

24 November 2009

HIV/HCV Policy and Programs Section
Communicable Disease Control Branch
Public Health and Clinical Co-ordination
Department of Health
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Dear Madam/Sir

Review of the Code for the Case Management of Behaviours that Present a Risk for HIV Transmission

The Australian Federation of AIDS Organisations (AFAO) represents Australian HIV/AIDS community-based organisations at a national level. AFAO members include AIDS Councils in each state and territory, the National Association of People Living with HIV/AIDS, the Australian Illicit and Injecting Drug Users League, the Anwernekenhe Aboriginal and Torres Strait Islander HIV/AIDS Alliance (ANA), and Scarlet Alliance, the national organisation representing sex workers. AFAO advocates for its member organisations, promotes medical and social research into HIV/AIDS and its effects, develops and formulates policy on HIV/AIDS issues, and provides HIV policy advice to Commonwealth, State and Territory Governments.

AFAO welcomes the South Australian Government's decision to review the Code for the Case Management of Behaviours that Present a Risk for HIV Transmission (the SA Code), and thanks SA Health for the opportunity to provide comment. In particular, AFAO commends the inclusion of: client exit strategies; direct communication with key agencies should a client's management under the Code cease or levels vary; and the continued application of public health measures while a person is engaged in the criminal justice process.

AFAO seeks to make comment on the Code in relation to the following:

1. Context and focus

Although the SA Code generally reflects priorities and processes identified in the 'National Guidelines for the Management of People with HIV Who Place Others at Risk' (the National Guidelines) and comparable state/territory guidelines, in many respects the Code is unduly focused on 'risk to the community'. This skewing of focus means that the importance of public health priorities is under-emphasised, with inadequate attention given to the context in which risk may arise, the effectiveness of



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education, and the accepted principle that 'public health objectives will be most effectively realised if the co-operation of people living with HIV infection and those most at risk is maintained' (as stated in the Queensland Protocol). The SA Code's inclusion of powers to isolate and detain people and to refer matters to the police, should not 'skew' the overall tone and focus of the document. These powers can only operate effectively if exercised within a robust HIV response that is supportive and respectful of human rights.

Set out below are some comparisons between the SA Code and other jurisdictions' guidelines which highlight our concerns regarding the focus of the SA Code.

The Guiding Principles (p.6) in South Australia's Code begin by stating:

The *overriding principle* is that the South Australian community has a right to be protected from persons whose behaviour may be presenting a risk of transmission.

AFAO submits that placing protection of 'the South Australian community' up front both exaggerates and distorts notions of risk, and locates HIV positive persons as possible perpetrators of harm against a significant population. This is at odds with public health rationale which generally defines 'risk' as arising as a result of particular behaviours and occurring between individuals not individual/s presenting a risk to whole populations (ie. the South Australian community). Given the fact that the media and other commentators can respond to any suggestion of risk behaviours on the part of people with HIV with hysteria (including recent references to 'AIDS predators' and 'innocent victims'), it is important that any overriding guiding principle in the Code be carefully framed.

The 'principles and assumptions' listed in the National Guidelines are a good example of guiding principles firmly anchored in public health rationale and practice, that effectively talk down the 'risk to community' from people who may place others at risk of HIV. They begin by stating that except in exceptional circumstances HIV testing should be voluntary and that HIV positive people should not be quarantined or socially excluded. It is then noted that:

Every individual has a responsibility to prevent themselves and others becoming infected and preventing further transmission of the virus.

By contextualising the Guidelines within a mutual responsibility message, interventions targeting those who place others at risk are located within the broad HIV response. The National Guidelines then reiterate the lack of risk to community/individuals from persons with HIV, by noting 'most people with HIV are motivated to avoid infecting others', etc.

A number of other jurisdictions have delivered comparable guidelines on managing those who put others at risk of HIV infection which firmly locate such interventions within firmly established priorities in the HIV partnership response. For example, the NSW Guidelines mirror the first seven of the principles and assumptions in the National Guidelines, including the mutual responsibility principle listed above.

Victoria's Guidelines begin by noting that: transmission occurs through specific behaviours (not casual contact); that HIV prevention may require changes in

behaviours that must be effective over the course of people's lives; that more directive strategies are difficult to sustain; and that each person [should] accept responsibility for preventing himself or herself becoming infected. Then, as its 6th point (rather than as an 'overriding principle' as in the proposed SA Code), the Guidelines state: 'The community as a whole has the right to appropriate protection against infection', before continuing to state four more broad principles.

Queensland's Protocol takes a different approach. While naming risk to community up front, the need to protect 'the community' has been directly counterposed against the need to respect 'individual rights':

The community as a whole has the right to appropriate protection against infection. However, public health interventions initiated in support of this right must always take account of individual rights.

This clause also describes the right to protection 'against infection' rather than the 'right to be protected from persons' as described in the SA Code's overriding principle. Similarly to the Victorian Guidelines, Queensland's Guiding Principles state that HIV transmission is preventable through appropriate changes in individual behaviour and that education and prevention programs can assist to bring about such changes, before noting that every person has a responsibility to prevent themselves becoming HIV infected. It is not until point 4 that the obligations of positive people are raised: 'People living with HIV/AIDS have a responsibility to prevent further transmission of the virus.' The Protocol continues to name twelve principles in total which, through combination of language, order, and content, firmly anchor the Protocol in public health rationale and practice.

Recommendation 1 – That the Code be reviewed so that the interventions outlined are more fully contextualised within the broad HIV response.

Recommendation 2 - That the Guiding Principles be reviewed, particularly the *overriding principle*, so that the interventions outlined are more fully contextualised within the broad HIV response.

2. 'Mandatory notification' by medical practitioners

Under 'Level 1: Notification and Initial Assessment of the Person's Behaviours', the Code includes a section (at p.9) titled 'mandatory notification' which states:

Where a *medical practitioner* involved in treating, caring for or counselling a person has formed a reasonable suspicion that the person has *intentionally infected, or is seeking to infect*, others with HIV, the medical practitioner must, as soon as is reasonably practicable, provide the Chief Executive with the name and contact details of the person and a brief description of the reason why the notification is being made.

AFAO argues that this provision should be reviewed or removed. Clearly a medical practitioner who believes a person has intentionally infected or is seeking to infect another person should seek immediate health department support and intervention.

The inclusion of the mandatory notification clause, however, is problematic for a number of reasons.

Firstly, the titling of the paragraph implies a mandatory reporting requirement similar to that relating to child sexual abuse: a requirement which is usually legislated (arguably a more appropriate location given the weighty implications of the state intervening to require action usually governed by professional and ethical boundaries). Mandatory reporting requirements on medical practitioners are not to be taken lightly. This proposed mandatory requirement appears to ignore the fact that in the course of their duties, medical practitioners can and do make complex ethical and professional judgments as a normal part of their work. Given 'guidance', medical practitioners can be trusted to adhere to public health guidelines. Imposing mandatory reporting requirements on medical practitioners regarding a subjective judgement such as a 'suspicion' is inappropriate and unworkable.

Secondly, the requirement sits outside the recommendations of the National Guidelines, including being at odds with the principle that 'the roles of clinicians and local service providers with clients and of public health officials in surveillance and enforcement should be kept distinct'. Comparable requirements exist in no other state or territory. Other jurisdictions instruct medical practitioners to take action if they become aware a patient is putting another at risk of HIV infection without resorting to such a heavy handed approach. For example, the Queensland Protocol states:

If a clinician has reason to believe that a person is recklessly placing others or could place others at risk of HIV infection ... they should enact Level One of the Protocol by notifying the Executive Director, Population Health Queensland in writing.

Thirdly, using 'mandatory notification' terminology increases the risk of this obligation becoming misconstrued in affected communities as a 'mandatory reporting requirement' relating to risk behaviours. The consequences are potentially dire at individual level (eg. adverse impact on the trust required to develop a strong therapeutic relationship) and at population/community level (eg. adverse impact on likelihood of persons to disclose risk behaviours as that plays out in terms of transmission risk at population level).

Fourthly, the language of the provision is highly problematic. 'Reasonable suspicion' is an odd turn of phrase. It is not commonly used in law or policy and requires those to whom it applies to come up with their own interpretation of what it may mean. This problem is compounded by the possibility that, if action were to be pursued against a physician in this regard, interpretation of this 'untested' turn of phrase would become the responsibility of a court or disciplinary body.

Finally, and perhaps of greatest concern, is the provision's language and focus on persons 'who have *intentionally infected, or [are] seeking to infect*'. Intention to infect has not previously been a measure by which the need for public health intervention is instigated. Management guidelines are generally understood as applicable to those whose behaviour puts others at risk, who may have some degree of awareness of

that risk or who have some cognitive impairment or other disability (including life chaos), and consequently struggle to modify their behaviour. They are not designed to apply to those trying to harm others.

Almost universally around Australia, health department interventions have been triggered in the cases of clients with complex needs and/or comorbidities that impact their capacity to manage their behaviours. Interventions targeting those who place others at risk of HIV infection must be enacted regardless of a patient's intent (i.e. they must also be enacted in instances where risk is not 'intended' but is real). In this instance, the bar for practitioner engagement with the public health process has been set too high.

The use of the above language (particularly use of 'intent') appears to reflect some slippage from criminal law, particularly concern about potential criminality. This is highly problematic, particularly as it appears under the listing of the first stage public health intervention, but also as it sits within a Code purporting to be highly focussed on public health principles. Issues of referral to police are dealt with under 'Referral to the Police' (p.15), where potential criminality has been appropriately 'sectioned off' from the remainder of the Code.

Recommendation 3 - That the section titled 'Mandatory notification' be reviewed, and that the mandatory reporting requirement be removed. Alternatively, if deemed necessary, the section should be replaced with a guideline that medical practitioners should contact the Chief Executive if they believe a person may place others at risk of HIV infection.

3. Inclusion of a lawyer on the Panel

Under 'Level 1: Notification and Initial Assessment of the Person's Behaviours', the Code suggests (at p.10) that the HIV Risk Behaviour Panel include:

a lawyer, who will be present at each Panel meeting and be available to provide advice. The role of the lawyer is to advise the Panel on questions of law and procedure relating to the Act, the operation of this Code and related questions.

AFAO is concerned that the presence of a lawyer may unnecessarily formalise the panel process and undermine the supportive environment most likely to trigger client engagement, enable disclosure of risk behaviours, and consequently, facilitate behavioural change. It is vital that interventions, particularly early interventions, are client-centred and do not become distracted by hypotheticals regarding the Department's own risk management practices.

The issue of legal expertise is raised in the National Guidelines (with the suggestion that 'panel members could usefully include' a 'legal policy advisor'), and a number of states include a legal advisor on their panel. In NSW, there is no legal representation on the Panel, however, Panel members are advised to contact the Department's Legal and Legislative Services Branch where necessary at Level 1. From Level 2, Panel recommendations are considered by Legal and Legislative Services Branch

before being communicated to the Chief Health Officer. Anecdotal evidence from panel members suggests this process is effective and that they have encountered no difficulties arising from it, particularly as it limits distractions from the client focus during meetings,. AFAO recommends South Australia consider adopting the New South Wales model in this regard.

Recommendation 4 - That the inclusion of a lawyer on the Panel be reviewed with particular reference to the NSW model.

Should the South Australian Government decide to proceed with the inclusion of a lawyer on the Panel, AFAO proposes the lawyer should be a person experienced in public health and related issues. In Queensland, the Protocol notes that the panel member legal advisor is to be a Queensland Health officer. The Western Australian Guidelines require the panel member to be a Department of Health Legal Officer. Public health law and practice is highly specialised, and that expertise is vital to effective consideration of any issues that may arise.

Recommendation 5 - That if a lawyer is to be included, the lawyer be a Health Department officer, fully familiar with public health practice.

Further, the issue of a lawyer's inclusion on the panel is raised under 'Level 1: Notification and Initial Assessment of the Person's Behaviours'. AFAO suggests that if a lawyer must be included, Level 1 is too early in the intervention process. In Queensland, for example, a legal advisor may be included on the Panel after a case has proceeded to Level Two (or interventions at a higher level) despite the panel considering Level One cases. That is also the case in Western Australia, where Level Two follows counselling, education and support arranged or undertaken by health department staff. As noted above, AFAO suggests the inclusion of a lawyer on the panel is unnecessary and may be counterproductive at least until Level 3, at which point restrictions are imposed by formal orders and the process formally engages with the legal system.

Recommendation 6 - That if a lawyer is to be included, the lawyer not sit on the panel until Level 3, when legal provisions are relevant. The inclusion of a lawyer panel member at Level 1 is counterproductive to Level 1 interventions likely to be framed as 'support'.

4. Representative from PLWHA SA on Panel

It is vital that the panel include peer representation, however, AFAO suggests that limiting that representation to PLWHA SA may be unnecessarily restrictive. In making this point, it is important to clarify that we are not aware of any failure on the part of PLWHA SA or its delegate, but are seeking to make the general point that limiting

selection to PLWHA SA may be unnecessary limiting when seeking a panel member. Allowing entry from a broader pool may also be useful for managing confidentiality/conflict of interest issues in relation to a particular case should they arise.

In Victoria, the panel must include 'two persons living with HIV', who are to be 'chosen to represent the interests of the community rather than simply to advocate on behalf of their organisation'. In Queensland, the panel includes 'a representative of a HIV/AIDS community organisation with peer involvement'. In Western Australia, the panel includes a community representative (if appropriate). AFAO suggests that panel membership should include a person living with HIV with community organisation involvement.

Recommendation 7 - That peer based panel membership be broadened to include a person living with HIV with community organisation involvement.

5. Detention

AFAO remains concerned about the limited appeals mechanisms available to those detained. This is in stark contrast to a number of other jurisdictions. For example, in NSW public health orders are subject to immediate judicial review through the Administrative Decisions Tribunal. In Victoria, a person has the right to appeal against any order made by the Chief Health Officer under the Health Act, and the impending *Public Health and Wellbeing Act* will allow appeals to the Victorian Civil and Administrative Tribunal.

Recommendation 8 – That the Department engage in discussion to develop mechanisms to ensure simpler appeals mechanisms for public health orders.

6. Language

The Code would benefit from a language-based edit. This should include (but not be limited to) consideration of the following:

- Use of 'Risk of HIV Transmission'

The document repeatedly uses the expression 'risk for HIV transmission' although the commonly accepted expression is 'risk of HIV transmission' (which is used in all other comparable state and territory codes on those who put others at risk, as well as in the National HIV Strategy).

Recommendation 9 - That the terminology 'risk for HIV transmission' be replaced with 'risk of HIV transmission'.

- Use of 'HIV Virus'

The Code refers to 'HIV Virus' (p.6). As the acronym 'HIV' means Human Immunodeficiency Virus, the second 'virus' is tautological.

Recommendation 10 - That 'HIV Virus' be replaced with 'HIV' or 'Human Immunodeficiency Virus'.

- Reference to Chief Executive

On a number of occasions inconsistent pronouns are used to reference the Chief Executive, for example, 'The Chief Executive may make directions they consider appropriate' (p.13), and 'The Chief Executive, having received any advice from the Panel, may if it 'is of the opinion...'

Recommendation 11- That all references to the Chief Executive be reviewed for consistency.

Thank you for the opportunity to provide input. Please do not hesitate to contact me should you wish to discuss these issues further.

Yours sincerely,

A handwritten signature in black ink that reads "Don Baxter". The signature is written in a cursive, slightly slanted style.

Don Baxter
Executive Director