

# National Guidelines for Managing HIV Transmission Risk Behaviours (2018)

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The National Guidelines for Managing HIV Transmission Risk Behaviours 2018 have been developed in consultation with the Blood Borne Viruses and Sexually Transmissible Infections Standing Committee (BBVSS) and the Communicable Disease Network Australia (CDNA), and endorsed by their parent committee the Australian Health Protection Principal Committee (AHPPC). These Guidelines have been developed, primarily for Chief Health Officers (CHOs), to ensure consistency in the way all Australian states and territories manage HIV transmission risk behaviours. These guidelines capture the knowledge of experienced professionals and provide advice on best practice based upon the best available evidence at the time of completion.

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## SECTION 1 - PREFACE

These Guidelines have been developed, primarily for Chief Health Officers (CHOs), to ensure consistency in the way all Australian states and territories manage HIV transmission risk behaviours.

It is estimated that approximately 10 per cent of Australians living with HIV have not been diagnosed and that this undiagnosed group of people contribute to a significant proportion of HIV transmission (1).

Service providers for people diagnosed with HIV should be aware of the potential for onward transmission and associated public health risks. They should regularly review behaviours of people that may be placing others at risk of HIV and provide support to eliminate this risk.

These Guidelines describe a staged, public health approach to managing the small minority of people living with HIV whose behaviours risk HIV transmission. The Guidelines have been updated primarily to reflect the latest scientific knowledge on the individual and public health benefits of treatment as prevention (TasP) for reducing HIV transmission. Research has shown that people with HIV who take anti-retroviral therapies (ART) daily as prescribed, and achieve and maintain sustained 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 a HIV-negative partner (2-19). While there is currently insufficient evidence to state the same for non-sexual routes of exposure (e.g. injecting drug use), it is likely that sustained viral suppression will also minimise the risk of HIV transmission in these situations.

The key objective of public health management under these Guidelines is the prevention of HIV transmission to others. The key to this is ensuring that the person of concern is able to sustain HIV viral suppression through high adherence to their prescribed ART by maintaining involvement in appropriate ongoing clinical care and treatment. The presence of a detectable viral load does not itself warrant management under these Guidelines, unless there are also behaviours that place others at risk of HIV transmission. People may also demonstrate additional risk reduction strategies (especially where the level of adherence to ART may not be ideal). These strategies may include the use of condoms and lubricant, sexual contact with partners who are taking HIV pre-exposure prophylaxis (PrEP), other safer sex practices and safer injecting drug use practices, including the use of sterile needles and syringes. Additionally, ART also has a role in prevention as post-exposure prophylaxis (PEP). Employing such strategies demonstrates the person's engagement in, and commitment to, reducing the risk of transmission to others.

Therefore the focus of overall prevention efforts should be on the early diagnosis of HIV infection through testing of at-risk individuals, followed by effective clinical care of those with a diagnosed HIV infection and effective management of persons whose behaviours place others at risk of HIV transmission. For people with newly diagnosed HIV infection, service providers should prioritise linking people to treatment and support to reduce infectiousness and increase resilience and reduce their felt stigma.

## SECTION 2 - PRINCIPLES

The Guidelines are based on the following principles and assumptions:

- Management under these Guidelines requires a consistency of approach across all client groups regardless of gender, gender identity, disabilities, mental health diagnoses, sexual practices and orientation, work practices (including sex work), injecting drug use, cultural background and or religious beliefs, in order to maintain transparency, ensure fair treatment and to avoid any implication of stigma or discrimination. Such factors, and HIV positive status, are not in and of themselves markers of risk behaviour 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 ART;
- except in exceptional circumstances, testing for HIV should be conducted on a voluntary basis;
- high adherence to ART, sustained viral suppression, and retention in appropriate ongoing clinical care and treatment monitoring minimise risk of HIV transmission;
- although HIV is a lifelong infection with no cure to date, it is now considered a manageable chronic health condition;
- people with HIV should not be excluded from any activities on the basis of their HIV status;
- restrictive matters such as detention or isolation to manage risk of HIV transmission should be very rarely required measures;
- HIV Advisory Panels should aim to de-escalate or discharge people from management under the Guidelines unless necessary to protect public health;
- every individual has a responsibility to prevent themselves and others from becoming infected with HIV and for preventing further transmission of the virus;
- HIV prevention awareness has been promoted in Australia over decades, including the concept of shared responsibility for the prevention of HIV. However, there is variation across the community in people's level of awareness, acceptance and understanding of the personal risks of acquiring HIV, and shared responsibility for preventing HIV.
- in all relationships a range of factors including cognitive ability and power differences can affect a person's ability to take preventive measures;
- perceived or actual stigma and discrimination, can impact an individual's willingness or ability to disclose their HIV positive status, to engage in care, to commence and/or adhere to treatment, or utilise prevention strategies;
- service providers should provide counselling and support services, including ongoing post-diagnosis counselling, to encourage behaviours 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 behaviours may be placing others at risk of HIV transmission;

- the majority of people with HIV with behaviours that may be placing others at risk of HIV transmission live with complex social, emotional, educational, cultural, intellectual and/or psychiatric factors which affect their daily lives including financial issues, homelessness and drug and alcohol use. The concept of safe behaviours 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 to resolving risk behaviours; and,
- 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.

### **SECTION 3 - APPLICATION OF THE GUIDELINES**

These Guidelines apply when a person with HIV presents a real and immediate risk of HIV transmission and where management of that risk by the person's health care team has been unsuccessful.

Research has shown that people with HIV who take antiretroviral treatment daily as prescribed and achieve and maintain sustained viral suppression have effectively no risk of sexually transmitting the virus to a HIV-negative partner (2-19) and are taking reasonable steps in preventing HIV transmission. Therefore, these Guidelines do not apply.

The presence of a detectable viral load does not itself warrant management under these Guidelines, unless there are also behaviours that place others at risk of HIV transmission.

However, where there is concern that a person with HIV who is engaging in transmission risk behaviours may not be able to maintain sustained viral suppression without close support and case management, public health management may be appropriate.

Reasonable steps in preventing HIV transmission encompass the following: high adherence to ART leading to sustained viral suppression, disclosure, condom use, safer injecting practices, PrEP and retention in appropriate ongoing clinical care and treatment monitoring.

At diagnosis and throughout their continuum of care every person with HIV should be provided with:

- effective clinical management, including access to treatment and monitoring;
- psychosocial support;
- counselling about prevention of transmission of HIV to others, including the role of treatment in reducing the risk of transmission;
- support to ensure that all at risk contacts or partners are identified and tested for HIV; and
- linkage to relevant specialist, community and peer support services.

Clinicians who provide effective management at an early stage and ongoing support are establishing the foundations for patient well-being and prevention of public health risks. In delivering the standard of on-going care clinicians are expected to:

- discuss new partners and risks;
- repeat counselling on prevention strategies including the importance of adherence to treatment;
- seek advice from the nominated public health HIV contact in their state or territory where a patient has a detectable viral load and there is concern about current transmission risks;
- seek advice from the nominated public health HIV contact in the state or territory where a patient has an undetectable viral load and there is concerns about current risk behaviors and the ability to maintain sustained viral suppression; and

- discuss partner notification with the person with HIV, and follow-up in accordance with relevant state and territory protocols.

A variety of strategies may be needed for some people with HIV including assistance with tracing and informing sexual and injecting partners that they may have been exposed, more intensive, individualised case management, assistance with meeting other health and social service needs and an escalating series of behavioural management techniques. This may include counselling, behavioural supervision, formal warnings and public health orders (sometimes referred to as 'directions').

Where a person being managed under these Guidelines is adherent to treatment and has a consistently undetectable viral load, a graded withdrawal of staged public health measures should be undertaken and the need for continued support assessed.

In general, escalation to the more interventionist strategies should not be considered until less restrictive alternatives have been tried and proven unsuccessful. However, there are cases where a step-by-step escalation through the full list of possible strategies will be considered inadequate for the particular situation. The best mix and order of strategies will be determined on a case-by-case basis.

## SECTION 4 - LEGISLATIVE PROVISIONS

While these Guidelines establish a consistent framework for managing people whose behaviours may present a risk of HIV transmission, each state and territory must work within:

- a) Local legislative and policy provisions, particularly;
  - public health and criminal legislation;
  - health information privacy protections;
  - provisions for the exchange of information;
  - human rights legislation, where applicable (e.g. Victorian Charter of Human Rights and Responsibilities); and
  
- b) National Legislation, including;
  - the *National Health Security Act 2007* provides a mechanism for the exchange of information across jurisdictional borders in circumstances where a threat to public health exists;
  - the *Privacy Act 1988* (Commonwealth) contains the Australian Privacy Principles which govern how governments and certain agencies 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; and,
  - the *Disability Discrimination Act 1992* (Commonwealth) outlines human rights protections for all people living with a disability. People living with HIV fall under the ambit of the Act.

It is recommended that legal advice be sought where legislation appears to be in conflict.

## **SECTION 5 - ROLES AND RESPONSIBILITIES**

An effective public health approach to addressing HIV transmission risks requires all relevant sectors, organisations and services to assist in managing issues. Services that may be critical to supporting a person to minimise the risk of HIV transmission include mental health, drug and alcohol, employment, housing, peer support, family services and others.

States and territories should aim to create supportive environments where health promoting messages are clearly and frequently reiterated. These messages should promote access to peer support, treatment uptake, challenge stigma and discrimination and support the principle of mutual responsibility. This messaging should also include consequences of behaviour that places others at risk. The means of HIV prevention (including ART to achieve sustained viral suppression, condoms and lubricants, sterile needles and syringes) should be readily available, along with access to regular health checks, testing, PrEP and PEP for partners.

### *Health Services*

Within health services all entities and professionals have a responsibility to work together. Their roles including the role of the state/territory CHO, health department, HIV Panel, clinical providers, local health services and private practitioners, should be clear.

The nominated state or territory public health HIV contact has responsibility for receiving referrals, and providing advice to clinicians and other healthcare workers. Additionally, mechanisms should be in place to investigate referrals from members of the public. The nominated public health HIV contact may be a public health specialist, sexual health specialist or the Chair of the state/territory HIV Advisory Panel or other delegate.

The designated state or territory authority referred to in these Guidelines may be the CHO, their delegate, or the Chair of the HIV Panel, depending on state or territory legislation, protocols and policies. The designated state or territory authority must be able to make Level 2 and above management decisions under these Guidelines. The nominated public health HIV contact and the designated state or territory authority may be the same person.

Local health services (including clinicians and other health workers in both the private and public sectors) have responsibility for notifying/referring a patient to the nominated public health HIV contact.

Under the continuum of care, clinical service providers should regularly review risks with clients who do not have a sustained suppressed viral load and have behaviours that place others at risk of HIV. Adherence to treatment, in both clients with detectable and undetectable viral loads, should be monitored on a regular basis as per clinical treatment Guidelines.

Clinicians and service providers can seek advice from the public health HIV team, as required.

### *Other Agencies*

Although cross agency communication will commonly occur between individual service providers, an escalated level of communication is appropriate where there are barriers or a need for priority access to a service or resource. The policies of states and territories

should clarify that management of people with HIV with behaviours that pose a real and immediate risk of HIV transmission is a priority.

## **SECTION 6 - EXCHANGE OF INFORMATION**

### **Confidentiality**

Information about a person's HIV status is 'health information' and is protected by Commonwealth, state and territory privacy legislation and, in some jurisdictions, by specific legislation on the disclosure of notifiable disease and HIV-related information.

Health professionals, including those working in public health, have a general duty to protect the confidentiality of a person's personal health information. In general, this information may be shared with others who are involved in the provision of care, treatment or counselling of the person, only if the information is required in connection with providing their care, treatment or counselling, and/or if the person has given their consent for the information to be shared for that purpose.

Protecting the confidentiality of people living with HIV in small communities, including rural communities or within cultural groups, can be a challenge to supporting that person and retaining them in care. Confidentiality is particularly important in this group and may present a safety issue.

### **Disclosure of information**

Limits to the protection of confidential information operate in circumstances where a duty to a third party is owed or where public health, or other relevant, legislation requires the provision of that information.

State/territory health authorities should ensure that health care workers have access to legal guidance on the appropriate circumstances and mechanisms that allow for the disclosure of health information where disclosure is required to manage HIV-related public health risk.

Contact tracing is a critical element of the public health management of people living with HIV. However, the public disclosure of the identity of a person who may have placed others at risk breaches the confidentiality of the person involved, contributes to the stigmatisation of HIV, and should not usually be needed to notify sexual or injecting partners. Public disclosure is not an appropriate strategy for notifying contacts, and should not be needed under normal circumstances.

### **Privacy**

The individual's privacy should be protected when discussing the individual's care with the HIV Advisory Panel, e.g. by using de-identifying names and the age of the person.

### **Inter-jurisdictional Cooperation**

The sharing of case information between clinicians who are, or will be, providing care for the person with HIV is good practice where it supports effective patient management. When a patient relocates it is important to make the person's new clinician aware that engagement with care should be monitored and early links made with the range of services of benefit to that person and for the protection of public health.

Where a state or territory public health authority has reasonable suspicion or knowledge that a person under Level 2 management, has travelled, or is planning extended travel or to relocate to another jurisdiction, the CHO or delegate should consider notifying the relevant jurisdictional CHO, or relevant delegate, about the person. If the person is being managed at Level 2 and has been issued with, or meets the criteria for, a letter of

warning, or anyone at Level 3 or above, then the CHO or delegate must make the referral. All necessary case information, including information that allows the identification of the person, to enable effective public health follow-up should be provided, where legally permitted.

## SECTION 7 - REFERRAL TO POLICE

HIV infection is a manageable, chronic condition due to the availability of effective treatments. However, stigma and discrimination related to the virus still persist.

Prosecution of people for the transmission of HIV, or for risking the transmission of HIV to others, perpetuates and worsens negative stereotypes of people living with HIV. This occurs both within the criminal justice system, including within the police force, and in the general public via media reporting of the prosecution case. Such stereotypes add to HIV stigma and discrimination and reduce the effectiveness of public health programs to reduce HIV transmission by deterring people from being tested for HIV. There is extensive local and international literature which documents the greater public health harms that may be caused by criminalisation of HIV transmission (20-22).

Referral to police should be based on the legal obligations applicable in each jurisdiction, with reference to these Guidelines. From a public health perspective, it is preferable that the referral be based on evidence regarding the person's ongoing behaviour and only occurs after consideration has been given to all options for effective management under these Guidelines.

Where mandatory reporting requirements are not otherwise specified, it is considered best practice for referral decisions to be made by senior public health officials (CHO or delegate), always with legal advice and, where appropriate, in consultation with the Chair of the HIV Panel following discussion with the full HIV Panel.

Where possible a person should be managed under these Guidelines in the first instance. However, where a person continues to act with clear intent to cause harm or with serious disregard for the well-being 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.

State and territory health departments should establish mechanisms for building relationships within local departments of police to strengthen police understanding of contemporary clinical and public health practice to manage and prevent HIV transmission. In addition, states and territories should have in place legislative and/or policy arrangements requiring police to inform their health department of HIV-related complaints, to enable public health measures such as contact tracing to be done. Discussions between health and police departments should include that a public health benefit of prosecution only accrues when the risk of transmission to others is on-going and management under the Guidelines has failed.

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.

A referral to police must not preclude the person to whom the referral relates from continuing to receive support, treatment or the application of public health interventions under these Guidelines.

Individuals referred by the CHO or delegate to the police should be made aware of their legal rights and obligations in each jurisdiction, which may include legislation and regulations that allow them to seek suppression orders in relation to their name, and/or the subject matter of any charges filed against them.

## SECTION 8 - THE MANAGEMENT FRAMEWORK

### Operational Arrangements

Jurisdictions should consider the development of local protocols consistent with the principles of these Guidelines, and adapted to the jurisdiction's legislation and local Guidelines, particularly to give effect to the functions of the HIV Advisory Panel. Local protocols should consider nomination of:

- i) public health HIV contacts to whom clinicians, other service providers and members of the public can direct their concerns about HIV transmission risk behaviours.
- ii) the designated state or territory authority able to make Level 2 and above management decisions under these Guidelines.

The framework for managing people with HIV whose behaviours may be placing others at risk of HIV transmission could include the following levels:

- |          |  |
|----------|--|
| Level 1: | <i>Counselling, education and support</i><br>Management in the community by the person's health care team with the assistance of specialist HIV case workers, as appropriate, and with advice from the nominated public health HIV contact but no formal involvement of the HIV Advisory Panel.  |
| Level 2: | <i>Counselling, education and support under advice from the designated state or territory authority and formal involvement of HIV Advisory Panel</i><br>Management in the community under recommendations from the CHO or delegate and/or the HIV Advisory Panel but without a behavioural order. This may include a formal letter of warning. |
| Level 3: | <i>Management Under behavioural order</i><br>Management under a behavioural order or equivalent. The order may include various measures from Level 1 and/or 2, thereby making them mandatory.  |
| Level 4: | <i>Detention and / or Isolation</i><br>Detention and / or isolation under a detention order and / or an isolation order or equivalent.   |

As the issues covered by these Guidelines are complex, the application of the various levels of management should be flexible, responsive to the circumstances, and not strictly sequential.

## HIV Advisory Panel

Local administration of these Guidelines recommends that each state and territory establishes a HIV Advisory Panel (the Panel). The function of the Panel is to provide expert advice to the CHO or delegate in the discharge of their responsibilities and to provide advice and support to clinicians or other service providers involved in the care of a person whose behaviour may be placing others at risk of HIV infection.

Jurisdictions have the responsibility of establishing a Panel. The Panel should be chaired by a senior medical practitioner with relevant expertise in the relevant field, such as a sexual health physician or a public health physician. Panel membership may include a HIV specialist, HIV community representative, legal policy advisor and/or an ethicist and others co-opted as appropriate for individual cases.

In addition to the permanent members of the Panel, the Chair may consider involving others able to inform the Panel's discussions and/or able to assist in advising about the implementation of Panel recommendations. These participants would be invited where relevant to the individual case discussion and could include people with expert understanding of issues related to culturally and linguistically diverse (CALD) or Aboriginal and Torres Strait Islander people, sex work, drug use, intellectual and/or physical disability, and/or mental health factors. Whenever possible, these experts should themselves be members of the relevant community.

The Panel could also consider inviting an appropriate clinical representative of the case to participate in Panel discussions. This would depend on whether the Panel has an advisory role only, or, as in some jurisdictions, is directly involved in service planning and delivery and therefore may already have the appropriate clinician on the Panel.

Consideration should be given to inviting the client to make direct representation to the Panel, with the support of a client advocate of their choosing. This serves to place Panel deliberations directly into the context of the client's life situation.

The state or territory department of health should consider nominating an appropriate officer to observe Panel meetings. The role of this observer would be clearly articulated in local Guidelines and may usefully include an oversight role to ensure that relevant jurisdictional policies and directives are being adhered to.

The Panel should meet as needed, if there are cases to consider, to receive a report from the Chair of the Panel: on enquiries received, including by the nominated public health HIV contact; on advice provided; and to review the progress of cases being managed under the Guidelines at Level 2 or above. For Levels 2 and 3 the Panel should meet at least every 4 months, and quarterly at Level 4.

Where the nominated public health HIV contact has received no enquiries and no cases are being managed at Level 2 or above, it may be agreed that no meeting of the Panel is required.

Where nominated public health HIV contacts receive referrals from another service provider or a member of the public, they will investigate the referral; take action as appropriate; and report on issues and action to the Panel at its next meeting, if necessary. If significant risk and management issues are involved, the referral will be treated as any other and be escalated to the Panel, as per local protocols.

When the designated state or territory authority decides that an individual should be managed under the Guidelines at Level 2 or above, the case should be reviewed by the HIV Advisory Panel to enable Panel discussion on the case. The Panel should advise on appropriate short and/or longer term follow up, and advise the CHO or delegate.

In advising on the follow up, it is suggested that the Panel should provide recommendations on who is responsible for implementing the Panel's recommendations and actions, and a suggested timeframe for this to occur. These details should be recorded in the minutes of the Panel meeting and/or minutes of Department meetings for use in assessing client progress. Depending on the nature of the recommendations, the individual(s) responsible may be the local clinician, other providers, or the state or territory department of health. A delegated member of the Panel should communicate all recommendations/determined actions to those individual(s) proposed to be responsible for their implementation.

At all stages of management under the Guidelines, clear documentation should be maintained on the rationale for recommendations, and progress made with their implementation.

Case files should be kept according to the records management policies and standards of the state or territory department of health. Unique identifier codes should be used in place of names wherever possible to prevent unnecessary and accidental identification. Administrative officers working with these files should be made aware of legislation and policies relating to the protection of confidential medical information.

## Maintenance, Discharge and Escalation under the Guidelines

It is suggested that, at Level 2 or above, all cases require review at least every four months by the HIV Advisory Panel. At each meeting, the Panel should consider the circumstances of the case, action taken, other relevant information, and provide advice about whether the management of the person is to be maintained, discharged or escalated under the Guidelines.

As outlined in Section 2 - Principles, HIV Advisory Panels should aim to de-escalate or discharge people from management under the Guidelines unless necessary to protect public health.

If the intervention recommended by the Panel is short term, a report back on implementation of the intervention should be considered at the next meeting of the Panel. If the risk issues are resolved, the designated state or territory authority may discharge the individual from under Level 2 or above management in the interim, and report the discharge to the next meeting of the Panel.

If the intervention adopted is longer term, a report should be provided back to the Panel at the next meeting when the case is scheduled for review so that recommendations can be made to the CHO or delegate on whether the person should be discharged from Level 2 or above management, or should remain under their management level.

In determining whether a person should be discharged from management at Level 2 or above under the Guidelines, the designated state or territory authority should consider in the broader deliberations:

- whether actions recommended by the Panel have been implemented and their effectiveness;
- evidence that the person is no longer placing others at risk of HIV transmission; and,
- an assessment of the likelihood that the person will not place others at risk of HIV transmission.

A person of concern who demonstrates sustained viral suppression, adherence to ART and engagement in appropriate ongoing clinical care and treatment monitoring, poses effectively no risk of sexually transmitting HIV.

The presence of a detectable viral load alone does not itself warrant management under these Guidelines, unless there are also behaviours that place others at risk of HIV transmission.

The designated state or territory authority should consider discharging the person from management under the Guidelines taking into account all relevant information. A graded withdrawal of staged public health measures and continued support may be required for persons with complex needs.

Discharge ends the Panel's involvement in the person's management. It is recommended that ongoing management and support of the person continue to occur via the local clinician/service provider. Local services should be reminded of their responsibility to monitor the person's ongoing engagement with HIV care. Services should actively follow up if the person disengages from care. Any loss-to-follow-up and concerns about new public health risks should be raised immediately with the designated state or territory authority.

Where the Panel's assessment of the result of actions taken is that they are ineffective or insufficient in protecting public health, or where there is evidence of increased risk of transmission of HIV to others, the Panel may advise an escalation of action in accordance with the Levels described below.

## SECTION 9 - LEVELS OF MANAGEMENT

### Level One: Counselling, education and support

Level	Suggested Steps	Services to consider	Proposed decision, decision maker and action
<p>Management in the community by the person's health care team with the assistance of specialist HIV case workers, as appropriate, and with advice from the nominated public health HIV contact but no formal involvement of the HIV Advisory Panel.</p>	<ul style="list-style-type: none"> <li>• The person's behaviour has been recognised by the health care provider as demonstrating a degree of risk the provider is concerned about – the person may not seem willing or able to protect sexual or needle-sharing partners.</li> <li>• This should be reported to the nominated public health HIV contact as appropriate for the arrangements in each state or territory.</li> <li>• The health care provider agrees to continue management of the person, at least in the first instance, possibly with follow up and support.</li> <li>• Review action of health care provider if concerns continue.</li> </ul>	<ul style="list-style-type: none"> <li>• HIV Clinical care.</li> <li>• Mental health and alcohol and other drug services as needed.</li> <li>• Counselling, education.</li> <li>• Contact tracing as appropriate</li> <li>• Support services, housing.</li> <li>• Peer support/navigation services where available.</li> <li>• Referral to case management services, if available.</li> </ul>	<ul style="list-style-type: none"> <li>• Decision is not to admit to management at Level 2 or above under Guidelines at this initial stage.</li> <li>• Made by the nominated public health HIV contact (depending on individual jurisdictional protocols), in consultation with treating clinician.</li> <li>• Nominated public health HIV contact makes note of conversation. The advice is tabled at next meeting of HIV Advisory Panel for noting.</li> <li>• In cases where there is no suitable health care provider, identify solutions.</li> <li>• Where the person is refusing to engage with their health care provider after exploration of all options to support engagement, refer the case to the HIV Advisory Panel to seek advice on whether Level Two management is required.</li> </ul>

## Level One Counselling, education and support

*Management in the community by the person's health care team with the assistance of specialist HIV case workers, as appropriate, and with advice from the nominated public health HIV contact but no formal involvement of the HIV Advisory Panel.*

While the information below provides a management framework, all issues of concern need to be dealt with on a case-by-case basis.

The preferred first steps in managing a person that has been recognised as demonstrating HIV transmission risk behaviours, are to provide counselling, education and support. Every effort should be taken to address any gaps in service delivery to support retention in care and adherence to HIV treatment.

It is important that service providers and local clinicians are able to seek advice from the nominated public health HIV contacts, without needing to provide identifying information. Although complex or serious issues will be referred on to the designated state or territory authority, generally where an issue is raised with the nominated public health HIV contact (i.e., Level 1 of these Guidelines) this will not automatically lead to the person being formally managed under the Guidelines at Level 2 or above. Case discussion with the nominated public health HIV contacts may lead to the provision of management advice or linkage with other professionals able to provide care and support.

In the first instance, the consent of the individual concerned should be sought to discuss their specific (identifiable) care with other providers and make appropriate confidential referrals. The individual's concerns about privacy and confidentiality can be addressed at this point.

If a clinician is not aware that a person under their care has been demonstrating HIV transmission risk behaviours, the jurisdiction should consider disclosure to the clinician, ideally with consent of the client.

Usually the person's local clinician is best placed to support HIV treatment adherence. In all instances local clinicians/service providers should remain active in the person's management. Where a local clinician has limited capacity and resources to manage a situation, alternative arrangements should be organised or secondary consultation and support to the local clinician. If a local clinician is not involved, the public health unit should ensure that their client receives the required support. Other service providers may also need to be involved.

Where the person involved has complex needs associated, for example, with cognitive impairment, mental health or alcohol and other drug problems, specialist tertiary services should be involved in the person's assessment and management. A case conference of service providers can be useful in developing a plan. Regular and intensive counselling with an experienced sexual health/HIV counsellor may be required.

Where possible a community organisation with HIV expertise should be involved to provide peer support to the person. Peer-based support and education is a demonstrated evidence-based activity that can provide assistance to persons coping with a diagnosis of HIV infection, disclosing their HIV status to others and understanding

and preventing HIV transmission risks. Such a referral must be confidential and with the consent of the individual.

On-going contact tracing in accordance with appropriate ethical and legal standards, including local protocols, as applicable in each jurisdiction, is also an essential element in the management of people with HIV who place others at risk.

## Consideration of escalation to Level 2

In determining whether to accept the person for management under the Guidelines at Level 2 or above, the designated state or territory authority will consider a range of matters including:

- the nature of the information provided, including the imminence of risk to the public;
- adherence to ART and capacity to adhere to ART;
- the credibility of the source and the information provided, including the basis for concluding that the person has HIV and is placing others at risk;
- any inquiry made by the nominated public health HIV contact or their nominee about the information provided and the outcome;
- the presence of a viral load above 200 copies/mL together with an assessment of the alleged risk; with consideration of other risk reduction strategies such as condom and lubricant use that attempts to reduce potential harm, and whether the person was aware that there was a real and immediate risk of transmission;
- the degree of consent by the partner(s); including whether the partner made inquiries about status, or the partners discussed HIV status at all, and whether the partner was on PrEP;
- the person's capacity or competence (or lack thereof) and co-morbidities (such as problematic drug or alcohol use or mental health presentations) and the impact of these on their behaviours;
- consideration of the range of social, economic and cultural factors impacting self-management of HIV diagnosis;
- the range and sufficiency of steps taken by the local clinician/service provider to manage the person's behaviours, and the prior involvement of appropriate services; and,
- the likelihood of ongoing actions under Level 1 management successfully reducing potential for public health risk.

Where there are barriers to the person engaging with services, every effort should be made to find solutions, such as providing transport and access to telehealth for people in rural and remote areas, telephone translators or translators from outside their community, or travel to neighbouring local areas to avoid identification in clinics.

## Level Two: Counselling, education and support under advice from HIV Advisory Panel

Level	Suggested Steps	Services to consider	Proposed decision, decision maker and action
<p>Management in the community under recommendations from the designated state or territory authority on advice from HIV Advisory Panel, but without a behavioural order.</p>	<ul style="list-style-type: none"> <li>No satisfactory reduction in risk after Level One management by health care team and the person is referred by the designated state or territory authority to the HIV Advisory Panel.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Agreement between the designated state or territory authority and health care provider that Level Two is appropriate initial management.</li> </ul>	<ul style="list-style-type: none"> <li>Psychiatric and medical assessments may be required if not previously obtained.</li> <li>Contact tracing as appropriate.</li> </ul> <p>Detailed recommendations on case management, including behavioural management or other services if indicated.</p> <ul style="list-style-type: none"> <li>Peer support/navigation services where available, and where the client is willing to accept.</li> <li>Initiation of next steps on basis of local legislation / policy in the event of non-compliance.</li> <li>Referral to social and community services as needed (housing, AOD treatment, etc).</li> </ul>	<ul style="list-style-type: none"> <li>Recommendation is to admit to management at Level 2 under the Guidelines.</li> <li>Made by designated state or territory authority, in consultation with health care provider/team.</li> <li>Convene HIV Advisory Panel for case review.</li> <li>HIV Advisory Panel considers case and provides written advice about management to the CHO and/or the health care provider/team.</li> <li>Consider need for appointment of a representative advocate for the person, if available.</li> <li>Considering issuing a <b>letter of warning</b> from the CHO or their delegate, to the person, formally advising them of their responsibilities and that their behaviour has come to the attention of, and is being monitored by, public health authorities, including across jurisdictions, if the person travels or relocates.</li> <li>Consider options for management under Mental Health Act, Guardianship Act, etc.</li> <li>Regular review by Panel for maintenance, discharge or escalation under Guidelines at not greater than four monthly intervals.</li> <li>Consider a letter of warning that next step may include a behavioural order.</li> </ul>

## Level Two: Counselling, education and support under advice from HIV Advisory Panel

*Management in the community under recommendations from the designated state or territory authority on advice from the HIV Advisory Panel but without a behavioural order. This may include a formal letter of warning.*

Where more assertive management is required the designated state or territory authority can make the decision to manage the person under the Guidelines at Level 2 or above.

Where possible, and appropriate, the individual concerned should be advised that the HIV Advisory Panel will discuss their care. In some situations, these discussions may need to be held without the individual's knowledge or consent. Appropriate documentation should be maintained in all circumstances.

The local clinician, with other service providers involved in the person's care should remain the central point of management in the case of longer-term interventions, it may be appropriate that public health, case management and clinical care functions are separated.

The CHO, their delegate, or the HIV Advisory Panel should fully review all aspects of each case. The Panel may be able to provide further guidance to local health care providers on the person's management. A multi-disciplinary case conference should be convened to develop a case management plan. A full medical examination, including a psychosocial assessment, may also be appropriate at this stage.

At Level 2 the Panel may recommend that the CHO or delegate issues a letter of warning noting that: the person's behaviours have been officially brought to the attention of the Department; specifies the responsibilities of the person with respect to their HIV infection; and identifies the expected changes in behaviours. In some cases, the letter of warning may be sufficient to prompt behaviour change. The letter should also again indicate where the individual can access support and resources to help them manage their HIV.

Written reports on the follow up of individuals managed under the Guidelines at Level 2 or above should be provided by the relevant clinician or case manager and considered by the Panel at each of its regular meetings.

### **Consideration of escalation to Levels 3 or 4**

Escalation to higher levels of management and the resulting restrictions and other requirements placed on a person, even though more directive, are intended to facilitate behaviour change. They should be approached as supportive measures rather than as a penalty or punishment.

## Level Three: Management under a Behavioural Order

Level	Suggested Steps	Services to consider	Proposed decision, decision maker and action
<p>Management under behavioural order or equivalent.</p> <p>At Level Three, specific powers that may be exercised include:</p> <ul style="list-style-type: none"> <li>• to order a person to undergo counselling;</li> <li>• to order a person to undergo treatment;</li> <li>• to order regular testing;</li> <li>• to order a person to refrain from specified behaviour or activities; and,</li> <li>• to order a person to be subject to supervision.</li> </ul>	<ul style="list-style-type: none"> <li>• Advice from HIV Advisory Panel to CHO or delegate following client assessment.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>• Urgent referral of case to designated state or territory authority.</li> </ul> <p>In both cases it is recommended that legal advice is obtained</p>	<p>Same range of services as Level Two but in addition:</p> <ul style="list-style-type: none"> <li>• Restrictions on behaviour or movement and/or order to participate in treatment and comply with behavioural requirements as specified in behavioural order.</li> <li>• Supervision and public health monitoring as required.</li> <li>• Initiation of next step on basis of local legislation/policy in the event of non-adherence with behavioural order.</li> </ul>	<ul style="list-style-type: none"> <li>• Implementation of a behavioural order or equivalent.</li> <li>• Made by CHO or delegate considering advice from Chair of HIV Advisory Panel following Panel deliberations and legal advice.</li> <li>• Avenue of appeal to administrative review mechanism or similar, is available and has been communicated to the person that is subject to the order.</li> <li>• Communication of behavioural order and its requirements to person together with offer of support and advocacy services.</li> <li>• Consider options for management under Mental Health Act, Guardianship Act, etc.</li> <li>• Trigger next steps in the event of non-adherence.</li> <li>• Regular review by Panel and advice to CHO or delegate regarding continuation or otherwise of Order, and maintenance, discharge or escalation under Guidelines at not greater than four monthly intervals.</li> <li>• Consider issuing correspondence indication that the next step may include a detention and/or isolation order.</li> </ul>

### Level Three: Management under a Behavioural Order

*Management under a behavioural order or equivalent and may include various measures from Level 1 and/or 2.*

Where a behavioural order or equivalent is recommended by the Panel as the appropriate course of action, the advice to the CHO or delegate should include the legislative provisions under which the action is recommended, the specific requirements for inclusion in the order, and justification for the advice.

An effective process should be in place for urgently communicating the advice from the Panel to the CHO, and the CHO or delegate should consider this advice as a matter of urgency.

Depending on the jurisdiction, the Panel or the CHO or delegate will advise on modification of the behavioural order when satisfied that the modification can be achieved without harm to the community.

The person to whom the behavioural order applies must be informed of the order and its implications, including the penalties for breaching the order, and the mechanisms for appeal, verbally and in writing, as appropriate to the jurisdiction.

A person may seek independent review of their behavioural order through the administrative appeals process or a similar mechanism available in their relevant jurisdiction. Arrangements should be made to assist the person to have appropriate advocacy and legal representation in the forums in which the order is made.

The person being subject to a behavioural order should have access to appropriate peer representation and should be made aware of this right. It is recommended that the person be advised that they may wish to consider seeking legal advice.

Written reports of follow-up of those managed under the Guidelines at Level 2 or above should be considered by the Panel at each of its regular meetings.

## Level Four: Detention and/or Isolation

Level	Suggested Steps	Services to consider	Proposed decision, decision maker and action
<p>At Level Four, specific powers that may be exercised include:</p> <ul style="list-style-type: none"> <li>to order a person to be subject to isolation; and,</li> <li>to order a person to be subject to detention.</li> </ul>	<ul style="list-style-type: none"> <li>Following advice from HIV Advisory Panel to CHO or delegate.</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Urgent referral of case to CHO or delegate by the Chair of HIV Advisory Panel.</li> </ul> <p>In both cases it is recommended that legal advice is obtained.</p>	<ul style="list-style-type: none"> <li>Detention in secure premises.</li> <li>Isolation in an appropriate facility.</li> <li>Full range of counselling, treatment and support services as required.</li> <li>Medical / psychological examination at intervals as specified by legislation, administrative or judicial body to ensure wellbeing of individual and that the order remains relevant.</li> </ul>	<ul style="list-style-type: none"> <li>Decision to implement a detention order and/or an isolation order, as per jurisdictional mechanism.</li> <li>Made by CHO or delegate considering advice from Chair of HIV Advisory Panel following Panel deliberations and legal advice.</li> <li>Mandatory review by administrative review mechanism or similar based on jurisdictional processes and access to avenue of appeal.</li> <li>Communication of order and its requirements to person together with offer of support and advocacy services.</li> <li>Consider options for management under <i>Mental Health Act, Guardianship Act</i>, etc.</li> <li>Regular review by Panel and advice to CHO or delegate regarding continuation or otherwise of order, and maintenance, discharge or escalation under Guidelines at least quarterly.</li> </ul>

## Level Four: Detention and/or Isolation

*Detention and / or isolation under a detention order and / or an isolation order or equivalent.*

Detention and isolation is a strategy of last resort. It has rarely or never been implemented in most jurisdictions and is expected to continue to be a rare event.

If detention and/or isolation are imposed on an individual, state and territory Departments' of Health should utilise a secure and appropriate facility where individuals placed under such an Order can be accommodated.

Where the person is already detained under a custodial sentence, the specific circumstances of implementing the order should consider:

- client confidentiality, legal and safety issues; and
- other issues that need to be negotiated with the state and territory departments responsible for carrying out the custodial sentence.

Written reports of follow-up of clients managed under the Guidelines at Level 2 or above should be considered by the Panel at each of its regular meetings. This will require liaison with the providers of secure detention services as appropriate.

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## Glossary

ART – Antiretroviral Therapy

CHO – Chief Health Officer

HIV Advisory Panel (the Panel) – state/territory specific Panel responsible for providing expert advice to clinicians and/or other HIV support service providers and the CHO on strategies to minimise transmission risks.

Nominated public health HIV contact - the nominated public health HIV contact may be an identified position in the state or territory Department of Health or Public Health Unit or the Chair of the HIV Advisory Panel.

PEP – Post-Exposure Prophylaxis

PrEP – Pre-Exposure Prophylaxis

TasP – Treatment as Prevention

Viral suppression – undetectable viral load or a viral load of less than 200 copies/mL