

# Responding to developments blood borne virus prevention and treatment: Integrating science and practice at a clinic level

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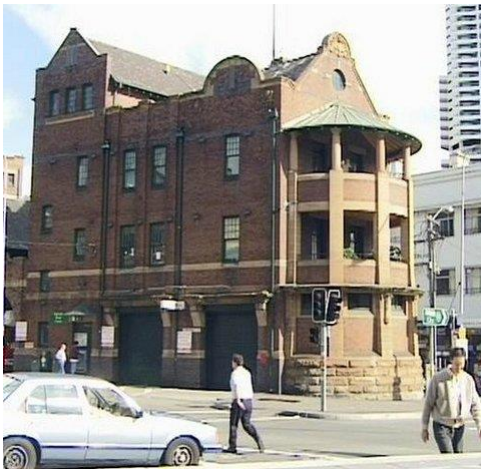
Kirby Seminar series 2018

# Outline of presentation

- Overview of the Kirketon Road Centre
- Policy and practice framework
- Examples of interface between strategy, research and clinical practice
  - HIV
  - Take home naloxone
  - Hepatitis C
- Challenges
- Future

# Kirketon Road Centre

- Established in Kings Cross in 1987
- An integrated primary health care service model which aims to meet the health and social welfare needs of “at risk” youth, PWID and sex workers
- Provide 14000 episodes of clinical and social care for >4000 people per annum
- 45% of consults are with PWID, 30% with sex workers
- Funded by NSW Health – part of SESLHD



# KRC principles: Primary Health Care

The PHC philosophy promotes that services should be:

- Accessible
- Acceptable
- Affordable
- Equitable



**Table 1**  
Services provided, staffing and reported accessibility and acceptability of primary healthcare outlets for IDUs.

The centre <sup>a</sup> (reference)	Placement of primary healthcare	Major services provided						Staffing			Facility		Reported accessibility	Reported acceptability
		NSP	OST	HCV/HIV treatment	Hepatitis B vaccination	Social and welfare services	Other basic medical services	Medical	Nursing	Counselling	Outreach	Drop-in		
Kirketon Road Centre (KRC), Sydney, Australia (van Beek, 2007)	Red-light area	+	+	+/+	+	+	+	+	+	+	+	+	+	+

Services should be:

- Non-threatening and non-judgmental
- Anonymous and confidential and
- Involve the affected community in service planning

# Services at KRC

- General medical care (often no GP)
- Chronic disease in aging population
- Wound care and drug related injuries
- HIV, hepatitis B, and C testing & treatment
- Hepatitis A and B vaccination
- STI screening/treatment
- Pap smears, contraception, pregnancy testing
- High-risk antenatal service
- Mental health clinic
- Methadone/Suboxone Access Program: 'low threshold' with intensive case management approach
- Smoking cessation
- Drug and alcohol counselling
- Social support: housing, debt, legal, ID, DV, centrelink





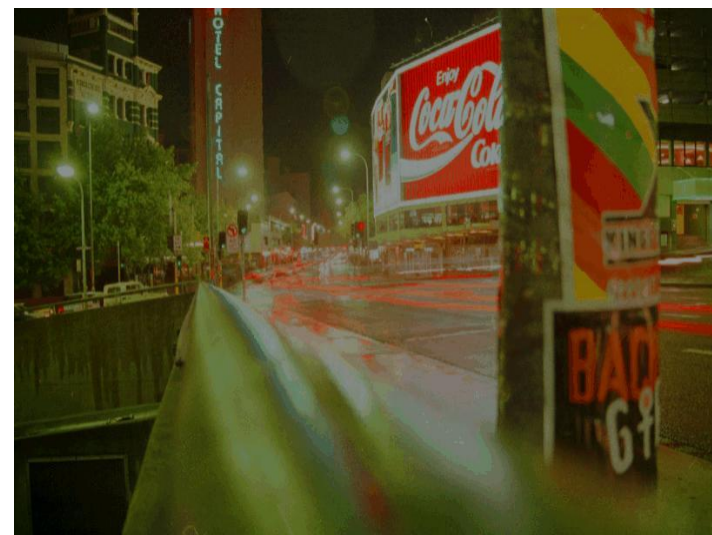
# Services at KRC

- Clinic 180- evenings and weekends- STI, NSP, counselling. aTEST with ACON
- Client support and activity groups- health promotion and community development activities
  - Art, weaving
  - Mindfulness
  - Gardening
  - music
- Specific Aboriginal program “itha mari”
- District-wide Needle syringe program
  - 3 primary NSP sites and 18 secondary sites
  - KRC South in Sutherland
  - 8 vending machines, 3 dispensing chutes
  - needle clean-up service
- Take-home naloxone training for overdose management
- Safer injecting workshops
- Daily and nightly foot and bus outreach



# Community partnerships and outreach:

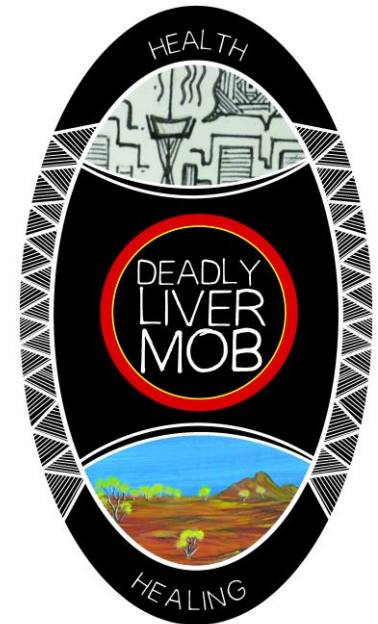
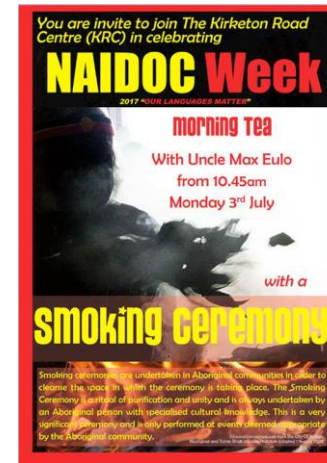
- A bus and on-foot outreach 7 nights a week – rough sleeping, injecting and sex work locations
- Nurse led clinical outreach
  - Local users peer-based NSP NUAA – importance of peer-involvement
  - Medically Supervised Injecting Centre
  - ACON NSP
  - Homeless hostels- Edward Eagar lodge, work closely with William Booth and Matt Talbot
  - Local disadvantaged youth services
    - Oasis
    - Twenty10
    - Ted Noffs
    - Wayside chapel



- University partnerships
- Sentinel surveillance (drug trends and HCV)
- Consumer participation in service development

# Aboriginal program “Itha mari”

- 2004- Itha mari
  - Barkindji “this way in the right direction”
- Holistic model- wellbeing, not disease focussed
- Aboriginal staff
- Client centred- set agenda
  - Decide which issues are important
  - Which barriers exist
  - What local solutions might work
- Activities/health promotion:
  - Groups- including on liver health
  - Lunches- NAIDOC week
  - Workshops
  - Art
  - Storytelling
  - Movies
- Aboriginal reference group
- Participation in Deadly Liver Mob

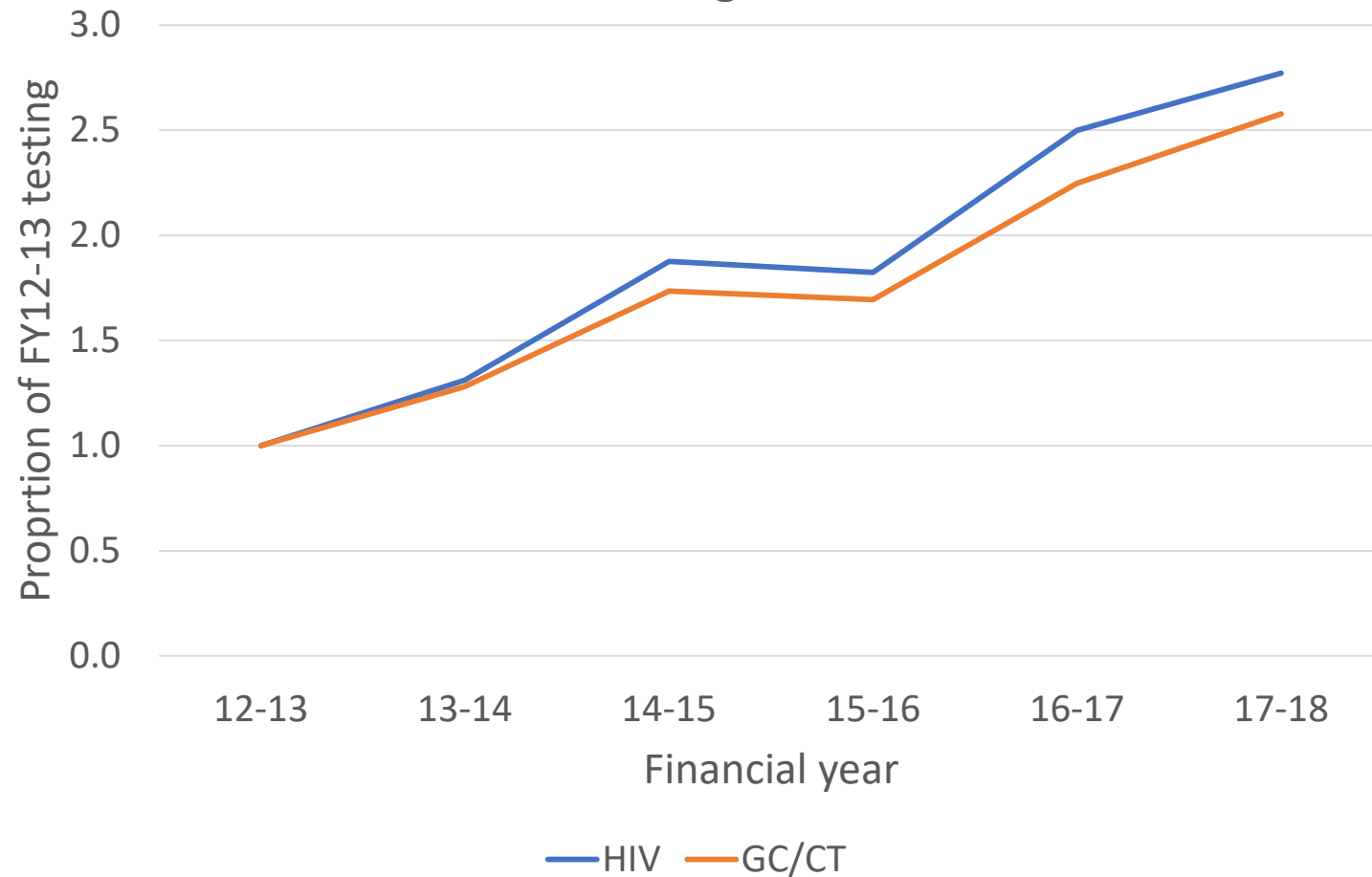




# HIV

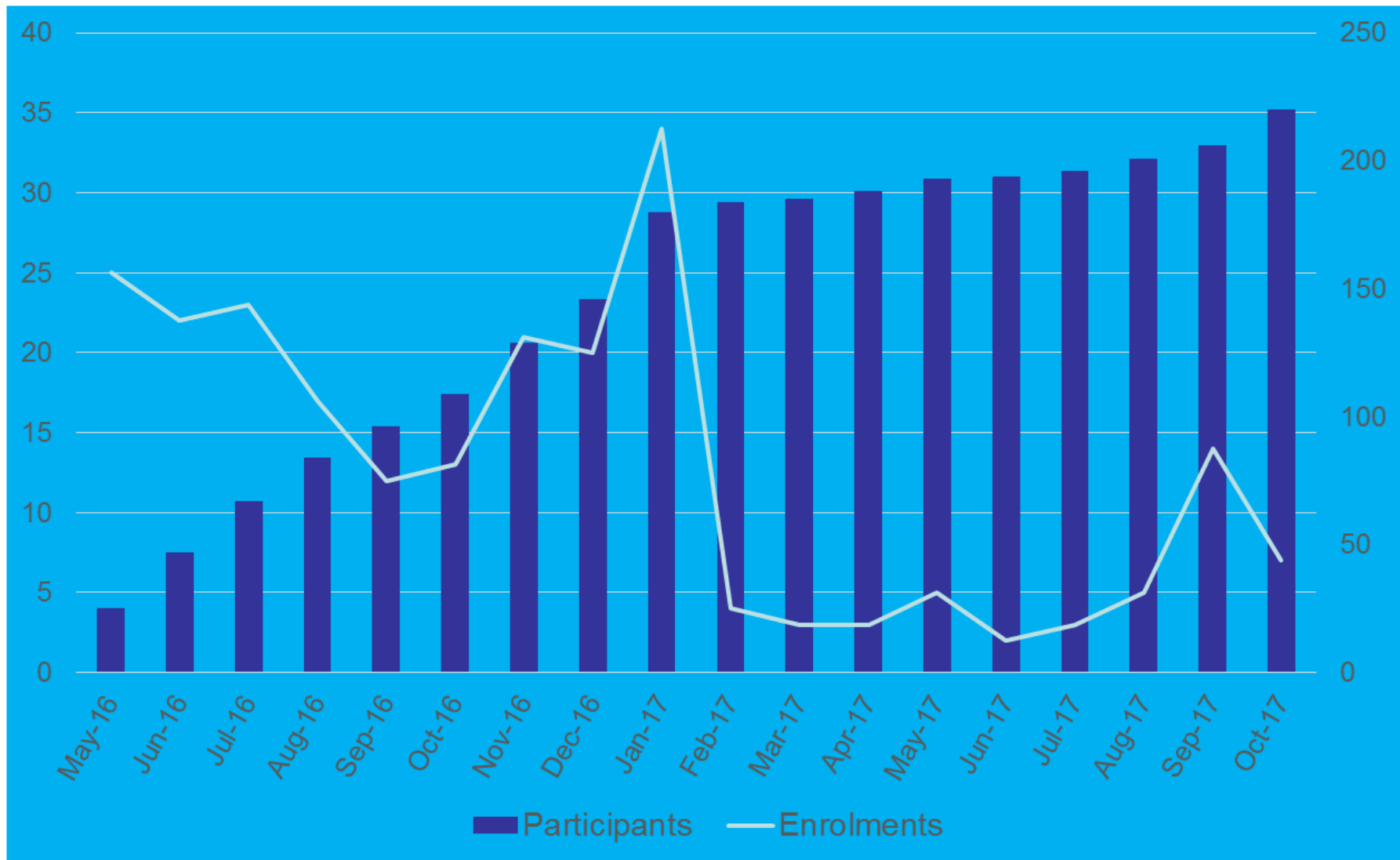
# Test often: increased 2.8 fold

## HIV and STI testing increase over time



FY	12-13	13-14	14-15	15-16	16-17	17-18
HIV	1.0	1.3	1.9	1.8	2.5	2.8
GC/CT	1	1.3	1.7	1.7	2.2	2.6

# Prevent: EPIC enrolments



# PrEP among people who inject

- Injecting risk not included in EPIC
- National guidelines- consider if
  - Sharing injecting equipment with gay men of unknown HIV status, or with someone known HIV positive not with detectable VL AND
  - Inadequate supply of NSP equipment
- Drug user organisations- concerns will detract from existing harm reduction, prohibition means unscaleable, PrEP studies in PWID limited
- Est 93,000 people who inject annually in Australia; may be some who fall within guidelines on individual basis; little data on PrEP in this group in Australia
- KRC and the MSIC, in partnership with NUAA, surveyed 200 clients in Dec 2016 on PrEP knowledge, risks, eligibility and risk compensation
- Over half had heard of PrEP, of whom 80% would be willing to take it if high risk of HIV with no evidence of significant risk compensation
- >10% of sample potentially eligible, but only 2.5% of heterosexual PWID without sexual risk
- Aim not to promote PrEP generally among PWID, but to include in conversation

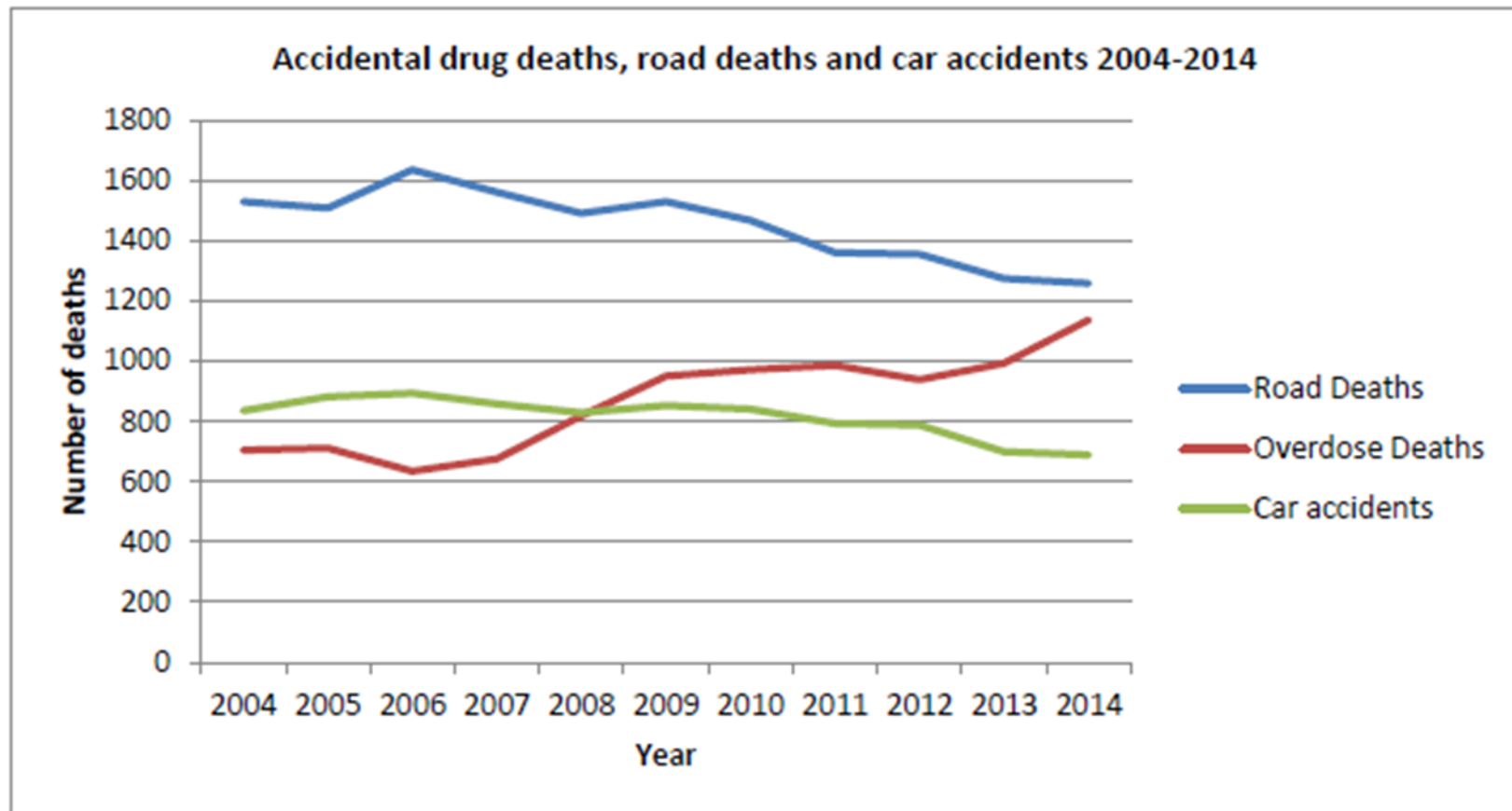
# Changing demographics?

	2012 – 13	2013 – 14	2014 – 15	2015 – 16	2016 - 17
% Aboriginal	20	19	18	20	19
% PWID	51	54	52	57	53
% Sex Worker	42	47	44	42	35
% At Risk Young Person	21	22	21	19	19
% MSM	8	10	23	25	36
% Other	28	24	18	17	15

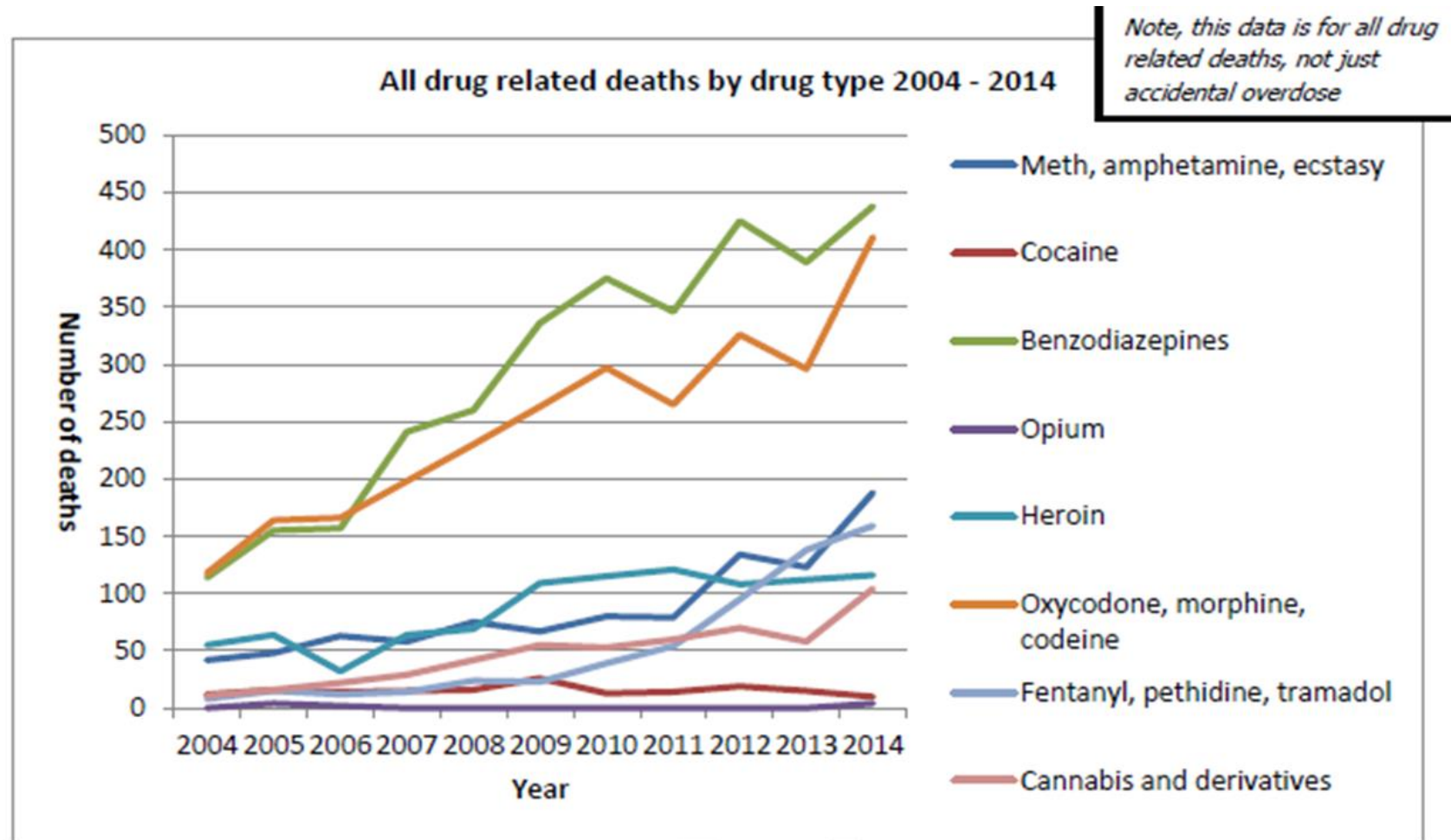


# Take home naloxone for overdose management

# Increasing OD Deaths in the last Decade



# Changing profile of all drug related deaths



# KRC: THN since 2012



## HARM REDUCTION FOR PEOPLE WHO USE DRUGS

6	All people from key populations who inject drugs should have access to sterile injecting equipment through <b>needle and syringe programmes</b> .
7	All people from key populations who are dependent on opioids should be offered and have access to <b>opioid substitution therapy</b> .
8	All people from key populations with harmful alcohol or other substance use should have access to <b>evidence-based interventions</b> , including brief psychosocial interventions involving assessment, specific feedback and advice.
9	People likely to witness an opioid overdose should have access to <b>naloxone</b> and be instructed in its use for emergency management of suspected opioid overdose. <b>NEW RECOMMENDATION</b>


## GUIDELINES



CONSOLIDATED GUIDELINES ON  
**HIV PREVENTION,  
DIAGNOSIS, TREATMENT  
AND CARE FOR  
KEY POPULATIONS**

JULY 2014

KEY POPULATIONS



**SAVE LIVES?  
BUT HOW??**

**OVERDOSE  
& NARCAN  
TRAINING**

**LEAVE WITH YOUR OWN SUPPLY  
OF NARCAN!**

Next Session:

@ KRC Group Room - Session runs for approx. 1-2 hours

More information:  
Speak to Rosie @ KRC Ph: 9360 2766

Where: Kirketon Road Centre (KRC),  
Above the Darlinghurst Firestation  
Cnr Victoria St & Darlinghurst Rd,  
Kings Cross

**Narcan Training takes 10 minutes.**

Got time to save a life?

Read a Paper  
Take a Shower  
Sing Bohemian Rhapsody  
Pick your nose

Eat a Burger  
Brush the Dog

Ten minutes is all it takes to get trained to use narcan & get a free take away that could save a mates life.

**Ask How - Here & NOW!**




@ KRC  
Phone  
9360 2766  
4 more info


# Take home naloxone

- Various models... >700 trainings- now Brief intervention



Special Issue

## Findings and lessons learnt from implementing Australia's first health service based take-home naloxone program

Karen J. Chronister , Nicholas Lintzeris, Anthony Jackson, Mihaela Ivan, Paul M. Dietze, Simon Lenton, John Kearley, Ingrid van Beek

First published: 13 April 2016 | <https://doi.org/10.1111/dar.12400> | Cited by: 7



# Naloxone evaluation at KRC

## Who Returns for Naloxone Replacement? A Real World Analysis of Clients Returning for Naloxone at the Kirketon Road Centre in Kings Cross, Sydney



J Kearley<sup>1</sup>, KJ Chronister<sup>1,2</sup>, R Gilliver<sup>1</sup>, I van Beek<sup>1</sup>, P Read<sup>1,2</sup>

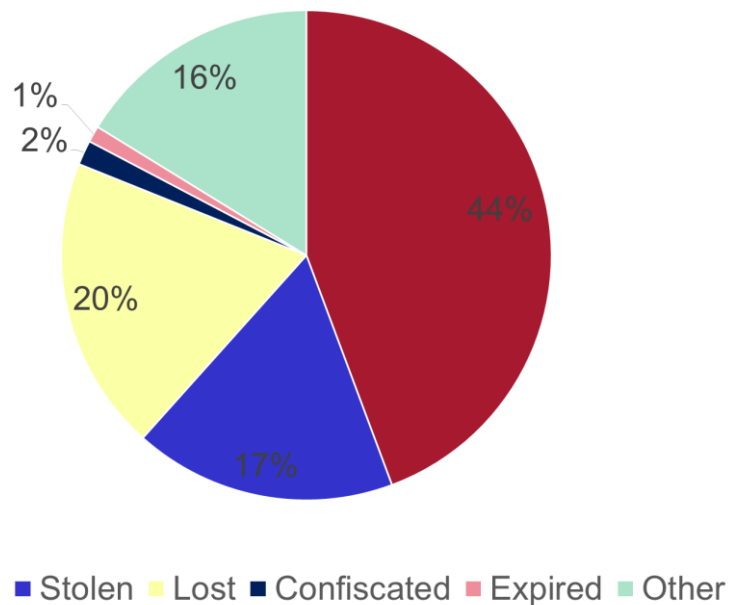
### Of first 203 clients trained

- 59 clients (29%) returned for more
- Some >3 times
- 44% replenished due to use

March 2014, KRC has continued initial prescription and subsequent replenishment of take-home naloxone

Female 24 (41) 50 (35) 74 (37)

resulted in a transfer to hospital. Seven were recorded as admitted to hospital and one death was reported



■ Used ■ Stolen ■ Lost ■ Confiscated ■ Expired ■ Other

## INCORPORATING OVERDOSE MANAGEMENT INTO ROUTINE CARE OF PEOPLE WHO INJECT DRUGS WHO ARE UNDERGOING HEPATITIS C TREATMENT WITH DIRECT ACTING ANTIVIRALS



J Kearley<sup>1</sup>, R Gilliver<sup>1</sup>, P Read<sup>1,2</sup>, KJ Chronister<sup>1,2</sup>  
<sup>1</sup> Kirketon Road Centre, South Eastern Sydney Local Health District, Sydney  
<sup>2</sup> Kirby Institute, UNSW Australia, Sydney

### Introduction

The Kirketon Road Centre (KRC) is a publicly funded primary health care facility involved in the prevention, treatment and care of HIV and viral hepatitis to people who inject drugs (PWID). Since September 2015 KRC has been treating hepatitis C (HCV) with direct acting antivirals (DAAs). However, PWID are also at significant risk of drug overdoses with

Table 1: Characteristics of clients assessed for HCV treatment, 2015 – 2016

Age in years – mean (std dev)	43.8 (10.9)
Gender – n (%)	
Male	101 (66.9)
Female	45 (29.8)
Transgender	5 (5.6)
Aboriginal – n (%)	33 (21.9)
Born in Australia – n (%)	121 (80.1)
Injecting drug use – n (%)	145 (97.9)



### Of first 151 clients treated with DAAs

- 61 had used opioids in last 12 months
- 49 were trained in THN
- 10 clients have reversed 21 overdoses

In pre-overdose management program.

### Aim

To describe the acceptability of overdose management and naloxone provision into routine care of PWID who are undergoing HCV treatment with DAAs.

### Method

All clients assessed for HCV treatment were offered training in opioid overdose management and provided with take-home naloxone as part of their routine care for hepatitis C. Clients' demographics, rate of uptake of training, clients who had experienced, witnessed, or managed an overdose in the past 12 months were analysed.

survived.

Factors significantly associated with receiving a brief intervention in naloxone and overdose management are shown in table 2.

Table 2: Comparison of clients by naloxone intervention

	Naloxone intervention (N = 49)	No intervention (N = 102)
Age in years – mean (sd)	40.4 (11.5)*	45.4 (10.4)
Gender – n (%)		
Male	31 (63.3)	70 (68.6)
Female	16 (32.7)	30 (29.4)
Transgender	3 (9.4)	2 (3.5)
Aboriginal – n (%)	12 (24.5)	20 (19.6)
Born in Australia – n (%)	38 (77.6)	83 (81.4)
Injecting drug use – n (%)	49 (100.0)	96 (97.0)
Opioids in last year – n (%)	29 (59.2)*	32 (31.7)
Previous overdose – n (%)	19 (38.8)	27 (26.7)

\* Indicates statistically significant differences (p < 0.05)

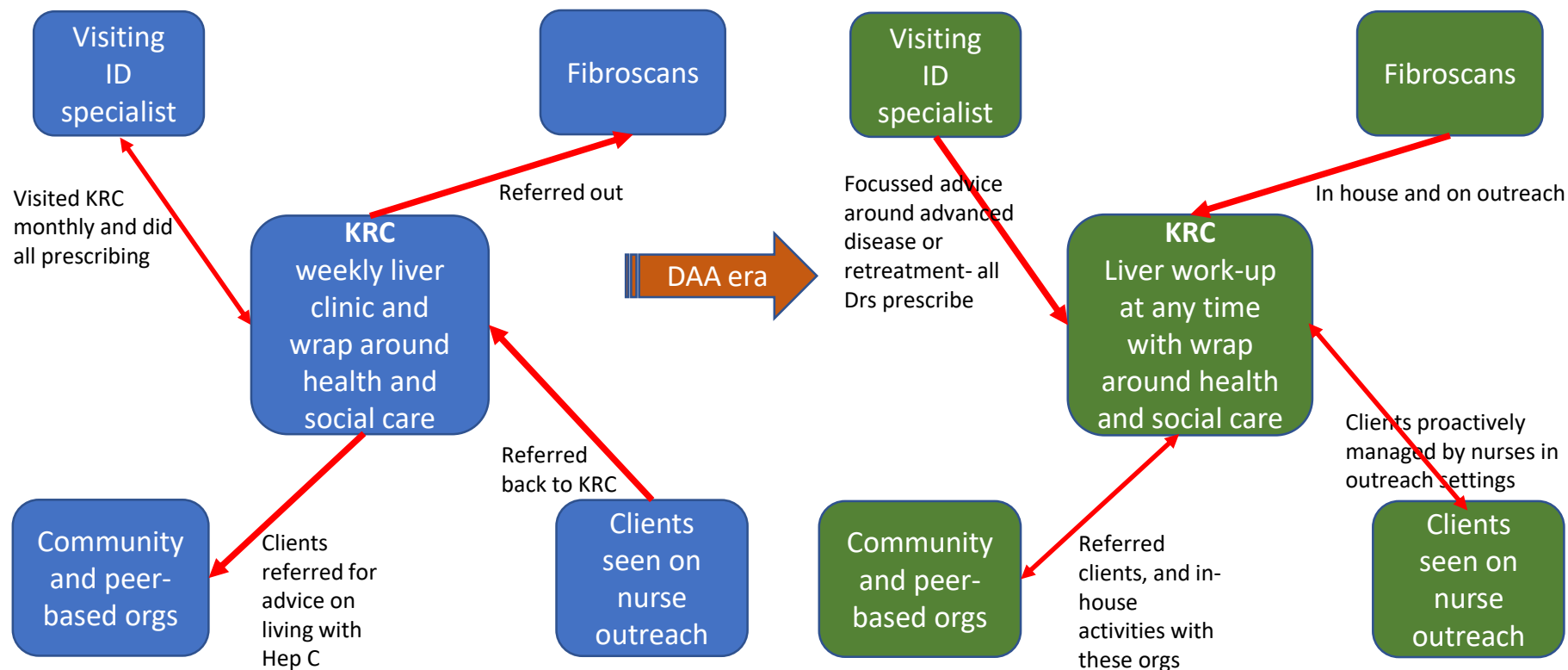
the health of PWID. Hepatitis treatment services should incorporate take home naloxone as part of routine HCV treatment and care for those likely to experience or witness opioid overdose.



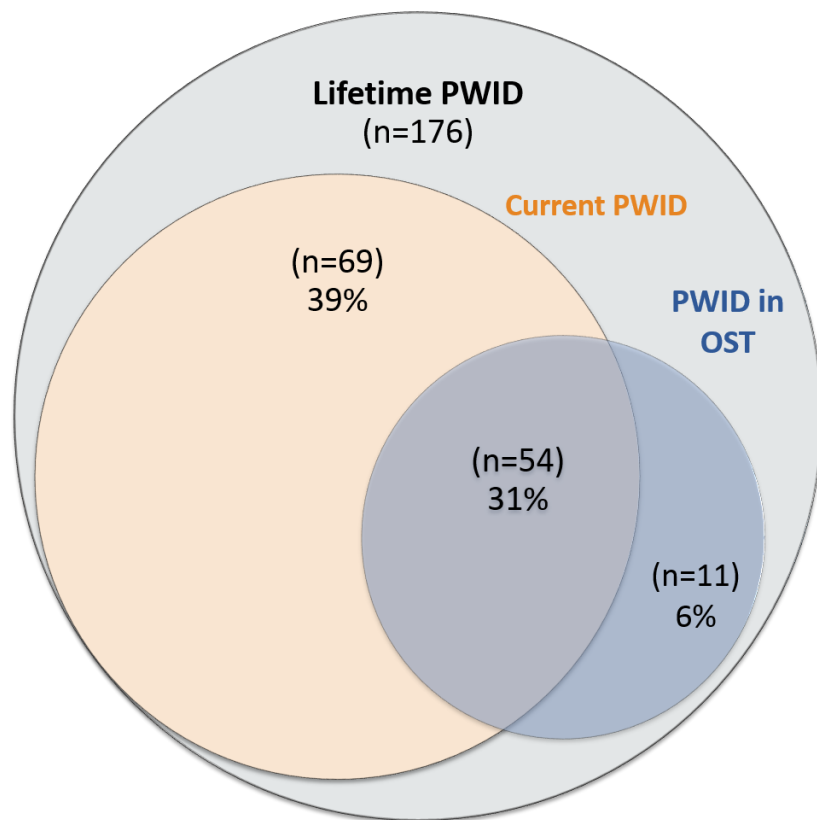
Contact  
Rosie Gilliver  
rosie.gilliver@health.nsw.gov.au  
Kirketon Road Centre  
PO Box 22  
Kings Cross NSW 1540  
(02) 9360 2766

# Hepatitis C

# Pre-post DAA changes



## Profile of Kirketon Road Centre clients initiating DAAs- first year

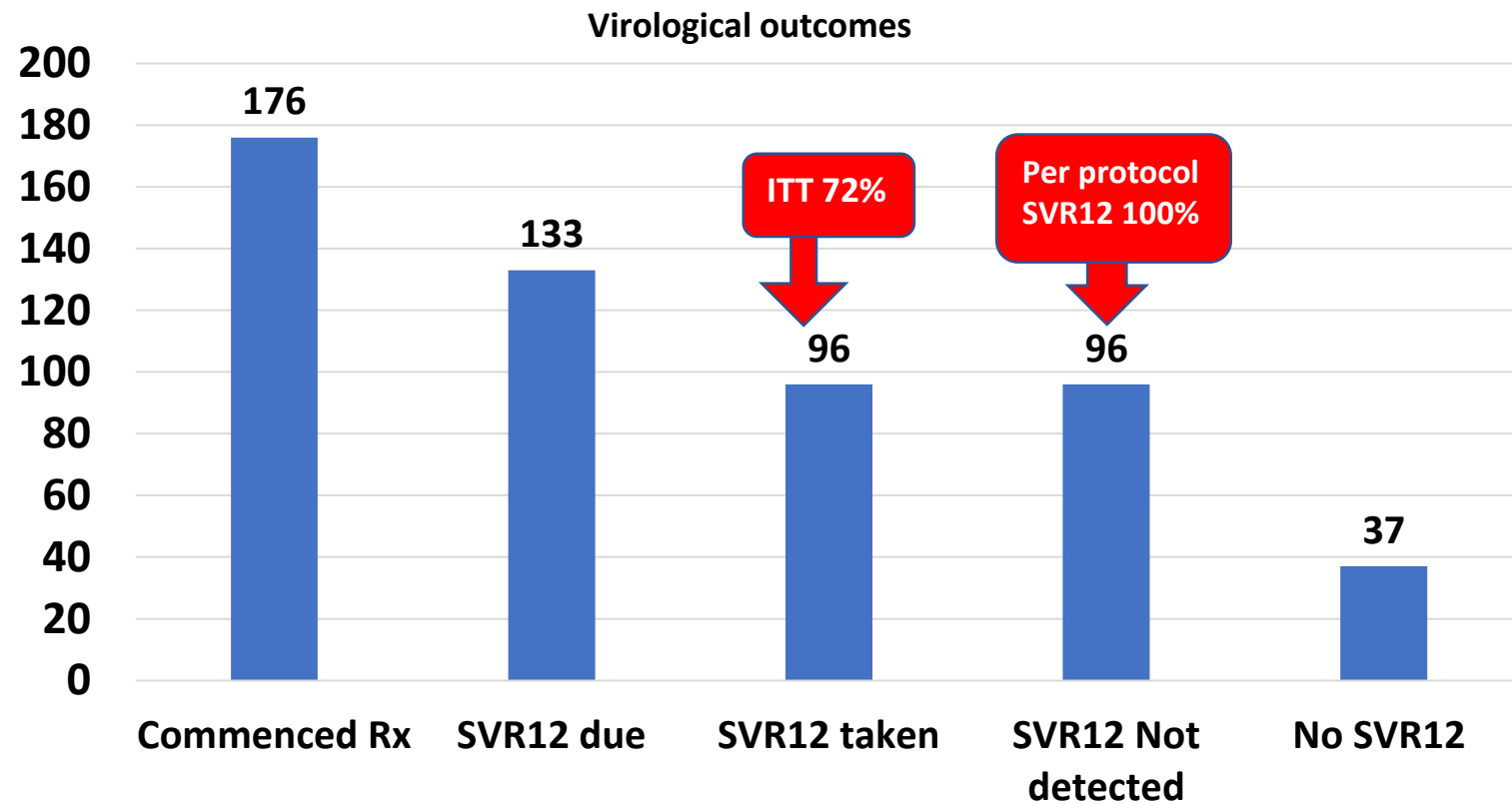


67% men  
37% currently homeless  
26% Aboriginal

### Other KRC services used:

58% drug and alcohol care  
43% mental health care  
50% HIV/sexual/reproductive health care  
58% social care- housing, debt, legal  
67% non-liver medical care  
28% first engaged in outreach setting

# Treatment Outcomes- first year



Read et al INSHU 2017



# Reasons for no SVR12 test

- **133 due: 37 not tested**
  - 4 died during treatment- 3 drug overdose, 1 unknown cause
  - 6 lost to follow-up on treatment
  - 1 deferred treatment and SVR12 date postponed
  - 1 pending (Successful ETR)
  - 25 completed treatment but late for SVR12
    - 6 less than 12 weeks late
- **Associations with no SVR12 test**
  - Homelessness (OR 3.7, 95%CI 1.0-12.9 p=0.042)
  - Poly-drug use (OR 3.3, 95%CI 0.8-13.9 p=0.109)
  - Neither significant in MV analysis
- **Homelessness associated with late SVR12**
  - aOR 25.4 95%CI 2.8-234.7, p=0.004



Read et al INSHU 2017

# Adherence and outreach support

- **61% managed monthly treatment**
  - Telephone support
- **39% utilised intensive support**
  - Daily dosing at KRC
  - Pick up medication weekly dosette box
  - Arrange dispensing through another facility
  - Delivery of medications to prison, psychiatric units, police cells, homeless hostels
  - Monitoring in outreach settings
  - Picking up medications at pharmacy
- **28% first engaged on outreach**
- **36% had some care delivered in an outreach setting**
  - NSP
  - Injecting centre
  - User organisations
  - Aboriginal programs
  - Homeless hostels
- Importance of primary health care model



# Using OTP infrastructure

79 clients now dosed daily or weekly through OST service

Half not taking OST

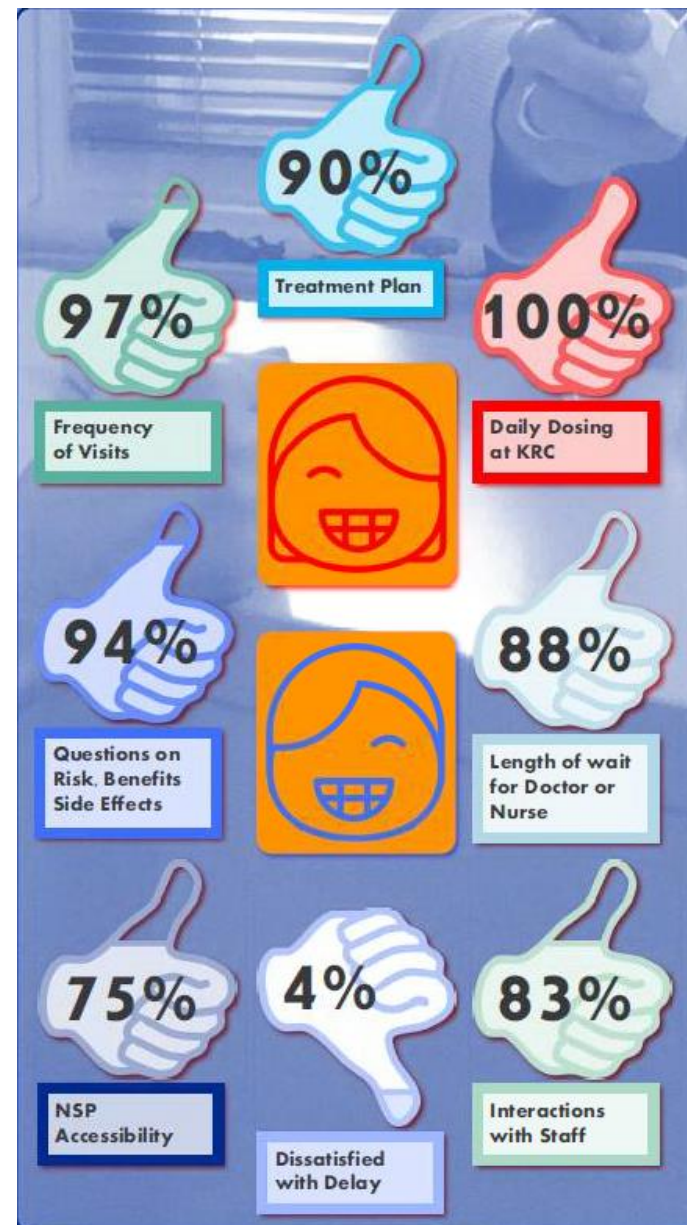
Evaluated impact on staff and other clients

No negative impact

Useful for homeless, less stable

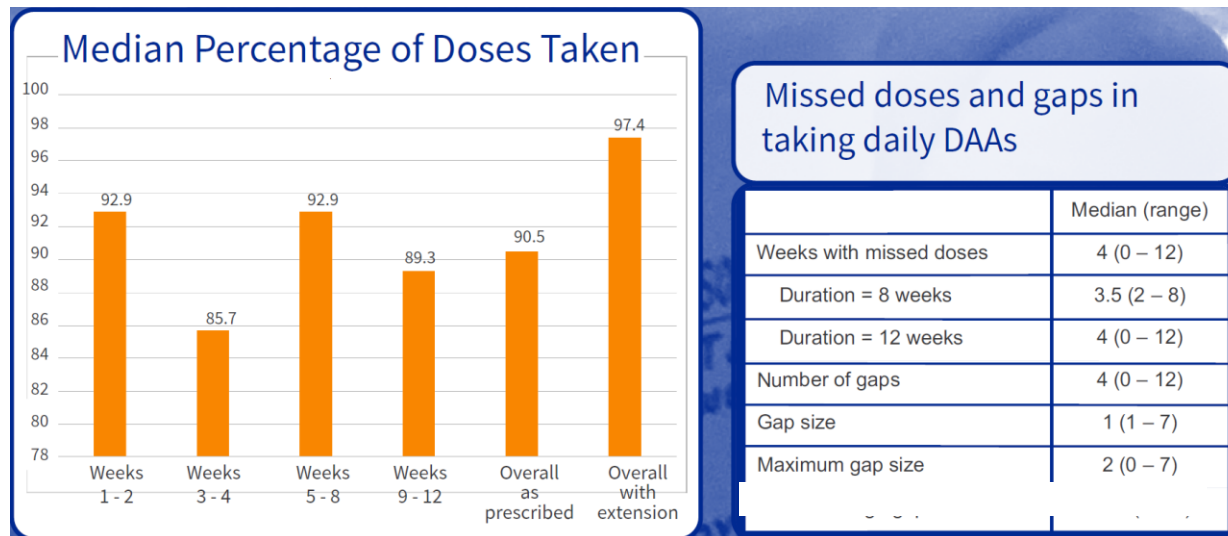
Individualised treatment plan

Chronister et al  
AVHEC 2017



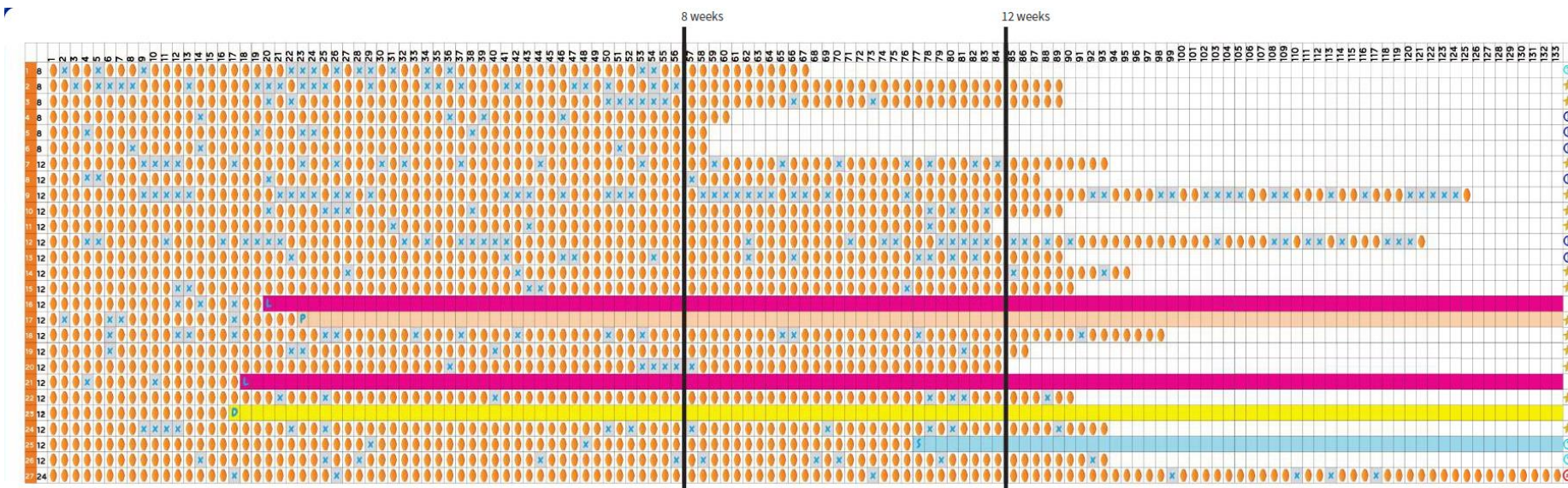


# Adherence to daily dosing



Now 79 daily dosers

- Young
- Homeless
- Poly-drug use
- Mental health disorder
- Aboriginal
- Taking OAT



Chronister et al AVHEC 2017

# Challenges

- Retaining focus on overall primary health care for populations we serve (including social)
- Commitment to principles; balanced by state and therapeutic disease-focussed targets and strategies
- Funding typically attached to specific public health aims
- Electronic medical record vs anonymity - Stigma
- Apply holistic integrated primary health care model to each situation
- Lots of training and resource requirements for staff
- Benchmarking- how to compare to more siloed services
- Funding rarely matches activity expectations
- Population changes- ensure marginalised people in Kings Cross/Woolloomooloo still have a voice



# Future directions for these clinical areas

- PrEP: here to stay- how to retain coverage and retention post EPIC- public system response
- Naloxone- state-wide implementation- training role
- Hepatitis C-
  - Focus on those not initiating
  - Collapse treatment cascade
    - Paradox that those who need collapsed cascade often the ones who need more overall healthcare
  - Role of DBS and POCT diagnostics- reinfection/SVR12 testing

# Summary

- Incredibly exciting time to be in BBV/AOD area
- Primary health care model professionally rewarding
- Continued belief in benefits of integrated targeted primary health care for marginalised groups
- Implementing and evaluating new medical advances in a real world setting continues to be vital
- Involvement of services like KRC in the public health response to diseases and social issues that disproportionality impact society's most disadvantaged and stigmatised is crucial if research is to be fully translated into practice

# Thank you

Basil Donovan & Rebecca Guy

Greg Dore & Jason Grebley

Lisa Maher

Karen Chronister/Rosie Gilliver/Rebecca Lothian/John Kearley

Ingrid van Beek

All staff and clients of KRC

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