Guidelines for the management of people with infectious diseases who put others at risk of infection

These guidelines relate only to those diseases that are notifiable under the *NT Notifiable Diseases Act*. While most people with infectious diseases conscientiously avoid behaviour which exposes others to the risk of infection, a very small number of individuals will continue to pose a risk of infection to other people in spite of the efforts of health professionals and others to assist and support them not to. The structures and processes outlined in this document aim to reduce the risk of infectious disease transmission by these individuals. Where these guidelines refer to a person who is HIV positive, this document may be read in conjunction with the *'National Guidelines for the Management of People with HIV who Place Others at Risk'*.

Legislative Basis and Related Documents

NT *Notifiable Diseases Act 1981*

NT *Public and Environmental Health Act 2011*

NT *Care and Protection of Children Act 2007*

NT *Criminal Code Act*

NT legislation available at
http://notes.nt.gov.au/dcm/legislat/legislat.nsf/d989974724db65b1482561cf0017cbd2?OpenView

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

Available at
http://www.health.gov.au/internet/main/publishing.nsf/Content/BF51F1922544BA6FCA2574DA007FE597/$File/hiv-at-risk.pdf

Objectives

To reduce the risk of notifiable infectious diseases being spread as a result of the actions of persons who are known or suspected to be infectious.

Target Group

Chief Health Officer and those acting in that position

Centre for Disease Control staff

Health Care providers

Department of Health Legal Support staff.

Authorising Officer: Vicki Krause Effective: 10 April 2013
Authorising Officer Position: Director, Centre for Disease Control

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Guidelines for the Management of People with Infectious Diseases who put others at Risk of Infection

These guidelines relate only to those diseases that are notifiable under the Northern Territory *Notifiable Diseases Act*. While most people with infectious diseases conscientiously avoid behaviour which exposes others to the risk of infection, a very small number of individuals will continue to pose a risk of infection to other people in spite of the efforts of health professionals and others to assist and support them not to. The structures and processes outlined in this document aim to reduce the risk of infectious disease transmission by these individuals. Where these guidelines refer to a person who is HIV positive, this document may be read in conjunction with the '*National Guidelines for the Management of People with HIV who Place Others at Risk'*.

The six principles underlying these guidelines are:

1. The community as a whole has the right to appropriate protection against infection.
2. Public health objectives will be most effectively realised if the co-operation of people with infectious diseases and those most at risk is maintained.
3. Transmission of infectious diseases is preventable through changes in individual behaviour; education and prevention initiatives are necessary to encourage such changes.
4. Cross-cultural issues are to be considered when managing people who put others at risk of infection and addressed as far as possible without compromising the public health.
5. The law should complement and assist education and other public health measures.
6. In relation to sexually transmitted infections (STIs) and blood borne viruses (BBVs), each person should accept responsibility for preventing himself or herself becoming infected through sexual intercourse or the sharing of needles and for preventing further transmission.

In managing individuals who put others at risk, the aim is to strike the right balance between protection of the community and the protection of the rights of the individual. In general terms the least coercive actions (i.e. counselling, education and other supportive strategies) should be used first at which point higher authorities may not need to be formally involved. However, there is the capacity to use legally enforceable coercive powers if there is a significant risk to public health. Invoking the law in this situation presents a wide range of complex ethical and legal issues. The primary aim of all management strategies is to place the person under the least restriction possible while protecting the public health and only use coercive measures when absolutely necessary.

The disease control powers vested in the Chief Health Officer (CHO) are outlined in the *Notifiable Diseases Act*. This Act confers upon the CHO very broad powers to prevent the transmission of notifiable diseases. The CHO may issue a section 11 notice or section 13 order under the Act obliging a person to undertake certain assessments, treatments or counselling, to remain in a certain place and to refrain from certain behaviours. Certain medical practitioners who are "authorised officers" under the *Public and Environmental Health Act* may also issue section 11 notices under the Act. If necessary, a person may be arrested and charged under the Act with the possible consequence of 6 months imprisonment should they fail to comply with a notice or order under the Act.

The approach outlined in this document aims to accommodate the complex social, psychological and health care needs of the clients while protecting the public health. This approach is comprehensive and also includes assessment, planning, coordinating, monitoring and advocacy. A multi-agency focus is essential to this process.

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The primary objective of all measures is to reduce the risk of infectious disease transmission. It is acknowledged that in some instances, people with mental illness, intellectual disability or a combination of conditions might place others at risk of infection, even though this behaviour may not be intentional. However, that the behaviour is not intentional or that the person may not be fully responsible for their actions, does not lessen the need to protect the public from disease transmission.

Summary of the process of managing a person who puts others at risk of infection

If allegations of unacceptable risk behaviour are made, then Department of Health (DoH) officers will investigate to determine whether:

- The person concerned does indeed have an infectious disease or the likelihood that they may have;
- The person with an infectious disease has in the recent past behaved in such a way as to put others at risk, for example as evidenced by:
- Admission by the individual or credible reports from others that he/she has exposed others to the infectious disease;
- The person is likely to continue such behaviour in the future; and
- The person's behaviour presents a danger of transmission to others.

If it is apparent that there is no basis for the allegation, then no further action is taken. If there is evidence to support any allegation(s) of risk behaviour, a Case Management Team will be established to manage the client using a 5-stage hierarchical process the stages of which are:

Stage One — Counselling, education and support provided by a Case Management Team

Stage Two — Formation of a Case Advisory Panel

Stage Three — Formal Warning

Stage Four — Use of Section 11 of the *Notifiable Diseases Act*

Stage Five — Use of Section 13 of the *Notifiable Diseases Act*

In the early stages interventions are undertaken on a voluntary basis. In stages 4 and 5, legally binding and enforceable orders can be made as a last resort if voluntary measures have not been successful. There are no specific criteria to determine what intervention is most appropriate or to specify when progression to the next stage is indicated. The nature of the interventions and their timing will vary according to the particular infectious disease in question and the circumstances of each case. However, at each stage of this process the following fundamental questions are considered:

- Have all voluntary options for the previous stage been exhausted?
- Have previous stages failed to modify behaviour?
- Do the actions of the client appear to be putting others at risk of infection?

It is important to note that if urgent action is necessary the staged process may be truncated. A legal notice or order under the Act may be implemented prior to beginning, or at any stage of, the 5-stage process. Under certain circumstances, the powers of the Act may be invoked on the basis of a reasonable suspicion (as opposed to a confirmed diagnosis) that a client has a notifiable infectious disease.

These powers are entirely separate from the *Criminal Code* and *Care and Protection of Children Acts* that might be used by Police in a criminal prosecution of a person who knowingly or recklessly puts others at risk or in the case of harm or exploitation of a person under 18 years of age. Sections relevant to this under the *Criminal Code Act* are 174B (1) & (2) and 174C & D.

Referral to Police

In some situations individuals who knowingly or recklessly expose others to infection may be prosecuted for offences under the *Criminal Code Act* for causing harm or the danger of harm. Likewise, the *Care and Protection of Children Act* specifies that individuals must report to Police or the Minister any belief of harm or exploitation concerning a person less than 18 years of age. When this occurs, police action takes priority until the court case is finalised.

Case management through the 5 stage hierarchical model will continue throughout this time.
A referral to the police can occur at any stage of the 5 stage hierarchical model and is the responsibility of any individual with knowledge or belief that a breach has occurred to either Act.

Confidentiality

Section 29 of the *Notifiable Diseases Act* obliges all persons involved in the management of a such a client to preserve and aid in preserving secrecy concerning all matters and things which come to their knowledge whilst so doing except where it concerns other obligations under the Act or if they are required by other law to answer questions. Failure to do so may incur a penalty of up to two years imprisonment.

INITIAL NOTIFICATION

Anyone concerned that a person with an infectious disease is likely to be putting others at risk of infection may request assistance from the DoH. This request is made through the Centre for Disease Control (CDC). Requests are forwarded to the Director of the CDC who will direct it to the section of the CDC that is appropriate for the infectious disease in question.

The head of appropriate section will delegate appropriate health staff (delegated officers) to first gather specific information from the individual notifying the DoH of the case including:

- The notifier's name and their relationship with the person.
- Details of the behaviour involved in the notification.
- Any evidence of infectious disease transmission.

These officers will have a delegation under section 31 of the *Notifiable Diseases Act* to seek relevant information from the person under section 9 of the Act.

INITIAL ASSESSMENT

The delegated officers will contact the person who is allegedly posing a risk to others, inform them of the notification and organise an interview. The aim of the interview is to identify whether the notification warrants further investigation or if no further action is necessary. The officers should, whenever possible, be appropriate to the person's gender and ethnic background. They are expected to conduct the interview in a non-threatening manner and they will try to develop rapport with the person, as they may have an ongoing involvement in subsequent management. The person is given the opportunity to identify an independent advocate who can provide support throughout the process.

The delegated officers will inform the person that the information gathered during the interview process may be used by the CHO to assess whether their behaviour may be putting others at risk of infection. Other information may be sought from the clinical records of a registered medical practitioner, an agency of the DoH or other relevant health services. Information Privacy Principle 2

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of the NT *Information Act* and the Commonwealth *Privacy Act* permit disclosure of patient information if it is necessary to lessen or prevent a serious and imminent threat to the health of the individual involved, the public health and safety or if there is reason to suspect that the person is engaged in unlawful behaviour.

The information necessary to help make this assessment may include:

- Confirmation of whether the person is infected or not.
- The person's response to the notification.
- Details of specific behaviours such as unsafe sex and needle sharing.
- Any evidence of transmission of the infection.
- Evidence of poor impulse control.
- A mental state assessment to screen for relevant psychiatric illness.
- An assessment of social supports.
- Evidence of alcohol or other drug dependency or abuse.

If it is clearly established that the notification has no basis, no further action is taken. Where an assessment is made that the person appears likely to put others at risk of infection with a notifiable disease, the delegated officers will inform the relevant CDC Section Head who will then inform the Director of CDC who will in turn inform the CHO. When this occurs the client is usually managed under the 5-stage approach as outlined by these guidelines.

A client may refuse to disclose whether they are infected to the delegated officers during the interview or may refuse to be tested. When this happens, the matter is to be immediately referred to the Director of CDC and then to the CHO. If the delegated officers have a reasonable belief that the client has a notifiable infectious disease and is likely to put others at risk, the CHO may consider whether a notice under the *Notifiable Diseases Act* should be made requiring that the person be examined and tested.

A client who is the subject of a notification may already be exhibiting an obvious incapacity to modify their behaviour in the short term and urgent intervention may be necessary. According to the circumstances, a section 11 notice may be served on the client prior to or at any stage during the 5-stage process. At this time, the client is usually referred for urgent medical, psychiatric and other relevant assessments. For example, a client with "open" tuberculosis who was refusing treatment and wished to board a commercial aircraft might be served a Section 11 Notice obliging them not to board the aircraft and to undergo treatment.

STAGE 1 – COUNSELLING, EDUCATION AND SUPPORT: THE CASE MANAGEMENT TEAM

Counselling, education and support are the first steps in the management of a client with an infectious disease who appears likely to put others at risk. These should be extensions of those services provided already, but will need to be more concentrated, specific 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 specific circumstances.

The CDC Section Head will form a Case Management Team to coordinate and assist in the provision of the client's day-to-day care and support. This might include staff from a range of agencies such as other specialist clinical services, Alcohol and other Drug Services, Mental Health Services, the Northern Territory AIDS and Hepatitis Council (NTAHC) and relevant primary health care services. If the client is Indigenous, it will usually be highly desirable to have Indigenous members on the management team. According to circumstances, it may include respected members of the client's community. If the client does not speak English as a first language, interpreter support may be

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needed (e.g. NT Interpreter and Translator Service - Office of Multicultural Affairs or the Aboriginal Interpreter Service - DCDS&CA).

It will be important for the client to be comfortable working with its members. Members of the team will need to maintain strict confidentiality. This may be particularly important in considering a member of the client's community to be part of the team. The composition of the Case Management Team and all interventions will be tailored to address the client's individual needs and take into account their age, health status, cultural and linguistic background and level of social and cognitive functioning. Its exact composition may therefore vary greatly with the individual.

In addition to providing care for the client, this team will be responsible to carefully document the process and provide reports via the CDC Section Head for the Case Advisory Panel should that be necessary.

The range of services that might be offered to the client for either assessment or ongoing care could include:

- Medical and psychological services.
- Alcohol and other Drug services.
- Counselling and education services to understand aspects of the particular infectious disease, sexuality, interpersonal relationships and help manage specific behaviours (e.g. negotiating safe sex).
- Assistance with housing or supported accommodation.
- Assistance with retraining and job placement.
- Life skills, for example assistance with budgeting and social skills.
- Home care support, for example, shopping, cooking and cleaning.
- Access to and advice concerning condoms and clean injecting equipment.
- Peer group support organisations.
- The CDC Section Head will oversee and supervise this process and keep the Director of CDC and the CHO regularly informed of progress. If it appears that the client is putting others at risk despite these supports, the CHO will be informed and will consider whether to take further steps.

STAGE 2 – INVOLVEMENT OF THE CHIEF HEALTH OFFICER AND THE CASE ADVISORY PANEL

If the CHO believes that the client continues to pose a risk to others, he/she may ask the Case Advisory Panel to consider the situation.

The Case Advisory Panel

A standing Case Advisory Panel meets regularly to consider clients in this situation. It is made up of persons deemed appropriate and necessary by the CHO and who have experience and expertise relevant to the management, health or social issues of such individuals being case managed. If necessary, extra members may be invited to participate in the consideration of particular individuals.

Usually, the panel might include:

- A medical infectious disease specialist;
- Where the disease is a blood borne virus (BBV), a person living with the same BBV;
- A legal advisor;

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- An Indigenous person if the client is Indigenous;
- A person of similar ethnic background for other ethnicities;
- Others as deemed important.

The Case Advisory Panel is totally separate from the Case Management team that is involved with day-to-day support and care for the client. The Panel would not be informed of the client's identity. The Panel plays an advisory role to the CHO in his/her efforts to ensure that all is being done to assist the client involved not to put others at risk and at the same time ensure that the public health is protected. The Panel is involved in regular reviews of the case to assess the client's response to interventions.

Operations of the Case Advisory Panel

- The CHO selects a Panel, or may delegate an appropriate person within the CDC to do so.
- The CHO may or may not choose to participate in Panel meetings.
- The CDC Section Head provides a report to the Panel outlining the history of the situation, describing the actions taken thus far and highlighting key issues. The report may include formal, expert assessments concerning any aspect of the client's situation (e.g. medical, psychiatric, alcohol or other drug dependency, disability, social circumstances).
- The Panel may identify specific areas where it requires additional information. Advice may be sought from both within and outside the DoH.
- All reports relevant to the case should be presented to the Panel in a manner that does not identify the client.
- The Panel will regularly review cases that are classified as current or active.
- As with initial assessments, the CDC Section Head will provide a summary of relevant issues and may include new assessment reports relating to the case.
- At the conclusion of each Panel meeting the advice of the Panel should be provided to the CHO for consideration. Such advice may outline one of the following options:
    1. That current measures continue.
    2. That current measures continue with the addition of further specific interventions.
    3. That current measures are inadequate and the client be moved to the next stage.
    4. That there has been a positive response to current measures and the client is moved back to an earlier stage or removed from regular review.

The CHO considers the advice of the Panel and any other relevant information before making a decision. However, the CHO is not bound to follow the Panel's advice. Ultimate responsibility for decisions in relation to the Act rests with the CHO.

STAGE 3 – FORMAL WARNING

If it appears that the client is continuing to put others at risk of infection despite previous voluntary interventions the Panel may advise the CHO to issue a formal warning. This warning advises the client of the actions on their part that are considered advisable, of the provisions of *Notifiable Diseases Act* and of the steps that may be taken if the client's future behavior is unacceptable and the CHO considers it necessary.

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Usually this will take the form of a letter, but may be delivered orally if a letter is neither practical nor appropriate. This might be done after a period of observation of the client's behaviour after the provision of support services or may be done earlier if the circumstances warranted it.

The Panel will determine who should issue the warning. It may or may not be appropriate for members of the day-to-day case management team involved with the ongoing management and support of the client to do so.

The delivery of the warning should be witnessed. If in the form of a letter it should be read to the client. Delivering the warning may require a security or police presence.

The formal warning:

- Describes the legal powers contained in the *Notifiable Diseases Act* to impose a notice directing the client to undertake certain actions to prevent the spread of the disease and of the possible consequences should the client fail to comply with that order.
- May describe any specific behaviour or actions the client should is requested to undertake or refrain from.
- May indicate a date by which the client must comply with any specific request(s).

STAGE 4 – SECTION 11 NOTICE

Where it appears that the client is still not taking steps to ensure that they do not put others at risk, the CHO or a medical officer in the meaning of the *Notifiable Diseases Act* may issue a Section 11 Notice under the *Notifiable Diseases Act*. This notice may direct the client to take whatever measures are deemed necessary to prevent the client from spreading the disease. It may oblige the client to remain at a certain place, to participate in formal assessments, education or counselling, to undertake treatments, or to refrain from certain behaviours. Failing to comply with the directions of a Section 11 Notice is an offence under the Act punishable by up to 6 months imprisonment.

Usually this would occur only after issuing a formal warning to the client. However, it may be done at any time and without having progressed through the above stages if the circumstances warrant it.

With regard to a Section 11 Notice:

- There is no requirement for a Section 11 Notice to be limited in time. However, a time limit may be put on it or a decision made for there to be regular review of it in conjunction with the Case Advisory Panel.
- The Section 11 Notice may be modified at any time to alter the directions it contains.
- A Section 11 Notice may be issued by the CHO or by a medical practitioner who is designated as an *authorised officer* under the *Public and Environmental Health Act* (i.e. a "medical officer in the meaning of the *Notifiable Diseases Act*)
- The Section 11 Notice must be in written form and be served directly to the person. The person who physically serves the notice does not have to be an *authorised officer*.
- A person subject to a section 11 notice under the *Notifiable Diseases Act* can appeal that notice to a Local Court that may confirm the notice, vary a direction contained within it or revoke it. However, the order stays in force until the Local Court has ruled on it.
- If a client breaches a section 11 notice, the CHO may initiate a prosecution which may lead to a fine and possible imprisonment.
- When the situation is resolved, the section 11 notice should be rescinded in writing.

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STAGE 5 – SECTION 13 ORDER

Should the client continue to put others at risk of infection or fail to comply with any of the directions of the Section 11 Notice, the CHO may invoke Section 13 of the *Notifiable Diseases Act*.

Under Section 13 the CHO may make an Order that the client undertake whatever measures are necessary to prevent the client from spreading the infection including their isolation. For people requiring isolation, the CHO should determine the appropriate facility and staff to best meet the needs of the client.

Invoking Section 13 does not require a written order to be served to the client. However, DoH operating procedures are such that the CHO will ordinarily do so.

A section 13 order may reiterate the conditions of the section 11 notice or may refer to the section 11 notice and stipulate that its conditions still apply.

A section 13 order may require a client to be detained. Reasonable force may be used in order to give effect to a section 13 order. The Police may be asked to assist in enforcing a section 13 order. Once a client has been detained, individuals (e.g. hospital security staff) will require a specific authorization from the CHO in order to be able to use reasonable force to ensure the client remains.

There is no requirement for a Section 13 Order to be limited in time. However, the CHO may choose to fix a time limit on it with a date for review.

If a client breaches a section 13 Order, the CHO may initiate a prosecution which may lead to a fine and possible imprisonment. The Police can arrest a client who breaches a section 13 Order.

In general, and in keeping with the spirit of these guidelines, the CHO would, with the advice of the Case Advisory Panel, determine a specific process to review the overall situation and the status of the Section 13 Order.

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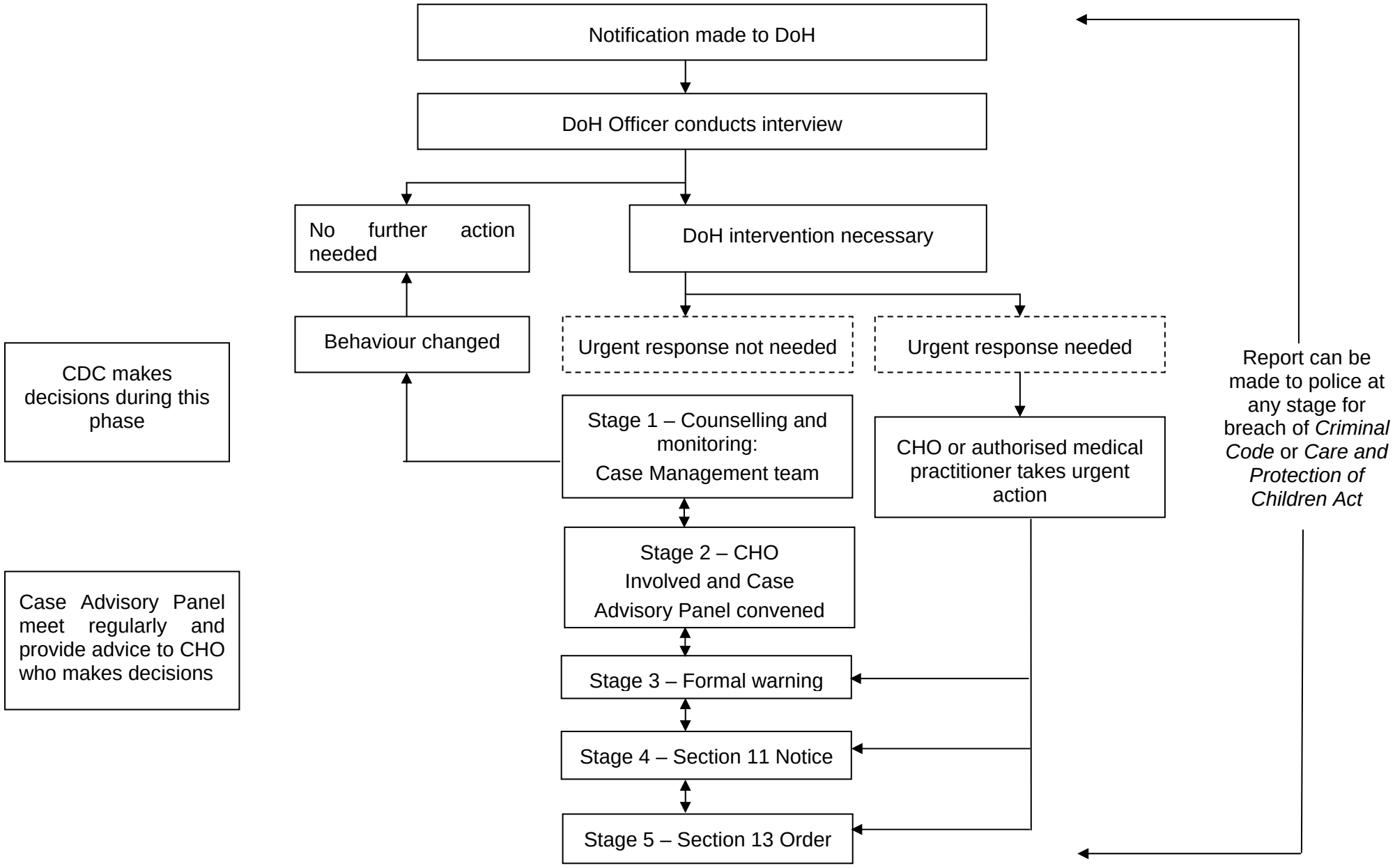

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