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Executive summary

Reports in this series

- 1 Executive summary
- 2 Understanding the law
- 3 Practice and procedure
- 4 Responsibility and public health
- 5 Identifying resources

Keeping Confidence is a qualitative research study that explores the perceptions of criminal prosecutions for HIV transmission among those providing support, health and social care services for people with HIV. The main findings of the study are described in detail in four focussed reports, listed in the box above. This executive summary gives information about the background and methods of the project, and provides an overview of key themes and findings, concluding with recommendations relevant to those planning and delivering services for people with diagnosed HIV.

BACKGROUND

In England and Wales, section 20 of the *Offences Against the Person Act (1861)* can be used to prosecute a person alleged to have recklessly transmitted HIV to a sexual partner. The number of successful prosecutions remains very low, as most cases that are initiated do not ultimately proceed to trial¹. Report 2 clarifies the specific evidence required to secure a conviction, and further information is given in relevant Crown Prosecution Service guidance². In other settings, terms such as ‘criminalisation’, ‘criminal prosecutions’, or ‘HIV and the law’ are sometimes used to refer to any prosecutions for a range of illegal behaviours implicated in HIV exposure (such as sex work or injecting drug use). However, this series of reports only uses these terms to refer to criminal prosecutions for the sexual transmission of HIV.

The intersection between HIV and the criminal law raises a number of questions directly relevant to people with diagnosed HIV and those who provide them with health and social care services. Existing social research from the UK offers insight into the way that men who have sex with men think about criminal prosecution for HIV transmission, including whether they agree with it and why³, and has described the views and reactions to prosecution among people with diagnosed HIV⁴⁻⁵. North American studies consolidate our understanding of the likely public health impact of criminalisation on those who are most likely to be involved in exposure⁶⁻¹⁰. Collectively, these studies indicate that criminalisation has a limited capacity to support HIV precautionary behaviour, such as enabling people to use condoms or disclose their HIV status to a sexual partner. It can also do considerable damage to principles of good sexual health, including: openness, mutual responsibility, and the reduction of HIV stigma.

Concern has also been raised about the extent to which criminal prosecutions for the transmission of HIV threaten the “relationship of trust and confidence between patients and healthcare professionals”¹¹. However, there has been little investigation into the extent to which criminal prosecutions impact on interactions between service users with HIV, and

service providers. Research recently undertaken in Canada has examined the way in which criminalisation impacts on service provision for people with HIV^{6,12-13}. Those findings demonstrated that service providers were often uncertain how to discuss criminalisation, that legal concerns served to erode trust in services, and some reported a shift toward HIV prevention advice framed within a universal moral obligation to disclose known HIV infection in all settings, irrespective of the degree of transmission risk.

The **Keeping Confidence** project set out to explore the specific ways that criminal prosecutions for HIV transmission in England and Wales are handled by those who deliver health and social care services for people with HIV. Specifically, we aimed to:

- Better understand how and when the topic of criminal prosecutions arose in the service setting, and the extent to which service providers felt adequately prepared and supported.
- Assess the perceived impact of criminalisation on provider capacity to deliver the best quality service.
- Establish the extent to which service providers felt that criminalisation had affected clients’ openness and trust within the service setting.

METHODS AND SAMPLE

Between August and December 2012, seven focus groups were conducted in England and Wales. Four were conducted with hospital-based staff in areas of contrasting higher and lower HIV prevalence. These groups comprised the full range of professionals who had contact with people with HIV as part of their diagnosis and ongoing clinical care, with only staff from that hospital in attendance. We refer to these variously as ‘clinical service providers’ or ‘clinicians’. We conducted three further focus groups with professionals from HIV charities, social care services, and other local organisations supporting people with diagnosed HIV. These groups were hosted in centrally accessible offices, or local HIV charities. In these groups invitations were

TABLE 1: A SUMMARY OF PARTICIPANT PROFESSIONAL CHARACTERISTICS

PARTICIPANT WORKPLACE		PARTICIPANT JOB ROLE	
HIV or sexual health clinic	48	Physician	21
HIV or sexual health VSO*	22	Nurse	15
Lesbian, gay, bisexual or trans VSO	3	Manager	10
BME or African VSO	3	Support worker	8
Local authority/social services	2	Health promotion specialist	6
GP or community health setting	1	Counsellor/psychotherapist	6
Acute health services/A&E	1	Outreach worker	5
Other hospital services	3	Social worker	3
Other	3	Administrator/receptionist	2
		Patient representative	2
		Public health specialist	2
		Midwife	1
		Other**	11

* Voluntary sector organisation

** Other job roles included: dietician; pharmacist; pharmacy technician, services advisor; clinical psychologist; director of services; peer support worker; team leader; student. Note that some participants ticked more than one workplace setting.

extended far beyond the host organisation, with the intention that the groups would capture a range of experience from across the community sector. We refer to those taking part in these groups as ‘community service providers’ as well as ‘non-clinical providers’. All participants were recruited to focus groups through professional contacts and local key stakeholders. A total of 75 people took part. They were asked to complete a form describing their workplace and job role, and a summary of these can be seen in Table 1. With regard to the range of organisations represented, participants worked in 12 different HIV charities, and 4 different hospitals or NHS Trusts.

Focus group participants were asked to describe their understanding of criminal prosecutions and they discussed the issue with service users. They were also asked to consider if, and how, such prosecutions had impacted on their clinical or social care (including record-keeping), their thoughts on the role of criminal prosecutions in the wider HIV public health debate, and to identify existing sources of information or resource need. It is worth noting that prosecutions for the transmission of HIV were not regularly at the forefront of the minds of many participants. As such, in a study that asks them to focus only on questions pertaining to this topic, it is difficult to extrapolate the extent to which such reflections emerge or influence their daily work routines. We have tried to offer evidence of this where it is available.

Focus groups lasted between one and one-and-a-half hours and were facilitated by the first four authors of this report series. With the consent of participants the discussions were digitally recorded and transcribed for analysis using NVivo 10. Ethical approval for this study was granted by the Research Ethics Committee of the London School of Hygiene & Tropical Medicine, and local research ethics approval was also obtained where necessary.

SUMMARY OF KEY FINDINGS

Understanding the law

One of the first issues explored in each focus group was the extent to which participants could describe the criminal law as

it relates to transmission of HIV. Accurate understanding of and ability to communicate about the law is an important skill for those who will be called upon to discuss the issue with service users. Many participants had a basic understanding of the conditions that could lead to a prosecution.

However, it was also clear that there remained significant confusion about the technical legal meaning of *recklessness*, and the specific precautionary behaviours that would provide a sufficient defence. There was considerable discussion about the extent to which a potential defendant’s use of condoms, or their maintenance of an undetectable viral load were sufficient to avoid a charge of recklessness. Others felt that disclosing HIV infection was the only means to avoid blame in such circumstances.

There were also instances, however, where participants’ understanding of the law was guided more by common sense and a sense of morality as it related to reckless behaviour, rather than being based upon a firm understanding of the law as it stands. Furthermore, there were others who declared that they did not feel confident in their knowledge of the law at all, and therefore they lacked confidence in managing the issue with service users.

Practice and procedure

There was considerable discussion in each group about the extent to which criminal prosecutions for HIV transmission arose with service users, and whether the topic influenced regular practices such as record keeping and communication about confidentiality. Given the varied nature of our groups, and the fact that we would anticipate a divergent set of routine practices in different types of settings, the findings related to practice and procedure are indeed varied. There were some participants (although few in number) who felt that criminal prosecutions for HIV transmission had not impacted greatly on their routine practices. Such individuals broadly felt that robust data management procedures and a user focus should always be at the centre of their work, and that such procedures were sufficient to support service users no matter what their circumstance.

This was not the experience described by all participants, however. Participants in each group described how they judged the best means of approaching the topic of criminalisation. They acknowledged this was complex information to convey, which needed to be well-timed and appropriately tailored for each individual, although there was a clear pattern that emerged between clinical and community-based service providers. Many clinicians described having a routine set of information that they were sure to pass on to those who are newly diagnosed with HIV, and information about criminal prosecutions was provided by all the HIV clinics where this research was undertaken. In contrast, community organisations frequently waited until a service user raised the issue before it was discussed, in order to avoid undue concern. Some participants did describe circumstances where behaviour that might put other people at risk of HIV acquisition might also prompt a professional to raise the topic.

When asked about experiences with service users who may be in a position to make a criminal complaint, the majority of

participants in all groups felt that this was unlikely to bring much benefit, and they generally sought to discourage it and to ensure that all other support needs are met. There were a small number who had supported, if not facilitated those who proceeded to make such complaints. With regard to their duty of care in cases where service users may be exposing others to the risk of harm, most participants described their primary function as helping to meet the needs of their patient or service user, and not their sexual partners. Conflicts did arise where both parties were service users at the same organisation, and various means of managing this were discussed.

When it came to record-keeping another clear pattern emerged. Those working in clinical settings described procedures whereby they frequently documented as much as possible to protect themselves from possible litigation, as well as to clearly document precautionary behaviours reported by patients. In contrast, those working in community-based organisations took additional caution with regard to what they did and did not record, and how sensitive information was stored, due to their consideration that any records could be requested by the courts.

Responsibility and public health

Whether prompted or unprompted, the themes of responsibility and protection of public health, as well as the public health impacts of criminalisation underscored most of the focus group conversations. With regard to responsibility, participants considered their own role as responsible professionals, in addition to reflections upon the responsibilities of those potentially involved in sexual HIV exposure. Some argued that as long as a person with diagnosed HIV has full awareness of how to prevent HIV, and is aware of the potential consequences, they should be primarily responsible for taking such precautions. However, this was a minority perspective in nearly all focus groups, with most participants arguing that responsibility was not uniform, and that it needed to be understood within specific circumstances that can constrain precautionary behaviour. These participants focused on the social structures which shaped the lives and experiences of people with HIV, such as pervasive social and economic inequality, power imbalance, HIV stigma and fears for safety and security. Some took this point further, arguing that consensual sex implied a shared responsibility for taking precaution against possible infection.

When discussing the idea of professional responsibility, there was considerable debate within the groups about the extent to which service providers owed a primary responsibility to the service user in front of them, or whether there was also a similar obligation to protect the health of others who may be at risk of infection. These debates about the practice of public health ethics among HIV health and social care service providers appeared in many cases to be the first time that such discussions were widely aired between colleagues, and we note that opportunities for this might be accommodated to some extent in team meetings. There may be further opportunities to explore the diverse views and values of staff members through the development of local policy and practice protocols related to criminal prosecutions for HIV transmission.

Despite descriptions of diverse viewpoints and practices, when asked about the public health outcomes resulting from criminalisation, no positive results were described. This would appear to be at odds with accounts by those who said they may recommend or facilitate criminal complaints, alongside those who described experiencing a conflict in their duties between a duty of care to their service user and to those at risk of acquisition. This suggests that some HIV service providers find that the availability of criminal prosecutions for the transmission of HIV can help to manage moral concerns about behaviour, by providing punishment for past transgressions. Yet it does not suggest that providers believe that criminal prosecutions support better public health. Thus it was most common to hear descriptions of criminal prosecutions leading to increased stigma, reduced trust between service users and providers, and traumatic consequences for those who get involved in such cases.

Identifying resources

In each of the focus groups, there were participants who identified practical professional resources and guidance documents that they had used to gain information about criminalisation, and some that were also of use for their service users. A full list of practical resources is given in Report 5 of this series. However, there were many taking part in the groups who had been previously unaware of documents and websites that may have been of help, underlining the need for improved dissemination. It is clear that in many HIV services, one or two colleagues are utilised as an 'in-house' information resource on the law.

Case management meetings, team discussions, and one-off training events were also mentioned by a range of participants as environments where colleagues had opportunities to find out more about case law, to explore ethics and duty of care with regards to breaches in confidentiality, and to discuss the management of complex or troubling cases. Many participants made it clear, however, that capacity for such discussions is limited in busy workplaces, although they maintained that it was important to ensure that there is time for future explorations of challenging topics in a supportive environment. The outcome of this should be improved confidence that they can provide clear information about prosecutions with service users in a way that best meets their needs.

A topic that arose in all of the focus groups was a clear lack of professional access to qualified legal advice from lawyers with criminal legal expertise in this area. Among those participants who had experience with emergent criminal cases, they felt that there was a dearth of information about who they could ask for relevant legal advice. The recommendations below focus directly on many practical interventions that should be relatively easy to implement at national, regional and local levels with the help of a few champions. With their implementation, it should be possible to improve access to clear information for service providers and their users, increase confidence to answer questions about the law and its limits, and contribute to the establishment of clear workplace policies and procedures addressing this topic that will enable service providers to feel professionally supported in carrying out their work.

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RECOMMENDATIONS

The following policy and practice recommendations arise from the study findings. Although specific actors have not always been identified to take forward every recommendation, we expect that consensus should quickly be reached in order to pursue any necessary funding to sustain these activities.

National recommendations

1. HIV service professionals will benefit from a single website or webpage that collates practical and accessible information about criminal prosecutions for the sexual transmission of HIV. It will need to be updated as new resources become available, and older ones are revised. New resources should be published as required in order to keep pace with clinical and scientific developments in the treatment of HIV that may impact on legal decision-making. The online resource can also identify the best sources of expert criminal legal advice where those are available.
2. A nation-wide programme of continuous professional development in the criminal law should be available to those who provide clinical and non-clinical HIV services. Topics covered should include: straightforward legal definitions and defence arguments, how and when to raise discussions about legal responsibilities, professional liability, communication skills development through the use of scenarios, and existing policy and practice models.
3. Key contacts with an interest in criminal prosecutions

should be identified in each clinical and non-clinical HIV service organisation. This process should feed into the development of an updated list for the explicit use of disseminating information about information and training discussed in recommendations 1 and 2 above. The key contacts will also be utilised as the main organisational contact for the development and dissemination of resources to inform people with HIV about the law in this area.

Local recommendations

4. Existing professional guidance and associated documents should be discussed and adapted for local use. This will translate differently in specific settings, and it may lead to the development of local criminalisation policies or protocols, or values statements in some workplaces. At a minimum, such activities should strive for internal consistency on advice, facilitation and support.
5. Opportunities should be created for clinics and community-based organisations to exchange best practice as it relates to criminal prosecution for HIV transmission and to discuss where they agree and disagree on a conceptual level about the ethics of responsibility and public health in HIV prevention.
6. Alongside the development of local criminalisation protocols, all organisations will need to review their confidentiality policies, ensuring that they are accessible to service users, and compatible with internal agreements about criminalisation.

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