TITLE PAGE

Title: Optimizing assessment and treatment for hepatitis C virus infection in illicit drug users: a novel model incorporating multidisciplinary care and peer-support

Short title: Optimizing HCV assessment in drug users

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Abstract (250 words)

Objectives: We evaluated assessment and treatment for HCV among illicit drug users accepting referral to a weekly HCV peer-support group at a multidisciplinary community health centre. **Methods:** From March 2005 to 2008, HCV-infected individuals were referred to a weekly peer-support group and assessed for HCV infection. A retrospective chart review of outcomes three years following the initiation of the group was conducted (including HCV assessment and treatment). **Results:** 204 HCV antibody-positive illicit drug users accepted referral to a weekly HCV peer-support group. Assessment for HCV occurred in 53% (n=109), with 13% (n=14) having initiated or completed treatment for HCV infection prior to attending the support group, evaluation ongoing in 10% (n=11) and treatment deferred/not indicated in 25% (n=27). The major reasons for HCV treatment deferral included early disease (30%), drug dependence (37%), other medical (11%) or psychiatric co-morbidities (4%). Sixty-eight percent of those deferred for reasons other than early liver disease demonstrated multiple reasons for treatment deferral. The first four weeks of support group attendance predicted successful HCV assessment (OR 6.03, 95% CI 3.27-11.12, $p<0.001$). Overall, 28% (n=57) received treatment. Among individuals having completed pegylated-interferon and ribavirin therapy with appropriate follow-up (n=19), the rate of SVR was 63% (12/19), despite illicit drug use in 53%. **Conclusions:** A high proportion of illicit drug users accepting referral to a weekly HCV peer-support group at a multidisciplinary health centre were assessed and treated for HCV infection. Peer-support coupled with multidisciplinary care is an effective strategy for engaging illicit drug users in HCV care.

Keywords: illicit drug users, injection drug users, hepatitis C virus, treatment, assessment

INTRODUCTION

Injection drug use accounts for >50% of existing and >75% of new cases of hepatitis C virus (HCV) infection in most developed nations [1]. Further, the prevalence of HCV infection among injection drug users (IDUs) is high and ranges from 65 to 90% [2, 3]. Although 25% will spontaneously clear their infection, the majority will develop chronic HCV infection and over decades will be at risk of developing cirrhosis, end stage liver disease and liver cancer [4].

Despite the long term consequences of HCV infection, uptake of treatment is low. Data from cohorts of illicit drug users in Canada, the United States and Australia have demonstrated that only 1 to 6% of infected individuals have received treatment for HCV [5-8]. This can be attributed to both physician and patient-associated factors. Firstly, treatment for HCV infection among illicit drug users is often withheld by physicians based on concerns of adherence, other medical co-morbidities, treatment side-effects and the potential for re-infection [9]. Secondly, poverty, psychiatric co-morbidities and poor social support are common among illicit drug users and HCV treatment may not be a high priority for them at any given time [10]. However, such treatment among current and former illicit drug users has been shown to be safe and successful [11-26] and rates of re-infection to date are low [13, 27, 28].

One strategy that has been proposed to enhance assessment for HCV infection is the integration of multidisciplinary care and peer-support. Sylvestre and colleagues at the Organization to Achieve Solutions in Substance-Abuse (O.A.S.I.S) have developed a successful peer-based

group model for engaging and educating HCV-infected patients [29]. This model was incorporated into an existing multidisciplinary program for the treatment of HCV infection among current and former illicit drug users in the inner city of Vancouver [24]. We evaluated the uptake of assessment and treatment for HCV infection among illicit drug users referred to a weekly peer-support group over a three year period at a multidisciplinary community health centre in Vancouver.

METHODS

All patients were HCV antibody positive illicit drug users attending an inner city multidisciplinary health clinic located in Vancouver, Canada. The Pender Community Health Centre provides primary care for an estimated 1,500 clients in the area. It also offers addiction services including methadone maintenance therapy, needle exchange, and counseling. There are up to seven physicians, four registered nurses (including a dedicated HCV research nurse), six drug and alcohol counselors and on-site infectious diseases specialists. Beginning in January 2002, this clinic initiated a program for the treatment of HCV infection among current and former illicit drug users. A description of this program and outcomes among the first 40 individuals receiving treatment up to March 2005 was published in 2007 [24].

Starting in March 2005, a weekly HCV support group was established at this clinic based on the O.A.S.I.S model developed in Oakland, CA by Sylvestre and colleagues [20]. The weekly peer-based HCV support group began by inviting participants previously treated for HCV infection to form the core of the group. HCV-infected individuals were then formally referred to the group by physicians, nurses and addiction counselors during regular clinic visits. The peer-support group was facilitated by an addictions counselor, with additional support from research staff. Initially, the support group began on Friday mornings, with a small breakfast and lunch being provided in the context of a two hour session.

In November 2006, research and counseling staff began conducting outreach in the community (which included informal HCV education for individuals attending addiction treatment centres, detoxification facilities and social services centres). This was accompanied by an increase in the number of people presenting to the clinic for participation in the group. As the number of participants consistently remained above 20 per week, two additional groups were added in November 2006 (Wednesday mornings, female-specific) and January 2007 (Thursday mornings). The female-specific group was developed in response to a request made by the women themselves, and was facilitated by a female HCV research nurse and female research staff.

Groups began with introductions and facilitators encouraged participants to discuss experiences related to HCV infection, including knowledge of HCV, issues of drug use, other lifestyle issues and personal experience with HCV treatment, if applicable. This provided an opportunity for treatment candidates to interact directly with those that were receiving or had completed treatment and to gain insight into the evaluation of liver disease and what to expect during this evaluation and subsequent treatment. As has been described previously by Sylvestre et al. [29], the addictions counselor would encourage the delivery of information using a Socratic approach, in which question-based inquiry is used to elicit answers from audience members, and to encourage active participation in the learning process. The counselor or researcher would be available to address any factual issues or add to the discussion.

Attendance to the once-weekly groups was not mandatory, but was recorded from the first day that the patient attended the group and monitored at subsequent weekly meetings. During the group sessions, nurses and physicians would also see patients one-on-one, performing medical assessments to determine treatment eligibility, HCV laboratory testing (phlebotomy provided on-site), treatment education and ongoing assessments during antiviral therapy.

Funding for HCV treatment in the province of British Columbia is provided through government programs and is either partially or fully reimbursed (based on patient income level). The clinical criteria for government reimbursement are: documented viremia, along with either elevated alanine aminotransferase (ALT) enzyme levels (1.5 times the upper limit of normal on 2 occasions at least 3 months apart) *or* liver biopsy demonstrating at least Knodell stage 2 fibrosis with no evidence of decompensated cirrhosis. Men and women $\geq$19 years of age who fulfilled these criteria for subsidized treatment and those adhering to pre-treatment assessment visits were eligible. Patients with any cause of chronic liver disease other than HCV, pregnant or breastfeeding women, those with active suicidal ideation or uncontrolled depression, or those otherwise judged inappropriate for treatment by their physician were not offered treatment for HCV infection.

Once a patient was established to be a candidate for treatment by the multidisciplinary care team [based on attendance to pre-treatment medical evaluations, social stability (e.g. stable housing) and absence of medical or psychiatric co-morbidities], a clinic physician completed a medical history and physical examination. Patients underwent testing for HIV, HCV and hepatitis B virus

as well as baseline hematology and biochemistry testing. Other potential causes of hepatic disease were also ruled out, as appropriate. Nursing staff provided education about treatment and side effects. Patients were required to see an addiction counselor to assess psychiatric status (depression and suicide risk), social stability and illicit drug use patterns, with an emphasis on ongoing risk for HCV transmission. Once therapy was initiated, patients attended the clinic weekly to be evaluated by a nurse. Patients received combination therapy with ribavirin (RBV, 800-1200 mg/day, based on weight) along with pegylated interferon α-2a (PEG-IFN alfa-2a, 180 μg once weekly) or pegylated interferon-α2b (PEG-IFN alfa-2b, 1.5 μg/kg once weekly). Treatment duration was 48 weeks in people infected with HCV genotype 1 and 24 weeks in those infected with HCV genotypes 2/3. Pegylated interferon injections were administered by clinic staff, while ribavirin was dispensed weekly and self-administered. During the weekly visits, the nurse recorded patient self-reported adherence, illicit drug use, side effects and ensured appropriate longitudinal toxicity and HCV RNA monitoring was conducted. Adherence was assessed by direct observation of pegylated interferon and ribavirin adherence was self-reported weekly. Addiction counselors provided additional individual support, with particular attention to symptoms of depression. The interim data on treatment uptake among the first 80 people referred to this group have been previously reported [25].

For the present study, we evaluated 1) assessment for HCV infection; 2) HCV treatment uptake; and 3) sustained virologic response (SVR) among treated individuals. A retrospective chart review was conducted among the people referred to group over a three year period. Assessment for HCV infection was defined as (1) having initiated or completed treatment for HCV infection

prior to attending the support group, (2) being under evaluation for HCV treatment, (3) being assessed for treatment with treatment deferred or not indicated or (4) having initiated treatment for HCV infection. Reasons for treatment deferral were evaluated via chart review in consultation with the treating physician. Individuals lost to follow-up or not interested in attending group were not considered to have been assessed for HCV infection. Individuals initiating treatment were specifically followed to document treatment response. To reduce the bias associated with early discontinuation, all individuals who initiated therapy between March 2005 and May 2007 were included for SVR evaluation (last subject with an evaluable SVR time point at the end of the study period). SVR was defined as an HCV RNA <50 IU/mL at 24 weeks post-treatment (COBAS AMPLICOR HCV Test v2.0, Roche Diagnostic Systems, Mississauga, Canada).

Factors associated with assessment for HCV infection were evaluated using χ^2 or Fisher's Exact Test, as appropriate. The Mann-Whitney test was used to assess differences in median attendance between groups of patients. The Cochran Mantel-Haenszel test was used to adjust for potential confounders. All two-sided p-values<0.05 were considered statistically significant. All experimental procedures were implemented in accordance with the Helsinki Declaration of 1975. The University of British Columbia Clinical Research Ethics Board approved this study.

RESULTS

Data were obtained on 204 participants who accepted referral to a weekly HCV support group within a multidisciplinary care program from March 2005 to March 2008 (Table 1). Of these, 83% were male and all had a history of illicit drug use. The median age was 47 (range, 24-62) years. The majority were infected with genotype 1 (57%). The median number of group visits was 6, with a range of 1 to 69, with 40% attending >10 visits. Weekly attendance and HCV treatment uptake during this period are shown in Figure 1. The overall mean attendance was 8 people per week (range: 2-27).

Of the 204 accepting referral to the HCV support group, 53% (n=109) were assessed for HCV infection (Figure 2). Of these, 13% (n=14) had initiated or completed treatment for HCV infection prior to attending the support group, 25% (n=27) treatment was deferred or not indicated, 10% (n=11) were still under evaluation and 52% (n=57) initiated treatment.

Among those in whom treatment was deferred or not indicated (n=27), we first evaluated the major reason why treatment was deferred in consultation with the treating physician. The major reasons for HCV treatment deferral included early liver disease (n=8, 30%), drug dependence (n=10, 37%), other medical co-morbidities (n=3, 11%), psychiatric co-morbidities (n=1, 4%), alcohol dependence (n=2, 7%), participation in a clinical trial (n=2, 7%) and other or unknown reasons (n=1, 4%). Among the 19 deferred for reasons other than early liver disease, we also evaluated the other reasons why treatment was deferred in consultation with the treating

physician. The majority (68%, n=13) demonstrated more than one reason for treatment deferral (two reasons, n=9, three reasons, n=4). These other reasons for treatment deferral (not mutually exclusive) included drug dependence (n=11, 58%), a lack of interest in treatment (n=5, 26%), other medical co-morbidities (n=4, 21%), psychiatric co-morbidities (n=3, 16%), alcohol dependence (n=2, 11%) and unstable housing (n=2, 11%).

To understand the factors associated with successful assessment for HCV infection, we compared the characteristics of individuals that had (n=109) and had not (n=95) been assessed (Table 2). Assessed individuals demonstrated a higher number of median visits to the support group (20 visits vs. 1 visit, $p<0.001$). Only 6% of people with HCV assessment attended 1 visit as compared to 53% among those not assessed. In univariate analyses (Table 2), factors associated with assessment for HCV infection included age $\geq$50 and attendance during the first four weeks of the HCV support group ($\geq$2 visits vs. 1 visit). However, age was not statistically significant when assessed using a likelihood ratio test under a logistic regression model. Sex, genotype, calendar year of first group attendance and day of support group attended were not statistically significantly associated with HCV assessment. The association of attendance during the first four weeks of the HCV support group and subsequent assessment for HCV infection maintained statistical significance after adjusting for age, sex, genotype and day of group attended when evaluated using the Cochran Mantel-Haenszel test.

A total of 57 (28%) initiated treatment for HCV infection and their characteristics are shown in Table 3. Eighty-six percent were male, the mean age was 49 years, 11% were co-infected with

HIV and 37% were receiving methadone maintenance therapy. Ongoing illicit drug use was reported in 21%, with an additional 32% reporting illicit drug use in the past 6 months. Over half (53%) were infected with HCV genotype 1. The median time from group entry to treatment initiation was 3.5 months [interquartile range (IQR), 1.9-5.5 months]. Outcomes were available on the first 19 of 57 who initiated HCV treatment during the study period. Despite the fact that 53% (10 of 19) used illicit drugs at least once during their treatment period, SVR was observed in 63% overall (12 of 19), 71% (10 of 14) among those infected with HCV genotypes 2/3.

DISCUSSION

We observed high rates of assessment (54%) and treatment (28%) for HCV infection among illicit drug users referred to a weekly HCV peer-support at an inner city community health centre providing multidisciplinary care.

The proportion of illicit drug users accepting referral to the weekly HCV peer support group and subsequently assessed for HCV infection in our cohort was 54%. This is higher than hospital-based studies of HCV mono-infected and HIV/HCV co-infected current and former IDUs referred for HCV clinical evaluation and care, where 22-45% of individuals accepting referral had an evaluation for HCV infection [6, 7, 30, 31]. The high reported proportion assessed for HCV infection may not be surprising given the presence of a multi-disciplinary program integrating general health, addiction and HCV treatment care and the availability, accessibility and predictability of the weekly HCV support group. On the other hand, the study population – as recruited - may also represent a group that is relatively more engaged in basic health care by way of their relationship with and access to the community health clinic, thus, making them more likely to engage in care for HCV under the right circumstances, such as the existence of a structure to allow them to do so.

Attendance to the weekly HCV support group during the first four weeks was predictive of subsequent assessment for HCV. These data is consistent with studies of HCV treatment among current and former IDUs, in which greater clinic attendance is associated with improved

response rates to therapy [12]. Our data demonstrate that early attendance can be used to identify individuals who are most likely to engage in care and treatment.

The major reasons for HCV treatment deferral in this study included early liver disease, drug dependence and other medical or psychiatric co-morbidities. This is consistent with other studies [7, 31-33]. However, the majority of previous studies have limited analyses to an evaluation of a single major reason for HCV treatment deferral. However, it is clear from the present study that among people deferring therapy for reasons other than early liver disease, the majority demonstrated multiple reasons for treatment deferral. Although drug dependence may be one barrier to therapy initiation, multiple barriers may be present which may preclude current treatment, including other medical co-morbidities or social issues (e.g. unstable housing, finances). Addressing these modifiable barriers on a case by case basis is a major focus for healthcare providers involved in this multidisciplinary model during preparation for treatment initiation.

The uptake of HCV treatment among illicit drug users in our cohort was very high at 28%. It should be noted that the treatment uptake among the total population of HCV-antibody positive illicit drug users attending this clinic is likely lower, given that the 204 individuals accepting referral to the HCV support group represents approximately one-quarter of the estimated 800 HCV antibody positive illicit drug users attending this clinic during this period. Irrespective of this, this is higher than reports from other community- and hospital-based cohorts of illicit drug users in the Canada, the United States and Australia, where only 1-6% of current and former

IDUs have received HCV treatment [5-8]. In fact, in one community-based cohort of 1,361 HCV antibody positive illicit drug users in Vancouver, undertaken in the same neighborhood as the multidisciplinary clinic in the present study, only 15 individuals initiated treatment for HCV infection from 2000 to 2004 [8]. The data presented in the current study demonstrate that high proportions of patients can be assessed for HCV with the appropriate programs in place. This is encouraging, as it indicates that people who engage in our model of care are also more likely to follow through and actually receive treatment. We and others have previously shown that large proportions of HCV-infected illicit drug users (>70%) are interested in receiving HCV treatment [34-37]. Factors for not seeking treatment include a lack of information, the absence of symptoms (including the perception that care and treatment are unnecessary) and the perceived side effects of treatment [7, 35]. All of these issues are addressed in the support group model, suggesting that it is well targeted to the existing barriers to care. Second, many illicit drug users are deemed ineligible for HCV treatment based on concerns of adherence, medical co-morbidities, treatment side effects, perceived patient unwillingness to receive treatment and re-infection risk [9]. Once again, this peer-support group model may set up conditions to address most of these concerns, by monitoring adherence, aggressively intervening to address medical issues and toxicities and providing information and counseling about re-infection risks.

The SVR rate among illicit drug users in our cohort was quite high at 63%, despite the fact that many individuals continued to use illicit drugs throughout their course of treatment. These results are comparable to response rates (54-56%) reported in large, randomized controlled trials using pegylated interferon in combination with ribavirin for the treatment of HCV infection [38, 39].

The responses in the present study are also comparable to other studies of HCV treatment with pegylated interferon and ribavirin in Germany, Italy, Norway, Australia and Canada among current and former IDUs who report SVR rates of 42 to 62% [18, 22-24, 26, 40].

This study also demonstrates the first successful application of a weekly peer-based HCV support group model developed by Sylvestre and colleagues [29] to a pre-existing multidisciplinary model for the treatment of HCV. As described previously by Sylvestre and Zweben [29], the peer-based HCV support group is a model that has allowed us to engage and provide care and treatment for HCV infection in a larger number of drug users, the majority of whom have multiple potential barriers to intervention. Peer support allows educational material to be tailored to individual knowledge levels, improves clinic attendance and encourages cooperation with medical recommendations [29]. It is also a powerful influence for those that attend regularly, moving between the emotional, educational and social support level [29]. Patients begin to improve other areas in their lives including general physical health (e.g. nutrition), mental health and addiction and improved social status (e.g. stable housing, education and employment). The results from this study demonstrate that a peer-based HCV support group can fit within the constraints of other settings and can be a powerful tool to significantly improve access to HCV care among current and former illicit drug users who may already be engaged in care for reasons unrelated to HCV infection.

There are several limitations to the study methodology in this report. First, the results may not be generalizable to other populations of illicit drug users in Canada or elsewhere. However, the

demographic characteristics in this study is similar to that of a large, community-based sample of illicit drug users in Vancouver [8], and our results may at least be applicable in a setting where a high concentration of IDUs in a well-defined geographic setting, where a program established in a single setting may be able to draw on a significant target population. Second, demographic information for those attending the group was collected by retrospective chart review and we were unable to specifically ascertain recent risk behavior information for individuals referred to the HCV support group. This limited our ability to make detailed comparisons of risk behaviours among those who did and did not follow through with formal assessment for treatment. It may well be that such attendance is a marker for specific illicit drug use behaviors or other factors and we will be able to evaluate this in further, ongoing prospective studies in our centre. Third, there may be significant biases associated with the fact that this study was performed among those accepting referral to an HCV peer-support group. This may have led to a bias towards the inclusion of individuals that access care more frequently and are engaged in the healthcare system, and that a significant proportion of our target population may not ever benefit from this intervention. Irrespective of this, the number of support group attendees engaged in care and treatment for HCV infection remains significant and this model may be a powerful tool to help provide the potentially curative benefits of HCV treatment to many who would not otherwise receive them.

In developed nations, IDUs constitute the vast majority of those living with HCV infection. Our study indicates that with the appropriate programs in place (including HCV peer-support), a significant proportion of these individuals may be assessed and treated for their infection.

Further, therapeutic response rates approaching those reported in the medical literature can be achieved within such programs, despite ongoing drug use in the treated individuals. It is clear that the passive recruitment approach for engaging illicit drug users in HCV care is insufficient. In order to make progress, the next critical steps need to include efforts towards improved awareness and active referral of HCV-infected IDUs to multidisciplinary settings such as ours. For these programs to be maximally successful, strategies will be required to 1) improve patient education about HCV infection; 2) identify those most motivated to receive treatment; and 3) improve the proportion completing and responding to therapy. This may be partly achieved through the integration of HCV peer-support groups into existing multidisciplinary programs providing HCV care. Increasing the proportion of HCV infected illicit drug users assessed and treated for HCV infection is a crucial and necessary component towards reducing the future disease and cost burden of HCV (and perhaps addiction in general) in the developed world.

Contributors: Authors J.G., J.D.R, F.D. and B.C. designed the study and wrote the protocol. J.G. managed the literature searches and summaries of previous related work. Authors J.G, E.K., K.G. and L.G. assisted with data collection and initial analyses. Authors J.G., E.K., K.G. and J.D.R. undertook the final statistical analysis, and author J.G. wrote the first draft of the manuscript. All authors contributed to and have approved the final manuscript.

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TABLES

Table 1. Baseline demographic characteristics of Canadian illicit drug users referred to an HCV peer-support group at a multidisciplinary community health centre studied for assessment and treatment for HCV infection (n=204)

Characteristic	n=204 n (%, range)
Median age (range)	47 (24-62)
<40	35 (17)
40-44	37 (18)
45-49	37 (18)
≥50	66 (32)
Unknown	29 (14)
Male sex[†]	170 (83)
History of illicit drug use	204 (100)
Genotype available	143 (70)
Genotype 1	82 (57)
Genotype 2	15 (11)
Genotype 3	45 (32)
Mixed genotype (Genotypes 1 and 3)	1 (1)
Unknown genotype	57 (28)
HCV RNA negative	4 (2)
Year of first group attendance	
2005-2006	47 (23)
2006-2007	81 (40)
2007-2008	76 (37)
Day of support group attended	
Friday	164 (80)
Thursday	26 (13)
Wednesday	14 (7)
Median number of group visits (range)	6 (1-69)
Number of group visits	
1	57 (28)
2 to 4	36 (18)
5 to 10	29 (14)
>10	82 (40)

[†]Sex was missing for two participants.

Table 2. Characteristics associated with having been assessed for HCV infection among illicit drug users referred to an HCV peer-support group at a multidisciplinary community health centre (n=204)

Characteristic	Assessed for HCV (n=109)	%, range	Not assessed for HCV (n=95)	%, range	OR	95% CI	p-value
Median age (range)	**48**	**(30-62)**	**46**	**(24-60)**	**-**	**-**	**-**
<40	**17**	**16%**	**18**	**19%**	**1.00**	**-**	**-**
40-44	**22**	**20%**	**15**	**16%**	**1.55**	**0.61 - 3.95**	**0.48***
45-49	**22**	**20%**	**15**	**16%**	**1.55**	**0.61 - 3.95**	**0.48***
≥50	**47**	**43%**	**19**	**20%**	**2.62**	**1.12 - 6.13**	**0.031***
Missing	**1**	**1%**	**28**	**29%**			
Female sex	**16**	**15%**	**16**	**17%**	**1.00**	**-**	**-**
Male sex	**93**	**85%**	**77**[†]	**81%**	**1.21**	**0.57 - 2.57**	**0.70**
Genotype assessment	**100**	**92%**	**43**	**45%**	**-**	**-**	**-**
Missing	**9**	**8%**	**48**	**51%**	**-**	**-**	**-**
Genotype 1	**55**	**55%**	**27**	**63%**	**1.00**	**-**	**-**
Genotype 2 and 3	**45**	**45%**	**16**	**37%**	**1.38**	**0.66 - 2.88**	**0.46**
Day of support group attended							
Friday	**84**	**77%**	**80**	**84%**	**1.00**	**-**	**-**
Thursday	**15**	**14%**	**11**	**12%**	**1.30**	**0.56 - 3.00**	**0.67**
Wednesday	**10**	**9%**	**4**	**4%**	**2.38**	**0.72 - 7.90**	**0.17**
First four group visits							
1 visit	**25**	**23%**	**61**	**64%**	**1.00**	**-**	**-**

2 to 4 visits	**84**	**77%**	**34**	**36%**	**6.03**	**3.27 - 11.13**	**< 0.001**

***Age was not a statistically significant variable when assessed using a likelihood ratio test under a logistic regression model. †Sex was missing for two participants.**

Table 3. Baseline demographic characteristics of Canadian illicit drug users initiating treatment with pegylated interferon alfa and ribavirin for HCV infection (n=57)

Characteristics	N=57 (n; %, SD or IQR)
Mean age (SD)	**49 (6.8)**
Mean weight (kg) (SD)	**82 (13.9)**
Male sex	**49 (86)**
HIV infection	**6 (11)**
Receiving methadone maintenance therapy	**21 (37)**
Previous depression	**30 (53)**
Last illicit drug use	
Ongoing	**12 (21)**
In the past 6 months	**18 (32)**
>6 months ago	**17 (30)**
Unknown	**10 (18)**
Genotype	
1	**30 (53)**
2	**9 (16)**
3	**18 (32)***
Year of first group attendance	
2005-2006	**15 (26)**
2006-2007	**27 (47)**
2007-2008	**15 (26)**
Regimen	
PEG-IFN alfa-2a and ribavirin	**47 (83)**
PEG-IFN alfa-2b and ribavirin	**10 (18)**
Median time from group entry to treatment initiation in months (IQR)	**3.5 (1.9-5.5)**

*total percentage does not equal exactly 100% due to rounding of percentages.

FIGURES

Figure 1. Cumulative weekly attendance and HCV treatment uptake from March 2005 to March 2008 among illicit drug users referred to an HCV peer-support group at a multidisciplinary community health centre (n=204)

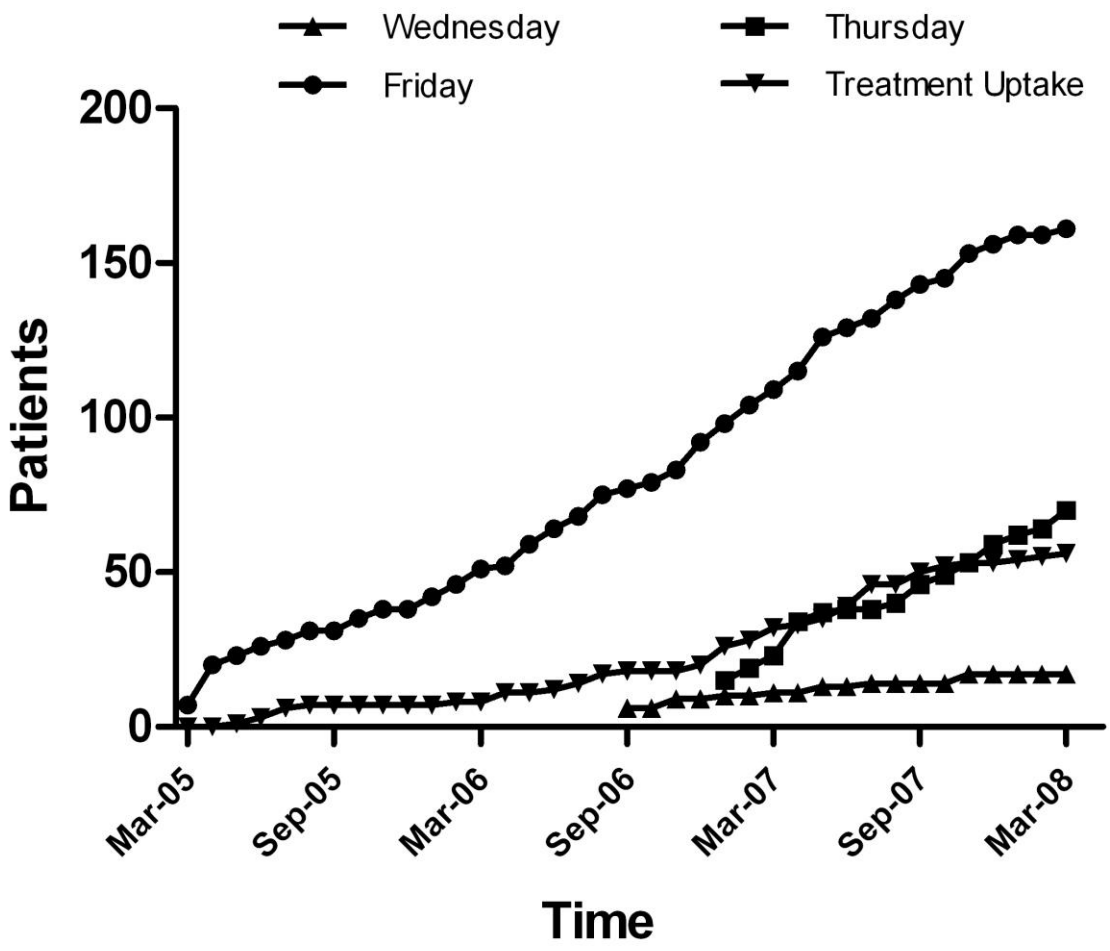
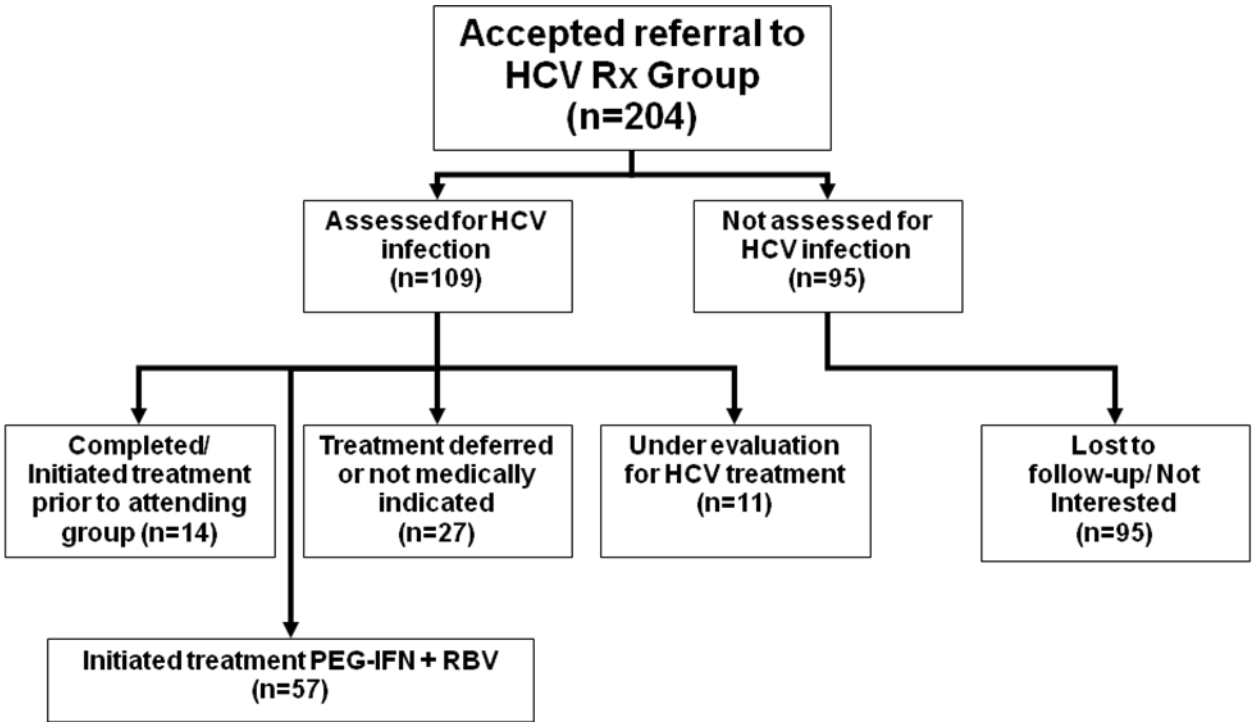

Wednesday
Thursday
Friday
Treatment Uptake
200
150
100
50
0
Patients
Mar-05
Sep-05
Mar-06
Sep-06
Mar-07
Sep-07
Mar-08
Time

Figure 2. Disposition of Canadian illicit drug users referred to an HCV peer-support group at a multidisciplinary community health centre studied for assessment and treatment for HCV infection (n=204)


Accepted referral to HCV Rx Group (n=204)
Assessed for HCV infection (n=109)
Not assessed for HCV infection (n=95)
Completed/ Initiated treatment prior to attending group (n=14)
Treatment deferred or not medically indicated (n=27)
Under evaluation for HCV treatment (n=11)
Lost to follow-up/ Not Interested (n=95)
Initiated treatment PEG-IFN + RBV (n=57)