Reducing HIV Transmission by People With HIV Who Are Unwilling or Unable to Take Appropriate Precautions

---

An Update

Ontario Advisory Committee on HIV and AIDS (OACHA)

May 2002

I. Background

In 1996, the Ontario Advisory Committee in HIV and AIDS (OACHA) submitted to the Minister of Health a report titled, **Reducing HIV Transmission by People With HIV Who Are Unwilling or Unable to Take Appropriate Precautions**. That document was the result of a six-year consultative process. Its goals were to:

- respond to the small proportion of HIV-positive people who know they HIV-positive but who are unwilling or unable to take precautions and, therefore, put others at risk
- identify strategies that will assist the small number of people who are unwilling or unable and, at the same time, reduce the negative impact/stigma of court cases and media coverage on the majority people with HIV who are responsible.

> The term unwilling or unable is used to describe the small proportion of people who know they are HIV-positive but do not take precautions to prevent the spread of HIV to others. In some cases, their unwillingness or inability is due to lack of information; in others, it may be due to personal and/or environmental factors or psychological or developmental reasons.

The report analyzed the different approaches in use in Ontario to reduce HIV transmission by people who are unwilling or unable to take precautions, and made a series of recommendations based on the following values and principles:

People with HIV are entitled to a quality of life that includes sexual intimacy.

People must take responsibility for their own risk behaviour. They cannot realistically expect authorities to ensure complete protection from HIV.

All people with HIV should not be judged in light of those who persistently expose others to HIV infection.

The intent of interventions aimed at changing the behaviour of people who intentionally put others at risk is to reduce risk, not to punish. The measures used should be the least intrusive, least restrictive, most readily available and most effective possible to successfully reduce transmission.

Interventions are only necessary when people are unknowingly put at risk. When HIV-negative people are informed of the risk of HIV infection, and consent to participate in risky activities, interventions are not required.

In 2001, OACHA reviewed the report and its recommendations (which have not been implemented) in light of the recent court decision (Cuerrier)[1]. In OACHA's view, the information and recommendations are still relevant, and offer an effective way to reduce both HIV transmission and stigma.

The following summarizes the information in the 1996 report, incorporates new developments, and makes recommendations designed to reduce HIV transmission by people who are unwilling or unable to take precautions.

II. Current Approaches to Reduce Transmission by People who are Unwilling or Unable

Ontario uses a variety of approaches to reduce HIV transmission. They are listed here, beginning with the least intrusive and continuing through the most coercive.

Prevention Education

Pamphlets, presentations and media campaigns are designed to raise awareness about the risks of HIV transmission and prevention methods. They can help create an environment that promotes and supports safer sex and drug use. A growing number of prevention programs focus on harm reduction – that is, identifying changes in behaviour/activities that will reduce but not necessarily eliminate risk. While these initiatives can be effective on a population basis, they are unlikely to have a significant impact on people who are unwilling or unable to take precautions or practice harm reduction.

Pre and Post-Test Counselling

Guidelines for HIV testing in Ontario recommend that everyone being tested[2] receive pre- and post-test counselling about the risks of HIV transmission and the precautions necessary to protect themselves and others from exposure to HIV. For people who test positive, post-test counselling is extremely important. It is an opportunity to provide valuable information, support and referrals to other

[1] In the Cuerrier case, the court ruled that where sexual activity poses a "significant risk of serious bodily harm," there is a duty on the HIV-positive person to disclose their status. Where this duty exists, not disclosing may constitute "fraud" that renders a sexual partner's consent to that activity legally invalid, thereby making the otherwise consensual sex an "assault" under Canadian criminal law.

[2] HIV testing is voluntary in Ontario (except in the case of blood, semen and organ donations), and should only occur with the person's informed consent.

resources. For people who test HIV-positive and are still healthy, it may be the only prevention counselling they receive until they become ill and enter the health care system (which can take many years). Because of this, the quality and consistency of post-test counselling is crucial. People who do not receive enough information or do not understand the information they have been given are more likely to continue risk-taking behaviours. Effective post-test counselling has the potential to give people the information they need to take precautions, while poor post-test counselling may contribute to them being unwilling or unable to protect others.

Because of the wide range and number of professionals who provide pre- and post-test counselling (e.g., anonymous testing programs, public health STD clinics, physicians) – some of whom may not have extensive experience with HIV or feel comfortable discussing sexual practices – it is difficult to ensure the quality and consistency of the counselling people receive. At the current time, only the province's HIV anonymous testing sites are legally required to provide pre-test counselling. They have also developed counselling guidelines designed to ensure quality and consistency. These guidelines are now widely used in other testing sites.

Counselling and Support Programs for People with HIV/AIDS

Community-based AIDS organizations, outpatient clinics and public health offices as well as private counsellors, psychotherapists and psychiatrists, provide a range of counselling and support services – including peer counselling -- for people living with HIV. Although there has been no formal evaluation of the overall effectiveness of these programs, there is some evidence that they can reduce people's sense of isolation and helplessness, and teach negotiating skills and strategies to reduce risks. One project evaluation indicated that people with HIV who have experience with peer groups or peer counselling are more likely to practise safer sex consistently.[3] Another showed that men who feel positive about their choices, receive support from their peers and have a sense of control in risk situations are more likely to protect themselves (96% of the time).[4] Given these findings, it appears that high quality, effective counselling and support programs have the potential to reduce transmission by people whose unwillingness stems from lack of information, skills, confidence or a sense of belonging.

---

[3] Tudiver, F., Myers T., et. al.., "The Talking Sex Project: Description of a Randomized Controlled Trial of Small Group AIDS Risk Reduction Intervention for 612 Gay and Bisexual Men" *Evaluation and the Health Professions* 15(4)26-42, 1992.

[4] Myers, T., Godin, G., Calzavara, L., Lambert, J., Locker, D., *The Canadian Survey of Gay and Bisexual Men and HIV Infection: Men's Survey*. Ottawa: Canadian AIDS Society, 1993.

For those whose inability to take precautions stems from drug or alcohol use or mental illness, psychotherapy or a psychiatric intervention may be more effective.

Health Protection and Promotion Act

Under the Health Protection and Promotion Act (HPPA), public health departments have a responsibility to prevent the spread of communicable diseases.[5] All positive HIV test results and cases of AIDS are required by law to be reported to public health by name – although names are often not requested unless the person poses a risk to others. Public health authorities are also responsible for ensuring that sexual and drug using partners who may have been exposed are informed of the possible risk. In some cases, the physician and person with HIV take responsibility for informing partners; in others, partner notification is done by public health.

As part of their responsibility for controlling infectious diseases, public health officials may become aware of people with HIV who are knowingly putting others at risk. This may happen in several different ways, including:

- a request to follow up with the person, made either by the person, his or her physician or another person or institution
- a subsequent report of a positive test for another STD (this would indicate that the person is not practising safer sex)
- a physician reporting a person's unsafe behaviour (as required by the HPPA)
- a complaint from a private citizen.

Under Section 22 of the HPPA, Medical Officers of Health (MOH) have the power to issue a written order for someone who is unwilling or unable that can, among other things, require the person to submit to a physician's examination, to refrain from specific activities that put others at risk, or to reveal the names of sexual or drug contacts.

Public health units report that they pursue a number of less intrusive measures – such as one-to-one counselling, referring the person to community-based organizations for counselling and support, monitoring the situation – before issuing the more coercive Section 22 order. Most report that an order is used as a last resort with people who do not respond to less coercive measures.

Although the HPPA does not explicitly require the MOH to ensure the order is the least intrusive possible to reduce transmission, this requirement is implicit in the

[5] HIV is classified as a communicable and infectious disease.

requirement of necessity set out in section 22(2)(c). The HPPA also provides a number of procedural protections to people who feel that a Section 22 order is not justified, including:

- informing the person that he or she is entitled to a hearing before the Health Protection Appeal and Review Board (HPARB)
- allowing the person to apply for a stay of the order until the hearing has occurred
- giving the person the right to documentary disclosure before the hearing
- allowing the person to be represented by counsel at the hearing, to test the evidence the MOH used to support the order (i.e., cross examine the MOH) and to introduce his or her own evidence
- giving the person the right to appeal the HPARB decision to Divisional Court.

Compared to other available coercive measures, the provisions of the HPPA ensure that the person's identity and the order (if issued) is kept confidential. Anyone who fails to obey an order or seems likely to breach an order can be subject to legal action in the courts, in which case, confidentiality would no longer be guaranteed.

While the involvement of public health officials in dealing with someone who is unwilling or unable is preferable to measures outside public health (e.g., criminal charges) there is little evidence to date that public health measures are effective in preventing or reducing HIV transmission. With most other communicable diseases (e.g., TB, syphilis) , section 22 orders are time-limited measures that are in place until the person is treated and no longer infectious or a risk to others. As there is no cure for HIV, the person cannot be rendered non-infectious and the only logical end point of a section 22 order is a change in the person's behaviour that reduces or eliminates the risk, which is difficult to prove or document. Therefore, detention or hospitalization may not be an effective long-term prevention or control strategy. At the current time, there is no regular review of an order after it is issued to ensure it is still relevant.

As there is no tracking of section 22 orders or their outcomes, it is difficult to know what role they play in behaviour change. There is also some concern that the use of orders may have a negative impact on prevention. The fear/stigma associated with dealing with public health authorities may discourage people from being tested – particularly if section 22 orders are seen primarily as a way to acquire the names of past sexual and drug contacts, rather than prevent future transmissions. If people at risk stop coming forward for testing, this will have a serious negative impact on Ontario's efforts to reduce HIV transmission.

The Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) provides access to and protection of personal information held by the municipal government. It could be used to release information to the public or people affected when it is in the public interest, and the information is of a grave environmental, health or safety hazard to the public. The person must be informed that this is going to happen if it is possible. Some have argued that there may be instances in which MFIPPA could be used if the person with HIV is posing a danger to others. The issue is extremely complex and questions about the interface of the HPPA and MFIPPA needs further discussion. These issues may be addressed in the planned Ministry of Health legislation on confidentiality of health information. The working group believes that section 39 of the HPPA ought to prevail and the use of MFIPPA is not appropriate for use in these circumstances.

The Mental Health Act

For someone whose inability to take precautions is due to a psychiatric disorder, the most appropriate intervention may be the Mental Health Act (MHA). However, HIV status alone is not sufficient to invoke the use of the MHA, and MOHs should have clear guidelines for when to use this legislation.

The Criminal Code

Over the past 10 years, several criminal cases have been brought in Canada against people for aggravated assault or criminal negligence causing bodily harm for allegedly infecting others.

In the cases where people pled guilty, they received prison terms of 1 and 11 years. However, until September 1998, when the Supreme Court of Canada ruled on the appeal of R. v Cuerrier, the applicability of the Criminal Code to an HIV-positive person for engaging in sexual activity without disclosing their HIV status had not been fully litigated. In that decision, the Supreme Court overruled lower-court decisions, and found that "where sexual activity poses a 'significant risk of serious bodily harm' there is a duty on the HIV-positive person to disclose their status. Where this duty exists, not disclosing may constitute 'fraud' that renders a sexual partner's consent to that activity legally invalid, thereby making the otherwise consensual sex an "assault" under Canadian criminal law."[6]

[6] Canadian HIV Legal Network. After Cuerrier: Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status.

Criminal charges are usually laid by a partner – although the case may be pursued by a Crown Prosecutor even after a complaint has been withdrawn, even though the Crown Prosecutor may not be knowledgeable about HIV. By its nature, the criminal process is more intrusive than the public health process. Although the accused could request a publication ban to protect his or her confidentiality, the court is unlikely to agree as it does not provide the same protection in other circumstances, and the case is likely to be covered by media. His or her identity and personal sexual history will become public property. The publicity, sensationalism and stigma associated with a criminal trial will affect not just the accused, but others with HIV.

The Criminal Code does not appear to provide a higher standard of procedural protection than the HPPA. The person who is charged is subject to arrest and jail, while a section 22 order restricts people's liberty without incarceration and, at its most coercive, detains people in a hospital setting rather than a jail. In general, the criminal justice system is too unwieldy to respond effectively to the majority of situations of alleged unsafe behaviour.

The possible outcomes of criminal proceedings are more limited than public health options. They generally involve incarceration, which is designed to provide the opportunity for rehabilitation, to protect the public, to provide a deterrent and to be punitive. However, it is debatable whether it is an effective way to reduce transmission of HIV or deter others. In fact, the criminalization of HIV may keep people from being tested, have a negative impact on prevention programs and further isolate people who are already stigmatized by this disease.

Conclusion

HIV is primarily a health issue, not a criminal justice issue, and is best managed within the health system. Although people with HIV will continue to be charged in the criminal justice system, the goal should be to reinforce public health interventions and legislation as the least intrusive, most appropriate and most effective way to respond to people who are unwilling or unable.

Public health law offers a range of approaches, which can be tailored to the needs of the individual. It also allows officials to be proactive and to take steps to reduce HIV transmission. However, every effort must be made to ensure that public health law is applied judiciously, with a focus on reducing risk, rather than retribution. Every effort must also be made to communicate to the public that

most people with HIV are responsible, and that those who knowingly put others at risk are a very small minority.

To ensure that Ontario consistently uses the least intrusive and most effective measure to reduce transmission, OACHA recommends the following:

Non-Legislative Changes

1. **Continue to pursue prevention/education efforts** at the provincial and local levels to promote risk and harm reduction strategies and to foster a supportive environment for risk and harm reduction.

2. **Develop counselling resources and strategies** to be used by people providing ongoing counselling and support services. The resource would identify the complex factors that contribute to risk behaviour and recommend counselling techniques. Consider a mentoring program and other strategies to implement consistent counselling techniques in various settings across the province.

3. **Develop standard pre- and post- test counselling guidelines** for physicians and counsellors. At a minimum the guidelines should include discussion of:
   - sexual practices in explicit language
   - barriers to practising safer sex
   - disclosure
   - HIV transmission in detail
   - partner notification

4. **Provide pre- and post-test counselling training/information sessions** (based on the anonymous HIV testing model) for physicians as well as the people already providing pre- and post-test counselling.

5. **Develop a policy guide for community-based AIDS organizations** to help them develop internal policies to engage a client who may be unwilling or unable. The goal is to help community-based organizations, who do not have a reporting responsibility under the HPPA, understand and resolve competing ethical and legal responsibilities and establish appropriate policies.

6. **Directives for Crown Prosecutors:** The working group recommends developing directives for Crown prosecutors across the province. The directives should include a strong recommendation to consult with public

health before criminal charges are laid (e.g., ensure counselling has occurred, examine strategies other than criminal charges, educate about HIV/AIDS, share appropriate information).

7. **Develop informal guidelines for Medical Officers of Health** to help ensure public health uses the least invasive, least restrictive, most effective and most readily available way to assist those who are putting others at risk. The guidelines should include:
   - how people are identified to public health (i.e., the current methods of identifying people include routine public health follow-up; physician reporting, including subsequent reporting if there are indications that the person may be unwilling or unable; and reports from sexual or needle sharing partners.)
   - the indicators that a person may be putting others at risk (see appendix)
   - the factors to consider when choosing an intervention, taking into account individual circumstances (e.g., if a partner is fully informed and consents to risk activities, no coercive intervention should occur) and the interventions to be used before issuing a section 22 order (see appendix)
   - some discussion of the content of section 22 orders to ensure that they are the least invasive and least restrictive to achieve the desired behaviour change. The goal of a section 22 order written under the HPPA against a person with HIV should clearly be to prevent HIV transmission.
   - a sample section 22 order in plain language that would include explicit information about which activities are prohibited.
   - how to ensure people understand their right to appeal. For example, in addition to the statement in the order, the MOH could explain the person's right to counsel and provide the name and telephone number of their local community-based organization or the HIV/AIDS Legal Clinic telephone number.
   - the process to use after issuing a section 22 (e.g., appeals, end point, review)

8. **Complete a review of HIV-related Section 22 orders** to assess their use, effectiveness and outcome.

Legislative Recommendations

9. **Develop a new designation** under the HPPA to address life-long infectious diseases, which will be more effective in responding to long-term infectivity

and provide better protection for individual civil liberties than the current designations.

10. **Require pre- and post-test counselling** for all HIV testing. Add a section to the HIV laboratory requisition to be checked when pre-test counselling is complete.

11. **Amend section 34(1) of the HPPA on Physician Reporting of Unsafe Behaviour to Public Health** to remove ambiguity and allow physicians to report people who are engaging in unsafe behaviour to public health. Develop guidelines for physicians to assist them, including a statement on informing patients of reporting requirements.

12. **Amend behavioural counselling orders under section 22 of the HPPA** to allow for the issuing of behavioural counselling orders for the purpose of preventing HIV transmission.

Legal Clarifications

13. **Clarify the appropriateness of the use of the Mental Health Act** in situations where psychiatric issues inhibit the person with HIV from taking appropriate precautions. Reinforce that HIV status alone is not sufficient to invoke the use of the MHA.

14. **Develop a mechanism to allow Medical Officers of Health to share information about section 22 orders** and allow them to cross reference a person with HI v who may be unwilling or unable with previous section 22 orders.

15. **Develop a mechanism to share appropriate information between public health and the Ministry of the Attorney General** before any criminal charges.

16. **Resolve the conflict between the Health Protection and Promotion Act** and the **Municipal Freedom of Information and Protection of Privacy Act**.

Monitoring and Administration

17. **Conduct a review** two years after implementing the recommendations to evaluate the effectiveness of the changes and to identify any additional steps required to ensure a consistent process across the province and protect the rights of people with HIV.

18. **Provide appropriate financial resources** to implement the recommendations.