



Family Planning with Substance-Using Women

April 2004

Introduction

Recent estimates put the number of babies born in the U.S. to women who used illicit substances during pregnancy at 222,000 per year (National Institute on Drug Abuse, 1997). The rates of illicit substance use during pregnancy for White, Black, and Hispanic women are 3.6%, 6.2%, and 1.7%, respectively (Substance Abuse and Mental Health Services Administration, 2004). The direct impact of prenatal substance use on the infant is controversial, with some research demonstrating significant damage, and other research showing insignificant lasting effects (National Abandoned Infants Assistance Resource Center, December 2003). The National Center on Addiction and Substance Abuse at Columbia University (1999) reports that substance use is to blame for the dramatic rise in child welfare cases in the last two decades, and The Child Welfare League of America found that parental substance use was a factor in child removal in at least 53% of cases throughout the country (CWLA, 2003).

In recent years, much attention has been given to preventing substance use during pregnancy and improving the lives of infants who are prenatally exposed to drugs. However, very little is being done to promote family planning and use of contraception with drug using women. This fact sheet examines the prevalence of contraceptive use and explanations for low rates of use among this population, and it describes some efforts to address this issue.

Substance Use and Contraception

Despite the fact that many female substance users view motherhood as definitive of their role as a woman and desire this role (Gutierrez & Barr, 2003; Kearney, Murphy, & Rosenbaum, 1994; Kenen & Armstrong, 1992; Sharpe, 2001; Worth, 1989), research suggests that the majority of pregnancies of substance users are unplanned. In a study of clients receiving substance abuse treatment, for instance, 76% of the female respondents reported that their last pregnancy was accidental (Armstrong, Kenen, & Samost, 1991). Similarly, in a study of women entering a detoxification center, 24 of 373 women were currently pregnant, 19 of the 24 were aware of their pregnancy, and only eight

reported that the pregnancy had been planned. This translates to an unplanned pregnancy rate of 67% (Shah, Hoffman, Shinault, & LaPoint, 1998). In comparison, based on a large, nationally representative study of the general population, Henshaw (1998) concluded that 49% of all births in 1994 were unplanned.

Great variability exists in the findings of studies that have attempted to measure contraceptive use among drug using women, ranging from 26% to 71%. This variation over the last 20 years of research may reflect different points in time, different sample populations, and/or different methodologies. In addition, as reported below, most of the studies have certain limitations in their reliability and/or validity, which may have skewed the findings as well. Nevertheless, these studies offer insight into the contraceptive behavior of some drug using women.

In one study of Native Americans, European Americans, and Mexican Americans in residential drug treatment, Gutierrez and Barr (2003) found that utilization of birth control was very low among all three groups. On a scale from 1 ("never") to 4 ("all of the time"), respondents reported how often in the past they or their partner had used contraception. For Native Americans, the mean was 2.34; for European Americans the mean was 2.45; and for Mexican Americans, the mean was 1.86. Contrary to predictions, they found that contraception use was higher among Mexican American and Native American women who had been sexually abused than among those women who reported no sexual abuse, but there was no difference in contraceptive use between white women who had and had not been sexually abused.

The Shah et al. (1998) study of admissions to a detoxification center revealed that 47% of the women were currently using some form of contraception, though 69% reported sexual activity in the previous month, and fewer than half used contraception every time they had sex. However, this rate of birth control utilization may be misleading because the authors did not account for homosexual activity, which would contraindicate the use of contraception. In addition, rather than counting individual women, the authors counted admissions because the interviews were conducted anonymously. As

a result, many of the women may have been included more than once in the findings.

Ralph and Spigner (1986) found that only 26% of a methadone-maintained sample of women used contraception in any form, compared with 48.5% of a national sample of women in the general population. However, the authors pointed out that the study did not explore the level of effectiveness of the birth control methods used, and it did not account for level of sexual activity. That is, those participants who were not sexually active may have been represented among those not using contraception.

Another study of women receiving treatment found that only 38% of those sexually active used contraception in the past month (Armstrong et al., 1991). In contrast, in a small Australian sample of methadone-maintained women, 71% of those who identified themselves as sexually active reported use of contraception (Harding & Ritchie, 2003). However, many used less reliable forms of contraception, even though they were aware of more reliable ones, and this relatively high rate did not account for regular versus sporadic use. Additionally, the authors made no attempt to ascertain the reasons behind contraception use or lack thereof, and they did not explore whether or not the women not using contraception were attempting to become pregnant.

The Family Planning Council of Southeastern Pennsylvania is working on a research project to evaluate the implementation of family planning service provision at an inner-city health clinic, Prevention Point Philadelphia, serving large numbers of substance users. This organization, which uses a harm reduction approach to serving adults, has a needle-exchange program and provides basic health care to predominantly economically disadvantaged men and women. Because the agency serves substance users and non-users alike, the project has the advantage of comparing contraception use between three groups: substance non-users, substance users, and substance abusers¹. The research project is currently in the data collection phase, but the first wave of surveys produced some notable preliminary findings. It does not appear that substance users and abusers use contraception less often than do non-users among the population served; in fact, it seems that substance non-users are using contraception less regularly than the other two groups. For instance, in response to the question "In the past month, how often did you use a condom?," 33% of non-users reported condom use every time or most of the time, whereas 50% of users and 41% of abusers reported use

¹ "Non-users" have used no illicit substances in the past month; "users" have used at least one illicit substance a few times in the past month; "abusers" have used at least one illicit substance at least a few times per week in the past month.

every time or most of the time (M. Berger, personal communication, March 24, 2004). These numbers should be cautiously considered, however, because of the preliminary nature of the study, the small sample size (n = 117), and the limited representativeness of the sample to the general population.

Why Are Substance Users Not Using Contraception?

Life Circumstances

Life circumstances such as early childhood exposure to violence and parental drug use; little education and few skills; violence in intimate relationships; and poverty, which may be exacerbated by drug use, make use of contraception low on the list of priorities for many substance users (Kearney et al., 1994). Many female substance users learn about birth control methods through family members and friends; however, this information is often inaccurate or inadequate (Kearney et al.). In addition, the reading level necessary to understand contraception instructions may be beyond the abilities of substance users (Ledbetter, Hall, Swanson, & Forrest, 1990). Some women observe a decrease or cessation of their menstrual period either directly from drugs or from lifestyle issues, and mistakenly believe they are infertile, rendering contraception unnecessary (Harding & Ritchie, 2003; Mondanaro, 1981). Kenen & Armstrong (1992) reported that many substance users admitted irresponsibility about contraception; while under the influence of substances, they did not take into account its importance during sexual activity. Similarly, Harding and Ritchie found that when using substances, users' inhibitions decreased resulting in less use of contraception.

Condom Use and Role of Partner

Though condoms may be the most easily accessible form of birth control, a number of studies have found that substance-using women do not consistently use them (Schilling, El-Bassel, Gilbert, & Glassman, 1993). Some reasons given include the following: they break, they reduce sexual feeling, they spoil the mood, and their partner would be upset at a request for use (Schilling, El-Bassel, Gilbert, & Schinke, 1991; Schilling, El-Bassel, Schinke, Nichols, Botvin, & Orlandi, 1991).

Additionally, condom use, unlike other forms of birth control, requires attention at every sexual encounter, making consistency more difficult than with other forms of birth control (Kenen & Armstrong, 1992). Because condom use requires active male participation in birth control, it may be complicated by gender and power issues (Harvey, Bird, DeRosa, Montgomery, & Rohrbach, 2003; Worth, 1989). For instance, in abusive relationships males often make decisions about birth control and when to have sex (Family Health

International, 2003). If a woman asks her male partner to use a condom, he will often misinterpret the request as distrust in him (Armstrong et al., 1991; Kearney et al., 1994; Muller & Boyle, 1996). Alternatively, it may imply that she is being unfaithful, that she is a prostitute, or that she is too aggressive in sexual relations (Kearney et al.; Muller & Boyle; Worth). Thus, the long-term risk of not using a condom may be mitigated by the short-term gain of not disrupting a relationship, including enduring domestic violence and abandonment by a male partner (Kalichman, Williams, Cherry, Belcher, & Nachimson, 1998; Worth).

However, in the study by the Family Planning Council of Southeastern Pennsylvania, the first round of surveys produced more encouraging results: among the adult population, 76% of abusers and 80% of users (compared to 88% of non-users) reported that it would be very easy or somewhat easy to convince a *steady* sex partner to use a condom to prevent pregnancy. The figures were different when asked about new partners: 83% of abusers, 71% of users, and 100% of non-users reported that it would be very easy or somewhat easy to convince a *new* partner to use a condom (M. Berger, personal communication, March 24, 2004).

Condom use may increase if females feel more comfortable participating in sexual decision-making and openly discussing condom use with their partners. For instance, Harvey et al. (2003) found that when young female IV drug users participated in sexual decision making, including contraception use and when to have sex, they were 20 times more likely to report contraception use in the past month than were those who did not participate in such decisions. Similarly, increased condom use was found among patients receiving methadone maintenance when they felt more comfortable discussing safer sex with their partners (Schilling, El-Bassel, Schinke, et al., 1991).

Sex-for-Drugs Exchanges

Another important area of concern is the phenomenon of sex-for-drugs exchanges, or prostitution to support a drug habit, which has most often been associated in the literature with crack cocaine use. Some female users become so anxious about the depressant effects occurring after a crack cocaine high, they will resort to behaviors they never would have previously believed themselves capable of, such as performing sexual acts for dealers, who are almost exclusively male (Kearney et al., 1994). The motivation to get high overwhelms many users' consideration of consequences for failing to use contraception (Sharpe, 2001). Sharpe's study of 34 women who regularly exchanged sex for crack found that over half of the women (19 of 34) never used any form of birth control, and many others used it inconsistently.

Eighteen of the thirty-four women reported that they had become pregnant because of such an exchange, and 11 of the 18 became pregnant more than once (four had become pregnant three times, and one had become pregnant four times). Also inherent in this situation is the fact that the man is paying the woman. Pressure from paying sexual customers coupled with economic desperation often results in no condom or other contraception use. On the other hand, some prostitutes will refuse to have sex unless their customer wears a condom, but will not require her primary (i.e., non-paying) partner to wear one (McCoy & Wasserman, 2001; Muller & Boyle, 1996). In fact, some female substance users reported that if their male partner carried a condom, it was an indication that he was being unfaithful to her (Armstrong et al., 1991).

Access to Health Care

Many chronic drug users simply do not have access to health care, or they do not utilize health care services when they are insured or otherwise have access to health care. In one study, Crandall, Metsch, McCoy, Chitwood, and Tobias (2003) found that only about half of low-income chronic or injection drug-using women had third party health coverage. Further, only 3% of chronic drug users utilized preventative reproductive health services (including family planning), compared with 25% of non-chronic drug users. Reasons for this low level of use for family planning and other health services included the following: lack of permanent address or telephone, lack of basic needs being met, high cost of health care, perception of low quality health care, experiences of stigmatization, lack of services in a geographic location, fear of legal punishment due to use of illicit substances during pregnancy, and misperceptions about the effectiveness of contraception methods.

Racial and Cultural Factors

Differences appear to exist between races regarding condom use and women's levels of comfort discussing the issues with their partners. For instance, it has been found that Hispanic women feel less comfortable than White or Black women discussing condom use with a male partner, and Black women use condoms less regularly than both White and Hispanic women (Schilling, El-Bassel, Gilbert, et al., 1991). The percentage of sexually active Black women not using contraception has decreased by about half, from about 14% to about 7% of women who are physically able to become pregnant and desire to avoid pregnancy in the last 20 years. Nonetheless, Black women are still using contraception less than other ethnic groups (Piccinino & Mosher, 1998), and they are having more unplanned pregnancies than other ethnic groups. In 1994, for instance, 72% of pregnancies of Black women were unplanned; for White women and women of other ethnic groups, the percentages were 43% and 50%, respectively (Henshaw, 1998). These results mandate

cultural and racial sensitivity in the development and provision of family planning services.

Responses to the Need for Services

Research suggests that little is being done to address specifically the issue of contraceptive use and family planning with substance users. One controversial initiative, started in California, C.R.A.C.K. (Children Require a Caring Kommunity), recently re-named Project Prevention, provides male and female active or recovering drug users a one-time payment of \$200 to participate in permanent or long-term birth control. The following methods are approved for payment: Depo Provera, Lunelle (a monthly contraception injection), IUD, tubal ligation, vasectomy, and Mirena (an insert that lasts up to five years) (Berlex, n.d.; Project Prevention, 2002a; Schwartz & Gabelnick, 2002). The flyer advertising the program makes uncorroborated claims that “babies born with drugs in their system often die at birth. The surviving infants don’t stand much of a chance at life, especially when they bounce around foster homes—rarely getting adopted” (Project Prevention, 2002b). Currently, there are chapters of this program in 16 states (Arizona, California, Colorado, Florida, Illinois, Indiana, Louisiana, Michigan, Nevada, New Jersey, New Mexico, Pennsylvania, Tennessee, Texas, Utah, and Washington) and the District of Columbia (Project Prevention, 2002b). Some consider this program to be coercive because many substance users are not in an emotional state to make an informed decision about the procedure (Roth, 2002). Further, the American Public Health Association (2001) opposes this and any other coercive program of this nature because it violates principles of civil rights, human rights, and reproductive freedom. They call instead for increased access to voluntary family planning programs and services, and programs and services that help women end harmful drug use.

Prevention Point Philadelphia offers a markedly different approach to providing services to inner city men and women, operating from a harm reduction philosophy in its provision of comprehensive health services. Although not designed exclusively for substance users, their needle exchange program, among a variety of other services, are available to a high number of substance users. The needle-exchange program operates out of a recreational vehicle and travels to six locations per week. Three times per week another van follows the RV, and medical providers, primarily medical students, provide medical services from this van. Recently, they have added a family planning component to the medical service provisions, including the addition of a nurse who conducts exams and distributes contraception. Exams occur in the van, and all forms of birth control are provided. There is no need for clients to travel to a traditional medical facility, and it is unnecessary to go to

a pharmacy to have a prescription filled. The addition of family planning services at their needle exchange/mobile health clinic makes family planning services more accessible to drug users who may not want or be ready to stop using (M. Berger, personal communication, March 24, 2004).

Several Abandoned Infants Assistance (AIA) programs, funded by grants from the U.S. Department of Health and Human Services’ Children’s Bureau, directly address family planning issues for families affected by substance abuse and HIV. For instance, the TIES Program in Kansas City, Missouri emphasizes overall physical health with client families, including talking with mothers about their plans for future children. They stress the importance of planning their families; that is, they stress preventing future pregnancies or planning the timing of future pregnancies, if that is the desired outcome. Staff members discuss options with the mothers and assist them with appointments to health care providers as needed (McMann, personal communication, March 1, 2004). The AIA program in Miami, Florida, Project SAFE, holds educational groups and seminars on a variety of topics, including family planning. Further, they maintain a relationship with the University of Miami to ensure they are giving their clients the most reliable and up-to-date information available. In addition, they maintain relationships with other agencies in the community to facilitate a community-based approach and ensure that their clients are given the most appropriate referrals for services (R. Campos, personal communication, February 9, 2004).

Bienvenidos Children’s Center, in East Los Angeles, CA, has an on-site health clinic that serves all agency clients, including families in their AIA funded program, Project Milagro. Recognizing that self health care has not been a priority for the substance-using women, the clinic approaches family planning and reproductive health care in a holistic, sensitive manner. For instance, two times per month, they close the clinic (which serves men and women) to the general public, and they provide special services for women who are using drugs or are in recovery. On these days, they bring in a female nurse who provides medical care and also conducts workshops that address issues such as awareness and education about reproductive health care and contraceptive use. They also have a dietician/nutritionist/herbalist who conducts workshops. The purpose of these workshops is to empower the women and help them learn to care for themselves in a holistic way. They also teach women to become comfortable with their sexuality, and they conduct risk reduction assessments with them. Further, they provide very practical advice such as how to feel comfortable purchasing condoms in a store, and how to make condom use fun and sexual. Finally, they provide

women with condoms, birth control pills, and other forms of contraceptives using the Family PACT program (A. Rodriguez, personal communication, April 1, 2004). The Family PACT program of California provides family planning services (any approved by the FDA), at no cost, to anyone not covered by insurance who desires family planning services (California Department of Health Services, Office of Family Planning, 2004). More than 2,700 licensed Medi-Cal providers (e.g., private physicians, OB/GYNs, and pediatricians) serve clients throughout the state.

Discussion

Gutierrez and Barr (2003) found that concern for contracting sexually transmitted diseases does not influence decisions about contraception practices, and that female substance users are more concerned than male substance users about pregnancy. Therefore, it is important to provide education and counseling specifically about family planning. These services should be available for women and men; however, women should fully understand that the responsibility to use contraception is ultimately theirs (Gutierrez & Barr; Ralph & Spigner, 1986). As discussed above, there are gender and power issues inherent in condom use because it requires active male participation. This necessitates outreach and education for alternate forms of birth control for female substance users, as well as counseling to address self-esteem, relationship, and power and control issues. Female substance users need training in assertiveness and communication skills in order to negotiate better with their partners the use of protection (Schilling et al., 1993). In addition, personal empowerment may help women better negotiate condom use with their partners (Muller & Boyle, 1996).

Further, general health care services should be expanded to reach more substance users, many of whom do not have access to adequate health care, and these services should include family planning counseling and provision of a variety of contraceptives. Because detoxification centers and treatment facilities have high rates of readmissions and serve many clients on a short-term basis, it may be beneficial to offer contraception and other health care services at these locales rather than providing referrals to outside agencies (Shah et al., 1998). The results of the study by the Family Planning Council of Southeastern Pennsylvania will provide additional insight into the efficacy of co-locating family planning services with services that clients are already accessing. Additionally, all substance use treatment, family support, and case management programs may be in ideal positions to discuss contraception use, particularly in the context of relationships and other factors in clients' lives.

In summary, the limited studies that have been conducted offer insight into the contraceptive behaviors of substance users, and the findings support the need for family planning services specifically designed for this population. However, more controlled studies, accounting for more variables, are needed to better understand the patterns and rates of contraceptive use and the reasons for non-use. Further, it is important for service providers to keep in mind that cultural belief systems and life circumstances other than drug use may be behind some family planning issues and should be considered in any counseling efforts. For instance, violence and abuse, partner issues, educational and employment problems, poverty, health problems, cultural belief systems and practices, and the disease of addiction all complicate the issues surrounding contraception use. Before any meaningful advances can be made in this area, more deeply seated problems must be addressed at both the individual and societal levels.

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