



RESPONSE: A CASE FOR COLLABORATIVE CARE

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Rachel Gonzales: My background is in looking at ways to assess hepatitis C accurately and in identifying outcomes that may have been affected by the combination of hepatitis C and continuous drug use. For example, we have begun to look at whether methamphetamine may be a particularly risky drug to abuse because of its association with high-risk sexual practices.

For those of us who don't have a medical background, Dr. Sylvestre's article (2007) is an excellent clinical overview. From a research perspective, the article points to several areas where studies may contribute to more effective clinical management and outcomes.

David Perlman: I'm an infectious disease physician and have done a lot of work in the health service aspects of infections in drug abusers—for example, we are currently studying how best to screen methadone participants for hepatitis A, B, and C and then link them to vaccinations or appropriate care.

Dr. Sylvestre's main point bears repeating: Despair is unwarranted. There is a lot of hype about this disease, and people can get very scared. However, as she points out, a significant percentage of patients have spontaneous remissions; treatment can be highly effective; and even infections that do not respond to treatment do not always progress to advanced liver disease.

Gonzales: Ideally, substance abuse clinicians' attention to hepatitis C should commence at the time the patient first enters treatment. You want to find out if the patient has hepatitis C so that you can provide appropriate additional screening, education, referral, and monitoring.

Perlman: As Dr. Sylvestre says, hepatitis C screening should be standard for people at risk—which includes most people entering substance abuse treatment. The sooner you find out a patient has hepatitis C infection, the sooner you can begin managing it. Alternatively, the sooner you know someone is not infected, the sooner you can reinforce behaviors to keep them that way.

Gonzales: I agree absolutely. It's terribly important to include messages for drug users who aren't yet infected in our models for preventing hepatitis C.

Perlman: Along with warning patients about the risk of injections with nonsterile or reused equipment, the messages might discuss heightened risks that are associated with the specific places and contexts in which people inject drugs. For example, data indicate that injecting drugs outdoors is generally riskier than injecting drugs indoors and that infection rates are especially high among people who inject drugs in shooting galleries. The reasons may have to do with the sharing of paraphernalia or other behaviors that occur in these settings. Whatever the reasons, this is good information to share with patients.

Gonzales: The issue of whether continuing drug abuse affects the potential toxicities of hepatitis medications or the progress of the disease is obviously very significant for clinicians. One key to answering this and many other issues will be getting accurate assessments of the time of onset of hepatitis C, especially in long-term drug abusers. That information will enable us to untangle all these relationships—what's due to the drugs, the infectious disease, the medication, or any of these together.

Perlman: The question of reinfection as a potential consequence of drug abuse or risky sexual practices comes up sometimes. Dr. Sylvestre cites data showing that this has not been an overwhelming problem in study populations so far. Clearly, there is a potential for reinfection, but just as clearly and more importantly, the fact that someone may relapse is no reason not to give all the care he or she needs. After all, we don't deny treatment to substance abusers with HIV infection, even though reinfection is possible there, too.

Program collaboration, system integration

Gonzales: I would like to see research on what substance abuse programs around the United States are doing in the area of infectious disease management and education, to set a context for moving forward. In the programs I have observed, addiction specialists have played a more limited role in hepatitis C management and education than is optimal.

Perlman: Dr. Sylvestre does well to point out that patients may benefit from being co-managed by an addiction specialist and someone with expertise in hepatitis C. The role of addiction specialists is crucial. They are uniquely equipped to help patients reduce or eliminate their alcohol intake. That is enormously important, because we know that the hepatitis C virus and alcohol are synergistically toxic. Similarly, anyone who screens patients and helps them avoid or get treated for concomitant hepatitis A and B does them a tremendous service. The vaccines for hepatitis A and B are very safe and highly effective. Addiction professionals can also monitor and provide support for the mental health issues that typically arise

in patients with hepatitis C, either as co-occurring problems or as complications of treatment.

There are many situations in which substance abuse treatment providers' input can be decisive. For example, methadone-maintained patients sometimes have symptoms that they perceive to be opiate withdrawal, but are, in fact, interferon side effects, or vice versa. When this happens, substance abuse professionals and hepatitis caregivers can together tease out whether the patient's methadone dosage or interferon dosage should be adjusted.

Gonzales: Substance abuse treatment providers and physicians who treat hepatitis need to practice collaboratively to treat this population. The psychosocial interventions and hepatitis medication regimens both place great demands on patients. Providers of both services can motivate patients to stay engaged in each other's, as well as their own, treatment programs.

Perlman: Dr. Sylvestre says it is difficult to find people to provide hepatitis care for drug abusers, but that has not been my experi-

ence. Many caregivers and resources are available and waiting for patients to show up. The problem lies in the lack of integration between substance abuse and hepatitis treatment systems. We need to find ways to motivate substance abusers to get screened, to consider biopsy and treatment, and to become engaged and keep appointments. As things stand, the vast majority who receive referrals for possible hepatitis treatment never follow through.

Gonzales: Learning how to integrate better models of hepatitis C screening and referral into substance abuse treatment programs is the subject of some of my research. One project in the works is to begin to examine some of the access barriers and service gaps that affect treatment coordination.

Perlman: We, too, are looking at ways to try to enhance these outcomes. It is clear that standard referral and education do not engage or keep drug abusers in hepatitis C care for terribly long. We are testing a model that mixes case management with some brief motivational interviewing. I think it has the potential to be useful for

drug abusers with hepatitis C, but we won't know if it works until we finish our study.

Gonzales: Motivational interviewing is an important part of the followup as well. We're going to be investigating its use at discharge to foster the coordination of aftercare services.

Perlman: I endorse Dr. Sylvestre's encouragement of substance abuse clinicians not to be nihilistic about approaching drug abusers to be screened and to consider treatment for hepatitis C. On one point, though, I think she overstates what the data show. That's when she interprets one study as suggesting that hepatitis C may follow a more benign course in drug abusers than in nonabusers. Overall, I don't believe there are convincing comparative data to show that the disease's natural history and response to treatment are truly better among drug abusers than among nonabusers. That said, these patients don't need to do any better than others to merit the same fair treatment that any patient should get.

REFERENCE

Sylvestre, D., 2007. Hepatitis C for addiction professionals. *Addiction Science & Clinical Practice* 4(1):34-42.