Public Health, Criminal Law and HIV/AIDS

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Introduction

The interaction of public health goals relevant to HIV/AIDS and the law, especially the criminal law, is not ideal in Australia and is in need of urgent reform. The response needed is for appropriate, effective and humane laws to be enacted in various key areas. This need was recognised in 1989 in the Federal Government's National HIV/AIDS Strategy which gave the task of reviewing laws impacting on HIV/AIDS to a new body, the Legal Working Party (LWP), operating as a subcommittee of the existing Intergovernmental Committee on AIDS (IGCA) reporting to the Australian Health Ministers Advisory Council (AHMAC).

The Legal Working Party comprised of representatives from Commonwealth, state and territory Attorney-Generals' and Health Departments and during 1991-92 the following nine Discussion Papers were issued:

- Legislative Approaches to Public Health Control of HIV infection;
- HIV/AIDS and Anti-Discrimination Legislation;
- Legal Issues Relating to AIDS and Intravenous Drug Use;
- HIV/AIDS Prevention, Homosexuality and the Law;
- Legal Issues Relating to HIV/AIDS, Sex Workers and their Clients;
- Employment Law and HIV/AIDS;
- Civil Liability for Transmission of HIV/AIDS;
- Therapeutic Goods and HIV/AIDS - Quality and Availability of Condoms, HIV/AIDS Test Kits, Needles and Syringes; and
Each of the Discussion Papers contained preferred options for law reform to stimulate and focus public discussion resulting in consultations and submissions which were considered and debated before a Final Report was released in November 1992.

This paper will concentrate on areas where public health may be adversely affected by the existing criminal laws - state and territory, rather than Commonwealth, laws are relevant:

- the stigmatisation of risk behaviour - homosexual acts, prostitution and injecting drug use;
- compulsory HIV testing and other coercive public health powers; and
- liability for exposure to or transmission of the virus.

The significant negative impact of the criminal law is in undermining the confidence and trust of responsible people who are infected or at risk of infection in presenting early for counselling, testing and treatment for fear of punitive action being taken against them. Laws criminalising risk behaviour also have a chilling effect on service providers - health educators can be exposed to charges of aiding and abetting offences linked to prostitution, injecting drug use and homosexual acts.

**Homosexuality**

The LWP recommended that criminal penalties for homosexual acts between consenting adults in private be abolished. Only Tasmania has such offences, and it is facing increasing pressure to repeal them since a complaint was lodged by gay activists to the UN Human Rights Committee under the First Optional Protocol of the International Covenant on Civil and Political Rights. The LWP also recommended the repeal of Western Australia provisions which were enacted when homosexuality was decriminalised and state that it is "contrary to public policy to encourage or promote homosexual behaviour". They could be interpreted to have an even wider ambit in relation to HIV/AIDS education than aiding and abetting offences associated with the old prohibition of homosexual acts. One of the most surprisingly controversial recommendations of the LWP was that the age of consent should be consistent for homosexual and heterosexual activity. For some strange reason the Australian Medical Association (AMA) took this as promoting homosexuality, rather than removing a discriminatory anomaly.

**Prostitution**
There should be no doubt that criminalisation of the sex industry is forcing workers underground. The Queensland Criminal Justice Commission reported an 80 per cent drop in health checks at the Brisbane STD clinic following a clampdown on the sex industry with the Fitzgerald Commission of Inquiry. There have also been incidents involving the actual seizure of HIV/AIDS preventative measures (that is, condoms being seized by police) in some jurisdictions as evidence of prostitution-related offences. The LWP identified two key public health objectives in overcoming the historical moral myth of sex workers being "purveyors of disease":

- encouraging responsible behaviour by sex workers and their clients, with a focus (as with other business regulation) on management, thereby facilitating a culture of safer sex within the industry and generally improving working conditions; and

- enabling a free flow of information and education on preventive measures by removing fears on the part of workers, of police prosecution, scapegoating and harassment, and of self-identification as sex workers which makes targeted programs harder to reach them — public identification with the stigma of being a sex worker also makes it more difficult for workers to freely leave the industry, or come and go as they wished as in any other employment.

The LWP's three main recommendations dealt with decriminalisation, regulation of working conditions and HIV/AIDS and sex work — this last topic being the most controversial. Although the current incidence of HIV infection in the sex industry is low in Australia, with the only reported incidents of worker to client transmission occurring overseas, the LWP wanted to ensure that future infection was prevented for occupational health and safety reasons, as well as public health.

If decriminalisation did not occur immediately, then the LWP recommended that the evidentiary use of condoms or HIV/AIDS prevention materials be legislatively prohibited for any prostitution or town planning offences. (Queensland has taken this softer option, but has also given health service providers privilege against being compelled to testify in cases involving prostitution-related offences.) If governments chose to apply special laws to a decriminalised industry (for example, Victoria and the ACT) then the LWP recommended that no regulation should require identification or mandatory HIV testing of individual sex workers, and any controls placed on operators or owners should not be so onerous as to drive some sectors of the industry underground. Most submissions received by the LWP agreed
that any system of health checks were notoriously open to abuse, and unreliable even if authentic once further sexual or needle-sharing contacts have been made after a HIV-antibody test. There was also support for regulating working conditions for example, requiring management to supply free condoms and health information, and prohibiting employers from requiring a worker not to use condoms. Sex workers should be treated as employees for industrial benefits such as holiday and sick pay, as well as obligations such as taxation – deprivation of these basic rights were exploitative and promoted unsafe working conditions because of a lack of a system of protection.

The LWP recommended that the sex industry should not be targeted by specific offences relating to HIV-infection. (NSW has an offence for owners/occupiers allowing premises to be used for prostitution where a party is HIV-infected. The ACT has an offence for operators failing to take steps to ensure that workers are not HIV-infected.) Instead general public health offences of knowingly transmitting or significantly exposing others to HIV should be used for exceptional cases (which are applicable to both clients and workers, and whether sex is of a commercial nature or not). A more detailed discussion of such offences will follow later.

**Injecting Drug Users**

The early existence of needle and syringe distribution and exchange programs in Australia has significantly contributed to the low rate of HIV-infection among injecting drug users, especially compared to the dramatic epidemics in Southern Europe and North America. There is of course an inherent tension in this harm reduction approach of educating users how to safely inject illegal drugs. The effectiveness of the program needs legislative backing and also the support of operational police through directives from senior officers and training and liaison with public health authorities. The LWP made the following recommendations to facilitate the successful operation of exchanges:

- pharmacists and exchange workers should be legislatively protected (they are not in WA and Tasmania) against aiding and abetting charges for primary drug offences in relation to needle and syringe distribution and exchange, and related educational tasks using materials such as pamphlets and videos, and equipment such as bleach, swabs and sterile water. This protection should extend to a wide class of people genuinely engaged in the program such as intermediaries passing on and returning equipment to their associates;
- Offences for possessing needles and syringes should be repealed (NSW, Queensland, SA and Tasman have already done so) and other equipment possession offences (for example, smoking implements - these being safer than injecting) should be reviewed;

- Self-administration offences should be repealed (only Queensland does not have this offence). If not, then their operation should be limited to essential cases, with a general police directive being to refer cases for treatment instead of prosecution;

- Exchange operations could be improved by providing immunity for used needles and syringes stored in an approved container (Queensland and the NT have the opposite - an offence for unsafe disposal), and prohibiting the evidentiary use of sterile needles and syringes in drug-related proceedings. By restricting the former immunity to used equipment and latter evidentiary exception to sterile equipment, these protections would not be available to dealers; and

- Injecting drug users should be kept out of the prison system where possible because of the increased risk of HIV-infection in incarceration (see R v Bayliss, Roden J, unreported, NSW CCA, 3 November 1988) - legislation should enshrine the principles of non-custodial sentences for minor offences and remove mandatory sentences (for example, s.37(2) Misuse of Drugs Act 1990, NT).

Coercive Measures

Coercion is generally counter-productive when dealing with an epidemic where infectivity is life-long and no cure or vaccine has yet been developed. In protecting individual rights (for example, privacy and freedom from discrimination) collective good, that is public health, is served by gaining the co-operation and trust of people who are infected or at risk of infection. However, where interactive rights and responsibilities conflict in exceptional circumstances then there is a role for penal law in balancing and ordering them - if restrictions on human rights are clearly identified and publicised, then it is more likely that behaviour will be modified accordingly.

In cases where an alleged assault has occurred involving a real risk of HIV transmission the LWP recommended that two exceptional circumstances (amongst others) existed to justify coercive measures:
- firstly, unauthorised dissemination of the known HIV status of the person charged with the offence, where the survivor has requested this; and

- secondly, compulsory HIV testing either of blood already collected from the person charged for other purposes by health authorities, or court-ordered collection and testing of blood.

These recommendations are controversial because the interests of the accused and victim are finely balanced. The main reason for wanting to determine the accused's HIV-status is whether to commence or continue antiviral prophylactic therapy, because treatment with AZT sometimes has toxic side effects and there are increasing doubts as to whether it has any real effect on seroconversion. Another difficulty is that the information collected may not be reliable enough to act on anyway - an existing test result may be too old, that is the person has subsequently engaged in risk activity, or a court-ordered test may be too recent, that is there may be a false-negative result because the formation of antibodies usually takes three months from exposure to infection (the "window period").

In favouring victim's rights over the accused, the LWP was probably following a general trend to legislatively authorise blood sampling for police investigation purposes. In NSW, SA, WA and the ACT there is a general power to medically examine and in Queensland, Victoria, Tasmania and the NT a specific power exists to sample blood - in both cases there must be reasonable grounds for believing that it will provide evidence relating to the commission of an offence. In the HIV/AIDS context this could be relevant to transmission/exposure offences (discussed below) and general criminal offences such as sexual assault (R v Wright unreported, Tas S.C., Cox J, 27 September 1990, R v Barry, unreported, Qld CCA, 19 September 1990 and R v Malcolm [1988] Crim. LR 189) where HIV-infection could be an aggravating factor. Blood tests could possibly determine whether the accused was infected at the time of the offence, and (if consent is not the main issue) the identity of the attacker using DNA fingerprinting, that is PCR analysis of the virus' genetic sequencing profile. In the USA the urge to know the accused's HIV-status has had inconsistent results for the victim - voluntary tests have been used as a tool in plea bargaining, or the anxiety associated with the possibility of infection has tainted the jury's view of the accused who would otherwise be presumed innocent. There is also a danger in the accused's HIV-status being used in a discriminatory way for bail purposes - there have been reports of it being refused having reference to the anticipated acts of the accused on release and the possible effect on others in the community (R. Browne "People with
On the other hand, in general criminal matters HIV-status has been used by prisoners as a mitigating factor in sentencing, as would any health condition which may be adversely affected by imprisonment (R v Harris, unreported, NSW CCA O'Loughlin J, 27 October 1987; R v Smith (1987) 44 SASR 587; Linou v Hayes (1988) 47 SASR 172; Bailey v DPP (1988) 78 ALR 116 and cf R v Bailey (1988) 35 A Crim R 458).

Another circumstance justifying coercion in the LWP's view, not only in the form of releasing test results or compulsory testing, but court-ordered (or confirmed) restrictions on living circumstances and employment is the following recalcitrant behaviour:

- the person has in the past wilfully or knowingly behaved in such a way as to significantly expose others to the risk of infection;

- the person is likely to continue such behaviour in the future;

- the person has been unsuccessfully counselled about changing his or her behaviour; and

- the person presents a danger to others.

Such restrictions should be staged or graded so as to be the least restrictive alternative available in order to be effective (for example, submit to supervision by a nominated health professional or, as a last resort, civil detention).

Unfortunately most State and Territory public health legislation does not follow this model. Wide discretions are not structured at all in old legislation and NSW, Victoria and SA only have partial due process protection in their modernised legislation providing for various public health orders.

**Liability for Transmission/Exposure**

If the above coercive preventative measures are seen as exceptional cases, then punitive measures should be reserved for seriously culpable acts. Liability for exposure to, or transmission of, the virus can arise under specific public health legislation provisions and the general criminal law. Public health legislation is antiquated in some jurisdictions, having completely inappropriate offences designed for diseases having casual modes of transmission applied in a knee-jerk fashion to HIV/AIDS for example,
working in skin penetration, the food handling, clothing or drug industries; sharing accommodation; attending school; taking a bus.

Specific transmission/exposure offences exist in four jurisdictions. In NSW a HIV-infected person is prohibited from having sexual intercourse unless his or her partner has been informed of the risk of transmission and voluntarily consented. The Victorian and Queensland provisions cover only transmission of the HIV, but by any mode for example, sex, needle sharing etc. The Victorian provision covers reckless as well as knowing transmission, but provides a defence that the other party knew of and voluntarily accepted the risk of infection (this defence is limited to spouses in Queensland). In SA it is an offence to fail to take all reasonable measures to prevent transmission to others. The following features of an offence were recommended by the LWP:

- a person knows that he or she is HIV-infected - a strict liability offence would dispose of the need for mens rea, except for this element; and

- significant exposure or infection of another person occurs without his or her consent.

A full defence would exist for significant exposure where protective measures (as advised by health authorities from time to time) are insisted upon - probably the significant exposure element would not then exist, but this defence would make it abundantly clear. A lesser penalty would apply for actual infection where protective measures have been taken, but failed to prevent transmission. In both cases, safer sex or sterilising needles are promoted by the law and thus give an incentive to use them if HIV-infected people continue risk behaviour without informing their partners of their infection for fear of rejection.

One submission received by the LWP criticised having consent available to the parties because this was a licence to increase the community's health and welfare expenditure. The contrary is in fact true - draconian measures would drive the epidemic underground where it could grow exponentially.

It is essential that the effect of consent be clarified because of unsatisfactory authorities on the lack of distinction between consent to sex and consent to sex with a person who is HIV-infected. The old case of *R v Clarence* (1888 22 QBD 23) was revived recently in *R v Mobilio* ([1991] VR 333) because consent to sexual assault could only be vitiated by fraud as to the nature of the act itself. In Canada the principle was specifically applied to a HIV/AIDS case (*R v Lee*
Clarifying consent in the offence itself also avoids the general problem of not being able to consent to the infliction of actual bodily harm, especially where the circumstances alleged to aggravate assault are considered to affect public morality (R v Donovan [1934] 2KB 498) for example, homosexuality, prostitution and needle-sharing.

An important feature also recommended by the LWP was that charges under this offence could only be brought after approval by public health officials (rather than police) so that significant risk of exposure could be objectively evaluated (for example, to exclude spitting incidents) and cases could be individually assessed as to the appropriate form of staged interventions, that is preventive detention or other less coercive measures have not been successful. This feature attempts to avoid the situation which occurred in St Kilda (Melbourne) last year where police and public health officials were at loggerheads over inappropriate charges being laid against HIV-infected sex workers performing safe sex services for reckless endangerment.

The LWP did not recommend that special criminal laws (beyond public health offences) be applied to HIV/AIDS as existing general ones for murder, manslaughter, assault etc. were seen as adequate. If already stigmatised groups are further alienated by special, for example, "needle bandit" offences, then the community is given an unrealistic and hysterical impression of imminent danger. Unfortunately several jurisdictions have enacted such laws, but fortunately they have not become self-fulfilling prophecies. More important in the LWP's view was the abolition of the outdated "year and a day rule" (that is, the death of the victim must occur within a year of the alleged act) which ignores developments in modern science and forensic medicine and has been roundly criticised by general criminal law reform bodies.

A further recommendation of the LWP was that courts or tribunals be empowered to protect the identity of parties where HIV status is in issue because of the economic and social consequences of public exposure.

Victoria already has such a provision, but in a case last week of reckless endangerment involving a HIV-infected defendant and his former girlfriend, allegedly infected by him, the media unsuccessfully attempted to persuade the court not to issue suppression orders which would protect both parties from the public stigma associated with HIV/AIDS.

Conclusion
The HIV/AIDS epidemic has presented enormous national and international challenges to public policy. A rational response forces public policy makers into areas which have always been controversial because the stigma of illegality has been given to highly ingrained private behaviour. Legislators must deal calmly with issues of sex and drugs which have always been trivialised or sensationalised by the popular media.

The co-operative efforts over the past few years of Commonwealth, state and territory officials, and accompanying extensive community consultation and debate which has produced a practical reform agenda must not be neglected. The choice now lies with Australian Parliaments. While the consequences of inaction may be political controversy, the public health consequences of inaction are far more serious and far-reaching.

Reference