



Principles to be Considered when Developing Best Practice Legislation for the Management of Infected Persons who Knowingly Place Others at Risk

National Public Health Partnership

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1. Introduction

Background

The control of notifiable disease in Australia largely rests with States and Territories, with each jurisdiction having its own public health legislation that provides powers for surveillance and control of such diseases.

These laws generally consist of three main components that can be broadly described as provisions that:

- detail the diseases that must be notified to the central agency, who must notify them and under what circumstances notifications must be made;
- provide powers to control public health risks presented by the environment for example where a public spa pool is not being maintained; and
- provide powers to control public health risks in the event of an epidemic or where infected persons knowingly or recklessly place others at risk.

This paper deals with the last of these components of public health legislation, specifically with the powers¹ that the legislation should provide with respect to managing persons who knowingly or recklessly place others at risk of infection. This is a difficult area where it is not easy to strike the right balance between protection of the community and protection of individual liberty. The Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD)² has noted “human rights and public health principles are usually compatible and complementary, but the area of disease transmission and exposure has a particular tension that requires adequate resolution.”³

Public health legislation in this area also has complex intersections both with the common law and other pieces of legislation. This can include the criminal law, but the individuals may also come to the attention of public health authorities as a result of being clients of other public authorities such as mental health services. The communication links between the various parts of the system therefore need to be managed sensitively and effectively. Decisions should be made reflecting the most appropriate mechanism for dealing with the individual in the circumstances (eg a mental health order or a public health order). Detailed processes for case management of such individuals should be included in protocols or guidelines developed within jurisdictions. Such processes should ensure a flexible approach to meet individual circumstances and have not been discussed in this paper.

Purpose

The best practice legislation for the management of infected persons who knowingly place others at risk is intended as a policy blueprint to aid the development of new legislation and reviews of existing legislation.

¹ While discussing the powers, the paper refers to 'public health official' and 'public health authority'. The reference to 'public health official' is a reference to the official (or the delegate) who has statutory power to make public health orders. The title and position of the official varies from jurisdiction to jurisdiction. In some it is the "Chief Health Officer", in others it is the "Director of Public Health" and yet in others it may be the Minister. The term 'public health authority' or 'health authority' is a reference to the Department that has principal responsibility for protecting public health (eg the Health Department or the Department of Human Services).

² ANCAHRD Position Paper provides an overview of the current situation relating to criminal offences in each jurisdiction.

³ Watchirs, H, ANCAHRD Position Paper, *Reforming the Law to Ensure Appropriate Responses to the Risk of Disease Transmission Occasional Papers: No 2*, May 2002 p. 1

It is not intended to prescribe the content of individual State or Territory legislation. In implementing or reviewing legislation in this area, States and Territories will remain responsible for determining the form and content of the provisions enacted in their own jurisdiction. Furthermore, it is not intended that the best practice proposals be adopted pursuant to a national legislative scheme. It is noted that the approach of the National Public Health Partnership to similar work in the past, has been to provide models for best practice and a framework for a consistent approach where appropriate. This approach recognises both the sovereignty of each State and Territory Parliament to enact laws in this field, and the desirability of flexibility for individual jurisdictions to adapt the proposals to local circumstances and systems as they see fit.

It should be noted that the paper addresses legislative powers available to public health officials in exceptional circumstances. The paper does not discuss non-legislative action, which is the normal approach to dealing with public health risks.

Scope

Most publications on this subject relate to HIV infected persons, however the principles and recommendations established for HIV can, in most circumstances, be applied to other infectious disease such as tuberculosis and the viral haemorrhagic fevers. The general principles should be applied, in a way that appropriately recognises the different circumstances, modes of transmission and treatments applying to different diseases. ANCHARD suggests that the strongest argument for differentiating management of HIV/AIDS and hepatitis C from traditional communicable diseases is that they are not casually transmissible.⁴

At present there are substantial differences between the public health laws in each jurisdiction that can broadly be described as public health order powers. These powers include the ability to order a person to be examined or tested and treated to determine disease status, submit to counselling or supervision, or be isolated or detained. Whilst all jurisdictions have the ability to act to protect public health, the extent of these powers, the basis on which they can be used and review procedures vary widely. This mismatch of powers and procedures makes the recognition of orders across borders legally very difficult.

Consideration of the issue arose out of discussion of the limits of public health law in workshops facilitated by the Australian Institute of Health Law & Ethics in 1997 (see *Public Health Law in Australia - New Perspectives*). This was picked up by the then Legislation Reform Working Group (LRWG) of the National Public Health Partnership (NPHP)⁵. Possible mechanisms for recognition of public health orders between jurisdictions similar to what applies in some jurisdictions for mental health orders was subsequently reviewed for the LRWG by Dr Chris Reynolds in 1999. He found that the differences between jurisdictions in their existing legislation in relation to public health orders made it difficult to establish a legislative mechanism to recognise orders from another jurisdiction.

Although exercised rarely and never without considerable debate and thought, the powers to issue public health orders are important safeguards for public health. Once made there are good arguments that they should be enforceable throughout Australia since a person subject to a public health order who moves to another jurisdiction continues to represent the same level of risk.⁶

⁴ Ibid p.1.

⁵ It is noted that following consideration of the NPHP priority agenda for 2002-2004, the LRWG has been repositioned as the Legislation Reference Network (LRN) and has been known as the LRN since October 2001. Work commenced prior to this change will refer to work of LRWG.

⁶ Principle 4 of the ANCAHRD Position Paper, relates to retention of public health powers including graded interventions which provide for appeal against orders restricting liberty; Watchirs H, ANCAHRD Position paper page 13.

The cross border transfer of information for public health control purposes is also an important and complex issue. Consideration should be given to issues of privacy and confidentiality when dealing with powers to control public health risk.⁷ Legislative restrictions on providing information between jurisdictions were the subject of an earlier 1998 report by Dr Reynolds

There is also a strong case that in this area of public health law, which impacts significantly on the rights of individuals, Australian citizens should be treated equally and equitably irrespective of their place of residence. Legislation must have regard for the significant impact on human rights that these powers, such as compulsory examination and detention, have on individuals and balance these rights with the need to protect the community.

Methodology

The paper has been developed through a consultative and iterative process, which has taken into consideration input from jurisdictions and all stakeholders who have provided comments on the various drafts.

The paper has been developed through various drafts. The original work was done as a LRWG project by a South Australian project officer, under the guidance of a LRWG Steering Committee. Various drafts were then commented upon by LRWG members, before the paper was endorsed by NPHP Group for circulation to other relevant groups within the NPHP for comment – Communicable Diseases Network Australia (CDNA) and the Intergovernmental Committee on AIDS, Hepatitis C and Related Diseases (IGCHARD). The Steering Committee was expanded to include CDNA and IGCHARD representation and the project is now being managed as a CDNA/LRN project.

Subsequently the paper was endorsed by the NPHP Group for circulation to other relevant national bodies as "work-in-progress". Comments were received from the Australian Federation of AIDS Organisations (AFAO), People Living with HIV/AIDS (NSW) (PLWHA), Australian National Council on AIDS, Hepatitis C and Related Diseases Legal Working Party (ANCHARD LWP), Public Health Laboratory Network (PHLN) and Office of Aboriginal and Torres Strait Islander Health (OATSIH). This paper takes those comments into account.

⁷ The issues involved have been considered by a separate, broader project on confidentiality and privacy in public health law. The report can be accessed at: <http://www.dhs.vic.gov.au/nphp/privacy.pdf> Jurisdictions also have various pieces of privacy legislation.

2. Guiding Principles

Given the unavoidable dual responsibility that public health officials have with regard to respecting individual rights and protecting public health, establishing guiding principles in legislation can serve two purposes.

These are to:

- provide a clear statement of the infected person's rights and responsibilities; and
- provide a framework within which public health official can act.

Examples Currently in Legislation

Both the Victorian Health Act 1958 and Australian Capital Territory (ACT) Public Health Act 1997 provide examples of provisions that clearly state the principles that underpin the legislation.

Section 119 Victorian Health Act

119. Interpretation

The following principles apply for the purposes of the application, operation and interpretation of this Part —

- the spread of infectious diseases should be prevented or limited without imposing unnecessary restrictions on personal liberty and privacy;*
- a person at risk of contracting or being infected with an infectious disease must take all reasonable precautions to avoid contracting or being infected with the disease;*
- a person who suspects that he or she has an infectious disease must ascertain —*
 - whether he or she is infected; and*
 - what precautions should be taken to prevent others being infected;*
- a person with an infectious disease must take necessary measures to ensure that other are not unknowingly placed at risk of becoming infected;*
- a person with an infectious disease or at risk of contracting or being infected with an infectious disease has a right -*
 - to be protected from unlawful discrimination; and*
 - to have his or her privacy respected; and*
 - to receive information about the medical and social consequences of the disease and any proposed treatment; and*
 - to have access to available and appropriate treatment —*
so long as those rights do not infringe on the well-being of others.

Section 99 ACT Public Health Act

99. Principles-notifiable conditions

This Part shall be construed and administered in accordance with the following principles:

- the investigation of notifiable conditions, and any actions taken as a consequence, shall be carried out in order to minimise the adverse public health effects of such conditions;*
- a person who engages in activities that are known to carry a potential risk of exposure to a transmissible notifiable condition, and any person responsible for the care, support or education of such a person, has the following responsibilities:*
 - to take all reasonable precautions to avoid the contracting of the condition by the person who engages in such activities;*
 - if there are reasonable grounds for believing that the person who engages in such activities has been exposed to the condition-to ascertain whether the condition has been contracted, and what precautions should reasonably be taken to avoid exposing others to the condition;*
 - if there are reasonable grounds for believing that the person who engages in such activities has contracted, or is likely to have contracted the condition-to comply with preventative measures or treatment that will minimise the risk to others of exposure to the condition;*
 - if there are reasonable grounds for believing that the person who engages in such activities has contracted, or is likely to have contracted the condition-to take*

reasonable measures to ensure that others are not unknowingly placed at risk through any action or inaction of the person or any person responsible for the care, support or education of the person;

- (c) *a person who has, or may have, a notifiable condition, or who engages in activities that are known to carry a potential risk of exposure to a notifiable condition, shall be accorded the following rights, to the extent that their exercise does not conflict with the requirements of this Part and does not infringe unduly on the well-being of others:*
- (i) *the right to privacy;*
 - (ii) *the right to receive all reasonably available information about the medical and social consequences of the condition and any proposed treatment.*

This type of legislation provides a clear indication of the rights and responsibilities of an infected person and guides administration of disease control provisions. Making such principles explicit gives a context to the legislation and highlights the need for a balance to be struck between individual rights and protecting public health.

General Provisions in Other Publications

The principles that should guide a public health official when administering this type of legislation have been discussed in documents such as the Final Report of the Legal Working Party of the Inter Governmental Committee on AIDS, 1992 (IGCA) and the National HIV/AIDS Strategy, 1989.

Since 1990, New South Wales (NSW) has had guidelines in place for the management of people with HIV infection who risk infecting others. The guidelines were developed in response to a situation involving a HIV positive sex worker who was the subject of public health action under the then NSW Public Health Act. They provide a detailed approach to utilising powers provided by the legislation. The NSW guidelines formed the basis of guidelines endorsed by IGCA as the national standard.

These documents adopt the following principles:

- That where possible:-
 1. Control of a disease should be by support and education to encourage co-operation and appropriate behaviour change.
 2. The least coercive power (ie counselling) should be used first at which point the authority may not need to be formally involved.
 3. The consent of the person should be sought for testing and examination.
- However, there should be capacity to use coercive powers as a last resort to deal with exceptional cases where there is a significant risk to public health.

Best Practice Legislation

The overriding general principles outlined above should be reflected in the legislation but in a way that provides options to the public health official. The general expression of rights and responsibilities as used in the Victorian and ACT legislation are appropriate as they provide a protection for individuals but do not prevent the authority responding to risks as appropriate on a case-by-case basis.

3. Basis For Orders

In addition to the Guiding Principles for legislation discussed in Section 2 above, there should be a clear expression of the basis on which orders can be made. They should also be subject to the review and appeal mechanisms discussed in Section 6 below.

The 1989 National HIV/AIDS Strategy recommended a staged approach to managing infected persons who pose a risk to public health. It acknowledged, however, that there should be capacity in public health legislation to deal with exceptional cases that may require placing restriction on an infected person's living circumstances and employment, and confinement as a last resort. The Strategy stated that these powers should be exercised using the following criteria:

- the person has in the past wilfully or knowingly behaved in such a way as to expose others to the risk of infection;
- the person is likely to continue such behaviour in the future;
- the person has been counselled, but without success, in achieving appropriate and responsible behaviour change; and
- the person presents a danger to others.

Although more explicit, criteria such as these reflect the guiding principles discussed above. That is, that the rights of individuals should be restricted as a last resort, and that any restrictions should be put in place only where there is a significant risk of harm to public health.

Best Practice Legislation

Legislation should reflect these underlying principles as this would provide the best mechanism for respecting individuals' rights whilst protecting public health on a national basis. The success of Australia's HIV response indicates that an approach that engenders trust, co-operation and involvement of affected communities produces a positive public health outcome.

There should generally be a distinction drawn between the powers that can be used when the public health official has 'reasonable grounds' for suspecting a person of having a particular infection and those that can be used when the person is known to have a particular infection.

Where a public health official suspects that a person may have a particular infection it should have the power to determine whether or not this is in fact the case. This would be via powers to order examination, which would include the taking of tissue (eg blood) for testing.

In most jurisdictions, the power to order examination or testing has been provided where the public health official 'believes on reasonable grounds' (NSW Public Health Act) that the person is suffering from a particular disease.

The Victorian Health Act (Section 121(1)) provides that public health orders, including for examination and testing, require that:

- (a) a person has an infectious disease or has been exposed to an infectious disease in circumstances where a person is reasonably likely to contract the disease; and
- (b) if infected with that infectious disease, the person is likely to transmit that disease; and
- (c) there is a serious risk to public health—

Under the Victorian requirement, the power to test is clearly linked not only to the likelihood that the person is infected but also to a reasonable belief that there is a serious risk to public health.

The ANCAHRD Legal Working Party considers that the Victorian model is preferred to the wider powers relating to examination and testing in the NSW Act, as compulsory testing and treatment should be justified on the grounds that the person is likely to transmit the disease. The power for ordering compulsory examination and testing should be separated from the more restrictive powers such as restricting behaviour and activities, compulsory supervision and treatment, detention or isolation, which should generally be based on knowledge that a person is suffering from a particular disease. This may be established by notification or certification from a medical practitioner of a positive test result. Before such powers are used criteria that demonstrates the person presents a serious public health risk should also be fulfilled.

The criteria that could be incorporated into legislation would include:

- either for the examination/testing powers, the public health official reasonably believes that the person is infected or exposed such that they are likely to have contracted a particular disease;
- or for the more restrictive powers, the person is known to be infected with a particular disease

AND

- the person is behaving in a way that is endangering, or is likely to endanger the health of the public;
- the person is likely to continue such behaviour in the future;
- the action is needed to prevent or alleviate a significant and serious public health risk; and
- the least restrictive or minimum action shall be considered first.

In practice, the application of the distinction between suspicion of infection and confirmation by a positive test result is complicated by delays in laboratory confirmation, the accuracy of laboratory testing and the effect of sero-conversion. There may be exceptional circumstances where coercive action is required before an infection is confirmed. In such cases, there may be other very strong evidence as to the infective status of the person.

4. Specific Powers

This paper is directed at the powers available to public health officials under legislation. It does not discuss those actions taken by medical practitioners or other health professionals, or health authorities, involving voluntary co-operation by the infected person. This is the way the overwhelming majority of potential public health risks are successfully managed.

Generally, it would be expected that all avenues for voluntary co-operation have been explored and exhausted before compulsory powers are contemplated. In particular, counselling of the person on their condition, treatment options, risks associated with particular behaviours and activities and possible consequences would have taken place. This may be seen also as part of the process of establishing the reasonable grounds for believing the person presents a significant public health risk, warranting some infringement of their human rights, in the exceptional cases where they continue to present a risk to others.

The powers that can be used to manage a person suspected, or known to be, infected with a disease that is a risk to public health are discussed in detail below.

Best Practice Legislation

The powers that should be available to public health officials to deal with those exceptional cases where there is a significant public health risk that cannot be addressed on the basis of voluntary co-operation, can be summarised as follows:

A. Ability to determine disease status and public health risk

This would occur using examination/testing powers.

B. Control of Public Health Risks

Where a person is known to be suffering from a particular disease (eg through a confirmed notification or positive test result) and they present a risk to public health, the following powers should be available using a case management approach.

From the least restrictive to most restrictive, they are:

1. Counselling;
2. Restriction of behaviour or activities - including employment;
3. Supervision;
4. Treatment - including the power to ensure treatment is completed
5. Detention; and
6. Isolation.

The general structure of the legislation should indicate that the powers provided form a general hierarchy from least to most restrictive, however there must be flexibility that allows a public health official to use these powers as needed to protect public health. The way in which powers are used should be on a case-by-case basis and will be affected by variables such as:

- the disease concerned;
- the availability of treatment for that disease;
- the infectivity and ease of transmission of that disease;
- whether urgent action will significantly affect the public health outcome;
- the degree of wilfulness that is exhibited by the person; and
- the capacity of the person to understand the public health risk they present (eg in the case of a patient with a mental illness).

C. *The power to apprehend*

This would be needed to enforce an order. The legislation would need to specify to whom the power to apprehend is to be given, and in what circumstances.

The following sections discuss each of those powers in more detail.

Testing & Examination

The HIV Testing Policy published by the Australian National Council on AIDS & Related Diseases (ANCARD) and Intergovernmental Committee on AIDS & Related Diseases (IGCARD) in September 1998, recommends that HIV testing should be voluntary with counselling and confidentiality a fundamental part of the process. The Policy acknowledges however that there are situations where compulsory testing is appropriate, but these circumstances should be strictly limited to special, clearly sanctioned situations and undertaken in an ethical and effective manner.

The policy elaborates by providing details of the types of situations where compulsory testing may occur. These include 'where a person suspected on reasonable grounds to be HIV positive, persistently behaves in such a way as to place other persons at risk of infection, and there is a clear indication that the person is likely to continue to behave in such a way.'

Current powers under State and Territory public health law for compulsory testing vary, with some jurisdictions having general powers to order a person to undergo an examination and/or testing compared with explicit provisions in WA allowing an order to be made that permits a medical practitioner to take samples.

This infringement on an individual's rights is considered necessary in the interest of public health to assess the risk to the community and whether more restrictive powers described below should be used. In practice, every effort to obtain consent would be made before any order was imposed, however, this power should be available to ensure that the true nature of the public health risk can be established.

As will be discussed below in Section 6, the use of public health order powers should be either confirmed by a court or tribunal as soon as possible or subject to readily accessible review by a court or tribunal. Where a public health official seeks confirmation of a compulsory examination order the legislation should provide the court or tribunal with the option to detain, or isolate, while a decision is being made or where particular circumstances warrant isolation or detention rather than examination.

Counselling

Generally, jurisdictions incorporate counselling as the first stage in the management process. This is either set out explicitly in legislation, which provide for the power to order a person to undergo counselling, or in guidelines for the management of infected persons. As indicated earlier, in relation to HIV/AIDS there have been agreed national guidelines based on NSW guidelines for some years.

Implicit in the process is that a case-by-case approach is used. The health authority initially has a consultancy role that involves supporting and advising other agencies and caregivers. While in almost all cases this will resolve the issues of public health concern, in a few instances it may become apparent that the management of the public health risk will require more formal processes.

For example, the South Australian *Guidelines for the Management of People Who Knowingly Place Others at Risk of HIV Infection* sets out counselling, education and support as the first stage of the management process. This process envisages regular and intensive counselling that enables trust to be built up and allows the counsellor to assess other interventions that may be required. Education would include an explanation that the person concerned knows that their behaviour has been identified as putting others at risk and

providing information on the means of preventing transmission of the infection. It should also be made clear that there is legislation in place that may be used should the counselling process fail.

As indicated, this paper focuses on the mandatory powers available to public health officials to deal with the exceptional cases of continuing significant risk. The public health law should provide reserve powers to control public health risks as summarised above and include provision for statutory recognition of any guidelines used in exercising those powers. Such guidelines should be publicly available and could be statutory instruments.

Restrict Behaviour or Activities

Where the counselling process does not result in a change in behaviour and the person remains a significant threat to public health, progression to the use of more restrictive powers may be considered.

The administrative procedures that are used from this point may include convening a panel with appropriate skills and knowledge that can advise the public health official including a personal advocate of the affected person or their choosing who can provide support.

Under current legislation most jurisdictions may give directions or order a person to refrain from specified behaviour or activities that give rise to a risk to public health. Employment or specified work activities may be restricted or prohibited using this type of power or there may be more specific powers directly relating to work activities.

Supervision

The next stage in the management process would be to place the person under supervision of a specified person. This power is available to some jurisdictions either explicitly or by using powers to issue directions. The person under supervision would continue to have access to any counselling, education or support they require but supervision would aim to modify any activities or behaviours that are a public health risk.

Treatment

The use of this power may not strictly fit into the staged management process depending on the disease concerned and the therapy, if any, that is available. For example if a case involves a person infected with tuberculosis it may be most appropriate to require treatment early in the process in conjunction with supervision or isolation, as antibiotic treatment for approximately two weeks will prevent the person from being infective therefore alleviating the public health risk.

Expert advice in this area suggests there are at least two practical differences between treatment of tuberculosis and the treatment of HIV to reduce infectivity.⁸

The first concerns the time course of therapy, which for tuberculosis is a matter of a few weeks for control of transmission, and several months therapy, which usually results in permanent cure. HIV, on the other hand, is an incurable infection, which requires continuous lifelong treatment to reduce HIV transmission. Interruption of therapy would result in rebound in viral load, and may increase infectivity, within a week or two of cessation of treatment. The available evidence suggests that although a very low or undetectable plasma viral load is likely to decrease the risk of HIV transmission, it does not exclude the possibility that transmission may occur (ANCAHRD Bulletin 28, July 2001). It was noted that if the individual was poorly adherent to the therapy, viral resistance would be likely to develop, and infectivity increase. Practically, this would mean that treatment would need to be supervised continually and indefinitely to ensure a continuing effect on HIV transmission.

⁸ Advice from Associate Professor Andrew Grulich, Head, HIV Epidemiology and Prevention Program, National Centre for HIV Epidemiology and Clinical Research.

Incomplete treatment may also present a public health risk as it may lead to the causative organism becoming resistant to the therapy being used. For example, an incomplete course of antibiotics may lead to antibiotic resistance when treating tuberculosis or as in the case of HIV poor adherence to therapy could lead to developing viral resistance and increase infectivity. Therefore the legislation should provide the ability to order treatment where appropriate and be completed as directed. For example, the system may need to allow renewal of public health orders after a period of 6 months, should it be necessary in the case of tuberculosis.

The second issue concerns the route of transmission. For a person with active tuberculosis, any social contact with an uninfected person, such as being on a train, or in the same room, poses a risk of transmission. For HIV in Australia, virtually all transmissions occur as a result of unprotected vaginal or anal sex or sharing of injecting equipment.

Thus there are serious practical limitations to the concept of enforcing public health treatment for HIV. If such enforcement resulted in poorly compliant therapy, it would be likely to have no effect on transmission, and might result in the transmission of resistant virus. In such instances, it may be appropriate for treatment to be omitted from the staged management process.

Clearly this raises some issues for use of treatment orders in relation to cases of HIV/AIDS.

Currently not all jurisdictions have the power to order treatment, with some taking the approach that where treatment is refused, other powers such as detention or isolation could be used to alleviate the public health risk.

Whilst the choice to refuse treatment is generally regarded as a fundamental right for a patient, the power to order treatment is intended to minimise the risk to public health by decreasing the infectivity of the person and not necessarily to improve the patient's prognosis. If alternative effective treatments are available, the individual should be given the right to choose between treatments.

As with other public health orders, orders for treatment should be either confirmed by an appropriate court or tribunal as soon as practicable or subject to very accessible review by a court or tribunal. See Section 6 below.

Isolation or Detention

These powers would in most cases only be used as a last resort in accordance with the principles discussed above.

Such an order may range from confining a person to their home to placing them in isolation or detention in a suitable place of quarantine such as a hospital.

These orders can also be issued in some jurisdictions for the purpose of providing treatment, for example while antibiotic treatment is administered to a person with tuberculosis.

The legislation should make detention and isolation separate powers to provide the flexibility to detain a person without the need to isolate them. This should also include such things as the availability of a telephone or other means of communication with friends and family. In some situations, detention may also involve controlled visitations from friends and family.

The legislation should also allow for the control of immediate public health risks where less restrictive measures would not be appropriate. In such a situation, the public health official needs the capacity to use isolation and detention powers as a temporary measure to protect public health.

Power to Apprehend

To ensure public health is protected, the power to seek a warrant to have an infected person who fails to comply with a public health order apprehended should be available to the public health official. This power would again only be used where there is an immediate risk to public health as a method of enforcing the legislation.

5. Criteria To Which Powers Apply?

In most jurisdictions, the powers discussed are provided only for a specific subset of the broader list of notifiable diseases. These can be categorised as 'Controlled Notifiable Diseases' as is the case in South Australia and Queensland.

Those jurisdictions that limit the public health orders to specified diseases, could use the following criteria to determine which diseases should come within that category:

- there is an overriding imperative to act quickly;
- action taken can improve the public health outcome;
- the disease can be transmitted directly from one person to another;⁹
- the conduct of the person with the notifiable disease affects the likelihood of the transmission of the condition;⁶ and
- the nature of the disease is such that its transmission results in long-term or serious deleterious consequences for the health of the individuals affected.⁶

⁹ Criteria proposed by QLD in a 1998 discussion paper 'Review of the Health Act, 1937 (Public Health)' for determining which diseases should be controlled notifiable conditions.

6. Confirmation, Review & Appeal

Due to the serious implications for individual's civil liberties of judgements being made by a public health official, the application of any public health order should be subject to confirmation by, or appeals to, a court or tribunal and periodic review with appeal rights provided to the person on whom the order is imposed.

Court confirmation of orders

The Final Report of the Legal Working Party of the Intergovernmental Committee on AIDS (IGCA) recommends that 'it should be necessary for coercive measures to be court ordered or at least court-authorized within a short period of time (eg three working days) after such measures have been carried out by [a public health official]'.¹⁰

As an example of a court-authorized order, in NSW confirmation of a public health order by a Local Court is required within 3 days for HIV/AIDS. This time restriction is currently under review¹⁰ and does not apply to diseases other than Category 5 conditions (eg HIV/AIDS). In other jurisdictions, Courts play a role in authorising extension or continuation of orders, such as isolation or detention, beyond specific timeframes (eg 48 hours in Tasmania) that are within the power of the public health official.

The current Queensland legislation requires the Chief Executive to apply to a magistrate to impose an isolation, detention or treatment order. However, this legislation is also under review and it is proposed to include a power that enables the Chief Executive to make an order that will allow detention where there is an immediate risk to public health whilst the order application is heard by a Magistrate.

Best Practice Legislation

To provide the ability for an authority to act quickly to protect public health the legislation should provide for the public health official to make orders based on the criteria discussed above (See Section 3) that must then be either confirmed by a court or tribunal as soon as practicable or subject to readily accessible review by a court or tribunal. The court or tribunal must be accessible and ensure that matters can be heard expeditiously.

Duration, Review and Appeal

Most jurisdictions prescribe maximum periods for isolation and detention by Court order, for example not more than 6 months in New South Wales, South Australia and Tasmania.

Review periods are also set for particular orders such as in Victoria, where an isolation order must be reviewed at intervals of not more than 28 days.

Most jurisdictions also provide for appeals against decisions of the public health official, court or tribunal that has imposed an order.

These provisions are an integral part of the process, which enable individual rights to be protected. As with the basis for issuing orders, streamlining the review and appeal provisions nationally will contribute to orders being more easily recognised across borders.¹

Best Practice Legislation

Maximum duration periods for orders should be prescribed for all orders to ensure that individual cases are kept under review. A maximum period of six months is considered most appropriate. At the end of this period a further order could be made if necessary.

¹⁰ The NSW issues paper Review of the Public Health Act, 1991 states that "It is likely that the '3 day rule' would deny the patient the opportunity to obtain legal assistance, while creating practical difficulties for the Department."

Minimum review periods should be provided by legislation to ensure the public health risk still warrants the order being in place. This could involve examination at specified intervals, or an assessment of the behaviour management that has been put in place. Flexibility is needed to allow appropriate responses to the many situations that may be presented. Thus provisions should stipulate that public health orders should be reviewed:

- as is necessary to determine the ongoing public health risk; or
- as directed by the court or tribunal; but
- at a minimum every 28 days.

The person on whom an order has been imposed should have the following appeal rights provided by the legislation:

- to the appropriate court or tribunal (eg local court, Magistrate or administrative review tribunal) against a decision of the public health official; and
- to a higher court (eg Supreme Court) against the decision of a lower court or tribunal in reviewing the original decision.

The legislation should also ensure that appeals and reviews are dealt with expeditiously, and that the processes involve minimal cost to the appellant.

7. Summary of Best Practice Legislation

1. *Guiding Principles*

An expression of Principles that indicate the rights and responsibilities of the infected person, and guide the administration of the legislation similar to those in the Victorian and ACT public health Acts and consistent with those set out in Section 3 ie:

- that where possible:
 - a. control should be by support and education to encourage cooperation and appropriate behaviour change;
 - b. the least coercive power (counselling) should be used first and at which point the public health authority may not need to be involved; and
 - c. the consent of the person should be sought for testing and examination.
- but that the legislation should provide the capacity to use coercive powers as a last resort to deal with exceptional cases where there is a significant risk to public health.

2. *Basis for orders*

- For examination/testing powers the public health official believes that the person is infected or exposed such that they are likely to contract the disease; or
- For more restrictive powers the person is known to be infected with a particular disease.

and

- the person is behaving in a way that is endangering, or is likely to endanger the health of the public;
- the person is likely to continue such behaviour in the future;
- that the action is needed to prevent or alleviate a significant and serious public health risk;
- the least restrictive or minimum action shall be considered first.

3. *Orders Powers to be Prescribed*

- a. Examination, which includes testing - *Order can be issued by a public health official to determine disease status. When heard by Court option provided for Court to replace with order to isolate or detain;*
- b. Counselling;
- c. Restrict behaviour or activities -*Including employment;*
- d. Supervision;
- e. Treatment - *Including the power to ensure treatment is completed;*
- f. Detention; and
- g. Isolation.

Powers (c) to (g) are only to be used when counselling has not been successful or it is not appropriate having regard to the nature of the disease or the circumstances of the case.

4. *Ability to apprehend*

Where an order has not been complied with.

5. *Confirmation, Review and Appeal*

All orders imposed by a public health official are to be either confirmed by an appropriate court or tribunal as soon as practicable or subject to very accessible review by a court or tribunal.

6. *Duration, Review and Appeal*

Maximum duration that any order may stand prescribed as 6 months only and by appeal or confirmation of a court or tribunal. A further order could be made if necessary at the end of this period.

7. *Minimum Review Period*

Minimum review period for all orders to be prescribed, as in the opinion of the public health official as needed to assess the ongoing public health risk, or as directed by the court or tribunal. In any case not greater than every 28 days.

8. *Accessible Appeal Rights*

Readily accessible appeal rights to be prescribed so that there is a right of appeal:

- to the appropriate court or tribunal (eg local court or Magistrate or administrative review tribunal) against a decision of the public health official; and
- to a higher court (eg Supreme Court) against the decision of lower court or tribunal in reviewing the original decision.

9. *Timeliness and Cost to Appellant*

Reviews and appeals are dealt with expeditiously and at minimal cost to the appellant.

8. References

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