

Hepatitis C Screening and Management Practices: A Survey of Drug Treatment and Syringe Exchange Programs in New York City

Chi-Chi N. Udeagu Pratt, MPH, Denise Paone, EdD, Rosalind J. Carter, PhD, and Marcelle C. Layton, MD

Injection drug users (IDUs) account for more than 60% of all new hepatitis C virus (HCV) infections in the United States.^{1,2} Fifty to eighty percent of new IDUs are infected within 6 to 12 months of initial injection.³ Current treatment regimens are not highly effective, and no vaccine against HCV is available.^{1,4-7}

Studies suggest that drug treatment and syringe exchange programs may play a role in reducing HCV infection among participants by promoting drug abstinence or safer injection practices among those who continue to use drugs.^{3,8-12} The New York City Department of Health conducted a survey of local drug treatment and syringe exchange pro-

grams to determine whether their HCV screening and counseling practices were carried out, as recommended in recent federal guidelines.¹

METHODS

In March 1999, a survey was mailed to the directors of 141 agencies (all 132 drug treatment programs listed in the directory of the New York State Office of Alcoholism and Substance Abuse Services and 9 syringe exchange programs). Programs were asked about (1) client characteristics, including their use of illicit drugs in the past 6 months; (2) hepatitis C screening (based on laboratory testing or client self-report) and treatment practices; (3) HCV education and counseling practices; and (4) barriers to offering hepatitis C services.

By June 1999, 99 (70%) programs had responded, including 95 drug treatment programs and 4 syringe exchange programs. Three agencies reported having no clients enrolled in drug treatment programs at the time of the survey and were excluded from further analysis. Eight agencies, representing affiliated but distinct programs that were not listed in the New York State Office of Alcoholism and Substance Abuse Services directory, completed 17 additional questionnaires.

Our analysis was based on 113 questionnaires completed by 109 drug treatment programs and 4 syringe exchange programs. Differences between programs were computed by χ^2 tests and associated 2-sided *P* values with SPSS for Windows, version 9.0 (SPSS Inc, Chicago, Ill) and Epi Info, version 6.04 (Centers for Disease Control and Prevention, Atlanta, Ga).

RESULTS

Program Characteristics

Of the 113 programs, 81 (72%) employed social workers, and 79 (70%) and 69 (61%) employed at least 1 physician and 1 nurse, respectively. Outreach workers and peer educators were employed less frequently. Sources of funding included state government (*n*=68, 60%), private (*n*=46, 41%), federal government (*n*=36, 32%), and local government (*n*=32, 28%). Most programs received the

greatest proportion of their funds from the state government.

Client Characteristics

Twenty-seven (24%) programs enrolled clients younger than 18 years; 6 (6%) drug treatment programs enrolled only clients younger than 25 years. Eighty-five (78%) drug treatment programs reported current drug use among their clients, including intranasal cocaine use (*n*=62, 73%), intranasal heroin use (*n*=53, 62%), and injection drug use (*n*=42, 49%). Three (75%) syringe exchange programs reported that their clients used previously used syringes.

Program Practices Regarding Hepatitis C Screening, Evaluation, and Treatment

Fifty-five (50%) of the drug treatment programs and none of the syringe exchange programs screened for HCV infection (Table 1), including 5 (19%) of the 27 programs that enrolled clients younger than 18 years. In the 58 programs that did not screen, reasons for not screening included the following: (1) not within the scope of services (*n*=39, 67%), (2) no health care providers on site to perform screening (*n*=10, 17%), (3) lack of funding (*n*=8, 14%), (4) clients' lack of medical insurance (*n*=3, 5%), (5) only a few IDUs enrolled in their programs (*n*=2, 3%), and (6) preferring to refer clients to other medical providers (*n*=2, 3%).

Of the 55 drug treatment programs that screened for HCV, 82% screened on admission to the program, 49% screened when liver function test results were abnormal, and 38% screened annually unless a client was known to be HCV antibody positive; 31% screened clients who were hepatitis B virus positive (Table 1). Programs that employed health practitioners (physicians and/or nurses) were more likely to screen than were programs that did not employ health practitioners (49 vs 6, *P*<.001). Ninety-six (85%) of all the programs provided hepatitis C-related referral services; only 6 (6%) drug treatment programs provided hepatitis C-specific antiviral treatment such as interferon and ribavirin on site (Table 1).

TABLE 1—Selected Program Screening, Evaluation, and Treatment Practices

	Programs	
	Yes, n (%)	No, n (%)
Screen for HCV? (n = 113)	55 (49)	58 (51)
When do you screen for HCV? (n = 55)		
On admission or acceptance to the program	45 (82)	10 (18)
When liver function test results are elevated	27 (49)	28 (51)
Annually unless client is known to be HCV positive	21 (38)	34 (62)
When client is positive for hepatitis B virus	17 (31)	38 (69)
Diagnosed clients with HCV in the past 6 mo? (n = 113)	69 (61) ^a	44 (39)
Provided referrals for clients with suspected or confirmed HCV for further medical evaluation and treatment? (n = 113)	96 (85)	17 (15)
Prescribed or recommended any treatment for HCV apart from consultation with a gastrointestinal specialist? (n = 113)	13 (12) ^b	100 (88)

Note. HCV = hepatitis C virus.

^aIncludes programs that refer clients to other medical providers for screening.

^bOnly 6 programs prescribed hepatitis C-specific treatment (interferon and ribavirin therapies). The remaining programs provided supportive or alternative therapies.

Hepatitis C Education and Counseling Practices

Ninety (80%) of programs (86 drug treatment programs and 4 syringe exchange programs) provided hepatitis C education and counseling. Nearly all programs advised their clients not to share needles (93%) and to use condoms when having sex (91%). Most consistently recommended not sharing toothbrushes or razors (78%), abstaining from or minimizing alcohol consumption (74%), using condoms in monogamous sexual relationships (69%), not frontloading or backloading (shared syringe use) (67%), and screening for HCV infection partners of clients who were HCV positive (60%). Only 34% and 46% of the programs always recommended hepatitis A virus and hepatitis B virus vaccines, respectively, to their clients. Programs that employed health practitioners were more likely to provide education and counseling than were programs with no health practitioners (75 vs 15, $P < .01$).

Barriers to Offering HCV Services

Program directors expressed the most concerns about the lack of educational and training materials for providers and clients (95 programs, 84%). Other concerns included funding and medical coverage (23 programs, 20%), need for a screening facility (16 pro-

grams, 14%), and difficulty arranging treatment with outside HCV providers (9 programs, 8%).

DISCUSSION

Our survey indicated that drug treatment programs and syringe exchange programs in New York City are engaged in varied ways in the diagnosis and management of HCV, with most providing HCV education and risk reduction counseling and treatment referrals. Nearly half of these programs already provide some form of screening for HCV (by client interview or laboratory testing). Barriers to offering hepatitis C services included lack of training and educational materials and inadequate funding. The survey also suggested that absence of health practitioners on site was a deterrent to offering HCV screening and counseling. The New York City Department of Health responded to concerns about lack of training materials for providers by developing and distributing guidelines on hepatitis C screening, diagnosis, and management to the health care community citywide.¹³

Several studies,^{9–11,14} including this survey, have found that despite enrollment in treatment programs, many clients continue to use illicit drugs and engage in practices that place them at high risk for HCV infection, such as

sharing syringes and frontloading or backloading. Because drug treatment programs and syringe exchange programs provide access to the highest-risk population for HCV, targeted screening at these facilities may prove cost-effective.^{15,16} Such targeted screening is most critically needed in programs that serve younger clients, who may have the highest incidence of HCV infection.^{3,17} Therefore, drug treatment programs and syringe exchange programs should be provided with adequate resources to initiate and expand their own hepatitis C screening programs or should be encouraged to establish relationships with agencies that can more efficiently provide screening and medical follow-up. ■

About the Authors

Chi-Chi N. Udeagu Pratt, Rosalind J. Carter, and Marcelle C. Layton are with the Communicable Disease Program, New York City Department of Health, New York, NY. Denise Paone is with the Chemical Dependency Institute, Beth Israel Medical Center, New York, NY.

Requests for reprints should be sent to Marcelle C. Layton, MD, Assistant Commissioner of Health, Communicable Disease Program, Bureau of Disease Intervention, New York City Department of Health, Box 22A, 125 Worth St, New York, NY 10013 (e-mail: mlayton@health.nyc.gov).

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Contributors

C.-C.N. Udeagu Pratt planned and organized the study. M.C. Layton conceived the study. All authors contributed to the design, analysis, and writing of the brief.

Human Participant Protection

No human subjects participated in this study.

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