Government of **Western Australia**
Department of **Health**

Guidelines for Managing HIV Transmission Risk Behaviours in Western Australia

2022

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Enquiries about this document should be referred to:

The Manager
Sexual Health and Blood-borne Virus Program
Communicable Disease Control Directorate
Level 3, A Block, 189 Royal Street
EAST PERTH WA 6004
Tel: (08) 9222 2235
Fax: (08) 9222 0227
Email: shbbvp@health.wa.gov.au

Document control

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1.0	June 2020	June 2022	Original version
2.0	July 2022	July 2025	Policy review and minor amendments to supporting information guidelines.

Contents

1. Definitions

ART	antiretroviral therapy
Authorised officer	a person designated to undertake duties under section 24 of the *Public Health Act 2016*
CDCD	Communicable Disease Control Directorate, WA Department of Health
CHO	Chief Health Officer designated under section 11 of the *Public Health Act 2016*
CMO	Case Management Officer from the ICMP
Department	Department of Health, Western Australia
Director, CDCD	Director of the Communicable Disease Control Directorate
DOT	directly observed therapy
GP S100 prescriber	a general practitioner qualified to subscribe HIV medications
Health professional	Health practitioners that may include but no limited to general practitioners, medical specialists, nurses, Aboriginal health workers/practitioners, social workers, psychologists.
Health Services Act 2016	*Health Services Act 2016*
HIV	human immunodeficiency virus
Health Service Provider	Health Service Provider as set out in section 6 of the *Health Services Act 2016*
ICMP	Integrated Case Management Program
MCDC	Metropolitan Communicable Disease Control, North Metropolitan Health Service
Minister	Minister for Health
National Guidelines	*National Guidelines for Managing HIV Transmission Risk Behaviours (2018)* published by the Department of Health, Commonwealth
Panel	Case Management and Coordination Advisory Panel known as the Case Management Advisory Panel, established by the CHO under section 144 of the *Public Health Act 2016*
PCH	Perth Childrens' Hospital
PHU	population health unit. 'PHUs' refers to regional PHUs, unless stated otherwise
Post-exposure prophylaxis	taking appropriate medication as prescribed by a doctor following exposure to HIV to reduce the risk of HIV transmission
PrEP or pre-exposure prophylaxis	taking appropriate medication as prescribed by a doctor prior to potential exposure to HIV to reduce the risk of HIV infection
Public Health Act 2016	*Public Health Act 2016*
SAT	State Administrative Tribunal
The Guidelines	this document entitled *Guidelines for Managing HIV Transmission Risk Behaviours in Western Australia* (2020)
WAAC CMOs	WAAC (formerly known as the WA AIDS Council) Case Management Officers
WAPOL	WA Police

2. Introduction

Human immunodeficiency virus (HIV) transmission is preventable. Additionally, there are a range of potential strategies to reduce transmission.

Integrated case management provides an approach to managing HIV transmission risks among people with HIV who have been identified as placing others at risk of HIV transmission. Under this approach, measures are used to address all of the biopsychosocial aspects of a person's life to reduce the transmission of HIV. The measures include counselling, education, medical treatment, providing social support and linkages with relevant organisations and if required, Test Orders or Public Health Orders, which may include detention and/or isolation conditions.

The main aim of integrated case management is to enable people with HIV to achieve a sustained undetectable viral load to prevent HIV transmission. This can be achieved via adherence to treatment and regular viral load testing.

The *Guidelines for Managing HIV Transmission Risk Behaviours in Western Australia* (2020) (the Guidelines) provide a consistent approach to HIV integrated case management in Western Australia (WA). The Guidelines are not mandatory for Health Service Providers but inform and/or support the implementation of MP 0137/20 *Managing HIV Transmission Risk Behaviours Policy*. The Guidelines are based on the four-level management program set out in the *National Guidelines for Managing HIV Transmission Risk Behaviours* (2018) (the National Guidelines) and on the current best-practice evidence-based management of HIV. Preference is given to the least restrictive approach that will be the most effective in the circumstances. Integrated case management in WA is primarily undertaken by the Integrated Case Management Program (ICMP) team in the metropolitan area and by population health units (PHUs) in the regions.

The National Guidelines do not apply to people with HIV who are undertaking antiretroviral therapy (ART) and maintaining a sustained undetectable viral load, as these people are taking reasonable steps to prevent HIV transmission and the risk of sexual transmission of the virus to their HIV-negative sexual partners is negligible[1].

The presence of a detectable viral load does not in and of itself warrant management under the Guidelines. However, where there is concern that a person with HIV may not be able to maintain sustained viral suppression without close support and case management, and is engaging in transmission risk behaviours, management under these Guidelines may be appropriate.

The Guidelines are subordinate to the *Public Health Act 2016* (and any other applicable legislation). Where the Guidelines refer to provisions of the Public Health Act (or any other legislation) it is not, and is not intended to be, a substitute for the relevant act.

3. Application of the Guidelines

The purposes of the Guidelines are to identify and explain the roles and responsibilities of various State and private entities in respect of managing a person with HIV who is placing others at risk of HIV transmission:

a) ensure a consistent approach to the integrated case management of HIV in WA;
b) set out the four levels of management under these Guidelines for managing a person with HIV who is placing others at risk of HIV transmission; and
c) identify the process by which a person is managed, and discharged from management, under these Guidelines.

[1] Centers for Disease Control and Prevention. *Evidence of HIV Treatment and Viral Suppression in Preventing the Sexual Transmission of HIV* [factsheet], 2018. https://www.cdc.gov/hiv/pdf/risk/art/cdc-hiv-art-viral-suppression.pdf

4. Guiding Principles

The Guidelines are based on the following principles and assumptions:

- Regardless of gender, gender identity, disabilities, mental health diagnoses, sexual practices and orientation, work practices, including sex work, injecting drug use, cultural/ethnic background, and religious beliefs, a consistent approach is required for each person with HIV being managed under these guidelines to maintain transparency, ensure fair treatment and avoid any implication of stigma or discrimination;
- A HIV-positive status is not itself a marker of risk behaviour nor are the factors listed above;
- HIV is a human retrovirus; transmission is possible through unprotected sexual contact or blood-to-blood contact with a person infected with HIV; for example, through contact from sharing injecting equipment or during pregnancy and delivery. The transmission of HIV relies on a detectable viral load being present;
- HIV transmission is preventable and there are a range of potential strategies to reduce transmission risk, including treatment as prevention (adherence to ART with a demonstration of a sustained undetectable viral load), barrier protection (condoms and water-based lubricant), pre-exposure prophylaxis (PrEP), post-exposure prophylaxis, and the provision of clean injecting equipment to minimise the risk of transmission via the sharing of injecting equipment;
- Under the Public Health Act, HIV is defined as a "notifiable infectious disease." This means that medical practitioners, nurse practitioners, and pathologists are required to notify the Chief Health Officer (CHO) if they form the opinion that a patient has or may have HIV;
- HIV is a lifelong infection with no cure; however, it is now considered a manageable chronic health condition;
- High adherence to ART, sustained viral suppression, retention in appropriate ongoing clinical care with treatment monitoring, and prevention measures (e.g. the use of condoms and water-based lubricant, and sterile injecting equipment) minimise the risk of HIV transmission;
- 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;
- There is a mutual obligation for both a person with HIV and a person who is at risk of contracting HIV to take all reasonable precautions to avoid disease transmission;
- Efforts should be made by health professionals to address perceived or actual stigma and discrimination to improve a person's willingness or ability to engage in medical management and use prevention strategies;
- 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 with HIV who are placing others at risk of HIV transmission often have complex psychosocial issues, such as problematic drug and alcohol use, or have coexisting comorbidities that may affect their ability to manage transmission risk behaviours. These factors should be identified and a multidisciplinary management approach should be adopted to provide adequate support to these people whilst being managed under these Guidelines; and
- Principles of procedural fairness will be applied with when considering and managing a case.

5. Public Health Risks

Under Part 9 of the Public Health Act, there is a mutual obligation for both a person with HIV and a person who is at risk of contracting HIV to take reasonable precautions to avoid disease transmission.

The Department of Health, Western Australia (the Department) has set out what it considers to be "reasonable precautions" to prevent HIV transmission in the *Fact Sheet Public Health Act 2016 (WA); Part 9 Notifiable Infectious Diseases and Related Conditions; Understanding 'Reasonable Precautions'*.

6. Management of a Person with HIV under the Guidelines

A person with HIV is managed under these Guidelines when there is a risk of HIV transmission to other people and where the initial management of that risk by the person's HIV clinical team, primary health care provider, or PHU has been unsuccessful. This includes people who are unable to maintain sustained viral suppression without close support and case management and who are placing others at risk of HIV transmission.

The decision to manage a person under these Guidelines usually occurs when there is an interplay of various factors. The presence of one or more factors will not necessarily lead to management under these Guidelines. Each decision to manage a person under these Guidelines is made on a case-by-case basis. The following is a non-exhaustive list of factors that may be considered when deciding whether a person should be managed under the Guidelines:

- Non-adherence to ART, as evidenced by an inability to demonstrate a sustained undetectable viral response;
- Non-engagement with the relevant health services and non-attendance at HIV clinic or prescriber appointments with a general practitioner qualified to subscribe HIV medications (GP S100 prescriber);
- The existence and nature of an allegation of HIV transmission, including a consideration of the credibility of the source;
- The imminence of the risk to the public;
- Non-adherence to other risk reduction strategies, such as the use of condoms and lubricant;
- A level of awareness that a behaviour could lead to the risk of transmission;
- Other comorbidities and psychosocial concerns (e.g. problematic alcohol and drug use) that may affect a person's behaviours;
- A person's ability to self-manage the HIV diagnosis;
- The interventions that have already been tried (without success) by the person's HIV clinical team; and
- The person is placing other people at risk of HIV transmission through other lifestyle factors.

7. Roles and Responsibilities

7.1 Communicable Disease Control Directorate, Department of Health, Western Australia

The Department of Health is the department that is principally assisting the Minister for Health (the Minister) in the administration of the Public Health Act and the *Health Services Act 2016*.

The Communicable Disease Control Directorate (CDCD) is an administrative unit of the Department, falling within the Public and Aboriginal Health Division, that is responsible for the prevention, control, and monitoring of notifiable infectious diseases.

The CDCD staff administer the ICMP and comprise the Director of the CDCD (Director, CDCD), the Manager of the ICMP team, and Case Management Officers (CMOs) of the ICMP team (see Section 7.2 below); all of whom are based in the Perth metropolitan area.

The Director, CDCD is the delegate of the CHO, and is able to exercise the delegated powers and functions in accordance with the Public Health Act.

7.2 The Integrated Case Management Program Team

The ICMP is a program within the CDCD. It was established in 1991 by the Director, CDCD and aims to prevent the risk of HIV transmission by individuals who place others at risk of HIV infection.

The daily administration of the ICMP is undertaken by the ICMP team, which includes the Manager of the ICMP (who is also the Manager of the Sexual Health and Blood-borne Virus Program) and the CMOs.

The Manager, ICMP works under the direction of the Director, CDCD to gather the information required to make decisions about the people being managed under these Guidelines and to implement these decisions.

The ICMP team:

- accepts referrals from all health professionals or members of the community who are concerned about people with HIV because their behaviour is placing, or has placed, others at risk of HIV infection;
- undertakes the integrated case management of people referred to the ICMP team who are located within the Perth metropolitan area (whether permanently or temporarily); and
- works collaboratively with regional PHUs in WA to assess and plan the care for people located outside of the metropolitan area, who are being managed under these Guidelines. Regional staff are responsible for the day-to-day management of these people.

The ICMP team can be contacted at any time for advice or support; any such contact will not automatically lead to a person being managed under these Guidelines or by the ICMP team. The ICMP team may assist with referrals to other agencies or professionals who are better placed to provide support.

The role and responsibilities of the ICMP team for managing a person under the four-level management program is discussed in more detail in Part 10 of these Guidelines.

7.3 The Chief Health Officer

The CHO is a person designated as such by the Minister and who has a number of functions in relation to the administration of the Public Health Act.

The CHO is responsible for developing and implementing policies and programs to achieve the objectives of the Public Health Act. The Guidelines are a supporting document to one of those policies under the Health Services Act. The CHO established the Case Management Advisory Panel (the Panel) (see Section 7.4 below) and receives advice from the Panel regarding the management of people with HIV under the ICMP. The CHO is responsible for providing advice or recommendations to Health Service Providers and relevant agencies on matters relevant to public health. The CHO may consider the Panel's advice on public health management of an individual.

The CHO is the officer to whom notification of a person who has, or may have, HIV must be given.

The CHO may delegate any of the CHO's functions under the Public Health Act to a public health official.

7.4 Case Management Advisory Panel

The Panel was established by the CHO under section 144 of the Public Health Act.

The membership of the Panel comprises:

- The Director, CDCD (Chairperson);
- The Manager, ICMP;
- CMOs, ICMP;
- A Medical Adviser, CDCD;
- A Legal Adviser, State Solicitor's Office;
- A Community Adviser, WAAC; and
- An advocate, Health Consumer's Council WA.

The Panel may seek additional expertise and services in relation to specific people, including the expertise and services of a HIV specialist doctor, GP S100 prescriber, regional public health physician, or other specialist.

The function of the Panel is to advise the CHO on the management of a person living with HIV, who is placing others at risk of HIV transmission. The Panel provides independent, expert advice to the CHO on the management of cases referred to the ICMP team that are classified as Level Two or higher.

The Panel meets at least once every six months to review the cases managed by the ICMP team. The Panel also has the capacity to convene at short notice in the event of an urgent case. All advice to the CHO, including recommendations and their rationale, will be documented in the Panel's meeting minutes.

During the case review process, the Panel may seek information from the PHU and/or the HIV clinical team to inform its case management recommendations.

7.5 Population Health Units

PHUs undertake various public health duties, including the public health management of notifiable infectious diseases.

In WA, regional PHUs undertake integrated case management duties for people with HIV, who are managed under these Guidelines within their region. PHUs consist of multidisciplinary teams that include a public health physician and public health nurse(s) and may also include a case management officer or Aboriginal Health Worker.

PHUs may obtain advice from the ICMP team at any time; this may lead to the ICMP team recommending that the PHU refer a person to the ICMP team. Referrals to the ICMP team for integrated case management are made using the ICMP referral form (see Section 11.2 Referral to the ICMP Team below). After a person has been referred to the ICMP team, the PHU will undertake integrated case management duties and the ICMP team will provide advice and support in an advisory role. The ICMP team will also coordinate the case reviews that will be conducted by the Panel.

Metropolitan Communicable Disease Control (MCDC), the Perth metropolitan PHU, do not undertake integrated case management duties, but may assist with tasks on a case-by-case basis.

7.6 The HIV Clinical Team

A HIV clinical team may comprise:

- HIV specialist doctors; and/or
- GP S100 prescribers; and/or
- Nurses, social workers, and other allied health professionals in some metropolitan tertiary hospitals; and/or
- Peer educator, where available and agreed by the client.

Along with primary health care providers, the HIV clinical team is often the first point of contact for people with HIV who commence management under these Guidelines. The HIV clinical team are responsible for regularly reviewing the HIV transmission risks of people with HIV:

a) who do not have a sustained undetectable viral load and engage in behaviours that intentionally place others at risk of HIV; and
b) who have an undetectable viral load, but who engage in HIV transmission risk behaviours in circumstances in which there is a concern about their ability to maintain a sustained undetectable viral load.

In such circumstances, the HIV clinical team is encouraged to seek the advice of the ICMP team.

A person's HIV viral load and adherence to treatment should be monitored regularly by the HIV clinical team. The frequency of monitoring should be determined on a case-by-case basis as per the national HIV management recommendations[2]. The HIV clinical team should regularly discuss new partners with people with HIV, offer testing for other sexually transmissible infections, discuss ways to manage HIV transmission risks, and provide counselling on prevention strategies. The frequency of such discussions should be determined on a case-by-case basis, but should occur at a minimum of once every six months. The HIV clinical team may also provide assistance with access to treatment, psychosocial support, counselling, and linkages to services, including specialist and community services.

The HIV clinical team is responsible for identifying people with HIV who are placing others at risk and liaising with the ICMP team. Referrals to the ICMP team for integrated case management are made using the ICMP referral form (see Section 11.2 Referral to the ICMP Team).

The HIV clinical team may assist in the implementation of interventions relating to integrated case management as directed by the CHO or a delegate of the CHO, as agreed and to the extent that doing so falls within the scope of its duties.

7.7 Primary Health Care Providers

Primary health care providers include general practitioners who are not S100 prescribers, Aboriginal medical services, and other primary health care services. These providers operate under a shared care model, under which they may undertake medical management duties that do not relate to HIV.

There may be some overlap among the duties performed by the ICMP team, PHUs, the HIV clinical team, and primary health care providers, including those related to coordinating referrals to other specialists (e.g. mental health and alcohol and drug services), assisting with access to housing or support accommodation, obtaining home care support, organising blister packs. and providing assistance with forms.

[2] Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine. *Plasma HIV-1 RNA (Viral Load) and CD4 Count Monitoring*, 2018. http://arv.ashm.org.au/plasma-hiv-1-rna-viral-load-and-cd4-count-monitoring/

8. Confidentiality, Disclosure, and Exchange of Information

8.1 Confidentiality

Health professionals in WA are subject to obligations of confidence in respect of a patient's health and medical information (which includes a person's HIV status).

The protection of confidentiality in small communities, including rural communities, or within cultural and social groups is especially important if a person is to be supported and is to remain living within the community.

The MP 0010/16 *Patient Confidentiality Policy* provides a broad overview of the common law duty of confidentiality, the exceptions to that duty, and the statutory duty of confidentiality and permissible disclosures introduced by the Health Services Act. The *Patient Confidentiality Policy* is binding on Health Service Providers and applicable to the Department.

In addition to the Health Services Act, which is expressly referred to in the *Patient Confidentiality Policy*, the Public Health Act contains an obligation of confidence and authorises disclosure of information in specified circumstances.

All health professionals (whether working within the Department, employed by a Health Service Provider, or other) must comply with any other applicable policies in relation to confidentiality.

8.2 Disclosure

It is the responsibility of the person making a disclosure to ensure that the disclosure is permitted or authorised. Health professionals involved in the management of people under these Guidelines should seek guidance from the relevant Health Service Provider or the Department in relation to the appropriate circumstances and mechanisms that authorise the disclosure of health information. Health Service Providers and Department officers should consider consulting the Director, CDCD before disclosing any information.

In circumstances in which disclosure is required to manage public health risks related to the prevention of HIV transmission, it is recommended that legal advice be sought before making a disclosure.

8.3 Privacy

Non-government health professionals may be subject to obligations under the *Privacy Act 1988*.

8.4 Exchange of Information

Any exchange of information should be undertaken in accordance with Sections 8.1 and 8.2 of these Guidelines and with the consent of the person where possible.

8.4.1 Interjurisdictional

If a person under the management of these Guidelines intends to relocate interstate, the ICMP team or the PHU should share appropriate case management information with the receiving HIV clinical team to continue to provide best-practice care. Such information should include an indication as to whether the person needs support to access any additional services.

In circumstances in which there is a reasonable belief or knowledge that a person being managed under these Guidelines has travelled or intends to travel to another State or Territory, and where deemed necessary, the CHO should notify the public health authority of that State or Territory of the person's HIV status and any statutory actions that have been taken. The Public Health Act provides a mechanism for the recognition of Public Health Orders that are made under a corresponding law of another State or Territory.

8.4.2 Intrastate

Where a person under the management of the Guidelines moves to another region within WA, the ICMP team should refer that person to the receiving regional public health doctor for ongoing case management. The ICMP team should provide the receiving regional public health doctors with all of the relevant details necessary for ongoing management.

Where a person under management of the Guidelines moves to a metropolitan area, the PHU should provide the ICMP team with all of the relevant details necessary for ongoing management.

8.4.3 Referral to Police

In some situations, people who expose others to HIV infection may be referred to the WA Police (WAPOL) and prosecuted for offences under the *Criminal Code Act Compilation Act 1913*. When this occurs, under these Guidelines, investigation(s) by the WAPOL take precedence over management until the legal proceedings are complete. However, support by the ICMP team for such people continues during this process as appropriate.

Sections 10.5.3 and 10.6.2 of these Guidelines address the involvement of WAPOL in enforcing orders made under the Public Health Act as contemplated by management under Levels Three and Four, respectively.

9. Legislative Provisions

9.1 The Public Health Act 2016

The Public Health Act is an act to protect, promote and improve the health and wellbeing of the WA public.

Of the Public Health Act, Parts 3, 4 and 9 (with the exception of Division 8) are the most relevant to the management of people with HIV.

Part 3 of the Public Health Act imposes a general duty on all persons to take all reasonable and practicable steps to prevent or minimise any harm to public health that might foreseeably result from anything done or omitted to be done by that person.

Part 4 of the Public Health Act creates offences relating to “serious public health risks” and “material public health risks” and imposes substantial penalties for such offences (including imprisonment). Proceedings for an offence may be commenced by the CHO or an authorised officer and may be commenced in addition to any action taken under Part 9 of the Public Health Act or by a referral to WAPOL.

Part 9 of the Public Health Act sets out a framework for the management of notifiable infectious diseases and notifiable infectious disease–related conditions. It uses four common public health tools that:

a) impose an obligation on medical practitioners, nurse practitioners, and pathologists to notify the CHO of notifiable infectious diseases and notifiable infectious disease–related conditions;
b) provide for Test Orders to be made compelling a person to submit to testing;
c) provide for Public Health Orders to be made that require a person to do or refrain from doing specified matters; and
d) enable information to be obtained to identify persons who have or who may be affected by or exposed to a notifiable infectious disease.

Part 9 of the Public Health Act also deals with the establishment and functions of the Panel.

10. The Four-Level Integrated Case Management Program

In accordance with the Public Health Act, the four-level management program outlines the requirements for managing HIV transmission risk behaviours through integrated case management in WA. Most people commence at Level One; however, the case management program is not strictly hierarchical or sequential. People should be managed at the appropriate level depending on their engagement and risk behaviours. Figure 1 provides an overview of the ICMP.

Health professionals involved in the clinical care of people managed under these Guidelines are required to exercise professional judgement based on the unique circumstances of each case. Managing the risk of potential harm to themselves or others, where other interventions have failed, underpins the reason for managing people with HIV under these Guidelines.

People should be encouraged and may choose to identify an independent person of their choice to act as their advocate for the duration of their management under these Guidelines; however, it is not mandatory that they do so.

10.1 Keeping the Person Informed

When a decision is made to manage a person with HIV under these Guidelines, that person must be provided with information:

a) about the implications of being managed under these Guidelines;
b) about the functions and powers of the CHO under the Public Health Act to make Public Health Orders and Test Orders as required;
c) that the Public Health Act contains offence provisions in respect of serious public health risks and material public health risks, and that penalties are applicable; and
d) that the *Criminal Code Act Compilation Act 1913* contains an offence provision in respect of acts likely to result in a person having a serious disease, and serious penalties are applicable; and
e) about HIV and some legal issues.

This information should be provided in person where possible in a supportive manner with the aim of changing the person's behaviour. A consumer fact sheet, entitled *The Integrated Case Management Program in Western Australia Fact Sheet*, is available from the Department's website and should be provided to the person. Verbal and written information should be provided in a culturally appropriate manner, at a level appropriate to the person's educational background, and steps should be taken to ensure that the information has been understood by the person.

An additional consumer resource, entitled *Disclosing you HIV status a guide to some of the legal issues Western Australia*, is also available.

The person responsible for providing the person with the information set out above:

a) in the Perth metropolitan area, is a member of the ICMP team; and
b) in a regional area, is an authorised officer as defined by the Public Health Act from the relevant PHU.

It should also be acknowledged that the management of a person under these Guidelines may affect their therapeutic relationship with the HIV clinical team and primary health care provider. Upon the request of the HIV clinical team or primary health care provider, additional support can be provided by the CMOs or the PHU.

10.2 Contact Tracing

Contact tracing or partner notification is the process by which the relevant contacts of a person identified with an infectious disease are identified so that these people can be informed about

their exposure and be offered a physical examination, investigations, and treatment. Contact tracing is highly confidential and an essential part of the clinical management of people diagnosed with sexually transmitted infections and blood-borne infections.

Contact tracing can be undertaken voluntarily or can be undertaken by authorised officers, including public health nurses, public health physicians and/or CMOs, under Part 6, Division 9 of the Public Health Act.

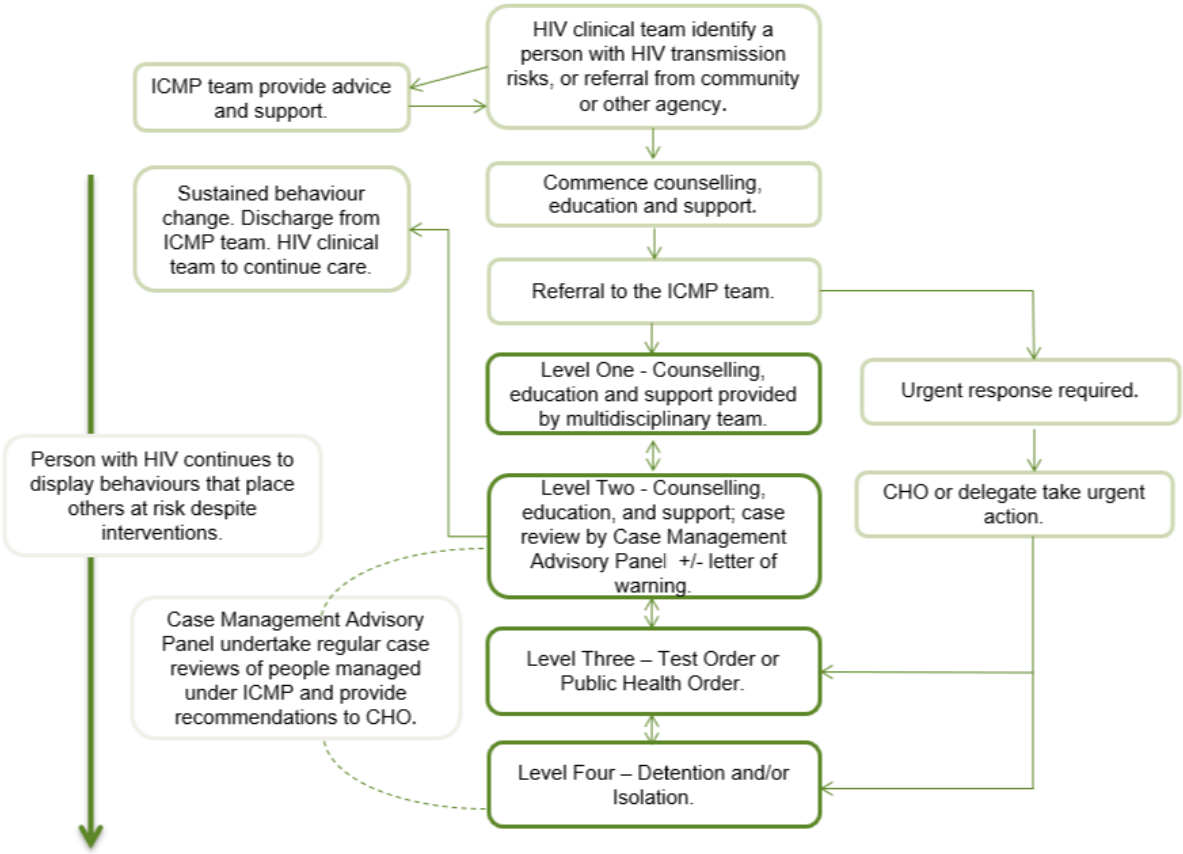
Contact tracing for HIV can be undertaken by the HIV clinical team or can be referred to PHUs in regional areas or to MCDC in the metropolitan area, as per the Silver Book[3].

Where contact tracing is required for a person in the metropolitan area for a notifiable infection other than HIV (e.g. a sexually transmitted infection), who is being managed under these Guidelines, it is the primary health care provider's responsibility. MCDC will assist with contact tracing as per the Silver Book.

If contact tracing has not already been undertaken or if people were previously unwilling to name their sexual or injecting drug use partners, the ICMP team may assist with contact tracing. This does not imply that the ICMP team is a specialist HIV contact tracing service. Where contact tracing is required for a person in the metropolitan area who is being managed under these Guidelines and who has a detectable HIV viral load, the ICMP team will assist by obtaining the details of any contacts. The ICMP team will then provide a list with the contact details of these people to MCDC or PHUs in the regions who will undertake the contact tracing.

[3] Department of Health WA. Silver Book, Human Immunodeficiency Infection (HIV) and Acquired Immunodeficiency Syndrome (AIDS). https://ww2.health.wa.gov.au/Silver-book/Notifiable-infections/Human-immunodeficiency-infection-HIV-and-acquired-immunodeficiency-syndrome-AIDS

Figure 1. Overview of the HIV Integrated Case Management Program in WA



10.3 Level One–Counselling, Education, and Support

Where a person has been identified as putting others at risk of HIV infection, the initial step is to implement Level One management by providing counselling, education, and support. Following a referral to the ICMP team, the ICMP team or the PHU (with the support of the ICMP team) will coordinate the Level One management. Some aspects of Level One management may be commenced by the HIV clinical team, the PHU or the primary health care provider.

Level One does not require any involvement from the Panel.

A biopsychosocial approach should be used during interventions under Level One and a review should be undertaken to identify any potential services and assistance that the person could benefit from with the aim of supporting the person to adhere to HIV treatment and care. Interventions should be adopted in agreement with the person and individualised to address their needs.

10.3.1 Level One Interventions

Each of the following interventions need to be considered or offered to a person being managed under Level One, dependent on consent being obtained from that person:

a) counselling and education relating to safe sex, injecting practices, transmission prevention, and the importance of adhering to medical treatment;
b) referrals, advocacy or liaison with government and non-government agencies in relation to a variety of concerns as appropriate, including referrals, advocacy or liaison for:
    i. HIV clinical care;
    ii. mental health, and alcohol and other drug services
    iii. culturally secure care;
    iv. counselling;
    v. peer support services and/or community-based organisations with a focus on HIV to provide additional support, counselling, or education;
    vi. access to housing or supported accommodation;
    vii. income assistance (e.g. Centrelink), employment or training agencies, or life skills training (budgeting, social skills);
    viii. home care support (e.g., shopping, cleaning, transport, and personal care);
    ix. disability services or other relevant services; and
    x. legal, mentoring, or other support.
c) free access to preventative materials, such as condoms and injecting equipment, including sterile needles and syringes;
d) assistance with transport to relevant appointments, including (where possible) to neighbouring local areas to avoid identification in clinics;
e) translating and interpreting services from outside of their community;
f) consideration of directly observed therapy (DOT) where there is poor adherence to ART or consideration by the treating clinician of injectable ART; and
g) the drafting of a written agreement (i.e. an undertaking) that outlines the management plan and responsibilities agreed upon by the person at that time, which should also include an undertaking to inform the ICMP team, the PHU, or the HIV clinical team of any intended change of address or contact details.

To develop a plan in a person-centred manner, it may be useful to schedule a case conference with the person to enable them to engage with the services. In relation to people with HIV who have complex needs, which are often associated with cognitive, behavioural, and/or mental health issues, specialist services should be involved in their assessment and management. If travel assistance to see a specialist is required, the Patient Assisted Travel Scheme should be used.

Some people with HIV may benefit from DOT. It is for the HIV clinical team or the PHU to determine whether DOT is required for clinical management. There may be cases in which DOT is not feasible; for example, it may not be feasible if a person is frequently mobile or transient. Thus, this decision needs to be considered on a case-by-case basis and discussed with the ICMP team. DOT will be arranged and funded by the Department, if a suitable provider exists (e.g. home and community care agencies and other non-government organisations) and if the person primarily resides at one address only. The Department will not fund the cost of blister packs for medications. However, blister packs for Aboriginal clients are usually free under Closing the Gap arrangements and this should be checked a preferred pharmacy

All efforts should be made to ensure that potential barriers to accessing support and services are addressed, including transport, access to telehealth, or the use of translators.

10.3.2 Responsibilities and Process

The PHU or the HIV clinical team can seek the advice of the ICMP team at any time without having to identify the person with HIV. Seeking advice from the ICMP team under Level One does not immediately lead to a person being managed under the guidelines at Level Two or above.

Level One interventions of the ICMP may be implemented by the ICMP team or the PHU. People need to be made aware of the implications of being managed under Level One of these Guidelines, including which steps they can take to be discharged from management under the ICMP. People need to be notified that non-adherence to management under Level One may result in escalation to Level Two or higher, which will require a case review by the Panel, and could include a letter of warning and a Public Health Order or Test Order.

10.3.3 Consideration of Management at Level Two or Higher

Management under Level Two should be considered where strategies under Level One appear to have failed and Level One options have been exhausted. The decision for a person to be managed under Level Two or higher will be made by the ICMP team.

Factors to consider in determining whether a person requires management at Level Two or higher include:

a) whether a person's behaviour continues to be high risk despite efforts of implementing Level One interventions; for example, a person:
    i. may not be engaging with strategies under Level One;
    ii. not be adhering to ART and may not be sustaining an undetectable viral load; or
    iii. not be adhering to other risk reduction strategies (e.g. there may be evidence that the person is sharing needles or has a newly acquired hepatitis C virus infection);
b) whether there is an imminent risk of HIV transmission;
c) the likelihood that undertaking ongoing actions under Level One will successfully reduce the potential of the person presenting a public health risk;
d) whether the potential barriers to the Level One interventions being successful have been addressed; and
e) whether or not, after sustained and documented efforts, the ICMP team, the PHU or the HIV clinical team have been able to establish a therapeutic relationship resulting in the person adhering to treatment. A sustained effort to contact the person may involve weekly contact attempts via telephone calls, text messages, social media (private messaging), emails, post or home visits; the duration of a sustained effort will differ for each case.

The HIV clinical team or the PHU are to consult with the ICMP team at this stage to assess whether additional efforts should be undertaken at Level One or whether management under Level Two or higher is necessary.

10.4 Level Two–Counselling, Education, and Support, and Case Review by the Case Management Advisory Panel

Management of a person under Level Two includes the provision of counselling, education, and support. The Panel is to undertake case reviews and provide advice to the CHO.

10.4.1 Level Two Interventions

In relation to the interventions that need to be implemented for people being managed under Level Two:

a) All of the interventions listed under Level One management need to be considered or offered to the person;
b) The Panel must undertake a case review and provide written advice to the CHO. It should be noted that:
    i. the case review may include a request for a full medical examination, including a psychosocial assessment;
    ii. the Panel may seek further information from the HIV clinical team, the PHU, or other specialists as deemed necessary; and
    iii. consideration should be given to a multidisciplinary case conference and discussion based on the goals set for the person;
c) Consideration should be given to whether the CHO or their delegate should issue a formal letter of warning to the person, advising of:
    i. that person's responsibilities under the Public Health Act and that the person's behaviour has come to the attention of and is being monitored by public health authorities;
    ii. any expected changes in behaviour;
    iii. the role of the ICMP and the Panel;
    iv. the availability of counselling, education, testing, treatment, and support services;
    v. the requirement that the person must initiate and maintain contact with particular agencies by a specified time(s); and
    vi. the next step, which may include seeking a Test Order or Public Health Order.

A letter of warning is a non-binding non-statutory notice that notifies people of the subsequent actions that may be taken if they do not change their behaviours. The decision to issue a letter of warning needs to be supported by evidence that a person has not responded to repeated efforts by the teams involved (e.g. the ICMP team or the PHU) to reduce their at-risk behaviour and public health risk. A letter of warning must be served by a process server in the metropolitan area and/or in conjunction with the PHU in regional WA. The Manager, ICMP needs to ensure that the person has received and understood the letter of warning and has been advised to discuss its contents with an independent advocate of their choice.

The ICMP team or PHU needs to provide written reports outlining the management programs for all people being managed under Level Two to the Panel for its consideration at its regular meetings.

People should be offered access to advocacy and legal representation during this process. People should be advised that they are being managed under Level Two of these Guidelines, which will include the Panel discussing their care.

10.4.2 Responsibilities and Process

On the request of the Panel, the HIV clinical team or the PHU may be required to be present at the Panel's meeting.

The Panel will advise the CHO on a recommended management program as determined via the case review. This advice will be provided as a written recommendation.

The HIV clinical team and/or the PHU is responsible for implementing management recommendations that are agreed to be within their scope of practice. The ICMP team will provide ongoing support to the HIV clinical team and/or the PHU, including advice on how to manage

people until a recommendation is made by the Panel, and will provide support during the implementation process.

The case will be reviewed again at the Panel's six-monthly meetings or earlier (as required).

10.4.3 Consideration of Management at Level Three or Higher

If people do not demonstrate evidence of any changes in their behaviours despite the implementation of Level Two measures and continue to place others at risk of HIV transmission through their behaviours, consideration should be given to managing such people under Level Three or higher. This decision must be made by the CHO with the advice of the Panel, where possible.

10.5 Level Three–Management under a Public Health Order or Test Order

10.5.1 Overview of the Intervention

To manage a person under Level Three of the ICMP, the CHO must issue a Public Health Order or a Test Order to the person where the relevant requirements of the Public Health Act are satisfied and otherwise in accordance with the Act.

Where all other measures under Levels One and Two have failed, management of a person under Level Three of the ICMP may be required. Under Level Three:

a) a decision is made that a Test or Public Health Order be issued to the person with HIV;
b) if a Test Order is deemed necessary, it may stipulate that the person undergoes testing for a specified sample;
c) if a Public Health Order is deemed necessary, it may stipulate that:
    i. the person undergo counselling;
    ii. the person undergo specified medical examination, testing, or treatment;
    iii. the person refrain from specified conduct or activities;
    iv. the movements of the person be restricted (e.g. the person may be required to stay at a particular address or in a particular town or region); and/or
    v. the person be subject to supervision;
d) the order may stipulate a timeframe in which these requirements need to occur;
e) all of the interventions listed under Level One and Level Two management must also be considered, and the availability of counselling, education, examination, and treatment, including assistance with access and support services should be reiterated to the person; and
f) consideration should be given as to whether the person needs to be advised of the implications of non-adherence, including that as a next step, a Public Health Order may be sought that could include conditions for detention and/or isolation.

10.5.2 Responsibilities and Process

The decision to issue a Test Order or Public Health Order is made by the CHO in accordance with the relevant requirements of the Public Health Act. The CHO will ordinarily consider the advice of the Panel following a case review or the advice of the ICMP, Manager and the Director, CDCD in urgent cases; however, there is no requirement that the CHO do so. Before making a Test Order or Public Health Order, the CHO should obtain legal advice either from the Department's Legal and Legislative Services Branch or the State Solicitor's Office, whichever is appropriate in the circumstances. A Public Health Order may be reviewed if a person is subsequently detained under a custodial sentence or placed in custodial remand.

The ICMP team are responsible for managing a person under Level Three in the metropolitan area and the relevant PHU is responsible for managing a person under Level Three in non-

metropolitan areas with the support and advice of the ICMP team. Resources will be allocated by the CDCD in the metropolitan area or the PHU in non-metropolitan areas so that this can be effectively achieved until it is deemed no longer necessary.

Sections 109 and 127 of the Public Health Act provide that a person subject to a Test Order or Public Health Order has the right to apply to the State Administrative Tribunal (SAT) for a review of the decision to make the order. The SAT will hear and determine any such application as soon as practicable. The person also has the right to obtain legal advice and to communicate with a lawyer. The ICMP team should provide information to assist the person to obtain appropriate advocacy and legal representation during any review process.

10.5.3 Involvement of the Police

The decision to request the assistance of the WAPOL needs to be considered specifically in relation to Level Three and Four orders. Under sections 106 and 122 of the Public Health Act, an authorised officer may request the assistance of a police officer to enforce a Test Order or Public Health Order. ICMP and CDCD will provide briefings and education on HIV transmission risk and contemporary HIV policy on prevention and the role on ART as a HIV transmission control strategy to WA Police officers, as required.

The assistance of the WAPOL should not be requested unless it is absolutely necessary and should only be considered as a last resort. Accordingly, the decision to involve the WAPOL in the enforcement of an order should be done with legal advice and the approval of senior management.

10.5.4 Management at Level Four

In the rare circumstances in which a person does not adhere to a Test Order or Public Health Order and poses a risk to public health of HIV transmission, the CHO may consider making a Public Health Order that includes conditions for detention and/or isolation. This should only be used as a last resort where all other strategies have failed.

10.6 Level Four–Detention and/or Isolation

If the requirements of the Public Health Act are satisfied and if the CHO believes a person is behaving in a way that is placing others at risk of HIV transmission, despite all of the other interventions being implemented, the CHO may make a Public Health Order to confine a person in the interests of public health. Ordinarily, the CHO will consider making a Public Health Order following advice from the Panel (but it is not a requirement that the CHO do so).

Making a Public Health Order that includes conditions for detention or isolation for the purposes of managing HIV public health risks is an option of last resort. This will need to be undertaken on the basis of a clearly documented risk reduction strategy that includes an indication as to where the detention/isolation will occur and states the goals of the intervention. It is expected that such orders will only be made rarely and will only be considered after all other measures to manage the public health risk of HIV infection have failed.

A Public Health Order may require the person to submit to being detained or isolated at a specified place, such as the person's home or another suitable location.

A Public Health Order may be reviewed if a person is subsequently detained under a custodial sentence or on remand.

In managing a person under Level Four of the ICMP:

a) a Public Health Order is made by the CHO to isolate or detain a person with HIV who continues to place others at risk of HIV transmission if the requirements of the Public Health Act are satisfied;
b) the CHO must review the person's detention at intervals not greater than 28 days; and
c) concurrent access should be provided to:
    i. counselling, education and behaviour change therapy;
    ii. ongoing medical management, if necessary, including psychiatric assessment and management;
    iii. assess and manage any drug and alcohol dependence;
    iv. ensure that the person has an independent advocate, and
    v. ensure contact with the family and that culturally appropriate and holistic support is being provided.

The person is entitled to obtain legal advice and communicate with a lawyer or to be represented by a responsible person. The ICMP team should assist the person to access legal advice.

10.6.1 Responsibilities and Process

It is the CHO's responsibility to place an individual under a Public Health Order under which a person is detained or isolated. Any such order must comply with Part 9 of the Public Health Act. In deciding whether to make a Public Health Order, the CHO will ordinarily consider the advice of the Panel, which will have undertaken a case review in collaboration with the HIV clinical team, the PHU, the ICMP team, and/or any other specialists deemed necessary; however, the CHO is not required to consider this advice. The CHO will ordinarily consider the advice of the Panel following a case review or the advice of the ICMP, Manager and Director, CDCD in urgent cases; however, there is no requirement that the CHO consider this advice. The CHO must be satisfied that the person is safely detained or isolated and ensure that the person has access to services, including legal representation, counselling and support services, clinical HIV management, and other medical management. The CHO must review the order at intervals not greater than 28 days to determine whether the detention of the person continues to be required.

Before making a Public Health Order, the CHO should obtain legal advice either from the Department's Legal and Legislative Services Branch or the State Solicitor's Office, whichever is appropriate in the circumstances. In cases in which the person may resist the order, this should also include a consideration of the provisions related to the involvement of the WAPOL and the requirements for secure isolation/detention.

Sections 109 and 127 of the *Public Health Act 2016* provide that a person subject to a Test Order or Public Health Order has the right to apply to the SAT for a review of the decision to make the order. The SAT will hear and determine any such application as soon as practicable. The person also has the right to obtain legal advice and to communicate with a lawyer. The ICMP team should provide information to assist the person to obtain appropriate advocacy, including culturally sensitive support and legal representation during any review or formal appeal process.

10.6.2 Involvement of Police

The decision to request the assistance of the WAPOL needs to be considered specifically in relation to Level Three and Four orders. Under sections 106 and 122 of the Public Health Act, an authorised officer may request the assistance of a police officer to enforce a Test Order or Public Health Order.

The assistance of the WAPOL should not be requested unless it is absolutely necessary and should only be considered as a last resort. Accordingly, the decision to involve the WAPOL in the enforcement of an order should be done with legal advice and the approval of senior management.

11. Integrated Case Management Program Procedures

11.1 Commencement of Management under these Guidelines

Where a person has been identified as requiring management under these Guidelines, initial Level One interventions may be coordinated by the person's HIV clinical team or the PHU. The HIV clinical team can contact the ICMP team for advice and support at any time, which may lead to the ICMP team advising that the person be formally referred for management by the ICMP team. The ICMP team will decide whether a person should be managed under these Guidelines. Either the ICMP team or the PHU with input from the ICMP team will undertake the management of a person under these Guidelines. The person should also be informed of their need to be managed under these Guidelines (see Section 10.1: Keeping the Person Informed).

11.2 Referral to the ICMP Team

Referral to the ICMP team is essential when a person with HIV requires integrated case management under these Guidelines. The referral should be made by the PHU or the HIV clinical team to the ICMP team using the referral form available from the Department's website. The referral form should identify the risk behaviours and the nature of the support or the intervention that is required and should clearly indicate who is taking responsibility for the referral. The ICMP team will send a receipt to acknowledge the referral and will aim to make contact with the person referred to the ICMP team within three working days.

In the event of an urgent referral, the HIV clinical team or the PHU can contact the ICMP team via telephone or refer the person as an urgent or high-risk referral using the referral form.

In the case of re-referral (i.e. the re-referral of a person who has been managed by the ICMP team within the past two years), a brief email or verbal re-referral outlining the risks/concerns will constitute a referral to the ICMP team; a full referral form will not be required.

Community members may make verbal referrals to the ICMP team.

11.3 Allegations of HIV Transmission

If an allegation of potential HIV transmission is made against a person being managed under the ICMP, the person will be interviewed by the PHU or the ICMP team.

If an allegation of potential HIV transmission is made against a person who is not currently being managed under the ICMP, the person will be interviewed by a CMO from the ICMP team, or if the allegation is raised in a regional setting, by the PHU or an authorised officer with the support of the ICMP team. A videoconference or telephone call with the CMOs may be held for a regionally-based person (with the consent of the person). A referral should be made to the ICMP team if assistance is required. The first interview with the person should be completed within three working days (or sooner in urgent cases) or as soon as contact is able to be made with the person. At the time of the interview, the person must be notified of the existence of the allegation (but not the source of the allegation or the identity of the person to whom the person is alleged to have transmitted HIV or put at risk of transmission of HIV).

Following the interview, the ICMP team will assess whether the person needs to be managed under the ICMP. Where necessary, the ICMP team may consult with the Director, CDCD regarding this decision. All people will initially be managed under Level One for intensive education and counselling, but this will be assessed on a case-by-case basis in consultation with the HIV clinical team or the PHU. If a person does not require management under these Guidelines, the interview notes will be retained by the CMOs and no further interventions relating to the ICMP will be undertaken.

11.4 Documentation

At all stages of management under these Guidelines, clear documentation about the rationale for decisions and the progress of implementation must be maintained. Records must be kept in accordance with the Department's MP 0002/16 *Patient Information Retention and Disposal Schedule Policy*. To protect people's privacy, unique identifier codes should be used in place of names wherever possible.

11.5 Monitoring and Reporting

The ICMP team, HIV clinical team and the PHU are required to maintain regular contact and review the ongoing management for each person under these Guidelines with a focus on the goals of care. This may be done via email or over the telephone. The ICMP team will contact the HIV clinical team or the PHU on a fortnightly basis to monitor a person's progress when managed at Level Two or higher. This is essential to evaluate the success of interventions and support being provided, and to consider whether any change in management is required.

When a person is being managed by the ICMP team, an Interagency Care Plan may be developed with the input of the ICMP team, the HIV clinical team, the PHU, and/or the primary health care provider. Interagency Care Plans can assist with goal setting and guide management. Other external service providers, such as the WAAC Case Management Officers, may be involved in the development of a plan. An Interagency Care Plan should include the goals of management, the roles and responsibilities of each agency, action plans, timelines for the completion of tasks, and expected management outcomes. These plans may be presented to the Panel and the CHO. Interagency meetings to review a care plan should occur every four months or more often if required.

The CMOs should meet least fortnightly, and as needed with the Manager, ICMP to provide case updates. The Director, CDCD (Chairperson of the Panel) and Manager, ICMP should meet weekly to discuss cases. The Manager, ICMP will provide a report on people with HIV being managed at Level Two and higher under the ICMP to the Panel on at least a six-monthly basis or more frequently if required. If an urgent case review is required before the next scheduled Panel meeting, the Manager, ICMP will discuss the case with the Director, CDCD (the Chairperson of the Panel), who will coordinate an urgent Panel meeting.

11.6 Changes to the Level of Management

The ICMP team will decide whether a person should be managed at Level One or higher. The level of management will be reviewed each time the Panel undertakes a case review. The CHO or a delegate of the CHO, on the advice of the Panel, will decide the level of management required. This decision will be communicated to the ICMP team, who will communicate the decision to the HIV clinical team or the PHU in writing. The ICMP team or the PHU are responsible for informing people about any changes to their management levels.

11.7 Discharge from the Integrated Case Management Program

For a person managed at Level Two or higher, the CHO or a delegate of the CHO will decide, on the advice of the Panel, when a person can be discharged from management under these Guidelines. Any such decision should also be informed by the advice of the HIV clinical team or the PHU and following consultation with community-based services (e.g. WAAC CMOs) to ensure that these services have the capacity to take on new clients. If community-based services are required on discharge, these services should also be involved in discharge planning from management under these Guidelines. The ICMP team will facilitate referrals to community-based services.

A person with HIV may be discharged from management under these Guidelines where there is evidence of:

- sustained adherence to ART and a demonstrated sustained undetectable viral load for at least 6–12 months, depending on the assessment of that person's stability;
- no further material public health risk concerns or allegations;
- engagement with a tertiary HIV clinical service, regional PHU, or GP S100 prescriber, and that the person has attended clinical appointments, undertaken testing, and adhered to ART (with or without other agency support); and
- the management of any psychosocial concerns or that person has declined referrals.

A person with HIV may be referred to the ICMP team prior to or soon after receiving a diagnosis of HIV for the purpose of that person being located for initial engagement to commence HIV management. If there are no known material public health risks, that person will be discharged from the care of the ICMP team upon engagement with the HIV clinical team, the PHU, or the primary health care provider. In such instances, the ICMP team will decide when to discharge a person from the management of the ICMP team, without the need to demonstrate sustained undetectable viral load for at least 6–12 months, provided that the general discharge criteria are met.

12. People who are Deemed to be Incapable Persons

A person may lack the capacity to provide consent or comprehend the implications of management under these Guidelines. In such circumstances, it is acknowledged that the person may have an existing guardian or that a guardian may need to be appointed.

If the person lacks capacity, the HIV clinical team, the PHU, and/or the ICMP team may seek advice from the Director, CDCD, including, if necessary, advice about the steps required to apply to the SAT under the *Guardianship and Administration Act 1990* for a guardian. Such cases are likely to require case-by-case consideration.

If a guardianship application is made to the SAT, evidence may be required on various matters, including impaired decision-making capacity. Depending on the person's situation, there may be sufficient evidence of cognitive impairment in existing Occupational Therapy cognitive assessments, mini-mental state examinations, medical assessments, and/ or relevant psychiatric assessments. If a higher level of evidence is required to assess whether the decision-making capacity of the person is impaired, a referral can be made for a neuropsychology assessment by the Neurosciences Unit, a state-wide mental health service administered by the North Metropolitan Health Service.

13. Clients who are Minors (Persons under the Age of 18 Years)

People with HIV who are minors (aged under 18) can be managed under these Guidelines, but additional steps are required. In such cases, the HIV clinical team, the PHU, and/or the ICMP team should consider specific issues, including consent, capacity, guardianship and confidentiality, and may seek the advice of the Director, CDCD.

Where appropriate, the Perth Children's Hospital (PCH) Infectious Diseases team will arrange for a minor to be assessed to determine if that minor has achieved "a sufficient understanding and intelligence to enable him or her to understand fully what is proposed" (Gillick competence) and is able to be treated as a mature minor. If assessed as being a mature minor for the purposes of being managed under these Guidelines, the minor will be able to consent and make decisions. However, if a minor is assessed as not being a mature minor, then a parent, guardian, or

responsible adult will need to be present at any interview with the minor to provide consent and make decisions.

Complex circumstances may lead to a minor being managed under these Guidelines. The minor's HIV clinical team at PCH should arrange referrals to other services for advice or input as required, which may include the Department of Communities, Child Protection and Family Support.

14. Clients with significant mental health issues

People with HIV who have significant mental health issues will be case managed with the support of forensic psychiatry and other mental health services. In such cases, the HIV clinical team, the PHU, mental health team and/or the ICMP team should consider specific issues and risk behaviours in providing advice to the ICMP, the Director, CDCD and/or the CHO.

This document can be made available in alternative formats on request for a person with a disability.