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RESPONSE: APPLYING HIV STRATEGIES TO HEPATITIS PREVENTION

Eric Ennis, director of adult outpatient services for Addiction Research and Treatment Services, University of Colorado Health Sciences Center, Denver, led five ARTS clinicians in a roundtable discussion.

Janelle Blake: In the past year or two, our clients who have died were lost to liver diseases and not HIV-related diseases. This is a very important article.

Marla Corwin: It's written clearly and simply. I feel that I could give it directly to clients and say, 'Read this,' and they would understand what they're reading.

The HIV analogy

Eric Ennis: I was struck by the fact that the article suggests the same strategies and techniques that we have used for years to counsel HIV-positive clients can also be applied to counseling hepatitis C patients and for use in prevention. It seems so obvious and yet it had never crossed my mind to use HIV prevention techniques as hepatitis B and C prevention techniques.

Corwin: The HIV prevention strategies that we use, talking to our clients and screening and education, those techniques could be incorporated and applied for free. This is the kind of counseling that we already do.

Ennis: As a general rule, injection drug users who know they are infected engage in high-risk drug and sexual activities less frequently than those who are uninfected or unaware of their HIV status. In applying this to hepatitis C, we could perhaps appeal to our hepatitis C-positive clients to reduce these same high-risk practices using the same appeals we make to our HIV-positive clients—to be considerate of others, to not spread the virus, respect themselves, respect others. I just never applied this to hepatitis C clients.

Counseling is important because of clients' resistance to testing and their shock when they test positive.

Client resistance

Ennis: As an administrator, I find this article minimizes the importance of client resistance.

Corwin: The counseling is important because of the clients' resistance to testing and their shock when they test positive. They don't think, 'Oh my God; I'm going to die,' like they do when they hear they are HIV positive. But they might think, 'Oh my gosh; I have a serious illness.' They are focused on 'I have this illness,' so it takes several more sessions to explain, 'This is what it means. Have you come up with questions since the last time we talked? What are your concerns? Here, I have gathered some information for you to read. It might help you formulate some questions.'

Olivia Estep: Where I struggle with my hepatitis C clients is getting them the care they need for blood work. Even though we have all these resources, they still tend to fall through the cracks.

Daria Leslea: There has been some resistance to that initial testing, because it is also our responsibility to inform the health department that we have such-and-such numbers of positive HIV cases and such-and-such numbers of positive hepatitis cases. I've come across patients saying they didn't want to be tested because they don't want this knowledge to be shared. We tell hepatitis patients that this information is confidential; we would just like to have some numbers about the pathology of a particular disease. I've had a hard time getting this across to patients.

Even if you have testing and vaccinations available for clients, there are still some problems. Some clients are concerned about the risks of vaccinations and the side effects of medicines, some do not want to take the time, others don't want to know whether they have HIV or hepatitis. Resistance is really high, especially in the African-American community and males.

Resource constraints and strategies

Blake: My understanding is that the insured clients are tested for all the hepatitis viruses and given vaccinations, but that there isn't funding available to do that for our clients who aren't insured.

Leslea: That's true. Where is the money coming from for hepatitis A counseling or vaccinations? It seems to me that there should be a protocol, and admission to the program would ensure that these things happen.

Ennis: The article says, 'Many of these activities (for instance, educating the staff about hepatitis) do not require additional resources, and some, such as building linkages to potential affiliate programs, make good sense for any organization.' While that may be true, it's a dismissal of the time and energy it takes to incorporate extra things into treatment. Even one additional risk assessment form adds 10 minutes. We all know how hard it is to get done what we currently are supposed to do.

Imagine if we had a half-time nurse whose job it was just to meet with new patients, to talk about infections related to drug use, and to screen them, test them, and then offer vaccines. And then if we had the money for the nurse and the vaccines, think about the huge impact that would have, even if we caught one person a month who hadn't been vaccinated yet and prevented that person from getting hepatitis C. It wouldn't cost that much. The funding out there is so piecemeal and so small. It's hard to keep consistent funding. It's hard to implement this kind of prevention activity in a consistent, long-term fashion because of the scramble to get the resources.

Scott Powers: There is an organization not mentioned in the article that provides a newsletter that is a good resource for clinicians and clients on the subject of hepatitis C. It's the Hep C Connection. Their newsletter is available online at no cost at www.hepc-connection.org. &