Victorian guidelines for managing HIV transmission risk behaviours (2021)

OFFICIAL

Department of Health

Victorian guidelines for managing HIV transmission risk behaviours

December 2021

To receive this publication in an accessible format phone 1300 650 172 using the National Relay Service 13 36 77 if required, or email <infectious.diseases@health.vic.gov.au>

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

© State of Victoria, Department of Health, December 2021.

Available at <https://www.health.vic.gov.au/publications/policies-and-guidelines>

Contents

Summary of revision history 5

Introduction 6

Principles 7

The scope of the guidelines 9

Legislative provision 11

Crimes Act 11

Charter of Human Rights and Responsibilities Act 12

Privacy and confidentiality 14

Considerations when working with diverse communities 15

Implementation 16

Notification 16

Role of partner notification officers 16

Role of clinical service providers 18

Role of the HIV Case Advisory Panel 18

The four-stage approach 20

Stage 1: Counselling, education and support 22

Stage 2a: Counselling, education and support under advice from the HIV Case Advisory Panel or the Chief Health Officer 22

Stage 2b: Letter of warning 22

Stage 3: Public health orders (behavioural) 23

Stage 4: Public health orders (detention and/or isolation orders) 24

Review of public health orders 25

Internal review by the Chief Health Officer 25

Statement of reason and external review by the Victorian Civil and Administrative Tribunal 25

Referral to police 26

Appendix: Public health orders (behavioural) 27

Statutory preconditions 27

Form requirements 27

The rights of a person subject to an order 28

References 29

Summary of revision history

Revisions of the guidelines for the management of people living with HIV who put others at risk.		
Version	**Date**	**Review/revisions**
Original guidelines	1989	
First revision	2002	Department of Human Services and key stakeholders undertook a review
Second revision	2008	Griew-Leach and the Scott- Falconer review was submitted to the Blood Borne Viruses and STI Sub-Committee of the Australian Population Health Development Principal Committee. This review formed the basis for the national guidelines.
Third revision	2009	Revision to account for the commencement of the *Public Health and Wellbeing Act 2008,* which replaced the former *Health Act 1958*, under which the guidelines were first made.
Fourth revision	2016	Revisions to reflect legislative changes: Repeal of s. 19A of the *Crimes Act 1958* and *Privacy and Data Protection Act 2014* replacing the *Information Privacy Act 2000.*
Fifth revision	2019	The Victorian guidelines were reviewed to reflect latest scientific evidence on treatment as prevention (TasP) for reducing HIV transmission and ensuring alignment with the revised *National guidelines for managing HIV transmission risk behaviours 2018.* Changes include: - reiterating the latest scientific evidence of U=U (undetectable viral load equals untransmissible) - removing stigmatising language such as ‘people placing others at risk’ and using non stigmatising language such as ‘managing risk behaviours’ instead - a more detailed description of roles and responsibilities - changing the management framework from five levels to four in line with the national guidelines - removing referral to police from the management levels.
Sixth revision	2021	Department of Health and key stakeholders undertook a review. List of key stakeholders available on Department of Health website <web page address TBC> Changes include: - changing the management framework from five levels to four, in line with the updated *National guidelines for managing HIV transmission risk behaviours, 2018* (1) - removing referral to police from the management levels - further reiterating the concept of U=U (undetectable viral load equals untransmissible).

Introduction

While most people living with human immunodeficiency virus (HIV) conscientiously avoid practices that expose others to transmission, a small number of people may engage in practices that require interventions and support to prevent transmission. This document outlines the Department of Health's (the department) policy in managing behaviours associated with HIV.

The Victorian guidelines are for all stakeholders who, as part of their job, need specific guidance for managing people engaging in HIV-related risk behaviour. However, these guidelines are mostly for the department's Partner Notification Unit officers. They have been revised and align with the *National guidelines for managing HIV transmission risk behaviours, 2018* <www.health.gov.au/internet/main/publishing.nsf/Content/ohp-hiv-guideline-at-risk>(1).

The revisions of the National and Victorian guidelines reflect the latest scientific evidence on the individual and public health benefit of interventions to reduce HIV transmission including antiretroviral treatment as prevention for reducing HIV transmission. Research shows that people living with HIV who take daily antiretroviral treatment as prescribed and achieve viral suppression (defined as an undetectable viral load or a viral load of less than 200 copies/mL) have effectively no risk of sexually transmitting the virus to an HIV-negative sexual partner (2-8). This approach to antiretroviral treatment is referred to as treatment as prevention (TasP).

There is not enough evidence to conclude the same for non-sexual routes of exposure (for example, injecting drug use). However, it is likely that sustained viral suppression will also substantially reduce the risk of HIV transmission in these situations.

The guidelines have been renamed to remove stigmatising language and better reflect their scope in 'managing HIV transmission risk behaviours' through supporting people in achieving positive behaviour changes. The updates also include:

- the use of person-first language
- a more detailed description of roles and responsibilities
- changes to the management framework from five to four levels in line with the national guidelines.

Invoking the law in the situation of HIV transmission risk behaviours presents a wide range of complex legal and ethical issues. The overall aim is to strike the right balance between mitigating the risk of HIV to the community and protecting the rights of individuals. Applying the Victorian guidelines is the responsibility of the Victorian Chief Health Officer (CHO), who has legal powers to manage risks associated with HIV transmission in the community to protect the public.

The powers of the CHO to manage disease transmission risk are set out in the *Public Health and Wellbeing Act 2008* (PHW Act). These capabilities include examination and testing, education and counselling, requiring certain assessments be undertaken (psychiatric or neurological), placing restrictions on certain practices or movements and, in extreme circumstances, detaining or isolating a person. The primary objective of all measures is to eliminate HIV transmission in Victoria. A key to successfully managing HIV transmission risk behaviours is to ensure the person of concern is supported and empowered to achieve and maintain a suppressed viral load. They can do this by linking with and continued engagement in clinical care, and with effective antiretroviral treatment.

OFFICIAL

Principles

The department recognises and adopts all principles outlined in the revised *National guidelines for managing HIV transmission risk behaviours, 2018* (1). These principles include but are not limited to the following:

- Management under the national guidelines requires a consistent approach across all client groups regardless of gender, gender identity, disabilities, mental health diagnoses, sexual practices/orientation, work practices (including sex work), injecting drug use, cultural background or religious beliefs. This will help maintain transparency, ensure fair treatment and avoid any implication of stigma or discrimination. Such factors, and HIV-positive status, are not in and of themselves markers of risk behaviours and should not be taken as proxy evidence of placing others at risk. Most people with HIV are motivated to avoid placing others at risk and will respond when given access to the information, education and resources needed to prevent transmission including condoms, sterile needles and syringes and access to antiretroviral therapies.
- Everyone has a responsibility to prevent themselves and others from acquiring HIV and for preventing further transmission of the virus.
- Most people living with HIV who engage in HIV transmission risk behaviours live with complex social, emotional, educational, cultural, intellectual and/or mental health factors that affect their daily lives. This includes financial issues, homelessness and drug and alcohol use. The concept of safe practices may therefore be difficult for a person to manage in their daily life in the presence of any, or a combination, of these factors. Finding strategies that will flexibly address these causal factors is fundamental to reducing or resolving risk behaviours.
- In all relationships a range of factors including cognitive ability and power differences can affect a person's ability to take preventive measures.
- Except in exceptional circumstances, testing for HIV should be voluntary and informed.
- A high level of adherence to antiretroviral therapies with sustained viral suppression, and retention in appropriate ongoing clinical care with regular treatment monitoring, will minimise the risk of HIV transmission and forewarn of potential transmission risk early in the case of non-adherence or detectable viral load.
- Service providers should provide counselling and support services, including ongoing post-diagnosis counselling, to encourage practices that minimise the risk of HIV transmission and ensure stable linkage to treatment and care. Specifically, clinicians have an ongoing role in routine management of their patients with HIV whose ongoing practices may be placing others at risk of HIV transmission.
- Perceived or actual stigma and discrimination can affect a person's willingness or ability to disclose their HIV-positive status, to engage in care, to start and/or adhere to treatment, or to use prevention strategies.
- Where more intensive measures are needed, case management may be appropriate. This should involve innovative planning with a range of health and other services to deliver individualised solutions.
- The aim is to de-escalate or discharge people from management under the guidelines, unless necessary to protect public health.

These guidelines aim to help realise the goal of the *Victorian HIV plan 2021–2025* to eliminate HIV transmission, eliminate stigma and discrimination related to HIV and achieve the 95-98-98 targets for diagnosis, treatment and viral load by 2025. This will be achieved through a focus on increasing effective HIV prevention, testing and treatment for Victorians.

In addition, the following principles apply to managing and controlling HIV under the PHW Act:

- A person at risk of contracting HIV should take all reasonable precautions to avoid contracting the disease.
- A person who is at risk of contracting HIV, or who has or suspects that they may have HIV, is entitled to receive information about HIV and appropriate treatments and, if infected, have access to appropriate treatments.
- A person who has or suspects they may have HIV should ascertain whether they have HIV and what precautions they should take to prevent transmission. They should take all reasonable steps to eliminate or reduce the risk of any other person contracting HIV from them.
- The transmission of HIV should be prevented or minimised with the minimum restriction on the rights of any person.

Escalating interventions may be needed, with preference always given to strategies that are least restrictive. Restrictive measures such as detention or isolation should only be very rarely applied and limited to extreme circumstances. In addition, referral or involvement of police is appropriate only as a last resort. Referral to police should be reserved for circumstances where the CHO or delegate reasonably believe that either a serious criminal offence has occurred, or that the person under management has intentionally transmitted HIV to another person.

In accordance with these principles the CHO expects that people living with HIV, or those who believe they may have HIV, will take all reasonable steps to eliminate or minimise their risk of transmission. What is considered reasonable is discussed in the next section. Similarly, there is an expectation that all reasonable precautions should be taken to avoid contracting HIV. The CHO recommends that all people practice safer sex and safe injecting.

OFFICIAL

The scope of the guidelines

These guidelines apply when the behaviours of a person living with HIV present a real and immediate risk of HIV transmission and where management of that risk by the person's health care team has been unsuccessful. The presence of a detectable viral load does not in itself warrant management under these guidelines unless it is also associated with transmission risk practices. **The guidelines do not apply when a person living with HIV is consistently taking reasonable steps to prevent onward HIV transmission.**

Reasonable steps to prevent transmission may include a combination of the following:

- having a sustained undetectable viral load of less than 200 copies/mL – public health risks are maximally reduced when a person has a sustained undetectable viral load with two documented undetectable viral loads at least three months apart in a six-month period (9) and is engaged in appropriate clinical care and treatment monitoring
- consistent condom use with lubricant
- consistent disclosure of positive HIV status prior to engaging in sex[1]
- seeking confirmation from sexual partners that they are taking HIV pre-exposure prophylaxis (PrEP)
- safer injecting practices including using sterile needles and syringes and avoiding distributive sharing of needles or equipment.

The current Australasian Society of HIV, Viral Hepatitis and Sexual Health Medicine's PrEP guidelines (2019) (10) recommend a timeframe of at least six months of viral suppression before the need for continued PrEP in serodiscordant relationships may end. The *Australian national guidelines for the management of healthcare workers living with blood borne viruses and healthcare workers who perform exposure prone procedures at risk of exposure to blood borne viruses* also require healthcare workers to have two undetectable viral loads at least three months apart before being cleared to return to performing exposure-prone procedures (11). The department acknowledges that with the development of new antiviral medications viral suppression may be achieved in much shorter timeframes than currently observed. However, to minimise risk it is essential that adhering to antiretroviral treatment and engaging in clinical care has been consistent and stable for at least six months in people who have engaged in transmission-risk practices or where there are specific concerns or barriers regarding adherence.

It is important that guidance provided to people with HIV on managing transmission risks should emphasise the critical role of other risk reduction strategies beyond solely that of an undetectable viral load. Antiretroviral treatment also has a key role in prevention as post-exposure prophylaxis (PEP).

People living with HIV who have a sustained undetectable viral load and **do not** disclose their HIV status to sexual partners before having condomless sex are not a target population for these guidelines. However, should the department receive an allegation of transmission risk practices, a risk assessment will need to be undertaken. This may include the department seeking confirmation that the person has a sustained undetectable viral load and is engaged in clinical care. The person (or their clinical service provider) must therefore be able to provide this evidence. If it is established that there has been risk of transmission, information about the person and the circumstances will be presented at a case management meeting, and it is the decision of the Deputy CHO or CHO as to whether the person is managed under the four-stage process (refer below).

[1] People with HIV in Victoria are not required to disclose their HIV status if they are taking reasonable precautions to prevent the transmission of HIV; however, it is a crime to falsely represent HIV status to induce another person into having sex (s. 45 of the *Crimes Act 1958*).

Those who choose not to disclose their positive HIV status prior to condomless sex, needle sharing or other activities that carry a risk of transmission should be aware that their sexual or drug-use partner(s) may report them to police, despite them having taken other actions to prevent transmission. People with HIV in Victoria are not required to disclose their HIV status if they are taking reasonable precautions to prevent the transmission of HIV; however, it is a crime to falsely represent HIV status to induce another person into having sex (s. 45 of the *Crimes Act 1958*).

It should be noted that in Victoria the fact that a sexual partner is aware of the risk of HIV transmission and accepts this risk may not be a defence. Negotiated consent may be relevant as a defence or mitigating factor in sentencing, but this would be considered by each court on the facts of each case.

The guidelines apply when:

- the practices of a person living with HIV present a real and immediate risk of transmission of HIV and where management of that risk by the person's healthcare team has been unsuccessful (a real and immediate risk requires both transmission risk practices and the presence of a detectable viral load)
- certainty cannot be established that a person may be able to maintain a sustained undetectable viral load, that they are engaged in clinical care and where there are concerns of transmission risk practices in the absence of close support or case management.

If a person whose transmission risk practices are being managed under these guidelines is adhering to treatment, has a sustained undetectable viral load and is engaged in clinical care, a graded withdrawal of public health measures will be undertaken and the need for continued support assessed.

OFFICIAL

Legislative provision

The Victorian guidelines work within the following local legislative and policy provisions:

- The PHW Act provides the CHO with a raft of powers for managing and controlling infectious diseases, including HIV. Among other things, the CHO can issue examination and testing orders and public health orders. Additionally, the PHW Act sets out a requirement under which medical practitioners and pathology services must notify the Secretary if a patient may have a 'notifiable condition'.
- The Public Health and Wellbeing Regulations 2019 prescribe, among other things, those infectious diseases and medical conditions that are 'notifiable conditions' and the reporting details for notifications, including the timeframe in which reporting must occur for each category of notifiable condition.
- The *Health Records Act 2001* provides the Health Privacy Principles, which protect health information collected and handled in Victoria by the Victorian public and private sectors.
- The *Privacy and Data Protection Act 2014* provides the Information Privacy Principles, which set out the minimum standard for how Victorian public sector organisations must handle personal information.
- The *Sex Work Act 1994* and Sex Work Regulations 2016 together provide a licensing system for, and regulate, sex work service providers, including through establishing offences relating to sex work and creating powers of inspection. At time of publication of these guidelines, a motion to decriminalise sex work in Victoria and repeal the Sex Work Act is underway. Note that under s. 20 of the Act, a person must not work as a sex worker during any period in which they know they are infected with HIV. A person who worked as a sex worker in a period during which they were infected with HIV is presumed to have known that they were so infected unless they can prove that, at the time of the alleged offence, they were undergoing regular blood tests for HIV (at least quarterly) and that they believed on reasonable grounds that they were not infected with HIV.

Crimes Act

There are several criminal offences in the Crimes Act that are relevant where a person's behaviours allegedly place others, deliberately or recklessly, at risk of contracting HIV. Allegations of this type may be reported to the police and they may investigate the matter and determine whether it would be appropriate to lay charges. It is important to note that, under these guidelines, the department can only involve Victoria Police as the last resort at any level of management.

Under ss. 22 and 23 of the Crimes Act, it is an offence for a person to recklessly engage in conduct that may place another person in danger of death or serious injury without a lawful excuse. There have been a number of prosecutions brought under these sections after receiving complaints from people who have contracted HIV.

Under ss. 16 and 17 of the Act, a person who, without lawful excuse, intentionally or recklessly causes serious injury to another person is guilty of an indictable offence.

Section 19A of the Act was repealed in 2015, abolishing the specific offence of intentionally infecting another person with a 'very serious illness', defined exclusively to mean HIV.

The enforcement of the criminal law by Victoria Police is a separate and distinct function to the role of the CHO, which is to protect public health through managing and controlling infectious diseases. Referral to police is only ever appropriate as the last resort at any level of management under these guidelines, and only if there are allegations of serious criminal behaviour (refer to the 'Referral to police' section for more information).

Charter of Human Rights and Responsibilities Act

The *Charter of Human Rights and Responsibilities Act 2006* is a Victorian law that sets out the basic rights and freedoms of all Victorians. These rights promote and protect the values of freedom, respect, equality and dignity. The Charter promotes and protects human rights in various ways, including by imposing an obligation on public authorities to act in a way that is compatible with the Charter rights.

Under s. 38 of the Charter, it is unlawful for a public authority (including the department) to act in a way that is incompatible with a Charter right or, in making a decision, to fail to give proper consideration to a relevant Charter right. Public authorities must accordingly consider how Charter rights are protected when implementing policies and delivering services. In applying these guidelines, the department must consider any possible impact on the rights of individuals with HIV, as well as on the rights of people who may be affected by their actions.

As a public authority, the department, in implementing these guidelines, must act compatibly with those Charter rights that are applicable, subject only to justified limitations in accordance with s. 7(2) (discussed below). Relevant rights include:

- **Recognition and equality before the law (s. 8):** You have the right to be recognised as a person, to enjoy your rights without discrimination, to be treated equally under the law and to be protected from discrimination.
- **Right to privacy and reputation (s. 13):** This protects your right not to have your privacy, family, home or correspondence interfered with. It also gives you the right to not have your reputation unlawfully attacked.
- **Right to liberty and security of a person (s. 21):** This protects your right to liberty and security. It means you cannot be arrested or detained unless it is allowed by the law.
- **Right to humane treatment when deprived of liberty (s. 22):** This protects your right to be treated humanely and with respect and dignity if you are detained.
- **Right to a fair hearing (s. 24):** When appearing before a court or tribunal – whether in a criminal or civil case – you have the right to a fair and public hearing, and to have your case decided by a competent, independent and impartial court or tribunal.

Under s. 7(2) of the Charter, a Charter right may be subject to limitations, but only to such reasonable limits as can be justified in a free and democratic society based on human dignity, equality and freedom. Accordingly, Charter rights are not absolute and can be limited if it is reasonable, necessary, justified and proportionate to do so.

From time to time, in applying these guidelines, it may become reasonable and necessary for the department to proportionately limit an individual's Charter rights. For example, the right of a person with HIV to liberty may be limited in exceptional circumstances where a public health order is reasonable, necessary, justified and proportionate to curtail HIV transmission risk practices when all other measures have been unsuccessful. In such circumstances, the limitation of the rights of the person with HIV are balanced against the rights of those who may be affected by their actions. The use of public health orders under these guidelines is discussed in 'Stage 3: Public health orders (behavioural)' below.

The following national legislation applies:

- The *National Health Security Act 2007* provides a mechanism for exchanging information across jurisdictional borders in circumstances where a threat to public health exists.
- The *Privacy Act 1988* (Cwlth) contains the Australian Privacy Principles, which govern how the Commonwealth government and certain agencies and companies handle personal information, including health information. The privacy and confidentiality of any parties involved must be protected at all times, with information shared only when both necessary in the circumstances and legally allowed.

OFFICIAL

- The *Disability Discrimination Act 1992* (Cwlth) outlines human rights protections for all people living with a disability. People living with HIV fall under the ambit of the Act.

Privacy and confidentiality

Privacy rights in Victoria are protected by a number of laws including the Health Records Act, the Privacy and Data Protection Act and the Charter of Human Rights and Responsibilities Act. Patient confidentiality is also protected by the professional and ethical obligations and practices of Victoria's registered health and medical practitioners.

The right to the privacy of personal and health information and patient confidentiality are recognised and respected by the department. There are a range of measures in place to protect all personal information and health information in the department's possession from unauthorised and illegal use or disclosure.

The law also provides that individual rights to privacy and confidentiality may occasionally be limited (in specific ways) in order for appropriate agencies to address, for example, a serious risk to public health or safety or a law enforcement issue.

Careful and limited disclosure and use of personal information, health information and confidential information may become necessary in managing HIV transmission risk practices. Such disclosure and use should occur where a clear public health need can be demonstrated and must only ever occur in accordance with the relevant laws. This means that clinicians and other health professionals can notify the department if they believe a patient with HIV is placing others at risk of infection.

From time to time, Victoria Police have sought and obtained a search warrant from the Magistrates' Court seeking information held by the department for the purpose of enabling Victoria Police to exercise its functions under the Crimes Act. Prior to issuing a search warrant, a magistrate must be satisfied under s. 465 of the Crimes Act that there are reasonable grounds to believe there is information that will afford evidence as to the commission of an indictable offence. To enable the department to comply with the search warrant, when a search warrant is issued, information requested in the search warrant is searched for and released to the court, which releases the information to Victoria Police.

OFFICIAL

Considerations when working with diverse communities

Every effort will be made to ensure that, throughout the management process, all clients, and particularly those from culturally diverse backgrounds, are provided with understandable information in their preferred language and presented in a culturally appropriate manner. From first contact with the department, this will ensure clients:

- are clear regarding the processes involved
- understand the system of rights and obligations in Victoria as laid out in the PHW Act and as clarified in these guidelines
- are suitably informed, directed and supported to undertake the required behavioural changes to eliminate transmission risk practices.

This clarity will assist in preventing unnecessary escalation to more coercive forms of management.

Where required, qualified interpreters will be employed and vetted to ensure they are not known to the person, are knowledgeable and are not biased or stigmatising around the issue of HIV. Official documents such as letters of warning or public health orders will be translated into the client's preferred language to ensure health literacy, including terms and the implications of the document.

Considerations when working with culturally diverse communities on engagement with HIV testing and care should not be restricted to issues of language alone but also be cognisant of nuances of cultural competency, the impact of cultural prejudice, the migrant experience, and First Nations history. All processes associated with these guidelines should emphasise the importance of ensuring that management of transmission risk is both trauma-informed and culturally safe.

For those with an intellectual disability, communication and information provision will be tailored to meet specific needs to ensure understanding and recall.

OFFICIAL

Implementation

These guidelines are intended to guide partner notification officers (PNOs), clinicians and other providers involved in the management and care of people with HIV, as well as the HIV Case Advisory Panel. The guidelines are operationalised as follows.

Notification

Anyone concerned that a person is engaging in HIV transmission risk practices may request assistance from the department, which will employ a public health approach to assess and manage this risk under the PHW Act. This request is made to the PNOs who are specialist clinical staff. Email the PNOs <contact.tracers@health.vic.gov.au> or call 9096 3367.

The overwhelming majority of people who engage in HIV transmission risk practices can be suitably managed under these guidelines using an approach that aims to achieve long-term behavioural change, linkage into care and treatment, and a sustained resolution of risk.

Role of partner notification officers

The role of the PNOs is to assist the CHO to reduce HIV transmission and protect public health. The PNOs are the key point of contact for individuals concerned about people who may engage in HIV transmission risk practices. The PNOs will assess the notifications and, if deemed necessary, support and manage the person with transmission risk practices under these guidelines.

PNOs are registered nurses often with a background in a community nursing, psychology, mental health or sexual health. They are provided with direct support from the Deputy CHO.

Assessing a notification

The PNOs will gather specific information from the person notifying the department of their concerns including:

- the notifier's name and their relationship with the person being reported (the client)
- details of the behaviours of concern
- any evidence of the person's HIV status or transmission.

The PNOs will contact the client and organise an interview to assess whether the notification warrants further investigation or action. The interview will be conducted in a discreet, non-threatening and confidential manner. The client is given the opportunity to identify an independent advocate or support person who can provide support throughout the interview.

The PNOs will introduce themselves and present photo identification to confirm their status as an authorised officer under the PHW Act. They will explain the process involved in investigating an allegation, including the relevant provisions in the PHW Act, and provide the client with a summary sheet about these guidelines. The client will be given information on avenues for legal representation. The PNOs will advise that the information gathered during the interview will be used by the CHO to assess whether their behaviour may be putting others at risk of HIV infection. The information necessary to help make this assessment includes:

- confirmation of the client's HIV status
- the client's response to the allegation
- details of specific risk practices such as condomless sex or sharing of drug injecting equipment
- whether the client has consistent access to reasonable precautions like TasP, condoms and sterile needles and syringes

OFFICIAL

- whether the client has a sustained undetectable HIV viral load
- the client's adherence to TasP, continued engagement in care (including regular monitoring of HIV viral load)
- whether the client's risk practices are current and likely to continue
- the client's understanding of their HIV status and how their own practices risk transmission of HIV to others
- whether the client understands how they can prevent transmitting HIV, including the concept of U=U (undetectable viral load equals untransmissible)
- any evidence of HIV transmission
- a brief mental state assessment
- an assessment of social and welfare supports
- evidence of substance use or dependence.

If, after interviews, the client's HIV status remains unclear and there is no alternative means of confirming their status, then the CHO or delegate may consider making an order requiring the person to be HIV tested under s. 113 of the PHW Act. This should only be made in exceptional circumstances, and testing for HIV should be conducted on a voluntary basis wherever possible. An order may be made if:

- it is believed the client has HIV
- the client is likely to transmit HIV and thereby constitutes a serious risk to public health
- a reasonable attempt has been made to provide the client with information about HIV and the need to test (or it is not practicable to do so)
- the order is necessary to ascertain if the client has HIV.

It is an offence not to comply with an examination and testing order, and the maximum penalty for this offence is 60 penalty units[2] (s. 116, PHW Act). If a client has refused to undergo testing, the CHO may order that they be detained, or detained in isolation, for a period not exceeding 72 hours, to enable them to be examined and tested (s. 113(3)(c), PHW Act). Only in the case where the client refuses to cooperate with the CHO order, a member of Victoria Police may use reasonable force to detain and take a client who is subject to such an order to a place where a test is to be carried out (s. 123(4), PHW Act).

If required, an application for a warrant may be made to the Magistrates' Court to arrest a client who is the subject of an examination and testing order. The client shall be given the option of legal advice through community legal services. The warrant may specify conditions, and the client detained under these circumstances must be informed at the time of arrest of the reasons for being arrested or detained (s. 123, PHW Act).

Ongoing client management

The PNOs maintain direct client contact and communicate any directions from the CHO or delegate. They may coordinate counselling services or other community services that are required, especially for clients with multiple and complex needs. The PNOs play an essential role in supporting and reinforcing the required change in client practices and providing clients with information about their legal obligations and the processes involved. They report the client's progress to the CHO or delegate and, when required, to the HIV Case Advisory Panel.

[2] A penalty unit is worth a $165.22 (as of 1 July 2020). 120 penalty units is $19,826.40

Role of clinical service providers

Clinicians who provide effective and early HIV management with ongoing support provide the foundations for patient wellbeing and prevention of public health risks. Recommended standards in HIV clinical care include:

- effective clinical management, including access to HIV treatment and monitoring
- psychosocial support (or referral to support)
- counselling about prevention of transmission of HIV to others, including the role of treatment in reducing the risk of transmission and U=U
- support to ensure all at-risk contacts or partners are identified and tested for HIV (the PNOs can assist in this process)
- links to relevant specialist, community and peer support services.

Clinical service providers have a responsibility to monitor the person's ongoing engagement with HIV care. Services need to actively follow up if the person disengages from care. If patients are lost-to-follow-up and there are concerns about public health risks, this should be raised immediately with the department's PNOs. Adherence to treatment, in both clients with detectable and undetectable viral loads, should be monitored on a regular basis in accordance with clinical treatment guidelines. Clinical service providers should regularly review risk practices with patients who do not have a sustained undetectable viral load.

A referral to the PNOs should be made by the treating clinician when:

- a client has a **detectable viral load** and there is concern about current transmission risks practices and management of this risk cannot be undertaken sufficiently by the clinical team
- a client has an **undetectable viral load** *and* there is concern about current risk practices and the ability to maintain sustained viral suppression and engagement in clinical care.

It is important that service providers and local clinicians can seek advice from the nominated public health HIV contacts without needing to provide identifying information. Although complex or serious issues will be referred to the department, generally where an issue is raised with the nominated public health HIV contact this will not automatically lead to the person being formally managed under these guidelines. Case discussion with the nominated PNO or clinician may lead to providing management advice or links to other health and related professionals who can provide care and support.

Role of the HIV Case Advisory Panel

The HIV Case Advisory Panel is independent of the department. It is one source of advice that the CHO considers when formulating actions to monitor, evaluate and contain the risk clients pose to public health.

The panel is appointed by the minister and diversity of members is ensured, including an even gender balance, where possible. The chair is elected by the members, and membership is anonymous.

The panel has the following members:

- two people living with HIV
- two medical practitioners (one hospital based; one community based) with infectious diseases experience
- a psychiatrist
- a health worker with mental health experience
- a person with an appropriate qualification in law.

The panel meets quarterly but can be convened at any time at the request of the CHO or delegate. Panel members are appointed for three years and are eligible for reappointment. Specific groups may put forward names of people who they believe would provide useful advice to the CHO. Members are

OFFICIAL

chosen to represent the interests of the community rather than simply to advocate on behalf of their organisation and all are required to sign a confidentiality agreement. The chairperson of the panel is elected by its members.

Information on clients who are being managed under these guidelines is presented to the panel in a de-identified way. Cultural background may be discussed, if relevant, but anonymity is still preserved. Advice may be sought to support particular cultural backgrounds. Clients for whom the CHO or delegate seeks advice (stage 2 or above) are discussed in detail. An update is provided on clients at stage 2 or above, while those at stage 1 are listed for noting only. The panel is free to raise any questions in relation to client management, and the chair of the panel may consider involving other health professionals who may usefully inform the panel's deliberations, including advocates from the affected communities. Where specialised scientific advice is required, the panel may seek specific external expertise, protecting the anonymity of clients.

The CHO or delegate attends the panel meeting as an observer. The panel's advice and any specific requirements of the client are recorded in the panel minutes. The CHO or delegate considers this advice, together with any other relevant information and advice, before making a decision on further action. Although all clients are de-identified, if a panel member believes they may know the client being discussed, then this will be raised as a potential conflict of interest. Consideration will be made by the chair as to whether that member should remain in that portion of the meeting or be excused.

OFFICIAL

The four-stage approach

The four-stage approach uses a range of measures to manage and mitigate transmission risk practices. The initial stages in this approach are aimed at modifying practices with the voluntary participation of the client, while the latter involve coercive public health management powers vested in the CHO under the PHW Act. Deciding which measures are appropriate is an ongoing process. This is done through regular contact with the client by PNOs, with the agencies involved in the client's management and, where appropriate, with the professional making the notification.

If alternative effective measures are available to minimise the risk that a client poses to public health, the measure that is the least restrictive of the client's rights should be chosen (s. 112, PHW Act). In exceptional circumstances and when required, the stages may be applied in a non-sequential order (refer to Figure 1).

Information is collected to assess the client's response to the proposed interventions. This includes:

- details of ongoing specific risk practices such as condomless sex or sharing of drug injecting equipment
- any evidence of HIV transmission
- assessment of social supports and welfare needs, mental status and substance and alcohol use or dependence.

The PNOs or the medical advisor of the Partner Notification and Support Unit (refer to stage 2) may liaise with treating clinicians or services to assess the prevailing risks in developing or coordinating management plans to modify risk practices and address their underlying drivers.

The decision to escalate the public health response to higher stages is made if there is an ongoing pattern of practices that puts others at risk of HIV infection. This may also be considered if there is an ongoing failure of the client to undertake the required actions to enable the CHO or delegate to adequately monitor their risk. Isolation and detention are rarely required and are always a last resort.

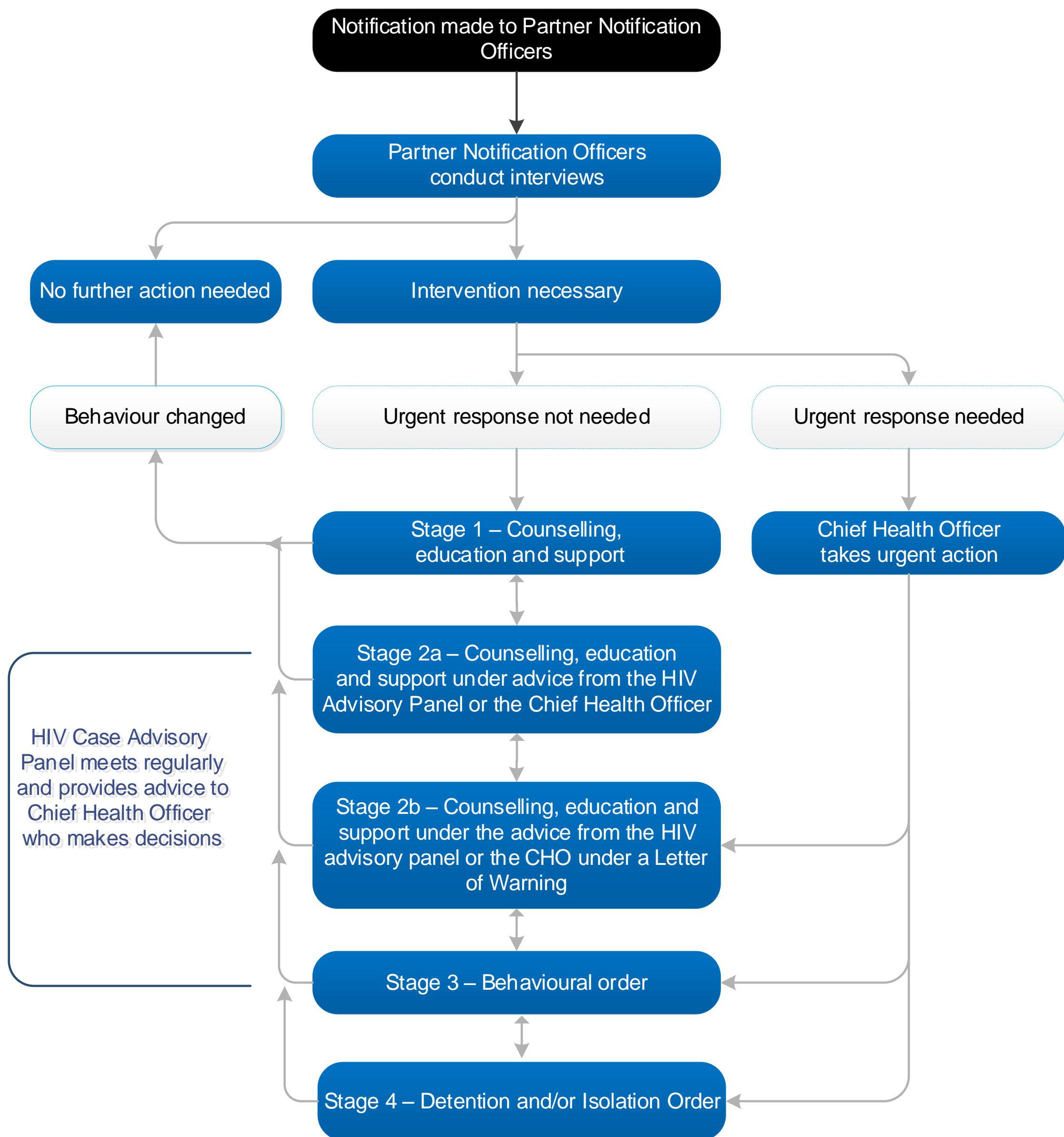
At each stage of this process the following fundamental questions are considered:

- Have all voluntary options for the previous stage been exhausted?
- Have previous stages failed to modify practices and why?
- Does the client continue to engage in HIV transmission risk practices?

When clients are engaged in the following four-stage approach, the PNOs maintain regular contact with the client. In practice, this may mean frequent contact until the client's HIV clinical management stabilises.

OFFICIAL

Figure 1: The four-stage approach to client management



OFFICIAL

Stage 1: Counselling, education and support

Counselling, education and support are the first steps in managing HIV transmission risk practices. Where possible, these services should be provided as extensions of services already being received by the person, but in a more concentrated form, with greater specificity and more extensively resourced. Regular and intensive counselling should be encouraged and should be initially directed towards building a relationship that enables the counsellor to address the client's circumstances.

PNOs play an important role in case coordination. In most instances they will have established a relationship with the client and will coordinate counselling services and specific interventions. Although PNOs do not provide therapeutic counselling, they provide support and play a role in reinforcing appropriate HIV risk management.

All interventions are tailored to address the client's needs and take into account their age, health, socioeconomic status, cultural background and level of social and cognitive functioning.

At this stage, the client voluntarily undertakes action to modify their practices and there are no specific requirements placed upon them. Peer support and case conferences with other agencies will be undertaken as necessary.

During stage 1, PNOs provide support to the client's primary care provider and clarify if a more specific intervention is required. Where required, PNOs may assist in referring the client for:

- counselling services to understand aspects of sexuality, improve skills around HIV status disclosure or negotiating condom use, or to help manage particular practices with a higher risk of HIV transmission
- support from peer-based organisations
- access to condoms and safe injecting equipment
- medical, psychological, psychiatric and drug and alcohol services
- housing or supported accommodation
- job training and placement
- financial assistance
- home care support such as shopping, cooking and cleaning.

If the client does not voluntarily engage with PNOs in assessing and monitoring their risks, then the CHO or delegate may require them to meet with PNOs under the authority of a letter of warning (refer to stage 2b) or, if required, under a public health behavioural order (refer to stage 4).

Stage 2a: Counselling, education and support under advice from the HIV Case Advisory Panel or the Chief Health Officer

The CHO or delegate assesses the response to stage 1 measures and, if it appears the client is not complying with these voluntary measures, or that the measures have not resulted in any meaningful or sustained change in risk practices, then the CHO may direct PNOs to undertake further action, seek advice from the HIV Case Advisory Panel and issue a letter of warning that the next step will be considered.

Stage 2b: Letter of warning

If it appears that the client is continuing to engage in HIV transmission risk practices despite previous counselling, education and support, or if the situation on first contact warrants it, the CHO or delegate may issue a letter of warning. This letter advises the expectation of the CHO that those with HIV should take all reasonable steps to eliminate or reduce the risk of any other person contracting HIV.

In addition, the letter of warning describes the legal powers vested in the CHO in certain specified circumstances (s. 117, PHW Act) to impose public health orders and that such steps may be taken if the CHO considers it necessary.

PNOs deliver and read this letter to the client, using an interpreter where necessary to ensure this formal communication from the CHO is received and understood. The letter of warning is translated into the client's preferred language when required. It is important that the interpreters used are well versed in engaging with culturally diverse communities including those living with or at increased risk of HIV.

Stage 3: Public health orders (behavioural)

Where a client continues to engage in HIV transmission risk practices and it appears that all previous measures have been unsuccessful, the CHO or delegate may consider issuing a public health order under s. 117 of the PHW Act.

Public health orders that fall under stage 3 (behavioural orders) can include orders to:

- participate in education or counselling
- undergo an assessment by a specified psychiatrist or specified neurologist
- refrain from carrying out certain activities
- refrain from specified risk practices
- refrain from visiting a specified place or places
- reside at a specified place of residence at all times or during specified times
- notify PNOs if there is a change in name or place of residence within three days of doing so
- submit to supervision by a person nominated by the CHO or delegate by attending meetings, receiving visits or providing information relevant to the public health risk.

Such public health orders can be made for a period of up to six months from the day on which the order is made and must be proportionate to the risk that the client poses to public health (s. 117(4), PHW Act).

The CHO or delegate will generally review such orders at intervals of at least three months but no more than six months (as per legislative requirement [s. 117(4) of the PHW Act]) and may choose to seek more frequent panel reviews; however, the frequency of review depends on the individual circumstances of each case.

All clients at stage 3 will be provided with information on the PHW Act, including their rights and entitlements under the Act and the process for review (refer to the Appendix for details). They will be advised to seek legal advice, and every effort will be made to ensure the client understands the order including, where required, using interpreters to explain the order and having the order translated into the person's first language. All public health orders may be subject to internal and external review processes. In some cases, it may be appropriate for the department to involve a support person of a client where it will assist the client in understanding their rights and how to seek legal advice.

The CHO or delegate may review and extend an order by a written notice for a period not exceeding six months. The order may be extended as many times as the CHO or delegate considers necessary consistent with the principles of these guidelines (s. 118(6), PHW Act).

The conditions included in a public health order may be varied by the CHO or delegate and will have effect from the time the notice of variation is served on the client (s. 118(4), PHW Act).

It is an offence for a client to not comply with a public health order made under s. 117. A court may issue a fine up to 120 penalty units for this offence (s. 120, PHW Act).

Stage 4: Public health orders (detention and/or isolation orders)

If there is evidence that a client is repeatedly engaging in HIV transmission risk practices and is not complying with the requirements of their public health order (behavioural), or a lack of evidence to support compliance, the CHO or delegate may issue an order that they be detained and/or isolated at a specific location (s. 117(5)(k), PHW Act), in the interests of public health.

The CHO or delegate will determine the appropriate facility and staff to best meet the needs of the client in detention and/or isolation.

Detention and isolation orders have the same legal requirements as behavioural orders detailed in the above section, namely:

- they can be made for a period of up to six months and must be proportionate to the risk that the client poses (s. 117(4), PHW Act)
- the CHO or delegate will review such orders at intervals of at least three months and may choose to involve the panel in more frequent reviews
- clients will be provided with information on the PHW Act, including their rights and entitlements under the Act and the process for review
- clients will be advised to seek legal advice
- the CHO or delegate may review and extend a detention or isolation order by a written notice for a period not exceeding six months – the order may be extended as many times as the CHO or delegate considers necessary (s. 118(6), PHW Act)
- it is an offence not to comply with a public health order and a court may issue a fine up to 120 penalty units for this offence (s. 120, PHW Act).

If required, Victoria Police may use reasonable force to detain a client who is subject to such an order to take them to the place required under the order.

In addition, a warrant may be sought from the Magistrates' Court for police to arrest, detain and transport a client under a detention or isolation order to the required site. At the time of arrest, the client must be advised of the reason for this arrest and detention (s. 123, PHW Act).

Review of public health orders

A public health order must be in writing and explain the client's rights and entitlements under the PHW Act, including their right to seek legal advice and have the order reviewed.

Internal review by the Chief Health Officer

A client subject to a public health order can apply to the CHO for a review of the order. This review must be conducted within seven days of receiving the application, at which time the CHO or delegate will decide to revoke, vary or confirm the order (s. 121, PHW Act).

Statement of reason and external review by the Victorian Civil and Administrative Tribunal

A client subject to a public health order has 28 days from the date of the order to request the CHO or delegate to provide a written statement detailing the reasons why the order was made (s. 122, PHW Act).

In addition, a client subject to a public health order may, at any time while the order is in force, apply to the Victorian Civil and Administrative Tribunal (VCAT) for a review of the CHO or delegate's decision to make the order, in accordance with the VCAT Act (s. 122, PHW Act). The individual is provided with details of how to contact VCAT and community and legal services.

OFFICIAL

Referral to police

There is extensive local and international literature that documents the greater public health harms that may be caused by criminalising HIV transmission (12-14). Prosecuting people for transmitting HIV, or for risking the transmission of HIV, perpetuates and worsens negative stereotypes of people living with HIV. Such stereotypes add to HIV stigma and discrimination and reduce the effectiveness of public health programs to reduce HIV transmission by potentially deterring people from being tested for HIV. Therefore, in the first instance, a person with identified HIV transmission risk practices should always be engaged within the processes outlined in these guidelines, unless there are allegations of serious criminal behaviour.

If in the course of the public health investigation evidence of a serious crime or reportable offence is identified, these should be reported through the usual processes. The CHO or delegate must consider whether the person's HIV status is relevant, particularly where the person's HIV viral load has been consistently undetectable or suppressed.

Where a person with HIV transmission risk practices continues to act with clear intent to cause harm or with serious disregard for the wellbeing of others, those actions may amount to a continuing offence under criminal and/or public health legislation. Under such circumstances, referral to police is only appropriate as the last resort at any level of management under these guidelines.

The referral decision is made by the CHO or delegate (always with legal advice) and, where appropriate, in consultation with the chair of the HIV Case Advisory Panel following discussion with the full HIV Case Advisory Panel. Referral to support services, including peer services, should be provided to the client during these processes. If the individual does not have capacity for decision making, consideration for a legal guardian should be sought.

A referral to police will not preclude the client from continuing to receive support or treatment or to receive public health interventions under these guidelines. Those referred by the CHO or delegate to the police should be made aware of their legal rights and obligations, which may include legislation and regulations that allow them to seek suppression orders from the courts in relation to their name and/or the subject matter of any charges filed against them.

Information held by the department – including a person's HIV status – is covered by privacy legislation and will therefore be protected. Only in very narrow circumstances will disclosure of that information be permitted. If criminal proceedings are initiated, it becomes a court matter and will be governed by different rules beyond the department's control. The accused can make an application to the courts for a suppression order pursuant to the *Open Courts Act 2013*, which, among other reasons, will be ordered by the court if necessary to protect the safety of a person or to prevent prejudice to the administration of justice. Whether a suppression order will be made is a decision for the courts, not the department, and so cannot be impacted by these guidelines.

Some individuals, however, may lack capacity to modify their behaviour due to cognitive impairment, mental illness or problematic drug and alcohol use. Such individuals are best managed under the PHW Act or, where appropriate, the *Mental Health Act 2014* or *Disability Act 2006*, thereby employing the full range of statutory powers and resources to contain the risks. Referral to Victoria Police in such a circumstance is not likely to be helpful in reducing the HIV risk to the public.

OFFICIAL

Appendix: Public health orders (behavioural)

Statutory preconditions

The statutory preconditions to the making of a public health order are as set out in ss. 117(1) and (2) of the *Public Health and Wellbeing Act 2008* ('the Act'), which are as follows.

That the Chief Health Officer (CHO) believes that:

- a person has an infectious disease or has been exposed to an infectious disease in circumstances where a person is likely to contract the disease
- if a person is infected with that infectious disease, a serious risk to public health is constituted by the infectious disease, or the combination of the infectious disease and the likely behaviour of that person
- if infected with that infectious disease, the person needs to take particular action or refrain from taking particular action to prevent, as far as is reasonably possible, that infectious disease constituting a serious risk to public health
- a reasonable attempt has been made to provide that person with information about the effect of the infectious disease on the person's health and the risk posed to public health or it is not practicable to provide this information before making the order
- it is necessary to make the public health order to eliminate or reduce the risk of the person causing a serious risk to public health.

That the CHO has had regard to the following factors:

- the nature of the infectious disease, including the ease with which it is transmitted
- the availability and effectiveness of treatment for the infectious disease
- the possible side effects and discomfort that may be caused to the person who is or may be infected with the infectious disease if he or she is required to undergo specified pharmacological treatment or prophylaxis for the infectious disease
- whether urgent action will significantly affect the public health outcome
- the capacity of the person who is or may be infected with the infectious disease to understand the risk to public health constituted by the person having the infectious disease
- any prescribed factors
- any other factors that the CHO considers are relevant in the particular circumstances.

Form requirements

The form requirements of a public health order are set out in s. 117(3) of the Act and are that the order must:

- be in writing
- identify the person to whom the order applies
- specify the purpose of the order
- specify the infectious disease that the CHO believes the person has or has been exposed to
- explain why the CHO believes that the person is infected with the infectious disease or has been exposed to the infectious disease in circumstances where a person is likely to contract the infectious disease
- specify the period for which the public health order continues to have effect, which must not exceed six months from the day on which the order is made and must be proportionate with the risk that the person poses to public health
- explain the person's rights and entitlements under the Act and the process for making an application for review to VCAT

- contain a statement that the person should seek legal advice
- explain that if the person does not comply with the order, the person commits an offence and is liable to a penalty not exceeding 120 penalty units.

The rights of a person subject to an order

A person subject to a public health order has the following rights of review under ss. 121 and 122 of the Act.

Internal review

- A person subject to a public health order may at any time while the order is in force apply to the CHO for a review of the order.
- An application for a review of a public health order must be in writing or in any other form approved by the CHO.
- Within the period of seven days after receiving the application for review, the CHO must review the public health order and may revoke, vary or confirm the order.

Review by VCAT

- A person subject to a public health order may at any time while the order is in force apply to VCAT for a review of the decision to make the order.

OFFICIAL

References

1. Department of Health. *National guidelines for managing HIV transmission risk behaviours.* Canberra : Australian Government, 2018.

2. *HIV transmission risk through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study.* Rodger AJ, Cambiano V, Bruun T, Vernazza P, Collins S, Degen O, et al. 10189, s.l. : The Lancet, 2019, Lancet, Vol. 393. 2428–2438.

3. *HIV transmission risk through anal intercourse: systematic review, meta-analysis and implications for HIV prevention.* Baggaley RF, White RG, Boily MC. 4, s.l. : International Journal of Epidemiology, 2010, Vol. 39. 1048–1063.

4. *Infectiousness of HIV-infected homosexual men in the era of highly active antiretroviral therapy.* Baggaley RF, White RG, Boily MC. 15, s.l. : AIDS, 2010, Vol. 24. 2418–2420.

5. *Effectiveness of highly active antiretroviral therapy in reducing heterosexual transmission of HIV.* Castilla J, Del Romero J, Hernando V, Marincovich B, Garcia S, Rodriguez C. 1, s.l. : Journal of Acquired Immune Deficiency Syndromes, 2005, Vol. 40. 96–101.

6. *Antiretroviral therapy for the prevention of HIV-1 transmission.* Cohen M, Chen Y, McCauley M, Gamble T, Hosseinipour M, Kumarasamy N, et al. s.l. : The New England Journal of Medicine, 2016, Vol. 375. 830–839.

7. *Heterosexual HIV-1 transmission after initiation of antiretroviral therapy: a prospective cohort analysis.* Donnell D, Baeten JM, Kiarie J, Thomas KK, Stevens W, Cohen CR, et al. 9731, s.l. : Lancet, 2010, Vol. 375. 2092–2098.

8. *Viral suppression and HIV transmission in serodiscordant male couples: an international, prospective, observational, cohort study.* Bavinton B, Pinto A, Phanuphak N, Grinsztejn B, Prestage G, Zablotska-Manos I, et al. 8, s.l. : The Lancet HIV, 2018, Vol. 2018. 438–447.

9. *HIV viral load and transmissibility of HIV infection: undetectable equals untransmittable.* Eisinger RW, Dieffenbach CW, Fauci AS. 5, s.l. : JAMA, 2019, Vol. 321. 451–452.

10. PrEP guidelines update. *Australasian Society of HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) .* [Online] ASHM, 2019. https://www.ashm.org.au/resources/hiv-resources-list/prep-guidelines-2019/.

11. Australian national guidelines for the management of healthcare workers living with blood borne viruses and healthcare workers who perform exposure prone procedures at risk of exposure to blood borne viruses. [Online] 2018. https://www1.health.gov.au/internet/main/publishing.nsf/Content/cda-cdna-bloodborne.htm.

12. European AIDS Treatment Group. *Position paper on the overly broad criminalisation of HIV transmission, exposure and/or non-disclosure.* 2013.

13. *Global Commission on HIV and the Law.* s.l. : Risks, Rights and Health, 2012.

14. (UNAIDS), Joint United Nations Programme on HIV/AIDS. *Ending overly broad criminalization of HIV non-disclosure, exposure and transmission: critical scientific, medical and legal considerations.* Geneva : UNAIDS, 2013.

OFFICIAL