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# **Review of Department of Human Services Management of a Specified Group of HIV Cases**

**Conducted by**

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**For the Department of Human Services Victoria**

**3 September 2007**

**CONFIDENTIAL**

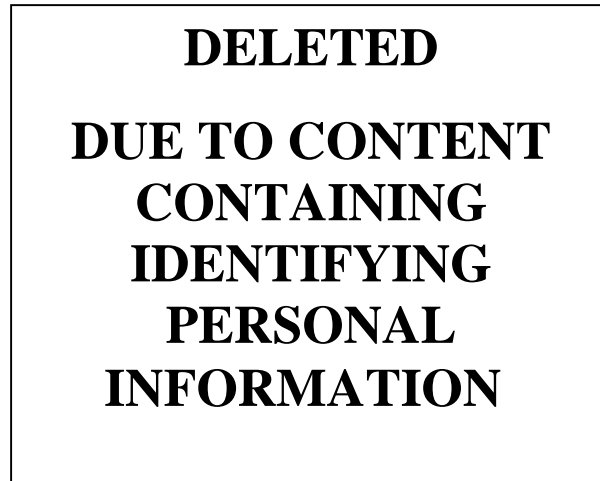
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# **Review of Department of Human Services (DHS) management of a specified group of HIV cases**

## **1. Background**

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## **2. Engagement**

2.1 The co-authors were engaged by the DHS for the purposes of undertaking this Review according to the Terms of Reference referred to below. These reviewers are Mr Robert Falconer of STOPline Pty Ltd, based in Hawthorn East, Victoria and Associate Professor John Scott of The University of Queensland. Both were formally contracted by the Department of Human Services on 28 May 2007.

2.2 Mr Falconer's background is in police operations and senior management and he has conducted a number of reviews and investigations as a consultant. Dr Scott is currently Director of the Centre for Young People's Health at The University of Queensland but previously was State Manager for Public Health Services in Queensland from 1996 to 2003 and Senior Executive Director of Health Services for Queensland Health from 2003 to 2005.

2.3 The reviewers spent the period from 29 May to 8 June 2007 at DHS reading and reviewing the relevant files and also interviewing key staff and other relevant persons see Appendix B.

2.4 The reviewers returned to the Department on 17 and 18 July 2007 to conduct further enquiries in order to finalise their draft report which is scheduled for discussion with the Department on 29 August 2007.

### 3. Terms of Reference

3.1 The Terms of Reference for the review were prescribed as:

1. *To examine the cases of the following clients subject to the provisions of Section 120 and 121 of the Health Act:*

- *All cases as at 1 April 2007 being reviewed by Partner Notification Officers (PNOs) prior to possible reference to the HIV Case Advisory Panel;*
- *All cases currently subject to Panel consideration (as at 1 April 2007);*
- *All cases (except those currently before the courts) whose files were taken by Police from DHS on 13 April 2006; and*
- *Any other cases known to be of interest to Police whether or not their files were taken by Police on 13 April 2006;*

*in order to inform the Secretary, DHS that all appropriate action has been taken by DHS including whether reference to Police should have been made.*

2. *To examine the adequacy of protocols between DHS and Police in managing clients subject to the provisions of Section 120 and 121 of the Health Act including but not restricted to;*

- *Protocols regarding the subpoena by Police of any file material relating to any client file; and*
- *Protocols regarding the sharing of knowledge and advice between DHS and Police on any clients who may be of interest to either party.*

3.2 The terms of reference required the reviewers to “*examine the cases ... in order to inform the Secretary, DHS that all appropriate action has been taken by DHS...*” This begs the question “What is ‘*appropriate*’ in terms of ‘*all appropriate action*’?” The reviewers encountered a large number of documents including Position Papers, Review Reports, Guidelines, Protocols, Strategies, and of course the relevant Victorian legislation.

3.3 These sources provide ample direction and advice on the handling of the type of cases under consideration, however compliance requirements within them vary from legal mandate to professional practice suggestions and of course the circumstances and human behaviour identifiable within individual cases varies enormously.

3.4 It is also pertinent to acknowledge at this point that while infection with and transmission of the Human Immunodeficiency Virus (HIV) is at issue here, the principles being considered, and the learnings from

this Review are relevant to infection with other agents like the Tubercle Bacillus, and while the scale being considered here is in the order of small numbers, similar principles may be applied to situations of pandemic or terrorist infections. These areas may also at least provide further perspective with regard to appropriate management of individuals placing others at risk.

- 3.5 Managing the line between the rights of the individual and those of society is fraught with value judgements and personal perspectives, and any degree of certainty for reviewers requires a clear statement of the prevailing “*official*” position from those in authority. Writing for the Australian National Council on AIDS, Hepatitis C and Related Diseases Position Paper, Reforming the Law to Ensure Appropriate Responses to the Risk of Disease Transmission<sup>1</sup> Watchirs noted “*human rights and public health principles are usually compatible and complementary, but the area of disease transmission and exposure has a particular tension that requires adequate resolution*”.
- 3.6 Clearly defining a single official position can be difficult. Human behaviour largely drives legislation development, sometimes prompting a response to a particular form of behaviour, sometimes necessitating a particular form of protection from a behaviour, and sometimes promoting a particular perspective on the behaviour, a perspective that may not be shared by all members of our society, by all political ideologies or even be reflected in all pieces of relevant legislation. Hence in addressing the second Term of Reference, as well as examining “*the adequacy of protocols between DHS and Police*” the reviewers were required to be mindful of not just the Health Act 1958 and the Crimes Act 1958, but also legislation related to issues that included anti-discrimination, mental health, judicial review, powers of attorney, guardianship, and privacy.
- 3.7 Beyond reflecting on these pieces of legislation, the reviewers needed to take account of issues of capacity for various departments and agencies, to consider existing workforce capability, and varying attitudes to issues like risk management which together further complicate a clear view of what might be considered “*all appropriate action*”.
- 3.8 And then there are other considerations such as individuals managed under state legislation who choose to relocate to another state. The National Public Health Partnership publication Principles to be Considered when Developing Best Practice Legislation for the Management of Infected Persons who Knowingly Place Others at Risk<sup>2</sup> notes “*whilst all jurisdictions have the ability to act to protect*

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<sup>1</sup> Watchirs, H, ANCAHRD Position Paper, *Reforming the Law to Ensure Appropriate Responses to the Risk of Disease Transmission* Occasional Papers: No 2, May 2002 p. 1

<sup>2</sup> National Public Health Partnership, *Principles to be Considered when Developing Best Practice Legislation for the Management of Infected Persons who Knowingly Place Others at Risk* December 2003 p. 2

*public health, the extent of these powers, the basis on which they can be used and review procedures vary widely. This mismatch of powers and procedures makes the recognition of orders across borders legally very difficult*". This is an issue which is probably outside the Terms of Reference of the Review but is nevertheless a key issue for Public Health and disease control across Australia.

#### **4. Legislation, Accepted Principles and Policy**

4.1 The following paragraphs relate to the relevant legislation, principles and policies the authors identified and applied to their interviews, deliberations and findings.

4.2 Part VI of the *Health Act 1958* relates to "*Management and Control of Infectious Diseases*". Section 119 of Part IV (Appendix C) is headed "*Interpretation*" and it lists a number of principles<sup>3</sup> (substituted into the Act in 1988) that apply for the purposes of the application, operation and interpretation of this Part. These are:

- (a) *the spread of infectious diseases should be prevented or limited without imposing unnecessary restrictions on personal liberty and privacy;*
- (b) *a person at risk of contracting or being infected with an infectious disease must take all reasonable precautions to avoid contracting or being infected with the disease;*
- (c) *a person who suspects that he or she has an infectious disease must ascertain*
  - (i) *whether he or she is infected; and*
  - (ii) *what precautions should be taken to prevent others being infected;*
- (d) *a person with an infectious disease must take necessary measures to ensure that other are not unknowingly placed at risk of becoming infected;*
- (e) *a person with an infectious disease or at risk of contracting or being infected with an infectious disease has a right -*
  - (i) *to be protected from unlawful discrimination; and*
  - (ii) *to have his or her privacy respected; and*
  - (iii) *to receive information about the medical and social consequences of the disease and any proposed treatment; and*
  - (iv) *to have access to available and appropriate treatment*

*so long as those rights do not infringe on the well-being of others.*

4.3 Also of note in that Part, Section 120 "*Offence of infecting other persons*"<sup>4</sup> declares:

*"In any prosecution under this section it is a defence to prove that the person infected with the infectious disease knew of and voluntarily accepted the risk of being infected with that infectious disease".*

<sup>3</sup> Victorian Government *Health Act 1958* p. 78

<sup>4</sup> Victorian Government *Health Act 1958* p. 79

- 4.4 The underpinnings of these principles were supported in 1992 by the Intergovernmental Committee on AIDS (IGCA)<sup>5</sup> when it asserted, where possible:
- (a) control of a disease should be by support and education to encourage co-operation and appropriate behaviour change.*
  - (b) the least coercive power (i.e. counselling) should be used first at which point the authority may not need to be formally involved.*
  - (c) the consent of the person should be sought for testing and examination.*
- 4.5 These principles were consistent with those contained in the 1989 National HIV/AIDS Strategy<sup>6</sup> but that document also addressed “*exceptional cases*” which require placing restrictions on an infected person's living circumstances and employment, and confinement as a last resort. These powers should be exercised only on the authority of a court order, using the following criteria:
- (a) the person has in the past wilfully or knowingly behaved in such a way as to expose others to the risk of infection;*
  - (b) the person is likely to continue such behaviour in the future;*
  - (c) the person has been counselled, but without success, in achieving appropriate and responsible behaviour change; and*
  - (d) the person presents a danger to others”.*
- 4.6 The *National HIV/AIDS Strategy 1996-97 to 1998-99*<sup>7</sup> was more explicit in listing guiding principles, albeit that they were spread through the document under a number of headings. They included:
- (a) 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.*
  - (b) Transmission of HIV is preventable through changes in individual behaviour; education and prevention programs are necessary to bring about such changes.*
  - (c) Each person has a responsibility to prevent themselves becoming infected with HIV through unsafe sexual intercourse or the sharing of needles.*
  - (d) People living with HIV/AIDS have a responsibility to prevent further transmission of the virus.*
  - (e) Public health objectives will be most effectively realised if the co-operation of people with HIV infection and those most at risk of HIV infection is maintained.*
  - (f) Confidentiality is not an absolute right. There are exceptions to the duty of confidentiality that can result in disclosure of personal information in*

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<sup>5</sup> Final Report of the Legal Working Party of the Inter Governmental Committee on AIDS, 1992 (IGCA)

<sup>6</sup> Commonwealth Department of Community Services & Health (1989), *National HIV/AIDS Strategy*

<sup>7</sup> Commonwealth Department of Community Services & Health, *Partnerships in Practice - National HIV/AIDS Strategy 1996-97 to 1998-99: A strategy framed in the context of sexual health and related communicable diseases*

*some circumstances.*

- (g) HIV test counselling and antibody testing should be on a voluntary basis.*
- (h) Quarantine measures or exclusion of people with HIV from activities where there is little risk of transmission are unnecessary and a violation of human rights.*
- (i) People with HIV known to be placing others at risk of infection should not automatically be isolated, but instead should be offered education and counselling on a personal basis.*
- (j) Management of people with HIV infection thought to be placing others at risk of infection is best handled at the level closest to the person's living situation. Therefore, wherever possible, community groups and community based service providers should be involved in their support, counselling and guidance.*
- (k) Management interventions should be developed on a case by case basis so as to be appropriate for each individual situation.*
- (l) Placing restrictions on the living circumstances and employment of a person with HIV should only occur in exceptional circumstances. Such restriction must be subject to judicial review.*
- (m) Confinement or isolation in a place of quarantine should be viewed as a response of last resort. The exercise of this power should only occur where a court order is obtained.*
- (n) The use of the criminal law and criminal sanctions should be used in extreme and exceptional circumstances only. Criminal sanctions are often ineffective in the control of communicable diseases and their threatened use can at times undermine public health objectives.*

4.7 Drawing this together the document "*Principles to be Considered when Developing Best Practice Legislation for the Management of Infected Persons who Knowingly Place Others at Risk*"<sup>8</sup> observed "*Where a person is known to be suffering from a particular disease (eg through a confirmed notification or positive test result) and they present a risk to public health, the following powers should be available using a case management approach. From the least restrictive to most restrictive, they are:*

- (a) Counselling*
- (b) Restriction of behaviour or activities - including employment*
- (c) Supervision*
- (d) Treatment - including the power to ensure treatment is completed*
- (e) Detention*
- (f) Isolation".*

4.8 In relation to these powers the document also notes "*the health authority initially has a consultancy role that involves supporting and advising other agencies and caregivers*".

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<sup>8</sup> National Public Health Partnership, *Principles to be Considered when Developing Best Practice Legislation for the Management of Infected Persons who Knowingly Place Others at Risk* December 2003 p. 8

4.9 The Victorian *Health Act* 1958 recognises these powers in Section 121 under the heading “Orders”<sup>9</sup> though it does not necessarily require that they are used sequentially. Further, Section 122 of the Act, “Appeals”<sup>10</sup>, lists the matters the Supreme Court must consider when determining an appeal against a restriction order, isolation order, or interim isolation order. These matters are:

- (a) *The method by which the disease is transmitted;*
- (b) *The seriousness of the risk of other people being infected;*
- (c) *The past behaviour and likely conduct of the person to whom the order relates;*
- (d) *The extent of the restrictions imposed on the person to whom the order relates*

4.10 Finally, the National Public Health Partnership paper discusses the approach taken by some jurisdictions to diseases where powers of detention and isolation may be required – the so-called Controlled Notifiable Conditions – and lists criteria for determining which diseases might fall within this category<sup>11</sup>:

- (a) *there is an overriding imperative to act quickly;*
- (b) *action taken can improve the public health outcome;*
- (c) *the disease can be transmitted directly from one person to another;*
- (d) *the conduct of the person with the notifiable disease affects the likelihood of the transmission of the condition; and*
- (e) *the nature of the disease is such that its transmission results in long-term or serious deleterious consequences for the health of the individuals affected.*

4.11 In terms of a statement of what behaviours might constitute a reasonable basis on which to determine a person is knowingly placing others at risk, the Queensland “*Protocol for the Management of HIV Positive People Whose Behaviour May Constitute a Public Health Risk*” cites the following situations as “*possible bases upon which to formulate a reasonable opinion that a person is placing others at risk of HIV infection. These situations should be considered in context with the person's behaviour, and known social situation and psychological state.*”

- *Diagnosis of HIV infection where the newly diagnosed person names another person*
- *with HIV infection as the source of that infection.*
- *Diagnosis of a Sexually Transmitted Infection in a person with HIV infection.*
- *Self reporting of unsafe behaviours by a person with HIV infection.*
- *Statement of intent to infect other people by someone with HIV infection.”*

<sup>9</sup> Victorian Government *Health Act* 1958 p. 88

<sup>10</sup> *Ibid* p. 92

<sup>11</sup> National Public Health Partnership, *Principles to be Considered when Developing Best Practice Legislation for the Management of Infected Persons who Knowingly Place Others at Risk* December 2003 p. 13

4.12 The Protocol also notes:

*“A person whose action not only places others at risk of HIV infection but also constitutes a criminal offence (eg stabbing someone with a syringe of HIV infected blood or rape or other assaults), should not usually be managed under these guidelines in the first instance. Such action should be dealt with through the criminal justice system.”<sup>12</sup>*

4.13 A number of states and territories in Australia, Victoria included, have developed protocols for dealing with HIV positive persons who appear to be placing others at risk. The Victorian document (Appendix D) is titled *“Protocol for management of HIV positive persons who appear to be placing others at risk”*. In terms of objective decision-making measures the document states an *“initial assessment will include ..... verifying and validating the nature of the allegations. It will also involve the collection of information to confirm that the person at the centre of the allegation is HIV positive”<sup>13</sup>*.

4.14 This section also makes reference to Appendix 1 of the document, the appendix titled *“Information as evidence”* which notes *“PNOs (Partner Notification Officers) initially assess information that is passed to the Department about persons allegedly placing others at risk of acquiring HIV.”*..... *“The PNOs have an important role as gatekeepers in this process. They make assessments of referrals and judgements as to what should or should not proceed in this process. This is based on the validity of the referral.”*.... *“Under section 12 of the Health Act 1958, the burden of proof required to justify a response by the CHO, is one of ‘reasonable belief’ and not ‘beyond reasonable doubt’. This allows the CHO to act promptly when the CHO reasonably believes there is a significant public health risk.”*..... *“Both the CHO and the (HIV Advisory) Panel require the information that has been gathered to be presented to them in a manner that is accurate, consistent and complete.”<sup>14</sup>*

4.15 The document describes the functions of The HIV Advisory Panel, convened to provide *“expert advice for the Chief Health Officer to consider, about cases that come before it”*..... *“The Panel will consider all information presented and the chair will steer discussions to explore all relevant issues.”<sup>15</sup>*

4.16 As a *“high level”* document the Protocol provides general direction with respect to management of HIV positive persons who appear to be placing others at risk and also gives some specific parameters for measuring

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<sup>12</sup> Queensland Health, Protocol for the Management of HIV Positive People Whose Behaviour May Constitute a Public Health Risk June 2000 p. 6

<sup>13</sup> Department of Human Services Victoria, *Protocol for management of HIV positive persons who appear to be placing others at risk* p. 1

<sup>14</sup> *Ibid* p. 8

<sup>15</sup> Department of Human Services Victoria, *Protocol for management of HIV positive persons who appear to be placing others at risk* p. 5

effectiveness of management applied to different parts of the process.

4.17 The Department of Human Services also publishes a further document “*Guidelines for the management in Victoria of people living with HIV who put others at risk*” (Appendix E). This document describes the criteria used when deciding to exercise the powers delegated to the Chief Health Officer by the Secretary under the *Health Act 1958*<sup>16</sup>:

- *The person living with HIV has in the past behaved in such a way as to put others at risk;*
- *The person is likely to continue such behaviour in the future;*
- *The person’s behaviour presents a danger of transmission to others.*

4.18 The Guidelines list a set of “*guiding principles*”<sup>17</sup>:

- (a) *Transmission of HIV is preventable through changes in individual behaviour; education and prevention programs are necessary to bring about such changes.*
- (b) *Each person accepts a responsibility for preventing himself or herself becoming infected through sexual intercourse or the sharing of needles and drug using equipment, and for preventing further transmission of the virus.*
- (c) *The community as a whole has the right to appropriate protection against infection.*
- (d) *The law should complement and assist education and other public health measures.*
- (e) *Public health objectives will be most effectively realised if the co-operation of people with HIV infection and those most at risk of HIV infection is maintained.*
- (f) *These objectives are best achieved through the establishment of a working relationship based on respectful interaction, and when the individual is clearly aware of their rights, including the right of appeal, and adherence to principles of confidentiality.*

4.19 Interestingly these principles seem to differ in emphasis to some degree from the principles listed earlier from the *National HIV/AIDS Strategy*.

4.20 A number of interviewees expressed reasonable concern that “*active*” or “*directive*” approaches to managing persons thought, or known, to be placing others at risk of acquiring HIV infection would “*drive the issue underground*”, would cause homosexual people to be concerned with regard to their relationship and privacy in dealings with the Department and its officers, or would “*undo the significant good work and achievements of the last twenty years*”. These are issues that need to be managed very carefully but the reviewers believe that too often these concerns have prevented positive Public Health and clinical action that needed to be taken in the

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<sup>16</sup> Department of Human Services Victoria, *Guidelines for the management in Victoria of people living with HIV who put others at risk 2006-2009* p. 2

<sup>17</sup> Ibid pps.2-3

interests of the health and security of the individual, as well as the Gay and broader communities. There seems to be a perhaps “*unbalanced*” view in parts of the Department that the sanctions available under the Act are to be resisted rather than used as a last but necessary resort when other Public Health strategies have patently failed.

- 4.21 The position statement “*Criminal Prosecution of HIV Transmission*” produced by the Australian Federation of AIDS Organisations Inc and dated 28 March 2007 (Appendix F) is a timely and excellent account of the competing concerns involved and a useful statement of the common ground that can be attained in order to move these matters forward appropriately and successfully.

### **Specific Roles and Interventions**

- 4.22 General principles are important for defining strategic intent but the reviewers also sought documents that clearly laid out “*operational*” standards and direction for those working in the field. The Guidelines list tasks of the Partner Notification Officers (PNOs) when accepting and assessing a notification<sup>18</sup>. These include *inter alia*:
- Details of the behaviour involved in the notification.
  - Any evidence of HIV transmission.
  - Confirmation of the person’s HIV status.
  - The person’s response to the notification.
  - Details of specific behaviours such as unsafe sex and needle sharing.
  - Screening for factors like poor impulse control that might lead to risk behaviours.
  - A brief mental state assessment to screen for relevant psychiatric illness.
  - An assessment of social supports.
  - Evidence of drug dependency or use.
- 4.23 PNO’s are to “*conduct the interview in a non-threatening manner and they should try to develop rapport with the person*”. They should also give the person “*the opportunity to identify an independent advocate who can provide support throughout the process*”<sup>19</sup>.
- 4.24 The Guidelines also assert that “*at each stage of this process the following fundamental questions are considered*:
- *Have all voluntary options for the previous stage been exhausted?*
  - *Have previous stages failed to modify behaviour?*
  - *Do the actions of this person appear to be putting others at risk of HIV infection?*<sup>20</sup>
- 4.25 In terms of interventions at each of the five stages of the management

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<sup>18</sup> Department of Human Services Victoria, *Guidelines for the management in Victoria of people living with HIV who put others at risk 2006-2009* pps. 4-5

<sup>19</sup> Ibid p. 4

<sup>20</sup> Ibid p. 6

process, the Guidelines outline a range of options<sup>21</sup> from general support and assessment in Stage One, to involvement of the HIV Advisory Panel from Stage Two onwards, to the use of a Letter of Warning in Stage Three, to Orders for counselling and restriction in Stage Four “*where it appears the person has not complied with a voluntary request for counselling*” or “*where the person continues to put others at risk of HIV infection and it appears that all previous measures have been unsuccessful*”, to isolation in Stage Five where “*it appears that person is repeatedly placing others at risk of HIV infection and is not complying with the terms of the restriction order*”.

4.26 The *Protocol for management of HIV positive persons who appear to be placing others at risk* (Appendix D) mentions “*Handover Meetings*” – fortnightly meetings of departmental officers to discuss management of currently active cases. These meetings are meant to discuss<sup>22</sup>:

- Case background and allegations.
- Investigations, interventions and outcomes to date.
- If relevant, an assessment of the ability of the case to undergo behavioural change.
- The Panel’s advice pertaining to the case.
- Relevant directions and orders/letters from the Chief Health Officer.
- Review of planned actions (completed or pending).

4.27 This section also requires “*any non-compliance or breach of Orders relating to restriction of behaviour or movements of individuals.... be identified and brought to the attention of the Secretary through the Executive Director, RRHACS through a formal briefing.*”

4.28 The Protocol raises the issue of the “*Relationship with the Police*” and directs that “*at each handover meeting the behaviour of the case will be assessed to determine whether a referral should be made to the Victoria Police for their investigation. This assessment will be guided by the following principles. Factors to consider:*

- *Is there any information suggesting that the case is consciously intending to infect others with HIV?*
- *In the course of the public health investigation, has the Department become aware of information that leads it to believe that the case may be committing a criminal offence?*
- *Is the case amenable to change or constraint through resources available to public health (e.g. mental health/counselling services, drug and alcohol services, intellectual disability services) or does the case present a level of risk that cannot be managed by these measures?”*

4.29 Finally, when referring to the work of the HIV Advisory panel the Protocol

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<sup>21</sup> Ibid p. 8-11

<sup>22</sup> Department of Human Services Victoria, *Protocol for management of HIV positive persons who appear to be placing others at risk* p. 3

requires “*following the completion of the quarterly post panel documentation, the secretariat will undertake a briefing on behalf of the CHO to the Secretary. The briefing will communicate the advice provided by the panel for each case, and departmental actions in relation to each case*” and further “*an annual review of cases will be undertaken by the PNOs in December each year to provide increased transparency and a broad overview.*”<sup>23</sup>

### **Process**

- 4.30 Good process is the element that ensures the management of people under these principles and protocols is appropriate, effective and efficient. Good clinical process helps ensure individual circumstances and needs are well understood and appropriately met in a timely fashion in order to maximise outcomes and individual commitment, and helps to identify management gaps and thereby minimise discontent, overlap, misunderstanding, and deficiency in services offered.
- 4.31 Good administrative process is important when legal issues are involved. It helps lay down a coherent and defensible trail of evidence and it aids understanding of decisions and explains apparent conflicts when final actions may not seem to accord with earlier advice. Good administrative process “*protects*” individuals in a decision hierarchy and helps final decision makers feel more comfortable in making decisions that affect the lives of others and are open to public scrutiny.
- 4.32 By the nature of the documents cited in this report, most of which are high level policy documents, the direction with respect to process is contained in a small number of official publications. The *Protocol for management of HIV positive persons who appear to be placing others at risk*, at various stages in the document, lists expectations of various individuals and groups. These include:
- “*At the time of contact information will be provided to the informant as to the nature of the two different systems of response to such allegations, namely section 121 of the Health Act 1958 and powers delegated to the Chief Health Officer, and the criminal justice system with the involvement of the police. The informant will be advised who to contact at Victoria Police, should they wish to pursue this avenue, and how this contact can be made.*”<sup>24</sup>
  - “*The PNOs will contact the Assistant Director, Communicable Disease Control Unit (AD) within 24 hours of urgent/sensitive new cases, or in their absence the Deputy Chief Health Officer (DCHO) and actions planned or undertaken (sic). A decision will be made at that time to arrange either an urgent meeting with the PNO’s, BBV/STI Program Medical Adviser (MA), AD and DCHO to discuss the case or, to do so at*

<sup>23</sup> Department of Human Services Victoria, *Protocol for management of HIV positive persons who appear to be placing others at risk* p.5

<sup>24</sup> Department of Human Services Victoria, *Protocol for management of HIV positive persons who appear to be placing others at risk* p. 1

*the next routine fortnightly handover meeting. A similar process will be followed when the PNOs receive new and important information pertaining to current cases.*<sup>25</sup>

- *“There will be fortnightly meetings between the PNOs, the MA, AD and DCHO and actions recorded on the relevant PNO file. Assessment of the potential of the cases presented to undergo behaviour change will be discussed, documented and monitored.”*<sup>26</sup>
- *“Draft Minutes of the (HIV Advisory) Panel’s deliberations will be prepared by DHS secretariat and provided to the CHO in 1 day if urgent action is required and 1 week if not urgent. The creation of these draft minutes will include input from the AD. Copies will be provided to the PNOs, MA, AD, DCHO and the CHO by the secretariat. A copy of these confirmed minutes will be kept on the file and in the Panel’s reference folder”*<sup>27</sup>
- *“In the week following each HIV Case Advisory Panel meeting, there will be a Post Panel meeting involving the PNOs, MA, AD and the DCHO. The aim is to consider the advice provided, plan and allocate tasks and to ensure appropriate documentation. The meeting will be chaired by the AD and the minutes of the Panel meeting will be presented and discussed. The program’s response will be developed through a work plan to be completed at this meeting. It will lay out the Panel’s advice, the key points made at this meeting, the actions planned and the officer assigned to the action. The resulting document will be endorsed by the AD, and provided to the CHO. The final ratified document will be circulated to all involved and placed on file, and copies of relevant extracts on individual case files”*<sup>28</sup>
- *“If a person on a Public Health Order enters into a custodial setting then Public Health will liaise with Corrections Victoria to suitably advise them of the Department’s concerns. A face-to-face meeting may be convened and the case discussed”*<sup>29</sup>
- *“A current Memorandum of Understanding is held between the Director, Public Health and the CEO of the Victorian Institute of Forensic Mental Health, which outlines how DHS will use the restriction site at the Jardine precinct. This site has recently been lost to a redevelopment and an alternative site is being sought. The identified accommodation will be utilised if a restriction and/or isolation Order is to be served”*<sup>30</sup>

4.33 The “Guidelines for the management in Victoria of people living with HIV who put others at risk 2006-2009” (Appendix C) give no specific process directions, nor does the community-focussed DHS document “What happens if a person appears to be knowingly and recklessly transmitting HIV” or the Health Act 1958. (Appendix G)

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<sup>25</sup> Ibid p. 1

<sup>26</sup> Ibid p. 3

<sup>27</sup> Ibid p. 4

<sup>28</sup> Ibid p. 4

<sup>29</sup> Ibid p. 6

<sup>30</sup> Ibid p. 6

- 4.34 With regard to the second Term of Reference “*to examine the adequacy of protocols between DHS and Police in managing clients subject to the provisions of Section 120 and 121 of the Health Act*” no jointly-endorsed protocol, Memorandum of Understanding or other document currently exists to define the relationship and associated processes between the Department of Human Services and Victoria Police<sup>31</sup>. An undated protocol in draft form, in a variety of iterations, was provided to the reviewers by each entity but these documents have yet to be agreed to by both parties and formally ratified by senior management. In discussions with various parties in both agencies at a variety of levels of management it was clear that this draft document was very much a work in progress and the reviewers found no evidence that it had influenced the behaviour of either party in any actions relevant to the Terms of Reference. The document largely describes the powers available to both parties under The Health Act 1958 and The Crimes Act 1958 but it also identifies “*uncovering of a serious crime such as child abuse, child pornography, major drug dealing and significant violent crime in the course of a public health investigation*” as issues that “*would fall outside the scope of the Health Act 1958 and trigger contact with Victoria Police*”.
- 4.35 The draft protocol also says “*contact could be initiated if the Chief Health Officer felt that the risk posed by the alleged offender was proving difficult to contain with the public health measures available*” and also “*if there was uncertainty from either party managing the case as to possible referral to the other, then a meeting would take place between DHS and the Sexual crimes Squad.*” “*The aim of such a meeting would be to present a picture of the events in order to have a clear and frank discussion about the preferred responses and legal obligations of each organisation, without any identifying information being disclosed. Such discussions will clarify a set of future actions, which may include formal information sharing.*”<sup>32</sup> It appeared to the reviewers that work on this protocol had only commenced after the incidents of 2006 and in fact was still being modified while this review was taking place.
- 4.36 A Protocol regarding service and execution of warrants exists between the Department of Human Services and Victoria Police also in draft form and is yet to be formally agreed to and ratified. This document offers little relevant to the current Review as it does little more than describe a communication process between the two agencies and contains nothing specific with regard to what information might or should be shared.
- 4.37 Also found on a DHS Departmental file was a document titled “*Management and control of infectious diseases – the role of Victoria Police*”. This document was undated but had been faxed apparently on 9 February 1998 and listed Dr Graham Rouch as Chief Health Officer. The document stated

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<sup>31</sup> Personal correspondence from DHS and Victoria Police

<sup>32</sup> Department of Human Services Victoria, ***Protocol between Department of Human Services Public Health Branch and Victoria Police regarding the management of HIV positive persons who are allegedly placing others at risk*** p.4

*“The management of serious infectious diseases is a complex matter that requires careful negotiation with some individuals by health workers. The actions of the police must support the efforts of the health authorities to manage the public health risk. Members are requested to consult with senior colleagues, the Senior Medical officer, the Officer in Charge, Community Liaison Division or the Manager of the STD/AIDS Unit of the Department of Human Services whenever doubts exist”.*<sup>33</sup>

#### **Review Methodology and Report Format**

- 4.38 Drawing the relevant points from the above documentary sources provided a comprehensive list of objective assessment criteria against which the reviewers could inspect the files of individuals described in Term of Reference One of this Review. The reviewers traced the general history of the client from the first notification and endeavoured to assess actions taken by Departmental staff, interaction with other clinicians and agencies, responses of clients to directions and management approaches, possible trigger issues that determined when action was or was not required, and evidence suggesting that each case was moving towards an end-point that ensured the best Public Health outcome. The assessment criteria used by the reviewers is listed at Appendix H.
- 4.39 Each of the fifteen cases defined by the Terms of Reference of the Review was independently assessed against these criteria using whatever notes and other material were contained in the file on that client. Concurrent with this process of case review, the reviewers interviewed a number of key informants from within and from outside the Department or who had previously worked in the area. The list of interviewees is presented at Appendix B.
- 4.40 Together, the detailed case review and the information acquired in meetings and interviews was used to determine whether *“all appropriate action has been taken by DHS including whether reference to Police should have been made”* as required by Term of Reference one. The reviewers’ findings follow in the next section.
- 4.41 With regard to the second Term of Reference *“to examine the adequacy of protocols between DHS and Police in managing clients subject to the provisions of Section 120 and 121 of the Health Act”* in the absence of any agreed protocols the reviewers concluded that protocols must be seen as inadequate. The higher level documents described earlier give some direction as to how the relationship between DHS and Police should function. The reviewers used these documents, the files reviewed under Term of Reference one and their learnings from the interviews to provide the findings that follow in the next section.

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<sup>33</sup> Department of Human Services Victoria, *Management and control of infectious diseases – the role of Victoria Police* p.5

**5. Key Elements Identified Regarding Specific Components of Term of Reference One.**

**Legislation**

- 5.1 The legislation applied by the reviewers in examining the files and case management that were the subject of this review was the Health Act 1958, Sections 120 and 121 (Appendix C) (as prescribed in the Terms of Reference) and Sections 19A, 22 and 23 of the Crimes Act 1958. (Appendix I)
- 5.2 There was no evidence to suggest the current *Health Act* creates problems with regard to the management of clients who appear to be knowingly or recklessly placing others at risk.
- 5.3 The approach mandated for managing people under the Act is consistent with good practice and if handled appropriately allows an ordered progression in management from a supportive, behaviour-change focus ultimately to isolation if required.
- 5.4 There was no evidence to suggest the legislation had been misused at any time.
- 5.5 There was no evidence that the relevant sections of the *Crimes Act 1958* are inappropriate for its intended use or that it had been misused.
- 5.6 The reviewers noted uncertainty or lack of clarity has developed in interpreting some of the intent and meaning of sections in both Acts relating to offences of infecting others. This uncertainty or difference in perspective seems to have developed as treatments for Human Immunodeficiency Virus (HIV) have improved, as prognosis has changed and as new measures like viral load have become increasingly part of the assessment of a person's status and potential for presenting a threat to others.
- 5.7 Within the two pieces of legislation there is no explicit statement of how the individual sections relating to infecting others are meant to “*harmonise*”. In interpreting the respective Acts DHS and police quite naturally apply their own policies, perspectives and knowledge. While the author's accept that there is consultation and co-operation at the operational level it appears there was little or no collaboration at a management level. This can, and has, at times resulted in an over legalistic and adversarial approach being adopted in interactions between the two departments. Of course this lack of rapport and shared understanding managerially can be magnified as a problem when a particular case becomes high profile and urgent. When discussing the topic of inter agency collaboration privacy was presented as an inhibiting factor. While protecting an individual's privacy is vital, in many respects this is a separate issue to a professional and productive relationship between two government departments and the two matters should not be confused. The reviewers see this problematic relationship as a deficiency, which if addressed would promote greater strategic and operational collaboration between DHS and Victoria Police and should lead to more effective and

appropriate management of clients. While cross referencing the two primary Acts would require Ministerial and parliamentary activity and agreement the ratification of clear and agreed protocols in an MOU between the two agencies should be easily achieved. This work would clarify the government's position on these issues with the end product hopefully containing a more concise statement of direction on when clients should be managed by which agency and how, if agreement could not be reached, any impasse would be resolved.

#### **Assessment and Comment**

- 5.8 The real test of legislation lies in its application. The reviewers discovered the application of Section 120 and 121 of the *Health Act* was haphazard in its response to specific issues, often did not follow a logical path of escalation as matters were not resolved or new issues arose, and frequently no clear plan was apparent as to what constituted desired outcomes or agreed parameters of a successful resolution.
- 5.9 Judging from the case files available to the reviewers it appears orders and notices are not served on the basis of specific “trigger” actions and sometimes appeared to be lifted for no readily apparent reason that was recorded in the file. As will be described later this perspective may be in part generated by the poor administrative procedures for generating and maintaining files.
- 5.10 However, in summary, the authors could not find written, organised, endorsed processes for managing the application of the legislation other than the higher level statements of protocols and guidelines referred to above. On specific issues like isolating clients under level five of the *Health Act* process the reviewers found there were no clear arrangements in place to manage people in these circumstances, no processes to ensure basic needs for support and rights like legal representation were addressed, and after recent changes no facility available that could be used to hold a person and ensure both their safety and the safety of others. The reviewers found there is currently no endorsed process for aligning the actions of the Department of Human Services and Victoria Police when they are working within the separate pieces of legislation for which they each have primary responsibility.

#### **Recommendations**

- 5.11 The Department of Human Services should review its processes and practices to move through the actions identified in relevant subsections of section 121 of the *Health Act* 1958 in order to:
- Ensure clear triggers and processes are defined for serving Orders, for restricting clients' movements, and for isolating and detaining clients should any of these actions become necessary.
  - Guarantee a sustainable solution is always available for managing clients isolated under the Health Act in a risk-free, appropriate environment with appropriate staff available for supervision.
  - Define protocols and processes to be followed to ensure basic rights like access to services such as legal representation, access to interpreter

services, appropriate mental health assessment, and addiction services are respected for all clients whose movements are restricted or who are detained and isolated.

- 5.12 The Attorney-General and the Ministers for Health and for Police and Emergency Services should be advised of the need to ensure a process to align the relevant sections of the *Health Act* and the *Crimes Act* in order to direct departmental policy and operations processes in ensuring effective, efficient and harmonious function of government services in addressing the area of HIV and human behaviour that is either inappropriate or reckless.

### **Policy**

- 5.13 The Methodology section of this paper presents the broad range of documents that exist to define high-level strategic policy on these matters.
- 5.14 There is no lack of credible strategic policy in this area but what is sorely needed is a clear statement of *prevailing operational policy* and *operating procedures* for dealing with people who are knowingly and recklessly placing others at risk.
- 5.15 Linked to this is a need for consistent action that demonstrates and strengthens commitment to this operational policy and a well prepared communications strategy that engages the key communities of interest and ensures their support in implementing and maintaining an operational policy that is directed at only a handful of high-risk individuals.
- 5.16 The reviewers found that at present there appears to be no clear policy approach operationally to client actions and needs and each client seems to be addressed as presenting an entirely new problem with no regular approach taken in regard to common problems, no learnings from earlier clients and no common measure of what was good or bad progress. In reviewing the case notes the reviewers found instances where action had been swift and decisive and other occasions where the evidence demanded action but none was forthcoming or at least not as demonstrated in the case files, which to say the least were disorganised.
- 5.17 Links between the Department of Human Services PNO's and operational units of Victoria Police seem to operate well from the evidence gathered by the reviewers. This suggests inter-agency policy pursued at the operational level is appropriate and from the evidence uncovered it seems this relationship operates within the general intent of the National Privacy Principles<sup>34</sup> and PNO's seem to be very clear that the confidentiality of these clients can and should be protected. The reviewers believe that with a little more work to develop clear statements of operational policy from the perspective of both parties, this relationship could be strengthened to ensure more productive sharing of "*intelligence*" without substantial threat to client privacy and confidentiality.

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<sup>34</sup> The **National Privacy Principles** in the *Privacy Amendment (Private Sector) Act 2000* as at 03/07

- 5.18 It is essential that on-going liaison between the two departments occurs regularly and not only in crisis situations.
- 5.19 At higher levels there is very little formal alignment of policy-based approaches and little interaction between the two agencies, though evidence to hand suggests this was not always the case, at least up to the late 1990's. Interviewees spoke of quarterly meetings between senior Health Managers and the then holders of Assistant Commissioner rank for Victoria Police.
- 5.20 Lack of an agreed set of protocols or Memoranda of Understanding other than those that have existed in draft form for some years (and are yet to be ratified) is clear testimony to this lack of an appropriate working relationship seemingly at the middle management level.
- 5.21 This situation is not peculiar to Victoria and is likely to be the case in other states where similar "*tensions*" are known to exist between criminal and health legislation and departmental relationships have not been properly defined and developed to avoid misunderstanding, miscommunication and lack of coordinated action.
- 5.22 From the interviews more than the case notes, the reviewers formed the opinion that key, potentially contentious Public Health decisions were regularly referred to the legal area of the Department for an opinion on whether a particular course of managerial/medical action should be initiated. It appears that Public Health decisions are frequently deferred to seek legal opinions on whether a problem exists or could exist with respect to application of Health Act and relevant medical and departmental principles. These decisions are taken "*internally*" to the Public Health area and in some cases resulted in significant delays in action being taken. In the interim period advice was not always provided to the Secretary, and sometimes not even to the Chief Health Officer on the status of the case and the justification for seeking a legal opinion. Perhaps a request to these levels for a government or departmental direction on what course should have been followed, with a statement of preferred Public Health intent may have been more useful. In the Methodology area of this report those sections of the Protocol and Guidelines documents requiring regular reporting of cases to the Secretary and reporting by exception of key cases of concern were highlighted. As well as not providing best advice and decision-making opportunities to the senior executive and Minister, taking these decisions with the very best of professional intent within the Public Health area alone clearly entails personal risk for individuals managing these clients.
- 5.23 The reviewers believe the Department of Human Services has not arrived at a clear understanding of the client groups likely to present difficulties with clinical supervision and more likely to need managing under the *Health Act*, or at least this issue has not been formally addressed. This in turn leads to a lack of clear policy on how to manage clients presenting with particular issues.
- 5.24 Changing patterns of behaviour in young men and women potentially at risk

of HIV infection, emerging difficulties with HIV infection in refugees or people immigrating from parts of Africa, the impact of new treatments for HIV, and the interpretation of new tests like viral load estimations and their impact on behaviour are all areas that need clarification with regard to what they mean for policy responses. Some important areas of behaviour rely on anecdotal evidence of current attitudes. For example, and pertinent to recent issues of concern to the Minister, more research is needed on areas like behaviour of people with multiple partners actively seeking new experiences<sup>35</sup>. In turn, greater clarity should lead to explicit position statements on these matters leading to greater certainty in how clients are managed.

- 5.25 In examining the circumstances and management of cases involving African immigrants one issue that came to light was the problems associated with obtaining interpreters. On occasions operational staff utilised family or friends but clearly they are not impartial nor necessarily totally honest and accurate and the client's privacy can be significantly compromised. Even that level of service can be difficult to obtain and access to authorised interpreters is minimal. In the case of one dialect the only authorised interpreter is based in Perth. The need for access to accredited African language interpreters is not confined to DHS; the same problem applies to the police dealing with the African people.
- 5.26 More resources need to be applied to the area of partner notification, case tracking and new case finding in order to ensure that a complete picture of clients' behaviours and potential risks can be fully understood and appreciated.
- 5.27 In order to provide a snapshot of the range of behaviours relevant to this area Appendix J gives a summary of cases of interest reported from two capital city sex-on-premises venues over the space of two years. The reviewers are very clear that the activities described in this appendix are not representative of the actions of the vast majority of gay and bisexual men. But the legislation is not intended to be used in other than a very small minority of "difficult" clients and this summary highlights the sorts of clients that are in need of health services support if common misunderstandings are to be addressed and appropriate levels of counselling and treatment are to be provided to men and women at risk. Adequate levels of staffing are not available in these areas in any state but the current situation in Melbourne that acted as the catalyst for this report should promote a greater understanding of the need and a greater commitment to addressing this need. The current level of staffing of the PNO area is not sufficient to allow time and resources for the Department to understand the actions, perspectives and needs of these problematic clients.

#### **Assessment and Comment**

- 5.28 Term of Reference one includes "*all appropriate action ... taken by*

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<sup>35</sup> Albury, K. *Swinging subcultures* Australian Federation of AIDS Organisations *HIV Australia* Volume 5, Number 4 page 24-25

*DHS including ... reference to Police*". The earlier considerations of high level policy work identified the tensions that exist between managing clients under Public Health versus Crimes Act legislation. It is not an easy decision to take and perspectives can differ between agencies, from the worker at the coal face through to the Minister.

- 5.29 The reviewers believe from the case review that *involvement of Police* even without the client being *referred to Police* has not always happened when it should have, and this is by no means a recent issue. The reviewers believe this reflects the difficulties involved in making these decisions, a concern with maintaining privacy and confidentiality for individuals, and a desire to maintain the faith and trust of individuals living with HIV and to some degree the faith and trust of the Gay community. The authors believe with the benefit of hindsight these decisions can be demonstrated to be inappropriate to the circumstances of some of these cases.
- 5.30 With respect to Term of Reference two and "*the adequacy of protocols between DHS and Police in managing clients subject to the provisions of Section 120 and 121 of the Health Act*" the reviewers have already stated their opinion that any protocols that exist, even in draft form are inadequate. Linked to the recommendation for work to align work under the different pieces of legislation in this area, there is a need to develop clear operational policy to guide staff of the Department of Human Services and Victoria Police. This work should address operations at all levels of each agency, should promote dialogue and understanding between the two agencies, should clearly delineate the lead agency in each situation and the role of other agencies pertinent to particular situations, should also clearly define triggers that would escalate the involvement of either agency in any particular situation, and should identify appropriate contacts in senior positions in each agency who can make decisions with regard to action when required.
- 5.31 The final form of the agreement should be a Memorandum of Understanding between the Victoria Police and Human Services. The functionality of this Memorandum of Understanding should be reviewed annually as should general satisfaction of both parties with the handling of cases of interest from the preceding twelve months.
- 5.32 While acknowledging that all clients are individuals, with specific needs and circumstances, an examination of the case notes shows that clients that come to the attention of the Department as requiring intensive management possibly under the *Health Act* can be broadly aggregated into a number of key groups of interest in order to ensure "*all appropriate action will be taken by DHS*". These groups of clients include:
- (a) those with an intellectual disability or a chronic mental health problem;
  - (b) those with an alcohol, drug or situation-related life crisis affecting their ability to make "*rational*", non impulse-driven decisions;
  - (c) people who have donated blood while knowingly or unknowingly

- infected with HIV;
- (d) people coming to Australia as immigrants or refugees from high HIV prevalence countries;
- (e) individuals who primarily demonstrate no apparent concern for the wellbeing of others.

- 5.33 Each of these groups presents its own set of issues and requires a unique set of approaches and inputs from relevant clinical disciplines. From the reading of the files available it seems possible to determine a formal approach reflective of “*good practice*” in dealing with each of these groups. Such an approach should identify which clinical services are most appropriate to which client’s needs, should allow some estimate of the likelihood of successful management with available resources, should determine realistic milestones and timeframes by which to track client responsiveness, and also identify what approaches reflect a good practice escalation of tactics in response to lack of effect with more conservative approaches to client management.
- 5.34 In order to ensure a timely and useful understanding of current attitudes, influences and activities within the client groups of interest, a greater level of investment should be made in researching problematic attitudes and behaviours of “difficult” members of these groups in order to identify for these problematic behaviours, responses that are both effective and appropriate to the needs and values of the groups involved.
- 5.35 Aligned with this work, a greater investment needs to be made in the staff resource engaged in partner notification or contact tracing following diagnosis of a new HIV infection or report of risky behaviour. Currently there are only three officers funded to address reports from across the state and this is not a sufficient resource to allow the Department and the government to be confident that all that needs to be done is being done, or that the attitudes, beliefs and behaviours of the clients of interest are known and understood.
- 5.36 Developing policies based on groups of clients also allows broad testing and ultimately determination of legal principles appropriate for application to these client groups. This should give Departmental staff more clarity and confidence on what can and can’t be done with regard to areas of principle that include privacy, confidentiality, natural justice, public interest disclosure and “*reasonable belief*” with respect to preventing a serious and imminent threat to an individual’s life, health or safety. If this is done it should then be “*easier*” for Public Health staff to act predominantly to protect the safety of the community, confident in the knowledge that they have appropriately respected the rights of the individual and addressed all relevant legal concerns to the best of their ability and to the greatest extent allowed by the individual circumstances.

### **Recommendations**

- 5.37 Operational and policy-related units of Human Services and Victoria Police should develop a Memorandum of Understanding that clearly defines their

working relationship in terms of issues such as roles and responsibilities, lead agency for particular situations, trigger points for escalation of management of clients based on clear measures of progress, and legal principles that will inform specific activities or approaches. This relationship, along with the performance of each agency should be jointly reviewed on at least an annual basis and provision should be made for joint scenario planning and exercises where appropriate.

- 5.38 The Public Health Branch of the Department of Human Services should develop clear guidelines for the oversight of specific client groups, including agreed approaches to clinical referral, specific high-level contacts in other agencies to facilitate rapid and effective referral of clients of concern, legal principles that must be considered in any decision, and evidence-based milestones that allow tracking of client progress and early identification of developing problems and concerns.
- 5.39 The Public Health Branch should ensure immediate reporting of “*cases of concern*” to the Secretary and the Minister in order to ensure that the Public Health approach accords with the policy approach preferred by the Minister and the Secretary and also highlights any potential conflict of this approach with legal advice in order that a position of principle can be decided by the Minister and Secretary. This recommendation is based on a view that ultimately the elected representative of the people and the senior executive of the Department must decide on issues where a conflict may exist between Public Health principles, legal principles and political interpretation of the prevailing will of the public.
- 5.40 Human Services should work with Victoria Police and relevant community-based organisations to develop a shared understanding of the need for appropriate action to protect the health of individuals and the community and the range of strategies that will be used to achieve these goals, as well as to explore potential communications strategies to ensure appropriate engagement of relevant communities and representative agencies in this work.

## **6. Monitoring of HIV positive clients**

- 6.1 Earlier sections of this document refer to the changing nature of the HIV epidemic in Australia. Increasing numbers of new HIV cases have been reported from most parts of Australia at least from the early years of this decade, associated with changes in the demographic of reported cases and variability in the rate of reporting of new cases between states<sup>36</sup>. This increase has been most marked in Victoria and has led to varied responses and reporting in the popular press<sup>37,38</sup>. Interestingly it seems there is still uncertainty as to the true increase in “*risky behaviour*” and rates of infection

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<sup>36</sup> Rebecca J Guy et al *HIV diagnoses in Australia: diverging epidemics within a low-prevalence country* MJA 2007 187:1-4

<sup>37</sup> “*Risky*” HIV Carriers to be reported Julia Medew and Carol Nader The Age, July 25, 2007

<sup>38</sup> *Government considering \$10m HIV campaign* Sydney Morning Herald, January 30, 2007

related to the number of HIV positive individuals versus increases in raw numbers of notifications<sup>39</sup>. At least there seems to be uncertainty as judged by the public comments of some high profile activists in the area. What is clear on any analysis is that New South Wales seems to be performing better than the other states with respect to numbers of new cases but the reason for this is unclear. At paragraph 6.4 the reviewers recommend greater resourcing should be applied to understanding the drivers of the current changes, the drivers of altered behaviours and of safer behaviours, and the means by which health promotion strategies in their broadest sense can be applied to reducing new cases of HIV infection.

- 6.2 The PNO's represent the first line of reporting with respect to new clients and their partners. The PNO's experience represents a wealth of knowledge on what is shaping behaviours and importantly they are also the first line of investigation of "risky" or "illegal" behaviours that appear to have led to an innocent individual or individuals acquiring HIV infection. They are also the first and most timely source of valuable intelligence for the Department on recent changes in attitudes or behaviours. This "immediate intelligence" is supplementary to and in some respects preliminary to the work that funded, national level agencies are also doing and on which these agencies routinely publish. As noted earlier there are currently only three PNO's doing this work around the state – clearly not a sufficient resource to address all of the issues at hand.
- 6.3 It was not clear to the reviewers how this first hand intelligence links to information available from the database of notifiable conditions, genotyping of HIV isolates and other relevant technical and epidemiological information in order to build a comprehensive picture of current trends and influences to drive development of policy, new strategies and basic disease control and health promotion endeavour in groups of clients known to be at risk. Much is written about issues such as amphetamine use and new HIV infections<sup>40</sup> but as yet the evidence is unclear. Information links to alcohol and drug services, better education and research through these services and through other avenues like sex-on-premises venues will help to better understand the "new" epidemic and will complement and hopefully support publications from national-level bodies and agencies.

#### **Assessment and Comment**

- 6.4 The PNO resource needs to be strengthened and enhanced. This is recommended at paragraph 6.5 with regard to the basic work of contact tracing. Greater resources should be put in place to allow time for these officers to engage in basic "intelligence gathering" aimed at answering some of the questions posed by reported trends. At the same time this experience needs to be tied to epidemiological analysis of new cases of HIV and sexually transmitted infections in order to develop a more comprehensive picture of current trends for those areas of the Department working on policy

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<sup>39</sup> Personal correspondence Dr C Fairlie, Director, Melbourne Sexual Health Centre

<sup>40</sup> Professor David Cooper, speaking at the International AIDS Society conference in Sydney and reported by AAP 24 July 2007

and strategy in the area of HIV. This is the sort of work that will allow the Secretary to be properly briefed on what constitutes “*all appropriate action*” and may be best achieved by ensuring at least six-monthly meetings between PNO’s, epidemiologists and policy officers in order to identify current trends, to identify questions posed by those trends and to promote applied research that will help answer some of those issues. These meetings should involve other relevant services such as those working with substance abuse, those working with newly arrived refugees and organisations such as those representing sex workers and gay men in order to gain as complete a picture as possible.

### **Recommendations**

- 6.5 Urgent steps should be taken to review the workload of the PNO’s in order to provide sufficient resources to allow at least a doubling in the staff establishment of the PNO’s to boost tracing and notification of client partners when a new HIV infection is reported. These new resources, along with the existing positions, should be organised as outlined at paragraph 7.2 to allow for a separation of clinically-related contact tracing from legally-based investigation and monitoring of clients suspected of, or actually knowingly and recklessly engaging in risky behaviour. As will also be identified in Section 7, these resources should form part of an outcome-focussed management process designed to ensure problem people or issues are recognised and addressed as soon as possible.
- 6.6 The Department of Human Services through the Public Health Branch should ensure processes are in place to help better identification and understanding of areas of concern that might not otherwise be notified but that need investigation to ensure Public Health is being protected. These should include:
- Regular reports from the HIV Register on issues of concern, clusters of cases, and increases in rates of notification in geographic areas, with a formal process for Departmental review of these reports.
  - Regular conferencing with groups working in the area such as the Melbourne Sexual Health Centre, Alcohol and Drug Clinics, Immigrant Support Groups, Victorian AIDS Council, PLWHA, and Victoria Police in order to “*share*” information, concerns and current approaches to specific issues.

## **7. Notification Process**

- 7.1 Significant benefits can be achieved with a well-organised surveillance system for communicable diseases. The notification process is where the individual client is first engaged with the health system and where the first evidence is acquired regarding the circumstances and events leading to acquisition of HIV infection or to a notification of concern regarding an individual’s behaviour. This is a very important part of the process but also one that needs to be carefully considered with regard to the intended use to be made of the notification. The reviewers were concerned that there appeared to be no specific, objective process for separating the clinical work

of tracing contacts of a client with a sexually-transmissible infection from the process of collecting evidence that may be used to prosecute a breach of the law. This is not a problem that is peculiar to this part of Public Health and similar considerations arise with respect to for example Environmental Health issues.

- 7.2 Specifically the problem is (a) separating the work of a clinician providing care for an individual from the enforcement role of an officer under an Act directing and monitoring the management and behaviour of an individual (b) ensuring the collection of an evidentiary trail that may be required later in a court hearing and which must be seen to be as objective and independent of the witness's influence as possible (c) ensuring that a combined clinical and enforcement caseload does not overwhelm the performance of an individual to the point where important actions required under legislation to protect others are neglected due to pressure of work (d) ensuring that an officer under an Act is able to maintain the professional separation that is necessary for them to counsel clinicians when it appears that their performance may not be up to the standard required or to demand action of agencies when their performance is not delivering the required outcomes.
- 7.3 The reviewers found that the PNO's are currently required to fulfil all these roles, including accepting notifications, visiting clients, organising access to services when required, tracking clients when they go missing, liaising with police with regard to possible criminal activities or gathering of intelligence or evidence, briefing senior departmental officers or the HIV Advisory Panel on progress, and arranging restrictions on behaviour or isolation when these are required. The reviewers are strongly of the view that these activities are both too big a workload and also constitute poor process with regard to separating clinical and legislated management of clients. The result is potentially a diminished clinical performance, inability to deliver "*all appropriate action*", and a conflict between professional responsibility to a client and "*sharing of knowledge and advice*" with Victoria Police. To date, the performance of the Department in this area has rested to a considerable degree on the professionalism and commitment of the three PNO's, which the author's judged to be admirable.
- 7.4 The reviewers found there are no operating procedures to guide formal receipt and assessment of a notification of "*risky*" behaviour and no formal process to determine what behaviours contained in a notification might constitute grounds for referral to Victoria Police. This should not be taken to imply that the PNO's have not done a good job of assessing notifications to date and of talking to Victoria Police regarding concerns that may have come to light. Rather, the current process leaves too much to the professional judgement of the PNO's, opening them to criticism if management does not go according to plan. Also there is no current departmentally-ratified process that can be presented in court if required as evidence that a notification has been handled according to good practice and Departmental preference.
- 7.5 Earlier, under "*Policy*", the reviewers recommended managing clients in broad groups defined by source or aetiology of the behaviour of concern.

This was intended to ensure that appropriate process, timeframes and milestones were clearly defined in order to support transparent and defensible monitoring of progress. In the cases reviewed there appeared to be little process definition and management and monitoring of progress were left to the discretion and work pressures of the few officers given the task of monitoring progress. This is not the best way to optimise both clinical management of individual clients or to ensure best process with regard to addressing threats to the health and safety of members of the public. This is also not the best way to give clients clear expectations of their behaviour when they are being managed under a process mandated by law.

### **Assessment and Comment**

- 7.6 The reviewers believe these deficiencies impact seriously on the operational procedures and effectiveness of the notification and management process. This is directly relevant to Term of Reference one. The reviewers believe steps should be taken to separate the processes of clinical contact tracing and partner notification from the process of managing a client under the provisions of the *Health Act*. This does not necessarily mean staff should be given separate tasks in perpetuity as the caseload of clients being managed under the legislation is relatively light. PNO's should be able to engage in clinical management and contact tracing at some times and operations under the Act at others. What is important is that they do not try to undertake both tasks for one client at one time.
- 7.7 The case has been put earlier for properly designed, evidence-based protocols for managing clients based on the factors driving their problematic behaviour. These protocols will ensure management is properly understood and endorsed by all levels of the administration hierarchy. If other agencies and services are collaboratively engaged in the development of the protocols this should also help with communication of the approach taken by Human Services, should foster a spirit of cooperation between Human Services and other agencies, and should make managing clients under these protocols easier to defend in court or in the broader public arena.

### **Recommendations**

- 7.8 The notification process should be redeveloped to:
- Separate contact tracing from investigation of specific notifications of concern in order to ensure the evidentiary process remains “*untainted*” and the best service is given to all client groups.
  - Incorporate a formal process (with guidelines agreed preferably between the Human Services and Victoria Police) to determine if notification to or involvement of Victoria Police is needed at the initial notification stage eg in relation to concern regarding related crimes or to gain other information needed to form an accurate picture.
  - Promote identification of the key elements of a client's issues at an early stage in order to promote a clear plan of management from the earliest phase of engagement with a client. The plan of management should be based on protocols developed to be appropriate to the common drivers of problematic client behaviour as identified in earlier sections of this

report.

- Include clear “*rules of engagement*” readily communicated to and understood by all clients. These should advise clients on what is expected in terms of information/attitude/commitment from those notified, should clearly identify for newly notified clients their responsibilities and rights, should clearly outline the powers available under legislation should they not comply, and should clearly identify what parameters will be used to determine non-compliance and when more active management is required under legislation.

## 8. Supervision & Management of Process

- 8.1 Managing clients with HIV infection is a complex process involving a range of issues from testing and diagnosis, to tracing of contacts, understanding how the infection was acquired, appreciating the life circumstances of the parties involved in transmission of the virus, their attitudes to treatment, and their preparedness to change aspects of their behaviour and lifestyle that may place them and others at risk of acquiring the disease. This undertaking requires a range of strategies and support from a number of organisations. This Review examined only the Department of Human Services approach to the regulation and control component of these strategies.
- 8.2 The reviewers identified the range of relevant documents listed earlier in this report and from these established the set of criteria for assessing performance from the case notes (Appendix H). The comments that follow are based on a reading of the case notes of the clients relevant to the Terms of Reference of the Review and provided for the reviewers by Departmental staff, as well as minutes of Handover Meetings, HIV Advisory Panel meetings and other documents considered relevant such as specialist reports. The following comments reflect the reviewers’ assessment of the performance of the Department based on these criteria and materials.
- 8.3 The reviewers take issue with a number of components of the existing approach to supervision and management of the regulatory process. These are as follows:
- (a) There appears to be no formal “*entry point*” for managing a client under the provisions of the *Health Act*. By this is meant there are no formal criteria for determining when a notification of concern regarding a client constitutes the beginning of the formal five stage process described in Part VI of the Act.
  - (b) As a consequence any initial assessment and determination of need for management under the *Health Act* rests with the PNO’s in what is a relatively subjective assessment of a client’s circumstances. There does not appear to be clarity with respect to the reporting lines of the PNO’s in an operational sense. While they appear to be the prime information point for the legislated process, and while they are the key contact point for the client with this process, there are three layers of management between them and the Chief Health Officer who is the decision-maker. This appears to complicate process, to frustrate good communication, and to

- delay decisions.
- (c) If the PNO's decide to escalate management of the client to the *Health Act* process contact is made with senior staff in the Public Health Branch at what is called, inappropriately in the view of the reviewers, the "*Handover Meeting*". This seems to imply a "*handing over*" of the client though the PNO's continue to be involved in the management of the client in both a clinical and statutory sense.
  - (d) These meetings determine what form management will take but do not seem to take decisions based on agreed protocols (such as those described earlier under Policy). While this may be appropriately reflective of the individual nature of client management, in a process based on legislation and requiring a trail of evidence it leaves a perception that decisions are made in an *ad hoc* fashion. Indeed, reading and comparing client case notes to determine the clinical basis of decisions to act or not to act further promote this perception.
  - (e) Clients being managed under a statutory regime, apparently with mandated expectations on their personal behaviour, often were uncontactable for a period of time or did not comply with management decisions taken at Handover Meetings, yet no specific action resulted on a number of occasions. The conclusion seems to be that either there was no substance to the Handover Meeting decision, the client did not take the direction seriously, or no action was warranted to reinforce the gravity of the situation. The seriousness of this situation is reinforced by the fact that the reviewers were only asked to review fifteen of these cases (and two others are before the courts) in a period of over fourteen years. If the numbers of cases being managed under legislation are not large then the reviewers expect they would have been managed more closely as pressure of work is not a contributory cause for not closely managing clients under the Act.
  - (f) A number of clients who clearly were in breach of reasonable expectations regarding their behaviour or who were demonstrably and beyond reasonable doubt acting inappropriately did not have their management escalated to the next level of control. Particularly in these clients it was clear no firm expectation of their behaviour had been negotiated with them in order to make any subsequent action defensible in terms of a "*client-Department*" contract.
  - (g) There seemed to be a preference to use the HIV Advisory Panel as a decision-making body rather than in an advisory capacity. In the view of the reviewers this is inappropriate as the Panel is not a statutory body within the legislation, but is rather a body designed to give high level policy advice or advice only on individual clinical cases. Using the Panel in the current manner undermines the professionalism of the advice and decision-making expected of the Chief Health Officer in the capacity delegated by the Secretary under the legislation.
  - (h) Under the Policy section above the reviewers provided their recommendation with regard to clarifying legal principles relevant to client management. This recommendation is stimulated in part by a reading of the notes of one particular client where management decisions were delayed for a number of months while legal advice was sought from

other parts of the Department, and in part by other notes where reasonable decisions were delayed while possible legal obstructions were debated or second-guessed. Delays of this type are not difficult to understand but are difficult to defend.

- (i) Again the Policy section above recommends immediate reporting of cases of concern to senior Departmental officers and to the Minister, as well as regular reporting of cases managed under the legislation. This is a vexed area in that senior Public Health managers are employed and expected to “*manage*” without having to request advice from their seniors on every issue. They also have a fine line to tread with regard to maintaining the trust and support of colleagues working in community-based organisations and bodies representing the interests of clients. They are also regularly required to manage difficult clients who may come to the attention of the media, often with media criticism of the department whatever decision has been taken. All of these matters must be taken into account but it is still in the best interests of good process to report “*upwards*” in order that Ministers and senior executives are not “*surprised*” by developments, and decisions that must be taken on policy and politics are taken by the most appropriate people, the elected representatives. The reviewers were unable to find any evidence in the notes of a regular, consistent briefing process to the Secretary or to the Minister and briefings to the Chief Health Officer contained in the files did not appear consistent with respect to what circumstances prompted a briefing.

#### **Assessment and Comment**

- 8.4 The reviewers see the identified concerns in relation to case management and file supervision as significant issues for the Department to address. We are of the view that very significant changes must be made to the supervision and management of the processes used to administer clients under the relevant sections of the *Health Act*. These changes require adoption of concise operating procedures, changes in the reporting arrangements of the PNO’s to ensure they have a much more direct line of communication to the decision-maker i.e. the Chief Health Officer, a preparedness by senior officers to take timely decisions based on good Public Health principles often in the face of significant scrutiny and opposition, and at all times a willingness to work with all parties including Victoria Police and non-government agencies to ensure that the intent of the legislation and resultant strategies are focussed on protecting the health of individuals and the broader community. With these objectives in mind the reviewers offer the following suggestions.

#### **Recommendations**

- 8.5 Written operating procedures should be developed to guide staff in the management of clients and those standard operating procedures should embody the following principles and objectives:
  - (a) Written procedures should be based on the protection of Public Health as the Department’s prime responsibility. If evidence is gathered that clearly supports concern with regard to the gravity of the threat then the Department should have the confidence to proceed in the knowledge that

privacy and confidentiality principles support appropriate disclosure and subsequent management.

- (b) Procedures should ensure appropriate clinical management of clients using clear guidelines incorporating milestones for “*performance*” is balanced with clear and defensible processes for ensuring an evidentiary trail is maintained should it be needed.
- (c) Clinical management should be individually tailored but should also recognise commonalities wherever possible eg clients with mental disability, clients with problematic drug use leading to impaired judgement and check-lists should be developed to ensure actions are considered and taken at the right times where appropriate.
- (d) Procedures should be cognisant of what other agencies/processes (eg Victoria Police, Adult Guardian, Mental Health Act) could/should be involved at what time and formal processes should be explored to facilitate easy but appropriate communication with these agencies.
- (e) Operating procedures should be based on ensuring “*separation*” of PNO’s work from “*routine*” clinical work to ensure the evidentiary trail is maintained and protected.
- (f) Operating procedures should ensure the safety and wellbeing of PNO’s and other staff involved in managing clients is a consideration at all times.

8.6 Clear reporting lines and rules must be established for use by those staff managing clients under the provisions of the *Health Act*. In addressing this recommendation the following elements should be taken into account:

- (a) The process of managing cases must be very clearly based on a “*no surprises*” approach where regular reporting passes through the “*chain of command*” to the Chief Health Officer, to the Secretary and to the Minister on any area of concern where Public Health and legislated responsibilities are an issue.
- (b) As a principle the PNO’s should report on these clients directly to a Manager reporting to the Chief Health Officer (the reviewers recommend this should be the Assistant Director, Communicable Disease Control Unit) to shorten the “*chain of command*” and enhance communication (though administratively they could be managed at a lower level).
- (c) When operating in a statutory capacity the PNO’s should see themselves, and be seen by others, as part of a management team stretching from them to the Chief Health Officer – the concept of “*handover*” should be dispelled and concerns regarding “*clinical care-related*” privacy should be managed by separation of duties between clinical and statutory functions.
- (d) An administrative arrangement should be put in place to ensure the Chief Health Officer receives regular advice on cases from the PNO’s and Public Health management, and that advice from the HIV Advisory Panel is maintained as separate from that of the Department to ensure the best, most impartial advice from both sources.

- 8.7 A clear case-management approach should be used for all clients. In addressing this recommendation the following points should be taken into account:
- (a) New notifications should be case-conferenced among the PNO's when first notified and a decision should be taken, based on clearly documented parameters, as to whether the client should be managed under the *Health Act*, or through standard clinical practices.
  - (b) If standard clinical practices are to be used then all PNO's should understand that clients should be case-conferenced in the future if their behaviour is considered to be "*risky*".
  - (c) If the provisions of the *Health Act* are to be used then a case management plan should be developed and signed-off by the senior manager who the PNO's report to on these issues. This plan should identify issues of concern and strategies for addressing these issues, including milestones and timeframes.
  - (d) To ensure objective case management under the *Health Act*, to ensure an unbiased evidentiary trail, and to promote timely escalation of issues there should be separation of client clinical management from management under the Act. This means these two functions should be managed separately and independently by different PNO's and wherever possible the reviewers recommend clinical client management should be directed by the PNO's to a third party, preferably a general practitioner or staff member of a sexual health centre.
  - (e) A process for regular review (at a minimum monthly) should be developed and triggers for escalating at shorter intervals should be clear to all parties. Reviews should include sign-off on progress by all parties. For complex cases the senior manager may choose to involve senior managers from other relevant agencies in a management "*panel*" to ensure consideration of all relevant factors and to expedite management between agencies where necessary. The senior manager may choose to involve an advocate for the client who would necessarily be a person recommended and agreed by the client, in these meetings.
  - (f) All meetings of the senior manager with PNO's and other parties engaged to provide advice on specific clients should be thoroughly minuted and records kept on independent client files.
  - (g) Case management plans should identify expectations of other agencies and senior management should be informed early if any problems arise with liaison, with demarcation, or with performance of any party.
  - (h) Case management plans and notes on progress should form the basis for reports on progress to senior management or briefings to the HIV Advisory Panel, should an opinion be sought from this body.
- 8.8 The HIV Advisory Panel should function as an independent group convened to provide management advice on specific clients or high level policy advice to the Chief Health Officer and should not be influenced by Departmental processes. To achieve this:
- (a) The Panel should have a designated administrative officer responsible for

preparing agendas and minutes under the direction of the Chair of the Panel.

- (b) Clients should be referred to the Panel only on the direction or with the agreement of the Chief Health Officer if the Chief Health Officer requires advice on the management of a particular client.
- (c) A formal briefing signed off by the Chief Health Officer and without any patient identification, should be presented to the Panel well before the meeting to allow members sufficient time to read and consider the case information in order to frame their opinion of the case before the meeting.
- (d) The Panel should be provided with the client's Departmental file and be verbally briefed at the meeting by Departmental staff only if the Panel, through its Chair, requests this assistance.
- (e) Any new information considered relevant can be provided to the Panel at the direction of the Chief Health Officer.
- (f) Any advice from the Panel should be formally provided in writing (or in exceptional circumstances verbally) to the Chief Health Officer, signed off by the Chair of the Panel with specific advice on recommended actions and with a copy maintained on the individual client departmental file.
- (g) The Panel should be advised of actions taken in relation to their recommendations at the next Panel meeting.

8.9 The Chief Health Officer should meet regularly (at least twice each year) with appropriately senior members of Victoria Police in order to confer on the efficacy of the Memorandum of Understanding (MOU) for managing persons suspected of putting the Public Health at risk and/or potentially committing offences under the *Crimes Act*, and also to monitor the quality and performance of the overall working relationship between the two Departments.

- (a) The MOU should recognise the inherent tensions between a criminal prosecution approach as demanded by *Crimes Act* legislation and a Public Health approach based, at least initially, on counselling and health promotion and disease prevention approaches.
- (b) For clients being managed under the *Health Act* the MOU should promote as much as possible a shared approach to information, to monitoring of progress with clients, to decision-making with regard to management of clients, and ultimately to ensuring the best outcomes for the individual and for the community while respecting the privacy of the client and the confidentiality of their personal information.
- (c) The MOU should be based on the Department of Human Services taking the lead role in the management of clients notified to the Department, should specifically recognise and delineate the support role Victoria Police can offer in this phase, but should also identify triggers that would escalate the role of Victoria Police.
- (d) Both Departments should work to foster a relationship based on mutual professional respect. This should be promoted by an initial workshop designed to inform all parties of the role and activities of each agency

and would be further enhanced by at least twice yearly sessions designed to share de-identified information on management of clients, to test hypothetical situations, and to promote general communication.

## **9. File Management and Administration**

- 9.1 The area of file management and administration demands special comment from the reviewers as it was something that both frustrated a relatively easy and efficient review of the cases presented to the reviewers, and also caused considerable concern when taken as an example of the overall processes used by the Department in this area.
- 9.2 The reviewers' experience of public sector processes has given them the view that a departmental file should present a chronology of events with regard to a specific issue, supported by specific briefings and submissions to senior management that reflect the views and concerns of relevant staff and demonstrate clearly the direction the department has chosen to take and the basis for the decisions that led to this direction. Almost without exception this was not the case with the files examined.
- 9.3 Instead the files presented a large volume of clinically-related information on the progress of the client with little evidence of departmental processes, few briefings to senior management, few instances of specific responses to briefings, little evidence of how decisions were reached, and often only limited reports from treating clinicians or specialist consultants on elements of the client's case. In short, it was very difficult from the files to develop an appreciation of why decisions were taken or what issues had caused a particular line of management to progress or not to progress.
- 9.4 In a Department like Human Services this is not the only field where confidential information is held and used in determining the best management approach for a client. This is also the case in the areas of disability, mental health, addiction, and practitioner regulation to name a few. There are generally agreed processes by which confidential client information can be separated from "*administrative*" information but these files did not demonstrate any evidence that these processes had been followed. When questioned staff gave the impression that lack of administrative support was to blame and maybe this is the cause in part.
- Assessment and Comment**
- 9.5 The record keeping and file management system used for tracking clients being managed under the *Health Act* must be reviewed and upgraded as a matter of urgency. This review must be based on information and file management processes endorsed (and presumably mandated) by public sector principles and guidelines and must be adequately resourced in order that all files can be brought up to an agreed level of quality as soon as possible.

## **Recommendations**

- 9.6 The record keeping system must be reviewed and comprehensively overhauled to ensure it is clear, complete, and defensible both administratively and in an evidentiary sense.
- (a) Patient files including PNO File Notes should be kept separate from the formal Departmental files and the latter should contain summaries of progress or file notes describing important developments related to potential Public Health risks and action taken.
  - (b) Codes to protect privacy and confidentiality concerns must be used at all times and items placed on files should only relate to the individual of interest and not be, for example minutes of meetings where other individuals are also discussed.
  - (c) Files should be constructed according to standard Departmental protocols and should be maintained in order that “*the file can tell the whole story*”.
  - (d) Files must contain all official notes and correspondence including specialist reports relevant to possible contravention of the Health Act or possible Public Health risk, minutes of meetings that detail case management committee or HIV Advisory Panel consideration of the individuals, and copies of Orders in chronological order.
  - (e) Maintenance of files, taking of meeting minutes, and other relevant administrative duties should be the responsibility of one administrative officer and appropriate resources should be committed to ensure this individual is able to give this work their full attention.

## **10. Conclusion**

- 10.1 In this report the reviewers have tried to acknowledge the difficulties inherent in managing clients with HIV-related concerns, in being sensitive to the needs of individuals who may for a variety of reasons be unable to understand or respond to the concerns of the community and of other people, in managing a politically-charged environment, and in responding to the concerns of individuals and groups with a very significant personal investment in seeing that discrimination is avoided and privacy is respected. The reviewers again make the point that this work relates to a very small group of difficult individuals from diverse backgrounds. This report in no way should be taken to present recommendations on how the broader management of individuals living with HIV should be conducted – this document is directed specifically to the small group of individuals identified in the Terms of Reference who represent an extreme end of these broader community spectrums.
- 10.2 The reviewers are also very aware of the difficult environment that senior public servants now work in, potentially exposed to criticism from the media with little right of reply, addressing complicated issues with little ability to find a forum where the complexity of these issues can be given the depth of analysis they deserve, and balancing the concepts of harm reduction and community engagement with statutory responses reserved for a non-responsive few. These are thankless tasks where a case of disease prevented will never gain the attention that it deserves.

- 10.3 In reviewing the client cases and interviewing key informants it became clear that the system as it stands can and should be improved. In light of the reservations expressed above it is difficult to be unreservedly critical of the system and when the complexity of the task of managing clients is considered across the levels of the Department, across the agencies involved and in light of the relative paucity of resources committed to the work, it is difficult to be critical of any individuals.
- 10.4 The authors have found the system is in need of significant overhaul and improvement. This is probably not just the case in Victoria and the issues canvassed here are likely to need work in other jurisdictions and indeed across jurisdictions. The reviewers have tried to provide a positive agenda for change in the areas of legislation, policy, monitoring, notification, supervision and management relevant to problematic clients living with HIV, and for file management and administration in the Departmental areas charged with these responsibilities. If this work is only confined to government and to the Department of Human Services then the job is only partially complete.
- 10.5 What is needed is an approach that is inclusive of the community of people living with HIV and AIDS, the Gay community, organisations that represent small subsets of the population with special needs, and the community more broadly. Legislation is a legitimate Public Health approach but it is one that must be reserved for the last resort, one that must be understood and supported by the community and one that is administered with the wholehearted endorsement of its elected representatives. If they are unable to give their support or endorsement then they must be prepared to define the alternatives that will ensure public health and safety. These are the true challenges ahead.

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## APPENDICES

- A List of cited references.
- B List of interviewees.
- C Part 6 (Divisions 1 – 3) Health Act 1958.
- D Protocol for Management of HIV persons who appear to be placing others at risk.
- E Guidelines for the management in Victoria of people living with HIV who put others at risk 2006 to 2009.
- F “Criminal Prosecution of HIV Transmission” by Australian Federation of AIDS Organisations Inc, 28 March 2007.
- G DHS pamphlet “What happens if a person appears to be knowingly and recklessly transmitting HIV”
- H Assessment criteria utilised by reviewers.
- I Sections 19A, 22 and 23 of the Crimes Act 1958.
- J (NOT RELEASED)