

THINK CHANGE

Victorian Department of Human
Services

*Review of Guidelines for the
management in Victoria of
people living with HIV who
put others at risk and (draft)
Protocol for management of
HIV positive person who
appear to be placing others
at risk*

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Recommendation 1) That DHS should undertake an editing exercise at the end of this review process, to ensure that policy issues relating to managing people with HIV who risk infecting others are addressed in the Guidelines and only implementation issues are addressed in the Protocol.

Recommendation 2) That DHS reconsider its 2005 position and advise Government to introduce legislative amendment to allow decisions of the Chief Health Officer under this part of public health legislation to be subject to appeal to the VCAT.

Recommendation 3) That DHS also consider advising Government to introduce amendments to clarify in more detail the role and powers of the Chief Health Officer and other significant players in managing people with HIV who risk infecting others.

Recommendation 4) That DHS involve the PNOs, their supervisors and Public Health Branch management in a process to define the PNO role more clearly and establish clear lines of clinical supervision for their work; and that these roles be widely explained and included in the Guidelines.

Recommendation 5) That information be prepared for the PNOs to distribute to clients explaining their roles and processes for making complaints regarding their work.

Recommendation 6) That DHS Public Health Branch collect and report performance data on the PNO program.

Recommendation 7) That the Panel be used as a forum for seeking advice on client management strategies before it is considering escalation to coercive measures such as behavioural, isolation or detention orders. And that DHS continue to invest in improving cross program case management as a need going across the Department's services.

Recommendation 8) That the Panel include two people with HIV among its membership.

Recommendation 9) That the Panel be provided with full documentation ahead of meetings, on a clear understanding of the confidentiality of the material.

Recommendation 10) That DHS Public Health Branch consider strategies to provide more support to primary care clinicians, especially but not exclusively those without high HIV caseloads, when they deal with people with HIV who may be putting others at risk.

Recommendation 11) That DHS and Victorian Police complete their protocol discussions, based on the criteria agreed nationally in the BBVSS Report and that the criteria decided be included in the Guidelines.

Recommendation 12) That, as DHS become confident that new arrangements and improved processes for managing this area have been put in place, that DHS managers review the number of meetings they have established to manage the activity and limit it to those most crucial to oversee the new arrangements.

1. Introduction

Background

There has recently been a great deal of media, political and public scrutiny of the way the Victorian Department of Human Services (DHS) manages people who expose others to the risk of HIV infection. Most of the recent public commentary on the Department's exercise of this responsibility has been negative.

DHS has conducted its own internal review of the way in which it manages HIV-positive people who place others at risk, and has commissioned two external reviews. The first of these reviews, by Dr John Scott and Mr Bob Falconer, has focussed on a number of specific cases, including those which recently attracted such adverse commentary.

DHS has also commissioned Robert Griew and Associates to conduct this review of the appropriateness of two policy documents: Guidelines for the management in Victoria of people living with HIV who put others at risk (hereafter referred to as 'the Guidelines') and (draft) Protocol for management of HIV positive persons who appear to be placing others at risk (hereafter referred to as 'the Protocol'). The former document is the most recent revision of guidelines originally developed in 1989 and is available on the Department's website. The second document is an internal DHS policy currently in draft form and which has been developed significantly in response to the recent difficult cases.

The review was conducted by Associate Professor Robert Griew and Mr Tim Leach. A list of the people consulted is at Attachment A. We also reviewed documents and the literature gathered for the recent national review of jurisdictional policies and legislation for the management of people with HIV who risk infecting others.¹

This review has considered the appropriateness of DHS policy response to situations where people with HIV may be wilfully or recklessly placing others at risk of infection. There are also some issues specific to the two documents.

Those involved in the management of these clients have in the past year been called upon to document and explain their role and perspectives several times, including to two external reviewers. Their work has been subject to considerable negative media analysis.

Given this background, the willingness of stakeholders to be interviewed for this review and to contribute ideas on how the system might operate more effectively has been impressive. This willingness appears consistent with a number of perspectives evidenced throughout the review:

¹ Griew R, Buchanan D & Russell L 2007, *Review of legislation and policy for the management of people with HIV who risk infecting others*, Blood Born Virus and STI Subcommittee

- A professional commitment to the proper management of clients for the benefit of the clients themselves and of the general public
- A strongly held view that the public health system is still the most appropriate place for management of difficult clients, except in the most exceptional of circumstances
- A sense that at least one recent case should have been handled differently and a shared disappointment in the outcomes of that case, together with a commitment to avoiding such problems in the future.

Understanding the Guidelines and Protocol

Neither the Guidelines nor the Protocol are referred to in the Health Act 1958 (Vic). They have no legislated force.

The Guidelines are intended to assist the DHS to implement the Act. Administrative law provides that the Guidelines cannot fetter application of the Act so, where there is any confusion or contradiction between the Act and the Guidelines, the Act prevails. As a public document, the Guidelines are a statement about how the DHS intends to exercise its powers in this area. As such, the Guidelines would ideally:

- Provide policy guidance about the key decision points in managing people with HIV who risk infecting others.
- Allay any public fears that the DHS is ill-prepared to deal with cases of people with HIV exposing others to risk of infection.
- Assure clients and their advocates that the DHS has a plan for protecting client rights.

The Protocol is intended to assist the DHS implement the Guidelines. It is not a public document. The Protocol has been drafted following the recent problems so it not surprising that in some ways it goes further than the Guidelines (e.g. in trying to describe the circumstances in which matters might be referred to Victoria Police). Ideally, the Protocol would:

- Outline an efficient procedural system for implementing the Guidelines
- Cover the entirety of the system so that each phase of DHS responsibility is appropriately dealt with
- Provide helpful direction to all Departmental officers who may be engaged in the management of difficult clients, such that it is applied universally across DHS
- Build confidence within DHS that it is equipped to respond to any eventuality.
- Avoid making policy pronouncements, which is the role of the Guidelines: the Protocol should only be a guide to implementing the Guidelines.

The issue in context

As mentioned, all stakeholders approached for interview were willing to contribute to the review. Many observed, however, that while the current focus on this area was understandable - given recent media attention - it was not in any sense 'the main game'. Many interviewees cautioned that

better management of this area, while beneficial, would have little impact on the overall epidemic and that undue focus would divert attention from more pressing challenges, such as addressing rising infection rates amongst gay men.

Caution was also expressed that this focus on risk behaviour not unduly colour people's perspectives on the sexual behaviour of people with HIV generally. On the whole, people with HIV continue to be at the forefront of efforts to prevent transmission of the virus.

2. Issues arising

2.1 The relationship of the Guidelines and the Protocol

In general terms, interviewees considered the Guidelines to be appropriate. It was noted that the development of the Guidelines has involved many highly experienced and well regarded people and that the Guidelines have been constantly reviewed. Proper involvement of appropriate stakeholders and regular review are hallmarks of good policy development, so it is not surprising that the Guidelines retain widespread support as a very reasonable statement of Departmental policy response.

The problems, such as they are, relate more to the 'system' itself, rather than to the Guidelines' attempt to describe it. As in other jurisdictions, there are some issues caused by inconsistency between public health and criminal law and some issues in the Guidelines that might usefully be more comprehensively covered in the public health law. These issues are not able to be addressed within the Guidelines, which are the scope of this report, and have been addressed in a recent national report commissioned by the Blood Borne Virus and STI Subcommittee (BBVSS) of the national Australian Population Health Development Principal Committee (APHDPC.)²

Those interviewees familiar with the Protocol similarly described it in favourable terms.

There are, however, some improvements that are needed in the policy approach and its implementation – in the actual system by which DHS manages these clients and the risk to public health – and making the necessary changes to address these issues will require some change to the Guidelines and Protocol. There is also an extent to which the recent development of the Protocol means that it now includes material that should be in the Guidelines. These include issues of policy pronouncement rather than implementation detail, such as when DHS should refer clients to the Victorian Police.

Recommendation 1) That DHS should undertake an editing exercise at the end of this review process, to ensure that policy issues relating to

² Griew R, Buchanan D & Russell L 2007, *Review of legislation and policy for the management of people with HIV who risk infecting others*, BBVSS

managing people with HIV who risk infecting others are addressed in the Guidelines and only implementation issues are addressed in the Protocol.

2.2 Pressure Points

A recent report, cited above, Review of policies and legislation for the management of people with HIV/AIDS who risk infecting others, was provided to the Blood Borne Virus and STI Sub-Committee of the Australian Population Health Development Principal Committee in June 2007. This paper is hereafter referred to as 'the BBVSS Report'.³

The BBVSS Report considered the different ways in which Australian jurisdictions are dealing with HIV-positive people who may expose others to risk, and the degree to which jurisdictional responses reflect principles prescribed by the National Public Health Partnership (NPHP) in 2003⁴, and subsequent evidence. The Report identifies a range of 'pressure points' – areas in which the application of NPHP principles has shown itself to be difficult or where evidence has moved on. This report begins with a focus on these pressure points.

2.2.1 Interstate differences

This review process started by considering areas where Victoria is different in approach to other States, or to the best practice approaches outlined in the BBVSS Report. It is of course possible for Victoria to be different to other States by having a better approach or an approach more attuned to its context. Our starting point, however, was to assess where these differences lay and assess if they marked areas of better practice, for Victoria, or where there might be something to learn either from elsewhere or from the BBVSS report model.

Appeal rights

The Victorian Health Act 1958, given its age, does not provide for a right of appeal to the Victorian Civil and Administrative Tribunal (VCAT). DHS decisions under the Act are subject to internal review by the Secretary of DHS and the application of administrative law, including review by the Supreme Court of Victoria. However, the absence of a right of appeal to VCAT reduces the likelihood that DHS decisions will be appealed. Appeals to the Supreme Court are, after all, usually prohibitively expensive unless legal aid can be obtained.

This is an area already made complex by the vulnerability of those DHS clients likely to be subjected to application of the Guidelines and the profound impact on individuals of isolation and detention orders. The fact that clients will find it difficult to appeal DHS decisions increases the pressure on the Department to get it right. This absence of appeal runs

³ *ibid*

⁴ National Public Health Partnership 2003, *Principles to be considered when developing best practice legislation for the management of infected persons who knowingly place others at risk*

contrary to the general principle that the existence of accessible independent review will improve the quality of decision making, guidelines development and internal review. In other jurisdictions, for example NSW, equivalent CHO decisions are subject not only to administrative Tribunal appeal but must also be confirmed by the Administrative Decisions Tribunal within 72 hours. That takes the same principles further, given the extreme coercive powers available under public health law.

The 2005 DHS Health Act review policy paper did consider this question and recommend against inserting additional review of CHO decisions by the VCAT.⁵ The 2007 BBVSS Report, on the other hand, recommended appeal by right in all States and Territories to the relevant administrative appeals tribunal (in Victoria's case, VCAT).

Recommendation 2) That DHS reconsider its 2005 position and advise Government to introduce legislative amendment to allow decisions of the Chief Health Officer under this part of public health legislation to be subject to appeal to the VCAT.

Descriptions of Chief Health Officer powers

The BBVSS Report notes that State Acts usually fail to mention the full range of powers required to restrict behaviour or supervise and/or compulsorily treat individuals. Victoria is better in this regard than some other States. In Victoria the Act mentions the powers to test, to order counselling, to order restrictions on the behaviour of the client and to isolate the client. However, the Victorian Act still fails properly to describe what might be included within these powers. For example, does the entitlement to order counselling permit the Chief Health Officer (CHO) to refer a client to a psychiatrist or only to a counsellor? What powers are included within the power to restrict – can clients be compelled to do things or only to refrain from doing things?

Interviewees generally noted that Panel members, the CHO and others engaged in behaviour management try to work as best they can within the legislative parameters, but there was support for a clearer description of powers.

Recommendation 3) That DHS also consider advising Government to introduce amendments to clarify in more detail the role and powers of the Chief Health Officer and other significant players in managing people with HIV who risk infecting others.

The role of the Partner Notification Officers (PNOs)

⁵ DHS 2005, Health Act Review policy discussion paper (see 4.14.3 and the legislative proposals in the appendix.)
http://www.health.vic.gov.au/healthactreview/downloads/review_health_act_draft_policy_paper2005_final_web.pdf

The existence of PNOs is unique to Victoria, and there was much discussion of the PNO role within the interview process and subsequently. Many interviewees held strong views on the role and future of the PNOs and there has been much discussion of their role within the Department and across the HIV sector.

The complexity of the role

The PNO role is multi-faceted, complex and challenging. It might be said that there are three components:

Investigation

A key responsibility of the PNOs is to investigate the situation for clients referred for their attention. This may involve:

- Undertaking a preliminary assessment of the reliability of notifications
- Initial interviews with clients
- Assessment of a new client's medical, psychiatric and social situations
- Taking steps to ascertain a client's HIV status, including taking blood samples for testing.

Encouraging behaviour change in order to promote community safety

Where there appears some legitimacy to complaints of unsafe behaviour, PNOs work to keep clients out of the more formal system of control and isolation by encouraging behavioural change. This might be done by any number of means, but interviewees broadly spoke of two main approaches.

- A *forceful* approach which makes clear that wilful exposure of others to risk is a serious matter with potential harsh consequences for perpetrators; in this approach the threat of the Department's control powers and the criminal law is utilised to ensure the client understands the severity of the allegation and potential consequences
- A more *gentle and encouraging* response - involving counselling and support – which aims to build rapport with the client, emphasises an understanding of the challenges they may be experiencing in behaving safely and offers encouragement to the client in order that this may assist in behaviour change.

These approaches are two different strategies that PNOs use to effect behaviour change and to promote the safety of the public.

Facilitation of improved health care for clients

This might be described as a *means* of achieving behaviour change rather than a separate component of the PNO role, but it is such an important aspect that it deserves a separate mention. The PNOs play an important role in facilitating improved care for clients – helping them towards more secure housing, drug treatment,

medical or psychiatric care etc. Where a client does not have a primary health care provider, this role can be a substantial one for the PNO and may border on case management.

Concerns with the role of the PNOs

Incompatible roles

A number of interviewees expressed concern as to whether the forceful and supportive roles could ever really be compatible. The proposition that these roles were inevitably in conflict had achieved some currency immediately after the Department became concerned that its performance in a number of cases had let it down. It was suggested that what is needed is a strong and consistent position from a person with authority clearly indicating to clients that behavioural change is required or there will be serious consequences. This is incompatible, it was suggested, with an understandable desire to protect the client from the sort of Departmental intervention that results in isolation or worse. On this analysis, the desire to protect the individual and the desire to protect society too easily become incompatible and this had in fact caused the alleged mismanagement of at least this client.

Linked to this complaint are two slightly more specific criticisms: that the PNOs are too heavy handed and that they are not heavy handed enough. Both views were expressed throughout the consultations.

Clinical supervision

Some interviewees indicated concern at what they perceived as the lack of clinical supervision of the PNO role. The PNOs undertake important clinical and social assessments and it was not clear to these interviewees that this work was subject to appropriate levels of supervision. This concern was mostly expressed in relation to supervision of clinical medical and psychiatric assessments, although it was also expressed more generally about the PNOs' work.

Isolation of the PNOs

The PNOs' role is inadequately described and not clearly understood by many stakeholders. It has evolved in response to changing demands. The PNOs are located away from the Department at the Melbourne Sexual Health Centre, but even here there is a sense of separateness from the institutional environment. This can be described as a positive – clients are less intimidated accessing PNO services here than would be the case if they had to attend the Department's premises.

This isolation, however, contributes to the degree to which the PNO's work is misunderstood, and may explain how PNOs can be

described as both overly and inadequately coercive. It has also contributed to a sense of the PNO's role being separate to the Department, as if DHS only gets involved if the PNOs can't manage the client. The separateness also impedes proper supervisory systems.

Suggestions for the future role of PNOs

People's concerns about the PNOs require serious attention, but they need to be considered in relation to some other factors:

- The PNOs have managed many, many difficult cases over the past twenty years with considerable success and with very few cases attracting any public scrutiny or criticism
- The job is a difficult one; even critics of the role and its performance accepted the PNO role as a very challenging one
- The level of commitment of individual PNOs to their work is not disputed.

The PNO role is inadequately defined. This would be easily remedied by a Departmental process that engages PNOs in a better description of their role, including the powers they are entitled to exercise on behalf of the Department. Additional clarity is required not only in relation to powers and roles, but also in terms of how these are to be executed (process issues). Improved clinical supervision is also needed. Once the parameters of role have been better articulated within DHS, they should be widely distributed, including in the Guidelines.

That said, it is not the conclusion of this review that the different roles played in practice by the PNOs are themselves fundamentally conflicted or unviable. A closer examination of the evidence does not support the conclusion that the role of the PNOs was a cause of the problems DHS has had with a number of individual cases. There are a number of examples of public officials with an enforcement role who also in practice use more supportive methods in managing situations and clients as well as their default coercive ones. Police officers would fall into this category on a routine basis. Interviews with the PNOs uncovered no confusion on the part of PNOs about the priority they owe to protecting the public health. In fact they feel the poor outcomes achieved in a number of cases as keenly as anyone we interviewed.

There do appear to have been failures in communication and in record keeping and administrative practices that have resulted in decisions not being made in as timely fashion as required, at a number of levels. These have not been limited to the PNOs. However, on closer examination, the PNO's roles per se do not appear to be the cause of the problems that have confronted the Department.

This review would conclude that, while the role of the PNOs is unique among State administrations and is, therefore, at odds with the BBVSS report, this is an example of a State idiosyncrasy that is not itself problematic, providing that the other work suggested regarding role definition and supervision is undertaken.

Recommendation 4) That DHS involve the PNOs, their supervisors and Public Health Branch management in a process to define the PNO role more clearly and establish clear lines of clinical supervision for their work; and that these roles be widely explained and included in the Guidelines.

While PNOs already distribute to clients information on the 5-stage Departmental process and privacy, it may also be advisable for PNOs to distribute to clients information on the powers and role of PNOs and how complaints might be made against them. While such complaints would presumably be rare, distribution of such information would be an important public statement of DHS commitment to openness and scrutiny. It would also reinforce the role clarification process.

Recommendation 5) That information be prepared for the PNOs to distribute to clients explaining their roles and processes for making complaints regarding their work.

A different problem that may sometimes have been interpreted as role conflict on the part of the PNOs was uncovered in discussion of this question of PNO roles. The emphasis on PNOs 'keeping people out of the system' has perhaps encouraged an unfortunate conceptualisation of the process more generally. This is a problem with how DHS and its partners have articulated the otherwise sound policy objective of avoiding premature escalation of client management.

As soon as clients come to the attention of the Department, they are already *in* the system. The Department needs to exercise a similar degree of clarity with regards to clients at this early stage as with clients subject to higher levels of management and control. The Department cannot 'sub-contract' its responsibility for clients at this stage to the PNOs because the PNOs are Departmental officers.

Recent Departmental efforts to redress this confusion are entirely appropriate. The PNO's responsibility is, of course largely to support primary care clinician primacy in client management at these lower levels of risk. But it is not helpful for the Department to describe this as keeping clients "out of the system". As the BBVSS report stressed, accountability will still attach to Departmental decision making about its role and strategy in these cases, especially because avoiding premature escalation does involve managing risk. PNOs need to understand their role and be seen by others as agents of the Department in undertaking this complex task.

Finally, the interviews indicated a pattern of concern about the capacity of the current PNO role to effectively manage clients. Criticisms of PNOs were not always factually accurate, but the decline in confidence in PNO capacity, expressed by several stakeholders, cannot be ignored. One way around this would be for the Department to collect and publish the sort of service data that might build confidence levels, including:

- Response times (notification to first contact, first contact to assessment, assessment to incidence of service etc.)

- Outcome data (health outcomes facilitated, number of clients referred for formal orders, orders made, cases closed etc.)

Recommendation 6) That DHS Public Health Branch collect and report performance data on the PNO program.

The role of the Panel

The composition and operation of the Panel has recently been changed, although its primary purpose remains the same: to provide the CHO with the best possible advice on how to manage difficult clients. The role of the Panel is, however, the second significant area where Victoria's policy approach differs from that suggested in the BBVSS report.

Interviewees generally commented favourably upon the work of the Panel and of Panellists. However, a few important issues do need to be addressed, to assess if Victoria's approach on this issue is, like the role of the PNOs, an appropriate divergence from the recommended national approach, or whether further modification is appropriate.

Client management

There were differences of opinion on the Panel's role in client management. Some interviewees suggested that the Panel play some form of case management role involving assessment of whether the client is receiving appropriate care and the offering of advice on what care the clients should be helped towards. This might not, strictly speaking, be a designated role, but there was some support for its exercise given the expertise among Panel members.

There was not universal support for this, however, and an opposing view proposed actively discouraging this role by removing the quarterly meetings and just convening the Panel when specific advice is required. It is also practice now within DHS for intensive case management meetings to be convened within the Department to ensure that client management is optimal and to minimise the chances the Panel will have to get involved and give advice that the CHO exercise various of his coercive powers.

On balance, the conclusion of this review is that it would be sound to utilise the Panel to give advice on clients at an early stage in the management process. This would be more consistent with the BBVSS report recommendations. This would not involve the Panel in case management directly and client management should still stay primarily with treating primary care clinicians, or professionals in other appropriate disciplines, including for example mental health, disability or drug and alcohol services. In fact, DHS has quite rightly identified the need for improved cross-program case management mechanisms as a fundamental need arising from this, as well as other service problems that often result from the challenge of clients with complex co-morbidities and social disadvantages.

There are, however, two reasons for involving the Panel earlier, regardless of the need also to invest in improved cross program case management mechanisms. First there is a pragmatic argument that there is a considerable amount of expertise on the Panel, which can be accessed in the form of advice to treating clinicians, without compromising the primacy of their management of the client, at earlier stages in the process. Second there is a danger in different case management committees convening for a series of individual cases, without consistent ongoing oversight of the quality of advice or of follow up. This could extend to the danger of inconsistent advice going to the CHO about different cases, not because of changing standards on the part of the Panel but because different case management meetings adopt different standards about which clients to refer to the Panel for consideration of escalation to higher levels of coercive management.

Recommendation 7) That the Panel be used as a forum for seeking advice on client management strategies before it is considering escalation to coercive measures such as behavioural, isolation or detention orders. And that DHS continue to invest in improving cross program case management as a need going across the Department's services.

Independence

The Panel is often described as providing independent advice to the CHO, but it is important to promote a shared understanding of what independence means as this principle could be overstated as a reason not to involve the Panel where it might usefully be consulted. Panel members are independent in the sense that they are engaged for their expertise and are not under pressure to deliver particular decisions on issues. On the other hand, the Panel itself is a creation of the Department, operates within departmentally-determined if not legislative parameters, and enjoys no quasi-judicial entitlement to challenge or overturn the Department's position. The Panel delivers expert advice grounded in the expertise, integrity and independence of its members.

The greater issue is, in fact, the independence of the CHO from the Panel, as it is important to the integrity of decisions he must make under the Health Act that these are his decisions, albeit with advice from both the Panel and the Department. The CHO will benefit from the opportunity to consider this independent perspective, together with the advice from the Department, but the value of both these advices will be reduced by any inappropriate CHO engagement in their formulation. For this reason, the CHO should remain removed from these processes until required to make a decision.

In summary, the principle of the independence of the Panel should not extend to keeping it distant from information about earlier consideration of client management strategies.

Attendance at Panel meetings

Recent procedural changes mean that many more people than was traditionally the case will attend Panel meetings. Meetings will now be attended by Panellists, the Assistant Director, the BBV Section Medical Supervisor, the officer providing DHS secretariat services and the PNOs. Despite occasional misgivings, most interviewees were generally confident that this would not compromise the integrity or independence of the Panel.

On the issue of PNO presence there were mixed views. People noted that it might make it more difficult to critique a PNO's performance, but nearly everyone noted the value in having PNOs there to directly answer questions.

Involvement of a person with HIV on the Panel

Previously the panel membership included two people with HIV; it now includes one. This makes it more likely that the Panel might be convened without a person with HIV. This would be a rare but problematic outcome.

Recommendation 8) That the Panel include two people with HIV among its membership.

Documentation

There were some criticisms of the way in which Panellists are required to quickly digest large amounts of information at meetings as no documentation is provided beforehand. The need to ensure confidentiality of documentation was universally acknowledged, but it was thought that there might be ways of ensuring this while still giving Panellists more support in absorbing information.

Interviewees were strongly supportive of Panellists having access to original reports (such as medical and psychiatric reports), rather than second-hand reports of the professional views of others.

Recommendation 9) That the Panel be provided with full documentation ahead of meetings, on a clear understanding of the confidentiality of the material.

Suggestions for ways forward with the Panel

The panel includes significant expertise and should be supported to add *maximum* value to DHS management of difficult cases, rather than be restricted to an unnecessarily narrow brief. It is suggested that it be encouraged to offer advice on the appropriate management of all clients in the system, and it is acknowledged that this represents an expansion of brief with some resource implications, although not substantial ones.

Under this proposed model, the Panel would:

- Offer enhanced scrutiny of the PNOs' work with clients and offer advice on the care required for clients;

- Continue to act as an independent forum in not being bound by DHS views and continuing to provide its own advice to the CHO; and
- Be better supported in its decision making by having enhanced access to relevant information before it is required to make a decision and to direct advice from providers of health services to clients.

2.2.2 Clients with complex needs

The BBVSS Report identified clients who may have knowingly exposed others to risk are disproportionately multiple service users, affected by psychiatric or intellectual disability or experiencing drug and/or alcohol problems. This is true also in Victoria. Several people interviewed during the review also raised the issue of client ethnicity. This probably deserves some further attention, for at least two reasons:

- Like the co-morbidities mentioned, language and cultural barriers prevent access to the medical or psychiatric care that might support people with HIV to maintain safe behaviour
- Some interviewees had questions about the capacity of the Department to work across all languages, particularly those for which there are few interpreters in the state: how can the Department assess risk to the community if it cannot understand what the client is saying?

The consultations also suggested that another relevant factor might be the capacity of primary care clinicians and service providers to deal with clients or behaviour they find unfamiliar or challenging. Clients coming to the attention of the Department will be disproportionately the patients of medical practitioners who are not experienced in relation to HIV and more isolated from clinical support. High case load GPs tend both to be more skilled in the area and not see all of the most isolated clients.

Opportunities to provide support to GPs for clinical support in the management of difficult clients need to be exploited. These opportunities include:

- Periodic communications between DHS and GPs;
- Section 100 training programs and other training initiatives undertaken by the Australasian Society for HIV/AIDS Medicine (ASHM) and/or the General Practice Divisions Victoria; and
- Clinical support and advice services provided formally or informally to isolated practitioners by The Alfred Hospital or the Victorian HIV Consultancy Service or, in some cases, by the Panel.

Recommendation 10) That DHS Public Health Branch consider strategies to provide more support to primary care clinicians, especially but not exclusively those without high HIV caseloads, when they deal with people with HIV who may be putting others at risk.

2.2.3 Referral to police

The BBVSS Report also identified a weakness in State and Territory policies in failing to explicitly address the criteria by which health authorities should determine whether or not to refer matters to the police.

In Victoria this weakness has been partially addressed through four recent processes:

- Discussions between DHS and Victoria Police about when to refer matters;
- Work towards the development of a protocol between DHS and Victoria Police relating to referral of clients who may be exposing others to risk;
- The development of a draft memorandum of understanding between DHS and Victoria Police; and
- Development of referral criteria in the DHS Protocol.

Recommendations on criminal referral made in the BBVSS Report were adopted by Australian Health Ministers and provide a national agreed and evidence based standard against which Victoria can also further clarify its policy position.

While the processes outlined above are mostly incomplete, there is every indication that DHS and Victoria Police will agree on most referral issues. Both entities will benefit from effective approaches that ensure most matters of exposure to risk are managed by the public health system and that those who ought to be referred for criminal investigation and prosecution are done so expeditiously.

The BBVSS Report recommended that cases with clear evidence of intentional infection will warrant immediate referral to the police, as will cases involving other serious offences such as child pornography, sexual assault, major drug dealing or violent crime.

Further investigation and action will be required, however, in relation to those cases where client behaviour falls short of intentional exposure to risk, but also seems initially immune to the effects of public health measures. As identified in the evidence considered by the BBVSS Report some proportion of those cases will be amenable to change through the more coercive powers available under the Health Act.

In such cases there may a keenness to refer to Victoria Police, yet it will often be the case that DHS will be as able as the police to protect the public through its powers of behaviour, isolation or detention orders, while other interventions are also explored. It is, of course, imperative that DHS act decisively in those cases to protect the public health while those interventions are trialled if that is judged necessary.

Whatever criteria is agreed upon, it would be more appropriate to include these in the Guidelines than the Protocol – it would be a reassuring indication to the public that the Department has a strategy for dealing with the most difficult clients.

In the meantime, the recent enhanced communication between the DHS and Victoria Police is a welcome development. Discussions or documents that affirm shared understandings and open up opportunities for discussion of different opinions are clearly worthwhile.

Recommendation 11) That DHS and Victorian Police complete their protocol discussions, based on the criteria agreed nationally in the BBVSS Report and that the criteria decided be included in the Guidelines.

2.2.4 Need for administrative rigour

Finally the BBVSS Report identified a lack of administrative rigour as a common weakness among the States and Territories. The scope of this review did not include examining those issues in DHS. This was the remit of the Scott and Falconer review.

It is sufficient for this review to observe that administrative systems need to service multiple functions – to assist internally in decision-making and management of clients, to enhance the Department's capacity to review and publicly explain its performance and to reduce the requirement for face-to-face meetings.

It is clear that people engaged in the management of clients in Victoria are already cognisant of the need for enhanced record keeping. Several interviewees not only noted this need but were able to report on recent steps they had taken to improve performance in this area. The development of the Protocol is an obvious example of such steps.

2.3 Other issues

2.3.1 New internal systems

DHS has recently reviewed its internal systems for managing clients and devised new processes which are outlined in the Protocol. This new procedure will certainly facilitate communication on issues of client management, but it does seem too onerous for key players and may confront issues of sustainability. The Protocol outlines that there will be:

- Quarterly Panel meetings involving Panel members, the PNOs, Medical Adviser (MA) and Assistant Director (AD);
- Quarterly post-Panel meetings involving the PNOs, MA and AD; and
- Fortnightly meetings involving PNOs, MA and AD.

This represents a lot of opportunities to meet and discuss a relatively small number of clients. It is possible that proper supervision of the PNOs, improved record keeping and the occasional meeting might be enough to enable sound management of clients. When a response to identified organisational failure is addressed by requirements for more meetings, there is always also a danger. The people whose attendance is essential to make meetings effective are all very busy and will not be able to sustain too heavy a schedule. As the sense of immediate crisis passes (and much has been done to address the issues identified in DHS) it is

important to identify the core set of essential meetings really needed to oversee this activity.

The danger is that for new arrangements to work and be sustained they need not to be reliant on a continuous cycle of meetings. The work that needs to be done needs not to be dependent on an unsustainable round of meetings but to happen as normal business. This is an issue that will be assisted by finalisation of Protocols and establishment of better supervision arrangements.

Recommendation 12) That, as DHS becomes confident that new arrangements and improved processes for managing this area have been put in place, that DHS managers review the number of meetings they have established to manage the activity and limit it to those most crucial to oversee the new arrangements.

2.3.2 DHS capacity to implement Guidelines

Some questions were raised about the Department's capacity to implement the Guidelines. Notably, people observed that DHS does not own appropriate properties in which to detain people under the Act. There will be times when a hospital or psychiatric bed will not be an appropriate detention site (leaving aside the willingness of such care facilities to take on this role) and the Department is currently ill-equipped to deal with such situations. It is understood DHS is close to having remedied this problem.

There is also a question about the impact of recent changes to record keeping and other procedures. Undoubtedly, the administrative workload of people engaged in the management of difficult clients has increased and this will require some responses in terms of resource allocation.

2.3.3 The Guidelines are incomplete

Taken together, the documents are a clear statement about what will happen in those areas where this is clear. There are, however, some notable omissions.

Neither the Guidelines nor the Protocol address appropriately the role of the Minister: they are silent on issues such as when to advise the Minister of a matter and the role of the Minister in intervening in the application of the Guidelines and Protocol. These may be matters requiring flexibility, but some mention of this issue would be appropriate.

It is also the case that neither document fleshes out *how* the PNOs undertake their work. These details are, instead, found in a very informative document produced separately by the PNOs. There would be some value in bringing these documents together.

2.3.4 The language of the Guidelines and Protocol – tension with Legal Services

There was some criticism amongst interviewees of the language applied in the Guidelines. Specifically, the Guidelines and Protocol language occasionally departs from the language of the Act. This is understandable – the audience for the Guidelines, a public document, is much broader than the group of people who would read the Act - yet the divergence inevitably leads to problems. Some departmental officers are ultimately surprised by advice from the legal team – in following the Guidelines they conclude they have been implementing the letter of the law, although occasionally this is not the case.

Similarly, the language of the Protocol departs from the language and interpretation of the Act. In fact, the departure is greater for the Protocol than for the Guidelines, so by following the Protocol departmental staff may find themselves, albeit rarely, acting in ways not entirely authorised by the Act.

The reality is that neither the Guidelines nor the Protocol are used by the legal team to guide its decision-making. Instead, and understandably, the legal team uses the Act and relevant case law. This partly explains how policy documents have been allowed to develop that fail to reflect the law in an entirely specific manner.

It was suggested in some interviews that this is a case of incompatible motivations: non-legal DHS staff are motivated to find constructive solutions to the problems being presented by clients and protecting public health, while DHS Legal Officers are concerned to ensure that the CHO behaves in ways that are legally robust, or that can at least be upheld on appeal.

In fact, these tensions are inevitable and the representation of the motivations simplistic. The only way in which such tensions can be managed, or ideally used to produce sustainable policy and effective support for program staff, is to engage the Legal department further. The next review of the Guidelines, and any further review of the Protocol, should more effectively engage DHS Legal Officers. The aim of the process should be to develop policies that best enable the Department to prevent infections while:

- Promoting its chances of not being appealed or overturned by the Supreme Court, and
- Affording clients natural justice.

3. Conclusion

This review has identified a number of issues and recommended some changes to the Guidelines and Protocol used by DHS to manage people with HIV who risk infecting others. These are based mainly on further reform to a couple of specific aspects of the approach used to manage these clients.

The changes suggested are consistent with the national position adopted by Health Ministers following the BBVSS Report, although in one case (the role of PNOs) we have suggested that this unique aspect of the Victorian approach should not be abandoned, albeit some tightening of procedures and role definition is required.)

We would again like to express our appreciation for the generosity of DHS staff and other experts who shared their perspectives with us and to express our confidence in the leadership and directions taken in the aftermath of acknowledged breakdowns confronted by Victoria over the last year.

Robert Griew
Tim Leach
September 2007

Annexure A

Interviewees

- Dr Jim Hyde, Director, Public Health, Victorian Department of Human Services (DHS)
- Philip Clift, Manager, BBV/STI Program, Communicable Diseases Control, Public Health, DHS
- Roger Nixon, BBV/STI Program, Communicable Diseases Control, Public Health, DHS
- Bronwyn Kaaden, BBV/STI Program, Communicable Diseases Control, Public Health, DHS
- Danny Csutoros, Medical Advisor, BBV/STI Program, Communicable Diseases Control, Public Health, DHS
- Louise Johnson, Director, Legal Services, DHS
- Jenny Giles, Principle Solicitor Health Team, DHS
- Kit Fairly, Director, Melbourne Sexual Health Centre
- Ruth Vine, Acting Executive Director, Mental Health Branch, DHS
- Dr Rosemary Lester, Assistant Director, Public Health Branch, DHS
- David Menadue, representative of PLWHA (Vic)
- John Daye, representative of PLWHA (Vic)
- Kevin Guiney, President, Victorian AIDS Council/Gay Men's Health Centre
- Mike Kennedy, Executive Director, Victorian AIDS Council/Gay Men's Health Centre
- Grant Davies, Board member, Victorian AIDS Council/Gay Men's Health Centre
- Associate Professor Dr Ann Mijch, Head, Victorian HIV/AIDS Service, The Alfred Hospital
- Brian Price, Business and Community Services Manager, Infectious Diseases Unit, The Alfred Hospital
- Associate Professor Dr Jenny Hoy, Infectious Diseases Physician, The Alfred Hospital
- Beth Hatch, Partner Notification Officer, Communicable Diseases Control, Public Health, DHS
- Tom Carter, Partner Notification Officer, Communicable Diseases Control, Public Health, DHS
- A written submission was received from Victoria Police