

# **Critical Components of Hepatitis C Prevention Education for HealthCare Providers for Substance Users**

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# Outline

- Problem
- Provider-patient interaction
- Basics of HCV care for IDU
- Importance of Substance Use
- Importance of Mental Illness

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# Epidemiology and the Problem

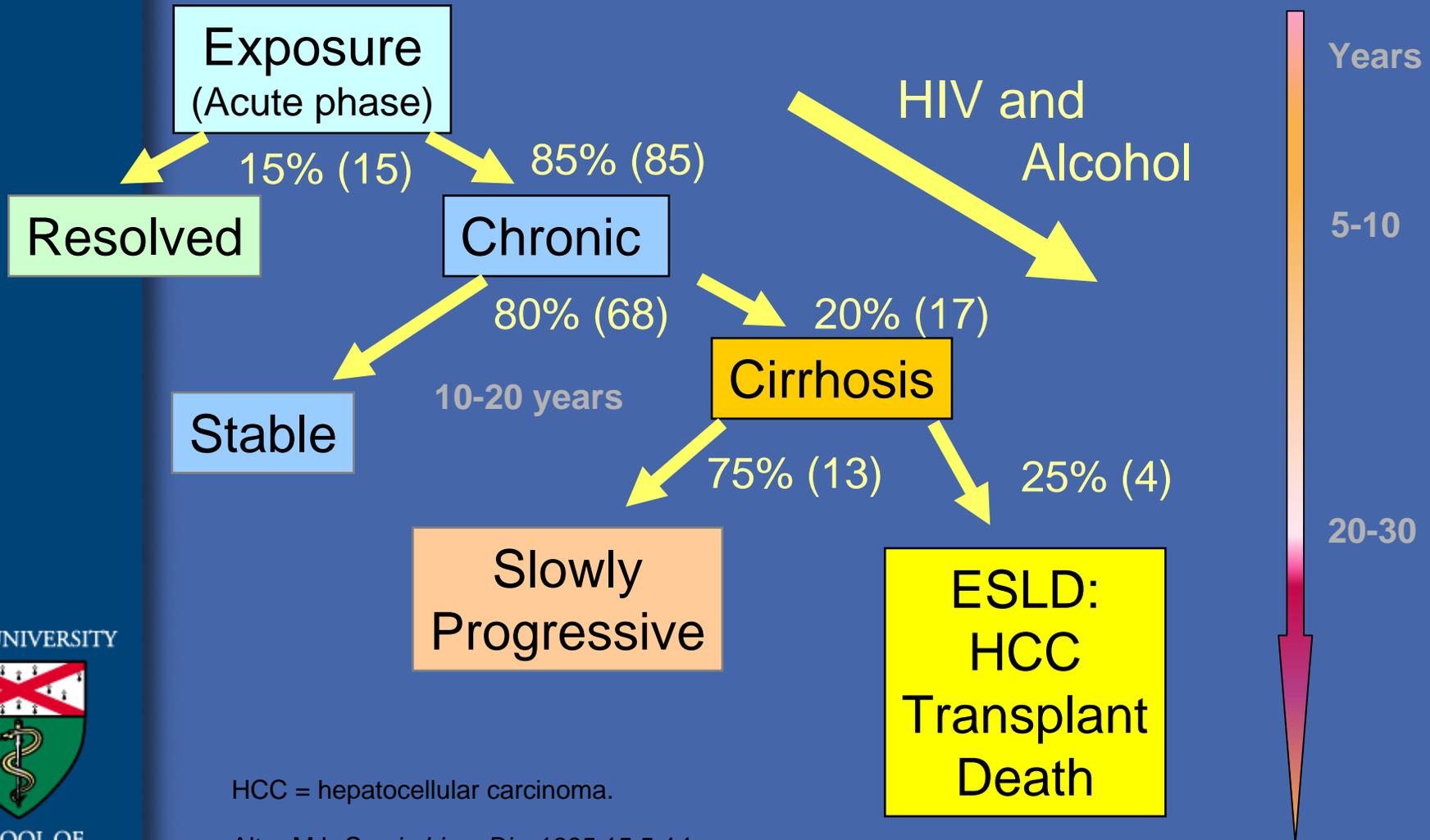
- IDU largest group with HCV infected persons
- Prevalence of HCV ab+ among IDU is b/w 80 and 90%
- CDC estimates of HIV exposure category range b/w 22 and 28% IDU
- To impact both of these epidemics will require designing and implementing effective interventions for IDUs.

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# Natural History of Hepatitis C Virus (HCV) Infection



HCC = hepatocellular carcinoma.

Alter MJ. *Semin Liver Dis.* 1995;15:5-14.

NIH Consensus Statement. Management of hepatitis C. National Institutes of Health; March 24-26, 1997.

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# Why Clinicians Won't Discuss Drug Use and Viral Infection Prevention - 1

- Chronic relapsing nature of addiction as a medical disease and heterogeneity of the population are not appreciated
- Wrongly interpret DU's antisocial behavior and substance use as a disregard for others and/or indifference to their own well-being
- Co-Morbid mental health challenges

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# Why Clinicians Won't Discuss Drug Use and Viral Infection Prevention - 2

- Mutual suspicion between clinicians and substance users
  - **Clinicians negative stereotypic views of DUs as manipulative and unmotivated**
  - **DU's distrustful of the health care system and expect to be treated punitively**
- Behavioral Skills
  - **Lack of transition strategies from treatment to prevention (e.g., provider-centered interview style)**
  - **Lack of necessary counseling skills to effectively promote drug use and HCV/HIV risk reduction**

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# Provider/Patient Relationship

- NON-judgmental
- Meet the patient where the patient is at
- A positive relationship is of critical importance
- Should encourage a dialogue where both parties can communicate openly about expectations

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# Clinical Care Strategies

- Nonjudgmental thorough history of patient's substance use, syringe use, complications, and treatment history
- Clinical assessment of pain management
- Discussion of the adverse health and social consequences of substance use and the benefits of risk reduction-abstinence
- Referral and on-site multidisciplinary team of ID/addiction specialists, mental health, social work, nurses to meet the complex treatment needs, and problematic behaviors of patients.

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# Clinical Care Strategies

- Define and agree on roles and responsibilities b/w provider and patient
  - **Formal treatment contract-specify services, expectations & behavior consequences**
- Set limits & respond consistently to behavior that violates those limits.
- Consider acute substance administration and neurological disease when evaluating behavior change (e.g., utox)
- Recognition and praise for risk reduction implementation (MET model)
- Expect relapse, but don't give up – plan for it.

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# Care for HBV/HCV Infection

- Screening for at risk behavior
- Testing for HCV, HIV, HBV, HAV
- Prevention counseling and education
- Vaccination for A and B as needed
- Evaluation for comorbidities
  - **Substance abuse services (e.g., BUP)**
  - **Psychiatric care**
  - **Social support**
  - **Liver disease evaluation (AFP, bx, etc.)**
  - **IFN-based therapy for HCV or antiviral therapy for HBV**

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# HCV care and Substance Abuse

- May be the cause of infection (e.g., IDU) and may lead to fears of re-infection
- May affect adherence to therapy
- May worsen the underlying illness (e.g., ETOH).
- Therefore, substance abuse must be identified at the outset of therapy

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# Treatment plan for SA

- Behavioral therapy and pharmacotherapy should be combined
- Behavioral therapies include both brief interventions and long-term comprehensive psychotherapy
- Pharmacotherapy is available for both opioid dependence and alcohol dependence, both of which are complicating factors in HCV care and treatment.

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# Pharmacotherapy for Opioids in HCV

- Both are substitutionary therapies
- Methadone
  - **Must be through SAMHSA regulated OTP**
  - **Full agonist**
  - **Drug-drug interactions with HIV therapy**
- Buprenorphine
  - **DATA 2000 allows for office-based use**
  - **Partial agonist (less diversion, safer)**
  - **Drug-drugs interactions less worrisome**

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# Pharmacotherapy for Alcohol in HCV

- Relapse prevention – are NOT substitutes
- Naltrexone
  - **Mu-opiate antagonist**
  - **Reduced reward effect**
  - **Cannot be used with opiate agonists**
- Acamprosate
  - **Normalizes glutamate neurotransmission**
  - **Reduced reward effect**
  - **Can be used with opiate agonists**
- Naltrexone and acamprosate work better together than separately; adherence is a greater problem than in opiate substitutionary therapy

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# Mental Illness

- Prevalent in this population and therefore evaluation for underlying mental illness should be routine (see Basu for review, et al).
- Often interrelated with substance use (e.g., “self-medication”) .
- Anti-viral therapy is rarely an emergency and this affords an opportunity to insure mental health is stabilized prior to therapy.
- May improve with treatment towards the infectious disease (neurocognitive effects of HCV?) or worsen with treatment (IFN)

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# Challenges

- Both SA and MH complicate therapies for infectious diseases such as HIV/HCV.
- Difficulties with adherence to therapies may be the result of relapse into SA or the unmasking of MH

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# Summary

- A strong patient-provider relationship is important
- Patients with HCV need screening for other viral infections, risk reduction counseling, and appropriate medical therapy.
- Patients should be screened and treated in substance abuse
- Patients should be screen and treated for underlying mental illness

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# Suggested Reading

- Kresina TF, Bruce RD, Cargill VA, and Cheever LW. "Integrating HCV Care and HIV Primary Care for the Injection Drug User Coinfected with HIV and HCV." *Clinical Infectious Diseases* July 2005; 41:S83-88.
- Kresina TF, Eldred L, Bruce RD, Francis H. "Integration of Pharmacotherapy for Opioid Addiction into HIV Primary Care." *AIDS* 2005, 19 (suppl 3): S221-S226.
- Basu S, Chwastiak LA, Bruce RD. "Clinical Management of Depression and Anxiety in HIV-Infected Adults." *AIDS* 2005, 19:2057-2067.

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