Integration of a contraception clinic into an opioid treatment setting to improve contraception knowledge, accessibility and uptake: a pilot study

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Abstract

Objective: To assess the feasibility and acceptability of integrating a contraception clinic within an opioid agonist treatment (OAT) service to improve access to contraception, especially long-acting reversible methods of contraception (LARC), for women receiving OAT, who have increased risk of unplanned pregnancies and adverse pregnancy outcomes.

Methods: A contraception clinic was established at a Sydney OAT service. Forty-eight female OAT clients were surveyed regarding their contraception knowledge and needs. Interested and eligible women were referred to the contraception clinic.

Results: Women were aged a median of 39 years (range 24–54 years). Most women (83%) agreed it was acceptable for their OAT clinician to discuss contraception with them. Eight women reported current LARC use and 21 reported they would consider using LARC. Twenty-three women were eligible for contraception (sexually active, aged <50 years, not using contraception, wishing to avoid pregnancy). Six months post-survey two women had presented to the clinic and two reported an unintended pregnancy.

Conclusion: Uptake of an on-site contraception service within OAT clinic was low, despite participants' expressed willingness to use the service. Access is therefore not the only driver of low contraception uptake for this group.

Implications for public health: Other issues besides access to contraception warrant investigation to improve contraception uptake for women receiving OAT.

Key words: opioid agonist treatment, service integration, women, long-acting reversible contraception

Access to effective contraception is an important public health issue and a human right. This is especially important for marginalised women with substance use disorders (SUDs), who are at increased risk of unplanned pregnancy and associated adverse outcomes (e.g. termination, stillbirth, premature labour and social services involvement)[1,2] that, in addition to the individual-level harm, also impact health and social services systems. Contraception use and knowledge among women with SUDs is reportedly low, especially use of the more effective long-acting reversible contraception (LARC) methods which include intra-uterine devices (IUDs) and hormonal implants.[3,4] Explanations for poor access and uptake in this group include limited knowledge, poor engagement in mainstream health services and general practice, and a dearth of suitable service providers.[3]

Despite some debate on contraception access for women with SUDs,[5-7] few programs have been trialled in Australia to improve contraception, especially the use of LARC, for this group.[3] US research suggests family planning services integrated within SUD treatment could be beneficial.[8,9] Attempts to integrate contraception services into substance use programs in Australia are lacking. Therefore, we established a pilot contraception clinic within an OAT program and examined the process factors key to the clinic's feasibility.[10] Firstly, we assessed via survey the women's: i) acceptability of both LARC and the provision of a contraception intervention in an OAT program; ii) eligibility for the clinic; and iii) compliance, as measured by clinic utilisation and follow-up.

Methods

The clinic model

A contraception clinic was established onsite at a Sydney inner-city public OAT program, a government-funded service providing free daily dosing of methadone or buprenorphine, staffed by a multidisciplinary team. The contraception clinic was available one day per week with an onsite general practitioner with contraception training (SR). Oversight and clinical governance were provided by the hospital-based study gynaecologist (KB). There was an appointment booking system and drop-in appointments were also available. All OAT staff were encouraged to

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refer women to the clinic. Hormonal implants were available for insertion onsite at no cost. IUD insertion was available at the hospital (across the road) by the study gynaecologist. All female clients could attend the clinic, but only women clients 'at risk' of pregnancy were considered eligible (i.e. heterosexually active, aged <50 years, not currently using contraception and not wishing to fall pregnant). Exclusion criteria were self-reported prior to bilateral tubal ligation.

Survey procedure

To determine eligibility, contraception use and knowledge, all women attending the OAT program during a two-week period prior to the commencement of the clinic were invited to participate in a 20-minute survey on reproductive health and contraception. All women were eligible to complete the onsite, interviewer-administered survey and clinic eligibility was determined based on the information provided during the interview. All eligible women were referred to the clinic. The survey comprised questions related to the women's substance use and related treatment history, obstetric and gynaecological history, and use and knowledge of contraception, especially LARCs (see Supplementary File 1).[11,12]

Written informed consent was obtained. Survey participation was voluntary and reimbursed with a $30 shopping voucher. The pilot clinic trial and participant survey were approved by the site's Human Research Ethics Approval (Protocol No X13-0388 & HREC/13/RPAH/532).

Results

Fifty-five women attended the OAT service during the initial survey period, 38 of whom agreed to be surveyed (69%). An additional 10 women were recruited six months later, giving an overall sample of 48.

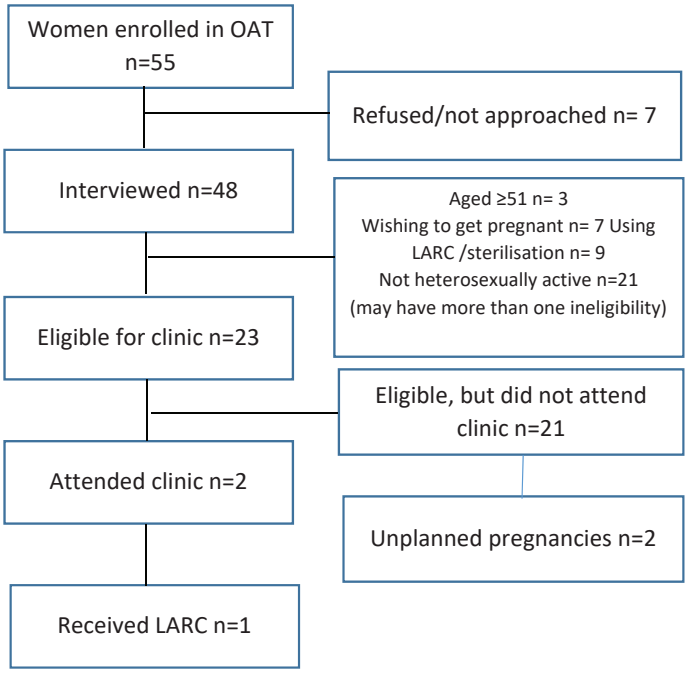
Client characteristics and clinic acceptability

The mean age of the 48 women was 38 years (SD 8.5); 45 women (93%) were aged less than 50 years. In terms of other clinic eligibility, 41 women were not currently trying to fall pregnant, and 27 reported vaginal sex with a man in the past year. Six women reported sterilisation (13%).

Forty-seven of the 48 women reported that they had heard of at least one form of LARC. Eight women reported LARC use in the preceding month and 21 reported they would consider using LARC.

Five (10%) of the women reported prior difficulties accessing contraception. Most women agreed, some strongly, that it was acceptable for their drug and alcohol doctor/prescriber (79%) or for their clinician/case manager (83%) to discuss contraception with them.

Figure 1: Flow diagram of study recruitment and outcomes.



Clinic eligibility and correlates

The survey identified 23 eligible and 25 ineligible women for the clinic (Figure 1). There were few differences between eligible and ineligible women. Eligible women were significantly younger (35.2±7.6 years) than ineligible (40.5±8.6 years) women (p=0.029), but no other differences in demographic or drug use characteristics were identified.

Clinic uptake

Only two of the eligible women accessed the clinic within the six months of operation. There was no active follow-up of the other women not attending the clinic, over and above their initial referral. One woman successfully received a contraceptive implant. The other, who also requested an implant, was referred for further assessment related to potential liver disease but failed to attend that referral or return to the contraception clinic for further follow-up.

During the study period, two women became pregnant, both unplanned. One woman had three children aged under 18 years in the care of another person and the other had five children aged under 18 years in her care. Both women reported prior involvement with Family and Community Service (FaCS) but none of the children had been removed from their mothers' care by age 12 months.

Discussion

This pilot study found that almost half the women surveyed had unmet contraception needs and were potentially eligible to attend an OAT co-located contraception clinic. The majority were supportive of their drug and alcohol worker, nurse and/or prescriber discussing contraception with them, but this interest was not matched with attendance – only two women presented to the clinic within the study period. A further two women had an unplanned pregnancy during the study period, despite expressing interest in the clinic. Results suggest that in addition to service integration, other factors need to be considered to support access to effective contraception in this population.

One explanation for low clinic uptake is a perception of low pregnancy risk, a belief identified in other research with women who use drugs.[13,14] As such, contraception may not be an immediate priority. Although a large proportion of the eligible women reported vaginal sex within the previous 12 months,

they reported few sexual episodes and infrequent menstruation and were generally older, thus perceived risk may have been low.

Another explanation may be related to staffing. All OAT staff were informed about the clinic and encouraged to refer clients. However, US research found that some addiction treatment staff may be uncomfortable talking about contraception with clients because it is "out-of-scope" and expressed concerns that initiating discussion about contraception is invasive.[8] We are unable to rule out this possibility, even though OAT staff indicated support before the clinic was established, but this is unlikely to fully explain the very low uptake as women could also self-refer to the clinic and were encouraged to visit the clinic on a 'drop-in' basis when surveyed by researchers. We recommend staff attitudes be carefully considered in any future work, including whether providing education about contraception need and methods, as well as training and support to speak to female clients about reproductive health, results in increased referrals to a clinic.

This was a single-site feasibility pilot designed to assess process issues.[10] Information on management issues – human and data optimisation problems[10] – was not formally collected. We are, however, aware of some issues that may have influenced clinic uptake. Although LARC was available onsite, in one case where further referral and assessment was required the woman did not attend the referral or return for further care.

Conclusion

Overall, we found that almost half the women attending the OAT program were potentially eligible for the contraception clinic and that most were supportive of the provision of contraception services within the OAT, yet few presented. A small randomised controlled trial in the US found contingency management effective at engaging women receiving OAT in contraceptive care, with 56% of women in the intervention group using LARC at six months compared to 7% in the control group and no reported pregnancies.[15] This approach requires further exploration in the Australian context, where overall patterns of contraceptive use are similar.[4] Evaluation of contraception clinic feasibility in other drug and alcohol treatment services for these women is also warranted to explore site and service-level barriers and facilitators to clinic integration across settings.

Implications for public health

Access to contraception is a human right and integral to public health. Our research has highlighted some of the challenges for providing contraception to vulnerable women in OAT, whose use of general practice and engagement with healthcare is often limited. As such, there remains an urgent need to better understand how to deliver effective contraception to this group in Australia.

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Supporting Information

Additional supporting information may be found in the online version of this article:

Supplementary File 1: Improving contraception uptake baseline questionnaire.