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INQUIRY INTO VICTORIA'S CRIMINAL JUSTICE SYSTEM
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Inquiry into Victoria's Criminal Justice System

A Joint Submission by Living Positive Victoria and Positive Women Victoria.

Mandatory Testing

In Victoria, informed consent is required for HIV testing in all but rare circumstances. The *Public Health and Wellbeing Act 2008* allows for mandatory testing of a person whose bodily fluids come into contact with caregivers or custodians. This includes a doctor, dentist, nurse, paramedic, pathologist, other health service employee or police. However, effective treatments mean that the vast majority of people living with HIV in Victoria have a low or undetectable viral load, making transmission unlikely or impossible in the types of circumstances covered by these laws.

This submission does not seek to trivialise the risks and trauma faced by emergency services workers who regularly encounter difficult and confronting situations. We do not condone assaults against emergency services personnel in any form, including spitting or biting, and condemn any intentional application of bodily fluids during an assault against an emergency services worker, regardless of HIV risk. We also note that, this is not an issue of 'us' and 'them'. The community of emergency service personnel is part of our community, and we are part of theirs (Bambridge & Stardust, 2018).

Unlike many occupations, policing and other emergency response work inherently involves engaging in difficult and dangerous situations in order to protect the health and safety of others. Although violence against emergency services workers may be increasing, the risk of HIV transmission is not. The odds of a first responder being exposed to HIV during their ordinary working lives are extraordinarily low. National surveillance data show there has not been a notification of HIV transmission in any occupational setting since 2002. In fact, there has never been a recorded case of occupational HIV transmission to a police officer in Australia, ever.

Fewer than 0.1% of the Australian population is living with HIV and HIV is not easily transmitted. There is no possibility of HIV transmission via contact with the saliva of a person living with HIV (including biting or spiting); no possibility of HIV transmission via contact with the saliva of a person living with HIV where the saliva contains a small quantity of blood (including biting or spiting); and negligible to no possibility of HIV transmission from biting where the person living with HIV's saliva contains a significant quantity of blood, and their blood comes into contact with a mucous membrane or open wound, and their viral load is not low or undetectable (Barré-Sinoussi, et al., 2018). This means that in effect, almost all emergency services officers will never come into contact with HIV in the course of their careers and, if they do, the chance of HIV transmission is either impossible or vanishingly small. Further, if against all the odds transmission of HIV was to occur, modern prevention treatments administered according to best practice in a timely manner would prevent seroconversion. Put simply, the risk of an emergency service officer becoming HIV positive through occupation related spitting or biting is so small as to be almost impossible in real world scenarios (Cameron, 2019).

Should a person actually be exposed to HIV, post-exposure prophylaxis (PEP) has a high success rate, preventing HIV from establishing itself in a person's body so that they do not become HIV positive. However, PEP's effectiveness at preventing transmission diminishes the longer someone waits to start the treatment. It is most effective if started within 72 hours of exposure. Further, in the context of modern treatment, the implications of living with HIV have been transformed, with the long-term health and quality of life of people living with HIV now drastically improved. Antiretroviral therapies have been so successful at preserving health and extending life that a person recently diagnosed with HIV who commences effective treatment will have an equivalent life expectancy to that of the HIV-negative general population (Barré-Sinoussi et al., 2018).

Victoria has a two-tiered system relating to the use of force to undertake blood testing. The Chief Health Officer has the power to make an examination and testing order or a public health order, but of particular relevance to this audit, under section 134, the Chief Health Officer also has powers to make an order if they believe that an incident has occurred where a 'specified infectious disease' could have been transmitted to a caregiver or custodian during the course of their duties. A specified infectious disease is currently defined as HIV, or any form of hepatitis which may be transmitted by blood or body fluid. Under Victorian law, an order must be in writing, must name the disease to be tested, and must be served before it takes effect. A person who is subject to a public health order may apply to VCAT for a review of the decision (s122). If the Chief Health Officer believes it is necessary to enforce an order, they may apply to the Magistrates' Court for an order to authorise a police officer to use reasonable force to take the person for testing, including to restrain the person to enable a medical practitioner to take a blood sample. Importantly, the section states the Magistrates' Court may make an order if satisfied that the circumstances are so exceptional that the making of an order is justified.

The *Public Health and Wellbeing Act 2008* requires the Chief Health Officer to "publish on a biennial basis and make available in an accessible manner to members of the public a comprehensive report on public health and wellbeing in Victoria". Victorian Department of Health and Human Services annual reports have routinely included details about the making of public health orders, showing that public health orders are only occasionally made or extended. Between July 2014 and June 2020, annual reports confirm that there had been no order for tests under section 134 after an incident has occurred. Therefore, making the legislation allowing mandatory testing to be unnecessary.

We would like it known that Victoria currently has the best model of dealing with mandatory testing within Australia. However, we could do better at appropriately dealing with HIV exposures to first responders. Exposure to communicable diseases should be dealt with by the department of health with appropriate reporting and transparency in place. This is to ensure that the person living with HIV is appropriately dealt with and linked into healthcare as well as preventative measures can be engaged for those exposed. The best course of action to prevent HIV transmission from an exposure is to immediately start PEP, and not to unnecessarily wait for testing.

Recommendation 1: The current mandatory testing provisions do not serve to protect those intended; caretakers and custodians. Waiting for the Chief Health Officer to determine whether or not there is a risk of transmission (with the above considerations it is highly unlikely they will think there is), and, furthermore, waiting for a magistrate to allow reasonable force to be used to undertake the test, will

waste precious time the person who is suspected to have been exposed from accessing PEP. If mandatory testing is truly about protecting those who may have been exposed, then it is much safer and effective to put that person on PEP than to wait for test results. Especially considering the mandatory testing laws are not currently being enforced and are an unnecessary part of the legislation.

Recommendation 2: All first responders should have a compulsory health literacy programme for relevant communicable diseases to ensure they have a stigma free understanding of the health risks involved and appropriate preventative options. This programme should also include compulsory vaccines for all communicable diseases that are available. In the event of exposure, PEP should be made readily available for first responders as the first line of prevention.

Dismantling Stigma of People Living with HIV

Not only are people living with HIV stigmatised by the general public, but they are also disproportionately mistreated within the Criminal Justice System. Police are much more likely to side with a negative person during domestic violence incidences when a person living with HIV's status is disclosed; people living with HIV receive higher penalties in cases involving assaults involving bodily fluids (even when the person living with HIV has an undetectable viral load) (HALC, 2012).

When dealing with sentencing of people living with HIV, there should always be a healthcare professional, or expert engaged who is well versed in the science regarding HIV and transmission risks. It is important for the risks of HIV transmission to be appropriately framed during proceedings. The risk of HIV transmission is often overstated and is used as a means of disproportionately punishing people living with HIV (HALC, 2012). This is not meant to diminish the severity of legitimate cases in which people living with HIV do put others at risk of HIV, but to appropriately frame those cases in which HIV is present, but not a significant risk factor.

It is important that all authority figures who deal with people living with HIV to have cultural training around what it means to live with HIV in an active effort to reduce and abolish stigma experienced by people living with HIV while engaged with the Criminal Justice System. We have found the best way to approach stigmatising perspectives is to present the lived experienced of people living with HIV alongside the science that is available which presents the reality of HIV transmissions and the risks involved.

Recommendation 3: All people of authority who deal with people living with HIV should undergo cultural and health literacy training for HIV. This training should be given, but not restricted, to police, prison staff, parole officers, judges, and mediators. In the absence of appropriate health literacy of HIV in court proceedings, an expert should be engaged to appropriately frame the context of HIV in the situation to ensure a person living with HIV is not unduly dealt with.

Care of People Living with HIV in Custody and Prison

Current treatments for people living with HIV are highly effective in reducing HIV to undetectable levels and preventing disease progression. Effective treatment now means that if someone's viral load is below 200 copies/ml then they are unable to transmit HIV to sexual partners (known as 'undetectable is untransmittable' or U=U), and the transmission of HIV in all contexts is considered to be reduced. To

maintain an undetectable viral load, daily medication is required. The consistency of this treatment is vital for people living with HIV to maintain their health. As such, the criminal justice system has a responsibility to care for those who are held in custody within the system.

If a person living with HIV is taken into custody, daily medication in line with their current treatment plan needs to be made readily available within the treatment timelines. Not only is consistent treatment important for people living with HIV to maintain their health, it is also important for maintaining future treatments. Inconsistency in treatment for people living with HIV has an increasing probability of developing a drug resistant strain of HIV. Drug resistance is a major problem for people living with HIV as being resistant to one drug makes the virus resistant to the whole class of drugs that it belongs to. Therefore, people living with HIV have increasingly diminishing returns from their healthcare each time their virus becomes resistant to a class of drugs. Furthermore, a person with a complicated treatment regime due to drug resistance will also generally have greater difficulty in maintaining an undetectable viral load. As such, they pose a greater risk to public health as they are more likely to transmit a drug resistant strain of HIV.

Similarly, for people living with HIV in prison. Although the healthcare of prisoners is taken care of by the state and not Medicare, it is important that people living with HIV have a consistent and considered treatment plan to avoid health concerns and drug resistance. If the Criminal Justice System is to have a reformative focus, rather than punitive, then being incarcerated or imprisoned should not have punitive effects on one's health or healthcare.

People living with HIV are often from communities in which multiple characteristics that are the subject of unacceptable discrimination and stigma are common. Thus, things like homophobia, racism, sexism and discrimination against people who use drugs often intersect with HIV related stigma and make it even more likely that people living with HIV in detention will suffer unjustifiable discrimination, from which they are in need of special protection, not least because while in detention, a person's ability to resist, report or prevent discrimination from State officers is curtailed.

Recommendation 4: People living with HIV require consistent treatment in order to maintain their health and minimise their risk of transmitting HIV. As such, people living with HIV must have readily available medications, that are in line with their current treatment plan, while incarcerated or imprisoned.

Recommendation 5: People living with HIV in detention or custodial settings should be given additional protection from discrimination and stigma on the basis of HIV and other intersecting protected characteristics. In particular, their access to appropriate HIV medication and care must be safeguarded and they must be given additional protection from racism, homophobia, transphobia, sexism and discrimination against people who use drugs.

Acknowledgments

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