Improving Contraception Counseling in Female Patients with Psychiatric Illness: An Educational Intervention for Psychiatry Residents

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Introduction

Psychiatric illnesses are among the most common and disabling illnesses afflicting reproductive-aged women worldwide and can contribute to adverse reproductive health outcomes. Women are 60-70% more likely to experience a depressive episode and an anxiety disorder than men (Hall 2015).

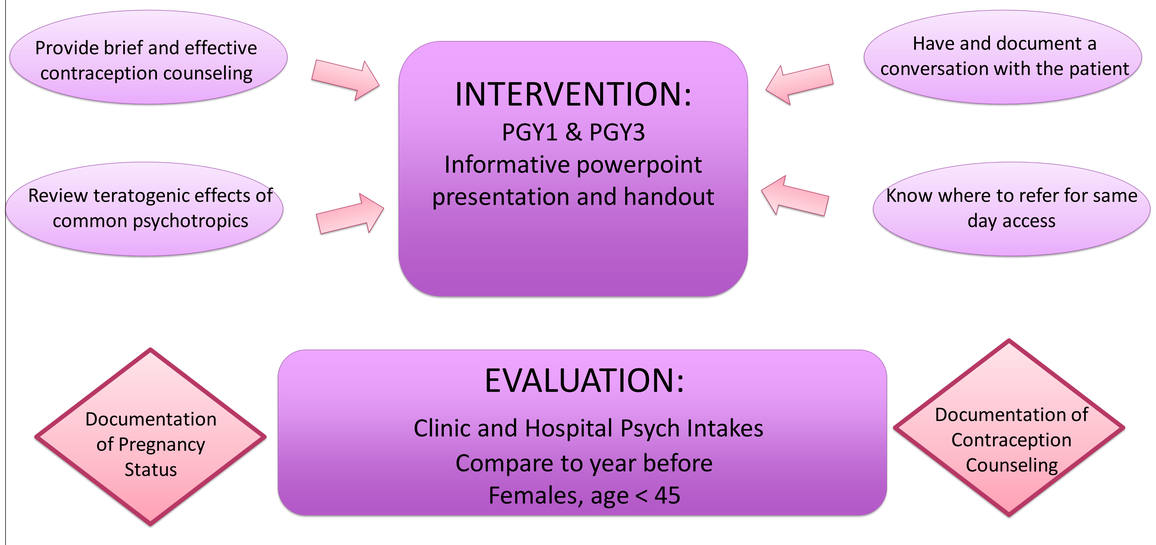
Women with psychiatric illnesses have a higher risk of unintended pregnancy and abortion than women without psychiatric illnesses. There are higher rates of contraception nonuse, misuse and discontinuation in women with psychiatric symptoms (Hall 2013). Women with psychiatric illness also have a higher risk of adverse perinatal and postpartum outcomes, including maternal and infant morbidity, obstetrical complications, preterm labor, stillbirth and low birthweight. Effective contraception in women who want to avoid unintended pregnancy can be a way to maintain and improve health and well-being. However, existing studies show low rates of contraception counseling by physicians, even when medications that are known to be unsafe in pregnancy are prescribed.

In a study of family practice residents (Fritsche 2011), an educational intervention was shown to significantly increase the rate of documented contraception counseling from 46% to 80% in a year. The goal of this study was to improve the quality of care provided to female patients with psychiatric illness by providing an educational intervention to their psychiatrists-in-training.

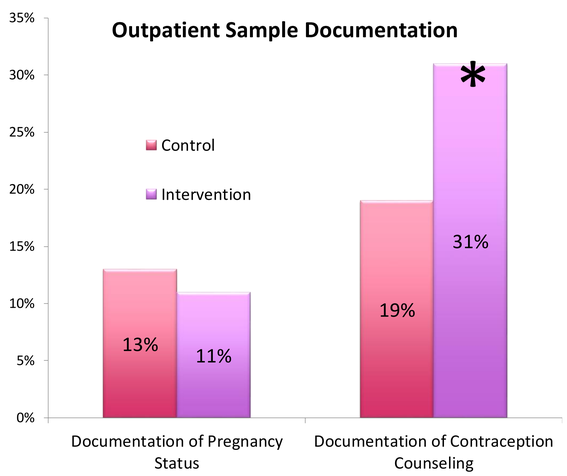
Sample Characteristics

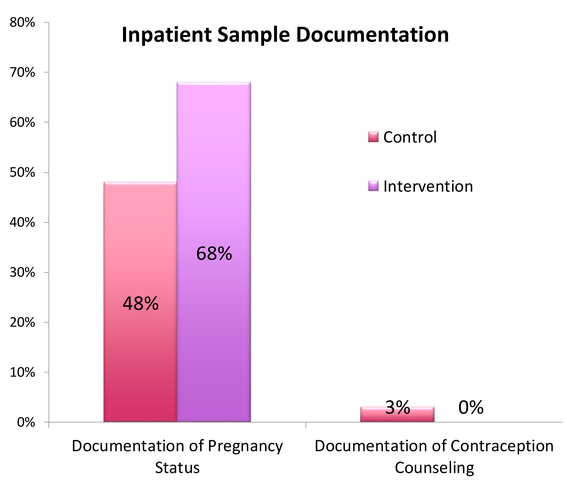
	CONTROL	INTERVENTION
OUTPATIENT		
N =	108	89
Age (mean)	34	34
Psychosis (%)	42.6	47.2
AEDs (%)	17.6	9.0
Antidepressants (%)	43.5	42.7
Antipsychotics (%)	60.2	68.5
Lithium (%)	10.2	11.2
Benzos (%)	10.2	13.5
PGY3 (#)	8	9
INPATIENT		
N =	29	22
Age (mean)	30	29

Method



Quantitative Results





Qualitative Results

"She is planning to become pregnant and has gone off of her birth control… We also *discussed in brief the risks of pregnancy with Haloperidol*, though specifically noted that the risks are likely outweighed by the benefits given her history… and that she should let us know if she does become pregnant so that *we can monitor her very carefully* and consider any necessary medication changes."

"…she was also educated on the risks of the medications if she were to become pregnant, and the patient **UNDERSTANDS** and *notes that she is not planning to get pregnant and is receiving a Depo-Provera shot for birth control.*"

"Also educated the patient on the risk of tremor, potential consequences of lithium toxicity, and *concerns for fetal toxicity* if the patient were to become pregnant. The patient does state that she has thought about becoming pregnant… but at this time is considering getting Depo…and *thus is comfortable continuing with lithium at this time as it has worked so well for her in the past*. The patient was instructed to immediately inform this physician if she does decide to start trying for a pregnancy."

Does Medication Matter?

Medication	Control	Intervention
Antiepileptics	11% (2/19)	25% (2/8)
Lithium	27% (3/11)	60% (6/10)
Benzodiazepines	9% (1/11)	33% (4/12)

Conclusions

I. In an outpatient academic setting, a brief educational intervention can improve physician behavior
II. Overall, rates of contraception counseling among psychiatry residents remains low, at about 20%.
III. Setting makes a difference, outpatient vs. inpatient. (though in this study this observation is confounded by level of training.)

Limitations include small sample size, data points are all based on documentation, and the intervention was voluntary.

Future Directions

I. Incorporating this topic into the curriculum
II. Adding a template in the EMR to remind physicians to document contraception
III. Subsequent research may address physician barriers to contraception counseling (attitudes, beliefs), as well as whether the intervention increased number of referrals or prescriptions and decreased rate of unintended pregnancy.

References

1. Fritsche MD, Ables AZ, Bendyk H. Opportunities missed: improving the rate of contraceptive counseling or provision when prescribing reproductive-aged women potentially teratogenic medications in a family medicine resident clinic, *Contraception* 2011; 84 (4): 372-376.
2. Hall KS, Steinberg JR, Cwiak CA, Allen RH, Marcus SM. Contraception and mental health: a commentary on the evidence and principles for practice, *American Journal of Obstetrics and Gynecology,* (2015); 212 (6): 740-746.
3. Hall K, Moreau C, Trussell J, Barber J. Role of young women's depression and stress symptoms in their weekly use and nonuse of contraceptive methods. *J Adolesc Health*, 2013; 53: 241-248.