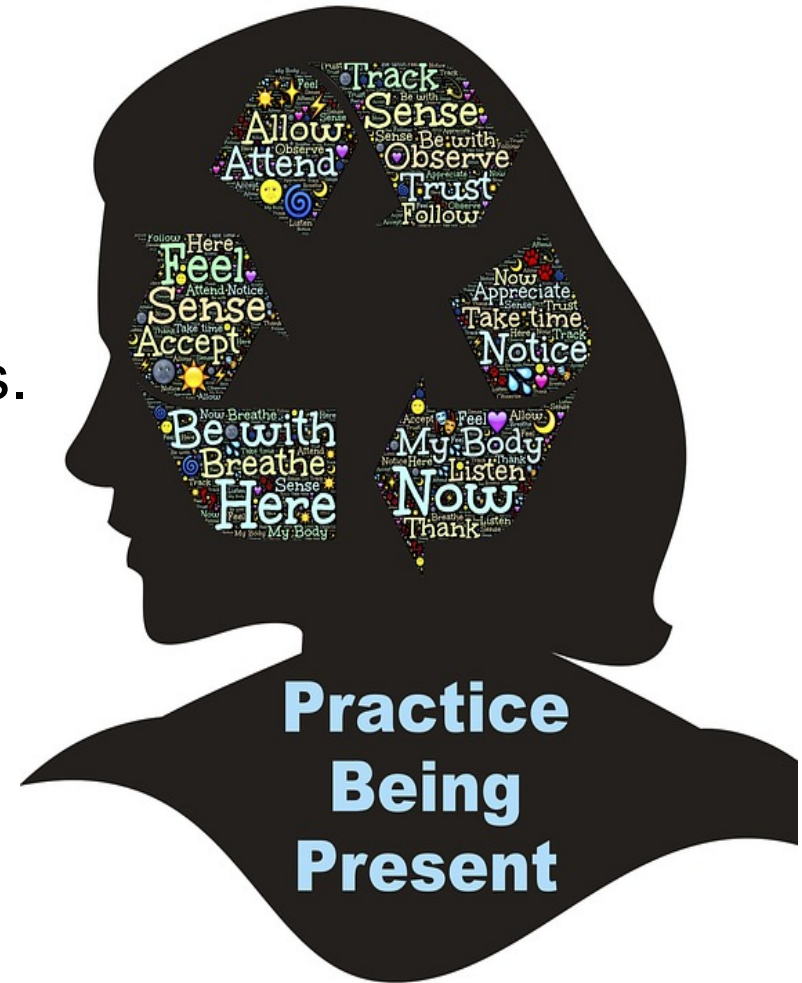
Trauma-Responsive Treatment
VS.
Trauma-Specific Treatment



Trauma-Responsive Services (1 of 2)

Characteristics:

- Minimize victimization and re-victimization.
- Hospitable and engaging for survivors.
- Aware of role of violence and victimization in women's lives.
- Facilitate recovery and healing.
- Empower
- Respect a woman's choices and control over her recovery.
- Goals are mutual and collaboratively established.
- Emphasize women's strengths.



Trauma-Responsive Services (2 of 2)

Principles:

- Respect trauma as a central concern in a woman's life.
- Symptoms are adaptations to traumatic experiences.
- Reframe 'Adaptive' behavior as positive coping.
- Violence and trauma have broad impact.
- Providers need to meet the woman where she is in her life experience.



Examples of Evidence-Based Trauma-Specific and SUD Interventions

ARTS

Assisted Recovery
from Trauma and
Substances.

(Triffleman et al., 1999)

ATRIUM

Addictions and Trauma
Recovery Integrated Model.

(Miller & Guidry, 2001)

COPE

Concurrent
Treatment with
Prolonged Exposure.

(Back et al., 2014)

CBT for PTSD

(McGovern et al., 2010)

Seeking Safety

(Najavits, 1998; www.seekingsafety.org)

Transcend

(Donovan et al., 2001)



Providers do not need to know if an individual experienced trauma to provide trauma-informed care

- From my experience of working with pregnant and postpartum, I often hear "this was the first time someone even asked me about my wants and needs as it relates to my body."
- I have also received similar messages for women who have given birth or received exams in their lifetime.
- You may be the first individual that has empowered them and contribute to their overall healing journey.



Providers Need to Recognize that Trauma Influences Interactions

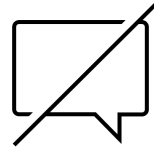
- Trauma shapes and informs our interactions with ourselves and others, and view of the world.
- It has a profound impact on our body, mind, and spirit. It often results in isolation, disconnection, learned helplessness, humiliation, shame, rage, self-loathing, guilt, and adverse physical conditions, including substance use disorders.

Women who have had childhood sexual trauma are less likely to use contraceptive practices.



Reluctance to Ask

Fear of re-traumatizing or upsetting patients

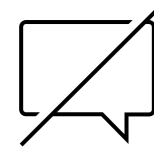


No follow-up support

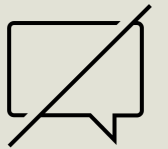
Feeling intrusive



One's own abuse issues



Denial



Responding To Risk of Violence

If a person endorses these or other questions indicating risk for violence:

- Listen to him/her and believe her.
- Acknowledge his/her feelings and let him/her know she is not alone.
- Let him/her know that no one deserves to be abused.
- Provide resources (hotline, shelter, spiritual).



Educate About Danger and Adapt Treatment Response

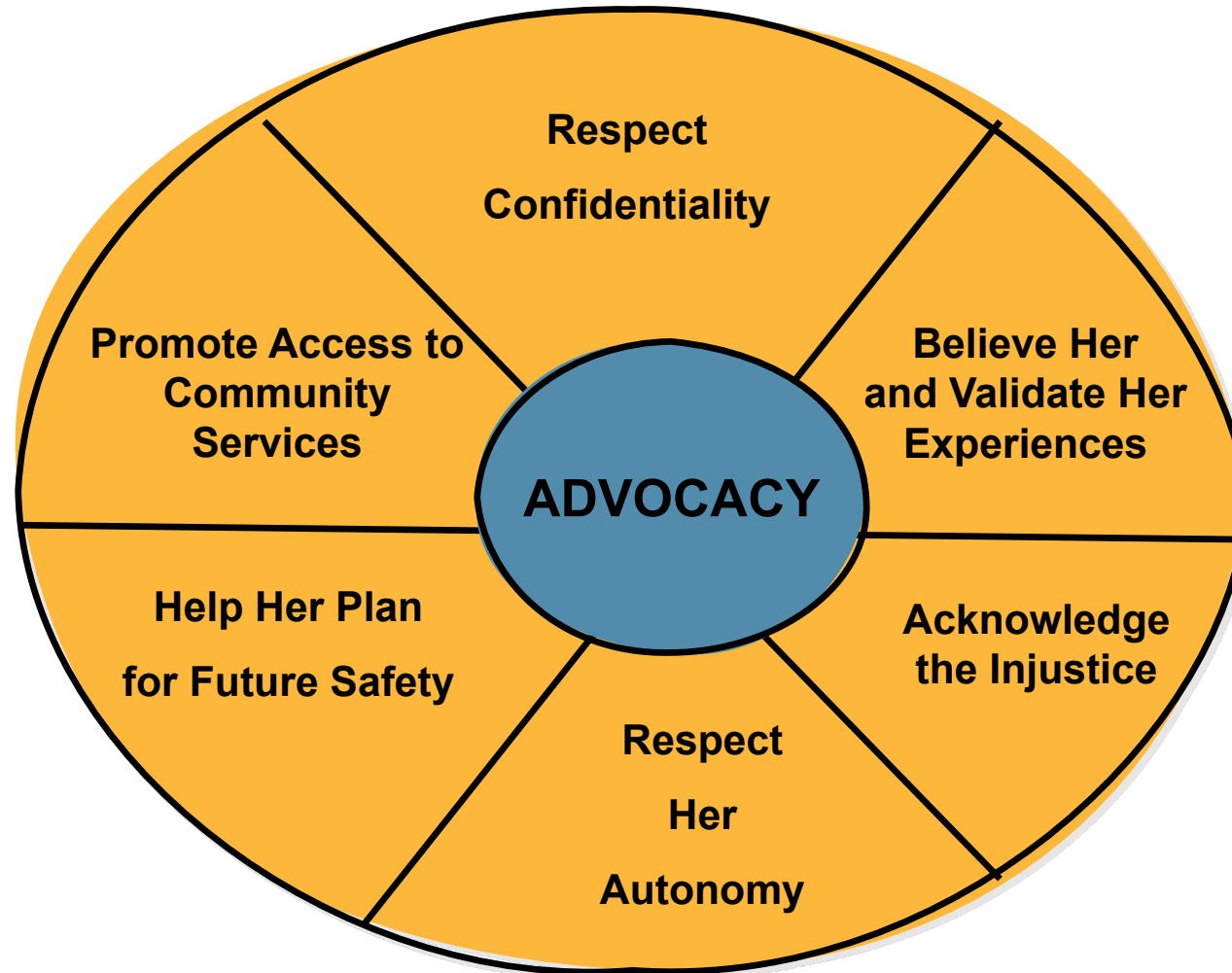
Signs of Increasing Danger

- Abuse happens more frequently.
- Abuse gets rougher.
- Abuser tries to choke her.
- Abuser threatens to kill her.
- There is a gun in house/car.
- Abuser forces sex.
- Abuser uses drugs.
- Abuser hits woman during pregnancy.
- Abuser has been reported for child abuse.
- Abuser is extremely jealous, possessive, controlling.

- ↳ Recognizing that there is a high chance that women and experienced one or more traumatic brain injuries (TBI).
- ↳ A TBI has implications for treatment and how best to help women learn, remember and apply information.



Interpersonal Violence: Empowerment



What is Safety?

- Achieve abstinence from substances.
- Eliminate self-harm.
- Acquire trustworthy relationships.
- Gain control over overwhelming symptoms.
- Attain healthy self-care.
- Remove oneself from dangerous situations (such as domestic violence, unsafe sex).
- *Seeking Safety*: Lisa Najavits.



Women Feel More Comfortable with a Trauma-Informed Approach (1 of 5)

For a trauma survivor to have the best experience in the office, medical staff need to be “trauma-informed,” that is:

- To understand the emotional issues, expectations, and special needs someone may have in health care settings.
- Survivors will come to understand and honor their concerns as normal responses that follow the experience of trauma.
- Survivors will seek out ways they can feel more comfortable in health care settings.

Trauma-Informed Care Principles:

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, Historical, and Gender Issues



Women Feel More Comfortable with a Trauma-Informed Approach (2 of 5)

Ways to help women feel safer and more comfortable

Before the Contraceptive Practice Appointment

- During the reminder call encourage patient to ask staff any questions about upcoming discussion.
- Send information like websites.

In the office or exam room

Offer a calming, soothing office environment

- Provide relaxed, unhurried attention to the patient.
- Talk over concerns.
- Give her as much control and choice as possible.
- Validate any concerns she might have as understandable and normal.
- Maintain a personable, friendly manner.
- Be straightforward and generous with information.
- Talk to her throughout and let her know what you are doing and why (check in with her about this approach first).



Women Feel More Comfortable with a Trauma-Informed Approach (3 of 5)

Ways to help women feel safer and more comfortable

If placing an IUD or giving a shot etc.

- Explain what each procedure is and obtain her consent.
- Ask her if she is ready for you to begin.
- Ask her if she feels comfortable with your positioning of the procedure.
- Be clear that she can pause or end the exam or procedure at any time.
- Encourage questions. Ask her if she is worried about any aspect of the exam or medical intervention.
- If possible, make sure the door is in her eyesight.
- Ask if she wants her head propped up to watch what you are doing.
- She might feel safer with the door ajar, opened, or closed.



Women Feel More Comfortable with a Trauma-Informed Approach (4 of 5)

Encourage her to do what makes her feel most comfortable wherever possible.

Such as:

- Listen to book on CD.
- Bring a pillow or blanket.
- Visualization or meditation CD.
- Lavender oil.
- Squeeze ball.
- Hand holding.
- TV on patient identified channel.

After the Appointment

Make a follow-up phone call to determine how it is working for her and to trouble-shoot side-effects.



Women Feel More Comfortable with a Trauma-Informed Approach (5 of 5)

Other Tips and Considerations

- Pay attention to non-verbal cues.
- Does she shut down emotionally?
- Biggest issue is to keep her coming back for care.
- Women sometimes talk about "my bubble" or "in my personal space,"
- Recognize that visits can be "triggering" because of how close the provider is to the woman's chest and face.
- Individuals may often get into a fetal position to protect themselves, which is the body's natural response to stress — how can we help them do this if needed?
- If limbs or body parts need to be numbed for pain control- this can be scary — talk about that process and recovery.
- May need to acknowledge that the person they are fearful of is sitting in the waiting room - ask all people to wait in the lobby.



Focus on Resilience for Providers

- Sensitivity for health care survivors.
- Supportive environments.
- Employee assistance programs.
- Self-care
 - Rest and exercise.
 - Opportunities for personal renewal.
 - Personal therapy.



Focus on Resilience for Patients

ATTACHMENT

Being able to form and maintain healthy emotional bonds and relationships.

ATTUNEMENT

Being aware of others, recognizing the needs, interests, strengths and values of others.

SELF-REGULATION

Containing impulses, the ability to notice and control primary urges as well as feelings such as frustration.

TOLERANCE

Understanding and accepting differences in others.

AFFILIATION

Being able to join and contribute to a group.

RESPECT

Finding value in differences, appreciating worth in yourself and others.



Decision Points in the Maze

Learning Objective Met: Examine the roles that trauma experiences and intimate partners play in access and implementing reproductive life planning for women who are pregnant or post-partum with SUD.

- Trauma is more than an event – it is the experience and effects of the event that makes an event traumatic.
- Providers can respond in trauma-informed ways without having to know if and what trauma exposure has occurred.
- Simple, thoughtful techniques can help women feel more comfortable and keep them engaged in reproductive life planning.

Summary



Completing the Maze: How to Have an Effective Sexual Health Conversation with Pregnant or Postpartum Women with Substance Use Disorders

What Women Need to Know

- Sexual health facts.
- What are the methods and which ones are the ones that are right for them.
- How to access methods when they want them.

- ▶ **Where to get more information about contraceptive methods:**
 - Bedsider.org/methods - a great resource for clients especially and maintained by The National Campaign to Prevent Teen and Unplanned Pregnancy
 - Office of Women's' Health, US DHHS [Birth control methods](#)
 - Best resource for contraceptive contraindications is [CDC Medical Eligibility Criteria for Contraceptive Use](#) (CDC 2010)



What Providers Need to Know

- How to be aware of their own feelings around sexual health.
- If they are not comfortable having these conversations, it is ok.
- Find someone who is comfortable to talk about the topic.
- Listen and not direct the conversation.
- Check in to be sure that the woman understands.
- Check often to see if she has questions.
- Be aware of prepared for common myths, etc.



Birth Control Methods

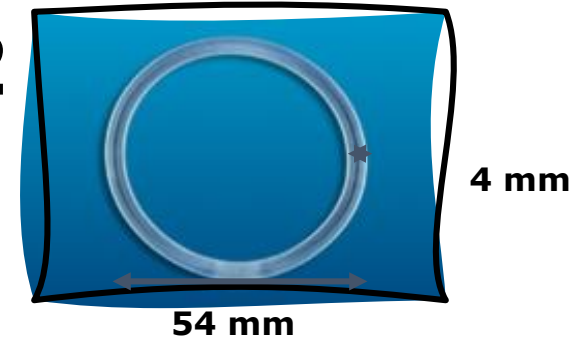
Hormonal Contraception:

1. Birth Control Pills
2. The Vaginal Ring
3. The "Shot"
4. The Patch
5. The implant
6. IUD
(there are also non-hormonal IUDs)

1



2



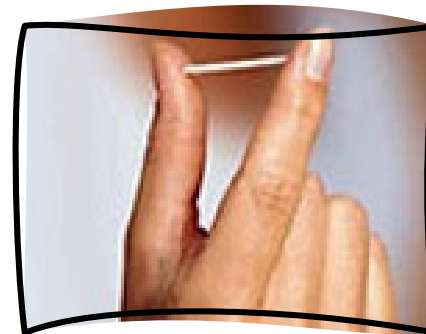
3



4



5



6



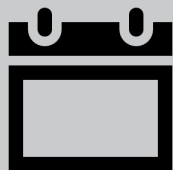
Hormonal Birth Control Methods

How Long Do They Last?

1 day →

The pill

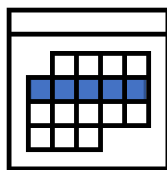
(many different kinds): you need to take it every day at roughly the same time for it to work.



1 week →

The patch

(Xulane®*): you put on a small beige patch (like a square Band-Aid) that contains hormones.



3 weeks →

The ring

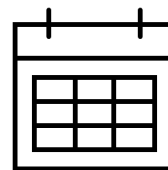
(NuvaRing®*): you insert a small ring which contains hormones into your vagina.



3 months →

The shot

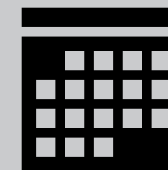
(Depomedroxyprogesterone or “Depo”): Your health care provider gives you this hormonal injection.



3 years →

The implant

(Nexplanon®*): your health care provider inserts a very small rod that contains hormones under the skin in your upper arm.



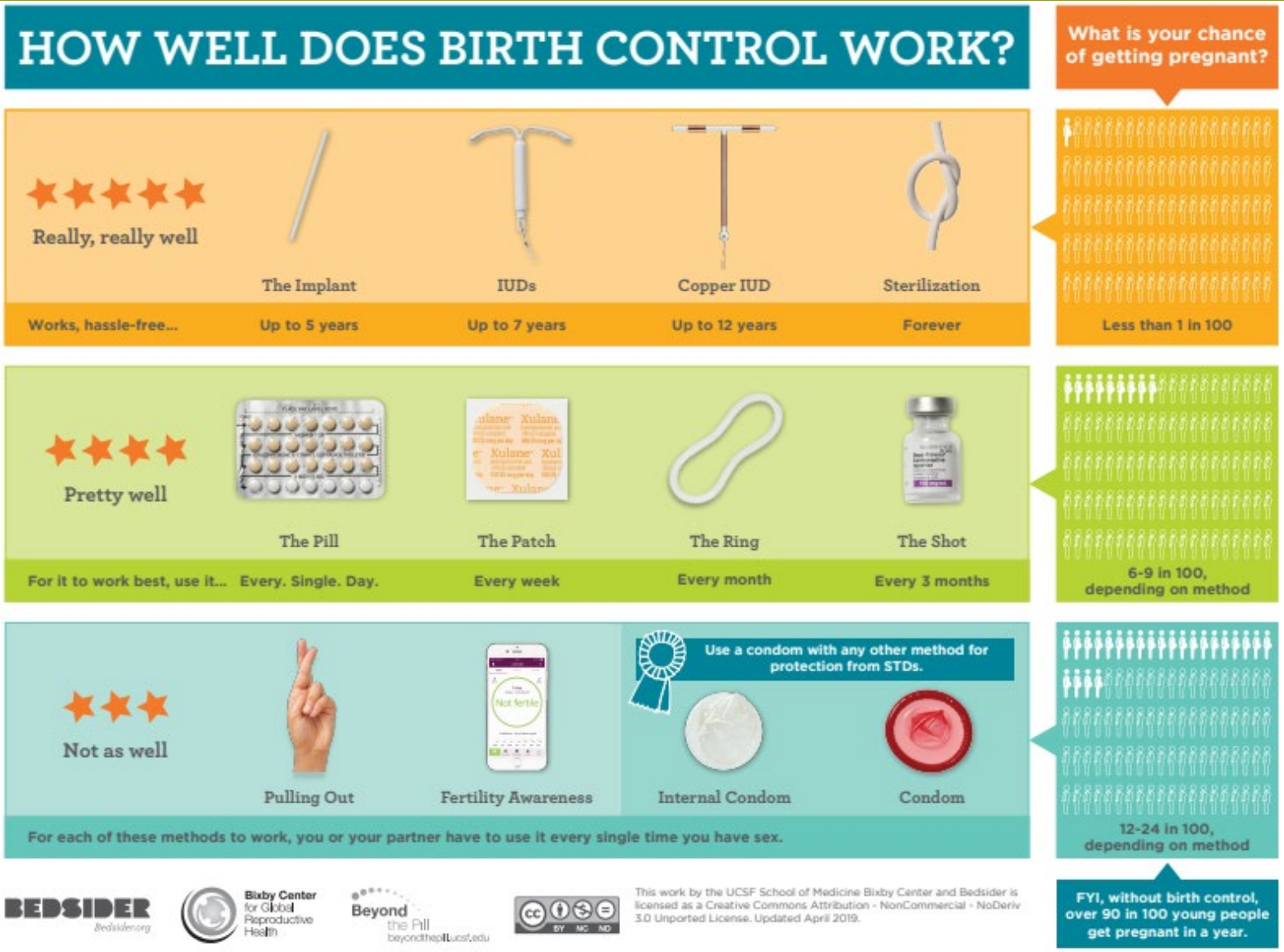
3 - 12 years →

The IUD

(2 basic types – hormonal and non-hormonal). Your health care provider inserts a small, t-shaped device into your uterus.



Effectiveness?



The Pill: Facts

Reminder

The pill and the shot (or any of the hormonal methods) do not protect against STIs.

The only way to be fully protected against STIs is abstinence. Condoms are the only other fairly effective way to protect yourself against STIs. Use a condom correctly each time you have sex to help prevent STIs.

Myth

Matt said: “I heard somebody say that as soon as she stopped using the pill she got pregnant but I thought there was some sort of half life to it? Like that it kind a goes down gradually?”

Fact

You can become pregnant as soon as you stop taking the pill.

If you stop using any hormonal method (the pill, the shot, the implant, etc.) you can get pregnant right away. If you miss a shot or miss one or more pills you should use a back-up method of birth control.



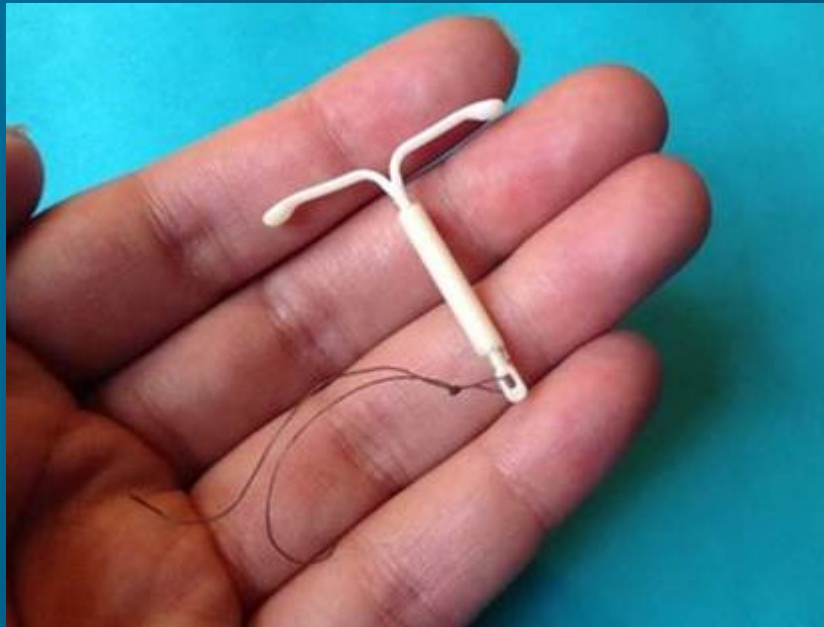
IUD: Facts

Fact

IUDs are safe, no more dangerous than other types of hormonal contraception. The World Health Organization (WHO) has conducted several studies with thousands of women and has found that women who use an IUD are no more likely to get a pelvic infection or to develop infertility than women who use other types of birth control.

Fact

Almost any woman can use an IUD, whether she has had a baby or not.



Fact

Having an IUD inserted can cause discomfort, but it is usually mild. Some women describe it as feeling similar to having a pap smear. It usually takes about one or two minutes to put an IUD in.

Fact

IUDs are placed inside the uterus. Soft, thin plastic strings are the only part of the IUD in the vagina, and the provider can usually tuck them out of the way so your partner will not feel them (or adjust them if he does feel them).



Depo “The Shot”: Facts

The shot will make me gain weight.

Truth: The Shot can cause increased appetite, which can lead to weight gain. Three out of 4 women gained on average 1.4 pounds in the first year while on Depo. Eating healthy and getting regular exercise helps to keep your body healthy.

Depo Myths



(Depomedroxyprogesterone acetate)

Depo will make my hair fall out.

Truth: Maybe. A Cornell University study found 10 percent of those surveyed experienced some hair loss while using Depo. Most women will not go bald or have noticeably thinner hair on the shot. If a woman does experience Depo-related hair loss, her hair will grow back when she discontinues this birth control method.



Choosing the Right Form of Contraception for You

How well will each method work for you?

- How effective is it?
- How will it fit into your lifestyle?
- What are the side effects?
- Is it affordable?

**Very personal
decision**

Remember: hormonal contraception does not provide STI protection



Women Talk About Their Choices

Lori has an implant (Nexplanon®*)



I like it. I don't have to remember anything, it's just there. They insert it in your arm, and you are good for three years. I don't have to remember to take a pill every day or get a shot every three months. And 9 times out of 10 you won't have a period that whole time so it's as simple as that."

Cassandra has an IUD (Mirena®*)



"I love my Mirena and I haven't had any problems with it. It's something I don't have to worry about being on time for. I'm not good with my time. I've never been good with my Depo shot. It's always either a month late or I didn't remember to get it and then uh-oh."

Tonya takes birth control pills



"The pill really works well for me. I mean, I think as long as you have a routine it can work well. I have a phone alarm that reminds me to take it at the same time every day and it works just fine. I like being in control of it- I can stop taking it when I want to and I don't have to go to a doctor to have something taken out"



What if...

- The condom breaks?
- You forgot to take your pill?
- Sex was forced?



Is there anything you can do to prevent pregnancy?



The answer is YES!

Within 5 days of unprotected sex:

- Use Emergency Contraception (EC).
- Several products and methods.
- Some require a prescription.
- Some are over the counter for women 17 and older.



Emergency Contraception

Levonorgestrel

1.5 milligrams *

- Will not work if you're already pregnant
- Work best the sooner you take them, up to 5 days
- If you are 17+, available over the counter.

**(many brands available)*

Ella®* (Ulipristal)

- Will not work if you're already pregnant
- Works consistently for 5 days
- Prescription-only at any age

Copper-IUD

- Provider must insert within 5 days of unprotected sex
- Most effective form of Emergency Contraception.



Using technology to learn more: Bedsider.org

A website dedicated to giving you clear information on birth control

Birth Control Methods

- Pictures, descriptions, situations in which to use them.

Where to get it

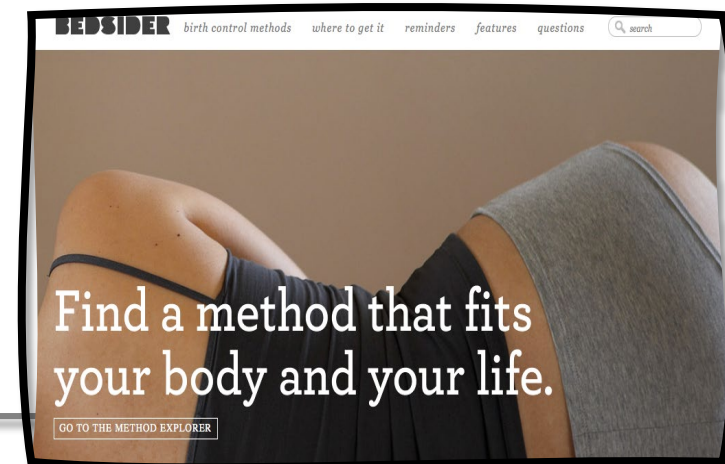
- Enter your zip code, get a list of health care centers near you.

Email and text reminders

- Doctors appointments.
- When to take and refill your birth control method.

Personal stories

- Hear what other people have to say about their experience with different methods - both men and women!



Summary of Key Points: Birth Control and STI prevention

- There are many methods to help you have control over when you get pregnant.
- Condoms are the only method that protect against both pregnancy AND STIs.
- Some forms of contraception, such as the IUD and the implant, are much more effective than others.



Talking to Your Doctor About Birth Control - Be Open and Honest

Before the visit:

- Do your research.
- Be prepared.
- Bring questions.



At the visit:

- Be open.
- Ask questions about access, cost, how long it lasts.



Tips for Talking to Your Doctor

- **Be honest**
- **Ask questions**
 - Prepare questions ahead of time and bring pen and paper to take notes.
 - Think about side effects and ask how to manage them.
 - Ask about risks and benefits.
- **Ask for an explanation**
 - No question is a dumb question.
Knowledge is power.



Trouble shooting with the patient about how to respond to doctors who ignore, dismiss or answer your question with words you do not understand.



Bring Your Partner to your Doctor's Visit

Involving your partner in family planning visits might be very helpful.

- You can choose a method together.
- You can choose one that both of you are happy with, which will make you more likely to use it.
- Your partner will hear the information too and can help remind you to use your method correctly.
- Both of you can be responsible for family planning! Here is what one partner had to say.

Greg: "Maybe she would tell the doctor something that she won't tell you personally, between one another, that you didn't know. So, if you go with her and she says well, when we have sex I'm hurting like this... but, you never told me that, you know, but she's telling the doctor. So, you know, you can get information like that, like I said, you might have questions that she's not coming up with or she might have questions that you didn't think was bothering her or you have questions you didn't think bothered her. That's why it's good to go together because you can learn more when you're together"



Talking to your Partner about Contraception

In any relationship, you need to talk to your partner about Birth Control and STIs

- Better to have conversations before you are about to have sex.
- Talk about these things when you are relaxed and alone.



Good topics to discuss

Sexual histories and risk for STDs. Many couples go together to get tested when they are in a new relationship.

- Options for birth control, pros and cons of different kinds.
- Cost of the selected birth control method and how this might be shared.
- Going together to the doctor to get the selected method (if needed).



Family Planning Matters to Both Women and Men

Talking about family planning **BEFORE** you are in the heat of the moment is very important. No one really wants to have a child that they are not ready to raise. Hear what some people who have been there would say to new partners:

***Veronica:** “I would be like, look, I have a 5-year-old and a 1-year-old and I'm still fertile, so yeah, if you don't use a condom this is what's gonna happen.”*

***Paul:** “I would say that... I already got a child that I'm not in the house with, so I do not want to bring another child into the world unless I know I am gonna get married, because I want this child, hopefully, to grow up with me. That's what I would tell them.”*



Condom Issues in the Real World

Are men usually willing to use a condom if their partner asks?



Jennifer: *“I think it depends on how they were raised, if they already got kids, how safe they are... if they ever had an STD, they're more willing to put a condom on.”*

Jason: *“Most men are in my experience. I feel like whenever a woman asks me to use a condom it's actually showing that she gives a (xxx) about herself. I respect that”*

Alberto: *“Most men prefer not to, but when it comes down to it, they probably will.”*



Condom Issues in the Real World (cont.)

What reasons have you heard for men not wanting to use a condom?

Serena: “Oh, we don't have time. I don't have one. It doesn't feel the same. Oh what, you think I got something? I can't get you pregnant.”

How do you negotiate with your partner about using a condom?

Staci: “I have never negotiated. It's either yes or no. If you don't have a condom, go get a condom.”



Do You Think You Can't Get Pregnant?

Some people believe that they can't get pregnant, so they do not use any method of birth control.

A few of the most common reasons for this belief are:

- They have had unprotected sex many times and haven't gotten pregnant.
- They feel that they have damaged their bodies (by use of drugs, alcohol, hard living, etc.) to the point that they don't think they can get pregnant.
- They believe that some illness (or health issue like ovarian cysts) or other physical condition would prevent them from getting pregnant.



Do You Think You Can't Get Pregnant? (cont.)

If you have health concerns you should discuss them with your health care provider. **Unless you are POSITIVE that you are unable to get pregnant, you should ALWAYS use birth control unless you want to become pregnant.**

Tina: *“I've heard a few people say that they can't get pregnant... my friend got pregnant because she stopped taking birth control after doing drugs and I've heard other people say that, too, like they couldn't get pregnant because they were on drugs. Well I'm here to tell you that's a lie.”*

Candace: *“A lot of women think if they don't have a period, they can't get pregnant or if they've had sex a lot and gone many years with unprotected sex and didn't get pregnant... well, it could be the man who was infertile and if you are with someone new you could get pregnant.”*



Ready for a Baby?

It can be very hard to decide if you want to have a baby, and your feelings about this may change.

The bottom line: **BOTH** you and your partner should be **SURE** that you are ready to raise a child before you stop using birth control.

Linda: *“Some people want to get pregnant, like for me, my first baby, I wanted to get pregnant because I wanted somebody I could love and that would love me back. I love my baby, but it is much harder than I thought it would be.”*

Maggie: *“I always think about having to be connected to somebody for the rest of your life if you have a baby together and that makes me insist on using a condom”.*



Fantasies about Pregnancy

Women may have many reasons for wanting to become pregnant, and some of these may be more fantasies than reality. For example, some women might think having a baby will “save” a troubled relationship or force them to change their lives or behavior.

Here is what some single moms had to say recently:

“I thought if I have a baby, my whole life is gonna change. If I just have somebody to love me, I’m gonna stop using... you get this pretty little picture in your head about this little white house, a white picket fence, a cat and a dog and it did not turn out that way. I had no idea that it was just work. A lot of work...”

“Some people get pregnant because they want to keep the man. They want to have a family a lot of times and they think that once they get pregnant, something magical is gonna happen and everything is gonna change and it does not.. You see this beautiful picture on TV, of this beautiful family and women holding children and light shining and flowers blossoming and that's not the way it is. A lot of times, the man won't even stick around.”
(Her friend responds) “Oh, hell no. He's gone.”



Child Support At Least?

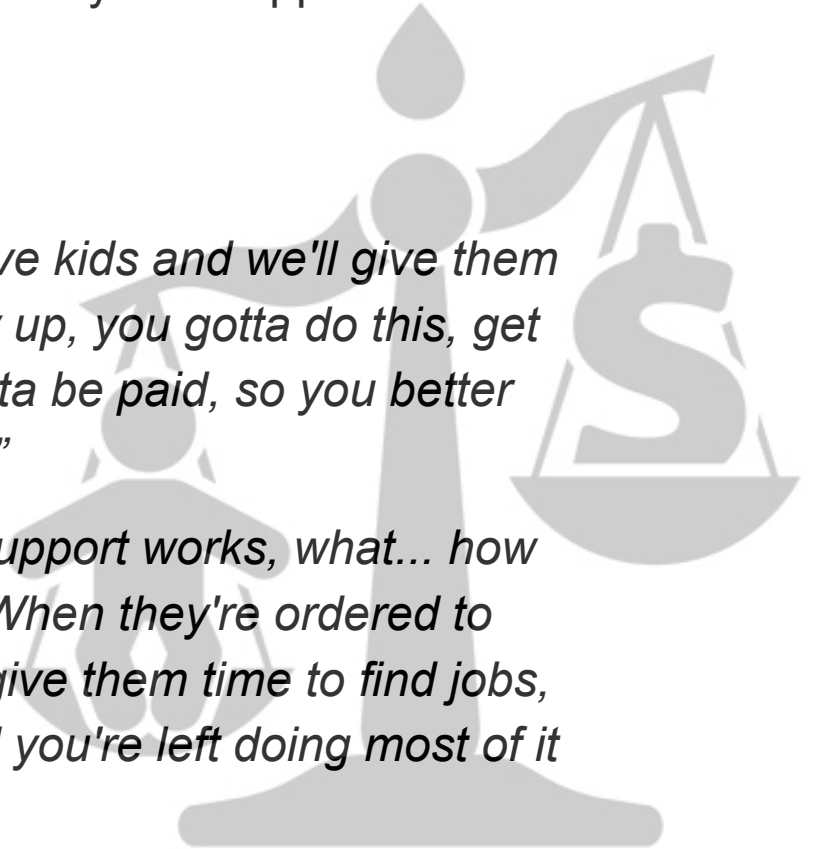
Some women may think that getting pregnant is a way to get their partner to stay and support them.

Here is what some single mothers had to say about their experience:

Amy: *“My baby's father owes me \$43,000.”*

Morgan: *“They should make young women partner off with women who have kids and we'll give them the responsibility and just kinda guide them around: you gotta pick the baby up, you gotta do this, get them dressed, be at this appointment, do this, do that. Oh, and the bills gotta be paid, so you better go out there and get a job because you ain't seen your old man in a month.”*

Latoya: *“Somebody needs to explain the court system to them, how child support works, what... how much you're gonna get, because if you have a job, it makes a difference. When they're ordered to pay, it doesn't mean automatically you're gonna start getting a check, they give them time to find jobs, they can say they got fired, they could take off, get paid under the table and you're left doing most of it on your own.”*



Some Women Want to Have Multiple Babies

- We have to know how to talk about safely spacing pregnancies, educating on the risks of having babies too close together, etc.
- Also, providers have to be able to let go of their own judgments about how many babies a woman “should have.”



Completing the Maze

Learning Objective Met: Discuss how to have productive and engaging conversation with pregnant or post-partum women with SUD about sexual health and reproductive planning.

- There is a birth control method that is right for everyone who does not want to get pregnant.
- Reduce STI exposure with condoms.
- Talk to your doctor or provider about methods.
- Only have sex with partners who you can talk openly with about sex.

Summary



My Reproductive Life Goals (brochure overview)



MY RECOVERY WITH REPRODUCTIVE GOALS

I want a child in the future: No
Yes

If yes, what do I need in my life of recovery to be ready for another child?

Finances _____

Family Support: _____

Education: _____

Job: _____

More support for recovery, specifically:

How important is it to me that I prevent pregnancy until I am ready to have children?

- Not important
- Somewhat important
- Very important

Breastfeeding?

Tell me more Yes I am! No way



Birth Control Options



BIRTH CONTROL OPTIONS: WHAT IS IMPORTANT TO YOU?						What to know
 Get it and forget it	Works for up to....	3 years 	5 years 	10 years 	Forever 	Implant can cause spotting or no period Hormonal IUD can cause spotting or no period Copper IUD can increase cramping
		Implant	IUD	Copper IUD	Sterilization	
 Remember often	Have to use it.....	Every day 	Every week 	Every month 	Every 3 months 	Pill is not a good choice if you are over 35 and smoke Shot can cause changes in bleeding and may increase hunger **May have to wait to start these methods if you want to breastfeed
		Pills	Patch	Ring	Shot (Depo-Provera)	
 Remember every time	Have to use every time that you and your partner have sex					Have to use diaphragm and condoms correctly every time you have sex Female partners do not have control over withdrawal
		Withdrawal	Diaphragm	Fertility Awareness	Condoms	



What Are My Next Steps?



- Appointment date and time
- Transportation options
- What support is needed to keep appointment
- What will I do if I cannot keep my appointment?

WHAT ARE MY NEXT STEPS?

When is my appointment?

DATE: _____

TIME: _____

My health care provider name is:

How will I get there?

Drive myself

Have someone give me a ride

Public transportation

Other _____

What other support do I need?

Childcare

Time off from work

Other

What will I do if I cannot keep my appointment?



Goal Setting: Your Action Plan

- Most women find that it is easier to achieve things when they set themselves goals.
- Goals give you a clearer idea about what it is you are trying to achieve and how long it will take.
- When women are trapped in addiction their days revolve around getting drunk or high.
- When this happens family planning is not always a priority.



What are Goals?

- Goals are specific and realistic.
- When accomplished, goals help women attain dreams and aspirations.
- Goals can be either short-term or long-term.

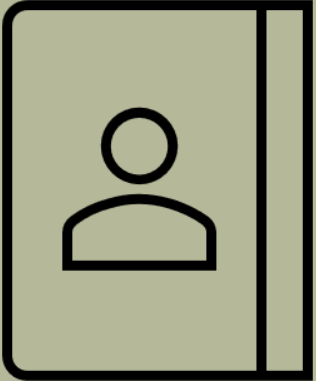


Setting Up Goals

- Construct effective goal statements.
- Break down goals into manageable steps.
- Review and re-evaluate your progress.



Let's Visit our Case Study a Fourth Time



Patient is a 29-year-old woman who is currently 8 weeks post-partum. During her pregnancy, she thought about having a tubal ligation but changed her mind. She has five other children. Currently two of her children live with her. She has previously expressed an interest in starting Depo injection but during this visit, she is feeling too overwhelmed to talk about contraception. She states that she and her partner are “mostly” using condoms.

- **What approach would you take to working with this patient about her goals?**
- **What are the next steps that you would take?**



Learning Objectives (Review)

- 1** **Identify** the unique and common issues women who are pregnant or post-partum with SUD face in accessing and implementing reproductive life planning.
- 2** **Identify** ways stigma, discrimination and prejudice play a role in access and implementing reproductive life planning for women who are pregnant or post-partum with SUD.
- 3** **Examine** the roles that trauma experiences and intimate partners play in access and implementing reproductive life planning for women who are pregnant or post-partum with SUD.
- 4** **Discuss** how to have productive and engaging conversation with pregnant or post-partum women with SUD about sexual health and reproductive planning.



Closing

Learning objectives met:

- 1 Discuss how to have productive and engaging conversation with pregnant or post-partum women with SUD about sexual health and reproductive planning.
- 2 It is important to have clear conversations and listen to women about their reproductive needs and plans.
- 3 Provide facts to remove myths.
- 4 Help empower women with knowledge to make the most informed choices.

