

MEDICAL CARE OF HIV-INFECTED SUBSTANCE-USING WOMEN

I. INTRODUCTION

Clinicians need to be cognizant of the differences in patterns of substance use in women as opposed to men in order to develop the most effective management strategies for them. Clinicians should also be aware of treatment needs that may be specific to women experiencing substance use disorders. This chapter addresses gender differences in the causes, progression, and effective methods of treatment for substance use disorders among women.

II. GENDER DIFFERENCES IN SUBSTANCE USE

A. Prevalence of Substance Use and Substance Use Disorders Among Women

The 2003 National Survey on Drug Use and Health (NSDUH, formerly the NHSDA) found that rates of lifetime, past-year, and past-month illicit drug use were higher for males than females among persons aged 12 or older (51 vs 42%, 17 vs 12%, 10 vs 7%, respectively); 12% of males met criteria for any illicit drug or alcohol abuse or dependence in the past year compared with 6% of females. However, gender differences were absent among adolescents (aged 12-17): rates of any illicit drug or alcohol abuse or dependence in the past year were 8.7% for males and 9.1% for females.¹

Twelve percent of women reported using an illicit drug in the past year: approximately 1.6% of women report having used cocaine, 0.1% having used heroin, and 8.4% having used marijuana.²

Key Point:

Women are more likely to misuse prescription drugs than men.

Although data from the 2003 NSDUH found that the non-medical use of psychotherapeutic medications was the same for men and women (2.7 vs 2.6%) in the past month, more complex multivariate analyses of NSDUH data have suggested that women are more likely to misuse prescription drugs than men.³ Additionally, an overview of literature from 1966 to 2000 found that although the incidence of alcohol abuse or dependence is greater among men than among women, women with alcohol abuse or dependence are more likely to seek medical help, but are less likely to be identified by their clinicians.⁴

The use of crack cocaine has been associated with high-risk behaviors and has disproportionately affected African American women.⁵ Studies have shown that smoking crack cocaine and exchanging sex for money are co-factors for the risk of HIV infection, especially for women.⁶ Women who smoke crack are more likely than non-crack-using women to 1) sell sex, 2) have more sexual partners, and 3) have an STD.⁶ Women who use crack are also more likely to be assaulted during a sex exchange.⁷

Another study assessed the prevalence of HIV infection between individuals who smoked crack and those who did not smoke crack. The results showed that the highest prevalence rate was found among crack-smoking women. Furthermore, the prevalence of HIV infection was three times higher in women who had exchanged sex for money or drugs compared with women who did not exchange sex.⁸

B. Patterns and Impact of Use

RECOMMENDATION:

The clinician should inquire about the addiction patterns of the patient's partner(s) when obtaining a patient's substance use history.

Although fewer than 30% of new AIDS cases among women are due to injection drug use, 60% of new AIDS cases in women are classified as drug-related due to women sexually acquiring HIV from drug-using partners.

Key Point:

Women injection drug users (IDUs) are more likely than male IDUs to adopt the drug use patterns of their partners and to share needles with their partners.^{9,10}

Clinicians should counsel patients to practice risk-reduction activities including safer sexual activities, needle sharing, and other drug-using activities that have potential for exposure to blood and body fluids to prevent acquisition or transmission of HIV and other STDs. See *Working With the Active User*. For more information, refer to the CDC prevention guidelines, also available at: www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm.

Although women often start using drugs and alcohol at older ages than men, some studies suggest that women may become addicted more quickly. Some studies suggest that women undergo a “telescoped course” from using to abusing alcohol.^{4,11,12} Alcohol-dependent women are at greater risk for developing alcoholic hepatitis and cirrhosis, when alcohol consumption and duration of drinking levels are considered.¹³ Several factors, including lower body weight, lower total body water, and lower levels of alcohol dehydrogenase, may contribute to greater sensitivity to alcohol's long-term sequelae among women than men.

III. BARRIERS TO TREATMENT

RECOMMENDATION:

When referring substance-using women to drug-treatment programs, clinicians should choose programs that are best able to meet the particular needs of the individual patient.

Women's access to HIV-related care and substance use treatment is often hampered by a variety of barriers, including childcare and eldercare obligations. Such barriers should be considered in each woman's evaluation and treatment. Pregnancy may pose additional barriers because some drug treatment facilities may not provide suitable support for women who are pregnant. Women with young children may have ongoing difficulty accessing outpatient day treatment programs and residential programs because of

inadequate or non-existent childcare or nurseries. For substance-using pregnant women, the possibility of HIV testing during pregnancy or incarceration for child abuse may generate or intensify fears, suspicion, and distrust of the healthcare system and treatment programs, thereby keeping them from seeking much needed services. Fear of removal of children from the home by the welfare system, lack of financial resources, and lack of emotional support from substance-using partners are other obstacles to treatment that some substance-using women confront.

Refer to *Substance Use Treatment Modalities* for more guidance on choosing the most suitable program for the individual patient.

IV. CONTRACEPTION FOR THE SUBSTANCE-USING WOMAN

RECOMMENDATION:

Clinicians should counsel all HIV-infected women to use latex or polyurethane condoms, regardless of current contraceptive method of choice.

Key Point:

Combined oral contraceptives may be contraindicated in women with abnormal liver function.

Because combined oral contraceptives are metabolized by the liver, they should generally be avoided in women with abnormal liver function, which may be caused by alcohol abuse, acute or chronic viral hepatitis, or ARV therapy. Some drug users may prefer other forms of contraception, such as an IUD or injectable progestogens, which both reduce user dependency and menstrual flow.

V. PREGNANT HIV-INFECTED SUBSTANCE-USING WOMEN

RECOMMENDATIONS:

Clinicians should counsel both HIV-infected pregnant women and HIV-infected women of childbearing age about the specific effects of alcohol and illicit drugs on the developing fetus.

Pregnant HIV-infected substance users should be co-managed by an HIV Specialist and an obstetrical care provider experienced in the care of HIV-infected women.

Although there is no mandate in New York State to report substance use during pregnancy to child protective services, New York State law requires clinicians to report cases of suspected abuse or neglect involving other children in the household to the New York State Central Registry at 1-800-635-1522.

Many women who use drugs during pregnancy either do not disclose their substance-using behavior or avoid prenatal care and treatment because of stigmatization, fear of losing custody of their children, or fear of prosecution. Because of the possible physical adverse effects to the fetus, such use during pregnancy can provoke strong emotions in

laypersons and clinicians alike. Clinicians should educate patients in a professional, nonjudgmental manner regarding the risks associated with each substance.

Clinicians can affect a patient's drug use by screening, identifying, and counseling about drug use and the benefits of drug treatment (for description of treatment modalities, see Chapter: *Substance Use Modalities*). Studies have shown that brief interventions by clinicians can reduce the rates of hazardous drinking in pregnant women.¹⁴

Currently, there is no mandate in New York State to report substance use during pregnancy to child protective services. However, if the clinician suspects that other children in the household are being abused or neglected, the clinician must report the case to the New York State Central Registry at 1-800-635-1522.

A. Opioid Use

RECOMMENDATIONS:

If a woman who is dependent on opioids becomes pregnant, the clinician should discuss treatment options with her, informing her that methadone maintenance is preferred to detoxification. If she is already enrolled in a methadone maintenance program, the clinician should advise her to continue it.

Clinicians should arrange a consultation between a pediatric HIV Specialist and the pregnant opioid user to discuss the possibility of neonatal withdrawal syndrome and the care of the neonate.

Methadone maintenance treatment is an effective therapy for opioid-dependency during pregnancy, and does not adversely affect fetal or post-natal development. Some women receiving methadone maintenance treatment are inappropriately urged to detoxify from methadone despite scientific evidence suggesting that opioid withdrawal may result in premature labor or spontaneous abortion. Thus, initiating or continuing methadone maintenance in pregnant women is a recommended and effective strategy for treating opioid-dependency. Buprenorphine, another pharmacotherapy for opioid dependency that is available in primary care settings, is not yet FDA-approved for use in pregnant women. However, Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines suggest that since no adverse affects of buprenorphine on pregnancy have been observed in case series, its use may be considered in pregnancy on a case-by-case basis.

B. Alcohol Use

RECOMMENDATIONS:

Clinicians should recommend inpatient or outpatient treatment for alcohol-dependent pregnant women.

Pregnant women who are physically dependent on alcohol should undergo medically supervised detoxification prior to initiating longer-term abstinence-based treatment.

Key Point:

Infants whose mothers consume excessive amounts of alcohol during pregnancy are at

high risk for adverse effects, such as fetal alcohol syndrome, regardless of the HIV infection status of the mother.

Currently, there is no known exact dose-response relationship between the amount of alcohol consumed during the prenatal period and the extent of damage caused by alcohol in the infant; thus, a safe level of prenatal alcohol consumption has not been determined. The US Surgeon General and the Secretary of Health and Human Services recommend abstinence at conception and during pregnancy.¹⁵ Binge drinking has a greater negative effect on the unborn infant than consumption of low amounts of alcohol over several days.

For more information on managing HIV-infected patients who use alcohol, see Chapter: *Clinical Management of Alcohol Use and Abuse in HIV-Infected Patients*.

C. Cocaine Use

RECOMMENDATION:

Clinicians should recommend inpatient or outpatient treatment for cocaine-dependent pregnant women.

Cocaine use reduces placental blood flow and may lead to intrauterine fetal growth restriction, premature labor, or placental abruption. Although many studies on the long-term effects of cocaine-exposed infants have not found a negative association with developmental test scores when other factors are adequately controlled for,¹⁶ use of cocaine should be discouraged during pregnancy and clinicians should refer cocaine-dependent pregnant women to in- or outpatient treatment.

VI. SUBSTANCE USE AND TRAUMA IN HIV-INFECTED WOMEN

RECOMMENDATION:

Clinicians should screen all substance-using women for trauma and physical and/or sexual abuse, which may trigger or exacerbate substance use in female patients. Initial assessments of new female patients should include questions that document whether a woman has a history of past or current physical or sexual abuse.

Numerous studies have found that women in substance use treatment are twice as likely as other women to report a history of childhood physical or sexual abuse, whereas a similar association does not exist among men. Substance use and physical and/or sexual abuse seem to be bi-directional: a prior history of trauma (physical/sexual abuse or violence) may predispose a woman to drug and alcohol problems, while drug and alcohol use may predispose a woman to trauma.¹⁷ Possible mediators of this association include resulting depression, anxiety, conduct disorders, and PTSD. Sexual abuse, untreated trauma, and the attendant stigma often result in reluctance or failure to seek medical care. See the *Mental Health and Substance Use in HIV-Infected Patients* chapter for additional information on domestic and sexual violence.

References

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