



The  
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Society

Division of Clinical Psychology  
Faculty of HIV and Sexual Health

# Criminalisation of HIV transmission

*Guidelines regarding confidentiality and disclosure*

January 2009

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The inspiration for these guidelines emanated from a Faculty conference on the criminalisation of HIV transmission in December 2005.

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# Contents

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1. Introduction	2
2. Best Practice Guidelines	4
3. General issues regarding HIV disclosure	9
4. Dealing with police enquiries and disclosing information during criminal proceedings	10
5. Overview of legal and professional guidance	11
6. Conclusion	15
7. Useful internet resources	17
8. Conclusions	18

***Disclaimer:* This document aims to set out some basic general principles in relation to the criminalisation of HIV transmission. It does not constitute legal advice and it is recommended that specific legal advice is taken in circumstances where legal issues arise.**

## **1. Introduction**

Over the past few years, a number of people in the United Kingdom have been prosecuted for the reckless transmission of HIV. These convictions have created considerable social debate and commentary. The legal perspective is that reckless HIV transmission is a form of assault and that the prosecution of it will motivate HIV-positive individuals to reduce risky sexual behaviour. However, the concern from many working in the HIV field is that just the opposite may happen. It has been argued that these prosecutions will inadvertently perpetuate the disease by intensifying secrecy, stigma and shame for people living with HIV. It is also feared by some that prosecuting reckless HIV transmission will also deflect the need for shared responsibility of safer sex away from people who are not diagnosed with HIV. No doubt the debate regarding these recent convictions of reckless HIV transmission will continue. In the meantime, it is important to address issues relating to HIV criminalisation amongst HIV-positive individuals and their healthcare providers.

These guidelines on HIV confidentiality and disclosure have been developed to assist clinical psychologists in situations where HIV-positive clients have not disclosed their status to their sexual partners and there is a significant risk for HIV transmission. These guidelines have also been developed to assist clinical psychologists when clients believe they have contracted HIV under these circumstances.

It is important to clarify that these HIV transmission scenarios highlight an ethical dilemma that clinical psychologists already have considerable experience with: the conflict between a client's right to confidentiality and the public's right to safety. These dilemmas also occur in a variety of other clinical contexts such as child protection,

forensic settings and working with clients at risk of suicide or self-harm. The dilemma of considering the need for public safety in the light of maintaining client confidentiality has been an issue for all helping professions long before the emergence of HIV.

Ethical codes and professional guidelines have been in place for many years to assist clinical psychologists in their deliberations on these types of dilemmas (see BPS, 2006; DCP, 1995; DH, 2003). Therefore, health professionals and the public should be reassured that clinical psychologists already have considerable experience and professional guidance to assist them in responding appropriately in these situations.

Nevertheless, these guidelines have been produced because of the special concerns and unique features of this situation. Breaking a client's confidentiality is a most serious and critical consideration because client confidentiality is a cornerstone of effective professional psychological care. Therefore, it is our hope that these guidelines will serve to reinforce everyone's confidence in our ability to create a safe and trusting therapeutic space to discuss any personal and sensitive issue.

## 2. Best Practice Guidelines

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The following guidelines are provided to help clinical psychologists manage the complex situation when they discover their HIV-positive clients are engaging in risky sexual activity without disclosing their HIV-status to their partners.

- 2.1 When appropriate, clinical psychologists should discuss issues related to risky sexual behaviour, regardless of a client's HIV status. There is considerable benefit to everyone concerned if clinical psychologists can help clients recognise health risks to themselves and their sexual partners and to support clients in minimising these risks as best they can.
- 2.2 These discussions about safer sex should be documented in a client's notes. Such documentation should include a description of what was discussed, whether the client understood the information given, what barriers to safer sex were identified and any discussions on how they could be overcome. Clinical psychologists need to be aware that such documentation can be used in Court so it must be clear, comprehensive and accurate.
- 2.2 As part of these discussions, HIV-positive clients should be advised that failing to disclose their HIV status to their sexual partners prevents their partners from making fully-informed decisions regarding their sexual activity. Clinical psychologists are encouraged to assist their HIV-positive clients in identifying the circumstances when non-disclosure occurs. They should also help clients explore possible reasons for not disclosing their HIV status and identify all possible outcomes of non-disclosure.
- 2.3 It has been argued that focussing on the possible legal ramifications of not disclosing one's HIV status and then transmitting it to someone else may not serve any purpose other than to escalate fear. In fact, there is little scientific evidence that such discussions can actually promote behaviour change to safer sexual practices. In light of this,

encouraging all clients regardless of their HIV status to practice safer sex should be a priority for psychologists who work in this field.

- 2.4 HIV-positive clients who admit they sometimes engage in risky sexual activity without disclosing their status to their sexual partners should be made aware of the recent successful prosecutions of HIV transmission.
- 2.5 They should be advised that the risk of conviction for reckless transmission of HIV is minimal if they disclose their status before engaging in penetrative sex. Risk of conviction is significantly increased if they mislead or give false information to their sexual partners about their HIV status.
- 2.6 If a client diagnosed with HIV has already engaged in unsafe sexual activity and there was a reasonable chance that HIV was transmitted, then disclosure should be encouraged if it is possible so the other individual involved can access medical attention (for possible post-exposure prophylactic treatment).
- 2.7 Such discussions should only take place if HIV-positive clients inform you that they engage in unsafe sexual activity without disclosing their HIV status. Discussing how someone may be convicted of intentional or reckless transmission of HIV is anxiety-provoking and may not be therapeutic, especially if it is not relevant and appropriate. Such inappropriate discussions could actually compromise a client's willingness to discuss personal and sensitive issues in a safe and accepting therapeutic environment.
- 2.8 If an HIV-positive client informs you that s/he engages in sexual activity that carries a risk of transmission without disclosing his/her HIV status but there is no identifiable sexual partner, then you are under no legal or ethical obligation to breach your client's confidentiality. There must be an identifiable person who is at risk in order for you to act in the interest of public safety. Breaching your client's confidentiality when there is no identifiable person at risk

would only jeopardise your therapeutic relationship and place you at risk of disciplinary action.

- 2.9 If an HIV-positive client is engaging in risky sexual activity with an identifiable partner without disclosing her/his status, then the therapeutic agenda should focus on disclosure and risk reduction. HIV-positive clients may not disclose their status for many reasons, including fear of rejection, discrimination, violence, and assumptions about the other person's status. Likewise, there are many reasons why clients may not use condoms when having penetrative sex. For example, partners may refuse to use condoms or they may want to have children. These and other possible scenarios need to be identified and discussed with the client, followed by clear and appropriate documentation.
- 2.10 If such discussions have taken place and the HIV-positive client continues to place an identifiable sexual partner at risk by engaging in unprotected penetrative sex without disclosing his/her HIV status, then you need to consider your duty to warn this identifiable sexual partner. If you decide to breach your client's confidentiality, then the following steps are recommended:
- Consult with your team, service manager and supervisor.
  - Inform your client that you may have to inform the identifiable sexual partner that s/he may have been placed at risk. This frequently serves as a sufficient motivator for the client to disclose their status.
  - You may want to set a deadline for your client to disclose his/her status to this identifiable sexual partner and offer any appropriate support around this process (e.g. provide information, offer to disclose with your client present, etc.). Again, this may facilitate client-led disclosure.
  - If you end up having to inform this identifiable sexual partner by yourself, then seek guidance from your colleagues and supervisor. If you work within a sexual health clinic, discuss which team member is best suited to

make this disclosure (e.g. health advisor, keyworker, or medical doctor).

- If you end up notifying this identifiable sexual partner by yourself, then under no circumstances should you disclose the identity of your client to this individual. All you need to communicate is that s/he may have been placed at risk for contracting a serious sexually transmitted infection and should seek a sexual health screening.
- Your actions with your decision making rationale need to be documented in your client's records taking care to omit third party identifying details where possible.

2.11 There may be exceptional circumstances when you would not contact this identifiable sexual partner. If you believe your own HIV-positive client may be placed at risk of harm following disclosure to this individual, then you may choose not to breach your client's confidentiality (e.g. in a domestic violence situation). This situation should be discussed with the team and your Trust legal department.

2.12 While there appears to be no current precedent for doing so, there may be an enhanced duty to consider warning others at risk of HIV infection, given exceptional circumstances such as the following:

- If the identifiable sexual partner is also one of your clients, then you have the same duty to care towards both individuals. This situation is most likely to occur if you work as a psychologist within an HIV clinic.
- If the identifiable sexual partner is a child then there is a legal requirement to protect this child's welfare.
- If the identifiable sexual partner is a pregnant woman or a woman trying to become pregnant.
- If the individual engaging in high risk behaviour is not aware him/herself that he or she is HIV-positive (e.g. an HIV-positive adolescent who is becoming sexually active but whose parents have not yet informed them of their status. In this situation, the adolescent's sexual partners

are at risk for contracting HIV if methods of protection are not used).

- 2.13 When you find yourself in an ethical dilemma of considering a breach of your client's confidentiality, then you must discuss this with your manager within your multidisciplinary setting. If you work for an NHS Trust, you may want to consult with the risk management/legal department. If you work independently in a private setting, then you should discuss this with your clinical supervisor and you may want to contact the legal services associated with your professional organisation. You and/or your clinic may want to develop a strategy and policies to manage these situations to guide you in your deliberations.
- 2.14 Whatever the outcome is, you should clearly document what happened in your client's clinical record. Proper documentation includes detailed records of what your client told you as well as any advice you gave your client. You should also record how you made your decision to breach or not to breach your client's confidentiality. Proper documentation is a necessity as your clinical records could possibly be used in legal proceedings.
- 2.15 If your HIV-positive client believes that s/he was an injured party in a case of reckless or intentional transmission, then s/he will need both specialist legal advice and peer support. There are non-statutory support agencies (e.g. The Terrence Higgins Trust) that offer individual and group support on this issue. Making a referral to such a service would be appropriate. It is not within your remit or area of expertise to offer legal advice to your client.
- 2.16 In such circumstances, it is for your client to decide if s/he wishes to bring the issue to the attention of the police. Approaching the police yourself without seeking your client's consent would constitute a breach of his/her confidentiality and place you at risk of disciplinary action. Taking such action could also discourage others from seeking support on this issue.

### 3. General issues regarding HIV disclosure

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The following comments pertain to the general issue of disclosure in working with HIV-positive clients. We are indebted to the British HIV Association (BHIVA, 2006) for developing their guidelines for this type of work, many of which are included below.

- 3.1 Disclosing one's HIV status to others can be very difficult and anxiety provoking. Clients should be helped to understand that coming to terms with their diagnosis is intricately related to the process of disclosure. It is important that HIV-positive clients are given enough time and appropriate support according to their individual needs.
- 3.2 Disclosure can be related to a variety of personal and social factors. Clients who are struggling with low mood and diminished self-worth may find it quite difficult to take risks in disclosing their HIV status. Disclosure can also be related to financial independence and a settled immigration status. Therefore, disclosure is complicated, multifaceted and vulnerable to a variety of forces.
- 3.2 Disclosure should be seen as a process rather than an event. Clients need to be given support throughout this process, which may take longer for some individuals than others. It is important to know that the police and courts do not bear this in mind, as they tend to perceive disclosure as a single event. This makes for a conflict between good clinical practice on one hand and the possible legal position on the other.
- 3.3 It is important for the topic of disclosure to be revisited periodically with your client as circumstances change. Appropriate advice and support need to be made available as the legal context evolves on this topic.
- 3.4 HIV-positive clients should be given information about where they can seek additional information, support and guidance on living with HIV and issues such as disclosure. Where necessary, referrals should be made to the appropriate voluntary support agencies that provide useful information, conduct support groups and other worthwhile services.

## 4. Dealing with police enquiries and disclosing information during criminal proceedings

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- 4.1 Clinical psychologists should be aware that they are not under any legal obligation to disclose information to solicitors, police officers, or any other third party (e.g. partners) unless they receive informed consent from the client or a Court order.
- 4.3 Clinical psychologists must notify their service managers and senior management when they have been instructed by the Court to release information.
- 4.4 Wherever possible, clients should be made aware of any request by police for information about them and their situation.
- 4.5 If a client contracts HIV and intends to prosecute a sexual partner for transmitting it, appropriate psychological support must be given to the client in adjusting to the diagnosis and life with HIV. Such support includes learning about HIV, encouraging the client to receive medical care and exploring the possible advantages and disadvantages of pursuing legal action.

## 5. Overview of legal and professional guidance

The following ethical codes and professional guidance should be used in a clinical psychologist's deliberations on such a situation:

### 5.1 **British Psychological Society Code of Ethics and Conduct (2006)**

Section 1.2 (Standard of Privacy and Confidentiality) of the first Ethical Principle of Respect clearly sets out how to preserve a client's confidentiality. However point (v) emphasises that there are clear boundaries to confidentiality and that this is to be communicated to the client:

*Ensure from the first contact that clients are aware of the limitations of maintaining confidentiality, with specific reference to:*

*(a) potentially conflicting or supervening legal and ethical obligation;*

*(b) the likelihood that consultation with colleagues may occur in order to enhance the effectiveness of service provision.*

The clinical psychologist is invited to

*(vi) restrict breaches of confidentiality to those exceptional circumstances under which there appears sufficient evidence to raise serious concern about: (a) the physical safety of clients; (b) the safety of other person who may be endangered by the client's behaviour; or (c) the health, welfare, or safety of children or vulnerable adults.*

This restricted 'breach of confidentiality' is tempered by the need to

*(vii) consult a professional colleague when contemplating a breach of confidentiality, unless the delay occasioned by seeking such consultation is rendered impractical by the immediacy of the need for disclosure*

with the advice to

*(viii) document any breach of confidentiality and the reasons compelling the disclosure without consent in a contemporaneous note.*

## 5.2 **Division of Clinical Psychology Professional Practice Guidelines (1995)**

Similar to the Society *Code of Ethics and Conduct* (2006), Section 6 of the DCP guidelines affirms the need for clinical psychologists to recognise that ‘the legal duty of confidentiality refers to identifiable personal health information’. It also states that ‘clients are entitled to expect that the information they give to psychologists about themselves and others will remain confidential’.

However, strong emphasis is placed on clinical psychologists having a ‘duty to inform clients of their confidentiality standards of practice at their first point of contact’ (6.1.2). Such limits of confidentiality include circumstances where ‘health, safety or welfare of someone else would otherwise be put at serious risk’ (6.1.3).

Point 6.3.2 of ‘Disclosure in the public interest’ states

*Circumstances may emerge where clients may present a risk to others or to themselves ... It is then necessary to discuss the importance of disclosure and to encourage it, for example to partners of HIV positive clients ... In exceptional circumstances, disclosure without consent, or against the client’s expressed wish, may be necessary in situations in which failure to disclose appropriate information would expose the client, or someone else, to a risk of serious harm (including physical or sexual abuse) or death.*

## 5.3 **Confidentiality: NHS Code of Practice**

The NHS Code of Practice (DH, 2003) sets out a very limited range of circumstances which may justify disclosure of confidential patient information in the public interest. According to the Code, breaching confidentiality may be permissible in order to prevent and support detection, investigation and punishment of serious crime and/or prevent abuse or serious harm to others (page 28, paragraph 30).

In relation to ‘serious crime’ the Code states there is no clear definition other than murder, rape, manslaughter, treason, kidnapping and child abuse and other cases where individuals have suffered or could suffer serious harm.

The Code also states that wherever possible the issue of disclosure should be discussed with the individual concerned and consent sought. Where this is not forthcoming, the individual should be told of any decision to disclose against his or her wishes.

#### 5.4 **General Medical Council Guidance on Serious Communicable Disease (2002)**

Paragraph 22 and 23 of these guidelines state:

Personal information may be disclosed in the public interest, without the patient’s consent, and in exceptional cases where patients have withheld consent, where the benefits to an individual or to society of the disclosure outweigh the public and the patient’s interest in keeping the information confidential. In all cases where you consider disclosing information without consent from the patient, you must weigh the possible harm (both to the patient, and the overall trust between doctors and patients) against the benefits which are likely to arise from the release of information. You must not disclose information to others, for example relatives, who have not been, and are not, at risk of infection.

#### 5.5 **UK Psychologist Professional Liability Insurers**

The Society endorses the SMG Professional Risk Insurance Company which covers most UK clinical psychologists who seek extra professional insurance. Their legal advice is that unless clinicians are directed by the Courts to disclose information regarding a client’s HIV status, then they have no legal duty to disclose or warn the client’s partners, and that those partners would in turn have no grounds to sue clinicians for failure to warn.

## 5.6 Recent publications

Two recent publications have direct impact on how clinical psychologists should respond to these situations. The British HIV Association's briefing paper on *HIV Transmission, the Law and the Work of the Clinical Team* was circulated for consultation in the spring of 2006. Many of the recommendations for clinical practice have been adapted in developing the guidelines in this document. We strongly encourage all clinical psychologists working in sexual health and HIV familiarise themselves with this document.

The Department of Health's *Policy Consultation on Confidentiality and Disclosure of Patient Information: HIV and Sexually Transmitted Infections (STIs)* was also circulated in the summer of 2006, and the Faculty of HIV and Sexual Health submitted a response to it. It is anticipated that the outcome of this consultation will involve guidelines that will apply to all NHS services.

## 6. Conclusion

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There have been a number of prosecutions for the reckless transmission of HIV over the past few years in the United Kingdom. As a result, there is considerable and understandable anxiety regarding this issue both for clients and health professionals. Reflecting on the complexity of this continues to be an essential part of a clinical psychologist's role in managing and responding to these situations.

At this point, clinical psychologists working with HIV-positive clients are under no strict legal obligation to disclose knowledge that an HIV-positive client is engaging in unprotected penetrative sex without disclosing their HIV-positive status. Clinical psychologists are required by law to maintain as confidential such information except in certain limited circumstances and/or where the client has given consent to the disclosure.

However, a difficult situation arises if an HIV-positive client is not willing to explore this subject and continues to engage in unprotected penetrative sex. It then becomes an ethical dilemma that may need to be acted upon if a clinical psychologist learns the identity of a sexual partner who may be at risk of contracting HIV. This is a situation where a clinical psychologist may need to consider breaching client confidentiality.

These guidelines are intended to assist a clinical psychologist in making sense of how to respond to such situations. As a general rule, it can be rather difficult to justify breaching confidentiality when there is no legal requirement to do so. At present, no one in Britain has been professionally disciplined for failing to breach client confidentiality in the interest of public safety. Therefore, clinical psychologists who break confidentiality place themselves at risk of disciplinary action and getting sued in civil court by injured parties.

Clinical psychologists should not act alone in such situations. As with any ethical issue, clinical psychologists must consult with their colleagues, seek supervision from senior staff and act with their line manager's consent. The responsibility for breaking confidentiality in

the interest of public safety does not rest with any particular individual. The clinical team, service manager and NHS Trust management must share this responsibility.

## 7. Useful internet resources

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If you need HIV-related legal advice, consult with your colleagues in your clinical service and legal department in your trust. The following internet resources can also provide information and direction specifically on the criminalisation of HIV transmission.

Aidsmap (<http://www.aidsmap.com/en/docs/0507DD86-195A-4C28-9914-CF89AE147AA0.asp>)

British HIV Association (<http://www.bhiva.org/cms1191673.asp>)

Crown Prosecution Service  
(<http://www.cps.gov.uk/publications/prosecution/sti.html>)

National AIDS Trust (<http://www.nat.org.uk/document/419>)

Terrence Higgins Trust  
(<http://www.tht.org.uk/informationresources/prosecutions>)

UK Law & HIV/AIDS Project, Keele University  
([www.keele.ac.uk/research/lpj/Law\\_HIV-AIDSPROJECT](http://www.keele.ac.uk/research/lpj/Law_HIV-AIDSPROJECT))

UNAIDS ([http://data.unaids.org/Publications/IRC-pub02/JC733-CriminalLaw\\_en.pdf](http://data.unaids.org/Publications/IRC-pub02/JC733-CriminalLaw_en.pdf))

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