Emergency contraception

for psychiatric patients

Dispelling certain myths can help you prescribe EC before your patient needs it

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Disclosures
The authors report no financial relationships with any companies whose products are mentioned in this article, or with manufacturers of competing products.
doi: 10.12788/cp.0300

Ms. A, age 22, is a college student who presents for an initial psychiatric evaluation. Her body mass index (BMI) is 20 (normal range: 18.5 to 24.9), and her medical history is positive only for childhood asthma. She has been treated for major depressive disorder with venlafaxine by her previous psychiatrist. While this antidepressant has been effective for some symptoms, she has experienced adverse effects and is interested in a different medication. During the evaluation, Ms. A remarks that she had a "scare" last night when the condom broke while having sex with her boyfriend. She says that she is interested in having children at some point, but not at present; she is concerned that getting pregnant now would cause her depression to "spiral out of control."

Unwanted or mistimed pregnancies account for 45% of all pregnancies.[1] While there are ramifications for any unintended pregnancy, the risks for patients with mental illness are greater and include potential adverse effects on the neonate from both psychiatric disease and psychiatric medication use, worse obstetrical outcomes for patients with untreated mental illness, and worsening of psychiatric symptoms and suicide risk in the peripartum period.[2] These risks become even more pronounced when psychiatric medications are reflexively discontinued or reduced in pregnancy, which is commonly done contrary to best practice recommendations. In the United States, the recent Supreme Court decision in *Dobbs v Jackson Women's Health Organization* has erased federal protections for abortion previously conferred by *Roe v Wade*. As a result, as of early October 2022, abortion had been made illegal in 11 states, and was likely to be banned in many others, most commonly in states where there is limited support for either parents or children. Thus, preventing unplanned pregnancies should be a treatment consideration for all medical disciplines.[3]

continued

JAMES O'BRIEN

Emergency contraception

Clinical Point

Emergency contraception does not impede the development of an established pregnancy and thus is not an abortifacient

Table 1

Oral emergency contraception myths and facts

Myth	Fact
EC pills are the same thing as medication-induced abortion	EC cannot end a pregnancy. It is effective only before pregnancy is established, and does not put either the mother or developing fetus at risk if taken during pregnancy[5]
Prescribing EC pills is medically controversial	Routine advance prescription of oral EC is recommended by professional societies, including the American College of Obstetricians and Gynecologists[6] and the American Academy of Pediatrics[7]
EC pills are unsafe	EC pills are very safe—so much so that in 2013 the FDA approved levonorgestrel for over-the-counter dispensation without age restrictions.[8] No deaths or serious complications have been causally linked to oral EC; the most common adverse effects are self-limited nausea and headache[9]
Managing EC pills is complicated	Prescribing and managing EC pills is straightforward. There are only 2 main types of emergency contraception pills, each available in only 1 dose. Neither medication has any contraindications other than established pregnancy, and neither affects psychotropic medications. There is no need for a physical exam or laboratory testing before prescription or use, and no need for routine follow-up after use[9]
Prescribing EC promotes risky sexual behaviors	Prescribing EC does not lead to patients having more unprotected sex, or being less likely to use condoms or other contraceptive methods[10]

EC: emergency contraception

Psychiatrists may hesitate to prescribe emergency contraception (EC) due to fears it falls outside the scope of their practice. However, psychiatry has already moved towards prescribing nonpsychiatric medications when doing so clearly benefits the patient. One example is prescribing metformin to address metabolic syndrome related to the use of second-generation antipsychotics. Emergency contraceptives have strong safety profiles and are easy to prescribe. Unfortunately, there are many barriers to increasing access to emergency contraceptives for psychiatric patients.[4] These include the erroneous belief that laboratory and physical exams are needed before starting EC, cost and/or limited stock of emergency contraceptives at pharmacies, and general confusion regarding what constitutes EC vs an oral abortive (***Table 1***[5-10]). Psychiatrists are particularly well-positioned to support the reproductive autonomy and well-being of patients who struggle to engage with other clinicians. This article aims to help psychiatrists better understand EC so they can comfortably prescribe it before their patients need it.

What is emergency contraception?

EC is medications or devices that patients can use after sexual intercourse to prevent pregnancy. They do not impede the development of an established pregnancy and thus are not abortifacients. EC is not recommended as a primary means of contraception,[9] but it can be extremely valuable to reduce pregnancy risk after unprotected intercourse or contraceptive failures such as broken condoms or missed doses of birth control pills. EC can prevent ≥95% of pregnancies when taken within 5 days of at-risk intercourse.[11]

Methods of EC fall into 2 categories: oral medications (sometimes referred to as "morning after pills") and intrauterine devices (IUDs). IUDs are the most effective means of EC, especially for patients with higher BMIs or who may be taking medications such as cytochrome P450 (CYP)3A4 inducers that could interfere with the effectiveness of oral methods. IUDs also have the advantage of providing highly effective ongoing contraception.[6] However, IUDs require in-office placement by a trained clinician, and patients may experience difficulty obtaining placement within 5 days of

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Table 2

Oral emergency contraception: Highlights

Category	Ulipristal acetate (UPA)	Levonorgestrel (LNG)
Dose	30 mg as needed, with refills	1.5 mg as needed, with refills
Appropriate patients	Any patient at risk of pregnancy, regardless of current intention regarding sexual activity. No physical exam or pregnancy test is required before prescription or use[9]	
Adverse effects	The most common are headache and nausea, as well as irregular bleeding; no causal links to death or other serious complications.[9] No known risks to the fetus if taken by a pregnant person; safe while breastfeeding[5]	
Psychiatric effects	None reported	Possible transient dysphoria in patients with similar responses to other hormonal contraception
Contraindications	None	None
Psychotropic interactions	No clinically significant impacts on psychotropic medications. The efficacy of both medications is likely decreased by strong CYP3A4 inducers (eg, carbamazepine)[5]	
Effectiveness	0% to 1.8% risk of pregnancy when taken within 5 days of at-risk sex[4]	0.3% to 2.6% risk of pregnancy when taken within 3 days of at-risk sex[4]
	Approved for use within 5 days of sex	Approved for use within 3 days of sex; may provide some benefit when taken up to 5 days after sex
	May be less effective for patients who are obese[15]	Less effective for patients who are overweight or obese[15]
Ease of access	Requires a prescription; not stocked by all pharmacies	Available by prescription or OTC (including online) without age restrictions.[8] Stocked or quickly available in most pharmacies
Bottom line	Recommended over LNG due to superior effectiveness, but requires a prescription and can be more difficult to get	Less effective than UPA (especially for heavier patients) but may be a good choice for patients wanting an OTC medication, or who do not have quick or reliable access to UPA

CYP: cytochrome P450; OTC: over-the-counter

unprotected sex. Therefore, oral medication is the most common form of EC.

Oral EC is safe and effective, and professional societies (including the American College of Obstetricians and Gynecologists[6] and the American Academy of Pediatrics[7]) recommend routinely prescribing oral EC for patients in advance of need. Advance prescribing eliminates barriers to accessing EC, increases the use of EC, and does not encourage risky sexual behaviors.[10]

Overview of oral emergency contraception

Two medications are FDA-approved for use as oral EC: ulipristal acetate and levonorgestrel. Both are available in generic and branded versions. While many common birth control pills can also be safely used off-label as emergency contraception (an approach known as the Yuzpe method), they are less effective, not as well-tolerated, and require knowledge of the specific type of pill the patient has available.[9] Oral EC appears to work primarily through delay or inhibition of ovulation, and is unlikely to prevent implantation of a fertilized egg.[9]

Ulipristal acetate (UPA) is an oral progesterone receptor agonist-antagonist taken as a single 30 mg dose up to 5 days after unprotected sex. Pregnancy rates from a single act of unprotected sex followed by UPA use range from 0% to 1.8%.[4] Many pharmacies stock UPA, and others (especially chain pharmacies) report being able to order and fill it within 24 hours.[12]

continued

Clinical Point

Advance prescribing eliminates barriers to accessing emergency contraception and does not encourage risky sexual behaviors

Emergency contraception

Table 3

Emergency contraception: What to tell patients

Factor	Instruction
When to pick up	Before you need it to ensure quick and reliable access when you want it; stable for at least 3 years when stored in a cool, dry place
When to take	As soon as possible after unprotected/inadequately protected sex
After taking	Get a pregnancy test if your period does not start within 3 weeks; seek care for persistent lower abdominal pain or persistent irregular bleeding[9]
If resuming oral contraceptives	Ulipristal acetate: Wait 5 days[5] Levonorgestrel: Start immediately[5]
Routine follow-up	None needed[9]

Clinical Point

Oral emergency contraception is unlikely to have a meaningful effect on psychiatric symptoms or management

Levonorgestrel (LNG) is an oral progestin that is available by prescription and has also been approved for over-the-counter sale to patients of all ages and sexes (without the need to show identification) since 2013.[8] It is administered as a single 1.5 mg dose taken as soon as possible up to 3 days after unprotected sex, although it may continue to provide benefits when taken within 5 days. Pregnancy rates from a single act of unprotected sex followed by LNG use range from 0.3% to 2.6%, with much higher odds among women who are obese.[4] LNG is available both by prescription or over-the-counter,[13] although it is often kept in a locked cabinet or behind the counter, and staff are often misinformed regarding the lack of age restrictions for sale without a prescription.[14]

Safety and adverse effects. According to the CDC, there are no conditions for which the risks outweigh the advantages of use of either UPA or LNG,[5] and patients for whom hormonal birth control is otherwise contraindicated can still use them safely. If a pregnancy has already occurred, taking EC will not harm the developing fetus; it is also safe to use when breastfeeding.[5] Both medications are generally well-tolerated—neither has been causally linked to deaths or serious complications,[5] and the most common adverse effects are headache (approximately 19%) and nausea (approximately 12%), in addition to irregular bleeding, fatigue, dizziness, and abdominal pain.[15] Oral EC may be used more than once, even within the same menstrual cycle. Patients who use EC repeatedly should be encouraged to discuss more efficacious contraceptive options with their primary physician or gynecologist.

Will oral EC affect psychiatric treatment?

Oral EC is unlikely to have a meaningful effect on psychiatric symptoms or management, particularly when compared to the significant impacts of unintended pregnancies. Neither medication is known to have any clinically significant impacts on the pharmacokinetics or pharmacodynamics of psychotropic medications, although the effectiveness of both medications can be impaired by CYP3A4 inducers such as carbamazepine.[5] In addition, while research has not specifically examined the impact of EC on psychiatric symptoms, the broader literature on hormonal contraception indicates that most patients with psychiatric disorders generally report similar or lower rates of mood symptoms associated with their use.[16] Some women treated with hormonal contraceptives do develop dysphoric mood,[16] but any such effects resulting from LNG would likely be transient. Mood disruptions or other psychiatric symptoms have not been associated with UPA use.

How to prescribe oral emergency contraception

Who and when. Women of reproductive age should be counseled about EC as part of anticipatory guidance, regardless of their

Table 4

When should a patient take emergency contraception?

After any sex without a condom or other contraceptive method
After missing 1 dose of the "mini pill" (norethindrone 0.35 mg), or after taking it more than 3 hours late in the 2 days before having unprotected sex
After missing 2 doses of oral contraceptive pills in the week before having unprotected sex

Table 5

Use of emergency contraception in special populations

Patients who are overweight or obese: LNG (and to a smaller extent UPA) is less effective at preventing pregnancy for patients who are obese; in contrast, IUDs remain highly effective at all BMIs.[4] The effectiveness of LNG appears to decline as a patient's weight rises above 70 kg (approximately 155 lbs),[17] and patients who are obese may be 4 to 8 times as likely to become pregnant after LNG use compared to those with lower BMIs.[15,18] Doubling the dose of LNG does not appear to restore its effectiveness for patients who are obese[19]
Patients taking strong CYP3A4 inducers: The effectiveness of both UPA and LNG may be decreased in patients taking strong inducers of the CYP3A4 enzyme, such as carbamazepine, St. John's wort, and topiramate.[5] Some groups recommend that patients using LNG take 2 tablets (3 mg), although the effectiveness of doing so has not been well studied; this approach is not recommended for UPA[20]
Patients age <18: Both UPA and LNG are safe and effective for patients of all ages, and the American Academy of Pediatrics recommends that pediatricians prescribe EC in advance of need to facilitate their effective use.[7] However, not all adolescents are able to discuss reproductive health issues openly with their parents or guardians, and there is wide variation across states regarding minors' right to consent to and obtain confidential contraceptive care (for your state's regulations, check the Guttmacher Institute's database https://www.guttmacher.org/state-policy/explore/emergency-contraception).[21] Patients who wish to use EC in a confidential fashion may prefer paper prescriptions paired with medication discount programs (such as GoodRx; https://www.goodrx.com/) to avoid inadvertent disclosure through insurance benefits forms, or to purchase LNG OTC or online

BMI: body mass index; CYP: cytochrome P450; EC: emergency contraception; IUD: intrauterine device; LNG: levonorgestrel; OTC: over-the-counter; UPA: ulipristal acetate

current intentions for sexual behaviors. Patients do not need a physical examination or pregnancy test before being prescribed or using oral EC.[9] Much like how intranasal naloxone is prescribed, prescriptions should be provided in advance of need, with multiple refills to facilitate ready access when needed.

Which to prescribe. UPA is more effective in preventing pregnancy than LNG at all time points up to 120 hours after sex, including for women who are overweight or obese.[15] As such, it is recommended as the first-line choice. However, because LNG is available without prescription and is more readily available (including via online order), it may be a good choice for patients who need rapid EC or who prefer a medication that does not require a prescription (***Table 2,***[4,5,8,9,15] ***page 37***).

What to tell patients. Patients should be instructed to fill their prescription before they expect to use it, to ensure ready availability when desired (***Table 3,***[5,9] ***page 38***). Oral EC is shelf stable for at least 3 years when stored in a cool, dry environment. Patients should take the medication as soon as possible following at-risk sexual intercourse (***Table 4***). Tell them that if they vomit within 3 hours of taking the medication, they should take a second dose. Remind patients that EC does not protect against sexually transmitted infections, or from sex that occurs after the medication is taken (in fact, they can increase the possibility of pregnancy later in that menstrual cycle due to delayed ovulation).[9] Counsel patients to abstain from sex or to use barrier contraception for 7 days after use. Those who take birth control pills can resume use immediately after using LNG; they should wait 5 days after taking UPA.

No routine follow-up is needed after taking UPA or LNG. However, patients should

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UPA is more effective in preventing pregnancy than LNG, but LNG is available without a prescription

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Related Resources

- American College of Obstetricians and Gynecologists Practice Bulletin on Emergency Contraception. https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2015/09/emergency-contraception
- State policies on emergency contraception. https://www.guttmacher.org/state-policy/explore/emergency-contraception
- State policies on minors' access to contraceptive services. https://www.guttmacher.org/state-policy/explore/minors-access-contraceptive-services
- Patient-oriented contraceptive education materials (in English and Spanish). https://shop.powertodecide.org/ptd-category/educational-materials

Drug Brand Names

Carbamazepine • Tegretol
Levonorgestrel • Plan B One-Step, Fallback
Metformin • Glucophage
Naloxone • Narcan
Norethindrone • Aygestin
Sertraline • Zoloft
Topiramate • Topamax
Ulipristal acetate • Ella
Venlafaxine • Effexor

Clinical Point

Patients who use emergency contraception repeatedly should be advised to pursue routine contraceptive care

get a pregnancy test if their period does not start within 3 weeks, and should seek medical evaluation if they experience significant lower abdominal pain or persistent irregular bleeding in order to rule out pregnancy-related complications. Patients who use EC repeatedly should be recommended to pursue routine contraceptive care.

Billing. Counseling your patients about contraception can increase the reimbursement you receive by adding to the complexity of the encounter (regardless of whether you prescribe a medication) through use of the ICD-10 code Z30.0.

Emergency contraception for special populations

Some patients face additional challenges to effective EC that should be considered when counseling and prescribing. ***Table 5***[4,5,7,15,17-21] (***page 39***) discusses the use of EC in these special populations. Of particular importance for psychiatrists, LNG is less effective at preventing undesired pregnancy among patients who are overweight or obese,[15,17,18] and strong CYP3A4-inducing agents may decrease the effectiveness of both LNG and UPA.[5] Keep in mind, however, that the advantages of using either UPA or LNG outweigh the risks for all populations.[5] Patients must be aware of appropriate information in order to make informed decisions, but should not be discouraged from using EC.

Other groups of patients may face barriers due to some clinicians' hesitancy regarding their ability to consent to reproductive care. Most patients with psychiatric illnesses have decision-making capacity regarding reproductive issues.[22] Although EC is supported by the American Academy of Pediatrics,[7] patients age <18 have varying rights to consent across states,[21] and merit special consideration.

CASE CONTINUED

Ms. A does not wish to get pregnant at this time, and expresses fears that her recent contraceptive failure could lead to an unintended pregnancy. In addition to her psychiatric treatment, her psychiatrist should discuss EC options with her. She has a healthy BMI and had inadequately protected sex <1 day ago, so her clinician may prescribe LNG (to ensure rapid access for immediate use) in addition to UPA for her to have available in case of future "scares." The psychiatrist should consider pharmacologic treatment with an antidepressant with a relatively safe reproductive record (eg, sertraline).[23] This is considered preventive ethics, since Ms. A is of reproductive age, even if she is not presently planning to get pregnant, due to the aforementioned high rate of unplanned pregnancy.[23,24] It is also important for the psychiatrist to continue the dialogue in future sessions about preventing unintended pregnancy. Since Ms. A has

Bottom Line

Patients with mental illnesses are at increased risk of adverse outcomes resulting from unintended pregnancies. Clinicians should counsel patients about emergency contraception (EC) as a part of routine psychiatric care, and should prescribe oral EC in advance of patient need to facilitate effective use.

benefited from a psychotropic medication when not pregnant, it will be important to discuss with her the risks and benefits of medication should she plan a pregnancy.

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Clinical Point

LNG is less effective at preventing pregnancy in patients who are overweight or obese