

**National Guidelines for the Management of People with HIV  
Who Place Others at Risk**

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## SECTION 1 INTRODUCTION

1. These Guidelines have been developed to inform, support and harmonise approaches by Australia's States and Territories to the management of people with HIV who place others at risk of HIV infection.
2. The Guidelines are informed by the findings of the 2007 *National Review of Policies for the Management of People with HIV who Risk Infecting Others* undertaken by Associate Professor Robert Griew, and by the 2003 National Public Health Partnership paper, *Principles to be considered when developing best practice legislation for the management of infected persons who knowingly place others at risk*.
3. The 2007 National Review made a number of recommendations in relation for legislative, policy and administrative change in the jurisdictional management of people with HIV who place others at risk. The implementation of those recommendations is being overseen by the inter-governmental Blood-Borne Virus and Sexually Transmissible Infections Sub-Committee of the Australian Population Health Development Principal Committee. The development of these Guidelines is one of those recommendations.
4. The National Review 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 education efforts based on the latest surveillance data and targeting high-risk populations as the highest priority.
5. 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 upon the liberty of an individual in order to protect the health of the public.
6. 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;
  - 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, 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; and
  - the roles of clinicians and local service providers with clients and of public health officials in surveillance and enforcement should be kept distinct.
7. 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 including counselling, behavioural supervision, formal warnings and public health orders, including, if necessary, detention or referral to Police.
  8. HIV is a lifetime 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 casual contact. Specific behaviours are linked to infection. Managing individuals with HIV who place others at risk therefore requires techniques that will be effective over a life course at modifying behaviours. Escalation to more directive strategies will generally not be preferred because these will be the most difficult to sustain.
  9. 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.

## SECTION 2 LEGISLATIVE PROVISIONS

1. These Guidelines provide a framework for the management of HIV public health risk within and across Australia's State and Territory jurisdictions. Implementation of the Guidelines at jurisdictional level must necessarily occur with specific reference and attention to relevant jurisdictional legislation. Relevant provisions are primarily found within Public Health legislation and Crimes legislation.
2. In implementing these Guidelines, jurisdictional health authorities will have regard to:
  - public health legislative measures that allow for the coercive management of people with HIV who place others at risk, including in relation to examination, testing, counselling, restrictions on behaviour or activities, supervision, treatment, detention, isolation and / or apprehension;
  - administrative or judicial review of decisions made to protect public health;
  - health information privacy and confidentiality protections, and provisions for the exchange of information between agencies in circumstances where a threat to public health exists; and
  - HIV-specific or general criminal offences in relation to grievous bodily harm or the transmission of disease through malicious, intentional or other acts.
3. In addition to State or Territory legislation (where such provisions exist), the *National Health Security Act 2007* provides a mechanism for the exchange of information across jurisdictional borders in circumstances where a threat to public health exists.

## **SECTION 3 EXCHANGE OF INFORMATION**

### ***Confidentiality***

1. Information about a person's HIV or AIDS status is 'health information' and is protected by State and Territory privacy legislation or, in some jurisdictions, by specific legislation on the management and disclosure of HIV-related information.
2. Health professionals, including public health authorities, 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.
3. 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 groups, can be especially important if the individual is to be stabilised and is to remain living within those communities.
4. Limits to the protection of confidential information operate in circumstances where a duty to a third party is owed. State and Territory health authorities should ensure that health care workers 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 HIV public health risk.

### ***Inter-jurisdictional Cooperation***

5. In circumstances where a State or Territory public health authority has reasonable suspicion or knowledge of travel planned or undertaken to another jurisdiction of a person who is subject to management at Level 2 or above under these Guidelines, the Chief Health Officer or equivalent should take steps to notify the inter-jurisdictional Chief Health Officer, equivalent, or delegate, of the client's HIV status, any Orders made and necessary case information, including information that allows the identification of the case, to enable effective public health follow-up.

### ***Referral to Police (See also Section 4 – Levels of Management – Level 5)***

6. State and Territory Health Departments should have in place with local relevant Police agencies agreed protocols for the exchange of information to ensure appropriate health and law enforcement responses.
7. The referral of information to the Police should be made by the Chief Health Officer or equivalent, always with legal advice:
  - immediately where there are clear grounds for a charge involving intentionally causing serious bodily harm; or

- after further examination and / or intervention, of unwillingness to alter behaviour that recklessly or negligently endangers or causes serious harm.

Such referrals should usually be made after consultation with the Chair of the HIV Advisory Panel.

8. 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 public health investigation or intervention.
9. Consideration of the referral to Police for investigation and possible prosecution under the Crimes Act or other relevant Act may be made at any Level of public health management under these Guidelines.

## SECTION 4 THE MANAGEMENT FRAMEWORK

### *Operational Arrangements*

1. These Guidelines provide guidance to jurisdictions that is necessarily generalist in nature. It is provided as overall guidance for the purposes of ensuring national consistency in the direction and manner of approach to the management of people with HIV who place others at risk. The Guidelines also provide a basis for inter-jurisdictional cooperation around these matters.
2. It will be necessary that jurisdictions review and administer the Guidelines in a manner consistent with local legislative, administrative and service delivery arrangements. This will require that jurisdictions develop local protocols that take account of these variances and give effect to these Guidelines. Local protocols should nominate a public health authority to receive initial reports of cases from clinicians and other service providers; this may be the State or Territory Department of Health or the Chair of the HIV Advisory Panel. For the remainder of this document, this person will be referred to as the 'nominated public health authority'.
3. The framework for management of people with HIV who place others at risk includes the following levels:

Level 1: *Counselling, education and support*

Management in the community by the client's primary health care provider, with the assistance of specialist HIV case workers, as appropriate, without the formal involvement of the HIV Advisory Panel.

Level 2: *Counselling, education and support under advice from HIV Advisory Panel or the Chief Health Officer or Equivalent*

Management in the community under recommendations from the Chief Health Officer or equivalent and / or the HIV Advisory Panel but without a Behavioural Order. This may include a formal letter of warning.

Level 3: *Management Under Behavioural Order*

Management under a Behavioural Order or equivalent.

Level 4: *Detention and / or Isolation*

Detention and / or isolation under a Detention Order and / or an Isolation Order or equivalent.

Level 5: *Referral to Police*

Referral to the Police under the Crimes Act or other relevant Act. Referral may be made at any stage under these Guidelines.

Each level is discussed in detail below.

4. 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 judgment based on the unique circumstances of each case.
5. The application of the various levels of management under these Guidelines should be flexible and not necessarily linear, again responding to the circumstances of each case. This includes the possible referral of information to the Police at any stage in accordance with Level 5 of these Guidelines. Lower levels of intervention based on counselling, education and support in which the complex social, psychological and health care needs of the clients are addressed should always be preferred as opposed to intrusive or coercive measures unless those measures are deemed necessary.

### ***HIV Advisory Panel***

6. To administer the recommended regime each State and Territory will need to establish a standing HIV Advisory Panel. The function of the Panel is to provide expert advice to the Chief Health Officer or equivalent 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.
7. The Panel should be chaired by a senior clinician with relevant expertise, such as a sexual health physician or a public health physician. Panel members could usefully include a HIV specialist, mental health service, HIV/AIDS community organisation with peer involvement, public health manager, legal policy advisor, and others co-opted as appropriate to an individual case.
8. 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.
9. The State or Territory Department of Health should nominate an appropriate officer to observe Panel meetings. Additionally, the secretary of the Panel should be an officer nominated by the Department. That secretary will be responsible for maintaining Minutes for the Panel. Minutes of Panel meetings should be reviewed and approved by the Chair.
10. The Panel should meet as needed or at least every four months in order to, at a minimum, receive a report from the Chair of the Panel on enquiries received by the Chair and advice provided in relation to clients being managed at Level 1 of the Guidelines, and to review the progress of clients being managed under the Guidelines at Level 2 or above. In circumstances where no enquiries have been received by the Chair and where no clients are being managed at Level 2 or above, it may be agreed that no meeting of the Panel is required.

11. It is considered essential that the Panel meet at least at every four months to consider clients at Level 2 management or above as management at these levels entails close case management with or without an Order that 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.
12. 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 nominated public health authority to request a determination of a suitable course of action. Depending on the State or Territory local protocols, either the Chief Health Officer or equivalent or the chair of the HIV Advisory Panel may decide either to support the local clinician and service providers with advice alone (that is, to manage at Level 1 of the Guidelines) or to accept that the client should be managed under the Guidelines at Level 2 or above.
13. When the Chief Health Officer or equivalent or the Chair of the HIV Advisory panel decides that an individual should be managed under the Guidelines at Level 2 or above, the HIV Advisory Panel should be convened to enable the individual's case to be discussed by the Panel. The Panel should determine a course of follow up that may be short or longer term, and advise the Chief Health Officer or equivalent accordingly.
14. In determining a course of follow up, the individual(s) who is/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 and / or minutes of Departmental meetings to assess progress of clients. Depending on the nature of the recommendations, the responsible individual(s) may be the local clinician, other providers, or the State or Territory Department of Health. The secretary to the Panel or the Chief Health Officer or equivalent will communicate all recommendations / determined actions to responsible individual(s).
15. 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.
16. Case files should be kept according to the records management policies and standards of the State or Territory Department of Health, with consideration given to protecting the privacy of individual clients. Unique identifier codes should be used in place of names wherever possible to reduce the number of people needing to know the identity of clients. 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.

### ***Maintenance, Discharge and Escalation under the Guidelines***

17. The cases of all individuals who are managed at Level 2 or above shall be considered at each meeting of the HIV Advisory 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.

18. 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 Chief Health Officer or equivalent may discharge the individual from management at Level 2 or above under the Guidelines in the interim and report this to the next meeting of the Panel.
19. If the intervention decided is longer term, a report will be provided back to the Panel at its next meeting and the Panel will advise the Chief Health Officer or equivalent either to discharge the client from management at Level 2 or above under the Guidelines at that meeting or to continue with management at Level 2 or above under the Guidelines.
20. In determining whether a client is to be discharged from management at Level 2 or above under the Guidelines, the Panel and the Chief Health Officer or equivalent 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.
21. In making this determination, the Chief Health Officer or equivalent should consider management under the Guidelines at Level 2 or above to lapse in the absence of an ongoing assessment that the client is endangering or likely to endanger others. Discharge from management at Level 2 or above under the Guidelines constitutes an end to the Department and Panel's involvement in the management of the client. Management will, of course, continue to occur via the local clinician / service provider.
22. A client who is discharged may be re-admitted for management under the Guidelines at Level 2 or above at any time, as determined by the Chief Health Officer or equivalent, should the view be formed that the behaviours of the client would warrant such action.
23. 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 increased risk of danger to others, the Panel may advise escalation of action in accordance with the Levels described below.

## Levels of Management

### Level One: Counselling, education and support

Level	Likely Pathway	Services to consider	Decision, decision maker and action
<p>ONE: COUNSELLING, EDUCATION AND SUPPORT</p> <p>Management in the community by client's primary health care provider, without the formal involvement of the HIV Advisory Panel or the Chief Health Officer or equivalent.</p>	<ul style="list-style-type: none"> <li>Individual's behaviour has been recognised by primary health care provider as demonstrating a degree of risk the provider is concerned about – client may not seem willing or able to protect sexual or needle-sharing partners.</li> <li>This should be reported to the nominated public health authority as appropriate for the arrangements in each State or Territory.</li> <li>Following discussion between the Panel Chair or Chief Health Officer or equivalent and the primary health care provider, however, provider agrees to continue management of client, at least in first instance, possibly with follow up and support.</li> <li>Review at initiative of primary health care provider, that is, if concerns continue.</li> </ul>	<ul style="list-style-type: none"> <li>HIV Clinical care.</li> <li>Mental health and drug and alcohol services as needed.</li> <li>Counselling, education.</li> <li>Support services, housing.</li> <li>Referral to case management services.</li> </ul>	<ul style="list-style-type: none"> <li>Decision is not to admit to management at Level 2 or above under Guidelines at this initial stage.</li> <li>Made by either the Panel Chair or Chief Health Officer or equivalent (depending on individual jurisdictional protocols), in consultation with primary health care provider.</li> <li>Chair of Advisory Panel or Chief Health Officer or equivalent makes note of conversation and tables this at next meeting of HIV Advisory Panel.</li> <li>In cases where there is no suitable health care provider, admit client to Level Two and appoint a person responsible for management.</li> </ul>

1. The first steps in the management of a person with HIV who is behaving in a way that endangers or is likely to endanger others are counselling, education and support. Usually this will be best undertaken by the local clinician who is also responsible for supporting maintenance of compliance with HIV treatment. Counselling with an experienced sexual health / HIV counsellor may also need to be regular and even intensive and other service providers may also need to be involved.
2. 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.

3. Contact tracing in accordance with appropriate ethical and legal standards should be considered.
4. Wherever possible and appropriate, a community organisation with peer group involvement should be involved to support appropriate behaviour by the person with HIV. Peer-based support and education is a demonstrated evidence-based means of providing assistance to individuals with HIV around coping with a diagnosis of HIV infection, disclosing their HIV status to others, and understanding HIV transmission risks, means by which HIV transmission can be prevented and peer-behavioural norms.
5. A supportive environment should be created where health promoting messages are clearly and frequently reiterated and the consequences of behaviour that places others at risk are spelt out. The means of prevention (including for instance, condoms, needles and syringes, and information) should be readily and easily accessible, along with access to regular health checks, testing and treatment.
6. At any stage, the nominated public health authority can be contacted for advice. It is important that service providers and local clinicians feel free to contact the nominated public health authority for advice if they feel that they are not able to manage the individual client's behaviour or if they feel that the matter should otherwise be brought to the nominated public health authority's attention.
7. Contacting the nominated public health authority will not automatically lead to the client being managed under the Guidelines at Level 2 or above. It may lead to the provision of advice or contacts with other professionals able to provide support. The Advisory Panel Chair or Chief Health Officer or equivalent may, however, judge it advisable to involve the HIV Advisory Panel, deciding that the client should be managed under the Guidelines at Level 2 or above.
8. In determining whether to accept the client for management under the Guidelines at Level 2 or above, the Chair or Chief Health Officer or equivalent will consider a range of matters including:
  - the nature of the information provided, including in relation to the imminence of risk to the public;
  - the 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 the nominated public health authority or their nominee;
  - 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 presentations (such as problematic drug or alcohol use

or mental health presentations) 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; and
- an assessment of the likelihood that local actions may succeed if allowed to continue to progress.

9. The above matters provide a framework only. Acceptance of clients for management under the Guidelines at Level 2 or above will be determined by the Chief Health Officer or equivalent or Chair of the HIV Advisory Panel on a case-by-case basis. Convenience to local clinicians / service providers will not be a factor in determining management under the Guidelines and in all instances local clinicians / service providers will be expected to remain active in the management of the client. However, consideration can be given to whether a local clinician has the capacity and resources to effectively manage a client who may be at risk of infecting others and alternative arrangements made where required.
10. The Chief Health Officer or equivalent or Chair of the HIV Advisory Panel will maintain a file note of any discussions and the advice provided. It is not necessary that such individuals' identities be recorded, although the identity of the person making the approach and the date must be recorded.
11. The Chief Health Officer or equivalent or Chair of the HIV Advisory Panel will make a report of such advice provided to local clinicians / service providers to the HIV Advisory Panel on at least a four monthly basis.

**Level Two: Counselling, education and support under advice from HIV Advisory Panel**

Level	Likely Pathway	Services to consider	Decision, decision maker and action
<p>TWO: COUNSELING, EDUCATION AND SUPPORT UNDER ADVICE FROM HIV ADVISORY PANEL OR THE CHIEF HEALTH OFFICER OR EQUIVALENT</p> <p>Management in the community under recommendations from the Chief Health Officer or equivalent and / or HIV Advisory Panel but without a Behavioural Order.</p>	<ul style="list-style-type: none"> <li>• No satisfactory change in behaviour after Level One management and individual referred by the Chief Health Officer or equivalent to the HIV Advisory Panel.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>• Agreement between the Chief Health Officer or equivalent or Chair of HIV Advisory Panel and primary health care provider that Level Two is appropriate initial management.</li> </ul>	<ul style="list-style-type: none"> <li>• Psychiatric and medical assessments may be required if not previously obtained.</li> <li>• Detailed recommendations on case management, including behavioural management or other services if indicated.</li> <li>• Additional human and financial resources to be available to allow effective public health management of client.</li> </ul>	<ul style="list-style-type: none"> <li>• Decision is to admit to management at Level 2 under the Guidelines.</li> <li>• Made by Chief Health Officer or equivalent or Chair of HIV Advisory Panel, in consultation with primary health care provider.</li> <li>• Convene HIV Advisory Panel for case review.</li> <li>• HIV Advisory Panel considers case and provides written advice about management to the Chief Health Officer and / or the primary health care provider.</li> <li>• Consider need for appointment of client advocate.</li> <li>• Consider issuing a letter of warning to the client formally advising the client of their responsibilities and that their behaviour has come to the attention of, and is being monitored by, public health authorities.</li> <li>• Consider options for management under Mental Health Act, Guardianship Act, etc.</li> <li>• Regular review by Panel for maintenance, discharge or escalation under Guidelines at not greater than four monthly intervals.</li> </ul>

1. In circumstances where counselling and support measures have failed, more assertive management should be initiated. This requires that the decision be taken that an individual be managed under the Guidelines at Level 2 or above. The basis of the decision is that the client is not being effectively managed within the resources of the local clinician and other services, even with advice from the Chair of the Panel. This decision is taken by the Chief Health Officer or equivalent or Chair of the Panel.
2. Each case needs to be considered on an individual basis. Use of a range of illicit and prescribed drugs, personality disorders, development disability, mental illness, homelessness and social isolation are some of the factors that singly, or in combination with HIV infection, can contribute to behavioural problems of the sort that might lead to management under the Guidelines at this Level or above.
3. The local clinician, with other service providers involved in caring for the client, remains the central point of client management, but now with support from the Department / Advisory Panel. If necessary, additional resources will be provided from other agencies.
4. In the case of longer-term interventions, it may be desirable for public health and clinical care / case management functions to be fully delineated at service provider level.
5. The Chief Health Officer or equivalent or HIV Advisory Panel should fully review all aspects of the case in question. The Panel may be able to provide further guidance to local health care professionals regarding client management. A multi-disciplinary case conference should be convened to facilitate identification of the causes of the person's failure to take responsibility for his or her actions as the basis for the development of a case management plan. A full medical examination, including a psychosocial assessment, may be appropriate at this stage.
6. At the recommendation of the Panel, a letter to the client from the Chief Health Officer or equivalent may be appropriate. This letter of warning will usually indicate that the client's behaviours have been officially brought to the attention of the Department, specify the responsibilities of the client with respect to their HIV infection, and identify expected behaviours of the client. In some cases, the letter of warning may be sufficient to prompt behaviour change.
7. Written reports on the follow up of clients managed under the Guidelines at Level 2 or above must be considered by the Panel at each of its regular meetings (every four months, or more frequently).

### **Level Three: Management under a Behavioural Order**

<b>Level</b>	<b>Likely Pathway</b>	<b>Services to consider</b>	<b>Decision, decision maker and action</b>
<p>THREE: MANAGEMENT UNDER A BEHAVIOURAL ORDER</p> <p>Management under Behavioural Order or equivalent.</p> <p>At Level Three, specific powers that may be exercised include:</p> <ul style="list-style-type: none"> <li>to order a person to undergo counselling;</li> <li>to order a person to undergo treatment;</li> <li>to order a person to refrain from specified behaviour or activities;</li> <li>to order a person to be subject to supervision.</li> </ul>	<ul style="list-style-type: none"> <li>Advice from HIV Advisory Panel to Chief Health Officer or equivalent following client assessment.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Urgent referral of case to Chief Health Officer or equivalent by Chair of HIV Advisory Panel.</li> </ul>	<p>Same range of services as Level Two but in addition:</p> <ul style="list-style-type: none"> <li>Restrictions on behaviour or movement and / or compulsion to participate in treatment and comply with behavioural requirements as specified in Behavioural Order.</li> <li>Supervision and surveillance as required.</li> </ul>	<ul style="list-style-type: none"> <li>Decision is making a Behavioural Order.</li> <li>Made by Chief Health Officer or equivalent considering advice including from Chair of HIV Advisory Panel following Panel deliberations.</li> <li>Avenue of appeal to administrative review mechanism or similar.</li> <li>Communication of Behavioural Order and its requirements to client together with offer of support and advocacy services.</li> <li>Consider letter of warning.</li> <li>Consider options for management under Mental Health Act, Guardianship Act, etc.</li> <li>Regular review by Panel and advice to Chief Health Officer or equivalent regarding continuation or otherwise of Order, and maintenance, discharge or escalation under Guidelines at not greater than four monthly intervals.</li> </ul>

1. In the event that a Behavioural Order or equivalent is considered the appropriate course of action by the Panel, the Panel should provide advice to the Chief Health Officer or equivalent accordingly. The advice to the Chief Health Officer or equivalent is made through 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 the Order. The Minutes of the Panel should provide justification for the advice. The Chief Health Officer or equivalent should consider this advice as a matter of urgency.
2. An effective process must be in place for the communication of the advice to the Chief Health Officer or equivalent by those Departmental officers who attend meetings of the Advisory Panel.

3. Advice from the Panel that the Behavioural Order can be modified will be made when the Panel is satisfied that this can be achieved without harm to the community.
4. Mechanisms of appeal of Behavioural Orders, via which a person subject to a Behavioural Order may seek independent review of the Order, must be in place via an administrative appeals or similar mechanism.
5. The person to whom the Behavioural Order applies must be informed of the Order and its implications, including the penalties for breaching the Order.
6. Arrangements should be made to assist the person to have appropriate advocacy and legal representation in the forums in which the Order is made.
7. Written reports of follow up of clients managed under the Guidelines at Level 2 or above must be considered by the Panel at each of its regular meetings (every four months, or more frequently).

## Level Four: Detention and / or Isolation

Level	Likely Pathway	Services to consider	Decision, decision maker and action
<p>FOUR: DETENTION AND / OR ISOLATION</p> <p>Detention and / or isolation under a Detention Order and / or an Isolation Order.</p> <p>At Level Four, specific powers that may be exercised include:</p> <ul style="list-style-type: none"> <li>to order a person to be subject to isolation;</li> <li>to order a person to be subject to detention.</li> </ul>	<ul style="list-style-type: none"> <li>Issuance of a Detention Order and / or an Isolation Order following advice from HIV Advisory Panel to Chief Health Officer or equivalent.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Urgent referral of case to Chief Health Officer or equivalent by the Chair of HIV Advisory Panel.</li> </ul>	<ul style="list-style-type: none"> <li>Detention in secure premises.</li> <li>Isolation in an appropriate facility.</li> <li>Full range of counselling, treatment and support services as required.</li> <li>Medical / psychological examination at intervals as specified by administrative or judicial body to ensure wellbeing of individual and that Order remains relevant.</li> </ul>	<ul style="list-style-type: none"> <li>Decision is making a Detention Order and / or an Isolation Order.</li> <li>Made by Chief Health Officer or equivalent considering advice including from Chair of HIV Advisory Panel following Panel deliberations.</li> <li>Mandatory review by administrative review mechanism or similar and access to avenue of appeal.</li> <li>Communication of Order and its requirements to client together with offer of support and advocacy services.</li> <li>Consider options for management under Mental Health Act, Guardianship Act, etc.</li> <li>Regular review by Panel and advice to Chief Health Officer or equivalent regarding continuation or otherwise of Order, and maintenance, discharge or escalation under Guidelines at not greater than four monthly intervals.</li> </ul>

1. Detention and / or isolation for the purposes of managing HIV public health risk are expected to be rare occurrences, as public health legislation and these Guidelines provide for a flexible range of responses, with detention and isolation considered to be strategies of last resort.
2. State and Territory Departments' of Health should ensure that adequate provision is made for a secure environment where persons to whom a Detention Order or Isolation Order applies may be secured. It is not expected that such a facility would be identified and remain unused; rather that a suitable facility could be made available at short notice if required. In addition, arrangements for the staffing of such secure environments on an ad hoc basis should be considered.

3. Where the client to whom the Detention Order or Isolation Order applies is already detained under a custodial sentence, consideration should be given to the unique circumstances of implementing the Order, including:
  - that client confidentiality, legal and safety issues be considered; and
  - that segregation measures may require negotiation with State and Territory Departments of Corrective Services and / or Juvenile Justice or equivalent.
4. Written reports of follow up of clients managed under the Guidelines at Level 2 or above must be considered by the Panel at each of its regular meetings (every four months, or more frequently). This will require liaison with the providers of secure detention services as appropriate.

## Level 5: Referral to Police

Level	Likely Pathway	Services to consider	Decision, decision maker & action
<p>FIVE: Referral to Police</p> <ul style="list-style-type: none"> <li>Referral to Police under the Crimes Act or other relevant Act.</li> <li>Consideration of the referral to Police for investigation and possible prosecution under the Crimes Act or other relevant Act may be made at any Level of public health management under these Guidelines.</li> </ul>	<ul style="list-style-type: none"> <li>By the Chief Health Officer or equivalent, always with legal advice: <ul style="list-style-type: none"> <li><u>immediately</u> where there are clear grounds for a charge involving intentionally causing serious bodily harm; or</li> <li><u>after further examination and / or intervention</u>, of unwillingness to alter behaviour that recklessly or negligently endangers or causes serious harm.</li> </ul> </li> <li>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 public health investigation or intervention.</li> </ul>	<ul style="list-style-type: none"> <li>Continued public health action and provision of services as needed.</li> </ul>	<ul style="list-style-type: none"> <li>Decision is referral to Police under Crimes Act or other relevant act.</li> <li>Decision made by Chief Health Officer or equivalent, always with legal advice, and usually after consultation with Chair of HIV Advisory Panel.</li> </ul>