

AFAO Workshop on Criminalisation of HIV Transmission: *Report*

A summary of the outcomes of the AFAO Workshop of Criminal Transmission of HIV held at Citigate Sebel Hotel, Surry Hills, Sydney on 10th November, 2006

The Australian Federation of AIDS Organisations (AFAO) conducted a workshop on criminal prosecution of HIV transmission in November 2006. The impetus for the workshop arose from several criminal prosecutions involving transmission of HIV currently before the courts, including the highly publicised allegations against Michael Neal in Victoria. Conducted as part of the AFAO General Meeting, the workshop also included speakers and participants from member organisations and other interested groups.

The workshop involved four sessions:

1. **Scene-setting:**
 - Public health law, criminal law and recent case law - Sally Cameron (former AFAO Policy Analyst)
 - Impact on service providers and communities - Mike Kennedy (Executive Director, VAC/GMHC)
2. **Hypothetical session –**
Facilitator – Bridget Haire (Policy Analyst, AFAO)
Respondents:
 - Geoff Honnor, ACON
 - Dr Bebe Loff (Head, Human Rights and Bioethics Unit, Monash University)
 - Philomena Horsley (ARCSHS, former Coordinator, Positive Women Victoria)
 - Dr Robert Finlayson, General Practitioner
 - Dr Anna McNulty (Convenor, Panel to assess people who knowingly expose others to the risk of HIV infection, NSW)
 - Dr Helen Watchirs (ACT Human Rights Commissioner)
3. ***Responsible for what? HIV and understandings about responsibility among gay men***
4. **Key issues and recommendations**



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Background information and scene-setting

The emergence of HIV in the 1980s generated a legal response. Some states (both criminal and public health legislation are under the jurisdiction of the states/territories) developed laws which provide for offences specifically relating to HIV transmission while others have used existing or expanded criminal laws.

The two sets of legislation have quite different purposes, with public health legislation designed to protect public health by effecting behaviour change in individuals while criminal law is principally designed to punish the offender and - in theory at least - act as a deterrent to others.

Organisations in the HIV sector have historically favoured the use of public health interventions and opposed HIV-specific criminal legislation, which has the potential to stigmatise people living with HIV. Public health legislation can have a punitive effect but typically reflects a series of graded interventions, ranging from cooperative measures such as counselling through to restrictive orders and detention 'as a last resort'. In a case that received widespread media attention, HIV-positive sex worker 'Sharleen' was detained under public health legislation in the late 1980s.

As a result, these two legislative responses to HIV now co-exist in Australian jurisdictions. Public health law has been the primary mechanism for responding to HIV, and criminal prosecutions have been rare. There were a number of convictions in Victoria for reckless endangerment involving HIV transmission during the 1990s, but these convictions were subsequently overturned. There have been no cases in Australia involving HIV exposure without transmission.

However, there has been a spate of criminal cases involving HIV transmission in the last few years. The reason for this is unclear, as cases have occurred in a number of states, including WA, South Australia, Queensland, New South Wales and Victoria. Most, but not all, involve heterosexual transmission.

Most recently, Melbourne man Michael Neal was arrested and charged with 35 offences including attempting to infect others with HIV. The case has not yet gone to court and the police investigation is continuing. The case is significant in that it involves a large number of alleged victims. Neal had also been the subject of complaints to the Department of Human Services and had failed to comply with public health orders prior to his arrest.

These cases highlight the gaps between criminal and public health legislation. While public health is generally the preferred mechanism with which to deal with HIV, it is not clear what happens when public health interventions fail. There is no mandatory reporting or referral of cases to the police. Conversely, criminal cases are typically initiated by complaints from victims in which the police are required to act. These issues are complicated by the number of different jurisdictions. The impact of changes such as improved treatments and the impact of undetectable viral load on criminal cases, is also unclear.

Impact on Service Providers and Communities

Victoria has a similar legislative framework to that of other states, involving both criminal and public health legislation. The Public Health Act is implemented through 'Guidelines for the management Victoria of people living with HIV who knowingly put others at risk 2006-2009', which are administered through the Communicable Disease Control Unit of the Public Health Branch (though these were implemented only after the allegations against Michael Neal).

The guidelines focus on balancing individual and community rights and provide for a five-stage process in dealing with people with HIV who place others at risk. This includes case management by a panel (which includes community representatives). Public health orders can also be made, at which stage the defendant can appeal to the Supreme Court. In Victoria witnesses can also be compelled to give evidence through the Magistrates Court Act (1989).

In the case of Michael Neal, criminal charges have been laid. The case has involved a wide-ranging police investigation, and it is possible that further charges will be laid. Police have liaised with community representatives regarding the investigation, as the alleged victims are gay men and some of them are clients of HIV services. Services have also been directly involved, with documents being subpoenaed from services; this has included police serving search warrants. Clients have also been served with subpoenas.

Confidentiality is a major issue in the Neal case, with HIV organisations being required to provide files and to provide client files which are normally confidential. VAC/GMHC has resisted these requests, and has received conflicting legal advice regarding its legal position. Management of the organisation's response to the case presents has had a significant impact on time and resources.

It is not yet known what evidence will be presented in the Neal case. However, the case raises important issues about the role of service providers and their legal and ethical responsibilities. It also raises issues about the nature of consent and possible defences to charges involving HIV transmission.

Regardless of the outcome of the Neal case, there was general agreement that organisations need to be mindful of the possibility of criminal prosecutions and of documents being subpoenaed. Therefore there is a need for clarity about the legal and professional requirements in relation to record-keeping and to confidentiality. Organisations need to have clear procedures in place and access to legal advice.

There is also potential for conflict between organisational policies and responsibilities and the professional obligations of individual professionals such as counsellors and social workers.

The case has the potential to have a significant impact on the gay community, with a large number of people and organisations being involved. There is potential for very negative representations of people with HIV generally.

The case has already received significant media attention and this is likely to increase when court proceedings begin. There was also agreement that organisations working in the HIV sector need to be prepared in advance to respond to media queries about this and other possible cases. There is a need for clear and consistent messages, both in terms of responding to media queries and dealing with client and community concerns.

Hypothetical

The following hypothetical scenario was presented:

Warren and Brendan arrange to meet after chatting through Gaydar. Warren's profile states that he always has safer sex. Brendan leaves this blank on his profile but he describes himself as 'fit and healthy'. They fuck with condoms. They meet again. In the next six weeks they have sex 210 times, almost always using condoms. They fall in love. They decide to 'talk test, test trust' together, and go to the doctor for STI screening. The doctor is a little surprised, because Brendan's file states he is HIV positive. Warren subsequently tests positive and the relationship breaks down.

Respondents were asked to consider how they would respond in this particular situation. Robert Finlayson (high caseload GP) talked about good practice in HIV testing and how clinicians might manage a situation in which one partner had not disclosed to another. This might include techniques such as asking clients to make separate appointments where appropriate and providing particular information but it would not include disclosure of a partner's status, as this would violate a patient's confidentiality.

There was discussion about whether a criminal prosecution might be possible in this hypothetical situation, and what effect this would have. Helen Watchirs (ACT Human Rights Commissioner) suggested that prosecution may be possible but would be unlikely under current circumstances. Robert emphasised that while a level of anger is understandable, attempts to pursue legal action invariably have a detrimental effect on the complainant's health. For this reason, it may be more helpful for service providers to offer support and strategies to assist clients in living with HIV rather than advising them to take legal action. Bebe Loff (ethicist) emphasised that while criminal sanctions may be appropriate in exceptional circumstances, there are often personal costs associated with prosecuting a case and other ways need to be found to recognise harm done to individuals.

There was discussion around the responsibility for preventing HIV transmission – where this responsibility lies, and to what extent. Philomena Horsley (former Coordinator, Positive Women Victoria) suggested that people living with HIV do have a responsibility not to infect others, or expose them to the risk of infection. She emphasised that the concept of shared responsibility for prevention is of limited value in situations where a partner deliberately withholds information or misleads a partner about their HIV status. Geoff Honnor also echoed this sentiment.

There was discussion about the perception of risk, and the adoption of risk reduction strategies. Assessment of risk is heavily dependent on context. For instance, a gay man in the inner city is likely to face a greater risk of HIV and also have access to different information than a heterosexual woman. The responsibility accruing to HIV-positive people who adopt different risk reduction strategies is also unclear; for instance, while in New Zealand the courts have apparently accepted that condom use discharges the responsibility to prevent transmission, the impact of undetectable viral load has not yet been tested.

Drug and alcohol and mental health issues may also be important, and referral to other services may be appropriate. Anna McNulty (Convenor, Panel to assess people who knowingly expose others to HIV infection, NSW) pointed out that people who come to the attention of the public health authorities frequently have intellectual or psychiatric disabilities.

Responsible for what?

Dean Murphy (HIV educator, AFAO) spoke about the theme of responsibility in HIV health promotion materials. This is part of a larger research project on responsibility in relation to HIV. Its aim was to examine the language used in HIV health education, in terms of who is being addressed, what they were being asked to do, the relationship between author and reader, and so on.

Three distinct chronological periods in HIV health promotion were identified:

- *Pre-1996*: This period was characterised by an emphasis on shared responsibility for HIV prevention. These materials frequently referred to notions of gay community such as 'we' or 'us', and focused on ending discrimination. 'Safe sex' and the use of condoms was heavily promoted.
- *Post-1996*: The introduction of antiretroviral therapy in 1996 precipitated a distinct shift in health promotion messages, with a greater focus on individual responsibility emerging. Materials from this period show a greater emphasis on risk and risk reduction strategies. The notion of 'safe sex' largely disappeared after 1996.
- *Post-2001*: Increases in HIV transmissions from around 2001 precipitated another shift in health promotion messages, with a focus on providing information about the increases and a return to notions of 'community'. This period has also seen an emphasis on disclosure and communication about HIV.

Jeanne Ellard (Research Officer, National Centre in HIV Social Research) spoke about understandings of responsibility that emerged in her study of gay men who had recently seroconverted. This qualitative research identified an absence of discourses of blame. In the majority of cases men did not tend to blame the person they believed infected them with HIV. Instead there was an emphasis on personal responsibility for the unwanted outcome of HIV.

Kane Race (Research Fellow, National Centre in HIV Social Research) emphasised the relational character of HIV prevention, and the multiplicity of different strategies for prevention. He discussed the emergence of discourses of 'barebacking' and 'serosorting' among gay men. These terms have emerged in the last ten years, and are used to describe the complex negotiation of sex between men in this context. 'Barebacking' was a term initially used by positive men to refer to sex without condoms with other positive men, and was seen as a liberating response to living with HIV. It received sensational (and often highly moralising) public attention and has since come to be used to describe all sex without condoms. Serosorting was initially used as a term to describe negotiating positive sex, but has become associated with conservative concepts of dating and monogamy. These shifts in meaning point to the difficulties of talking frankly about the complexities of negotiating positive sex.

Nick Corrigan (Director, Community Health, ACON) then spoke about education messages in relation to positive gay men. Targeting HIV+ men can be difficult because safe sex hold few 'rewards' for them. Targeting positive men can also create the impression that they are solely responsible for prevention, which HIV educators have historically sought to avoid. Nick questioned whether the notion of 'shared responsibility' is still useful when poz and neg men have different roles in prevention. The recent 'taking responsibility' campaign in the UK was quite successful. Altruism may also be a possible theme for health education.

Key issues and recommendations

In this session, workshop participants broke into groups to discuss key issues across the following broad areas:

Ethical implications:

- There was broad agreement that not disclosing positive HIV status and continuing to have unprotected sex was unethical, but not clear what communication strategies could be used around this without placing disproportionate responsibility on the person with HIV
- It is not reasonable for people who have high risk unprotected sex to assume that they are HIV-negative
- The need to cooperate with police may conflict with duty to protect client's privacy (as in recent Victorian case). 'Sealing' files before handing them over may be one way to deal with this problem.
- Duty of care may apply to those at risk of HIV as well as those with HIV.

Implications for health promotion:

- Criminalisation acts as a disincentive to HIV testing and treatment. It may also undermine the willingness of positive people to disclose their status.
- Increasing criminalisation may lead to an increase in the stigma surrounding HIV, and also in poz-poz serosorting
- Criminalisation has potential to impact more broadly on the gay community
- Challenges the way responsibility is understood by gay men
- Health promotion messages may be appropriate but there is also a need to respond to media attention
- There may be a need for more explicit health promotion messages regarding responsibility
- Need to articulate a moral position/values

Implications for people living with HIV

- Change in environment regarding criminalisation has implications for people living with HIV in terms of changed environment for disclosure, increased surveillance
- Potential impact on engagement with services and research, if people are not sure confidentiality will be maintained and become unwilling to disclose issues
- Increased responsibility for prevention apportioned to people with HIV
- Implications for education messages for people living with HIV
- Possible increase in stigma around being HIV-positive
- Changes in HIV, effects of undetectable viral load and HAART are not well understood in the wider community. As a result, legislation may be out of date.
- There is a need for education for HIV- people about shared responsibility
- There is also a need for education for HIV+ people about relevant legislation in different states and the implications of unprotected sex
- Need to affirm the right of people with HIV to have sex

**AFAO Workshop on Criminalisation of HIV Transmission
- Report -**

- Need to reduce the threat of criminalisation and emphasise that criminal cases do not reflect the behaviour of the majority of people with HIV
- Can someone consent to becoming HIV-positive?

Implications for service provision

- Services need clarity around:
 - requirements and best practice in documentation and note-taking
 - ethical responsibilities of professionals employed by services (e.g. social workers, psychologists)
 - reporting obligations
 - correct responses and terminology to be used in relation to allegations, hearsay
 - balancing privacy/confidentiality issues and information sharing between agencies
- Criminalisation has potential to impact on indemnity insurance, staff development needs. Involvement in criminal cases can have significant resource implications for sector organisations, e.g. in terms of staff time, legal expenses.
- Criminalisation tends to contribute to increased focus on individual rather than community care
- Dependency models in service provision versus empowerment models
- Balancing the needs of different clients – do services have to be all things to all people?
- Members should support Health Act over Crimes Act
- ‘*Poz sex*’ handbook should be updated
- Campaigns or public forums about legal rights and responsibilities by AIDS Councils
- Changes to ‘enabling environment’ should be highlighted in mid-term review of National HIV Strategy
- AFAO and member organisations produce position statements on reckless endangerment and criminalisation
- Member organisations develop strategies to minimise fallout with government, media, local community

Policy issues

- Increasing criminalisation has a negative impact on enabling environment
- More difficult to engage partners
- Problems with terminology – it is important to be clear about correct terminology
- Problem in working in multiple jurisdictions with different laws and policies
- Criminalisation may lead to an increased focus on bio-medical prevention
- Privacy issues (particularly in relation to new technologies such as the smartcard and electronic health records)
- What is the policy response to ‘bad apples’? Organisations need to articulate ethical standards; there is not necessarily community consensus on this issue.
- Criminalisation may generate opportunities as well as threats (e.g. media attention).