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Society of Family Planning clinical recommendations: Contraception and abortion care for persons who use substances

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ABSTRACT

Substance use and substance use disorder remain significant public health crises. Substance use disorder, or addiction, is a stigmatized and misunderstood disease. Accessing contraception and abortion care is particularly challenging, as people who use substances or are diagnosed with substance use disorder often experience internalized stigma and overt discrimination within the healthcare system. There are limited recommendations for the clinical care of persons with substance use disorder who seek abortion or contraception care, and limited data to support these recommendations. This Society of Family Planning clinical recommendation addresses counseling and provision of contraception and abortion for persons who use substances or have substance use disorder. As there are almost no safety or efficacy data on contraception, abortion and substance use, the recommendations utilize extrapolations of substance use disorder-adjacent medical conditions when necessary.

1. Background

1.1. Definition of substance use disorder/addiction

The use of illicit substances and associated morbidity remains a significant public health crisis. In the United States in 2019, 7.2 million women were identified as having a substance use disorder (SUD) [1], and opioid use disorder (OUD) remains the greatest contributor to overdose deaths [2]. In addition to opioids, cannabis and stimulant use has been increasing [1,3]. Using a substance does not indicate a patient has a substance use disorder, as most people who use drugs do not develop an addiction to them, and the harms of a substance are not isolated to addiction. Box 1 defines terms used in describing substance use [4,5].

Reproductive-aged people with substance use disorder may experience different reproductive health outcomes when compared to people without substance use disorder, including higher rates of sexually transmitted infections, and reported higher rates of unintended or unplanned pregnancies [6–12]. Data consistently find lower median contraceptive-use rates than the general population [6,9–14].

This guideline aims to provide guidance for safe abortion and contraceptive care for persons who use substances or have substance use disorders (excluding nicotine and alcohol), with an emphasis on those who use opioids. As there are currently limited safety or efficacy data on the impact of substance use on contraception or abortion, the recommendations utilize extrapolations of substance use disorder-adjacent medical conditions when necessary and may not make a distinction between those who use substances and those who carry a diagnosis of a substance use disorder, as extant data does not support clear differences in guideline recommendations. Therefore, the phrase “those who use substances” is utilized throughout the recommendation, reflecting patients with a diagnosis of a substance use disorder as well as those who use substances without the formal diagnosis.

1.2. Medication treatment for opioid and other substance use disorders

1.2.1. Opioid use disorder

Evidence-based treatment of opioid use disorder, a chronic disease, rests upon two classes of medication: methadone and buprenorphine (agonists), or naltrexone (antagonists) [15–17].

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Methadone is an opioid receptor agonist and may only be dispensed by a federally certified opioid treatment program. Buprenorphine is a partial opioid receptor agonist and can be dispensed from an opioid treatment program or prescribed by clinicians who obtain "X" DEA waiver. When administered correctly, these agonist medication for opioid use disorder (MOUD) treat the symptoms of withdrawal without inducing a sense of euphoria. Agonist medication for opioid use disorder does not provide pain control in persons with injuries or surgical procedures [18]. Naltrexone is an opioid receptor antagonist and can be prescribed by any licensed provider [17]. When administered correctly, naltrexone blocks the effects of opioid agonists (Appendix A describes principles medication for opioid use disorder).

1.2.2. Other substance use disorders

The evidence bases for treatment for other substance use disorders (aside from alcohol or nicotine) is more limited. No medications are Food and Drug Administration-approved for stimulant, cannabis, or sedative use disorder [19–21]. Abrupt cessation of both alcohol and benzodiazepines is dangerous and can be fatal [21,22].

1.2.3. Polysubstance use

Polysubstance use is exceedingly common among persons using substances [23]. Notably, many illicit substances are contaminated with other substances that the user may not be aware of [24], leading to side effects, toxic effects, and findings on toxicology testing inconsistent with the user's understanding of their substance use. Providers' awareness of this phenomena can help protect the patient-provider relationship especially when there are inconsistencies in reporting and toxicology results.

1.3. Stigma, bias, and patient experience

Persons with addiction frequently experience both external stigma from clinicians and the healthcare system, as well as internalized stigma based on prior healthcare experiences [18,25,26]. For example, persons with substance use disorder may be at higher risk for poor pain treatment due to both the hyperalgesia associated with the disease as well as being subjected to biased and incorrect provider beliefs. Common provider misconceptions include believing medications for addiction treatment provide analgesia and that persons with substance use disorder are "med-seeking" [18,25,26].

Additionally, criminalization of substance use has led to potentially coercive reproductive practices including long acting reversible contraception use or sterilization incentivized monetarily or by reduced criminal justice penalties [27,28]. It is critical for reproductive health clinicians to keep this socio-historical context in mind when counseling persons on family planning options [29].

2. Clinical questions

2.1. Can patients who use substances be cared for in the outpatient setting?

Most patients who use substances may safely obtain a surgical abortion in an outpatient setting [GRADE 2B]. Ample data supports use of ambulatory and outpatient surgical sites for surgical abortion with moderate or deep sedation [30–32]. Standard recommended protocols required for provision of routine moderate sedation (which vary by state and institution but generally include vital sign monitoring, readily available reversal agents, possibly capnography, and access to emergency care [33]) are appropriate for patients who use substances [33,34].

Patients should not undergo a procedure in an outpatient setting while clinically intoxicated. Clinical intoxication cannot be determined by toxicology testing [35–37]. A clinically intoxicated person (hypoxia in the setting of opioid use or tachycardia and/or hypertension in the setting of cocaine or stimulant use [38,39]) should not undergo a procedure in an outpatient center and should be referred to a hospital setting if unable to anticipate a time when outpatient care would be feasible [35,39].

Clinicians often inappropriately employ toxicology testing as a proxy for determining acute intoxication, or as a screening tool for recent substance use or abuse. Toxicology testing, which detects metabolites of selective substances, is distinct from substance use screening, which is an assessment of risk of substance use or misuse in someone without an addiction diagnosis, most often accomplished with validated questionnaires [40]. False negatives and false positives with serum or urine toxicology testing are common and vary depending on the substance being detected [41,42]. A positive result does not determine acute intoxication or in some cases even determine recent use, while negative results do not rule out use or misuse [41,42]. Toxicology testing results are not predictive of surgical outcomes or conscious sedation risk and should not be routinely utilized in surgical abortion decision making, including determining location of care [35–37].

The American Society of Addiction Medicine (ASAM) recommends limiting the use of toxicology testing to specific situations (acute clinical scenarios and monitoring persons prescribed MOUD or controlled substances) [43]. The American College of Obstetricians and Gynecologists (ACOG) concurs that urine toxicology testing should be used as an adjunct to confirm use, but not as a screening tool [44].

When clinicians utilize toxicology testing, best practices include obtaining patient consent and developing a transparent plan for managing potential results. Persons should always be informed of the testing results**. Toxicology testing should never be utilized as a screening tool. When employing toxicology testing, clinicians should respect the autonomy of any person declining to participate in testing** [45].

2.2. What are the recommendations for anesthesia options for persons who use substances seeking surgical abortion?

Clinicians may be anxious about both over-sedation and/or inadequate sedation and pain control while providing abortion for persons who use substances, in particular those who use opioids [18,46]. Local anesthesia, moderate sedation, and deep sedation may all be safely used for most persons who use substances.

Local anesthesia may be safely used for nearly all patients, including persons who use substances [18,47,48]. In particular, there may be specific benefit to patients who use opioids. **We recommend routine use of a paracervical block when providing both minimal and moderate sedation for persons with opioid use disorder. Providing a paracervical block is in line with recommendations to center non-opioid pain management options for persons with OUD** [18,47,49,50]**, is known to be effective for non-substance using patients utilizing only local anesthesia** [48]**, and may be helpful for post-procedure pain management [GRADE 1C**]. While the data supporting intra-procedure efficacy of a paracervical block are inconsistent when used with moderate sedation in a general population [33,48], it has not been studied in the chronic opioid or substance using population specifically [34].

Minimal sedation provided by oral agents (such as lorazepam and oral opioids) is not proven to reduce procedural pain in a non-substance using population [48]. There are no data on efficacy of these methods in for patients who use substances. Verbal support has been proven to help patients cope with the procedure but also

Table 1
Recommended moderate sedation dosing for persons receiving MOUD [34]

Methadone or Buprenorphine	Paracervical block. Fentanyl 200 mcg intravenous (higher initial doses are often needed). Midazolam 2 mg intravenous (may repeat 1–2 mg q 2–5 min). Can take 3–6 min before full effect. Consider ketamine 0.3–1.0 mg/kg (25–50 mg, slow push intravenous). NSAID (i.e., 30 mg IV ketorolac, 30 min prior to procedure)
Naltrexone	Paracervical block. Midazolam 2 mg intravenous (may repeat 1–2 mg q 2–5 min). Can take 3–6 min before full effect. Consider ketamine 0.3–1.0 mg/kg (25–50 mg, slow push intravenous). Consider dexmedetomidine 25 mcg slow push intravenous (repeat q5–10 min as needed). Fentanyl is not effective at office-based doses. NSAID (i.e., 30 mg IV ketorolac, 30 min prior to procedure)

MOUD, medication for opioid use disorder; NSAID, non-steroidal anti-inflammatory drug.

do not reduce pain [48]. They may be just as useful for patients who use substances as those without, but this is also not studied.

Providing moderate sedation may be challenging for patients with opioid use. Persons with chronic opioid use may require increased doses of oral agents to achieve analgesia, but data are mixed [46]. We recommend starting first with the anxiolytic, followed by the opioid, when using intravenous moderate sedation to maximize sedation [34]. **Persons who are newly opioid abstinent and not receiving MOUD are at risk of over-sedation and may require less medication due to opioid receptor upregulation** [18,47,49,51]**. Monitoring vital signs including respiration rate (ventilation) and oxygenation saturation will identify over-sedation and allow for rapid reversal** [33] **[GRADE 2B].** Additionally, the American Society of Anesthesiologists recommends monitoring exhaled carbon dioxide for all patients receiving moderate sedation for whom ventilation cannot be directly observed [52] [GRADE 1C]. Cannabinoids do not appear to pose unique risk to sedation options, as the sedation accommodations are similar to those needed by persons who smoke tobacco [39]. There are no specific peri-operative recommendations for people who use cannabis in the absence of acute intoxication [39,53]. Finally, there is no data to support withholding moderate sedation options from patients with a cocaine use, in the absence of acute intoxication.

Clinicians may consider additional types of anesthesia for patients who use substances. Propofol anesthesia, when provided by a licensed anesthesia provider, is a safe option for people who use substances, especially opioids, as it bypasses the opioid receptors completely [18,54]. Ketamine, increasingly used in outpatient clinics because of decreased risk of respiratory depression, may also provide anesthesia benefits in this population, and is well established as an adjuvant anesthetic agent that does not require an anesthesiologist to administer. Ketamine does not require unique monitoring. [55] However, ketamine can cause dysphoria or hallucinations, which may be partly mitigated by midazolam [34] **[GRADE 1B].**

2.3. What are the unique recommendations for sedation options for persons receiving MOUD?

Like all persons utilizing chronic opioids, persons receiving any type of MOUD will often require higher doses of opioids to reach therapeutic effect of that opioid. Clinicians should titrate medication to comfort and safety as measured by routine vital signs and cardiac monitoring [34]. The use of potent opioids, such as fentanyl, during moderate sedation will facilitate pain control, but may not consistently provide sedation. The National Abortion Federation provides general guidance for sedation options for persons receiving MOUD (Table 1) [34]. Additionally, existing data refutes a theoretical concern of increased risk of respiratory depression caused by additive effects of agonist medication for opioid use disorder with therapeutic opioids in the setting of acute pain [18].

Methadone and buprenorphine should not be stopped or decreased ahead of a procedure [GRADE 1B]. Cessation of these medications can lead to withdrawal, return to use, opioid use disorder recurrence, overdose, and overdose death [18,51].

Persons undergoing procedures with local anesthesia or deep sedation with propofol should be advised to continue all forms of medication for opioid use disorder [34].

Persons receiving an opioid either as an oral agent in minimal sedation or as part of a moderate sedation protocol should continue methadone or buprenorphine. Consensus publications provide specific guidance on use of buprenorphine in a peri-operative population including broad agreement on continuation of buprenorphine dosing throughout the peri-operative period for short procedures with little anticipated post-operative pain [51,56].

Naltrexone management is more nuanced. This medication is available in oral and extended-release formulations and is used to treat both alcohol use disorder and opioid use disorder. For patients who may require opioid therapy either for treatment of acute pain or as part of a moderate sedation protocol, continuation recommendations for persons prescribed oral naltrexone are inconsistent. Some guidance suggests discontinuation for 3 days prior which will allow for better effect of opioid pain medication [19,34,59]. In this case, providers should reference guidance for restarting naltrexone [58]. However, discontinuing oral naltrexone may be neither possible nor desirable and carries a risk of return to use and substance use disorder recurrence [18]. When patients continue naltrexone, they should be provided non-opioid pain management options. Similarly, some providers recommend delaying care by 3 to 4 weeks for patients utilizing extended-release naltrexone, however this is often not feasible or reasonable with abortion care. Clinicians should not delay procedures due to extended-release naltrexone use, and should anticipate non-opioid pain management options [19,34,57]. We recommend clinicians employ shared-decision making to help persons utilizing naltrexone, especially oral naltrexone, negotiate the risk of lesser-sedation versus risk of destabilization from temporary cessation of naltrexone or delay of care [GRADE2C].

2.4. What post-procedure or home pain management options are recommended for persons who use substances who are undergoing surgical or medical abortion?

Post-procedure pain control may be a specific challenge for persons who use substances, in particular persons who use opioids who are at risk of un- and undertreated pain [18]. There are no data evaluating post-procedure pain control for abortion patients who use substances.

We recommend a multimodal approach to post-procedure or medical abortion pain management. These recommendations are extrapolated from recommendations for post-procedure pain management in non-abortion patients with opioid use disorder, as well as patients seeking abortions who do not use opi-

Box 1
Terminology describing substance use [96,97]

Use	Use of any substances
Misuse	Hazardous use of substances (i.e., binge drinking, using someone else's prescription opioid medication)
Addiction	Treatable, chronic disease. Behaviors become compulsive and continue despite harmful consequences
Substance use disorder	Diagnostic term for "addiction" in the DSM5

oids. This approach includes non-steroidal anti-inflammatory drugs (NSAIDs) and acetaminophen primarily [34,47,50,60–62] **[GRADE 1B].** Additionally, short course or single-dose opioids may be used, with caution, in the acute post-operative or acute pain state for patients who are not adequately treated by non-opioid options [18,34,50] [GRADED 1B]. For those who require opioid therapy, the medication should be used for the shortest duration possible [34,63].

Gabapentin is increasingly used in general gynecological surgery as an adjuvant to improve post-operative pain and decrease post-operative narcotic use [62–64], and may have some benefit for post-operative pain after surgical abortion [65,66]. While this approach has not been evaluated in persons who use substances, National Abortion Federation guidelines include the option of gabapentin for some persons as adjuvant treatment during and after surgical abortion [34]. Gabapentin may be considered for patients who uses substances undergoing surgical abortion based on National Abortion Federation guideline, but there are not clear data for this guideline to determine if it should be recommended [34]. Gabapentin has not been found to be effective for persons undergoing medication abortion [67].

Concern about pain control may create barriers for persons accessing medication abortion. There are no data evaluating pain experiences among patients with substance or opioid use disorder undergoing medication abortion. However, NSAIDs are recommended as first line pain management for all persons undergoing medication abortion [34,70], and systematic review of data indicate that NSAIDs are adequate for most persons [68–70]. The addition of opioids have not been found to improve pain or satisfaction when compared to NSAIDs in patients without substance use disorder [71]. Patients should be adequately counseled about what to expect, particularly with medication abortion, and offered stronger pain medication when needed for the shortest duration possible [68]. **We recommend patients who use substances be offered NSAIDs as first line, in accordance with other post-operative pain recommendations** [34,47,50,59] **[GRADE1B].** We also encourage clinicians to be particularly judicious about routine prescription of opioids for all patients undergoing abortion, not just patients with substance or opioid use disorder. Most people do not require opioids for either medical or surgical abortion, and the presumptive prescription, rather than the necessary one, may increase risk of diversion of medication [72]. There are no data to suggest that persons with stimulant or cannabinoid use disorder would have either safety or efficacy concerns with standard recommendations for post-operative pain.

2.5. What must a clinician consider when providing medication abortion to persons who use substances?

Clinicians should not withhold medication abortion for patients who use substances if it is the person's chosen abortion method [68,73] **[GRADE 1C].** It is reasonable to extrapolate that failure of medication abortion would be similar among persons who use substances as in others [68]. There are no data investigating safety or efficacy of mifepristone and misoprostol for persons who use substances. While some practitioners may worry about adherence with follow up, including confirmatory testing, we recommend providers engage in person-centered counseling about risks of failed medication abortion, and asses with the person the safest modality for them. Substance use and use disorders in and of themselves do not confer an inability to understand or follow instructions, and providers should practice a person-centered approach, applying their judgement similarly as they would to persons who do not use substances.

2.6. What do clinicians need to know and consider when providing contraceptive care for persons who use substances?

Data regarding the safety of contraception and substance use, misuse, and addiction are sparse. The Centers for Disease Control Medical Eligibility Criteria does not include addiction as its own category or discuss medications to treat addiction and hence currently make no recommendation [74]. A recent systematic review of safety and efficacy of contraception among people who use opioids could find no theoretical safety concerns with contraception [75]. **There are no limitations to prescribing any contraceptive method for patients who use opioids or other substances** (aside from nicotine and alcohol, excluded in this guideline. However, clinicians should recognize the high prevalence of tobacco use among patients with substance and opioid use disorder)**. [GRADE 1C]**

Clearer recommendations exist around "aligned illness," or medical conditions for which people who use substances, including people who inject drugs, may be at increased risk. All contraceptive methods are considered safe for people at increased risk for HIV [74,76], as well as for persons with stable, compensated hepatitis C [74,75] [GRADE 1A]. For persons requesting an intrauterine device, the American Heart Association does not recommend antibiotics for prevention of bacteremia in persons with previous endocarditis [74,77], as data does not find a conclusive link between theoretical transient bacteremia after IUD placement and infective endocarditis. A recent retrospective review of safety of all long acting reversible contraceptive devices (intrauterine devices and implants) with a variety of cardiac conditions found no cases of infective endocarditis and no contraception-related complications [78], so intrauterine devices may be safely used in patients with cardiac conditions [GRADE 1A].

Understanding of contraception preferences among patients who use substances are more robust; uptake of methods considered highly effective is typically low and barriers to care are typically high in patients with substance use disorder [12,77,81]. Notably, knowledge about long acting reversible contraception is particularly low, as is interest in those methods [79]. For persons who choose to use long acting reversible contraception, side effects and reasons for dissatisfaction and termination of method are similar to those reasons given by persons who do not use substances [80].

2.7. What are best practice recommendations when providing contraception counseling to persons who use substances?

There are no explicit recommendations for contraception counseling for persons who use substances. Multiple major health organizations support the application of shared decision making to a variety of medical decisions, though no national body has an explicit guideline regarding shared decision making [81–84]. **Shared decision making is a medical decision making paradigm wherein persons and clinicians work together, sharing situated**

Box 2
Screening parameters for SUD [[44,100]] [GRADE 1B]

Screening can be reliably done by physicians and non-physicians
Screening should be applied equally regardless of age, sex, race or socioeconomic status
Screening frequency should increase during pregnancy and postpartum period

knowledge and medical expertise and arriving at a choice meeting the person's medical needs, preferences and values [81,85]. **It is particularly applicable to decisions that are "preference sensitive," where multiple options may have good medical efficacy, but there are trade-offs that are subject to person values** [85] **[GRADE 1B].**

While scant data examines the experiences of women who use substances and shared decision making for contraceptive and family planning decisions, a growing body of research for general populations demonstrates the power and benefits of shared decision making for contraceptive choice. Shared decision making is preferred by persons [86–88] when making contraceptive choices, and provides clinicians with key insights into the most useful supports for women [89–91]. This approach is particularly relevant for persons with substance use disorder, who may have specific decisional needs due to their specific experiences with substance use disorder, stigma and prior encounters with the healthcare system [92]. For example, persons with opioid use disorder frequently described a belief that they had reduced fertility due to substance use disorder, often in the context of opioid induced oligomenorrhea that lead them to deemphasize the importance of contraceptive use [92,93].

Clinicians who are counseling persons who use substances about contraception can use shared decision making approaches to assess person knowledge, support and values, as well as identify decisional needs and tailor their counseling accordingly, enabling persons to choose a contraceptive method that works best for them. Patients with substance use disorder experience discrimination in healthcare settings, rendering it critical for clinicians to consider their own biases that may lead to a tendency to recommend specific methods over others for substance use disorder persons. Using a shared decision-making approach can reduce these potential biases by creating the context and structure for exchange of experience and expertise, where the person is the expert on their life with substance use disorder, and the clinician is the expert on medical implications of different family planning choices, with the ultimate goal of the person choosing a contraceptive method that meets their recovery goals, medical needs and values [94].

2.8. Should reproductive health providers screen for substance use, misuse, and addiction?

The US Preventative Services Task Force (USPSTF) currently recommends universal screening for substance use disorder for adults over 18 years old *when services for diagnosis, treatment, or referral can be offered* [95] **[Grade 1A].** Given some persons only seek healthcare when requiring contraception or abortion services, those visits may be important opportunities to support people at risk of substance use disorder. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the American College of Obstetricians and Gynecologists concur on certain screening parameters (Box 2). **Screening should be conducted via a validated instrument, ideally matched to the population and the clinic** [40,44,95] **[GRADE 1B].** There are many screening tools available through the Substance Abuse and Mental Health Services Administration, some common ones are listed in Appendix B.

A "positive" screen is not a diagnosis of addiction. People who screen positive should be informed and provided a subsequent appointment or referral. Screening and referral resources are available in appendix B.

3. Conclusions

Substance use and substance use disorder are common conditions and are plagued by a long history of discrimination and misunderstanding in healthcare settings, leading to poor person outcomes and perpetuating provider biases. Providers should work to understand addiction, including the evidence in support of addiction treatment and the data in support of screening. The intersection of substance use disorder and family planning is poorly studied, but related topics of acute pain therapy and outpatient anesthesia may provide information which can be extrapolated to abortion care. NSAIDS and local anesthesia are first line therapies for pain management in both family planning and anesthesia literature and may be extrapolated to apply to persons with substance use disorder. Person-centered care including shared decision making is a central recommendation to counseling and should be the starting place for all contraception and pregnancy decision counseling conversations. Persons with substance use disorder may safely determine when and how to end their pregnancy and may safely participate in both medical and procedural abortion decisions. Providers who work to understand addiction may help to improve the outcomes, satisfaction, and trust in the healthcare system of a traditionally underserved population.

3.1. Recommendations

Please see Appendix C for a key to interpreting GRADE
The following are based on primarily high-quality evidence:

- Universal screening using a validated instrument is recommended for persons 18 years and older for substance use in any clinical setting including reproductive health clinics, when follow up for diagnosis, treatment or referral may also be offered GRADE 1A (USPSTF).
- Women at risk for HIV and hepatitis may safely use all contraceptive methods GRADE 1A.
- Women with compensated hepatitis may safely use all contraceptive methods GRADE 1A.
- Women with a history of infective endocarditis do not require antibiotic prophylaxis for placement of long acting reversible contraception methods GRADE 1A.

Non-opioid analgesic methods, including a multimodal approach with NSAIDs, acetaminophen, and local anesthesia, are first line treatment for acute post-procedure pain (not specific to abortion care) for persons with substance use disorder GRADE 1A.

- Any clinic using or stocking opioids should have reversal agents readily available GRADE 1A.

The following recommendations are based on limited or inconsistent scientific evidence:

- Routine use of a paracervical block is safe for use in patients with substance use disorder/opioid use disorder and may help with intra-procedure pain control GRADE 1B.
- Urine toxicology testing should not be used as a screening modality for substance use GRADE 1B.

- A person-centered approach, including shared-decision making, is the gold standard counseling approach for all persons, including those with substance use disorder GRADE 1B.
- NSAIDs should be first line pain therapy for persons with substance use disorder undergoing medical abortion GRADE 1B.
- First line pain therapy for post-procedural abortion persons include NSAIDs GRADE 1B.
- Opioids may be used with caution in the acute setting for unrelieved pain post-procedure for persons with substance use disorder, including those prescribed agonist MOUD (buprenorphine and methadone) GRADE 1B.
- Buprenorphine and methadone should not be discontinued ahead of a surgical abortion procedure GRADE 1B.
- Persons with substance use disorder may be cared for in outpatient and ambulatory settings GRADE 2B.
- Persons prescribed MOUD (buprenorphine and methadone) may safely use moderate sedation, although may have lesser sedation effects GRADE 2B.
- Persons with substance use disorder may safely receive routine conscious sedation with benzodiazepines and opioids in clinics with appropriate monitoring GRADE 2B.

The following recommendations are based primarily on consensus and expert opinion:

- Providers should be familiar with local resources for addiction treatment GRADE 1C (USPSTF).
- Providers should not withhold medication abortion from persons with addiction GRADE 1C.
- Contraception use is safe for individuals with substance use disorder, including opioid use disorder and individuals receiving medication for opioid use disorder GRADE 1C.
- Patients prescribed naltrexone may continue their medication ahead of a surgical or medical abortion GRADE 2C.

3.2. Recommendations for future research

The intersection of substance use disorder and family planning has ample opportunity for study:

- Efficacy study for medication abortion and persons with substance use disorder.
- Safety of moderate sedation for persons with opiate use disorder receiving MOUD, including person satisfaction, sedation levels, amounts of medication, and provider comfort.
- Studies of provider comfort in caring for persons with substance use disorder.
- Assessment of clinic comfort, by geographical region, and their policies and practices around caring for persons with SUD.
- Efficacy of alternative sedation or pain control options.
- Assessments of contraceptive preferences and decision-making experiences for persons with SUD.
- Studies of contraceptive service delivery for persons with SUD including integrated service models for SUD and family planning care.

4. Sources

The articles included in this guideline were obtained from a PUBMED and embase search of relevant articles from prior to August 20, 2020. The following MeSH terms and text words were used: addiction; substance use disorder; opioid use disorder; drug dependence; reproductive health, abortion; medical abortion; contraception; contraception counseling; moderate sedation; ambulatory anesthesia; shared decision making.

The "related articles" search in PubMed was used frequently to identify similar studies that were not included in the original search. Reference lists of identified studies were also handsearched for additional publications. Articles not published in English were excluded. Guidelines were also searched from relevant organizations, including National Abortion Federation, Planned Parenthood Federation of America, ACOG, American Society of Anesthesiologists, and Society for Ambulatory Anesthesia.

5. Intended audience

We anticipate this clinical recommendation will be used by primary care providers, family planning providers, addiction medicine specialists, and by anesthesiology providers caring for persons with substance use disorder. Although this review is intended to guide medical decision making, it is not intended to dictate care.

Declaration of Competing Interest

Dr. Patton, Dr. Samura, Dr. Terplan, and Dr. Woodhams report no relevant significant relationships with industry. Dr. White receives research support from Merck and Evofem. The Society of Family Planning receives no direct support from pharmaceutical companies or other industries for the production of clinical recommendations.

Authorship

This Clinical Recommendation was prepared by Elisabeth Woodhams, MD MSc; Tirah Samura MD; Elizabeth Patton MD MPhil MSc, Katharine White MD MPH, and Mishka Terplan MD and was reviewed and approved by the Board of the Society of Family Planning.

Appendix A. Summary of conclusions, from the committee on medication-assisted treatment for opioid use disorder [15]

Summary of conclusions
1. Opioid use disorder is a treatable chronic brain disease.
2. U.S. Food and Drug Administration (FDA)-approved medications to treat opioid use disorder are effective and save lives.
3. Long-term retention on medications to treat opioid use disorder is associated with improved outcomes.
4. A lack of availability of behavioral interventions is not a sufficient justification to withhold medications to treat opioid use disorder.
5. Most people who could benefit from medication-based treatment for opioid use disorder do not receive it, and access is inequitable across subgroups of the population.
6. Medication-based treatment is effective across all treatment settings studied to date. Withholding or failing to have available all classes of FDA-approved medication for the treatment of opioid use disorder in any care or criminal justice setting is denying appropriate medical treatment.
7. Confronting the major barriers to the use of medications to treat opioid use disorder is critical to addressing the opioid crisis.

Appendix B. Selection of commonly available screening tools and resources [98–101]

Instrument	Population	Website
Drug Abuse Screening Test (DAST)	Adults (over 18)	http://adai.washington.edu/instruments/pdf/Drug_Abuse_Screening_Test_105.pdf
NIDA Drug Use Screening Tool	Adults (over 18)	https://www.drugabuse.gov/sites/default/files/pdf/screening_qr.pdf
DAST-10	Adolescents (12–17)	https://cde.drugabuse.gov/instrument/e9053390-ee9c-9140-e040-bb89ad433d69
SAMSHA referral resources	Searchable by geography	https://findtreatment.samhsa.gov/

Appendix C. Key for GRADE recommendations[a]

Symbol	Meaning
1	Strong recommendation
2	Weaker recommendation
A	High quality evidence
B	Moderate quality evidence
C	Low quality evidence, clinical experience, or expert consensus

[a]Society of Family Planning clinical recommendations use a modified GRADE system. The GRADE system is described in several publications, with a comprehensive set of articles in the Journal of Clinical Epidemiology (J Clin Epidemiology, (2011) 64:383–394, 64:395–400, 64:401–406, 64:407–415, 64:1277–1282, 64:1283–1293, 64:1294–1302, 64:1303–1312, 64:1311–1316, (2013) 66:140–150, 66:151–157, 66:158–172. 66:173–183, 66:719–725, 66:726–735).

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