

Clinical Memorandum

Treating hepatitis C

February 2020



Authorising Body:	Board
Responsible Committee(s):	Committee for Evidence-Based Practice
Responsible Department:	Practice, Policy and Partnerships
Document Code:	CM PPP Treating hepatitis C

Purpose

This clinical memorandum provides information and guidance to psychiatrists to facilitate better healthcare for people living with mental illness who may also have, or be at risk of contracting, hepatitis C. Given recent advances in the treatment of hepatitis C virus, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) recognises the need to improve knowledge about hepatitis C treatment among psychiatrists.

Key messages

- People with hepatitis C have higher rates of mental illness, including substance use disorder, and people living with mental illness are themselves at increased risk of infection.
- Advances in hepatitis C treatment present potential significant benefits for many people living with mental illness.
- Shared care is particularly important in the treatment of hepatitis C. Optimal treatment requires effective communication and collaboration between health professionals including psychiatrists, physicians and general practitioners.
- Psychiatrists are well placed to screen for hepatitis C and liaise with treating practitioners to ensure people with hepatitis C obtain appropriate treatment.
- Psychiatrists working in services with high prevalence rates for hepatitis C should consider upskilling to provide direct treatment for uncomplicated cases with support from local hepatology and/or infectious diseases services where required.

Background

It is estimated that hepatitis C affects around 50,000 New Zealanders and 230,000 Australians (1, 2). Around 75% of people infected with hepatitis C develop chronic infection (2, 3), which is associated with significant morbidity and mortality. New infection rates are increasing in Australia (2) and some health professionals have expressed concerns that advances in hepatitis C treatment may have contributed to complacency about the risk and seriousness of infection among at-risk population groups. People who may have a higher risk of hepatitis C are those who:

- inject drugs, or have injected drugs in the past
- have been in prison
- had a blood transfusion in Australia before February 1990, or more recently in another country
- have a mother with hepatitis C infection
- have a sexual partner with hepatitis C infection
- are HIV positive
- have had haemodialysis

- were born in, or have had medical procedures in a country with a high prevalence of hepatitis C
- have had a tattoo or body piercing done by someone with poor infection control practices
- have had other blood to blood contact with another person (4).

People with hepatitis C have higher rates of mental illness and people living with mental illness are themselves at increased risk of hepatitis C infection, largely due to their higher rates of substance use (5, 6). Studies suggest prevalence rates of up to 28% for depressive and anxiety disorders among people with hepatitis C; some Australian studies have suggested even higher rates (5). Studies on the incidence of hepatitis C in Australia estimate 88.7% to be through injecting drug use (7).

Psychiatric comorbidities, including substance use disorder, can present significant complications to clinical management of hepatitis C. Comorbidities may reduce treatment access, compromise treatment adherence, impair treatment outcomes, increase fatigue and somatic distress, and decrease overall quality of life (3, 5, 8). Coinfection with hepatitis C and HIV may present particularly complex psychiatric complications due to the psychiatric comorbidities associated with both viruses (9, 10). Substance use may result in further physical complications including exposure to other blood-borne viruses and increased strain on the liver (3). As a result, various hepatological–psychiatric models of care have been developed in order to manage psychiatric comorbidity during hepatitis C therapy (8). The [Hepatitis Australia](#) website contains more information on hepatitis C and developments in treatment .

Treatment of hepatitis C

Advances in hepatitis C treatment present potential significant benefits for many people living with mental illness. New direct-acting antivirals (DAA) have been shown to be effective in treating hepatitis C with a success rate of over 95% (11). DAA treatment regimes can be used for treatment-naïve people as well as those who have failed previous attempts at therapy; even people with liver cirrhosis may be treated successfully although they require more extensive follow-up (2). Furthermore, there are no known psychiatric side effects from DAA treatment.

Previously, hepatitis C treatment centred on interferon, the use of which could produce a range of serious side effects including neuropsychiatric adverse events. Interferon is estimated to produce neuropsychiatric side effects in up to 40% of treated individuals with 20–30% developing depressive symptoms. Other potential reactions include mania, psychosis and suicidality (8, 12, 13). Interferon may also exacerbate pre-existing psychiatric conditions and is therefore contraindicated for people with uncontrolled psychiatric symptoms (8, 14). As a result of the side effect profile of interferon, it is estimated that around 20% of people did not complete treatment; even of those who did, only 50–60% were cleared of the virus (11). While DAAs present clear clinical benefits over interferon, the latter may still be used as a salvage therapy for people who do not respond to interferon-free therapies (2); in these situations, care should be taken to mitigate the potential neuropsychiatric risks. DAAs confer a minimal risk of additional neuropsychiatric side effects. Up-to-date information on medicines is available on the [NPS Medicine Wise](#) website (15).

Unfortunately, uptake of DAAs has been relatively low among people with hepatitis C in both New Zealand and Australia (2, 16). There may be various reasons for this including lack of knowledge among health professionals and the stigmas attached to HCV, mental illness and injecting drug use (6, 11, 13). In Australia the first of the new pan-genotypic DAAs, sofosbuvir/velpatasvir was added to the PBS list in 2017 (17); and glecaprevir/pibrentasvir was added in 2018 (18).

Best-practice

In order to prescribe DAA for hepatitis C, the following criteria must be considered:

- The person must be aged 18 years or older.
- The person must be treated by a medical practitioner or an authorised nurse practitioner experienced in the treatment of chronic hepatitis C infection; or in consultation with a gastroenterologist, hepatologist or infectious diseases physician experienced in the treatment of chronic hepatitis C infection.
- The details of the hepatitis C genotype.
- The person's cirrhotic status (non-cirrhotic or cirrhotic) (19).

Psychiatrists and in particular addiction psychiatrists, working in consultation with gastroenterologists, hepatologists and infectious disease physicians may be eligible to prescribe DAAs to patients suffering from chronic hepatitis C infections. Psychiatrists are well positioned to assist in screening and identifying people with hepatitis C, and facilitating treatment access. This is especially important for people living with mental illness who may not have accessed medical care for some time, and for whom a psychiatrist may act as a first point of contact into the medical system. Considering the established associations between mental illness and hepatitis C, psychiatrists have a vital role to play in increasing uptake of DAAs and advocating on behalf of patients to increase access. In order to fulfil this role, it is essential that psychiatrists have suitable knowledge about disease progression and treatment options, as well as an understanding which may facilitate hepatitis C screening and treatment (6). Psychiatrists who wish to become prescribers of DAAs will require experience in the treatment of chronic hepatitis C infection, or they will need to work in consultation with a gastroenterologist, hepatologist or infectious diseases physician experienced in the treatment of chronic hepatitis C infection.

Although DAAs do not present the same neuropsychiatric risks as interferon-based therapies, there is still a significant risk of adverse interactions between DAAs and some psychotropic medicines (8). Potential consequences of drug–drug interactions include increased toxicity, decreased exposure of either/both therapies, and the exacerbation of side effects which may lead to poor treatment adherence, viral breakthrough and the development of resistance. Sockalingam et al., 2013 provides detailed tables of drug interactions with psychiatric medications (8). The University of Liverpool have also developed an [interactive tool](#) to check potential interactions with hepatitis C medications.

Achieving adherence to treatment can be particularly challenging in the presence of psychiatric comorbidities (8, 20). When treatment is completed successfully, counselling or other psychiatric treatments may be useful to mitigate future risk associated with substance use and risk behaviours (13). As such, psychiatrists play a vital role in supporting people living with mental illness and hepatitis C to maintain treatment and obtain further care as required.

Shared care is particularly important in the treatment of hepatitis C. Optimal treatment requires effective communication and collaboration between health professionals including psychiatrists, physicians and general practitioners. The importance of a multidisciplinary approach to treatment has been recognised for some time with a number of established models of care which utilise the expertise of various health professionals to address issues which may be associated with hepatitis C infection (14, 21).

Health services can also play an important role in facilitating treatment referral pathways and implementing screening and education programs. Education and counselling programs have been found to improve screening rates among people with mental illness (22) while treatment compliance may be encouraged through the use of community nursing programs and mobile health care models (13). There is also robust research demonstrating the effectiveness of supervised injecting centres in mitigating risks associated with intravenous drug use (23).

It is important to consider different approaches and considerations that may be required for different population groups. For instance, successful treatment for people who inject drugs will require collaboration with specialists in substance use disorders (24).

Recommendations

To optimise health outcomes, the RANZCP recommends that psychiatrists:

- advocate to promote treatment for hepatitis C, and liaise with treating practitioners to ensure people obtain adequate treatment
- support people undergoing treatment, giving due consideration to individual risk factors and potential interactions of direct-acting antivirals with psychotropic medicines
- provide advice and referrals to individuals with hepatitis C
- work closely with other health professionals, including gastroenterologists and liver specialists, in multidisciplinary and shared care teams
- encourage psychiatric services to screen people as part of their protocol.

The RANZCP also recommends that health services institute robust processes to facilitate screening, education and counselling programs, as well as strong treatment referral pathways.

Further reading

Hepatitis C Virus Infection Consensus Statement Working Group (2018) [Australian recommendations for the management of hepatitis C virus infection: a consensus statement](#). Melbourne: Gastroenterological Society of Australia.

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REVISION RECORD

Contact:	Executive Manager, Practice, Policy and Partnerships Department		
Date	Version	Approver	Description
02/2020	1.0	B2020/1 R25	New document
02/2021	NEXT REVIEW		

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