Best Practices in Contraceptive Counseling: Perspectives from the Science of Decision Making

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Acknowledgements

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- Dr. Leslie Kantor, Planned Parenthood Federation of America
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Background

The two most commonly used methods of birth control in youth are birth control pills and condoms.

When youth first become sexually active, they tend to rely on condoms and then eventually transition to the pill or a related method as they define themselves as being “sexually active.”

The work I will talk about today addresses when youth come to clinics to obtain (or to continue to use) birth control.

The work is a collaborative effort with Planned Parenthood.

My Background

I was trained as a social/cognitive/developmental psychologist.

I have studied decision making and decision making processes in adolescents and young adults for the past 40 years.

I have studied attitude formation, attitude change, and communication as it relates to decision making.

I have applied the theories I work with to reproductive health issues in a wide range of contexts.
My Background

In 2010, I conducted a major review of all social science research on contraceptive behavior in young adults for the National Campaign to Prevent Teen and Unplanned Pregnancy.

This lead to the development of a brochure for the Campaign consisting of “tips for contraceptive counselors” to facilitate the counseling process.

I participated on numerous panels for the revision of Title X recommendations for contraceptive counseling. These activities led to funding from the Office of Population Affairs to formalize a contraceptive counseling protocol for use in clinics to integrate the science of decision making into current counseling approaches.

Four Facets of Contraceptive Behavior
The Facets of Contraceptive Behavior

The term “contraceptive behavior” is ambiguous.

There are four key facets of contraceptive behaviors that we can address and that have implications for unintended pregnancy:

1. **Contraceptive choice**: Choice of an effective method.
2. **Contraceptive accuracy**: Using the chosen method correctly.
3. **Contraceptive consistency**: Using the chosen method consistently.
4. **Contraceptive switching**: Gaps in protection during method switches and switching to less effective methods.

It is important for contraceptive counseling to address all four of these facets, not just method choice.

The perfect use effectiveness rate of the pill in preventing pregnancy is > 99%. The typical use effectiveness rate is 91%.

This 8-9% gap is due to incorrect use of the pill.

If we can reduce the typical use failure rate by 3% by increasing accurate pill use, this will lead to over 150,000 fewer unintended pregnancies per year or 12,500 per month in youth.

A Significant Trend in Contraceptive Counseling

Clinics are shifting primary contraceptive counseling tasks from physicians and nurse practitioners to health para-professionals.

An initial 15 to 20 minute counseling session is conducted first by the counselor or health care assistant. Then the patient sees the physician/practitioner to confirm choices, obtain additional information, and a prescription/method.

Our protocol is aimed primarily at such counselors but we work with the physicians and nurse practitioners as well.

Development of Protocol
Protocol Development

Based on the scientific literature and the combined collective experience of the research team, we evolved a set of 10 “best practices” for contraceptive counseling.

We then conducted qualitative research consisting of in-depth interviews focused on each practice with the following constituencies in multiple clinics:

- Clinic managers
- Regional medical/training staff
- Counselors
- Physicians/nurse practitioners
- Patients
- Physicians

We explored their reactions to each practice and had them identify obstacles and facilitators to the use of each.

We also had them describe, independent of the practices, what they thought good counseling entails.

Based on this, we fine-tuned our protocol and developed a training and implementation plan.

An obstacle we heard time and again was time! We needed to be respectful of the realities of time constraints.

Ten Best Practices in the Protocol

Practice 1: Establish expertise, trustworthiness, accessibility
Practice 2: Use of active memorable learning strategies
Practice 3: Simplify the choice process
Practice 4: Address lifestyle and broader context (POISE)
Practice 5: Address accurate and consistent use
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Practice 9: Address pregnancy ambivalence
Practice 10: Mention use of quick start

Establish Expertise, Trustworthiness, and Accessibility
Having TEA with Your Patient

**Expertise** refers to patient attributions that the counselor is an expert in the topic area and is knowledgeable about the topic.

**Trustworthiness** refers to patient attributions that the counselor has their best interest at heart and wants to do what is best for the patient rather than acting in their own self-interest.

**Accessibility** refers to patient attributions that they can access the counselor in the future for follow-up.

Research shows that each of these dimensions impact patient reactions to health messaging in consequential ways.

Research shows that counselors tend to assume patients attribute these qualities to them. It also shows many patients do not.

What small things can a counselor do or say at the outset of the session to help establish TEA and to reinforce this as the session continues?

Use of Active and Memorable Learning Strategies

Research shows people are less likely to recall or learn information when they passively listen to it as opposed to actively process it.

Research suggests the majority of patients often cannot recall key points from physician-patient interactions even within 30 minutes of the interaction.

Use of active learning strategies makes a difference (e.g., having patients repeat back important points in their own words; asking questions of the patient so they must articulate matters using their own thoughts and words).
There are over a dozen methods of birth control, each varying on about a dozen dimensions, so patients must consider over 150 pieces of technical information to make a choice. This is called *information overload* in the decision making literature.

Research shows in such scenarios, people often “jump around” from one piece of information to another and make decisions based on what is salient not what is important.

If they make a bad choice, they will become dissatisfied with the method and then either stop using it or switch to another method, with the risk of a gap in protection increasing.

We need to simplify the choice process. One approach that is gaining favor to do so is *tiered counseling*.

The counselor discusses methods with patients sequentially beginning with the most effective methods, LARC (IUDs and implants). If a “match” is found, the process stops.

If not, the counselor discusses the next most effective methods, namely hormonal methods (injections, pill, ring, patch). If a “match” is found, the process stops. If not, discussion turns to the lesser effective methods (e.g. condoms, diaphragm, sponge).

In our development work, we encountered resistance to this approach, not only on the part of counselors but also by patients.

There was voiced tension between simplifying the process on the one hand versus educating people about all their options and letting them choose once fully informed.
Simplify the Choice Process

“I don’t know if I like that. Because I feel she should know everything that’s out there, and then let her decide, even though we know this may be more effective – let her decide what she wants and give her all the options.” - Counselor

“What if the patient is a good candidate for category A but she wants category B but you’re not providing that service because the counselor thinks that the information given to the patient stops at category A” - Counselor

We developed a taxonomy of 11 perceived advantages and 33 perceived disadvantages of tiered counseling as voiced by patients and counselors.

Example Advantages

Facilitates getting patients onto most effective methods
Educates people about methods they know little about
Emphasizes methods that are convenient/easier to use
Emphasizes methods that are adherence forgiving
Helps to organize the conversation
Is easy to understand – it simplifies the decision task
Would normalize what are seen as esoteric methods
People choose what they hear first – strategy advantages this
Ensures the same information is shared with all patients

Example Disadvantages

Is “pushing” a method onto patients
Learning methods of interest to patients helps – this gets in way
Uses time by considering methods of little interest to patients
Uses time encouraging questions on methods not right for patient
Will make patient question current method; lose confidence
Tiers 1 and 2 offer no STD protection
It is bad to start discussion with methods that are not popular
Approach emphasizes effectiveness too much
Approach is too structured and inflexible
Research in decision making shows that there are five categories of variables that people take into account when making decisions to perform a behavior:

- Perceived advantages and disadvantages
- Social norms
- Image implications and fit with self concept
- Emotional reactions
- Self efficacy

When I examined extant counselor training protocols, aside from the pros and cons of traditional medical-like information (effectiveness, side effects, cost, convenience), none of these other core factors were addressed.

It is not feasible given time constraints to explore each of the five dimensions for each method. But we should at least try to touch base with them once a tentative choice has been made.
Address Lifestyle and Broader Context (POISE)

Perceived advantages and disadvantages: “What are the good things for you about using the method? Are there any bad things?

Other’s reaction: “Is there anyone important to you who wouldn’t want you to use the method?”

Image: “Does this method fit with the kind of person you are?”

Self efficacy: “Do you think you can do what needs to be done to use this method correctly and consistently?”

Emotional reactions: “Do you have any negative feelings about the method?”

Form a Plan for Method Switching

Switching to a less effective method increases the risk of an unintended pregnancy as do gaps in protection during switches.

Decision making research on implementation intentions shows that if people have “action plans” ahead of time for what to do when encountering unexpected and difficult situations, they are more likely to resolve those situations effectively - in this case, by not having a gap in protection during a switch.

Our counselors are trained to help patients form specific action plans of what to do if they become dissatisfied with their method.

The Training Protocol
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We developed a six-hour training protocol for counselors to teach them how to use and apply the best practices. For each practice we relied on the CMF model:

**Communicate:** Communicate to the counselor in clear and concise terms exactly what the practice is.

**Motivate:** Motivate the counselor to adopt the best practice. Get full counselor buy-in (exploring POISE).

**Facilitate:** Make it as easy as possible for the counselor to implement the practice. Address obstacles that may arise and how to deal with them.

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The Training Protocol

We use active learning strategies (role playing, group discussion, critiquing videotaped counseling sessions).

We tailor and individualize the practice to the counselor and their patients (use of 3X5 personalized index cards for scripting the counseling).

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Back-Up for Training Session: Shadowing

What back-up do we have if the training session does not work well?

After training, we have an expert in our protocol shadow the counselor for one or two days in the field and provide feedback at the end of the day and ensure the protocol is implemented to criterion.

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Back-Up for Counselor Infidelity: Waiting Room Handout

What if after training and shadowing, the counselor does not implement the protocol in the real world?

We developed a waiting room handout for patients with tips about how to communicate with their counselors and how to ask questions. We also suggest questions they might want to address, most of which map onto our protocol (asking about how to use the method accurately; asking about what to do if becomes dissatisfied with the method and wants to switch).
Research Design

Ten Title X clinics randomly assigned to one of two conditions (5 clinics per condition)

- Treatment as usual (TAU)
- Implementation of contraceptive counseling protocol (CCP)

N = 1,384 clients between 18 and 29 (about 135 per clinic)

TAU n = 758
CCP n = 626

Results for Just After Counseling

Surveys were administered:

- Immediately following counseling
  - Computer administered interview
  - Fidelity checks on counselor practices
  - Evaluation of effects of CCP on counseling satisfaction and related variables
- At 6 and 12 months later by phone to assess:
  - Gaps in protection
  - Accuracy/consistency of contraceptive use
  - Method switching
Time Differences in Counseling

We measured how much time transpired between the time clients left the waiting room to go to their session and when they returned to the waiting room to take the survey. We calculated the mean difference (CCP minus TAU), with covariate adjustments for center size:

- Mean diff in Region 1 = 3.3 minutes
- Mean diff in Region 2 = 0.9 minutes
- Mean diff in Region 3 = 2.5 minutes

Counselor Behavior (Based on Reports of Clients):
Percent of Sessions Behavior was Performed

<table>
<thead>
<tr>
<th></th>
<th>Exp</th>
<th>Ctrl</th>
<th>Sig Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussed how to use method correctly</td>
<td>98%</td>
<td>82%</td>
<td>Yes</td>
</tr>
<tr>
<td>Discussed plans for switching</td>
<td>94%</td>
<td>59%</td>
<td>Yes</td>
</tr>
<tr>
<td>Discussed side effects</td>
<td>93%</td>
<td>72%</td>
<td>Yes</td>
</tr>
<tr>
<td>Discussed STDs</td>
<td>91%</td>
<td>64%</td>
<td>Yes</td>
</tr>
<tr>
<td>Discussed plans for pregnancy</td>
<td>81%</td>
<td>36%</td>
<td>Yes</td>
</tr>
<tr>
<td>Discussed partner/others</td>
<td>76%</td>
<td>26%</td>
<td>Yes</td>
</tr>
<tr>
<td>Discussed starting method today</td>
<td>61%</td>
<td>48%</td>
<td>Yes</td>
</tr>
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Perceived Expertise of Counselor

Sum of two items (e.g. My counselor seemed very knowledgeable about birth control; range 2 to 10)

(Difference is statistically significant)

Perceived Trustworthiness of Counselor

Sum of two items (e.g. My counselor was sincerely interested in me; range 2 to 10)

(Difference is statistically significant)
**Effective Contraceptive Counseling**

**Perceived Accessibility**

I feel like it would be easy to access staff in the clinic; range 1 to 5

(Difference is statistically significant)

**Quality of Decision Process**

Sum of “My counselor made it easy for me to decide about birth control; I learned something new today about birth control.” Analyzed for clients who came to switch methods or start a method for first time

(Difference is statistically significant)

**Satisfaction with Method Chosen**

Sum of two items (e.g. I am very satisfied with the method I will use after today’s visit; range 2 to 10)

(Difference is statistically significant)

**Overall Evaluation of Counselor**

Sum of two items (e.g. Overall, I liked my counselor a great deal; range 2 to 10)

(Difference is statistically significant)
Evaluation of Counseling Session

Sum of two items (e.g., I was very satisfied with the counseling I got today from my counselor; range 1 to 5)

(Difference is statistically significant)

Evaluation of Clinic

Sum of three items (e.g., My attitude toward this clinic is very positive; range 3 to 15)

(Difference is statistically significant)

Follow-up Results

We are analyzing the follow-up data now, but initial analyses appear promising. We are seeing preliminary evidence for greater uptake of LARC methods, less method switching, fewer gaps in protection, fewer missed pills, reduced frequency of stopping birth control altogether and more dual use (But this is work in progress and needs to be flushed out more)

Concluding Comments
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Large segments of adolescents and young adults access birth control through clinics. The clinic experience is generally successful in that patients leave the clinic with a relatively effective method of pregnancy prevention.

But once they leave the clinic, “chaos” ensues – patients use the method incorrectly or inconsistently; they become dissatisfied with the method and stop using birth control altogether; they switch to a less effective method and/or experience gaps in protection during the switch.

Counseling needs to address the future “chaos”

Concluding Comments

LARC methods minimize the chaos, but….

- They offer no protection against STIs
- There is likely a ceiling effect to the number of women who will adopt them (about 25%)
- They can be costly for adolescents up-front or there may be privacy issues surrounding use of insurance to cover the costs

Thank You!
Ten Best Practices in the Protocol

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Address Accurate and Consistent Use

Research shows that obstacles to accurate and consistent use are rarely discussed during contraceptive counseling, but it is key to reducing the gap between perfect use and typical use effectiveness.

It is not uncommon for counselors to rely on patients reading package inserts for such information – which is unsatisfactory.

We need to tailor the information we give to patients based on their own behavioral tendencies and circumstances.

Common Reasons for Missing a Pill

Away from home (did not take with me)
Forgot to take it
No new pill pack (had not picked up a new pill pack)
Late (took it six hours late—was doing something else)
Work pressures (job transition; irregular schedule)
School pressures (final exams got in the way)
Late start (began period and thought had to wait)
Sleep disturbances (exhausted; fell asleep and forgot)
Health (had the flu; throwing up)
Side effects (had bleeding, so waited)
Routine disrupted (family crisis)
Decided to “let it go” just this once
Address Accurate Use

Help develop practical strategies for daily methods, such as the pill, to ensure do not forget, such as linking taking the pill to a daily habit

“What is something you do every single day?”

“What do you really do that every day?”

Information on what to do about missed pills given in writing – not a focus of the counseling (online resources given also). Have handouts on accurate/consistent use for every method.