Detention for tuberculosis: public health and the law

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ABSTRACT

- Non-compliance with treatment of pulmonary tuberculosis (TB) by an individual can put the community at risk of transmission of TB.
- Public health (detention) orders can be issued to detain non-compliant individuals, but this is a last resort and rarely used.
- Two recent cases in New South Wales illustrate the process of issuing a public health order in NSW, and some of the issues that may arise.
- The NSW law can also be applied to patients with severe acute respiratory syndrome (SARS) or HIV/AIDS.
- The other states and territories have similar laws, which often apply to a broader range of diseases and have fewer limits on issuing and extending orders.

MJA 2004; 180: 573–576

PULMONARY TUBERCULOSIS is a highly contagious disease that accounted for 58% of the 1028 tuberculosis (TB) notifications in 2002 in Australia.[1] Most patients complete therapy successfully.[1] A study in San Francisco confirmed through DNA fingerprinting that a single non-compliant TB patient could infect large numbers of people.[2] In Australia, non-compliant patients can be detained under coercive powers available to all states and territories. To our knowledge, 10 public health detention orders for TB carriers have been issued in Australia within the past 5 years (personal communication, March 2004, see Acknowledgements *page 576*). In New South Wales, there have been two recent cases in which this power was used (Box 1).

The process of issuing a public health order in New South Wales

Forced detention is the last resort rather than the initial step in addressing non-compliance. Internationally recognised guidelines, the 1984 "Siracusa Principles", address this issue.[3] These guidelines state that any restriction imposed on an individual must be legitimate, legal and the least restrictive measure possible.

In New South Wales, Health Department Circular 94/88 outlines the steps required to issue a public health order for non-compliant patients with TB.[4] The initial steps involve counselling, education and support to try to convince the individual to comply with treatment. The patient's peer group (ethnic, religious, family or otherwise) and hospital staff have extremely valuable roles at this early stage.

The next step involves a full psychosocial assessment to identify obstacles to compliance. Obstacles may include substance misuse, language difficulties, homelessness, social isolation, mental illness and intellectual disability. Correction of these factors may improve compliance.

If these measures fail, a warning letter may be issued. This states that the patient has been non-compliant with therapy, is putting the community at risk and that, if this behaviour continues, a public health order can be issued to detain the patient. Although letters had no effect on the two patients in NSW (Box 1), a study in New York City found that letters are effective: 13 of 17 people who received letters completed treatment without detention.[5]

Incentives such as provision of accommodation, income maintenance and other financial incentives should also be used to promote compliance. If these interventions fail, an assessment panel convenes to decide whether a detention order should be issued. The panel includes the Medical Officer of Health (a statutory position whose purpose is to enforce the Public Health Act), the Chairman of the NSW TB Advisory Committee, the Statewide Coordinator of TB Services, a physician, social worker or counsellor, and a representative of the patient's community or peer group.[4] A public health order can be issued under section 23 of the *Public Health Act 1991* (NSW) if the panel recommends it. An order must contain the reasons for its use and its duration (up to 28 days), and is signed by the Chief Health Officer. No court hearing is required.

To extend an order, an application must be made to the Administrative Decisions Tribunal under section 26 of the Act. Under the *Administrative Decisions Tribunal Act 1997* (NSW), the tribunal consists of at least two judicial members and a non-judicial member with expertise in the relevant field. The tribunal examines public health orders made under NSW legislation and can extend an order by up to 6 months. The detained individual has the right to legal representation at this stage and can contest the order.

Circular 94/88 again stresses that an order should only be issued as a last resort after all less restrictive measures have failed.

The detention legislation for infectious diseases varies significantly between the states and territories (Box 2). Some jurisdictions appear to have few safeguards for the issuing and extending of a detention order.

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1: Circumstances of two recent detention orders for tuberculosis in New South Wales

Patient 1

A young man had been in Australia for 3 years on a student visa. He spoke little English. A chest x-ray, performed as part of his visa extension process, revealed abnormalities suggestive of TB. Respiratory specimens were smear-negative for TB, but *Mycobacterium tuberculosis* was isolated from a bronchoalveolar lavage specimen. This was reported as fully sensitive, and standard four-drug directly observed therapy (DOT) was commenced. This was administered on an outpatient basis three times a week.

In the first 4 months of therapy, the patient was compliant with his treatment 80%–90% of the time. Radiological deterioration prompted retesting of the original specimen, and it was found to be multidrug-resistant. He was immediately admitted to hospital and commenced on appropriate therapy.

The patient was discharged from hospital 6 months after starting therapy, for daily DOT in the community. However, 6 weeks later, he was defaulting regularly from treatment. It became difficult to locate him as he had no fixed address. A warning letter was issued to him in English and Chinese, and the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) was notified of the case. DIMIA put a trace on the patient's mobile phone and planned to cancel his visa, giving police the power to detain him.

Two weeks later, after a series of assessment panel teleconferences, a public health order was issued. The Chinese consulate assisted in locating the patient. A few days later, during a teleconference of the panel, the Chinese consulate phoned and advised that they had found the patient and sent him to hospital. The Medical Officer of Health terminated the teleconference and drove straight to the hospital, where he served the order through a telephone interpreter service.

The patient was confined to a locked, negative-pressure hospital room with a security guard posted outside 24 hours a day. The patient was extremely unhappy with his detention, refused to eat and was losing weight.

Soon thereafter, at a teleconference involving DIMIA, hospital administration, Health Services Australia, Health Assessment Services, NSW Health Communicable Diseases Branch and NSW Legal Branch, it was decided to treat the patient in the isolation room for a further week, and that he would need 18 months of therapy in total. DIMIA officers reported that there were improprieties with his visa application and suggested that he be placed in custody in Villawood Detention Centre; this raised a number of public health concerns.

The following day, the patient escaped from hospital and to date has not been found.

Patient 2

An Australian-born man in his 50s was admitted to hospital with a diagnosis of cavitary pulmonary tuberculosis. He was highly infectious, with 4+ of acid-fast bacilli in his sputum. Cultures later confirmed fully sensitive *Mycobacterium tuberculosis*. He had a long history of substance misuse, consuming more than one cask of wine and smoking up to 70 cigarettes a day. He reported a long history of homelessness. He was admitted under the respiratory team with regular drug-and-alcohol team involvement.

He commenced standard four-drug therapy. The importance of remaining in isolation while infectious was regularly reinforced to the patient. However, he attempted to abscond from the hospital on at least six occasions, and was successful twice. Once, after absconding, he was found intoxicated at a major railway station. He was still infectious at this stage. His absconding threatened the public and interrupted his therapy. While hospitalised, the patient was aggressive towards staff, including threatening several times to spit on them.

An assessment panel convened to discuss the patient. They explored the possibility of detaining him under the *Mental Health Act 1990* (NSW), but this was deemed inappropriate. A warning letter was issued, but this had no effect on the patient's attempts to abscond. A public health order was issued and served on the patient. A security guard was placed outside his door 24 hours a day.

The patient's disruptive behaviour continued during his detention. He was still aggressive towards staff, threatening to assault them with furnishings in his room, so all non-essential furniture was removed. A lock was placed on his door.

A month later, the patient had improved remarkably, was no longer aggressive to staff and was compliant with therapy. This probably reflected improved control of both his TB and the substance misuse. He expressed a desire to never drink alcohol again, but conceded that, once he was discharged to the community, the temptation to start drinking again would be strong and he might "throw his pills out". As the patient was still infectious, with smear-positive sputum, an extension of the public health order was sought. The Administrative Decisions Tribunal convened, with the patient represented by Legal Aid. The tribunal extended the order for 2 months.

At the time of writing, the patient has been receiving DOT in the community for more than 3 months. Despite occasional difficulties, this has been largely successful and he is nearing completion of therapy. He is drinking alcohol again, but not in such large amounts as previously.

Patient and staff attitudes to detention

Both patients recently detained in NSW (Box 1) were extremely unhappy about being detained. Patient 1 stopped eating and lost weight while detained. Patient 2 considered his room to be a "jail cell". He also stated that he was frustrated and that his human rights were being "infringed". This highlights the fact that serving an order does not resolve the conflict — it merely provides a legal basis for detention. It does not ensure compliance, understanding or improved behaviour. However, detention can result in a positive outlook. Some TB patients detained on New York's Roosevelt Island eventually expressed gratitude to the city authorities for detaining them: "the chaos of their lives had been transformed into a calm in which they could reflect upon their life's course".[3] Of course, other patients did *not* look so favourably on their detention.

The whole process can also be distressing for hospital staff, who felt like jailers in both NSW cases. For Patient 2, the hospital administrators argued that their facility was an inappropriate place for detention. The use of prison and psychiatric facilities was explored, but this was also deemed inappropriate. Primacy is given to the fact that these patients have a medical condition complicated by social problems that impede compliance with treatment; they are not criminals to be punished.[6] Ideally, a dedicated medical facility should be available whenever the need arises. In New York City, where many more TB patients require detention, two hospitals are used for this purpose.[5]

2: Summary of legislation for detaining patients with infectious diseases in Australia

	Legislation	Diseases	Person who can issue an order	Court application required	Maximum duration of initial order before review	Maximum extension of order; Review body
Australian Capital Territory	*Public Health Act 1997*, ss 113–118	Transmissible notifiable condition (about 70 declared)	Magistrate	Yes	Unspecified	
New South Wales	*Public Health Act 1991*, ss 23–26	Category 4 (typhoid, SARS, tuberculosis) or 5 (HIV, AIDS) disease	Authorised medical practitioner*	No†	Up to 28 days	Up to 6 months; Administrative Decisions Tribunal
Northern Territory	*Notifiable Diseases Act 1981,* ss 11–13	Notifiable disease (about 40 declared)	Medical Officer of Health	No	Unspecified	
Queensland	*Health Act 1937,* ss 36–37	Infectious disease (more than 100 prescribed by regulation)	Justice (Magistrate)	Yes	Unspecified	
South Australia	*Public and Environmental Health Act 1987,* ss 32–34	Controlled notifiable disease (about 20 prescribed by regulation)	Magistrate	Yes	Up to 6 months with magistrate approval; longer with Supreme Court approval	
Tasmania	*Public Health Act 1997*, ss 41–44	Notifiable disease (about 70 declared)	Director of Public Health	Yes	Up to 3 days, or up to 6 months with magistrate approval	Unspecified; Supreme Court
Victoria	*Health Act 1958*, ss 121–122	Infectious disease (more than 100 prescribed by regulation)	Secretary‡	No§	Up to 28 days	Up to 28 days; Secretary, subject to administrative appeal
Western Australia	*Health Act 1911*, ss 251–254	Dangerous infectious disease (excludes venereal disease)	Public Health Officer¶	No	Unspecified	

* The Chief Health Officer or a doctor authorised by the Director-General of Health. † An application for the initial order must be made to a tribunal if the person has a Category 5 disease. However, an application is not necessary for Category 4 diseases, although section 23 states that restriction should only be used if it is the only effective way of protecting the public. ‡ The "Secretary" refers to (a) in relation to any act to which section 6(3) applies, the body corporate established under section 6; and (b) in any other case, the Secretary to the Department of Human Services. § Although a court application for the initial order is not necessary, section 119 states that only the minimal restrictions should be used: "the spread of infectious diseases should be prevented or limited without imposing unnecessary restrictions on personal liberty and privacy". ¶ The Public Health Officer can issue an order only if delegated by the Executive Director, Public Health, who, in turn, requires authorisation by the Minister. SARS = Severe acute respiratory syndrome.

Length of detention

The appropriate length of detention is not clear. One study in Denver found that short-term detention (< 60 days) was enough to promote compliance in 13 of 17 patients, and only three patients required long-term detention.[7] An argument could be made to continue detention until the patient completes treatment, but NSW Health policy states that the individual must have "active, untreated, infectious TB" and be endangering the health of the public for an order to be issued.[4]

In contrast, in England and Wales, "the prediction of future dangerousness" may be the basis for setting the duration of a court order.[8] The New York City regulations allow the health department to quarantine patients whom they believe are unlikely to complete therapy, even if this is not the least restrictive approach.[3]

Risk factors for detention

It appears that TB patients are more likely to require a detention order if they are socially disadvantaged. One study examined detention of TB patients in New York City in the early 1990s.[5] Over a 2-year period, 139 people with TB were detained, with a median of 31 patients detained at any one time. Overall, this represented no more than 2% of the TB population. However, individuals were more likely to be detained if they had been incarcerated (18%), used "crack" (13%), were homeless (9%), misused alcohol (7%), or had a history of injecting-drug use (5%).[5] The study in Denver also identified an association between alcohol misuse, homelessness and the use of incarceration.[7] Our second patient had two of these social problems.

In Australia, the Communicable Diseases Network Australia compiles an annual summary of TB notifications. This does not include information about non-compliant patients requiring detention. Thus, we have no information on which of the social and ethnic risk factors for detention identified in overseas studies might be extrapolated to the Australian situation. The annual summary does contain information about "defaulters" (ie, patients who failed to complete treatment). Such patients might require detention orders. Given the complexity of detention, the annual TB summary could be supplemented by collection of data on potential risk factors associated with defaulters and detainees.

Conclusion

In Australia, the detention of non-compliant TB patients is not undertaken lightly. We have described how powers under the NSW Public Health Act can be used to detain non-compliant patients with TB, highlighting two recent examples. These powers can also be used to detain patients with typhoid fever, severe acute respiratory syndrome (SARS), HIV and AIDS if there is a demonstrable threat to the community. In other states, similar powers can extend to a broader range of infectious diseases.

Acknowledgements

We thank the following people for providing information about the number of detention orders in the different jurisdictions: L Brown, Program Manager, Mycobacterial Infections, Department of Human Services, Melbourne, VIC; A Christensen, NSW TB Program Manager, NSW Health, Sydney, NSW; D Joyce, Clinical Nurse Consultant, Department of Thoracic Medicine, Canberra Hospital, Canberra, ACT; T O'Brien, Clinical Nurse Consultant, Queensland Specialised Health Services, Annerley, QLD; R Stapledon, Medical Officer, South Australia TB Services, Adelaide, SA; D Walker, Registered Nurse, TB Services, Department of Respiratory Medicine, Royal Hobart Hospital, Hobart, TAS; J Waring, Medical Officer, Perth Chest Clinic, Perth, WA; N Zweck, Medical Officer, TB/Leprosy Control Unit, Darwin, NT. We thank Dr Chris Reynolds, School of Law, Flinders University, SA, for his contribution to this article, and we acknowledge the care and compassion of the healthcare workers who looked after these two patients. Sanjaya Senanayake is funded by the Master of Applied Epidemiology Program through the Australian Department of Health and Ageing.

Competing interests

None identified.

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(Received 4 Nov 2003, accepted 16 Mar 2004) ❑