Government of **Western Australia**
Department of **Health**
Public Health

Case Management Program guidelines, 2012

A Program for individuals with HIV who knowingly expose others to the risk of infection

Enquiries about this document should be referred to:

The Manager
Case Management Program
Communicable Disease Control Directorate
Public Health and Clinical Services Division
Western Australian Department of Health
36 Moore Street
EAST PERTH WA 6004

Tel: (08) 9221 5026
Fax: (08) 9221 2001
Email: ken.waddell@health.wa.gov.au

List of abbreviations

Act	*WA Health Act 1911*
AIDS	Acquired immunodeficiency syndrome
CDCD	Communicable Disease Control Directorate
CALD	Culturally and linguistically diverse
Clinician	Medical practitioner, nurse practitioner or responsible pathologist
CMO	Case management officer
CMP	Case Management Program
EDPH	Executive Director, Public Health
Guidelines	Case Management Program Guidelines
HIV	Human immunodeficiency virus
IDU	Injecting drug use
Letter	Letter of warning
LWP	Legal working party of the inter-governmental committee on AIDS
Panel	HIV Case Management Panel
PEP	Post exposure prophylaxis
PHU	Public health units
Police	WA police service
Program	Case Management Program
STI	Sexually transmitted infection
WA Health	Western Australian Department of Health

Table of contents

1. Introduction

This document outlines the Guidelines for the operation of the Case Management Program (CMP), Department of Health Western Australia. While most HIV positive people conscientiously avoid behaviour which exposes others to the risk of HIV infection, a very small number of individuals continue to pose a risk of transmission. They demonstrate by their actions that they are not able or willing to take appropriate actions to minimise the risk of transmission to others. CMP aims to reduce the risk of HIV transmission by these individuals.

Invoking the law in this situation presents a range of complex ethical, legal and human rights issues. In 1989, the Legal Working Party (LWP) of the Intergovernmental Committee on AIDS prepared a strategy paper on managing such individuals and recommended that existing state public health legislation support the statutory elements of such policy. In response, the Department of Health, Western Australia, which had dealt with a very small number of individuals who admitted to placing others at risk of HIV infection, developed a set of guidelines and procedures for their management, with its statutory component underpinned by the WA *Health Act 1911*, Section 251. These guidelines were used to form the Case Management Guidelines, and CMP was established in 1991 under the direction of the then Communicable Disease Control Directorate.

The National Public Health Partnership published 'Principles to be considered when developing best practice legislation for the management of infected persons who knowingly place others at risk' in 2003. In June 2007, Associate Professor Robert Griew completed the 'Review of policies for the management of people with HIV who risk infecting others'. In February 2008, the 'National guidelines for the management of people with HIV who place others at risk' was endorsed by the Australian Population Health Development Principal Committee. The principles and recommendations of these papers have been incorporated into this revision of the WA CMP Guidelines within the limitations of the WA *Health Act* 1911.

In the first instance, the Guidelines ensure that every effort is made to assist an individual to change their behaviour, and intensive and regular counselling, education and support are provided. This preventive approach which promotes behavioural change is viewed as preferable to invoking the law, which should be seen as the last resort. The policy has been successful in Western Australia and only rarely have punitive measures such as isolation been used.

These Guidelines provide for the management of all individuals with HIV who risk infecting others. However, it is important to distinguish between those individuals whose behaviour would clearly support a charge based on 'intent to cause grievous bodily harm', who should be immediately referred to police with CMP support for their immediate management; and those whose behaviour is better characterised as 'recklessness' or 'negligence', who should be assessed and managed by CMP and the HIV Case Management Panel (Panel) to encourage behaviour change.

The design of the Program utilises a case management approach which accommodates the complex social, psychological and health care needs of clients. This comprises all aspects of case management such as assessment, planning, linking, monitoring and advocacy. In addition, a multi-agency focus is considered essential.

If there is evidence to support any allegation(s) of risk behaviour, the individual becomes a client and a 'Five level management program' is implemented.
The Levels of the program are as follows:

Level One — Counselling, education and support

Level Two — Referral to the HIV Case Management Panel

Level Three — Letter of warning

Level Four — Isolation

Level Five — Referral for prosecution

CMP provides a 7-day per week, 24-hour per day service to the metropolitan area and gives advice to country regions. The CMP Team consists of the Program Manager, two officers, secretary and three casual support Workers. CMP is responsible for managing clients who reside in the metropolitan area and, in addition, provides training and consultative services to non-metropolitan population health directors are responsible for the management of clients in their regions.

The Department of Health, Western Australia is also aware that, in some situations, individuals who expose others to HIV infection may be prosecuted for offences under the *Criminal Code 1913* (WA). When this occurs, police action takes precedence over CMP activity until the court case is finalised. However, support by CMP for the client continues during this process, as appropriate.

Since its inception, the Guidelines have been regularly reviewed. Whilst it is known that the WA *Health Act 1911* has significant limitations in regard to its application to people who knowingly expose others to the risk of HIV infection, the Guidelines are required to operate within this Act until the new public health legislation is promulgated. This document outlines the Program objectives, working definitions, statewide procedures and, in particular, details how the power to isolate an individual operates. It also describes the procedures of the Department of Health, Western Australia that are aimed at redressing the fact that the Act does not recognise an individual's right of review and appeal.

2. Legislative provisions

These Guidelines are underpinned by the:

- WA *Health Act 1911* Sections 251 to 255, 257, 258, 276, 276A and 289
- WA *Criminal Code* Section 294 (8).

2.1. Western Australian *Health Act 1911*

The provision most relevant to the management of HIV-infected individuals placing others at risk of infection is Section 251, which sets out some special powers in relation to the control of dangerous infectious diseases. Section 251 contains powers to require examination and isolation or quarantine of a person.

Section 251 states that the Minister may authorise the Executive Director, Public Health (EDPH), to do various things. The EDPH can delegate the powers to any public health official.

Section 251 provides the power to:

- Order (in writing) a person who is reasonably believed or suspected of having a dangerous infectious disease to submit to a medical examination; [S251 (5)].
- Order a person to be isolated or quarantined [S251 (6)] and forbid the person from leaving that place, and enforce their return, if they leave, for as long as they have the disease [S251 (6) and (8)].

Section 252 of the WA *Health Act 1911* enjoins the co-operation and assistance of the police force and local authorities in exercising these powers. The EDPH and any public health official may do anything necessary or reasonably necessary to enforce an order and carry it into effect. This includes issuing a warrant:

- To police to apprehend a person to be quarantined or isolated and take the person to the place of isolation or quarantine; and
- To the person in charge of the place to keep the person as required by the order.

It is an offence to obstruct, hinder, refuse, or fail to comply with a direction or order [S255].

Under Section 276A, a medical practitioner, nurse practitioner or responsible pathologist (clinician) needs to report any person who they suspect of placing others at risk of HIV infection. As well, the WA Department of Health can request information from the clinician if they suspect that an individual is placing others at risk of contracting the virus [S276A].

The provision of this information to the Department of Health, Western Australia is not in contravention of any confidentiality obligation on the clinician [S289].

2.2. Criminal Code 1913

An individual can make a complaint to the Police if a person commits any act that is likely to result in another person having a serious disease [S 294 (8)]. As well, the Director General, Department of Health, Western Australia can refer a case to the police for their investigation. This offence carries a maximum of 20 years imprisonment.

3. Appeals against decisions

The WA *Health Act 1911* does not specifically provide for a review of the exercise of the powers provided. However, the Supreme Court has general jurisdiction to review administrative action under common law rules including denial of natural justice. The Parliamentary Commissioner for Administrative Investigations (Ombudsman) may also investigate the exercise of such powers.

In addition, a client can make an appeal in writing to the EDPH if they wish to dispute a decision. The EDPH will then review the decision in view of the information provided by the individual. Appeals can also be made to the Director General, Department of Health, Western Australia and/or the Minister for Health to review decisions made by the EDPH. Community agencies can provide advocacy and assist the client in this process.

4. Exchange of information

4.1. Confidentiality

Information about a person's HIV or AIDS status is 'personal health information' and is protected by confidentiality legislation.

Health professionals have a general duty to protect the confidentiality of individuals' personal health information. In general, this information is able to be shared with others who are involved in the provision of care, treatment or counselling of the individual, if such information is required in connection with providing that care, treatment or counselling.

In managing people with HIV whose behaviour places others at risk, the protection of confidential health information can assist in ensuring that individuals are able to remain in the community and retain personal and other support structures that enable safe behaviours. The protection of confidentiality in small communities, including rural communities or within cultural and social groups, can be especially important if the individual is to be stabilised and is to remain living within those communities.

Limits to the protection of confidential information operate in circumstances where a duty to a third party is owed. The WA *Health Act 1911* [S 276A] requires medical practitioners, nurse practitioners and responsible pathologists to report any person they suspect of engaging in risk behaviour(s) to the Department of Health, Western Australia.

Health service managers should ensure that staff have access to guidance on the appropriate circumstances and mechanisms that allow for the disclosure of health information where such disclosure is required for the management of risks to public health.

4.2. Referral to other agencies

When a client needs to be referred to another agency (government or community) for assistance then this is done with the permission of the client. It is advisable to ask the client to sign a "Release of Information Form". Also permission from the client is gained for the other agency and CMP to share information to enable better management and access to services for the client. Only such information is shared that is required for successful management. If the client's HIV status is not material to the situation, then this is not disclosed to the other agency.

4.3. Intra-state

Where a current CMP client moves through or to another region, the CMP Manager and/or the regional Director, PHU responsible for the client's case management refers the client to the receiving regional Director, PHU for ongoing case management. In making that referral, the Manager, CMP and the population health director or delegate are entitled to provide to the receiving Director such details as are necessary to allow for the ongoing management of that client without thereby contravening any applicable legal requirements relating to patient confidentiality.

4.4. Inter-jurisdictional

In circumstances where there is a reasonable belief or knowledge that a CMP client has or will travel to another State, the Director, Communicable Disease Control Directorate (CDCD) or equivalent should take steps to notify the inter-jurisdictional public health authority of the client's HIV status, any statutory actions taken and other necessary case information, as described in the 'National guidelines for the management of people with HIV who place others at risk, 2008'.

4.5. Referral to police

The Director General, Department of Health, Western Australia on advice from the EDPH can refer a case to the police for criminal prosecution. This is done after receiving legal advice that there are clear grounds for a charge involving intentionally causing grievous bodily harm or other illegal act; and

Referrals to police should also be made if a serious crime (for example rape, child sexual abuse, or child pornography) has been identified in the course of the CMP investigation or intervention.

Consideration of the referral to police for investigation and possible prosecution under the *Criminal Code* may be made at any time during the 'Five level management program', should evidence be found of illegal activity by the client.

5. The case management program

5.1. Program objectives

- To reduce the risk of HIV transmission from infected individuals who knowingly expose others to the risk of infection.

- To reduce the risk of HIV transmission from infected individuals with mental illness and/or intellectual disability who place others at risk of HIV infection, but this behaviour is not wilful.

Mother-to-child transmission is not the subject of these guidelines due to the complex legal and ethical issues involved. Clients who wish to have a child are referred to the 'Multi-disciplinary pregnancy team' for specialist treatment and counselling provided by Royal Perth Hospital, King Edward Women's Hospital and Princess Margaret Hospital.

5.2. Guiding principles

These guidelines have been developed in line with the documents listed in the Introduction.

The 'Review of policies' for the 'Management of people with HIV who risk infecting others', found that the number of individuals whose behaviours require intervention utilising coercive public health management strategies is small and that these individuals do not drive Australia's HIV infection rate. The Review noted that the continued effective management of HIV/AIDS in Australia is reliant on sustained investment in prevention and education strategies based on the latest surveillance data and targeting high-risk populations as the highest priority.

The Guidelines provide direction on the management of the sub-set of people with HIV who place others at risk in circumstances where it may be necessary to take steps that infringe the liberty of an individual in order to protect the health of the public.

The Guidelines are based on the following principles and assumptions:

- Except in special circumstances, testing for HIV should be conducted on a voluntary basis.
- People with HIV should not be quarantined, or excluded from social or sexual activities unless their behaviour continues to place others at risk of infection.
- Every individual has a responsibility to prevent themselves and others from becoming infected and preventing further transmission of the virus.
- Most people with HIV are motivated to avoid infecting others and the risk of transmission by most people with HIV is best managed through access to information, education and resources for the prevention of transmission and HIV treatment services.

- Counselling and support services, including post-diagnosis counselling, should be provided to encourage behaviours that minimise the risk of infecting others.
- For people with HIV who place others at risk, a variety of increasingly interventionist strategies may be needed, with preference being given to strategies that are least restrictive, as these will generally be the most sustainable and effective in the long term.
- The right to equitable, non-discriminatory and transparent dealing, including the right of review and appeal, should be preserved.
- If the client is of a culturally and linguistically diverse (CALD) background, written material should be in their native language (when available) and/or an appropriate interpreter service is used.
- The roles of clinicians and local service providers and that of public health officials in surveillance and enforcement should be kept distinct. This may not be possible in country regions as the same staff member(s) may need to fulfil both roles.

The management of people with HIV who place others at risk requires a variety of strategies including access to the range of services generally available to people with HIV; information and education about HIV transmission and prevention; access to HIV treatment and clinical care; and access to goods, such as condoms and needles and syringes. It may also require more intensive, individualised case management, a variety of responses to other health and social service needs and an escalating series of behavioural management techniques. These may include counselling, formal warnings and if necessary detention or referral to law enforcement authorities.

HIV is a life-long infection. There is, as yet, no cure. HIV treatments are understood to reduce infectivity but that is not by itself a safeguard. HIV transmission does not occur via normal day to day contact. Specific behaviours are linked to infection, e.g. unsafe sex, sharing needles or injecting equipment, blood to blood contact. Managing individuals with HIV who place others at risk therefore requires techniques that will be effective over the long term. Escalation to more directive strategies will generally not be preferred because these will be the most difficult to sustain.

In general, therefore, pre-emptive escalation to the more interventionist of these strategies will not be considered until less restrictive alternatives have been tried and have not been successful. However, there are cases where a step-by-step escalation through the full list of possible techniques will be considered too slow to respond to the behaviour of a

particular individual. The best mix and order of strategies will be determined on a case-by-case basis.

5.3. Definitions

It is important to define several terms used in this document.

Non-complying individuals

A non-complying HIV-positive individual is a person who knows and understands that they are infected with HIV and continues to engage in activities that expose others to the risk of HIV infection, despite counselling to modify their behaviour.

In summary, a non-complying HIV-positive individual is a person who meets all of the following criteria:

a) Is known by the Director, CDCD to be HIV-positive.

b) Has, in the past, wilfully and knowingly behaved in such a way as to expose others to risk of infection.

c) Has been counselled on the subject of appropriate and responsible behaviour change.

d) Has, in spite of interventions to modify behaviour, been assessed by the Manager, CMP, the Director, CDCD and the Panel as posing a significant risk of infection to others.

e) Is likely to continue such behaviour in the future.

Counselling

Counselling refers to a process within a professional relationship which offers support, information and education and aims to change attitudes, feelings and behaviours in the person being counselled.

Risk behaviour

Risk behaviour constitutes the failure of an HIV-infected person to inform a prospective sexual or injecting equipment sharing partner of their HIV-positive status and subsequent engagement with that person in unsafe behaviour such as:

a) Unprotected penetrative sex.

b) Sharing unsterilised injecting equipment.

c) Other activities that are likely to transmit the virus, e.g., violence involving the risk of exchange of blood.

5.4. Procedures

5.4.1. Key elements

Further to the Guiding Principles, key elements underpinning the procedures for managing both the allegations and non-complying individuals in Western Australia are:

An individual and case by case approach to management is essential.

Written and oral information on the choices and responsibilities of HIV-positive individuals is made available in the language in which they are most proficient (where possible).

The CMP process aims to provide the person with a high level of support and encouragement to enable appropriate lifestyle changes with a minimum of disruption to their life.

The value of positive outcomes for the infected person should be recognised as important to the overall likelihood of a reduction of public health risk.

To the extent that it is possible, having regard to any relevant considerations of confidentiality, the involvement of community groups, is sought. Referral to a specialised agency may include inter-agency and inter-sectoral collaboration, when appropriate.

There should be recognition of the need to appropriately manage those who may not be able to take responsibility for preventing the transmission of HIV, e.g. people with an intellectual disability or minors.

Any procedures instituted are appropriately documented (that is, process and outcome) to a standard that would be likely to be considered sufficient in the event that any part of the management of the client were to become the subject of any legal proceedings.

Coercive and restrictive responses are to be avoided where possible so that the use of the legal processes available under the WA *Health Act 1911* occurs if it is necessary, but is generally treated as the last resort.

That consideration is given, where appropriate, to any impact which the step(s) proposed to be taken in the management of a client may have on the broader control of HIV transmission.

A person should be managed under these Guidelines only while the Panel is of the opinion that the person will continue to place others at risk of HIV infection. When this opinion is no longer held the person should be released from management under the Guidelines. Those responsible for the management should regularly review the situation to determine if continuation of management is warranted.

5.4.2. The role of the HIV Case Management Panel

The function of the Panel is to provide expert advice to the Manager, CMP; regional population health directors and the EDPH in the discharge of their responsibilities and, if requested, to provide advice and support to clinicians or other service providers involved in the care of a client whose behaviour places others at risk of HIV infection. A full description of the role, members and responsibilities of the Panel is contained in 5.4.4 Five level management program.

5.4.3. Director, CDCD urgent case consultation

The Director, CDCD can seek specialist advice when there is urgent action needed in respect of a particular client. Reasons for this may include statutory action, movement of a client between Levels or other situations where client behaviour and/or their circumstances have changed and requires a quick response. The purpose of the consultations(s) will be to advise the Executive Director, Public Health on action(s) that may be required to assist the client modify their behaviour(s) and protect others from the risk of HIV transmission.

The consultation(s) will usually only be concerned with one client, unlike the Panel which reviews all clients. Notes will be taken of all decisions made at the consultation and reported to the Panel.

The consultations can occur between any of the following members:

- Manager, Case Management Program
- Public health physician
- Client clinician, GP or nurse
- Legal representative

- Community advisor
- Client advocate
- Regional population health director or delegate (when appropriate)
- Or others deemed appropriate by the Director, CDCD, e.g. psychologist, psychiatrist, etc.

The decisions made arising from the consultations and the client's progress will then be reviewed by the Panel at their next meeting.

5.4.4. Maintenance, discharge and escalation under these guidelines

(a) The cases of all individuals who are managed at 'level two' or above shall be considered at each meeting of the Panel during the time in which they are under such management. At each such meeting, the Panel shall consider the circumstances of the case, action taken, other relevant information, and shall provide advice about whether the individual is to be maintained, discharged or escalated under the Guidelines.

(b) If the intervention decided is short term, the report back on the implementation of the Panel recommendations will be considered at the next meeting of the Panel. If the intervention is successful, the Director, CDCD or the Manager, CMP may discharge the individual from management under the Guidelines in the interim and report this to the next meeting of the Panel.

(c) If the intervention decided is longer term, a report will be provided back to the Panel at its next meeting. The Panel will advise either to discharge the client from management under the Guidelines at that meeting or to continue with management.

(d) In determining whether a client is to be discharged from management, the Panel will have regard to:

- whether actions recommended by the Panel have been implemented
- the effectiveness of the implementation of the recommendations
- continued information or evidence that the client is endangering others, and
- an assessment of the likelihood of the client endangering others.

(e) In making this determination, the Panel should consider discharging the client from active case management unless there is an assessment that the client is currently endangering or likely to endanger others in the future. Discharge from management

constitutes an end to the Department of Health, Western Australia and Panel's involvement in the management of the client. Management will, of course, continue to occur via the local clinician / service provider. In the country regions, this may involve the same staff who were supervising the client under the CMP Guidelines.

(f) A client who is discharged may be re-admitted for management under the Guidelines at any time, as determined by the Director, CDCD or the Manager, CMP, should the view be formed that the behaviour of the client would warrant such action.

(g) In circumstances where the Panel forms a view that the actions taken are not effectively or sufficiently protecting public health, or where there is evidence of risk of danger to others, the Panel may recommend escalation of action in accordance with the Levels described below.

5.4.5. Investigations of allegations of risk behaviour

Throughout, the Manager CMP and the Director, CDCD should be aware of the importance of not pre-judging (one way or the other) any matters which may be asserted in a complaint. However, they should also consider, in cases where there is some doubt as to the veracity of the complainant, whether it would be prudent to request the complainant to provide a Statutory Declaration in which he or she formally verifies the matters alleged before the investigation is commenced. An explanation is given to the complainant of the investigation process and the use which may be made of any information provided by the complainant during that process. To assist with the investigation, as much relevant information as possible should be obtained from the complainant.

After receipt of the allegation, background information on the accused individual is gathered including whether they are listed on the confidential WA or National HIV Registers.

The next stage of the investigation involves a request for interview with the accused individual referred to in the allegation. They are advised of the investigation process and its purpose, and given an opportunity to respond to the allegation. The individual should be asked to provide confirmation of their HIV status and relevant information about their social history and behaviour.

During the investigation an attempt should be made to ascertain if any of the following has occurred:

(a) Admission by the individual that he/she has knowingly exposed others to the virus.

(b) Confirmation of the diagnosis of a notifiable sexually transmissible infection (STI) after the diagnosis of HIV, where the medical practitioner believes that this infection has occurred as a result of unsafe behaviour(s).

(c) Other reasonable belief that an individual has knowingly placed others at risk of infection.

The Director, CDCD is informed about the outcome of the investigation and reviews the evidence supporting the allegation. In discussion with the Manager, CMP, the Director will decide if the person should be placed under the CMP and what level of intervention is required. A report of the case is tabled at the next scheduled meeting of the Panel.

When the allegation refers to an individual living outside of Perth, then the case is referred to the population health director or delegate of the region concerned. Under the instruction of the population health director or delegate, the local staff carry out the investigation and report back to their Director. In discussion with the Manager, CMP and the Director, CDCD, the local population health director or delegate then decides if it is appropriate to place this person under Case Management and what level of management is applicable. This is then reported to the Panel.

In determining whether to accept the client for management under the Guidelines, the Manager, CMP, the Director, CDCD and the Panel will consider a range of matters including:

- Nature of the information provided, including (in relation to) the imminence and/or seriousness of risk to the public.
- Credibility of the information provided and the source of the information, including the basis on which conclusions have been drawn regarding the client having HIV infection and placing others at risk or being likely to place others at risk.
- The outcome of any inquiry into the information that may be undertaken by CMP.
- An assessment that the risk is or may be ongoing.
- An assessment of the bearing that a client's capacity or competence (or lack thereof) or co-morbid conditions (such as problematic drug or alcohol use or mental health issues) may have in relation to management of the client's behaviours.

- The range of and sufficiency of steps taken by the local clinician / service provider to manage the client's behaviours, and the prior involvement of appropriate services.
- An assessment of the likelihood that local actions may or may not succeed if allowed to continue to progress.

If any risk behaviours have taken place or are suspected of having occurred then attempts should be made to identify any other persons who may have been exposed to the virus. These names are forwarded confidentially to appropriate public or community health officers for contact tracing. This will allow for the early testing of contacts and in some instances the provision of post exposure prophylaxis (PEP) can be considered (and maybe appropriate). If the person is initially unwilling to provide this information, further attempts at a later time should be made.

5.4.6. Five level management program

While most clients will commence at level one, this management program is not strictly hierarchical or sequential. The client should be assessed and then the appropriate level of intervention applied.

The issues covered by these Guidelines are complex. At all stages of their implementation, public health authorities and health care workers involved in the management of people who place others at risk of HIV infection are required to exercise considerable professional judgement based on the unique circumstances of each case.

Level one – counselling, education, support

Level	Pathway	Services to consider	Decision, decision-maker & action
One: counselling, education and support Management in the community by the Case Management Program (CMP) with review by the Panel.	• After receiving an allegation of unsafe behaviour the circumstances are investigated by CMP. If allegation is proven then individual is placed under Case Management – client may not seem willing or able to protect sexual or needle-sharing partners. • This is reported to Director, CDCD and at the next meeting of the Panel. • Following discussion between Director, CDCD and Manager, CMP, client to be managed, at least in first instance, with follow up, education, counselling and support. • Ongoing review by Manager, CMP and the Panel of risk behaviour, i.e. if concerns continue. • Review at initiative of primary health care provider, i.e. if concerns continue.	• HIV clinical care. • Mental health and substance abuse services as needed. • Support, counselling, and education. • Referral to appropriate services.	• Decision is to admit to CMP and at what level at this initial stage. • Made by Director, CDCD in consultation with Manager, CMP. • Manager makes note of the decision. • Consider placing the client on an 'Undertaking' (see pg 15). • In cases where the client resides outside Perth, the Manager CMP refers the case to the population health director or delegate of the region for management in consultation with CMP in Perth. • The case is reported to the Panel at next meeting for review.

Counselling, education and support for the client to modify their behaviour is provided by CMP. Initially, counselling is directed towards building a relationship of trust and support. This enables the counsellor to address issues relating to the client's life circumstances, such as financial difficulties and income source, psycho-social problems, drug and alcohol use, as well as any HIV and other health issues.

After assessment of the individual's situation, interventions are adopted in agreement with the client. Such agreements are individualised to address the client's needs and take into account their age, health status, gender, cultural norms and level of cognitive and social functioning. The content may include the following:

- Regular and intensive counselling and education to strengthen relationships, improve health, understand aspects of sexuality and the means of HIV transmission.
- Education about the legal requirements and penalties for the client if they place others at risk of infection.
- Referral for medical, psychological and/or psychiatric assessment.
- Referral to suitable counselling, medical treatment, or drug and alcohol rehabilitation services, if appropriate.
- Access to the means of prevention such as condoms and sterile injecting equipment.
- Assistance with retraining and job placement.
- Assistance with housing or supported accommodation.
- Financial planning and access to assistance.
- Providing advocacy where appropriate.
- Life skills, e.g. Assistance with budgeting and social skills.
- Home care support, e.g. Shopping, cooking, cleaning.
- Providing transport for attendance at relevant appointments, etc.
- Referral to appropriate community agencies and peer-group organisations for support.

At this time, the client is encouraged to identify an independent person of their choice to act as their advocate for the duration of their involvement with CMP.

The Manager, CMP and the Director, CDCD will regularly review clients in 'level one'. Where there is evidence that the client has modified their behaviour appropriately, no further steps are taken and the client is discharged from the CMP process, in line with these Guidelines.

A case conference of local services engaged with an individual is often useful in developing a plan with the individual client. In the case of people with HIV who have complex needs often associated with cognitive, behavioural, and/or mental health problems, specialist tertiary services should be involved in assessment and management

for the client. In some country regions these services may not be available. Teleconferencing or video conferencing with the client and relevant specialist in Perth may be necessary. Also in some cases, the client may need assistance to travel to see a specialist.

It may be considered appropriate to get a signed, written agreement (Undertaking) with the client so it is clear as to what is expected from the client and CMP. The Undertaking is based on the individual's risk factors, needs and situation at the time. In addition to the dot points above, elements contained in the Undertaking might include:

- to always use safe behaviours and not place others at risk of infection
- to continue counselling, education and support with CMP
- to comply with medical treatment
- to access appropriate services from other community and government agencies
- to start/continue with an alcohol and/or drug program
- to consent to assessments, e.g. psychological, psychiatric, etc
- to inform CMP of any intended change of address.

As well incentives are usually built into the Undertaking in the form of services that can be provided by CMP. These can include assistance with:

- accessing Centrelink payments or other income
- finding accommodation
- finding employment or training
- transport to appointments, etc
- assistance with legal issues, e.g. accessing Legal Aid or Aboriginal Legal Service, advocating with Fines Enforcement, etc
- assisting with child custody issues and access visits
- making sure that clients in prison have access to appropriate services and a support program for when they are released.

If not already undertaken, or if the client was previously unwilling to name sexual or injecting drug use (IDU) partners, CMP will assist with contact tracing in accordance with appropriate ethical and legal standards.

At any stage, CMP can be contacted for advice. It is important that service providers and local clinicians feel free to contact CMP if they are not able to manage the individual client's behaviour or if they feel that the matter should otherwise be brought to CMP's attention. CMP will also provide feedback to the service provider and/or clinician, as appropriate.

Contacting CMP will not automatically lead to the client being managed under the Guidelines. It may lead to the provision of advice, referrals to other agencies or professionals better placed to provide support.

When a decision is made to manage a client according to the Guidelines, the Manager, CMP will provide a report on every client to the Panel on at least a four-monthly basis and more frequently if required.

In circumstances where the strategies used in 'Level one' appear to have failed, elevation to 'Level two management' is considered by the Panel. When considering this escalation, examination of the nature and reliability of evidence indicating non-complying behaviour is taken into account. If the evidence suggests there is a reasonable belief that a person has not modified their behaviour and continues to put others at risk then 'Level two' interventions are commenced (see 5.4.3 Investigations of allegations of risk behaviour for more detail).

Level two – HIV Case Management Panel

Level	Likely Pathway	Services to consider	Decision, decision maker & action
TWO: counselling, education and support under advice from HIV Case Management Panel Management in the community under recommendations from the Panel but without a Letter of warning.	• No satisfactory change in behaviour after 'Level one management'. OR • Agreement between Director, CDCD and Manager, CMP that 'Level two' is appropriate initial management.	• Psychiatric and medical assessments required if not previously obtained. • Detailed recommendations on case management, including behavioural management or other services if indicated. • Additional resources/services may be required to meet the client's needs.	• Decision is to escalate the case to Level Two. • Made by Director, CDCD, Manager, CMP and the Panel in consultation with the primary health care provider. • Reviewed by Panel. • Panel considers case and provides written advice about CMP management. • Consider placing the client on an 'Undertaking'. • Consider need for appointment of client advocate. • Consider letter of warning. • Consider management under Mental Health or Guardianship Acts, etc. • Interventions reviewed by Panel for management or discharge.

The Panel:

(a) The function of the Panel is to provide expert advice to the Manager, CMP; regional population health directors and the EDPH in the discharge of their responsibilities

and, if requested, to provide advice and support to clinicians or other service providers involved in the care of a client whose behaviour places others at risk of HIV infection.

(b) The Panel should be chaired by the Director, CDCD and include the Manager, CMP. Panel members could usefully include a HIV specialist, a representative of an HIV/AIDS community organisation with peer involvement, a representative from an advocacy organisation, a public health physician, legal policy advisor, and others co-opted as appropriate to an individual case. When a client is from a country region, the population health director or delegate from that region can be linked in to the Panel meeting by teleconference or video conference, if appropriate.

(c) In addition to the permanent members of the Panel, the Chair may give consideration to involving others who may inform the Panel's deliberations and who may be able to assist in the implementation of Panel recommendations.

(d) An appropriate senior departmental officer should be nominated to observe Panel meetings to make sure departmental procedures and policies are followed. The Chair will appoint a secretary to the Panel who will be responsible for maintaining minutes for the Panel. Minutes of Panel meetings should be reviewed and approved by the Chair.

(e) The Panel should meet as needed or at least every quarter in order to, at a minimum, receive a report from the Manager, CMP on enquiries received and advice provided in relation to any new clients and to review the progress of existing clients being managed under the Guidelines. In circumstances where no enquiries have been received and where no clients are being managed at 'Level two' or above, it may be agreed that no meeting of the Panel is required.

(f) It is considered essential that the Panel meet at least every quarter to consider clients at 'Level two management' or above as management at these levels entails close case management, with or without an 'Order', which is coercive. A regular meeting schedule, with additional meetings scheduled where necessary, allows for regular review by the Panel of the sufficiency and effectiveness of public health action under the Guidelines and, where appropriate, for change to be made to the Level at which a client is being managed under the Guidelines.

(g) Should a person to whom operation of the Guidelines might properly apply come to the notice of local clinicians or other service providers, contact should be made with the Director, CDCD or the Manager, CMP to request a determination of a suitable course of action. The Director, CDCD or the Manager, CMP may decide either to support the local

clinician and service providers with advice alone or to accept that the client should be managed under the Guidelines at Level One or above.

(h) When the EDPH, the Director, CDCD or the Manager, CMP decides that an individual should be managed under the Guidelines, the Panel should be informed at its next meeting. The Panel should determine a course of follow up that may be short or longer term, and advise the Director, CDCD and Manager, CMP accordingly.

(i) In determining a course of follow up, the individual(s) who are to be responsible for implementation of any recommendations / determined actions and the timeframe for implementation will be specified. These will be recorded in the Minutes of the Panel meeting. Depending on the nature of the recommendations, the responsible individual(s) may be the local clinician, other providers, or the CMP. The Manager, CMP will communicate all recommendations / determined actions to the responsible individual(s).

(j) At all stages of management under the Guidelines, clear and appropriate documentation about the rationale for decisions made and the progress of implementation must be maintained.

(k) Case files maintained by CMP or in the regions, should be kept according to the records management policies and standards, with consideration given to protecting the privacy of individual clients.

(l) Unique identifier codes should be used in place of names wherever possible, to reduce the number of people who know the identity of clients.

(m) Consideration should be given to induction or training activities for administrative officers working with these files to ensure that they are aware of policies relating to the protection of medical information.

(n) The Panel should meet in order to:

- Receive a report on the progress of each client.
- Review all clients and provide advice on their further management.
- Formulate and/or endorse the management plan for any new clients.
- Decide if any client should be changed to a new level of management or discharged from the CMP process.
- Refer the case to the EDPH, if appropriate, (e.g. where an official warning is necessary).

- Determine a course of follow up and to specify the individual(s) who are to be responsible for implementation of any recommendations / determined actions and the timeframe for implementation.
- Ensure that at all stages of management, clear and appropriate documentation about the rationale for decisions made and the progress of implementation is maintained.
- Receive reports of short term interventions for further consideration. If the intervention is successful, the Director, CDCD or the Manager, CMP may discharge the individual from CMP management and report this to the next meeting of the Panel.
- Receive reports on longer term intervention(s). The Panel will decide either to discharge the client from management or to continue with management.
- Determining whether a client is to be discharged from management under the Guidelines, having regard to:
    - Whether actions recommended by the Panel have been implemented.
    - The effectiveness of the implementation of the recommendations.
    - Continued information or evidence that the client is endangering others
    - Whether it is appropriate to allow management under the Guidelines to lapse in the absence of an ongoing assessment that the client is endangering or likely to endanger others. Discharge from management under the Guidelines constitutes an end to the Department of Health, Western Australia's and Panel's involvement in the management of the client.
- Determine if a client who has previously been discharged needs to be re-admitted for management under the Guidelines at any time, should the view be formed that the behaviour of the client would warrant such action.

Where the Panel concludes that action is warranted using the powers of the WA *Health Act 1911*, the Panel should provide advice to the EDPH by documentation in the minutes of the Panel meeting and should indicate the legislative provisions under which action should be considered and the specific requirements of the client that should be considered for inclusion in any action or 'Order'. The minutes of the Panel should provide justification for the advice. The EDPH should consider this advice as a matter of urgency.

Level three – 'letter of warning'

Level	Likely pathway	Services to consider	Decision, decision maker & action
Three: "letter of warning'. If recommended by the Panel, a formal letter is written by the EDPH to the client. This Letter advises that the Department of Health, Western Australia is aware of the client's continued risk behaviour and warns of further action that may be taken unless this behaviour ceases immediately. The Letter may also require the client to comply with other conditions, e.g. to attend counselling, continue with drug/alcohol program, etc.	• Advice from the Panel to the EDPH following client assessment OR • Urgent referral of case to the EDPH by the Director, CDCD.	Same range of services as Levels One & Two but in addition: • May be required to continue counselling, attend drug/alcohol program, etc as directed by the EDPH. • Supervision and surveillance as required by CMP.	• Decision is to refer the case to the EDPH. • Made by the Panel or Director, CDCD in urgent cases. • Case reviewed by the EDPH and 'Letter of warning' written. • Consider management under Mental Health Act, Guardianship Act, etc, if appropriate. • Review by Panel and advice given to the EDPH regarding compliance with the Letter and any further action that may be required.

The Panel may recommend that a 'Letter of warning' be sent by the EDPH to the client. This Letter is an official warning to the person to discontinue any activity that places other people at risk of HIV infection. It will describe the legal powers vested in the EDPH to isolate persons or have the case referred to the Police, should this behaviour not cease immediately.

The 'Letter' will reiterate the availability of counselling, education and support services for the individual and may state that it requires that the person makes contact with and maintains contact with, particular agencies by a specified time or times.

The Manager, CMP ensures that the person has received and understood the ‘Letter of warning’ and in addition, she/he has been advised to discuss its contents with an independent advocate of their choice.

An appeal of a ‘Letter of warning’ can be made as detailed in Section 3.0 Appeals against decisions. Arrangements should be made to assist the person to have appropriate advocacy and legal representation during this process.

Level four – isolation

Level	Likely pathway	Services to consider	Decision, decision maker & action
Four: curfew and/or isolation (statutory action) Curfew or isolation as directed by an Order of the EDPH under the Section 251 of the *WA Health Act 1911*. This level enables the exercise of the following specific powers: • To order a person to be subject to a curfew; • To order a person to be subject to isolation.	• Issue a Curfew Order or an Isolation Order following advice from the Panel to the EDPH OR • Urgent referral of the case to the EDPH by the Director, CDCD or Panel	• Curfew during stated hours in suitable premises. • Isolation in an appropriate facility. • Full range of counselling, treatment and support services as required. • Medical/ psychological examination to ensure wellbeing of individual and that order still relevant • Further assessment(s) of the client to assist with counselling, education, etc.	• Decision is making a Curfew Order or an Isolation Order. • Made by the EDPH on advice from the Panel or in urgent cases the Director, CDCD. • Review by the Manager CMP, the Director, CDCD and Panel during and at the end of the Order. • Communication of Order and its requirements to client together with offer of support and advocacy services. • Issuing of appropriate Warrants to Police by the EDPH should they be required. • Consider management under Mental Health Act, Guardianship Act, etc • Review and re-issuing or discharge as required.

Detention and/or isolation for the purposes of managing HIV public health risk are expected to be rare occurrences, as these Guidelines provide for a flexible range of responses, with detention and isolation considered to be strategies of last resort.

When the Panel believes that a person is behaving in a way which continues to place other individuals at risk of HIV infection, and is exhibiting behaviour which has not been

modified in a satisfactory way by other means of intervention, it may request the EDPH to issue an order to confine the person in the interests of public health. An Isolation Order may specify the home of the individual or other suitable location and may be in the form of a curfew for certain hours each day, or for extended periods of days to weeks.

Where the client to whom an Order of Isolation applies is already detained under a custodial sentence or on remand, consideration should be given to the revoking of the Order due to the complex legalities for the enforcement of the Order, while the client is under detention by the Police or the Department of Corrective Services.

The Panel may recommend to the EDPH that an Order of Isolation be commenced for a specified and limited period of time. This will be subject to regular review by the Director, CDCD; the Manager, CMP and the Panel. The isolation will include concurrent counselling, education and behaviour change therapy. Ongoing medical management, if necessary, is continued. Treatment of psychiatric and psychosocial conditions and drug and alcohol dependence is also provided, when appropriate. If there is found to be a psychiatric condition underlying the person's behavioural problems, a psychiatric assessment may lead to referral and committal (voluntary or involuntary) to a psychiatric institution. This may or may not involve isolation.

Level five – referral for prosecution

Level	Likely pathway	Services to consider	Decision, decision maker & action
Five: Referral for prosecution Referral to police under the *Criminal Code*.	• By the Director General, DEPARTMENT OF HEALTH, WESTERN AUSTRALIA on advice from the EDPH. Always with legal advice: • Immediately on clear grounds for a charge involving intentionally causing serious bodily harm or other illegal act; or • after intervention the client demonstrates an unwillingness to alter behaviour that recklessly or negligently endangers or causes serious harm. • Referrals to Police should also be made if a serious crime (e.g., rape, child sexual abuse, or child pornography) has been identified in the course of the CMP investigation or intervention.	• Continued provision of services as needed. However, police action takes precedence over CMP interventions.	• Decision is referral to Police under the *Criminal Code*. • Made by Director General, Department of Health, Western Australia after consultation with the EDPH and with legal advice.

If the person continues to place others at risk of HIV infection and all other strategies of behavioural change have failed, then the EDPH can refer the case to the Director General, Department of Health, Western Australia. The Director General, Department of Health, Western Australia, under legal advice, may then refer the case for legal prosecution under the Criminal Code. The EDPH may also refer a case to the Director General, Department of Health, Western Australia if there has been a breach of the law by the client, e.g. rape, paedophilia, child pornography, deliberate infection of another person, or other actions that may warrant the immediate referral of the case to the police.

5.5. Statewide case management

These Guidelines are to be used throughout WA. In the regions outside of the metropolitan area, the population health director or delegate of each public health unit

(PHU) is responsible for the management of clients with HIV who place others at risk of infection under these Guidelines.

The population health director may delegate the duties under these Guidelines to the public health physician and/or other staff members. These officers can facilitate the development of an appropriate regional, multi-agency network to enable effective case management. He/she can also maintain a separate database for recording case management activities and liaise with CMP staff in Perth.

The Manager, CMP and the Director, CDCD are available to advise and assist the population health director or delegate with any client. As well the Panel will provide advice on the management of clients. When necessary, staff from CMP (based in Perth) will travel to the region to assist with difficult cases and situations.

CMP will assist with training regional staff in managing clients with HIV who place others at risk of infection. As well, updates and additional training will be provided by CMP for all officers in WA involved in managing CMP clients.

As all CMP clients are reviewed by the HIV Case Management Panel, the regional population health director or delegate is to provide a report on each client. This report will be presented to the Panel at each meeting. The population health director or delegate will also facilitate the implementation of the recommendations of the Panel for their client(s).

If and when a regional client needs to be placed on a curfew or isolated under an Order by the EDPH, this is preferably carried out in a suitable location in the region. This will enable the local staff to work with the client. Clients may also have an adverse reaction to being removed from their local environment during the period of the Order. Only if no suitable facility is available for this purpose, then a client can be isolated at the special unit in Perth.

It is recommended that each non-metropolitan region develop protocols and strategies suited to clients in their region. These will reflect the local epidemiological, social and cultural context. Where feasible, regional Department of Health, Western Australia workers, CMP staff and local communities contribute to the development and ongoing review of these protocols and strategies.

Where a current CMP client moves through or to another region, the Manager, CMP and/or the regional population health director or delegate will refer the client to the receiving regional population health director or delegate for ongoing contact and/or case

management. In making that referral, the Manager, CMP and the population health director or delegate are entitled to provide to the receiving population health director or delegate such details as are necessary to allow for the ongoing management of that client without thereby contravening any applicable legal requirements relating to patient confidentiality.

When a regional client is travelling to Perth or other region for medical reasons or doctors' appointments, then the regional population health director or delegate will need to ensure that the client has the necessary return tickets, accommodation and money, and that all other arrangements are made, before the client leaves home.

5.6. Clients who are minors (persons under the age of 18 years)

Clients who are minors will be managed under these Guidelines but there need to be additional steps taken when dealing with these persons. Consideration needs to be made to ascertain if the client can be assessed as being a "mature minor" and being able to comprehend the situation and make informed decisions for them selves. If not, a parent, guardian or responsible adult needs to be present at any interview with the minor.

At all times, officers need to be aware of and conversant with the Guidelines for Protecting Children 2009 - Operational Directive OD 0218/09. These Guidelines can be accessed from:
http://cahs.hdwa.health.wa.gov.au/__data/assets/pdf_file/0008/68381/2193CHILDABUSEGUIDELINES.pdf

The Guidelines give direction on how to deal with minors and give contact numbers for experienced staff if advice needed.

6. Bibliography

1. ANCARD Working Party, *the National Indigenous Australians' Sexual Health Strategy 1996 – 97 to 1998 – 99: A Report of the ANCARD Working Party on Indigenous Australians' Sexual Health*, Canberra, Commonwealth of Australia, 1997.
2. Commonwealth of Australia, *Partnerships in Practice*: National HIV/AIDS Strategy 1996 – 97 to 1998 – 99, AGPS: Canberra, 1996.
3. Department of Health and Aging, *The National HIV/AIDS Strategy 2005-2008: Revitalising Australia's Response*, 2005.
4. Griew R, *Review of Policies for the Management of People with HIV who Risk Infecting Others*, 2007.
5. Health Department of Victoria, *Guidelines for the Management in Victoria of HIV Infected People Who Knowingly or Recklessly Risk Infecting Others*, 1992.
6. Intergovernmental Committee on AIDS (IGCA), *Guidelines on the Management of People with HIV/AIDS Knowingly Placing Others at Risk of Infection*, 1989.
7. McCaul P, *The Region with Special Needs HIV/STD Prevention and Control Strategic Plan. Perth*, Health Department of WA, 1998.
8. Queensland Health, *Protocol for the Management of HIV Positive People Whose Behaviour May Constitute a Public Health Risk*, 2000.
9. South Australian Health Commission, *Revised Guidelines for the Management in South Australia of People Who Knowingly Place Others at Risk of HIV Infection*, 1997.
10. South Australian Health Commission, *Draft South Australian Guidelines for the Management of People Who Place Others at Risk of HIV Infection*, 2000.
11. WA Department of Health, *Choices and responsibilities for HIV positive people*, 2008.
12. WA Department of Health, *Western Australian Aboriginal Sexual Health Strategy 2005 – 2008*, 2005.
13. WA Department of Health, Western Australian HIV/AIDS Action Plan, 2006 –2008, 2006.

Delivering a **Healthy WA**