Hepatitis C among DU in the Netherlands

The situation and the policy

Esther Croes, MD PhD
Senior research associate Drug Monitoring and
Dutch Focal Point for the EMCDDA

Trimbos instituut
Netherlands Institute of
Mental Health and Addiction

Historical background

Early heroin problem (early 1970's)
Injecting most popular between 1970-1985
Early rise of HIV epidemic (1980's)

Early harm reduction measures:

- Needle exchange started mid 1980's
- Needle exchange at full capacity 1990
- Methadone programs started in 1981
- Methadon programs reached 80% of IDUs mid 1980's
- cART widely available since 1996

The size of the HCV problem

Estimated HCV prevalence in Dutch drug users: 63%
(Wiessing et al, 2004)

drug users:
Opiate users: ~17,700 (Cruts&van Laar, 2010)
Opiate users in treatment: >12,000 (LADIS, 2011)
Crack users in treatment: >6,000 (LADIS, 2011)
Current injecting: ~10% (LADIS, 2011)

Also ex-DUs may be infected
Estimate: **20,000 exposed to HCV through IDU**
(Kretzschmar, 2004)
Number HCV carriers identified ??? (only a minority)

HCV dynamics

Amsterdam Cohort Studies (ACS) among DU, since 1985

HCV **incidence** has strongly declined in the last years, both in ever-injectors and in never-injectors
Incidence rate since 2005: 0.35 cases/ 100 person years (Grady et al, 2012)
Incidence rate (IDU and non-IDU) in 2010: 0/100 p.y.
(van Sighem et al, 2011)

HCV **prevalence** is substantial
Modelled prevalence of chronic HCV infection in (ever) injecting drug users in Amsterdam (n=4353): 80.7% (Matser et al, 2011)

Economical considerations

A former Dutch Minister of Health considered HCV to be a heavily bearing and expensive public health problem (Hoogervorst 2005)

Screening of IDUs can be cost-effective:

- Every 1.6 test will identify a HCV carrier
- This is substantially higher than in other risk groups (Kretzschmar 2004)

Treatment of IDUs is as expensive as treatment in other risk groups (Helsper et al, 2012)

Treatment costs

Real life costs of treatment with ribavirin and peg-interferon
Health care perspective (# consultations, admission to hospital, length of stay, medication use, # diagnostic tests, homecare, etc.)
Not including indirect costs such as absence from work

Mean treatment costs

	genotype 1 and 4	genotype 2 and 3
All patients, irrespective of treatment outcome	€ 12,900	€ 9,900
Sustained viral response	€ 15,500	€ 10,100
Patients with a relapse	€ 16,800	€ 12,100
Costs per cured patient	**€ 28,500**	**€ 15,400**

Treatment practice

HCV treatment responsibility in hospital
HCV treatment support by addiction care

Throughout the country 11 addiction care institutes
Limited # of locations have a regular program for HCV treatment support

Municipal health service Amsterdam also offers active HCV treatment and support (DUTCH-C)

Number of active DU treated for HCV ???
max several hundreds

Organisation of HCV support

Highly different between locations

Ranging from identification of HCV-positive patients and referral, to almost complete package of HCV treatment

Increasingly, HCV physician or HCV nurse has a (weekly) consultation moment IN the addiction care (methadone posts)

Policy

There is no national HCV strategy
Several (generic) HCV guidelines are in place
Addiction care: national network for infectious disease and harm reduction
Hospital care: recently specialised hepatitis centres throughout the country

Guidelines (1)

Guideline from the centre of infectious disease control (agency of the Ministry of Health)

- Treatment should be considered in all patients with RNA-HCV
- Contra-indications should be taken into account before starting treatment, including: level of fibrosis, chance on SVR (a.o. depending on HCV genotype, viral load, HIV status), expected side effects, compliance of the patient
- An active risk reduction policy is implemented, including NSP, methadon maintenance, counseling and testing for HCV, drug user rooms, education on safer injecting, and discouragement of injecting.

Guidelines (2)

Guideline from the professional organisation of treating gastro-enterologists/ hepatologists

- Consider treatment in all patients with a chronic HCV infection
- Absolute and relative contra-indications are formulated, but drug use is not one of those
- Update expected spring 2013, including treatment with protease inhibitors boceprevir and telaprevir

Guidelines (3)

Guideline education, screening and treatment for HCV in detention (2012) (Ministry of Justice)

- Step by step summary of all actions to be taken, including cooperation with other fields (addiction care, hospital, social work, GP)
- Focus on continuity of care
- Start of hepatitis C treatment in prison is only permitted when the detainee has a remaining sentence duration that will exceed the length of the hepatitis C treatment

(Note that the sentence of DU is on average < 6 months)

Guidelines (4)

Guidelines from addiction care

- Guideline “RIOB” (updated 2012) focuses on methadone maintenance therapy and all related aspects
- Guideline “MDR” (expected medio 2013) is a multidisciplinary guideline also including heroin treatment
- Patients should be tested on HCV at intake and every year in case of risk behaviour
- No description of HCV treatment support
- Topic HCV is only present in 1/~150 pages

C/ little attention for HCV from the addiction care guidelines

DRID Support for addiction care

The Ministry of Health finances the national Network Infectious Diseases & Harm reduction in Drug Users
Several websites for drugs users with hepatitis C are developed (e.g., sickofit.nl, hepikhepatitis.nl)
Regular meetings with infectious disease experts (nurses) in addiction are organised for information exchange
Comprehensive guidelines and Factsheets on infectious disease and related topics are published (e.g., depression in HCV patients; aftercare)

Summary HCV in DU in NL

DU are among the highest HCV risk groups
Few HCV carriers have been identified
Screening of DU is cost-effective
Screening is moderately embedded in regular care
Treatment of DU is as expensive as treatment of other risk groups
Treatment is feasible (support is needed)
(treatment options have improved)
Treatment is described in relevant guidelines

BUT

HCV treatment uptake in DU is very low

Actions taken

Nationwide HCV information campaign (’09/’10)
Effectiveness study of the information campaign
Study on factors hampering the implementation of HCV trajectory on a larger scale
“Break through” project to be started this spring

HCV Information campaign

Health Council advised to provide information on improved treatment options on a large scale
Nationwide campaign in 2009/2010 (6 months)
Targeting drug users, migrants, and receivers of a blood transfusion <1992 (+general public)
Including addiction care, GPs, MHS and mass media

Aim: to increase level of knowledge
Assumption:

- increased level of knowledge will increase risk perception
- risk perception will increase motivation for testing

Implementation of the campaign

Participation of relevant locations in addiction care was limited
>3000 flyers have been distributed
1424 counseling talks have been performed
761 HCV tests have been done

(Note that >12.000 methadone clients are registered, who have 33 registered contacts with any care taker in addiction care per year, excluding the methadone contacts)

C/ The reach of the campaign was limited

Effectiveness of HCV campaign

KNOWLEDGE:
In DU exposed to the campaign, a small but statistically significant increase of HCV knowledge was found
Increased knowlegde is associated with a *decreased* willingness to test ("Now I know what treatment is like, I would rather not know whether I am infected")
In HCV-positives: increased knowlegde is *not* associated with decreased willingness to be treated
C/ in DU reached, the campaign was effective
C/ right amount of information at the time

NUMBERS: counseling talks, tests and treatment

Barriers in HCV treatment

Complex, time consuming trajectory

Limited focus on somatic disorders in addiction care

- Difficult to organise dedicated hours (management)
- Difficult to incorporate HCV trajectory in existing somatic care procedures (floor)

Organisational aspects in addiction care

- Instability in team (esp. MDs)
- Lack of knowledge, lack of communication
- “Tired of constant changes”

External barriers

Financing system: only hospitals are reimbursed for the HCV treatment

- Addiction care has no “code” for their supportive role, they have to finance it from the methadone budget

Registration systems are insufficient to find results and follow HCV test and treatment progress

Hesitation of treating physicians in hospitals

“Break through” HCV project

Systematic and well known method for change
Short PDCA cycles, total time 1.5 yr
Expert group for advice (experts in HCV treatment in addiction care, “break through” experts, financial experts)
8-10 teams (addiction care, incl manager, hospital)
Work out a “path” to bring drug users in addiction care to HCV treatment
Test and consolidate the path
Disseminate the path in the institution