



### HIV CASE MANAGEMENT:

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



## **TABLE OF CONTENTS:**

<b>1.0</b>	<b>INTRODUCTION</b>	<b>1</b>
<b>2.0</b>	<b>THE HIV CASE MANAGEMENT PROGRAM</b>	<b>3</b>
2.1	Program Objective	3
2.2	Guiding Principles	3
2.3	Terminology	4
2.4	Procedures	5
2.4.1	Key Elements	5
2.4.2	Investigations of Allegations of Risk Behaviour	6
	Stage One - Counselling, Education, Support	6
	Stage Two - HIV Case Management Panel	7
	Stage Three - Letter of Warning	8
	Stage Four – Isolation	9
2.5	Statewide HIV Case Management	9
<b>3.0</b>	<b>BIBLIOGRAPHY</b>	<b>11</b>

## 1.0 INTRODUCTION

This document outlines the policy of the HIV Case Management Program, Department of Health. Whilst most HIV positive people conscientiously avoid behaviour which exposes others to the risk of their 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 protect their sexual or needle-sharing partners. The HIV Case Management Program 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 then Health Department of 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 formed the Case Management policy, and the HIV Case Management Program was established in 1991 under the direction of the Communicable Disease Control Branch.

The guiding principles of the Third and Fourth National Strategy are at the core of this policy. In the first instance, the policy ensures 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 has isolation been used.

The design of the Program utilises a case management approach which accommodates the complex social, psychological and health care needs of the 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 of the Program and the first stage of a 4-stage hierarchical model is implemented. The stages of the Program are as follows:

Stage One — Counselling, Education and Support

Stage Two — HIV Case Management Panel

Stage Three — Letters of Warning

Stage Four — Isolation

The HIV Case Management Program provides a 7-day a week, 24-hour a day statewide service. The Team consists of the Program Manager, two Officers,

secretary and three casual Support Workers. The staff is responsible for managing clients who reside in the Metropolitan area and, in addition, provide training and consultative services to non-metropolitan Public Health Units who are responsible for the management of clients in their regions. Strategies adopted by the regional Public Health Units when implementing this policy reflect their local context.

The Department of Health 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 priority over Case Management activity until the court case is finalised.

Since its inception, the Case Management policy has 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, HIV Case Management policy is required to operate within this Act until the new Infectious Diseases legislation is promulgated. This policy document outlines the Program objective, working definitions, statewide procedures and, in particular, details how the power to isolate an individual operates. It also describes Departmental procedures aimed at redressing the fact that the Act does not recognise an individual's right of review and appeal.

## **2.0 THE HIV CASE MANAGEMENT PROGRAM**

### **2.1 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.

### **2.2 Guiding Principles**

Responses to clients referred to the HIV Case Management Program conform to the guiding principles of the Third and Fourth National HIV/AIDS Strategy and the recommendations of the LWP Strategy Paper. The following specific principles underline the Program:

- Transmission of HIV is preventable through changes in individual behaviour. Education and prevention programs are necessary to bring about these changes.
- Each person accepts responsibility for preventing them becoming infected through sexual intercourse or the sharing of needles. However, it is recognised that there are circumstances in which individuals are not capable of, or are prevented from taking such responsibility, for example when intellectual disability, imprisonment or mental illness are present.
- The community as a whole has the right to appropriate protection against infection.
- Public health objectives will be most effectively realised if the co-operation of people with HIV infection and those most at risk is maintained.
- Specific informed consent should be obtained before any test is performed to diagnose a person's HIV infection status. The result should remain confidential, and appropriate pre- and post-test counselling should be provided.
- People infected with HIV retain the right to participate in the community without discrimination and have the same right to comprehensive and appropriate health care, income support and community services as other members of the community.

## 2.3 Terminology

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 have been 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, Communicable Disease Control Directorate or the regional Public Health Director 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 or the regional Public Health Director as posing a significant risk of infection to the others; and
- 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 following:

Omission by an HIV-infected person to inform a prospective sexual partner 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; and
- c) other activities that are likely to transmit the virus: for example, violence involving the risk of exchange of blood.

## 2.4 Procedures

### 2.4.1 Key Elements

Elements underpinning the procedures for managing both the allegations and non-complying individuals in Western Australia are:

1. An individual and case by case approach to management is essential.
2. Written and oral information on the rights and responsibilities of HIV positive individuals is made available.
3. Management 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.
4. 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.
5. 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.
6. There should be recognition of the need to protect those who may not be able to take responsibility for preventing the transmission of HIV, for example, intellectually disabled or minors.
7. 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.
8. Coercive and restrictive responses are to be avoided where possible so that the use of the legal processes available under the Health Act occurs if it is necessary, but is generally treated as the last resort.
9. Any restrictive measures are applied in such a manner that the infected person is placed in the least restrictive environment, whilst taking the interests of the community into account.
10. 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.
11. A person should be managed under these guidelines only while the Manager or Director 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.

#### **2.4.2 Investigations of Allegations of Risk Behaviour**

Throughout, the Manager or Director, 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, the Manager or Director 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. The Manager or Director should explain to the complainant the investigation process and the use which may be made of any information provided by the complainant during that process.

The investigation involves a request for interview with the individual in whom they are told about the allegation, the investigation process and its purpose, and given an opportunity to respond. The Manager or Director also requests the individual to provide confirmation of the individual's HIV status and relevant information about the person's social history and behaviour.

If any of the following evidence exists:

- a) Admission by the individual that he/she has exposed others to the virus; or
- b) The diagnosis of a notifiable sexually transmissible disease after the diagnosis of HIV infection; or
- c) Other reasonable belief that a person knowingly places others at risk of infection,

then the individual becomes a Case Management client. At this time, the person is encouraged to identify an independent person of their choice to act as their advocate for the duration of their involvement with the Program. In such cases, the Director of Disease Control is informed about the outcome of the investigation and reviews the evidence supporting the allegation.

#### **Stage One - Counselling, Education, Support**

Counselling, education and support for the client to modify their behaviour is provided by the HIV Case Management Program Team or by Department of Health staff as directed by the relevant regional Public Health Director. 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, psycho-social problems, drug and alcohol use, and unemployment.

After assessment of the individual's situation, interventions are adopted in agreement with the individual. 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 and understand aspects of sexuality.
- Referral for medical, psychological 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 injecting equipment.
- Assistance with retraining and job placement.
- Assistance with housing or supported accommodation.
- Financial assistance.
- Life skills, for example assistance with budgeting and social skills.
- Home care support, for example, shopping, cooking, cleaning.
- Referral to an appropriate peer group organisation for support.

The Program Manager or relevant regional Public Health Director and the Director, Communicable Disease Control regularly review the situation of clients in Stage One. Where there is evidence that clients modify their behaviour no further steps are taken. However, in circumstances where the strategies used in Stage One appear to have failed, referral to the HIV Case Management Panel (Stage Two) is considered. When considering referral to the Panel, the Program Manager or Public Health Director examines the nature and reliability of evidence indicating non-complying behaviour. If the evidence suggests there is a reasonable belief that a person has not modified his/her behaviour and continues to put others at risk then the case is referred to the HIV Case Management Panel.

### **Stage Two - HIV Case Management Panel**

This assessment Panel is convened by the Director of the Communicable Disease Control Directorate on an ad hoc basis as required. Membership of the Panel will include:

- Director, Communicable Disease Control Directorate (Chair)
- Manager, HIV Case Management Program
- Regional Public Health Director, if appropriate
- Manager, Sexual Health & Blood Bourn Virus Program
- Legal Officer, Department of Health
- an appropriately experienced personal advocate chosen by the client
- a community representative (if appropriate).

Additional members, for example, the client's primary health care provider, can be suggested by the Director.

The role of the Panel is to:

1. To review the client's medical and psychosocial assessment as well as the previous management.
2. To seek referral for additional assessment and support, eg referral to psychiatric services, etc.
3. To provide advice and recommendations about the management of the case to the Executive Director of Public Health (EDPH).
4. To coordinate and monitor the continued management of the client in order to minimise the future risk of HIV transmission.

Finally, the Panel recommends management strategies that aim to balance protecting other individuals in the community and protecting the rights of the client.

### **Stage Three - Letter of Warning**

The Panel may recommend that a Letter of Warning be sent by the EDPH to the person. This Letter is an official warning to the person to discontinue any activity that places other people at risk of HIV infection. It describes the legal powers vested in the EDPH to isolate persons who continue to knowingly put others at risk of infection. The Letter reiterates 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 CMP Manager or relevant Public Health Director ensures that the person has received and understood the Letter of Warning and that, in addition, she/he has been advised to discuss its contents with an independent advocate of their choice. The client is advised that if they believe they have grounds upon which they consider that the decision to issue the Letter of Warning should be reviewed they may notify the EDPH in writing of those grounds and the EDPH will review the case.

## **Stage Four - Isolation**

When the Case Management 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 and safety. An Isolation Order may specify the home of the individual or other suitable location in their local environment and may be in the form of a curfew for certain hours each day.

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 and will include concurrent counselling, education and behaviour change therapy. Ongoing medical management, if necessary, is continued. Treatment of psychiatric and psychosocial disorders 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.

### **2.5 Statewide HIV Case Management**

Protocols developed and strategies adopted by the non-metropolitan Public Health Units for managing Case Management clients in regional Western Australia reflect the local epidemiological, social and cultural context. Where feasible, regional DoH WA workers, Case Management Program staff and local communities contribute to the development and ongoing review of these protocols and strategies.

In regions where there are a number of Case Management clients, the regional Public Health Director may choose to designate a health worker to the position of Case Management Officer. In this instance, it is recommended that the Case Management Officer is responsible for the daily management of Case Management clients under the direction of the regional Public Health Director. The Officer can facilitate the development of an appropriate regional, multi-agency network to enable effective Case Management. He/she can also maintain the separate database for recording Case Management activities and liaise with Case Management Program staff.

Where a current Case Management client moves through or to another region, the Manager of the Case Management Program and the regional Public Health Director refers the client to the receiving regional Public Health Director for ongoing contact. In making that referral, the Manager and the Public Health Director 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.

Case Management training is provided throughout the state by the Case Management Program. At all times, the Program Manager is available for consultation about the management of clients and for regular case reviews.

### 3.0 BIBLIOGRAPHY

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.

*ANCARD Review of the Third National HIV/AIDS Strategy*, 1999.

Commonwealth of Australia. *Discussion Document Towards a Fourth National HIV/AIDS Strategy*, 1999.

Commonwealth Department of Health and Aged Care. *Fourth National HIV/AIDS Strategy: Draft for Consultation at National Forum*. Canberra, 1999.

Commonwealth of Australia. *Partnerships in Practice: National HIV/AIDS Strategy 1996-97 to 1998-99*. AGPS: Canberra, 1996.

Health Department of Western Australia. *Rights and Responsibilities of People with HIV Infection*. 1996.

Health Department of Victoria. *Guidelines for the Management in Victoria of HIV Infected People Who Knowingly or Recklessly Risk Infecting Others*. 1992.

Intergovernmental Committee on AIDS (IGCA). *Guidelines on the Management of People with HIV/AIDS Knowingly Placing Others at Risk of Infection*, 1989.

McCaul P. *The Region with Special Needs HIV/STD Prevention and Control Strategic Plan*. Perth, Health Department of WA, 1998.

Queensland Health. *Protocol for the Management of HIV Positive People Whose Behaviour May Constitute a Public Health Risk*. 2000.

South Australian Health Commission. *Revised Guidelines for the Management in South Australia of People Who Knowingly Place Others at Risk of HIV Infection*. 1997.

South Australian Health Commission. *Draft South Australian Guidelines for the Management of People Who Place Others at Risk of HIV Infection*. 2000.

# Delivering a Healthy WA

